8x8, Inc.

8x8, Inc. Employee Benefits Plan

WRAP PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

PLAN NUMBER: 501

AMENDED AND RESTATED EFFECTIVE: January 1, 2022

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1. INTRODUCTION

The 8x8, Inc. Employee Benefits Plan (the "**Plan**") is an employee benefits plan maintained by 8x8, Inc. for the benefit of its Eligible Employees and any of its affiliates who are participating in the Plan with the approval of the Plan Sponsor. The participating employers and the Plan Sponsor are together referred to as the **"Employer**" or the **"Company."**

The Plan was originally established May 1, 2005. The Plan is hereby amended and restated effective January 1, 2022.

THE PLAN DOCUMENT

This document is the official "**Plan Document**" for the 8x8, Inc. Employee Benefits Plan. This document is established in accordance with the federal Employee Retirement Income Security Act of 1974, as amended ("**ERISA**").

The Plan Document sets forth the terms of the Plan and incorporates by reference ("wraps around") the policies, contracts, and other documents designated by the Plan Administrator for the Coverages described in Appendix A of this document. Further, the Plan incorporates by reference the provisions of the Company's Section 125 Plan Document applicable to the **Health Flexible Spending Account(s)** ("**Health FSAs**"), if any.

If the terms of a contract, policy, Evidence of Coverage (EOC), booklet or other document (collectively, "**Benefits Booklet(s)"**) prepared by a carrier or third party administrator conflict with the terms of the Plan Document, the Plan's terms will generally govern, to the extent permitted under applicable law.

THE SUMMARY PLAN DESCRIPTION

This document is also the official **Summary Plan Description** ("**SPD**") for the Plan. Employers sponsoring ERISA benefits are required to describe the terms of the plan and the coverages in an SPD. This document describes certain terms of the Plan, such as the eligibility rules, the types of benefits that are offered, and certain obligations of the Plan Sponsor and Plan Participants. However, the actual benefits under the Plan are described in accompanying materials that insurance carriers or benefit administrators have prepared and which this document wraps around. Those accompanying materials, referred to throughout this document as Benefits Booklet(s), contain important information about the Coverage available under the Plan. Therefore, this document, along with the Benefits Booklet(s) that apply to the Coverage(s) under the Plan, constitutes the Plan SPD (as that term is defined by ERISA).

In some cases, the Plan may update the SPD by using a separate document called a **Summary of Material Modifications** ("**SMM**"). Enrollment materials may include such updates and may represent an SMM for the SPD. Employees enrolled in the Plan should review, retain, and share all of these materials with their Dependent(s).

For ease of reference, this document is referred to as the SPD in the remainder of this document, although it also constitutes the official Plan Document.

KEEP YOUR RECORDS UPDATED

Make sure that the Company always has your current home address and phone number to correctly administer your benefits and to send you important Plan information.

GENERAL GUIDELINES

Not all Eligible Employees, as defined in Section 2, are Plan Participants. Coverage is contingent on completion of any necessary Forms including any salary reduction necessary to pay for your portion of the Coverage cost. All references to "**Forms**," in this SPD include any interface approved by the Plan Administrator by which you may submit or update information with the Plan, insurance carriers, or third party administrators. This may include, but is not limited to, paper Forms, on-line Forms, and telephonic data entry processes.

Some persons may be extended the opportunity of participating in this Plan, but may (as determined by the Employer) have declined participation (orally, in writing, or otherwise), which means that these persons are not Participants. A person may be excluded from the Plan under any provision set forth under the Plan.

An individual may be an Eligible Employee under the Plan, but not eligible to participate in all of the Coverages offered under the Plan. Specific eligibility rules may apply to eligibility for a particular Coverage and a person has no right to a particular Coverage unless he or she meets those specific eligibility rules. Eligibility for specific Coverages, as well as the amount, type, and duration of Coverage are determined in accordance with the terms of the Plan and/or applicable insurance contracts or policies, and the terms of enrollment of the particular Coverage. Eligibility for any specific Coverage is set forth in the applicable Benefits Booklet(s).

DOCUMENTATION

To verify eligibility for your family members, the Company, insurance companies and/or other third parties may request documentation needed to verify the relationship, including but not limited to: birth certificates, adoption records, marriage certificates, verification of domestic partnership, proof of adult dependent eligibility, disability, student status, and/or tax documentation.

In addition, the Company may request information from you regarding Medicare eligibility and enrollment, family member eligibility, address information, Social Security numbers, and more. You are required to promptly provide the requested information within the timeframe specified by the Company.

The Company reserves the right to de-enroll any family member from Coverage for failing to provide documentation when requested.

LOSS OF FAMILY MEMBER ELIGIBILITY

It is your responsibility to disenroll your ineligible family member from Coverage by notifying the Plan Administrator. If you do not provide notification, you may be liable for any excess costs and claims that should not have been paid by the Company or the Plan. Premiums will not be refunded if you do not

remove an ineligible family member from Coverage within the time required. In addition, enrolling or continuing coverage for an ineligible dependent could subject you to disciplinary action up to and including employment termination. If your dependent becomes ineligible for coverage during the year, you must contact the Plan Administrator within 30 days of the date that person becomes ineligible for coverage under the terms of the Plan.

See Section 8, "Continuation of Health Care Benefits," for information about continuing Coverage under COBRA.

TERMINATION OF COVERAGE FOR FRAUD OR INTENTIONAL MISREPRESENTATION

If the Plan covers an ineligible Dependent of an employee as a result of fraud or misrepresentation of fact, the employee may be subject to the Company's disciplinary actions, which may include the retroactive termination of the employee's or the employee's Dependent's Coverage, subject to applicable limitations under the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act (the "**Affordable Care Act**" or "**ACA**"). Fraud or intentional misrepresentation includes but is not limited to submitting falsified claims or covering an individual who is not eligible to participate in the Plan (for example, not informing the Plan Administrator about a divorce or enrolling a child who does not meet the Plan's definition of eligible Dependent). The Plan Administrator may also seek reimbursement for all claims or expenses paid by the Plan as a result of fraud or intentional misrepresentation, may reduce future benefits as an offset for amounts that should be reimbursed, and may pursue other equitable action against the employee. Moreover, the Company may pursue disciplinary action, up to and including employment termination, and may seek other legal or equitable remedies.

NO DUAL COVERAGE

If you and your spouse or domestic partner are both Company employees, you may each have single coverage or one of you may be covered as a dependent under your spouse or partner's coverage. That is, you may not cover each other as a dependent. Also, if you and your spouse or partner have a child(ren), only one of you may enroll the child(ren) in Company coverage.

THE PLAN YEAR AND COVERAGE PERIODS

The Plan Year is the 12-consecutive-month period starting each January 1. Certain Coverages may have a Coverage period that does not coincide with the Plan Year and certain Coverages may have a Coverage period that exceeds one year. When Coverage periods overlap more than one Plan Year, the Participant's payment for that Coverage will be paid at least annually and payments from one Plan Year will not be used to pay for benefits in a subsequent Plan Year.

2. ELIGIBILITY REQUIREMENTS

ELIGIBLE EMPLOYEE

All Active Employees, who qualify under one of the classes below.

- Regular Full-Time Employees: Employees designated by the Employer as Regular Full-Time Employees who are scheduled to work at least 20 hours per week. Coverage for Regular Full-Time Employees becomes effective on the date the Employee is employed as a Regular Full-Time Employee, subject to completion of enrollment requirements.

  An Employee's status as a Full-Time or Part-Time Employee will be determined on the basis of the average number of hours worked during an initial or standard measurement period, as applicable, as established by the Plan in accordance with applicable law. The Employee's eligibility (or lack of eligibility) for Plan coverage on the basis of his or her Full-Time or Part-Time status will extend through the stability period established by the Plan in accordance with applicable law. In calculating the average hours worked, the Plan will count hours paid and hours for which the Employee is entitled to payment (such as paid holidays, vacation, pay, etc.). An Employee's status as a Full-Time or Part-Time Employee will be determined on the basis of the Employer's standard employment practices.

  Your coverage may continue for up to six months during an approved temporary leave of absence.

All employees who were on the Plan effective March 1, 2020 will remain eligible for continued enrollment on the Plan despite any actively-at-work or minimum-hour requirements during the COVID-19 pandemic state of emergency that:

(a) the employee is on furlough or reduced hours furlough with an offer of medical benefits; or

(b) until the employee is able to return to work following an absence in order to provide care for an immediate family member or themselves related to COVID-19, or to provide primary care for children where there is no other viable childcare available due to the closure of schools or childcare centers related to COVID-19 precautions, whichever is longer.

Contact the Human Resources Department for additional information.

INELIGIBLE PERSONS

The term “Eligible Employee” does not include persons classified by the Employer as independent contractors or as being in one of the following ineligible categories, even if the classification is later deemed to be incorrect, except to the extent required under applicable law:

☒ Persons who are not regularly scheduled to work 20 hours per week as determined in accordance with the measurement periods under the ACA;

☒ Persons whom the Employer classifies as short-term, temporary employees, as employed to work on discrete projects, or as the equivalent (such as interns) to the extent permitted under the ACA;

☒ Persons who are working under a collective bargaining agreement that does not provide for their Plan participation;

☒ Foreign nationals the Employer classifies as employed under a formal or informal exchange program, except to the extent such individuals are working in the United States on an H-1B visa under circumstances that require them to be afforded Plan eligibility by Section 212(n) of the Immigration and Nationalities Act;

☒ Persons working for a non-participating employer that provides goods or services (including temporary employee services) to the Employer;

☒ Persons who are not classified by the Employer as its common law employees but who must be taken into account in testing the Plan for discrimination or for other statutory purposes;

☒ Persons whom the Employer has determined to have permanently ceased to render services but who it continues to treat as employees for certain purposes;

☒ Persons who are leased employees within the meaning of Internal Revenue Code (the "**Code**") Section 414(n);

☒ Persons who are classified as employed but do not reside within the United States;

☒ Persons who are resident, undocumented aliens;

☒ Persons who have committed fraud or intentional misrepresentation on the Plan; and

☒ Employees on unprotected, unpaid leaves of absence, persons whom the Employer classifies as being on unprotected, unpaid leaves of absence except to the extent the Employer, by written notice, elects to extend continued benefits during the leave or as provided under the Employer's leave of absence policy.

ELIGIBLE DEPENDENTS

A "**Dependent**" is any individual who may receive Coverage under the Plan because of that individual's relationship with a Participant.

The following are Eligible Dependents under the Plan:

- Your **Spouse**.

The term "Spouse" shall mean the person with whom the covered Employee has established a valid marriage under applicable State law.

The term "Spouse" shall also mean the person who is currently registered with the Employer as the Domestic Partner of the Employee. An individual is a Domestic Partner of an Employee if that individual and the Employee meet each of the following requirements:

- The Employee and individual are 18 years of age or older and are mentally competent to enter into a legally binding contract.
- The Employee and the individual are not married to anyone.
- The Employee and the individual are not related by blood to a degree of closeness that would prohibit legal marriage in the state in which they reside.
- The Employee and the individual share the same principal residence(s), the common necessities of life, the responsibility for each other's welfare, are financially interdependent with each other and have a long-term committed personal relationship in which each partner is the other's sole domestic partner.

- Your Child(ren). "**Child(ren)**" means your children up to age 26, or any age if permanently, totally disabled and chiefly dependent upon you for support and maintenance due to physical or mental incapacity provided the child was covered at age 26. Child(ren) includes:
  - biological or adopted children (including children placed in your home for adoption);
  - stepchildren and domestic partner's children;
  - children for whom you are responsible to provide health coverage under a **Qualified Medical Child Support Order** ("**QMCSO**");
  - children for whom you have been appointed by a court as legal guardian

  Children may be eligible for medical, dental, vision, other under the Plan until the end of the month in which they turn age 26 or until such age as mandated by any state law, or if disabled (as defined above), in which case Coverage may be extended beyond age 26. In order for your child to be covered under the Plan, you must also be enrolled for Coverage.

  If different rules apply to other benefits include: Children may be eligible for Voluntary Life & AD&D Coverage under the Plan until age 20 years (to 26 if full-time student).

3. HOW TO ENROLL

ELECTING COVERAGE

Your enrollment materials are sent to you electronically and are available on the 8x8 benefits website.

CHANGING COVERAGE MID-YEAR

In most cases, the elections you choose at open enrollment or when you otherwise are eligible to make elections for Coverage cannot be changed until the next open enrollment period. However, you may be

able to drop or add Coverage for yourself and/or for a Dependent during the Plan Year if you experience a status change or special enrollment event. See Section 6, “Making Changes To Your Elections” for details about status changes.

ABSENCES FROM WORK

Your Coverage will not be affected during paid absences such as paid sick days, weekends, vacation, and holidays. However, leaves of absence may result in termination of certain Coverages either because you cease to be an Eligible Employee under the terms of the Plan or cease to be eligible for the specific Coverage as described in the Benefits Booklet(s). Contact the Plan Administrator before you go on a leave of absence for information on benefit continuation.

PLAN ENTRY DATE

An Eligible Employee or Eligible Dependent with Coverage under the Plan is a “**Plan Participant**” or “**Participant.**”

Unless a Benefits Booklet provides otherwise, Coverages generally take effect:

- Immediately on the date of hire. You must enroll within 30 days after becoming eligible. Coverage for your Dependent(s) will begin on the same date, provided you enroll them within 30 days after becoming eligible.

If you experience a special enrollment event related to a new baby or adopted child, Coverage will start on the date of birth, adoption, or placement for adoption provided you enroll the child within 30 days of the date of the birth, adoption, or placement for adoption.

If you make changes to your elections for other reasons than birth or adoption during the year, Coverage will generally start on the first day of the month following the event as long as you make your election within 30 days of the date of the event. If you experience a “CHIP” or Medicaid special enrollment event, you will have 60 days to enroll in coverage.

WHEN PARTICIPATION ENDS

You will cease to be a Participant in the Plan as of the earliest of:

- the date on which the Plan terminates;
- the end of the Plan Year (unless you are enrolled in Coverage under the Plan for the next Plan Year);
- the date you cease to be an Eligible Employee under all Coverages under the Plan (see your Benefits Booklet(s) for termination applicable to specific Coverage);
- the end of the period for which you last made a required contribution for the cost of the Coverage; or
- the date the Plan Administrator terminates Coverage due to fraud or intentional misrepresentation to the Plan as described in Section 2.

Coverage for your Dependent(s) will generally end when your coverage ends or when the Dependent is no longer eligible for Coverage.

If your or your Dependents' Coverage is extended through applicable COBRA laws, different rules apply.

4. PAYING FOR COVERAGE

EMPLOYEE CONTRIBUTIONS

You and the Company share the cost of certain Coverages, as described in your enrollment materials. Your portion of the cost varies according to the benefits and Coverage levels (i.e., single, family, etc.) you elect. The cost of Coverage does not include your costs for any applicable deductibles, copays, out-of-network charges, or non-covered items.

Active employees generally pay their contributions for health benefits on a "pre-tax basis," that is, before any required income and employment taxes are deducted from their paychecks. In addition, contributions to any Health Flexible Spending Accounts are paid pre-tax. If you contribute to a Health Savings Account (HSA), your contributions are generally paid pre-tax for federal and state purposes. However, contributions to HSAs are subject to state taxes in California and New Jersey. This information is subject to change and the Company will advise, if necessary, if any change applies.

Paying for benefits on a pre-tax basis means that Social Security taxes will not be deducted for the pre-tax contribution. As a result, the earnings used to calculate your Social Security benefits at retirement will not include these payments. This could result in a small reduction in the Social Security benefit you may be eligible to receive when you become eligible for such benefits.

Contributions for retiree benefits, if any, are paid on an after-tax basis.

CONTRIBUTIONS DURING LEAVES OF ABSENCE

Employees on *paid* leaves of absence generally pay for Coverage on a *pre-tax* basis. Employees on *unpaid l*eaves of absence will generally pay on an *after-tax* basis during the leave. For information about Coverage during leaves of absence, contact the Plan Administrator.

TAXABLE COVERAGE FOR CERTAIN INDIVIDUALS

Coverage provided to "**Tax Dependents**" is generally not taxable under federal or state law. A Tax Dependent is a person who meets the definition of "Dependent" for purposes of tax-free health coverage under federal tax law. However, the cost of Coverage provided to an individual who is not a Tax Dependent (e.g., a Domestic Partner) may be taxed as imputed income for federal tax purposes. Certain states may exempt from taxation the cost of Coverage provided to Domestic Partners for state tax purposes. Contact your Employer if you believe that your Domestic Partner's benefits are exempt from federal and/or state taxes.

5. COVERAGE INFORMATION

The Plan includes the Coverages listed in Appendix A. For eligibility information, see Section 2.

BENEFITS BOOKLET(S)

The Benefits Booklet(s) for the Coverages in which you are enrolledare available on the 8x8 benefits portal.

The Benefits Booklet(s) describe the nature of covered services, such as:

- which services or benefits are payable;
- coverage of drugs, emergency care, preventive care, medical tests and procedures, and durable medical equipment;
- eligibility for services;
- exclusions and limitations;
- cost-sharing (e.g., deductibles and copayment amounts);
- annual and lifetime limits, if any;
- circumstances under which services or Coverage may be denied, reduced, or forfeited;
- procedures for obtaining services; and
- procedures for the review of denied claims and appeals.

PROVIDER NETWORKS

If you are enrolled in a health program that provides benefits through provider networks, a list of providers is available on the insurance carriers website. The website URLs are located in Appendix A of this document.

6. MAKING CHANGES TO YOUR ELECTIONS

GENERAL RULE

In general, an election for Coverage may not be changed during the Plan Year except as provided below. In addition, any election for benefits paid on an after-tax basis may be revoked or changed only to the extent permitted under the applicable insurance contract or policy as described in the applicable Benefits Booklet(s). This section describes the general election change rules permitted under the **Internal Revenue Code** ("**Code**") for benefits paid on a pre-tax basis, excluding Health Savings Accounts, if any. The Employer's cafeteria plan may set forth specific rules applicable to mid-year elections for Coverage available under the Plan.

CHANGE IN STATUS

You may prospectively revoke an election for the remainder of the Plan Year and, if desired, change or make a new election (if none was previously in effect) if the election is made on account of, and consistent with, the following events:

Life Events

The following are "change in status" events which permit an election change *if the event affects eligibility for benefits:*

- ***Legal Marital Status***
  A change in your legal marital status, including marriage, death of a Spouse, divorce, annulment, and legal separation.
- ***Domestic Partnership Status***
  A change in your domestic partnership status, including establishment or termination of the partnership.
- ***Number of Dependents***
  A change in the number of your eligible children, including by birth, adoption, placement for adoption, or death.
- ***Employment Status***
  A change in employment status for you or your Dependent(s), including by termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, or a change in worksite that affects eligibility for Coverage.
- ***Dependent's Satisfying (or Ceasing To Satisfy) Eligibility Requirements***
  A change in eligibility status of your children (e.g., due to age).
- ***Residence***
  A change in your place of residence or the residence of your Dependent(s) that affects eligibility for coverage.

Dependent Care FSA. You may change or terminate your election with respect to a Change in Status event for a Dependent Care FSA only if (a) such change or termination is made on account of and conforms with a Change in Status that affects eligibility for coverage under the Dependent Care FSA; or (b) your election change is on account of and conforms with a Change in Status that affects the eligibility of dependent care expenses for tax exclusion.

Other Changes Applicable to Group Health Plan Coverages

With respect to group health plan coverage, you may change your election:

- to comply with a Qualified Medical Child Support Order ("QMCSO");
- due to entitlement to or loss of eligibility for Medicare or Medicaid;
- if you or your Dependent(s)s become entitled to HIPAA special enrollment rights due to a newly acquired Dependent (through marriage, birth, domestic partnership, adoption, or placement for adoption) or loss of other medical plan coverage. If you or your Dependent is entitled to HIPAA special enrollment rights, as described in Section 9, you may revoke your prior election concerning medical coverage and make a new election. The election change must be requested within the timeframe stated in Section 3;
- due to a loss of coverage under a group health plan sponsored by a governmental or educational institution, for example a state children's health insurance program or certain Indian Tribal programs;
- due to a change in coverage under another employer plan, including a plan of your Spouse or Dependent's employer, so long as (a) the other cafeteria plan or qualified benefits plan permits its participants to make an election change permitted under IRS regulations; or (b) the Plan permits Participants to make an election for the Plan Year that is different from the plan year under the other cafeteria plan or qualified benefits plan;
- due to eligibility for Marketplace special enrollment period or annual open enrollment period, provided you and/or your Dependent(s) seek to enroll in a Qualified Health Plan through the Marketplace and that the Marketplace coverage is effective no later than the day immediately following the last day of your coverage under this Plan. This prospective election change applies to the Plan's medical Coverage only;
- if your work hours are reduced from 30 or more hours of service per week to less than 30 hours of service per week and you seek coverage in another plan that provides minimum essential coverage as defined by the Affordable Care Act. In this case, you may prospectively revoke or change your election with respect to your and your Dependents' medical Coverage. The reduction in hours does not need to affect your eligibility for the Plan's medical Coverage. The new coverage must be effective no later than the first day of the second month following the month in which your Coverage under this Plan is revoked;
- due to any other event allowed by the Employer and by the Internal Revenue Code and/or Treasury regulations.

ELECTION CHANGE PROCEDURES

In order for you to change your elections mid-year, you must submit your request to the Plan Administrator within the timeframes stated in Section 3. If the election form is not submitted as instructed within the required period, the election request may be denied. However, if the Plan Administrator determines that the failure to timely submit the election form was due to good cause or administrative error, the Plan Administrator may, if all affected insurance carriers agree, approve the Coverage change. In such case, it may be necessary to pay for the Coverage on an after-tax basis.

7. CLAIMS AND APPEALS PROCEDURES

This section provides general information on how to file a claim or appeal for benefits under an ERISA plan. Specific claim-filing information is described in the applicable Benefits Booklet(s). Some Coverages have special claims procedures such as voluntary appeals, arbitration, or mandatory external review process.

Be sure to review the Benefits Booklet(s) to determine which rules apply to specific Coverages. These rules will control over those outlined in this section to the extent they meet or exceed the applicable requirements under ERISA. You or your beneficiary must exhaust the Plan's reasonable claims procedures prior to bringing any court action to obtain Plan benefits.

The "**Claims Administrator,**" as referenced in this section, is the named fiduciary that serves as the final review committee and, in its sole discretion, has the authority to interpret Plan provisions as well as facts and other information related to claims and appeals. You will find the contact information for each Claims Administrator in Appendix A.

Where you submit your claim for benefits and the deadline for filing your claim depends on which benefits you are claiming. In some Coverages, the provider will file a claim for you if you go to a network or contracted provider. Otherwise, you will need to file a claim yourself. Generally, you should file a claim as soon as possible (even if you have not met your deductible, if applicable under such Coverage). If you do not file a proper claim within the particular Coverage's claim filing deadline, your claim for benefits will generally be denied. Contact the Claims Administrator listed in Appendix A if you would like further information about filing claims.

Your claim for benefits will be reviewed fairly and fully, and a decision will be made on your claim within the time period outlined in the "Claims and Appeals Timetable" below for the applicable Coverage and claim type following receipt of your review request. As described in the Claims and Appeals Timetable, if additional time is needed to render a decision, you will be notified of the reasons why the extension is needed and the date by which you may expect a decision.

If a claim must be decided before you can obtain health services and you failed to follow the proper claims procedures, you will be notified of the failure as soon as possible but no later than 24 hours for urgent care claims and 5 days for pre-service claims after your claim was received by the Claims Administrator. The notice will describe the proper procedures for filing a claim. The time period only

applies if your request is made to the proper person and the request names the claimant, his or her specific medical condition or symptom, and the specific treatment, service, or product being requested.

Sometimes additional time is needed to decide a claim. If an extension is needed, you will be notified before the end of the initial claims period described in the Claims and Appeals Timetable below and within 24 hours for urgent care claims. The notice will tell you why the extension is necessary and when the Claims Administrator expects to render a decision. If an extension is necessary because you failed to submit required information, the notice will specify what information is needed and you will have at least 45 days (48 hours for urgent care claims) to provide it. You will be notified of the Claims Administrator's decision within 15 days (48 hours for urgent care claims) after the receipt of the additional information for health claims, within 30 days for disability claims, and within 90 days for other claims. If you are providing additional information, the decision will be made within 15 days (30 days for disability claims and 48 hours for urgent care claims) after the information is received or the deadline to provide the additional information passes, whichever is sooner.

Once the Claims Administrator for the particular Coverage reviews your claim, they will approve or deny the claim, in whole or in part. If your claim is approved, benefits will be paid either to you or on your behalf.

IF YOUR CLAIM FOR BENEFITS IS DENIED

For purposes of the claims and appeals procedures, a denial is defined as a denial as well as reduction, termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Participant's or beneficiary's eligibility to participate in the Plan. The definition also includes determinations regarding group health claims based on utilization review, experimental and investigational exclusions, and medical necessity.

In addition, if the medical plan is non-grandfathered, a denial includes any rescission of coverage whether or not the rescission has an adverse effect on any particular benefit at the time.

If your claim for a benefit payment is denied, you will receive a written notice of denial from the Claims Administrator within the applicable time period outlined in the Claims and Appeals Timetable below.

HOW TO REQUEST REVIEW OF A DENIED CLAIM

If you do not agree with the claim decision made by the Claims Administrator, you or your authorized representative may request that your claim be reviewed by the Claims Administrator or other entity that denied your claim in accordance with the reasonable claims procedures described in the applicable Benefits Booklet(s). Contact information for the Claims Administrators is available in Appendix A.

Unless the applicable Benefits Booklet(s) provides otherwise, you must file your written request for review of any group health coverage or disability coverage claims for benefits within 180 days after you receive the written notification of benefit denial. All other written requests for review must be filed within 60 days after you receive the written notification of benefit denial (unless the applicable Benefits

Booklet(s) provides otherwise). Your request for review must be in writing and must include the information required in the notice of denial.

During the time limit for requesting an appeal, upon request and free of charge you will be given reasonable access to and copies of all documents, records, and other information (other than legally or medically-privileged documents) relevant to your claim for benefits.

The party considering the appeal of a group health or disability claim will not give deference to the initial claim denial and the review will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the initial adverse benefit determination nor his or her subordinate. Additionally, if a group health coverage or disability coverage determination is based in whole or in part on a medical judgment (including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate), the fiduciary deciding the appeal will consult with an appropriate health care professional who was not consulted during the initial adverse benefit determination and is not subordinate to a professional consulted during the initial adverse benefit determination.

Upon your request, the Claims Administrator will identify any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the denial without regard to whether the advice was relied upon in making the benefit determination.

NOTICE OF DECISION ON APPEAL

If the Claims Administrator determines that your explanation and additional information support the payment of your claim, the Claims Administrator will process your claim in accordance with the reasonable claims procedures described in the applicable Benefits Booklet(s). Benefits are generally paid to you or your beneficiary unless, in the case of a group health coverage, the provider notifies the Claims Administrator that you have authorized payment of benefits directly to that provider.

If the original denial is upheld in whole or in part, you will receive a written notice within the time period outlined in the Claims and Appeals Timetable below.

Non-grandfathered medical plans are subject to additional internal claims and appeals procedures under the ACA, including the requirement to provide an opportunity for external review of decisions involving a coverage rescission or medical judgment. See the Benefits Booklet(s) for the specific requirements and procedures that your medical Plan will follow.

CLAIMS AND APPEALS TIMETABLE

Type of Plan	Type of Claim	Timing for Claim Decision	Timing and Notification of Appeal Decision(s)
▪ Medical ▪ Dental ▪ Vision ▪ Health Flexible Spending Account ▪ Employee Assistance Plan	Urgent Care Claims	As soon as possible, taking into account the medical exigencies, but not later than **72 hours** after receipt of your claim by the Claims Administrator. This notice may be given to you orally within the applicable time period and a written or electronic notice will follow within 3 days of such oral notice.	As soon as possible, taking into account the medical exigencies, but not later than **72 hours** after receipt of your request for review by the Claims Administrator.
	Pre-Service Claims	Within a reasonable period of time appropriate to the medical circumstances but not later than **15 days** after receipt of your claim by the Claims Administrator unless an extension of up to an additional **15 days** is necessary due to matters beyond the control of the Claims Administrator.	A reasonable period of time appropriate to the medical circumstances, but not later than **30 days** after receipt of your request for review by the Claims Administrator.
	Post-Service Claims	Within a reasonable period of time, but not later than **30 days** after receipt of your claim by the Claims Administrator unless an extension of up to an additional **15 days** is necessary due to matters beyond the control of the Claims Administrator.	A reasonable period of time, but not later than **60 days** after receipt of the request for review by the Claims Administrator.
	Concurrent Care Claims	An extension of a course of treatment will follow the pre-service, post-service, or urgent care procedures above, but a claim for urgent care continuation submitted **24 hours** before the end of the approved course of treatment must be processed within **24 hours** instead of **72 hours**.	An appeal for an extension of a course of treatment will follow the pre-service, post-service, or urgent care procedures above.

Type of Plan	Type of Claim	Timing for Claim Decision	Timing and Notification of Appeal Decision(s)
▪ Long Term Disability Insurance ▪ Short Term Disability Insurance	Initial Claim	Within a reasonable period of time, but not later than **45 days** after receipt of your claim by the Claims Administrator unless an extension of up to an additional **30 days** is necessary due to matters beyond the control of the Claims Plan Administrator.	A reasonable period of time, but not later than **45 days** after receipt of your request for review by the Claims Administrator. It may be extended for an additional **45 days**.***

Other Benefits	Type of Claim	Timing for Claim Decision	Timing and Notification of Appeal Decision(s)
All Eligibility Determinations* and Other Benefits	Initial Claim	Within a reasonable period of time, but not later than **90 days** after receipt of your claim by the Claims Administrator.	A reasonable period of time, but not later than **60 days** after receipt of the request for review by the Claims Administrator. It may be extended for an additional **60 days**.**

*If an eligibility determination is part of a benefit claim, the rules and timing applicable to that type of claim will apply.
**Upon written notice explaining the special circumstances that create a need for an extension.
*** If, prior to the end of the first 30-day extension period, the administrator determines that, due to matters beyond the control of the plan, a decision cannot be rendered within the first extension period, the period for making the determination may be extended for up to an additional 30 days.

8. CONTINUATION OF HEALTH CARE COVERAGE

COBRA COVERAGE

INTRODUCTION

This section generally explains coverage, when it may become available to you and your family, and what you need to do to protect your rights to receive it. COBRA coverage applies only to the health Coverages offered under the Plan. Additional information is provided in the Company's General Notice of COBRA Continuation Rights which is provided to Eligible Employees upon enrollment in the Plan.

COBRA coverage is a continuation of health coverage to which you may be entitled due to a "qualifying event." Specific qualifying events are described below in the section entitled "Who Is Entitled to Elect COBRA?"

COBRA COVERAGE MAY BECOME AVAILABLE TO "QUALIFIED BENEFICIARIES"

After a qualifying event occurs and any required notice of that event is properly provided to the Company, COBRA coverage must be offered to each person losing Plan Coverage who is a "qualified beneficiary." You and your Spouse and your children could become qualified beneficiaries and would be entitled to elect COBRA if Coverage under the Plan is lost because of the qualifying event.

COBRA-LIKE CONTINUATION COVERAGE FOR DOMESTIC PARTNERS

Although Domestic Partners are not qualified beneficiaries under COBRA, the Company currently provides COBRA-like continuation coverage to Domestic Partners and their children who were covered under the health Coverages when group coverage would otherwise have been lost.

In this is section, whenever the term:

- Spouse is used and wherever "qualified beneficiary" when referring to a Spouse is used, the term "Domestic Partner" as defined by the Plan generally applies.
- Whenever the terms "child" or "children" are used, or wherever "qualified beneficiary(ies)" when referring to a child or children is used, the child/children of the Domestic Partner also generally applies.
- Wherever the term "divorce" is used, termination of domestic partnership also generally applies.
- Wherever the term "COBRA continuation coverage" is used, COBRA-like continuation coverage also generally applies.

However, be aware that certain insurance carriers and HMOs may not allow continuation coverage for Domestic Partners or their children. Check with your carrier for more information.

COBRA COVERAGE FOR THE HEALTH FSA

COBRA coverage under the Health FSA, if available under the Plan, will be offered only to qualified beneficiaries losing coverage who have under-spent accounts (that is, those who have not exhausted their annual election amount). A qualified beneficiary has an under-spent account if the annual limit

elected by the covered employee, reduced by the reimbursable claims submitted up to the time of the qualifying event, is equal to or more than the amount of the premiums for Health FSA COBRA coverage that will be charged for the remainder of the Plan Year.

When Health FSA COBRA Coverage Ends

COBRA coverage will consist of the Health FSA available balance minus outstanding claims at the time of the qualifying event. The "use or lose" rule will continue to apply, so any unused amounts will be forfeited at the end of the Plan Year when COBRA coverage will terminate.

WHO IS ENTITLED TO ELECT COBRA?

QUALIFYING EVENTS FOR THE COVERED EMPLOYEE

If you are a covered employee, you may elect COBRA if you lose your group health Coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

QUALIFYING EVENTS FOR SPOUSES

If you are the spouse of an employee, you will be entitled to elect COBRA if you lose your group health Coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct; or
- You became divorced or legally separated from your spouse. Also, if your spouse (the employee) reduces or eliminates your group health Coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce or separation.

QUALIFYING EVENTS FOR CHILDREN

If you are the child of an employee, you will be entitled to elect COBRA if you lose your group health Coverage under the Plan because any of the following qualifying events happens:

- Your parent-employee dies;
- Your parent-employee's hours of employment are reduced;
- Your parent-employee's employment ends for any reason other than his or her gross misconduct;
- You stop being eligible for Coverage under the Plan.

ELECTING COBRA AFTER FMLA LEAVE

Special rules apply if an employee does not return to work at the end of a Federal **Family and Medical Leave Act** ("**FMLA**") leave. Some individuals may be entitled to elect COBRA even if they were not

covered under the Plan during the leave. Contact the Company for more information about these special rules.

Special second election period for certain Eligible Employees who did not elect COBRA

Certain employees and former employees who are eligible for federal trade adjustment assistance (TAA) or alternative trade adjustment assistance (ATAA) are entitled to a second opportunity to elect COBRA for themselves and certain family members (if they did not already elect COBRA) during a special second election period of 60 days or less (but only if the election is made within six months after Plan coverage is lost). If you are an employee or former employee and you qualify for TAA or ATAA, contact the Company promptly after qualifying for TAA or ATAA or you will lose any right that you may have to elect COBRA during a special second election period.

Individuals who are eligible for TAA and ATAA and eligible PBGC pension recipients may be entitled to a Health Coverage Tax Credit (HCTC) to pay a portion of COBRA or other qualified health insurance premiums. Coverage through the Health Insurance Marketplace is not eligible for the HCTC and individuals will not be able to claim both the HCTC and a premium tax credit for the same months.

Contact the Company for more information about the special second election period and the HCTC.

WHEN IS COBRA COVERAGE AVAILABLE?

When the qualifying event is the end of employment, reduction of hours of employment or death of the employee, the Plan will offer COBRA coverage to qualified beneficiaries. You do not need to notify the Company of any of these qualifying events.

NOTIFY THE COMPANY OF CERTAIN QUALIFYING EVENTS

For the other qualifying events (divorce or legal separation of the employee and spouse or a child's losing eligibility for coverage), a COBRA election will be available to you only if you notify the Company in writing within 60 days after the later of (1) the date of the qualifying event or (2) the date on which the qualified beneficiary loses or would lose coverage under the terms of the Plan as a result of the qualifying event.

NO COBRA ELECTION UNLESS YOU FOLLOW THE PLAN'S NOTICE PROCEDURES

You must follow the procedures specified in the section below entitled “Notice Procedures.” If these procedures are not followed or if the notice is not provided to the COBRA Administrator during the 60-day notice period, YOU WILL LOSE YOUR RIGHT TO ELECT COBRA.

ELECTING COBRA COVERAGE

HOW TO ELECT COBRA

To elect COBRA, you must complete the COBRA election form that is part of the Plan's COBRA election notice and mail or hand-deliver it to the COBRA Administrator as instructed in the form. An election notice will be provided to qualified beneficiaries at the time of a qualifying event.

DEADLINE FOR COBRA ELECTION

If mailed, your election must be postmarked no later than 60 days after the date of the COBRA election notice provided to you at the time of your qualifying event (if later, 60 days after the date that Plan Coverage is lost). If hand-delivered, your election must be received by the individual at the address specified on the election form. IF YOU DO NOT SUBMIT A COMPLETED ELECTION FORM BY THIS DUE DATE, YOU WILL LOSE YOUR RIGHT TO ELECT COBRA.

INDEPENDENT ELECTION RIGHTS

Each qualified beneficiary will have an independent right to elect COBRA. Any qualified beneficiary for whom COBRA is not elected within the 60-day election period specified in the Plan's COBRA election notice WILL LOSE HIS OR HER RIGHT TO ELECT COBRA COVERAGE.

SPECIAL CONSIDERATIONS IN DECIDING WHETHER TO ELECT COBRA COVERAGE

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse’s plan), even if that plan generally doesn’t accept late enrollees.

LENGTH OF COBRA COVERAGE

The COBRA coverage periods described below are maximum coverage periods. COBRA can terminate coverage before the end of the maximum coverage period for several reasons, which are described below.

DEATH, DIVORCE, LEGAL SEPARATION, OR CHILD'S LOSS OF ELIGIBILITY

When Plan Coverage is lost due to the death of the employee, the covered employee's divorce or legal separation, or a child's losing eligibility, COBRA coverage under the Plan's health care Coverages can last for up to a total of 36 months.

MEDICARE ENTITLEMENT BEFORE TERMINATION OF EMPLOYMENT OR REDUCTION OF HOURS

When Plan Coverage is lost due to the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage for qualified beneficiaries other than the employee who lose Coverage as a result of the qualifying event can last until up to 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight months before the date on which his or her employment terminates, COBRA coverage for his or her spouse and children who lost Coverage as a result of his or her termination can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months

minus eight months). This COBRA coverage period is available only if the covered employee becomes entitled to Medicare within 18 months BEFORE the termination or reduction of hours.

TERMINATION OF EMPLOYMENT OR REDUCTION OF HOURS

When Plan Coverage is lost due to the end of employment or reduction of the employee's hours of employment, COBRA coverage under the Plan's health Coverages generally can last for only up to a total of 18 months (except for the Health FSA).

EXTENSION OF MAXIMUM COVERAGE PERIOD

If the qualifying event that resulted in your COBRA election was the covered employee's termination of employment or reduction of hours, an extension of the maximum period of Coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify the COBRA Administrator of a disability or a second qualifying event in order to extend the period of COBRA coverage. Failure to provide notice of a disability or second qualifying event will eliminate the right to extend the period of COBRA coverage. The period of COBRA coverage under the Health FSA cannot be extended under any circumstances. These extension opportunities also do not apply to a period of COBRA coverage resulting from a covered employee's death, divorce, or legal separation or a child's loss of eligibility.

DISABILITY EXTENSION OF COBRA COVERAGE

If a qualified beneficiary is determined by the Social Security Administration (SSA) to be disabled and you notify the COBRA Administrator in a timely fashion, all of the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the covered employee's termination of employment or reduction of hours. The disability must have started at some time before the 61st day after the covered employee's termination of employment or reduction of hours and must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months, as described above). Each qualified beneficiary will be entitled to the disability extension if one of them qualifies.

YOU MUST NOTIFY THE COBRA ADMINSTRATOR OF A QUALIFIED BENEFICIARY'S DISABILITY

The disability extension is available only if you notify the COBRA Administrator in writing of the SSA's determination of disability within 60 days after the latest of:

- the date of SSA’s disability determination;
- the date of the covered employee’s termination of employment or reduction of hours; and
- the date on which the qualified beneficiary loses or would lose Coverage under the terms of the Plan as a result of the covered employee’s termination of employment or reduction in hours.

No disability extension will be available unless you follow the Plan's notice procedures and meet the notice deadline. If these procedures are not followed or if the notice is not provided to the COBRA

Administrator during the 60-day notice period and *within 18 months* after the covered employee's termination of employment or reduction of hours, THEN THERE WILL BE NO DISABILITY EXTENSION OF COBRA COVERAGE.

SECOND QUALIFYING EVENT EXTENSION OF COBRA COVERAGE

An extension of coverage will be available to spouses and children who are receiving COBRA coverage if a second qualifying event occurs during the 18 months (or, in the case of a disability extension, the 29 months) following the covered employee's termination of employment or reduction of hours. The maximum amount of COBRA coverage available when a second qualifying event occurs is 36 months from the covered employee's termination of employment or reduction of hours. Such second qualifying events may include the death of a covered employee, divorce or legal separation from the covered employee, or a child's ceasing to be eligible for coverage as a Dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. This extension is not available under the Plan when a covered employee becomes entitled to Medicare after his or her termination of employment or reduction of hours.

- **You must notify the COBRA Administrator of a second qualifying event.** This extension due to a second qualifying event is available only if you notify the COBRA Administrator in writing of the second qualifying event within 60 days after the date of the second qualifying event.
- **You must follow the Plan's notice procedures and meet the notice deadline.** You must follow the notice procedures specified by the COBRA Administrator identified in Appendix B. If these procedures are not followed or if the notice is not provided to the COBRA Administrator during the 60-day notice period, THEN THERE WILL BE NO EXTENSION OF COBRA COVERAGE DUE TO A SECOND QUALIFYING EVENT.

TERMINATION BEFORE THE END OF THE MAXIMUM COVERAGE PERIOD

COBRA coverage will automatically terminate before the end of the maximum period if:

- any required premium is not paid in full and on time (including any applicable grace period);
- a qualified beneficiary becomes covered, after electing COBRA, under another group health plan;
- a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing COBRA;
- the employer ceases to provide any group health plan for its employees; or
- during a disability extension period, the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled (COBRA coverage for all qualified beneficiaries, not just the disabled qualified beneficiary, will terminate). For more information about the disability extension period, see above.

COBRA coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving COBRA coverage (such as fraud).

You must notify the COBRA Administrator in writing within 30 days if, after electing COBRA, a qualified beneficiary becomes entitled to Medicare (Part A, Part B, or both) or becomes covered under other

group health plan coverage. In addition, if you were already entitled to Medicare before electing COBRA, you must notify the COBRA Administrator of the date of your Medicare entitlement.

NOTIFY THE COBRA ADMINISTRATOR IF A QUALIFIED BENEFICIARY CEASES TO BE DISABLED

If a disabled qualified beneficiary is determined by the Social Security Administration (SSA) to no longer be disabled, you must notify the COBRA Administrator of that fact within 30 days after the SSA's determination. You must follow the notice procedures specified by the COBRA Administrator.

COST OF COBRA COVERAGE

Each qualified beneficiary is required to pay the entire cost of COBRA coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% (or, in the case of an extension of COBRA coverage due to a disability, 150%) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA coverage. The amount of your COBRA premiums may change from time to time during your period of COBRA coverage and will most likely increase over time. You will be notified of COBRA premium changes.

PAYING FOR COBRA COVERAGE

- ***How premium payments must be made***
  Your first payment and all monthly payments for COBRA coverage must be made as instructed in the election notice provided to you at the time of your qualifying event.

- ***When premium payments are considered to be made***
  If mailed, your payment is considered to have been made on the date that it is postmarked. If hand-delivered, your payment is considered to have been made when it is received by COBRA Administrator. You will not be considered to have made any payment by mailing or hand-delivering a check if your check is returned due to insufficient funds or otherwise.

FIRST PAYMENT FOR COBRA COVERAGE

If you elect COBRA, you do not have to send any payment with the election form. However, you must make your first payment for COBRA coverage not later than 45 days after the date of your election. This is the date your election form is postmarked, if mailed, or the date your election form is received at the address specified for delivery of the election form, if hand-delivered. See the section above entitled “Electing COBRA Coverage.”

Your first payment must cover the cost of COBRA coverage from the time your Coverage under the Plan would have otherwise terminated up through the end of the month before the month in which you make your first payment. For example, Sue's employment terminates on September 30 and she loses coverage on September 30. Sue elects COBRA on November 15. Her initial premium payment equals the premiums for October and November and is due on or before December 30, the 45th day after the date of her COBRA election.

You are responsible for making sure that the amount of your first payment is correct. Contact the COBRA Administrator to confirm the correct amount of your first payment. Claims for reimbursement will not be processed and paid until you have elected COBRA and made the first payment for it.

If you do not make your first payment for COBRA coverage in full within 45 days after the date of your election, you will lose all COBRA rights under the Plan.

MONTHLY PAYMENTS FOR COBRA COVERAGE

After you make your first payment for COBRA coverage, you will be required to make monthly payments for each subsequent month of COBRA coverage. The amount and the due date will be disclosed in the election notice provided to you at the time of your qualifying event.

GRACE PERIODS FOR MONTHLY COBRA PREMIUM PAYMENTS

Although monthly payments are due on the first day of each month of COBRA coverage, you will be given a grace period of 30 days after the first day of the month to make each monthly payment. Your COBRA coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment. However, if you pay a monthly payment later than the first day of the month to which it applies, but before the end of the grace period for the month, your Coverage under the Plan will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a monthly payment before the end of the grace period for that month, you will lose all rights to COBRA coverage under the Plan.

MORE INFORMATION ABOUT INDIVIDUALS WHO MAY BE QUALIFIED BENEFICIARIES

- ***Children acquired due to birth or adoption***
  A child born to, adopted by, or placed for adoption with a covered qualified beneficiary during COBRA coverage is also considered to be a qualified beneficiary. The child's COBRA coverage begins when the child is enrolled in the Plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements (for example, regarding age).

- ***Alternate recipients under QMCSOs***
  A child of the covered employee who is receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order (QMCSO) received by the Company during the covered employee's period of employment with the Company is entitled to the same rights to elect COBRA as an eligible child of the covered employee.

NOTICE PROCEDURES

You must follow the Plan's notice procedures regarding timing, format, and delivery or you and all related qualified beneficiaries may lose rights under COBRA or will lose the right to an extension of COBRA coverage, as applicable.

Any notice that you provide must be in writing and must be submitted in accordance with the instructions provided by the COBRA Administrator.

You must notify the Company of divorce or legal separation or a child's losing eligibility for coverage. Send written notice to the Plan Administrator at the address noted in Appendix C within 60 days after the later of:

- the date of the qualifying event; or
- the date on which the qualified beneficiary loses or would lose Coverage under the terms of the Plan as a result of the qualifying event.

All other notices must be sent to the COBRA Administrator noted in Appendix B within the timeframe required for the specific event.

STATE CONTINUATION OF COVERAGE RIGHTS

Many states require insured medical plans and HMOs to provide extended health coverage to participants after their group coverage ends. These rights generally supplement federal COBRA, or provide continuation coverage to those who are ineligible for federal COBRA coverage. Because the laws vary greatly from state to state, you should review your Benefits Booklet(s) or contact your health plan directly to learn about any rights you may have under state law. That way, you can meet any election and premium requirements necessary to take advantage of these continuation rights.

FMLA AND OTHER LEAVES OF ABSENCE

If you go on an unpaid leave of absence under the Family and Medical Leave Act of 1993 ("**FMLA**") or another type of leave of absence that provides benefits continuation (such as California Family Rights Act or California Pregnancy Disability Leave), you may be eligible to continue or revoke the coverage for you and your eligible Dependent(s) during the leave.

To the extent possible, arrangements for benefits continuation should be completed before you go on the leave of absence, in accordance with the Plan Administrator's procedures. Upon return from leave, you may reenter the Plan on the same terms that applied to you prior to taking such leave or as otherwise required by the FMLA or other applicable law. Consult the Company's leave of absence policy or contact the Plan Administrator or for more information about coverage during, and reinstatement of coverage following, a leave of absence.

UNIFORMED SERVICE EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT LEAVE ("USERRA")

If you are absent from employment with the employer because you are in "uniformed service," as that term is defined by the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), you may elect to continue participation in the Plan, as required by USERRA. The coverage

period will continue until the earliest of (a) the completion of the 24-month maximum USERRA continuation period; (b) the date you fail to pay required premiums (unless timely payment is impossible, unreasonable, or prevented by military necessity); (c) the date the employer terminates all group health plan coverage; or (d) the date you fail to apply for reinstatement or to return to employment with the employer within the period required by USERRA.

You are responsible for making the required premium payments and contributions under the Plan during the period during which you are in uniformed service. The manner in which such premium payments and contributions are made will be determined by the Plan Administrator, and for later periods, in a manner similar to COBRA. This continuation coverage will run concurrently with any applicable continuation coverage period (e.g., under COBRA, or state continuation benefits), to the extent allowed by law.

If your Coverage under the Plan is terminated on account of your being in uniformed service and you are later reinstated, you will not be subject to a new exclusion or waiting period requirement imposed by the Plan, provided that such requirements would not have been imposed if Coverage had not been terminated as a result of the uniformed service. Consult the Company's leave of absence policy or contact the Plan Administrator for more information about coverage during, and reinstatement of coverage following, a leave of absence.

9. SPECIAL HEALTH PLAN COVERAGE NOTICES

This section describes special rights and responsibilities that apply to the health plan Coverages under the Plan.

SPECIAL ENROLLMENT NOTICE

If you are declining enrollment for yourself or your Dependent(s) (including your Domestic Partner) because of other health insurance or group health plan coverage, you may in the future be able to enroll yourself or your Dependent(s) in medical insurance provided under the Plan if you or your Dependent(s) lose eligibility for that other coverage (or if the Employer stops contributing toward your or your Dependents' other coverage). However, you must request enrollment in accordance with the Plan's procedures and deadline which may not be less than 30 days after your or your Dependents' other coverage ends or after the Employer stops contributing toward the other coverage.

If you have a new Dependent as a result of marriage, establishment of domestic partnership, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependent. However, you must request enrollment in accordance with the Plan's procedures and deadline which may not be less than 30 days after the marriage, establishment of domestic partnership, birth, adoption, or placement for adoption.

Additionally, you may be entitled to special enrollment rights pursuant to the **Children's Health Insurance Program Reauthorization Act of 2009** ("**CHIP**") if you or your Dependents' Medicaid or CHIP coverage is terminated as a result of loss of eligibility or if you or your Dependent(s) becomes eligible for a Medicaid or CHIP subsidy. If a special enrollment right is provided pursuant to the CHIP, you may change your election consistent with such special enrollment right and the election must be made within 60 days from the date of eligibility in accordance with Plan rules.

To request special enrollment or obtain more information, contact the Plan Administrator, whose contact information is listed in Appendix C.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT NOTICE

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

The laws of your state related to hospital stays in connection with childbirth may differ from these federal requirements. Refer to the applicable Benefits Booklet(s) or contact the Claims Administrator listed in Appendix A for more information. You may also contact the Plan Administrator, whose contact information is listed in Appendix C.

WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICE

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the **Women's Health and Cancer Rights Act of 1998** ("**WHCRA**"). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the Plan. Your Benefits Booklet(s) describes these deductibles and coinsurance.

If you would like more information on WHCRA benefits under a particular coverage, contact the Claims Administrator listed in Appendix A. You may also contact the Plan Administrator, whose contact information is listed in Appendix C.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

The Plan will provide health benefits as required by any **Qualified Medical Child Support Order** ("**QMCSO**"), as required under ERISA §609(a) or other qualified orders as may be applicable to the Employer. The Plan Administrator has established written procedures for determining whether an order or a National Medical Support Notice qualifies as a QMCSO, if applicable. Participants and beneficiaries may obtain a free copy of these procedures by contacting the Plan Administrator, whose contact information is provided in Appendix C.

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT

All coverage maintained under this Plan that provides both medical and surgical benefits and offers mental health or substance use disorder benefits will provide such benefits subject to the following:

- the financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the Plan (or Coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits; and

- the treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the Plan (or Coverage) and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.

PATIENT PROTECTION NOTICE

Your health plan may require or allow for the designation of a primary care provider. If so, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members, including a pediatrician, as the primary care provider. Until you make this designation, the health plan may designate one for you.

You do not need prior authorization from the health plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan or procedures for making referrals.

For information on how to select a primary care provider, a list of participating primary care providers, or a list of health care professionals who specialize in obstetrics or gynecology, contact the Claims Administrator at the number listed in Appendix A.

10. COORDINATION OF HEALTH CARE BENEFITS

This section describes the general procedures and timeframes under the Plan's coordination of benefits (COB) rules applicable to the Coverages. Refer to the Benefits Booklet(s) for the specific rules applicable to your Coverages.

If you and your Dependent(s) are enrolled in a Plan Coverage as well as another employer-sponsored coverage, the Plan Coverage coordinates its coverage with the other coverage. Here's how the COB rules work, in general:

- When the Plan Coverage pays first, or if the Plan Coverage is the "primary" plan, the Plan pays benefits as though no other plan exists. The other plan may or may not pay benefits.
- When the Coverage pays second or if the Plan Coverage is the "secondary" plan, the Plan may or may not pay a benefit, depending on what the other plan (the "primary") has paid.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance up to each one's plan formula minus whatever the primary plan paid. This is called non-duplication of benefits. The total reimbursement will never be more than the amount that would have been paid if the secondary plan had been the primary plan -- 50% or 80% or 100% -- whatever it may be. The balance due, if any, is the responsibility of the Covered Person.

WHICH PLAN PAYS FIRST?

If you or your covered Dependent(s) are also covered under another health plan, the first of the following rules that applies will determine which plan is primary:

- A plan without a COB provision is considered primary.
- A plan in which you are covered as other than a Dependent (for example, as an active employee) rather than as a Dependent is primary. If you also are a Medicare beneficiary, and as a result of federal law, a plan covering you as an active employee is primary, Medicare is secondary, and a program covering you as a retiree (if applicable) determines benefits and pays last. If you are covered as a Dependent of an active employee and you are a Medicare beneficiary, the plan covering you as a Dependent is primary, Medicare is secondary, and the plan covering you as a retiree (or as other than a Dependent) determines benefits and pays last.

When a child's parents are divorced or legally separated, these rules will apply:

- This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.
- This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.

- This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent.

- If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.
- For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.
- For a child whose parents are divorced or separated or are not living together, whether or not they were ever married, and the child is covered under both parents' plans, the birthday rule does not apply. Instead, the Plan uses the following rules to determine which plan pays benefits first:
    - o First, the plan of the parent to whom the court specifically assigned financial responsibility for health care expenses (for instance, through a Qualified Medical Child Support Order),
    - o then, the plan of the parent who has custody,
    - o then, the plan of the spouse married to the parent who has custody,
    - o then, the plan of the parent who does not have custody, and
    - o finally, the plan of the spouse married to the parent who does not have custody.

A plan in which you are enrolled as an active employee (or as that employee's Dependent) rather than as a laid-off or retired employee is primary.

In most cases, a plan in which you are enrolled as an active employee or subscriber rather than as a COBRA participant is primary.

The plan covering the individual for the longest period of time is considered primary.

If none of the above rules determines which program is primary, the allowable expenses will be shared equally between the plans.

11. HIPAA PRIVACY AND SECURITY PROVISIONS

The provisions in this section apply to the health benefits provided under Self-Funded Coverages and any Insurance Coverages described in Appendix A, for which the Plan Sponsor receives **Protected Health Information** ("**PHI**"). With respect to such health benefits, the Plan will use PHI to the extent of and in accordance with the uses and disclosures permitted by the **Health Insurance Portability and Accountability Act of 1996** ("**HIPAA"**) and any amending regulations or laws thereto. Specifically, the Plan may use and disclose PHI for purposes related to payment for health care and health care operations as set forth below.

HEALTH PLAN PAYMENTS

"**Payment**" includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for Coverage and provision of Plan benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

- determination of eligibility, Coverage and cost sharing amounts (for example, cost of benefit, plan maximums and co-payments as determined for an individual's claim);
- adjudication of health benefit claims (including appeals and other payment disputes);
- subrogation of health benefit claims;
- establishing employee contributions;
- risk adjusting amounts due based on enrollee health status and demographic characteristics;
- billing, collection activities and related health care data processing;
- claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to Participant inquiries about payments;
- obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);
- medical necessity reviews or reviews of appropriateness of care or justification of changes;
- utilization review, including precertification, preauthorization, concurrent review and retrospective live review;
- disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of provider, and/or health plan); and
- reimbursement to the Plan.

HEALTH CARE OPERATIONS

"Health Care Operations" include, but are not limited to, the following activities:

- quality assessment;
- population-based activities relating to improving health or reducing health care costs, protocol, development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;
- rating provider and Plan performance, including accreditation, certification, licensing and credentialing activities;
- underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance);
- conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
- business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment method or Coverage policies;
- resolution of internal grievances;
- due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a "covered entity" under HIPAA or, following completion of the sale or transfer, will become a covered entity; and
- business management and general administrative activities of the Plan, including, but not limited to:
  - management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements, or
  - customer service, including the provision of data analyses for policyholders, Plan sponsors or other customers.

THIRD PARTIES WITH AUTHORIZATION

The Plan will use and disclose PHI to its "**Business Associates**," as defined by 45 CFR §160.103, who have agreed in writing to comply with all applicable HIPAA regulations for purposes related to the administration of the health Coverages under the Plan. Any other third parties may use or disclose PHI only pursuant to an individual's signed authorization to release or disclose PHI.

PLAN SPONSOR

The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that this Plan contains the limitations and conditions required by HIPAA and contained in this section. The Plan Sponsor agrees to:

- not use or further disclose PHI other than as permitted or required by the Plan Document or as required by law;

- ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
- not use or disclose PHI for employment-related actions and decisions unless authorized by an individual;
- not use or disclose PHI in connection with any other benefits or employee benefits plan of the Plan Sponsor unless authorized by an individual;
- report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- make PHI available to an individual in accordance with HIPAA's access requirements;
- make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- make available the information required to provide an accounting of disclosures;
- make internal practices, books, and records relating to the use and disclosures of PHI received from the Plan available to the HHS Secretary for the purposes of determining the Plan's compliance with HIPAA; and
- if feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which the disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

ACCESS TO PHI

In accordance with HIPAA, only the following employees or classes of employees may be given access to PHI:

- the HIPAA Privacy Officer;
- the HIPAA Security Officer; and
- Human Resource staff designated or authorized by the Privacy or Security Officer.

The persons described in this section may only have access to and use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan. If the persons described in this section do not comply with this Plan Document, the Plan Sponsor will provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

SECURITY

The Plan Sponsor further agrees that if it creates, receives, maintains, or transmits any electronic PHI (other than enrollment/disenrollment information and summary health information, which are not subject to these restrictions) on behalf of the Plan, it will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information, and it will ensure that any agent (including subcontractors) to whom it provides such electronic PHI will agree to implement reasonable and appropriate security measures to protect the information. The Plan Sponsor will report to the Plan any

security incident of which it becomes aware. The Plan Sponsor will ensure that the provisions of this section are supported by reasonable and appropriate security measures to the extent that the designees have access to electronic PHI.

BREACHES OF PHI

To the extent required under HIPAA, the Plan will ensure that any affected individuals will receive notice in the event of a breach of unsecured PHI as required by the regulations.

12. GENERAL PLAN PROVISIONS

PLAN ADMINISTRATOR

The Plan Administrator is the named fiduciary for the Plan. The Plan Administrator has the sole discretionary authority and responsibility to administer and control the Plan in accordance with its terms. To the extent permitted under applicable law, the Plan Administrator has, without limitation, the discretionary authority to interpret the Plan or its terms unless such authority is retained or assumed pursuant to an insurance policy or a contract.

The Plan Administrator's powers include making and enforcing rules it deems necessary or proper for the efficient administration of the Plan, allocating its responsibilities under the Plan to other persons, and deciding all questions concerning the Plan and Plan interpretation, including determining eligibility for Plan benefits and payment of permissible expenses from plan assets.

The Plan Administrator may delegate all or a portion of its responsibilities to one or more agents or to a committee. Such delegation includes discretionary authority unless that authority is specifically limited in the delegation. The Plan Administrator keeps the records for the Plan and will also answer any questions you may have about the Plan.

RIGHT TO AMEND OR TERMINATE THE PLAN

The Plan Sponsor is under no obligation to continue the Plan. The Plan Sponsor or the Plan Administrator, either one acting in its non-fiduciary settlor capacity, has the power to amend the Plan or to terminate it at any time, prospectively or retroactively, for any reason. The Plan may be amended or terminated by written instrument with or without written notice to Plan Participants. Formal resolutions will not be required to approve amendments to this document, Summaries of Material Modifications (SMMs), any Coverages, benefits materials, or other documents that comprise the Plan.

In the event of such termination, any health Coverage under the Plan which is regulated by the ACA will not materially change until 60 days after notice is provided as required by the ACA. Further, such health Coverage will not be retroactively terminated except for certain specifically allowed reasons under the ACA such as nonpayment of premiums or due to fraud or intentional misrepresentation as described in Section 2. In terminating or amending the Plan, the Company cannot generally retroactively reduce the benefits to which a Participant is entitled prior to the termination or amendment, except as permitted under applicable law.

RIGHT TO DETERMINE ELIGIBILITY

Acting on behalf of the Employer in its capacity as Plan Sponsor and settlor, the Plan Administrator has the discretion to determine whether an employee has satisfied any age, service, or other requirements for Coverage and benefits under the Plan, and whether or not such employee is employed in a class of employees to which the Plan has been extended.

CIRCUMSTANCES THAT MAY LIMIT, TERMINATE, OR REDUCE BENEFITS

Participation in the Plan will terminate upon the occurrence of any of the events described in this SPD and as otherwise described in the applicable Benefits Booklet(s). Other circumstances may result in the termination, reduction, loss, offset, or denial of benefits including but not limited to exclusions for preexisting conditions (under non-medical Coverages only), exclusions for certain medical procedures, limitations on preventive care, limitations of Coverage for new drugs, termination of Coverage for false representations and rights of recovery or reimbursement as described in this SPD.

Benefits under a particular Coverage may also be subject to coordination of benefits if you or your beneficiary has coverage under another plan. Some income replacement benefits will be reduced by income that you receive from other sources. Refer to the applicable Benefits Booklet(s) for more information about the circumstances which may affect benefits under particular Coverages.

THIRD PARTY RESPONSIBILITY

The Plan provides benefits for covered expenses incurred for any illness, injury, disease, or condition resulting from an act or omission of a third party ("**third party expenses**") *only to the extent* the expenses are not otherwise paid (or are not or do not become payable) by the third party by way of a lawsuit, verdict, settlement, compromise, arbitration award, satisfaction of a judgment, or otherwise, without regard to how any such recovery may be itemized, structured or allocated, and without regard to whether responsibility is accepted or denied by the third party or insurance (including insurance covering the third party, uninsured or underinsured motorist coverage, or other insurance coverage or fund).

If the Plan pays benefits for any claim you incur as the result of negligence, willful misconduct, or other actions of a third party, the Plan will be subrogated to all your rights of recovery. The Plan has a right to full reimbursement and subrogation of any and all amounts paid for any such third party expenses. Subrogation means that the Plan can substitute itself in your place to pursue a claim for reimbursement for expenses paid by the Plan for which a third party is responsible. This could happen, for example, if you are injured in a car accident which is the fault of a third party and the Plan pays your medical expenses. You will be required to reimburse the Plan for amounts paid for claims out of any monies recovered from a third party, including, but not limited to, your own insurance company as the result of judgment, settlement, or otherwise. In addition, you will be required to assist the administrator of the Plan in enforcing these rights and may not negotiate any agreements with a third party that would undermine the subrogation rights of the Plan.

The Plan will not be responsible for any fees or costs associated with your pursuit of a claim against any third party or insurance carrier, including but not limited to attorney fees and court costs. The Plan has no obligation to represent any injured party in any action. The Plan Administrator may, however, in its sole discretion, reduce the amount of reimbursement otherwise required to account for special circumstances. The Plan Administrator also has a right to enforce this section in any way allowed by law or equity, including bringing an action against any person who receives Plan benefits and fails to comply with the provisions of this section.

If an action is brought under state law, this provision of the Plan will be reformed solely for purposes of that enforcement action to comply with the laws of that state. If the Plan Administrator brings an action to enforce its rights under this provision, the Plan is entitled to recover any attorney fees and costs associated with such action.

The Plan does not waive any legal, contractual, or Plan-based rights by making payment for third party expenses. Anyone who received benefits under the Plan agrees, as a condition to receiving benefits under the Plan, to provide to the Plan a first lien on those amounts when they are paid, to fully cooperate with the Plan in enforcing its reimbursement and subrogation rights, and to avoid prejudging the Plan.

Payment from third parties for third party expenses paid by the Plan, and any proceeds from such payments, will be the property of the Plan. Anyone receiving such property will hold the property in trust for the Plan and forward it to the Plan as soon as practicable. Failure to forward such property will create a constructive trust over such property and will subject such Participant or other constructive trustee, among other available remedies, to an equitable action by the Plan for disgorgement.

Specific Coverages may contain additional or different subrogation and reimbursement provisions and those specific provisions will be applicable to that Coverage. To the extent that the specific provisions for subrogation or reimbursement for a specific Coverage conflict with this provision, the specific provisions will be enforced and the conflicting provision in this provision will be void with respect to that Coverage.

USE OF INSURANCE REBATES

To the maximum extent permitted by applicable law, the Plan Administrator, at its sole and unfettered discretion, may use funds accumulated under this Plan for any Coverage (whether funds accumulated from insurance contract reserves, medical loss ratio (MLR) rebates, insurance company refunds or dividends, Participant or Company contributions or administrative fees) to reduce the level of contributions that the Company would otherwise make to the Plan for any benefits program.

Any insurance rebates received may be credited to the Plan Sponsor (or Plan trust, if premiums are paid from a trust) and current Participants of that insurance policy on a pro-rata basis based upon the Employer/employee share of the monthly premium utilized in the prior Plan Year.

If the rebate portion to be credited is insignificant, it may be deemed administratively prohibitive to credit to individual employees. Such amounts will be available to fund the benefits provided by any Coverages under the Plan.

PLAN FUNDING INFORMATION

Benefits provided under the Insurance Coverages listed in this SPD are funded through insurance contracts and policies purchased from various insurance carriers. The insurers and not the Employer are financially responsible for the payment of claims under Insurance Coverages. Premiums for those insurance contracts and policies are paid from the general assets of the Employer and employee

contributions (if any) and benefits are administered and paid by the insurance carriers pursuant to the insurance contracts and policies.

The Self-Funded Coverages listed in this SPD, if any, are funded out of the Employer's general assets. No amounts are held in trust or otherwise segregated from the general assets of the Employer. You may be required to contribute toward the cost of Coverages, as described in this SPD and in your enrollment materials.

AUTHORIZED REPRESENTATIVE

You are permitted to designate an authorized representative to act on behalf of you in pursuing a benefit claim or appeal of a denied claim. To appoint an authorized representative, you must either provide the Plan Administrator, insurer or Claims Administrator with a written statement that identifies the authorized representative and the scope of his or her authority, or satisfy any other procedures that are required by the Plan Administrator, insurer or Claims Administrator. In the case of an urgent care claim, however, a health care professional with knowledge of your medical condition is permitted to act as your authorized representative without needing to satisfy the written statement requirement.

ANTI-ASSIGNMENT

You cannot assign your rights to receive any benefits or reimbursements under this Plan or to bring a claim or lawsuit for benefits or breach or violation of any other duty or obligation owed to you under this Plan, to any person or entity, including an out-of-network healthcare provider (or any representative or agent of the provider), either before or after healthcare services or supplies are provided to you. These rights are yours alone and may not be transferred to another person or entity. No health care provider or any other person or entity is permitted to bring a claim against the Plan under ERISA (or any other law) through a claimed assignment, and any attempt to assign your rights are void and not enforceable.

This does not mean, however, that you may not authorize the Plan to pay a provider directly for its covered charges for medical or other services or supplies provided to you. Any payment made under this Plan to any such person or entity fully discharges the Plan's responsibility to you for benefits under the Plan to the full extent of the payment.

Your authorization for the Plan to make direct payments to a provider does not mean that you have assigned to the provider (1) any legal right enforceable by the provider to the payments or other benefits provided under the Plan, or (2) the right to bring a claim or lawsuit for benefits under the Plan (or ERISA or any other law). Direct payment does not mean that the Plan recognizes any claimed assignment of benefits or any other claims made by the provider. The legal rights to benefits payments or reimbursements, and any associated claims, are yours and yours alone.

In no event will the Plan or the Company be liable to any out-of-network provider to whom you may be liable for any health care related treatment or services or supplies that were provided by the out-of-network provider.

LIMITATIONS PERIOD FOR FILING SUITS

Unless provided otherwise in the applicable Benefits Booklet(s) for Coverage(s), any action at law or in equity with respect to any and all claims relating to the Plan must be brought for recovery within one year from the earlier of (1) the date of a final internal adverse benefit determination, if applicable, or (2) the accrual of any claim under or relating to the Plan that does not result in a final internal adverse benefit determination. If the specific Coverage's separate Benefits Booklet expressly states a limitations period for bringing an action thereunder, then the Coverage's separate Benefits Booklet will control.

13. YOUR RIGHTS AND PRIVILEGES UNDER ERISA

As a Participant in this Plan, you are entitled to certain rights and protections under the **Employee Retirement Income Security Act of 1974** ("**ERISA**"). ERISA provides that all Plan Participants are entitled to:

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

- Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

CONTINUE GROUP HEALTH PLAN COVERAGE

Continue health care coverage for yourself, spouse (as defined under federal guidelines or as otherwise provided under this Plan) or Dependent(s) if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependent(s) have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

ENFORCE YOUR RIGHTS

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to

provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court after you have exhausted the Plan's claims and appeals procedures. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor (listed in your telephone directory) or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor at 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

14. ADOPTION OF THE PLAN

I, acting on behalf of the Plan Sponsor with full authority to act for the Plan Sponsor, hereby adopt the Plan as described in this Plan Document and Summary Plan Description.

For the Plan Sponsor:

Signed: DocuSigned by: Ines Fontanella 80DB5B41A68641C... Date 1/24/2023

Print Name: _Ines Fontanella_____

Title: ___Director, Global Benefits_____

APPENDIX A: Plan Coverages

INSURANCE COVERAGES

Insurance Coverages are provided through fully-insured insurance contracts and policies entered into between the Plan Sponsor and the insurance company. Claims for benefits are sent to the Insurance Company. The Insurance Company (not the Employer) is responsible for paying benefits. Note that the Insurance Company and the Plan Administrator share responsibility for administering the benefit plans.

The Plan provides the following Insurance Coverages:

Benefit Type	Grand-fathered Status [Yes/No]	Policy Number	Insurer/Claims Administrator Contact Information	Evergreen Benefit (Election Continues to next plan year unless election changed)	Contributions are paid pre-tax, after-tax, N/A?
Medical – Kaiser HMO and Kaiser DHMO	No	37065 (Northern California) and 234255 (Southern California)	Kaiser Permanente 800-464-4000 www.kp.org	Yes	Pre-tax is default
Employee Assistance Plan – CuraLinc	N/A	8x8	CuraLinc 800-490-1585 www.curalinc.com	N/A (no election required)	N/A (employer paid)

APPENDIX A: Plan Coverages (cont.)

Benefit Type	Grand-fathered Status	Policy Number	Claims Administrator Contact Information	Evergreen Benefit (Election continues to next plan year unless election changed)	Contributions are paid pre-tax, after-tax, N/A?
Group Term Life Insurance and AD&D	N/A	723584	Voya 800-955-7736 VoyaClaims@voya.com	N/A (no election required)	N/A (employer paid)
Supplemental Life Insurance and AD&D	N/A	723584	Voya 800-955-7736 VoyaClaims@voya.com	Yes	Post-tax is default
Long-Term Disability	N/A	723584	Voya 800-955-7736 VoyaClaims@voya.com	N/A (no election required)	N/A (employer paid)
Business Travel Accident	N/A	8x8	AIG 877-244-6871 (within US) 715-346-0859 (outside US) Travelguard.secure.force.com travelassist@aigbenefits.com	N/A (no election required)	N/A (employer paid)

SELF-FUNDED COVERAGES

The benefits paid from Self-Funded Coverages are paid out of the Employer's general assets.

The Plan provides the following Self-Funded Coverages under the Plan:

Benefit Type	Grand-fathered Status [Yes/No]	Group or Contract Number	Claims Administrator Contact Information	Evergreen Benefit (Election continues to next plan year unless election changed)	Contributions are paid pre-tax, after-tax, N/A?
Health FSA and Limited Health FSA	No	8x8	PlanSource 866-266-1732, option 2 Plansource.wealthcareportal.com/	No	Pre-Tax
Health Savings Account (HSA)	No	20541	HealthEquity 866-346-5800 memberservices@healthequity.com	No	Pre-tax
Medical – 8x8 PPO and 8x8 PPO with HSA	No	8x8	HealthComp Administrators 1-800-442-7247 Hconline.healthcomp.com	Yes	Pre-tax is default
Prescription Drug – Bundled with 8x8 PPO and 8x8 PPO with HSA	N/A	M15 BIN Number: 015433	Southern Scripts 800-710-9341 support@southernscripts.net	N/A (no election required – bundled with 8x8 PPO and 8x8 PPO with HSA)	N/A (no add'l premium)
Vision – VSP	N/A	30106506	VSP 800-877-7195 vsp.com	Yes	Pre-tax is default
Dental – Delta Dental	N/A	21434	Delta Dental 888-335-8227 deltadentalins.com	Yes	Pre-tax is default
Basic Short-Term Disability	N/A	8x8	Larkin 650-938-0933 www.thelarkincompany.com	N/A (no election required)	N/A (employer paid)

APPENDIX A: Plan Coverages (cont.)

CAFETERIA PLAN COVERAGE HIGHLIGHTS

The following chart provides highlights of the cafeteria plan sponsored by the Employer. The components listed below, except for the Health FSA, are not subject to ERISA but are included in this document for ease of reference. Further details are provided in the Benefits Booklet and the Employer's separate cafeteria plan document.

Cafeteria Plan Component	Minimum and Maximum Benefits	Automatic Election unless written waiver?	Election Automatically Terminates at Plan Year End? [Yes/No]	Claims Administrator Contact Information
Health FSA and Limited FSA	Min: none Max: IRS Maximum	No	Yes	PlanSource 866-266-1732, option 2 Plansource.wealthcareportal.com/
Dependent Care FSA	Min: none Max: IRS Maximum	No	Yes	PlanSource 866-266-1732, option 2 Plansource.wealthcareportal.com/
Health Savings Account	Min: none Max: IRS Maximum	No	Yes	HealthEquity 866-346-5800 www.healthequity.com memberservices@healthequity.com

APPENDIX B: Other Important Contacts

Human Resources/Benefits	8x8, Inc. 675 Creekside Way Campbell, CA 95008 866-305-3950 hr@8x8.com www.8x8benefits.com
Enrollment Assistance	PlanSource 866-775-4169
COBRA Administrator	PlanSource 888-266-1732
Non-Kaiser Medical Third Party Administrator	HealthComp Administrators PO Box 45018 Fresno, CA 93718: 1-800-442-7247 Hconline.healthcomp.com