THIS IS A SUMMARY PLAN DESCRIPTION FOR THE 8X8, INC. SHORT TERM DISABILITY PLAN. UNLESS OTHERWISE STATED, THE PROVISIONS OF THIS SUMMARY APPLY TO DISABILITIES BEGINNING ON OR AFTER JANUARY 1, 2023. THIS PLAN COMPRISES PART OF THE 8X8 HEALTH AND WELFARE PLAN.

INTRODUCTION

The purpose of the 8x8, Inc. Short Term Disability Plan is to assist you in meeting your reasonable income needs in the event you suffer a short-term disability and are unable to work.

What follows is a Summary Plan Description that is required by the Employee Retirement Income Security Act (ERISA). (Read your ERISA rights on page 4 of this Summary.) Because this summary has been written to conform to Department of Labor (DOL) regulations, it does not contain a complete explanation of each and every provision and term contained in the more comprehensive Plan Document. If your particular circumstances are not described within this summary or if you do not understand something described in this summary, a copy of the entire Plan Document is available for your review on ***Plan Source***.

TABLE OF CONTENTS

8x8, Inc. (the Company) has contracted with The Larkin Company (the Claims Administrator) to process claims in accordance with the Plan Document. However, the Company, in its capacity as Plan Administrator, has the ultimate authority and discretion to determine whether or not you are entitled to Plan benefits.

The Company reserves the right to amend or terminate the Plan at any time. If the Plan is terminated and you meet or continue to meet the requirements of the Plan, benefits will continue to be paid for any disability that began before the termination date.

Certain capitalized terms used in this summary have the meanings set forth on page 6.

PARTICIPATION

Who may participate? You, provided you are a regular, 8x8, Inc. employee who is scheduled to work 20 hours or more per week at a Company location in the United States of America or its territories. You are also eligible to participate if you meet the above requirements but are assigned to work at a location outside the U.S.A. or its territories and you are paid by U.S.A. payroll. Interns, externs, seasonal or temporary employees and individuals performing services for the Company as independent contractors or through an employment or leasing agency are not eligible to participate.

How do I enroll? You don't need to. If you satisfy the eligibility requirements (20 hours or more per week, etc.) you are automatically enrolled. You must be at work on the day that your participation in the Plan begins. If you are not at work on that day, your participation will be delayed until you are back at work.

When does my participation in the Plan end?

When any of the following occur:

- you cease to be an eligible employee. For example, your scheduled work week is reduced to fewer than 20 hours per week.
- you are no longer employed by the Company;
- you are laid off (provided, however, a temporary shut-down initiated by the Company is not a layoff for the purposes of this Plan);
- on the date you begin an unpaid leave of absence, including temporary layoff or furlough. (This provision does not apply if you are on an approved leave under the Family and Medical Leave Act (FMLA) or similar state or local law); or,
- the Plan terminates.

What is it going to cost me?

What is it going to cost me? Nothing. The Company pays all Plan costs. Benefits from this Plan are taxable. Benefits paid, and taxes withheld will be included on the W-2 you receive from 8x8 Payroll.

DISABILITY

What is a disability? For the purposes of the Plan, any of the following:

- you suffer an injury or illness (physical and/or mental) which prevents you from performing the material duties of your regular and customary occupation (or any reasonably related occupation);

- your pregnancy prevents you from performing the material duties of your regular and customary occupation (or any reasonably related occupation);
- you contract or are exposed to a communicable disease (e.g., TB, chickenpox), and your Physician or Practitioner (or a bona fide health official) states, in writing, that you must stay away from work; or
- you are under treatment for alcohol or drug abuse. To qualify for benefits you must participate in an accredited residential program or an approved outpatient program that requires your attendance for a minimum of 5 days per week for a minimum of 8 hours per day. Benefits for alcohol or drug abuse treatment are limited to a maximum of 90 days.

You will not be considered disabled if you are doing work of any kind for the Company or any other employer (including self-employment) for pay or profit without first obtaining approval from the Plan Administrator. You will not be considered disabled if you turn down alternative employment offered by the Company that is within your capabilities and is comparable in status and pay to your regular job.

Who determines when I am disabled? The Claims Administrator, based on a certificate from your Physician or Practitioner, objective medical evidence and any other information that may be relevant.

BENEFITS

When will my benefits begin? Your benefits begin on your 8th consecutive day of disability, provided you see a Physician or Practitioner during that 8-day period.

Successive periods of disability due to the same or related causes are considered one disability unless separated by a return to your normal work schedule for more than 60 days.

How much will I receive? If you are disabled, you will be paid 100% of your weekly Earnings with no maximum for the first 12 weeks, and 66.67% of your weekly Earnings to a maximum of $2,800 thereafter.

Partial weeks are paid at a daily rate that is 1/7th of your weekly benefit.

How are benefits determined? Benefits are based on your earnings. "Earnings" mean your weekly salary received on the first of the month just before the date of disability. Earnings do not include overtime pay or any other special compensation not received as basic salary. However, Earnings will include commissions, bonuses and incentive pay you received averaged over the lesser of: (1) the number of weeks worked; or (2) the fifty-two (52) weeks as of the first of the month just prior to the date disability began.

An increase in your Earnings during a period of disability will not increase your weekly benefit amount under the plan.

Will I still be eligible for benefits if I return to work on a part-time basis? If you are disabled and return to work for fewer hours than you are regularly scheduled to work for the Company, your weekly benefit (as described above) will be reduced by 100% of the income you earn from part-time employment.

You may not engage in work of any kind for pay or profit without first obtaining approval from the Plan Administrator.

What is deducted from my benefit? Any of the following for which you are eligible: (i) temporary or permanent disability payments (whether total or partial), vocational rehabilitation payments and any other amounts awarded or allocated under workers' compensation or similar occupational disease law; (ii) benefits under a state disability plan or a Company plan providing disability benefits in place of a state plan; and (iii) benefits under any other plan, fund, arrangement, by whatever name known, providing disability benefits pursuant to a compulsory act or law of any government. ***If you do not apply for these benefits, your benefits from this Plan will be reduced by the amount you would have received had you applied. If you have applied but not yet received these other benefits you will be required to sign an agreement to reimburse this Plan before benefits may be issued.***

Can benefits be suspended? Yes. The Claims Administrator may request that a Physician or Practitioner examine you at the Company's expense. Your benefits will be suspended as of the date of the examination. However, if the examination establishes that you are still disabled, your benefits will resume retroactive to the examination date. If you fail to furnish information about your disability within 30 days following a written request by the Claims Administrator, your benefits will be suspended. Finally, if you leave your Physician's or Practitioner's care, or you reject the treatment plan recommended by your Physician or Practitioner, your benefits will be suspended. Benefits will resume once you comply with these requirements. In no event will you be paid benefits for the period when you were out of compliance with the Plan.

When do benefits end? Benefits are not payable beyond your 180th day of disability. However, if your disability ends before then (or in the event of your death), your benefits will end as of that day.

Overpayments In the event you are paid benefits by the Plan in excess of those to which you are entitled, the Plan has a right to recover the overpayment.

The Claims Administrator will make reasonable arrangements for you to repay the Plan. In no event will you be required to repay more than the amount of benefits paid to you.

EXCLUSIONS

Are there conditions under which I will not be eligible for benefits? You will not receive benefits if:

- you were not a Plan participant when your disability began;
- your illness or injury was self-inflicted;
- you became disabled because of your commission or your attempted commission of a felony or other illegal occupation;
- you are incarcerated (in jail or any other facility) as a result of a criminal conviction;
- you are injured in a war (as a civilian or soldier), riot, insurrection, or rebellion;
- you are no longer under the care of a Physician or Practitioner, unless the Claims Administrator determines that your disability does not warrant such attention;
- you are receiving unemployment compensation under any federal or state program;
- you receive Company-paid sick leave (PTO) or salary continuation pay during your period of disability, unless the combination of sick leave pay or salary continuation and your benefits does not exceed your regular weekly Covered Earnings; or
- you are receiving in-lieu-of-notice pay.
- your disability was caused or contributed to by any of the following:
    - Cosmetic Surgery (see definition on pg.5)
    - in vitro fertilization
    - embryo transfer procedures
    - artificial insemination
    - reversal of sterilization
    - liposuction or
    - radial keratotomy

CLAIMS

How do I file a claim? Notify 8x8's leave and Claims Administrator, The Larkin Company, at (650) 938-0933 or toll-free at (866) 923-3336, or by emailing 8x8leaves@thelarkincompany.com as soon as reasonably possible following the commencement of a disability. The Larkin Company will send you an information packet including claim forms. Fill out the disability forms and return them to The Larkin Company. (See Claims Administrator information on page 5.) **To avoid losing some or all of your benefits, your claim for benefits must be filed not later than 45 calendar days after the date you would have been eligible to receive benefits** (unless you can show it was not reasonably possible for you to comply with this requirement); **otherwise, you may lose some or all of your benefits**. No claim will be accepted if filed more than 6 months after benefits were payable.

Note: due to the COVID-19 pandemic, the deadline for submitting claims has been extended. If you have any questions regarding these extended claims deadlines, please refer to the attached "Addendum" or contact your Larkin administrator at (866) 923-3336.

What must I provide to have a valid claim? You must submit a claim that includes a certificate from your Physician or Practitioner. The certificate must include the medical facts of your disability, including his or her opinion as to the probable duration of your disability. The certificate must include a diagnosis or diagnostic code prescribed in the International Classification of Diseases. If no diagnosis has been made, a statement of symptoms must be included. All of the above must be based on a physical examination and documented medical history.

In order to qualify for benefits, the Claims Administrator may require that you submit other information relevant to your claim.

Time limit for a claim decision The Claims Administrator must make a determination no later than 45 days after receipt of your claim. If a decision cannot be made in that period, the Claims Administrator may extend that period up to 60 days (in 30-day increments) provided you are notified, in writing, prior to the expiration of the deadline(s), of the cause of the delay, of the standards on which entitlement is based, of any unresolved issues or additional information needed to resolve those issues, and the date that a decision is expected. If additional information is needed, you will have 45 days in which to provide it.

Note: due to the COVID-19 pandemic, the deadline for submitting claims has been extended. If you have any questions regarding these extended claims deadlines, please refer to the attached "Addendum" or contact your Larkin administrator at (866) 923-3336.

When can I expect payment? After you have submitted all the needed information, your claim will be evaluated. If it is approved, the amount of your benefit will be calculated and The Larkin Company will issue you a voucher. The voucher will show you the period covered and the amount of your benefit. 8x8, Inc. payroll will also be notified of the period covered and the benefit amount – your benefits will be included in the check(s) you receive from 8x8, Inc. on or near your next regularly scheduled payroll date(s).

Disputing a denied claim If your claim is denied, you will receive written notification of the determination. The notification will be written in a culturally and linguistically appropriate manner and will set forth the following: (i) the specific reason for the denial; (ii) references to the specific Plan provisions on which the denial is based; (iii) a description of any additional material necessary to perfect your claim and an explanation of why such material or information is necessary; (iv) a description of the Plan's claim review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review; (v) if applicable, the rule (or similar criterion) on which the denial was based or, if the denial was not based on a rule (or similar criterion), a statement that these were not used; (vi) if applicable, an explanation of the scientific or clinical judgment used in making the determination and a statement that such an explanation is available, on request, free of charge; and (vii) an explanation as to why the Plan disagreed with the views of your treating Physician or Practitioner, medical or vocational experts, or the Social Security Administration, if applicable.

If you receive notice that your claim has been denied, **you have 180 days following receipt of the denial to file a written request for a review**. You may submit any documentation you feel will support your claim including any comments, documents, or other information that you feel are relevant to your claim. You are entitled to a copy of the Plan Document and other documents relevant to your claim. **Send your written request for a claim review to: Plan Administrator, Short Term Disability Benefit Plan, 8x8, Inc., 2125 O'Nel Drive, San Jose, CA 95131.**

Note: due to the COVID-19 pandemic, the deadline for submitting claims has been extended. If you have any questions regarding these extended claims deadlines, please refer to the attached "Addendum" or contact your Larkin administrator at (866) 923-3336.

Claim review time limit and notification requirements The Plan Administrator will render a written decision within 45 calendar days of receipt of your request. The review of your claim will: (i) give no weight to the initial denial; (ii) be of your entire file including any new material and arguments you submit; (iii) provide you, free of charge, with any new or additional evidence considered as soon as possible and sufficiently in advance of the end of the 45-day period; (iv) be done by an individual or individuals who neither made the initial denial nor is a subordinate of that individual; and (v) be made with the consultation of a health care professional (with the appropriate training and experience) who was not the health care professional consulted on the initial denial nor a subordinate of that health care professional, if the initial denial was made in consultation with a health care professional or was based in whole or in part on a medical judgment. If new or additional evidence is received and relied upon while your claim is being reviewed, you will be provided with that evidence as soon as possible and sufficiently in advance of the date on which the review of the adverse determination is due and you will be afforded the opportunity to respond.

If a decision cannot be reached within 45 days, you will be notified, in writing, prior to the expiration of that deadline. The notice must include the reason for the delay and the date a decision is expected. In no event will the decision process take more than 90 days from the date your request for review was received.

If, on review, your claim is denied you will receive written notification of the determination. The notification will be written in a culturally and linguistically appropriate manner and will set forth the following: (i) the specific reason(s) for the denial; (ii) reference(s) to the specific Plan provision(s) on which the denial is based; (iii) a statement that you are entitled to receive, free of charge upon request, reasonable access to, and copies of, all documents relevant to your claim; (iv) a statement that you have the right to file a civil suit under Section 502(a) of ERISA no later than 6 months after the date of the final determination; (v) the calendar date on which the 6 month deadline will expire; (vi) if applicable, the rule (or similar criterion) on which the denial was based, or, if not applicable, a statement that these were not used; (vii) if applicable, an explanation of the scientific or clinical judgment used in making the determination

and a statement that such explanation is available on request, free of charge; and (viii) if applicable, the identity of any medical or vocational experts whose advice was obtained during the decision process, and (ix) a discussion of the decision, including an explanation of the basis for disagreeing with or not following the views presented by the Participant's Physician(s), Practitioner(s) or vocational experts, the views of the medical or vocational experts whose advice was obtained on behalf of the plan, and the disability determination presented by him or her to the Plan made by the Social Security Administration.

ERISA INFORMATION

As a participant in the 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 will be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office, all documents governing the Plan, including 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. If you wish to examine any of these documents, contact the 8x8 Benefits Center.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan 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 the summary annual financial report.

Prudent Action 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 employee benefit 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 Plan benefit or exercising your rights under ERISA.

Enforce Your Rights

- If your claim for a Plan 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 this 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 the Plan documents or the latest annual report from the Plan Administrator 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. 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.
- If you receive this document through electronic means, you have the right to request, free of charge, a paper copy of this document.

Assistance with Your Questions

If you have any questions about the Plan, contact the Plan Administrator. If you have any questions about this statement or your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you may contact the nearest office (listed in your telephone directory) of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor. EBSA also has a national toll-free number: 866 444-EBSA. You may also contact EBSA by writing to the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, DC 20210.

DEFINITIONS FOR KEY TERMS

"Physician" means a physician or surgeon holding an MD or DO degree, Psychologist, optometrist, dentist, podiatrist, or chiropractic practitioner, who is licensed and acting within the scope of his or her practice. "Psychologist" means a licensed psychologist with a doctoral degree in psychology and who either (i) has at least two years of clinical experience in a recognized health setting, or (ii) has met the standards of the National Register of Health Service Providers in Psychology.

"Practitioner" means a Nurse Practitioner or physician assistant (provided the physician assistant has performed a physical examination and collaborated with a Physician or surgeon) duly licensed or certified by the state or foreign country in which he or she practices and acting within the scope of his or her license or certification. With regard to disability resulting from normal pregnancy or childbirth, Practitioner will also include a midwife or nurse midwife, or Nurse Practitioner. "Nurse Practitioner" means a licensed nurse practitioner who has completed a transition to practice in their licensed state of a minimum of three (3) full-time equivalent years of practice or 4,600 hours.

"Cosmetic Surgery" means surgery performed to revise or change the texture, configuration, or relationship of contiguous structures of any feature of the human body that would be considered by the average observer to be within the broad range of normal and acceptable variation for age and ethnic origin. Such procedures are performed for conditions judged by competent medical opinion to be without potential for jeopardy to physical or mental health. "Cosmetic Surgery" does not include reconstructive surgery that is considered by the Participant's Physician or Practitioner to be medically necessary to repair a loss or defect, relieve pain, relieve discomfort, or improve health. Reconstructive surgery may include, but is not limited to, breast reconstruction following mastectomy, nose reconstruction to improve breathing, breast reductions, and weight loss surgery.

MISCELLANEOUS

8x8's Short Term Disability Benefit Plan does not provide job protection or return to work rights. You may have job protection rights if you are eligible for a leave under the federal Family and Medical Leave Act (FMLA) and/or any other applicable state or local mandated leave law that provides for such protections. These protections (if eligible) may run concurrently with any approved disability benefits.

PLAN INFORMATION

Plan Name
8x8, Inc.
Short Term Disability Benefit Plan
(Part of the Health and Welfare Plan)

Type of Plan
Welfare benefit plan providing temporary disability benefits.

Funding
All Plan benefits and costs are paid out of the Company's general assets.

Plan Administrator and Agent for Service of Legal Process
8x8, Inc.
2125 O'Nel Drive
San Jose, CA 95131

Employer ID Number
26-3592641

Plan Number
501

Plan Fiscal Year End
December 31

Claims Administrator

The Larkin Company

PO Box 910
Roseville, CA 95661
www.thelarkincompany.com
Toll Free (866) 923-3336
Local (650) 938-0933
Fax (916) 594-0131 or (650) 938-0943

Short Term Disability Plan Addendum

Due to the Coronavirus (COVID-19) pandemic and the declaration of a national emergency, the period of March 1, 2020 until 60 days after the COVID-19 national emergency end date is announced (the "Outbreak Period") will be disregarded for all short-term disability benefit claims subject to the Employee Retirement Income Security Act "ERISA" regulations and requirements for the purpose of counting the following Participant time frames under ERISA's claims procedures:

- The filing date for an initial qualifying claim
- The appeal filing date for adverse benefit determinations
- The deadlines for requesting external review for claims, including the date within which a claimant may file information to perfect a request for external review upon a finding that the request was not complete.

In no case will a Participant's maximum time period for the claim filing deadlines above exceed more than a year.