8x8 INC. PPO
PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION
AMENDMENT #6

This amendment is attached to and made a part of the 8x8 Inc. PPO Plan Document and Summary Plan Description. Amendment #5 is effective on the below dates and reflects the following changes:

EFFECTIVE JANUARY 1, 2021

(1) Amend the How to Submit a Claim language to clarify 12 months as shown below with strikethrough and underline.

WHEN CLAIMS SHOULD BE FILED

Claims should be filed with the Claims Administrator within 12 months of the date charges for the services were incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined or reduced unless it's not reasonably possible to submit the claim in that time.

This ~~fifteen~~ twelve month period will not apply when the person is not legally capable of submitting the claim.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

EFFECTIVE JANUARY 1, 2022

(1) Amend the Schedule of Benefits section to add Balance Billing language as shown below with the underlined language.

(2) Amend the Cost Management Services section to modify Continuity of Care language following the Case Management section as shown below with strikethrough and underlined language.

(3) Amend the Defined Terms section to add definitions for Certified IDR Entity, Independent Freestanding Emergency Department, No Surprises Act (NSA), Participating Health Care Facility, Qualifying Payment Amount as shown below with the underlined language. The definition of Medical Emergency is replaced with Emergency Medical Condition and Emergency Services is replaced as shown below with the underlined language and the strikethrough. The Qualified Payment Amount has been added to the definition of Recognized Charge as shown below with underlined language.

(4) Amend the Plan Exclusions for Alcohol, Complications of non-covered treatments, Illegal Acts, Illegal drugs or medications, Non-compliance and Self-Inflicted as shown below with underlined language.

(5) Amend the How To Submit A Claim, External Review Process section as shown below with the underlined language.

SCHEDULE OF BENEFITS

MEDICAL BENEFITS

All benefits described in this Schedule are percentages paid by the plan and are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; that charges are based on the

Recognized Charges; that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

This document is intended to describe the benefits provided under the Plan but, due to the number and wide variety of different medical procedures and rapid changes in treatment standards, it is impossible to describe all covered benefits and/or exclusions with specificity. Please contact the Plan Administrator if you have questions about specific supplies, treatments or procedures.

BALANCE BILLING

The No Surprises Act, part of Title I of the Consolidated Appropriations Act of 2021, prohibits Physicians, Providers, health care facilities and air ambulance companies from balance billing Covered Persons or otherwise holding Covered Persons liable for any more than the applicable cost sharing amounts they would have owed for Network care. Specifically, these balance billing protections apply when a Covered Person receives Emergency Services from a Non-Network provider or facility, when a Covered Persons receives certain non-Emergency Services from a Non-Network provider at Network hospital or ambulatory surgical center, and when a Covered Person receives Emergency Services from a Non-Network air ambulance service.

However, these protections against balance billing do not apply if the Covered Person consents to treatment by a Non-Network provider (this consent exception generally does not apply in emergency situations).

In addition, this Plan generally will cover Emergency Services without precertification; cover Emergency Services by Non-Network providers; base cost sharing amounts on Network benefits; and count any cost sharing amounts for services subject to balance billing protections toward a Covered Person's Network deductible and out-of-pocket limit.

If a Covered Person believes he or she has received a balance bill that is protected under the No Surprises Act, please contact HealthComp Administrators, Inc. at (800) 442-7247 for additional information.

Please visit www.dol.gov/agencies/ebsa/laws-and-regulations/laws/no-surprises-act for additional information regarding the No Surprises Act.

COST MANAGEMENT SERVICES

~~**Continuity of Care**~~

Transition Assistance for New Members

Transition Assistance is a process that allows for continuity of care for new Members receiving services from a Non-Network Provider. If you are a new Member, or new Covered Person, you may request Transition Assistance if any one of the following conditions applies:

- An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of Covered Services shall be provided for the duration of the acute condition.

- A serious chronic condition. A serious chronic condition is a medical condition due to a disease, illness or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of Covered Services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another Provider, as determined by us in consultation with the Covered Person and the Non-Network Provider and

consistent with good professional practice. Completion of Covered Services shall not exceed twelve (12) months from the time the Member enrolls with us.

- A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of Covered Services shall be provided for the duration of the pregnancy.

- A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one (1) year or less. Completion of Covered Services shall be provided for the duration of the terminal illness.

- The care of a newborn child between birth and age thirty-six (36) months. Completion of Covered Services shall not exceed twelve (12) months from the time the Member enrolls with us.

- Performance of a surgery or other procedure that we have authorized as part of a documented course of treatment and that has been recommended and documented by the Provider to occur within 180 days of the time the Member enrolls.

Please contact Member Services at the telephone number on the back of your Member Identification Card to request Transition Assistance or to obtain a copy of the written policy. Eligibility is based on the Covered Person's clinical condition; it is not determined by diagnostic classifications. Transition Assistance does not provide coverage for services not otherwise covered under the Agreement.

We will notify you by telephone, and the Provider by telephone and fax, as to whether or not your request for Transition Assistance is approved. If approved, the Member will be financially responsible only for applicable Deductibles, Coinsurance and/or Copayments under this plan. Financial arrangements with Non-Network Providers are negotiated on a case-by-case basis. We will request that the Non-Network Provider agree to negotiate reimbursement and/or contractual requirements that apply to Network Providers, including payment terms. If the Non-Network Provider does not agree to negotiate said reimbursement and/or contractual requirements, we are not required to continue that Provider's services. If the Covered Person does not meet the criteria for Transition Assistance, the Covered Person is afforded due process including having a Physician review the request.

~~**Continuation of Care after Termination of Provider**~~

~~Subject to the terms and conditions set forth below, we will pay benefits to a Covered Person at the Network Provider level for Covered Services (subject to applicable Copayments, Coinsurance, Deductibles and other terms) rendered by a Provider whose participation in Anthem's Provider network has terminated, including when the termination is without cause.~~

- ~~The Covered Person must be under the care of the Network Provider at the time of our termination of the Provider's participation. The terminated Provider must agree in writing to provide services to the Covered Person in accordance with the terms and conditions of his/her agreement with Anthem prior to termination. The Provider must also agree in writing to accept the terms and reimbursement rates under his/her agreement with Anthem prior to the termination. If the Provider does not agree with these contractual terms and conditions, we are not required to continue the Provider's services beyond the contract termination date.~~

  ~~We will furnish such benefits for the continuation of services by a terminated Provider only for any of the following conditions (includes treatment for Mental Health and Substance Abuse, where applicable):~~

  - ~~An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of Covered Services shall be provided for the duration of the acute condition.~~

  - ~~A serious chronic condition. A serious chronic condition is a medical condition due to a disease, illness or other medical problem or medical disorder that is serious in nature and~~

that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of Covered Services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another Provider, as determined by Anthem in consultation with the Member and the terminated Provider and consistent with good professional practice. Completion of Covered Services shall not exceed twelve (12) months from the Provider's contract termination date.

- A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of Covered Services shall be provided for the duration of the pregnancy.

- A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one (1) year or less. Completion of Covered Services shall be provided for the duration of the terminal illness.

- The care of a newborn child between birth and age thirty-six (36) months. Completion of Covered Services shall not exceed twelve (12) months from the Provider's contract termination date.

- Performance of a surgery or other procedure that we have authorized as part of a documented course of treatment and that has been recommended and documented by the Provider to occur within 180 days of the Provider's contract termination date.

- Such benefits will not apply to Providers who have been terminated due to medical disciplinary cause or reason, fraud, or other criminal activity.

- Please contact Pre-Authorization Review Department at the telephone number on the back of your Member Identification Card to request continuation of care or to obtain a copy of the written policy. Eligibility is based on the Covered Person's clinical condition; it is not determined by diagnostic classifications. Continuation of care does not provide coverage for services not otherwise covered under the Agreement.

  We will notify you by telephone, and the Provider by telephone and fax, as to whether or not your request for continuation of care is approved. If approved, the Covered Person will be financially responsible only for applicable Deductibles, Coinsurance and/or Copayments under this plan. Financial arrangements with terminated Providers are negotiated on a case-by-case basis. We will request that the terminated Provider agree to negotiate reimbursement and/or contractual requirements that apply to Network Providers, including payment terms. If the terminated Provider does not agree to negotiate said reimbursement and/or contractual requirements, we are not required to continue that Provider's services. If you disagree with our determination regarding continuation of care, please refer to the "Third Party Recovery" section for additional details.

The provider, patient or family member must call this number to receive certification of certain Cost Management Services. This call must be made at least in advance of services being rendered or within 24 hours after a Medical Emergency.

Any costs incurred because of reduced reimbursement due to failure to follow cost management procedures will not accrue toward the 100% maximum out-of-pocket payment.

CASE MANAGEMENT

Case Management. The Plan may elect, in its sole discretion, when acting on a basis that precludes individual selection, to provide alternative benefits that are otherwise excluded under the Plan. The alternative benefits, called "Case Management," shall be determined on a case-by-case basis, and the Plan's determination to provide the benefits in one instance shall not obligate the Plan to provide the same or similar alternative benefits for the same or any other Covered Person, nor shall it be deemed to waive the right of the Plan to strictly enforce the provisions of the Plan.

A case manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

-- personal support to the patient;

-- contacting the family to offer assistance and support;

-- monitoring Hospital or Skilled Nursing Facility;

-- determining alternative care options; and

-- assisting in obtaining any necessary equipment and services.

Case Management occurs when this alternate benefit will be beneficial to both the patient and the Plan.

The case manager will coordinate and implement the Case Management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Plan Administrator, attending Physician, patient and patient's family must all agree to the alternate treatment plan.

Once agreement has been reached, the Plan Administrator will direct the Plan to cover Medically Necessary expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan. Unless specifically provided to the contrary in the Plan Administrator's instructions, reimbursement for expenses incurred in connection with the treatment plan shall be subject to all Plan limits and cost sharing provisions.

Note: Case Management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

CONTINUITY OF CARE

In the event a Covered Person is a continuing care patient receiving a course of treatment from a Provider which is In-Network or otherwise has a contractual relationship with the Plan governing such care and that contractual relationship is terminated, not renewed, or otherwise ends for any reason other than the Provider's failure to meet applicable quality standards or for fraud, the Participant shall have the following rights to continuation of care.

The Plan shall notify the Covered Person that the Provider's contractual relationship with the Plan has terminated, and that the Covered Person has rights to elect continued transitional care from the Provider. If the Covered Person elects in writing to receive continued transitional care, Plan benefits will apply under the same terms and conditions as would be applicable had the termination not occurred, beginning on the date the Plan's notice of termination is provided and ending 90 days later or when the Covered Person ceases to be a continuing care patient, whichever is sooner.

For purposes of this provision, "continuing care patient" means an individual who:

(1) is undergoing a course of treatment for a serious and complex condition from a specific Provider,

(2) is undergoing a course of institutional or Inpatient care from a specific Provider,

(3) is scheduled to undergo non-elective surgery from a specific Provider, including receipt of postoperative care with respect to the surgery,

(4) is pregnant and undergoing a course of treatment for the Pregnancy from a specific Provider, or

(5) is or was determined to be terminally ill and is receiving treatment for such illness from a specific Provider.

Note that during continuation, Plan benefits will be processed as if the Provider termination had not occurred and the Covered Person is responsible for their In-Network share of cost.

DEFINED TERMS

Certified IDR Entity is an entity responsible for conducting determinations under the No Surprises Act and that has been properly certified by the Department of Health and Human Services, the Department of Labor, and the Department of the Treasury.

Emergency Medical Condition means a medical screening examination and associated services to treat a condition that requires immediate medical attention that would reasonably expect to result in (a) serious jeopardy to the health of an individual (or in the case of a pregnant person, the health of the unborn child); (b) serious impairment to bodily function; or (c) serious dysfunction of any bodily organ or part. Emergency Services include pre-stabilization services that are provided after a patient is moved out of the emergency department and admitted to a Hospital, as well as any additional services rendered after a patient is stabilized as part of Outpatient observation or an Inpatient or Outpatient stay with respect to the visit in which other Emergency Services are furnished. These services include those provided at an Independent Freestanding Emergency Department as well as a Hospital emergency department. A decision of what constitutes Emergency Services will not be defined solely on the basis of the diagnosis but rather will be a determination that takes into account the reasonableness of each situation as defined by a prudent layperson.

~~**Emergency Services** means a medical screening examination (as required under Section 1867 of the Social Security Act (EMTALA)) within the capability of the Hospital emergency department, including routine ancillary services, to evaluate a Medical Emergency and such further medical examination and treatment as are within the capabilities of the staff and facilities of the Hospital and required under EMTALA to stabilize the patient.~~

Emergency Services means, with respect to an Emergency Medical Condition, the following:

(1) An appropriate medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital or of an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and

(2) Within the capabilities of the staff and facilities available at the Hospital or the Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd), or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further examination or treatment is furnished).

When furnished with respect to an Emergency Medical Condition, Emergency Services shall also include an item or service provided by a Non-Network Provider or Non-Participating Health Care Facility

(regardless of the department of the Hospital in which items or services are furnished) after the Participant is stabilized and as part of Outpatient observation or an Inpatient or Outpatient stay with respect to the visit in which the Emergency Services are furnished, until such time as the Provider determines that the Participant is able to travel using non-medical transportation or non-emergency medical transportation, and the Participant is in a condition to, and in fact does, give informed consent to the Provider to be treated as a Non-Network Provider.

Independent Freestanding Emergency Department is a health care facility that is geographically separate and distinct, and licensed separately, from a Hospital under applicable state law, and which provides any Emergency Services.

~~**Medical Emergency** means a medical condition manifesting itself by acute symptoms of sufficient severity including severe pain such that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in (1) serious jeopardy to the health of an individual (or, in the case of a pregnant woman, the health of the woman or her unborn child), (2) serious impairment to body functions, or (3) serious dysfunction of any body organ or part. A Medical Emergency includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.~~

No Surprises Act (NSA) is the Title I of the Consolidated Appropriations Act of 2021 or any provision or section thereof and which may be amended from time to time.

Participating Health Care Facility is a Hospital, Ambulatory Surgical Center, or other Provider as required by law, which has a direct or indirect contractual relationship with the Plan with respect to the furnishing of a healthcare item or service. A single direct contract or case agreement between a health care facility and a plan constitutes a contractual relationship for purposes of this definition with respect to the parties to the agreement and particular individual(s) involved.

Qualifying Payment Amount: The median of the contracted rates recognized by the Plan for the same or a similar item or service provided by a Provider in the same or similar specialty in the same geographic region. If there are insufficient (meaning at least three) contracted rates available to determine a Qualifying Payment Amount, said amount will be determined by referencing a state all-payer claims database or, if unavailable, any eligible third-party database in accordance with applicable law.

Recognized Charge is the lower of:

(1) The provider's usual charge to provide a service or supply, or

(2) The charge the Claims Administrator determines to be the recognized charge percentage for the service or supply, or

(3) The charge the Claims Administrator determines to be appropriate, based on factors such as:

- **(a)** The cost of supplying the same or similar service or supply;
- **(b)** The manner in which the charges for the service or supply are made;
- **(c)** The complexity of the service or supply;
- **(d)** The degree of skill needed to provide it;
- **(e)** The provider's specialty; and
- **(f)** The Recognized Charge in other areas.

(4) The Qualified Payment Amount.

For Non-Network charges subject to the No Surprises Act, the recognized charge may be the amount deemed payable by a Certified IDR Entity.

PLAN EXCLUSIONS

(6) **Complications of non-covered treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan are not covered, except as required under the No Surprises Act.

(28) **Illegal acts.** Charges for services received as a result of Injury or Sickness occurring directly or indirectly, as a result of the Covered Person's commission of or attempt to commit a Serious Illegal Act, or a riot or public disturbance. For purposes of this exclusion, the term "Serious Illegal Act" shall mean any act or series of acts that, if prosecuted as a criminal offense, a sentence to a term of imprisonment in excess of one year could be imposed. It is not necessary that criminal charges be filed, or, if filed, that a conviction result, or that a sentence of imprisonment for a term in excess of one year be imposed for this exclusion to apply. Proof beyond a reasonable doubt is not required. This exclusion does not apply if the Injury or Sickness resulted from an act of domestic violence, or a medical (including both physical and mental health) condition, or as required under the No Surprises Act.

(29) **Illegal drugs or medications.** Services, supplies, care or treatment to a Covered Person for Injury or Sickness resulting from that Covered Person's voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for Injured Covered Persons other than the person using controlled substances and expenses will be covered for Substance Abuse treatment as specified in this Plan. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition, or as required under the No Surprises Act.

(36) **Non-compliance**. All charges in connection with treatments or medications where the patient either is in non-compliance with medical orders issued while an inpatient at, or is discharged against medical advice from a Hospital or Skilled Nursing Facility, except as required under the No Surprises Act.

(49) **Self-Inflicted.** Any loss due to an intentionally self-inflicted Injury, except as required under the No Surprises Act. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

HOW TO SUBMIT A CLAIM

EXTERNAL REVIEW PROCESS

If a claimant receives a Final Adverse Benefit Determination under the Plan's internal Claims and Appeals Procedures, he or she may request that the Claim be reviewed under the Plan's External Review process. For requests made on or after September 20, 2011, the External Review process is available only where the Final Adverse Benefit Determination is denied on the basis of (1) a medical judgment (which includes but is not limited to, Plan requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; eligibility for a reasonable alternative under a wellness program; or application of non-quantitative treatment limitations), (2) a determination that a treatment is experimental or investigational, (3) a rescission of coverage, or (4) consideration of whether the Plan is complying with the surprise billing and cost-sharing protections set forth in the No Surprises Act. The request for External Review must be filed in writing within four (4) months after receipt of the Final Adverse Benefit Determination.

It is agreed that these changes shall be an amendment to the 8x8 Inc. PPO Plan Document and Summary Plan Description and shall become a part of the Plan, but shall not otherwise vary, alter or extend the terms of the Plan.