8x8 PPO WITH HSA PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION FOR

8X8 INC.

Effective January 1, 2021

8x8 INC. PPO WITH HSA
PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION
AMENDMENT #1

This amendment is attached to and made a part of the 8x8 Inc. PPO with HSA Plan Document and Summary Plan Description. Amendment # 1 is effective **January 1, 2021** and reflects the following changes:

- Change the language to reflect that Network and Non-Network deductibles are combined as shown below in the Schedule of Benefits.

MEDICAL BENEFITS SCHEDULE

COVERED CHARGES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
DEDUCTIBLE, PER CALENDAR YEAR - Network and Non-Network Deductibles are combined. Medical and Prescription amounts are combined.		
Individual Plan	$1,500	$1,500
Family Plan (aggregate)	$3,000	$3,000

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.

8x8 INC. PPO WITH HSA
PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION
AMENDMENT #2

This amendment is attached to and made a part of the 8x8 Inc. PPO with HSA Plan Document and Summary Plan Description. Amendment #2 is effective **January 1, 2021** and reflects the following changes:

- Add Family counseling to the Schedule of Benefits as shown below.
- Add Family counseling to the Covered Charges section as shown below.

MEDICAL BENEFITS SCHEDULE

COVERED CHARGES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Family Counseling	10% after deductible	40% after deductible

MEDICAL BENEFITS

COVERED CHARGES

(q) **Family counseling** regardless of diagnosis.

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.

8x8 INC. PPO WITH HSA
PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION
AMENDMENT #3

This amendment is attached to and made a part of the 8x8 Inc. PPO with HSA Plan Document and Summary Plan Description. Amendment #3 is effective **January 1, 2021** and reflects the following changes:

- Add medical and prescription drug coverage for the diagnosis and treatment of the underlying cause of infertility.

MEDICAL BENEFITS SCHEDULE

COVERED CHARGES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Infertility	Covered the same as any other Illness based on place and type of service	Covered the same as any other Illness based on place and type of service
Includes: care, supplies and services for the diagnosis, charges for surgical correction of physiological abnormalities of infertility.		

MEDICAL BENEFITS

COVERED CHARGES

(w) Care, supplies and services for the diagnosis, charges for surgical correction of physiological abnormalities of **infertility**.

PLAN EXCLUSIONS

(30) Infertility. Care, supplies, services, treatment and prescription drugs for infertility, except for diagnostic services rendered for infertility evaluation, charges for surgical correction of physiological abnormalities. This exclusion includes all impregnation procedures. Please refer to the Prescription Drug section for Prescription Drug coverage.

PRESCRIPTION DRUG BENEFITS

Expenses Not Covered

(13) Infertility. A charge for infertility medication, except for medications to treat the underlying cause of infertility. All infertility medications require prior-authorization.

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.

8x8 INC. PPO WITH HSA
PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION
AMENDMENT #4

This amendment is attached to and made a part of the 8x8 Inc. PPO with HSA Plan Document and Summary Plan Description. Amendment #4 is effective **January 1, 2022** and reflects the following changes:

- Amend the Plan to change the Prescription Drug Pharmacy Option Generic Drugs copayment from $10 to $15.
- Amend the Plan to change the Prescription Drug Mail Order Option Generic Drugs copayment from $20 to $30.
- Amend the Plan to change the Prescription Drug Pharmacy Option Preferred Brand Name Drugs from $25 to $30.
- Amend the Plan to change the Prescription Drug Mail Order Option Preferred Brand Name Drugs copayment from $50 to $60.
- Amend the Plan to change the Prescription Drug Pharmacy Option Non-Preferred Brand Name Drugs from $40 to $45.
- Amend the Plan to change the Prescription Drug Mail Order Option Non-Preferred Brand Name Drugs copayment from $80 to $90.
- Add a Medical Benefit for services received Traveling Outside of the United States.
- Add a Plan Exclusions for Services Received Outside of the United States.

MEDICAL BENEFITS SCHEDULE

COVERED CHARGES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Pharmacy Option (First Choice Pharmacies - up to 90 Day Supply. Non-First Choice Pharmacies up to 30 Day Supply)		
Generic Drugs	$15 copayment after deductible is satisfied	Not Covered
Preferred Brand Name Drugs	$30 copayment after deductible is satisfied	Not Covered
Non- Preferred Brand Name Drugs	$45 copayment after deductible is satisfied	Not Covered
Specialty Drugs	30% after deductible is satisfied, up to $200 maximum payment per prescription	Not Covered
Mail Order Option (90 Day Supply - Mail Order and First Choice Pharmacies)		
Generic Drugs	$30 copayment after deductible is satisfied	Generic Drugs
Preferred Brand Name Drugs	$60 copayment after deductible is satisfied	Preferred Brand Name Drugs
Non- Preferred Brand Name Drugs	$90 copayment after deductible is satisfied	Non- Preferred Brand Name Drugs

MEDICAL BENEFITS

COVERED CHARGES

(pp) In the case of illness or injury while **traveling outside the United States**, the plan will cover eligible medical expenses incurred within a foreign country for urgent and emergent care, provided the travel was not for the purpose of obtaining the treatment. Services while traveling outside of the US are covered as out of network. The member may be responsible to pay all providers directly for any services obtained while traveling outside of the US. Members will need to request an itemized billing statement, translated into English, from the facility or provider where services were rendered. In addition, the member will need to submit proof of payment with the itemized bill, directly to HealthComp for processing of the claim as a direct member reimbursement for services covered under the health plan.

Reimbursement will be based on the currency conversion rate on the day the claim(s) is processed by HealthComp, not the day services were incurred.

PLAN EXCLUSIONS

(51) Services Received Outside of the United States. Services rendered by Providers located outside the United States, unless the services are for Emergency Care, Urgent Care and Emergency Ambulance resulting from an Illness or Injury. Services provided out of the United States are considered Non-Network charges.

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.

8x8 INC. PPO WITH HSA
PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION
AMENDMENT #5

This amendment is attached to and made a part of the 8x8 Inc. PPO with HSA Plan Document and Summary Plan Description. Amendment #5 is effective **January 1, 2022** and reflects the following changes:

- Change the Ambulance Service, Non-Emergent - Air Transport benefit as shown below.

SCHEDULE OF BENEFITS

MEDICAL BENEFITS SCHEDULE

COVERED CHARGES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Ambulance Service – Non-Emergent - Air transport	10% after deductible Air transport is limited to $50,000 per trip	10% after deductible $50,000 maximum payment by plan per trip
Ambulance Service – Non-Emergent - Ground transport	10% after deductible	40% after deductible $50,000 maximum payment by plan per trip

It is agreed that these changes shall be an amendment to the 8x8 Inc. PPO with HSA 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.

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

This amendment is attached to and made a part of the 8x8 Inc. PPO with HSA Plan Document and Summary Plan Description. Amendment #6 is effective on the below dates and reflects the following changes:

EFFECTIVE JANUARY 1, 2022

(1) Amend the Schedule of Benefits section to add Balance Billing language.

(2) Amend the Cost Management Services section to modify Continuity of Care language following the Case Management section.

(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. The definition of Medical Emergency is replaced with Emergency Medical Condition and Emergency Services is replaced as shown below. The Qualified Payment Amount has been added to the definition of Recognized Charge.

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

(5) Amend the How To Submit A Claim, External Review Process section.

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

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.

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 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.

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.

EFFECTIVE JANUARY 1, 2023

(1) Amend the Medical Benefits aggregate HDHP Deductible and embedded Out-of-Pocket language as shown below.

(2) Amend the Medical Benefits Schedule to reflect individual coverage as Self-only as shown below.

MEDICAL BENEFITS

Medical Benefits apply when Covered Charges are incurred by a Covered Person for care of an Injury or Sickness and while the person is covered for these benefits under the Plan.

DEDUCTIBLE

Deductible Amount. This is an amount of Covered Charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year a Covered Person under Self-only coverage must meet the Self- only deductible shown in the Schedule of Benefits. For family coverage, the entire family deductible must be met before benefits will be paid.

Family Coverage. When the maximum amount shown in the Schedule of Benefits has been incurred by members of a Family toward the Calendar Year deductible, the deductibles of all members of that Family will be considered satisfied for that year. In the case of Family Coverage, the entire family deductible must be met before benefits from this Plan will be paid.

BENEFIT PAYMENT

Each Year, benefits will be paid for the Covered Charges of a Covered Person that are in excess of the deductible. Payment will be made at the rate shown under reimbursement rate in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount or any listed limit of the Plan.

OUT-OF-POCKET LIMIT

Covered Charges are payable at the percentages shown each Calendar Year until the out-of-pocket limit shown in the Schedule of Benefits is met for Self-only coverage. Then, Covered Charges incurred will be payable at 100% (except for any charges excluded as shown in the Schedule of Benefits) for the rest of the Calendar Year.

When a Family Unit reaches the out-of-pocket limit, Covered Charges for that Family Unit will be payable at 100% (except for any charges excluded, as shown on the Schedule of Benefits) for the rest of the Calendar Year.

MEDICAL BENEFITS SCHEDULE

COVERED CHARGES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
DEDUCTIBLE, PER CALENDAR YEAR - Network and Non-Network Deductibles are combined. Medical and Prescription amounts are combined.		
Self-only	$1,500	$1,500
Family Coverage (aggregate)	$3,000	$3,000
No benefits will be paid for any member of a Family until the Family deductible has been met regardless of the number of participants it takes to meet the family deductible.		
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR - Network and Non-Network Out-of-Pocket amounts are not combined. Medical and Prescription amounts are combined.		
Self-only (embedded)	$3,000	$6,000
Family Unit	$6,000	$12,000
The Covered Person will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached. Once the Family out-of-pocket is reached, the Plan will pay 100% of the remainder of Covered Charges for the entire family for the rest of the Calendar Year unless stated otherwise.		

It is agreed that these changes shall be an amendment to the 8x8 Inc. PPO with HSA 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.

8x8 INC. PPO WITH HSA
PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION
AMENDMENT #7

This amendment is attached to and made a part of the 8x8 Inc. PPO with HSA Plan Document and Summary Plan Description. Amendment # 7 reflects the following changes:

EFFECTIVE JANUARY 1, 2022

(1) The Plan Exclusions for Self-Inflicted is replaced as shown below.

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

EFFECTIVE MAY 12, 2023

(1) Cost Sharing will apply to all services related to COVID-19 screenings and or testing. These services are allowed the same as any other illness based on place of service.

(2) The Note below in the Preventive Care section of the Medical Benefits Schedule has been deleted. The benefit for Network (and Non-Network if applicable) COVID-19 immunizations are the same as any other Preventive Care.

It is agreed that these changes shall be an amendment to the 8x8 Inc. PPO with HSA 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.

8x8 INC.
GROUP HEALTH PLAN AMENDMENT # 8

This amendment is attached to and made a part of the 8x8 Inc. Employee Health Plan. Amendment # 8 is effective **January 1, 2024,** and reflects the following changes:

- Change the name of the Prescription Benefits Manager from Southern Scripts to Liviniti.
- Increase Self-only deductible from $1,500 to $1,750 for both Network and Non-Network Providers.
- Increase Family deductible from $3,000 to $3,500 for both Network and Non-Network Providers.
- Increase Self-only Out-of-Pocket maximum from $3,000 to $3,500 for Network Providers.
- Increase Individual Out-of-Pocket maximum for Family coverage from $3,000 to $3,500 for Network Providers.
- Increase Family unit Out-of-Pocket maximum for Family coverage from $6,000 to $7,000 for Network Providers.
- Add Prior Authorization requirement to the Prescription Drug Benefit as shown below.

PLAN CONTACT INFORMATION

PRESCRIPTION BENEFITS MANAGER

Liviniti
(800)710-9341
www.liviniti.com

MEDICAL BENEFITS SCHEDULE

COVERED CHARGES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
DEDUCTIBLE, PER CALENDAR YEAR - the Network and Non-Network Calendar Year Maximum Deductible amount is combined. Medical and Prescription Drug amounts are combined.		
Self-only	$1,750	$1,750
Family coverage (aggregate)	$3,500	$3,500
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR - the Network and Non-Network Calendar Year Maximum Out-of-Pocket amount is combined. Medical and Prescription Out-of-Pocket Maximums are combined.		
Self-only	$3,500	$6,000
Family coverage Individual Family Unit	 $3,500 $7,000	 $6,000 $12,000
The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached. The Family out-of-pocket includes an embedded out-of-pocket whereby once an individual reaches the individual out-of-pocket, the Plan will pay 100% of the remainder of Covered Charges for that individual for the rest of the Calendar Year unless stated otherwise. Once the Family out-of-pocket is reached, the Plan will pay 100% of the remainder of Covered Charges for the entire family for the rest of the Calendar Year unless stated otherwise.		

PRESCRIPTION DRUG BENEFIT

Prior-Authorization

Prior-Authorization is required for the following:

(1) Prior Authorization is required for GLP-1 Receptor Agonists, brand weight loss medications, and CGRP Inhibitors regardless of previous use.

(2) Prior Authorization is required for new utilizers of Brand GI medications and PCSK-9 Inhibitors.

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

PLAN CONTACT INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group health Plan and the administration is provided through a Third Party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees. The Plan is not insured.

PLAN NAME
8x8 Inc. PPO with HSA

PLAN NUMBER: 501

TAX ID NUMBER: 77-0142404

PLAN EFFECTIVE DATE: January 1, 2021

PLAN YEAR ENDS: December 31

EMPLOYER INFORMATION
8x8 Inc.
675 Creekside Way
Campbell, California 95008
866-305-3950

PLAN ADMINISTRATOR
8x8 Inc.
675 N Creekside Way
Campbell, California 95008
866-305-3950

NAMED FIDUCIARY
8x8 Inc.
675 Creekside Way
Campbell, California 95008

AGENT FOR SERVICE OF LEGAL PROCESS
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CLAIMS ADMINISTRATORS
HealthComp Administrators
P.O Box 45018
Fresno, California 93718
1(800) 442-7247

PPO NETWORK
Anthem Blue Cross
P.O Box 60007
Los Angeles, California 90060-0007

PRE-AUTHORIZATION REVIEW ADMINISTRATOR
Anthem Blue Cross
(800)274-7767

PRESCRIPTION BENEFITS MANAGER

Southern Scripts
(800)710-9341
southernscripts.net

COBRA ADMINISTRATOR

PlanSource
(888)266-1732

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INTRODUCTION

This document is a description of 8x8 Inc. PPO with HSA (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses. This Plan is designed to be used with Health Savings Accounts (HSA).

The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, exclusions, limitations, definitions, eligibility and the like.

To the extent that an item or service is a covered benefit under the Plan, the terms of the Plan shall be applied in a manner that does not discriminate against a health care provider who is acting within the scope of the provider's license or other required credentials under applicable State law. This provision does not preclude the Plan from setting limits on benefits, including cost sharing provisions, frequency limits, or restrictions on the methods or settings in which treatments are provided and does not require the Plan to accept all types of providers as a Network Provider.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other cost management requirements, lack of Medical Necessity, lack of timely filing of claims or lack of coverage. These provisions are explained in summary fashion in this document; additional information is available from the Plan Administrator at no extra cost.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.

It is the intent of this Plan and the Plan Administrator to comply with all applicable Federal and State laws and regulations. In the event of non-compliance with any such law or regulation, the Plan Document will be deemed amended to comply with said law or regulation as of its effective date, and the remainder of the Plan Document will remain in full force and effect. Similarly, in the event a law or regulation applicable to this Plan becomes effective after the initial effective date of this Plan Document, said law or regulation will be deemed included in this Plan Document as of its effective date and without the necessity of an amendment to this Plan Document.

No action at law or in equity shall be brought to recover under any section of this Plan until the appeal rights provided have been exercised and the Plan benefits requested in such appeals have been denied in whole or in part.

A Member may not assign or transfer any benefits or rights that arise under the Plan or applicable law to any other person, including a healthcare provider, and any purported assignment or transfer is void. This includes (but is not limited to) an attempted assignment or transfer of claims for payment of benefits, breach of fiduciary duty, penalties or any other claim or remedy. For convenience, the Plan may pay any undisputed benefit directly to the healthcare provider, but this is not a waiver of this anti-assignment provision and does not make the healthcare provider an assignee or confer any other rights on the provider. Similarly, the Plan recognizes an authorized representative for purposes of the Plan's claims and appeal procedures, but the authorized representative is not an assignee and has no derivative rights with respect to the claim. However, this anti-assignment provision will not apply (1) to an assignment of a Covered Person's rights to the Plan or the Plan Administrator, or (2) to the extent required under Medicaid laws.

If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to Covered Charges incurred before termination, amendment or elimination.

This document summarizes the Plan rights and benefits for covered Employees and their Dependents and is divided into the following parts:

Schedule of Benefits. Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

Eligibility, Funding, Effective Date and Termination. Explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates.

Benefit Descriptions. Explains when the benefit applies and the types of charges covered.

Cost Management Services. Explains the methods used to curb unnecessary and excessive charges.

> **This part should be read carefully since each Participant is required to take action to assure that the maximum payment levels under the Plan are paid.**

Defined Terms. Defines those Plan terms that have a specific meaning.

Plan Exclusions. Shows what charges are **not** covered.

Claim Provisions. Explains the rules for filing claims and the claim appeal process.

Coordination of Benefits. Shows the Plan payment order when a person is covered under more than one plan.

Third Party Recovery Provision. Explains the Plan's rights to recover payment of charges when a Covered Person has a claim arising out of an accidental illness or injury, including but not limited to worker's compensation claims.

Continuation Coverage Rights Under COBRA. Explains when a person's coverage under the Plan ceases and the continuation options which are available.

ERISA Information. Explains the Plan's structure and the Participants' rights under the Plan.

Notice re U.S. Code §1557 Compliance
Discrimination is Against the Law

8x8 Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

8x8 Inc. does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

SCHEDULE OF BENEFITS

MEDICAL BENEFITS

All benefits described in this Schedule are percentages paid by the Covered Person 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.

Note: The following services must be pre-authorized or reimbursement from the Plan may be reduced.

(1) All inpatient Hospital and Skilled Nursing Facility stays.
(2) Facility based Treatment for Mental or Nervous Disorders or Substance Abuse.
(3) Home Health Care.
(4) All Organ and Tissue Transplants, peripheral stem cell replacement and similar procedures.
(5) Infusion Therapy that includes Specialty Drugs in the specialty pharmacy program, and related services (for each Course of Therapy) in any setting, including, but not limited to: Physician's office, infusion center, outpatient Hospital or clinic, or your home or other residential setting.
(6) Certain surgical, diagnostic procedures, Durable Medical Equipment and/or prosthetics wherever rendered as specified by Anthem Blue Cross. For a list of current procedures that require pre-authorization, please contact Anthem Blue Cross toll free at (800) 274-7767.

The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

Please see the Cost Management section in this booklet for details.

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care providers, which are called Network Providers. Because these Network Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees.

When a Covered Person uses a Network Provider, that Covered Person will receive a higer reimbursement from the Plan than when a Non-Network Provider is used. It is the Covered Person's choice as to which Provider to use. Terms of agreements that allow the Plan access to Network Providers and other discounts may differ from provisions of the Plan and will be honored by the Plan as required except those claims related to dialysis.

Under the following circumstances, the higher In-Network payment will be made for certain Non-Network services:

If a Covered Person has a Medical Emergency requiring immediate care. Please see definition of Medial Emergency on page 39.

If a Covered Person has no choice of a Network Provider and receives services by a Non-Network Provider at a network facility.

Deductibles and certain Copayments are payable by Plan Participants.

Copayments and Deductibles are dollar amounts that the Covered Person must pay before the Plan pays. See the Schedule of Benefits for details.

A deductible is an amount of money that is paid once a Year per Covered Person or Family Unit. On the first day of each Year, a new deductible amount is required. For individual coverage, the Covered Person must meet the individual deductible before any money is paid by the Plan for any Covered Charge. For family coverage, the Plan will begin to pay Covered Charges when the entire family deductible has been met. Deductibles accrue toward the 100% maximum out-of-pocket payment.

MEDICAL BENEFITS SCHEDULE

COVERED CHARGES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
DEDUCTIBLE, PER CALENDAR YEAR - Network and Non-Network Deductibles are not combined. Medical and Prescription amounts are combined.		
Individual Plan	$1,500	$1,500
Family Plan (aggregate)	$3,000	$3,000
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR - Network and Non-Network Out-of-Pocket amounts are not combined. Medical and Prescription amounts are combined.		
Per Covered Person (embedded)	$3,000	$6,000
Per Family Unit	$6,000	$12,000
The Covered Person will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached. The Family out-of-pocket includes an embedded out-of-pocket whereby once an individual reaches the single coverage out-of-pocket, the Plan will pay 100% of the remainder of Covered Charges for that individual for the rest of the Calendar Year unless stated otherwise. Once the Family out-of-pocket is reached, the Plan will pay 100% of the remainder of Covered Charges for the entire family for the rest of the Calendar Year unless stated otherwise.		
The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%. Amounts over the Allowed Amount Penalties for failure to follow pre-authorization procedures		
COVERED CHARGES		
Note: The maximums listed below are the total for Network and Non-Network expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total which may be split between Network and Non-Network providers.		
Percentage Payable – by the Covered Person unless otherwise stated.	10% after deductible	40% after deductible
Acupuncture	10% after deductible 30 visits per calendar year maximum	40% after deductible 30 visits per calendar year maximum
Ambulance Service - Emergent	10% after deductible	10% after deductible
Ambulance Service - Non-Emergent	10% after deductible	40% after deductible $50,000 maximum payment by plan per trip
Autism Spectrum Disorders		
Office Visits and Medication Management	10% after deductible	40% after deductible
Mental Health Psychotherapy	10% after deductible	40% after deductible
Habilitative Therapy	10% after deductible	40% after deductible
Applied Behavioral Analysis Therapy	10% after deductible	40% after deductible
Bariatric Surgery – Must be performed at a Blue Distinction facility	10% after deductible	Not Covered
Bariatric Surgery Travel – The Covered Person must reside 50 miles or more from the approved Blue Distinction facility	No Charge $3,000 maximum per surgery	Not Covered
Birthing Center	10% after deductible	40% after deductible $1,000 maximum payment by plan per day
Contraceptive Methods - In accordance with Patient Protection Affordable Care Act	No Charge	40% after deductible
CT Scans, MRI and PET Scans	10% after deductible	40% after deductible $800 maximum payment by plan per procedure when done in an outpatient setting
Diabetes Education	10% after deductible	40% after deductible
Diabetes Supplies/Equipment	10% after deductible	40% after deductible
Dialysis - Home	10% after deductible	40% after deductible
Dialysis - Outpatient	10% after deductible	40% after deductible $350 maximum payment by plan per service

COVERED CHARGES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Durable Medical Equipment	50% after deductible	50% after deductible
Emergency Room Visit – Including professional services. Please see definition of Medical Emergency on page 38.	10% after deductible	10% after deductible
Gene Therapy	Covered as any other illness based on place and type of service.	Not Covered
Home Health Care – includes Private Duty nursing	10% after deductible 100 visits per calendar year maximum	40% after deductible 100 visits per calendar year maximum
Home Infusion Therapy	10% after deductible	40% after deductible $600 maximum payment by plan per day
Hospice Care	10% after deductible	40% after deductible
Bereavement – if within 12 months of loss	10% after deductible	40% after deductible
Respite Care	10% after deductible	40% after deductible
Hospital Services		
Inpatient - the semiprivate room rate	10% after deductible	40% after deductible $1,000 maximum payment by plan per day. Maximum payment does not apply to Emergency services.
Ambulatory/Outpatient Surgery Facilities	10% after deductible	40% after deductible $350 maximum payment by plan per service
Outpatient Services	10% after deductible	40% after deductible $350 maximum payment by plan per service
Jaw Joint Conditions / Temporomandibular Joint Syndrome (TMJ)	Covered as any other illness based on place and type of service.	Covered as any other illness based on place and type of service.
Lab & X-ray	10% after deductible	40% after deductible
LiveHealth Online	No Charge after deductible	Not Covered
Mental Disorders		
Inpatient - the facility's semiprivate room rate	10% after deductible	40% after deductible $1,000 maximum payment by plan per day. Maximum payment does not apply to Emergency services.
Outpatient	10% after deductible	40% after deductible
Office Setting	10% after deductible	40% after deductible
Residential Treatment Facility	10% after deductible	40% after deductible $1,000 maximum payment by plan per day. Maximum payment does not apply to Emergency services.
Nutritional Counseling	10% after deductible	40% after deductible
Organ Transplants – for recipient and donor. Must use an approved Center of Medical Excellence.	Covered as any other illness based on place and type of service. $30,000 per transplant maximum payment by plan for unrelated donor searches.	Not Covered

COVERED CHARGES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Accommodations and Travel for Organ Transplants	10% after deductible $10,000 maximum payment by plan per transplant if to a Center of Medical Excellence facility when member resides 75 or more miles away.	Not Covered
Orthotics – including foot orthotics if related to diabetes	10% after deductible	40% after deductible
Physician Services		
Inpatient visits	10% after deductible	40% after deductible
Office visits	10% after deductible	40% after deductible
Office Visit Services – including Minor Surgery, Lab, X-ray, and Supplies	10% after deductible	40% after deductible
Surgery (Inpatient and Outpatient)	10% after deductible	40% after deductible
Assistant Surgeon and Anesthesiologists	10% after deductible	40% after deductible
Allergy Injections, and Serum	10% after deductible	40% after deductible
Allergy Testing	10% after deductible	40% after deductible
Pre-Admission Testing	10% after deductible	40% after deductible
Pregnancy	Covered as any other illness based on place and type of service.	Covered as any other illness based on place and type of service.
Prenatal testing	No Charge	40% after deductible
NOTE: AFP screening/testing through the State of California will be paid 100% deductible waived for Network and Non-Network providers.		
Prescription Drug Benefit Please contact the Prescription Drug Administrator for additional information.		
Pharmacy Option (First Choice Pharmacies - up to 90 Day Supply. Non-First Choice Pharmacies up to 30 Day Supply)		
Generic Drugs	$10 copayment after deductible is satisfied	Not Covered
Preferred Brand Name Drugs	$25 copayment after deductible is satisfied	Not Covered
Non- Preferred Brand Name Drugs	$40 copayment after deductible is satisfied	Not Covered
Specialty Drugs	30% after deductible is satisfied, up to $200 maximum payment per prescription	Not Covered
Mail Order Option (90 Day Supply - Mail Order and First Choice Pharmacies)		
Generic Drugs	$20 copayment after deductible is satisfied	Not Covered
Preferred Brand Name Drugs	$50 copayment after deductible is satisfied	Not Covered
Non- Preferred Brand Name Drugs	$80 copayment after deductible is satisfied	Not Covered
Variable Copay Pharmacy-CRx: The plan has adopted the Southern Scripts Variable Copay™ Program to help members who utilize manufacturer copay programs save money on prescription drugs. Under the Variable Copay™ Program, your out-of-pocket cost for prescription drugs may be reduced or eliminated by a drug manufacturer's copay subsidy. If you are eligible to receive a manufacturer copay subsidy for a drug, your copay obligation for that drug will be the maximum manufacturer copay subsidy for that drug. Note Any manufacturer copay subsidy obtained under the Variable Copay™ Program will not accumulate toward your deductible or out of pocket costs. If you are not eligible to receive a manufacturer copay subsidy, your copay obligation will be the copay amount listed for the drug in the standard formulary under the plan. Note if you are eligible for a manufacturer copay subsidy for a drug but fail to obtain the subsidy, your copay obligation – and the out-of-pocket cost you may be required to pay – will be the maximum manufacturer copay subsidy for that drug. A		

COVERED CHARGES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
detailed schedule of subsidies available through manufacturer copay programs under the Variable Copay™ Program is available at www.crxspecialty.com. Manufacturer Free Drug Initiative: The plan offers voluntary enrollment in the Manufacturer Free Drug Initiative to help members save money on prescription drugs. If you choose to enroll and receive a drug at no cost through a manufacturer free drug program, that drug will not be covered under the plan and you will have no cost sharing obligation to the plan for that drug. Sample language may be incorporated (as applicable) in the SBC templates produced jointly by the Department of Labor, Internal Revenue Service, and Department of Health and Human Services and is intended to satisfy the requirements of 26 C.F.R. Part 54, 29 C.F.R. Part 2590, and 15 C.F.R. Part 147. The language must be incorporated in a manner that satisfies the formatting requirements of the Summary of Benefits and Coverage, Instructions Guide for Group Coverage. Each employer should have its own attorney or other qualified advisor review the sample language and ensure its SBC complies with applicable law. Prescribing Physicians E-Prescribing to CRx*: (NPI 1336141381*) If you are the prescriber and you are E-Prescribing to CRx Variable Copay Pharmacy and have not updated your Electronic Medical Record (EMR), CRx may show up as Causey's Pharmacy. The NPI for CRx is 1336141381. In the event, you have an updated EMR system and are unable to locate CRx by the NPI provided, please add CRx to your existing database. CRx in short represents Causey's Pharmacy. Please send faxes and/or E-Prescriptions to 318-214-4190. If a prescription is sent to CRx and the medication cannot be filled through CRx, CRx will route the Prescription to a pharmacy within the Southern Scripts Preferred Network to be filled.		
In addition, it is the Plan Administrator's intent to comply with federal law regarding preventive care benefits under the Patient Protection and Affordable Care Act (PPACA). All prescriptions which qualify for the preventive care benefit, as defined by the appropriate federal regulatory agencies, and which are provided by a network-participating pharmacy, will be covered at 100% with no deductible or co-insurance required. Please Contact Southern Scripts at 1(800) 710-3941 for additional information.		
Preventive Care – Services as defined by the Patient Protection Affordable Care Act for Network and Non-Network Providers. See page 29 for additional information regarding Preventive Care services.		
Routine Well Care – All ages	No Charge	40% after deductible
Note: Cost sharing (deductibles, copayment and coinsurance) will be waived for FDA-approved COVID-19 vaccines for Network and Non-Network providers.		
Prosthetics	10% after deductible	40% after deductible
Rehabilitation – includes Physical, Speech, and Occupational Therapies		
Inpatient	10% after deductible	40% after deductible $1,000 maximum payment by plan per day
Outpatient	10% after deductible	40% after deductible
Skilled Nursing Facility – the facility's semiprivate room rate	10% after deductible 100 days allowed per calendar year maximum	40% after deductible 100 days allowed per calendar year maximum.
Spinal Manipulation Chiropractic	10% after deductible 30 visits per calendar year maximum	40% after deductible 30 visits per calendar year maximum
Substance Abuse		
Inpatient - the facility's semiprivate room rate	10% after deductible	40% after deductible $1,000 maximum payment by plan per day. Maximum payment does not apply to Emergency services.
Outpatient	10% after deductible	40% after deductible
Office Setting	10% after deductible	40% after deductible
Telemedicine – includes Mental Health and Substance Abuse	10% after deductible	40% after deductible
Transgender Surgery	Covered as any other illness based on place and type of service.	Covered as any other illness based on place and type of service.

COVERED CHARGES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Transgender Surgery Travel	No Charge. $10,000 maximum payment. Ground travel when the member lives 75 miles or more from the facility. Air travel if the member lives more than 300 miles from the facility.	
Urgent Care - includes physician services	10% after deductible	40% after deductible
Voluntary Sterilization		
Female	No Charge in accordance with PPACA	40% after deductible
Male	10% after deductible	40% after deductible

NOTE: Cost sharing (deductibles, copayments and coinsurance) will be waived for office visits, telehealth visits, urgent care center visits and emergency room visits that result in an order for or administration of an FDA approved COVID-19 diagnostic test, but only to the extent that services relate to the furnishing or administration of the COVID-19 test or to the evaluation for purposes of determining the need of the COVID-19 test for Network and Non-Network providers.

ELIGIBILITY, FUNDING, EFFECTIVE DATE TERMINATION PROVISIONS AND OPEN ENROLLMENT

Please refer to the 8X8, Inc. Employee Benefits Plan Wrap Plan Document and Summary Plan Description for this information.

MEDICAL BENEFITS

Medical Benefits apply when Covered Charges are incurred by a Covered Person for care of an Injury or Sickness and while the person is covered for these benefits under the Plan.

DEDUCTIBLE

Deductible Amount. This is an amount of Covered Charges for which no benefits will be paid. Before benefits can be paid in a Year a Covered Person under single coverage must meet the individual deductible shown in the Schedule of Benefits. For family coverage, the entire family deductible must be met before benefits will be paid.

Family Unit Limit. When the maximum amount shown in the Schedule of Benefits has been incurred by members of a Family Unit toward their Year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that year. In the case of family coverage, the entire family deductible must be met before benefits from this Plan will be paid.

BENEFIT PAYMENT

Each Year, benefits will be paid for the Covered Charges of a Covered Person that are in excess of the deductible. Payment will be made at the rate shown under reimbursement rate in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount or any listed limit of the Plan.

OUT-OF-POCKET LIMIT

Covered Charges are payable at the percentages shown each Year until the out-of-pocket limit shown in the Schedule of Benefits is reached. Then, Covered Charges incurred by a Covered Person will be payable at 100% (except for any charges excluded as shown in the Schedule of Benefits) for the rest of the Year.

When a Family Unit reaches the out-of-pocket limit, Covered Charges for that Family Unit will be payable at 100% (except for any charges excluded, as shown on the Schedule of Benefits) for the rest of the Year. Covered Charges for an individual family member who meets the individual out-of-pocket limit before the out-of-pocket limit for the Family Unit is met will be covered at 100% (except for any charges excluded as shown in the Schedule of Benefits) for the rest of the Year.

COVERED CHARGES

Covered Charges are the Allowable Charges that are incurred for the following items of service and supply. These charges are subject to the benefit limits, exclusions and other provisions of this Plan. A charge is incurred on the date that the service or supply is performed or furnished.

(1) **Hospital Care.** The medical services and supplies furnished by a Hospital or Outpatient Surgical Center or a Birthing Center. Covered Charges for room and board will be payable as shown in the Schedule of Benefits. After 23 observation hours, a confinement will be considered an inpatient confinement.

Charges for a Private Room will be limited to the semi-private room rate. The private room rate will apply if the facility only has private rooms available.

Charges for an Intensive Care Unit stay are payable.

(2) **Coverage of Pregnancy.** Charges for the care and treatment of Pregnancy are covered the same as any other Sickness.

Group health plans 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).

(3) **Skilled Nursing Facility Care.** The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if and when:

(a) the patient is confined as a bed patient in the facility; and

(b) the attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and

(c) the attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility.

Covered Charges for a Covered Person's care in these facilities are payable as described in the Schedule of Benefits.

(4) **Physician Care.** The professional services of a Physician for surgical or medical services.

Charges for **multiple surgical procedures** will be a Covered Charge subject to the following provisions:

(a) If bilateral or multiple surgical procedures are performed by one (1) surgeon, benefits will be determined based on the Allowable Charge that is allowed for the primary procedures; 50% of the Allowable Charge will be allowed for each additional procedure performed through the same incision. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;

(b) If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on Allowable Charge for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the Allowable Charge percentage allowed for that procedure; and

(c) If an assistant surgeon is required, the assistant surgeon's Covered Charge will not exceed 20% of the surgeon's allowance.

(5) **Private Duty Nursing Care.** The private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.). Covered Charges for this service will be included to this extent:

(a) **Inpatient Nursing Care.** Charges are covered only when care is Medically Necessary or not Custodial in nature and the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive Care Unit.

(b) **Outpatient Nursing Care.** Charges are covered only when care is Medically Necessary and not Custodial in nature. The only charges covered for Outpatient nursing care are those shown below, under Home Health Care Services and Supplies. Outpatient private duty nursing care on a 24-hour-shift basis is not covered.

(6) **Home Health Care Services and Supplies.** Charges for home health care services and supplies are covered only for care and treatment of an Injury or Sickness when Hospital or Skilled Nursing Facility confinement would otherwise be required. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan.

Benefit payment for nursing, home health aide and therapy services is subject to the Home Health Care limit shown in the Schedule of Benefits.

A home health care visit will be considered a periodic visit by either a nurse or therapist, as the case may be, or four hours of home health aide services.

(7) **Hospice Care Services and Supplies.** Charges for hospice care services and supplies are covered only when the attending Physician has diagnosed the Covered Person's condition as being terminal, determined that the person is not expected to live more than twelve months and placed the person under a Hospice Care Plan.

Covered Charges for Hospice Care Services and Supplies are payable as described in the Schedule of Benefits.

Bereavement counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family (covered Spouse and/or other covered Dependents). Bereavement services must be furnished within twelve months after the patient's death.

(8) **Other Medical Services and Supplies.** These services and supplies not otherwise included in the items above are covered as follows:

(a) Surgical methods of terminating a pregnancy also called elective **abortion**.

(b) Charges for **acupuncture**.

(c) **Asthma Treatment Equipment and Supplies.** Benefits are available for inhaler spacers, nebulizers (including face masks and tubing), and peak flow meters when Medically Necessary for the management and treatment of pediatric asthma, including education to enable the Member to properly use the device(s).

(d) **Attention Deficit Disorders (ADD) and Attention Deficit Hyperactivity Disorders (ADHD).** Services, supplies, care or treatment to a Covered Person for the diagnosis of Attention Deficit Disorders (ADD) or Attention Deficit Hyperactivity Disorders (ADHD).

(e) Local Medically Necessary professional land or air **ambulance** service. A charge for this item will be a Covered Charge only if the service is to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided unless the Plan Administrator finds a longer trip was Medically Necessary.

(f) **Anesthetic**; oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.

(g) **Bariatric Surgery.** Services and supplies in connection with medically necessary surgery for weight loss, only for morbid obesity and only when performed at a designated Blue Distinction facility.

(h) **Bariatric Travel.** Certain travel expenses incurred in connection with an approved, specified bariatric surgery, performed at a designated Blue Distinction facility that is fifty (50) miles or more from the Covered person’s place of residence, are covered, provided the expenses are authorized in advance.

The following travel expenses incurred by the Covered person and/or one companion are considered Covered travel expenses:

- Transportation for the Covered person and/or one companion to and from the Blue Distinction facility.
- Lodging, limited to one room, double occupancy.
- Other reasonable expenses. Tobacco, alcohol, drug and meal expenses are excluded from coverage.

(i) **Cardiac rehabilitation** as deemed Medically Necessary provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; and (c) in a Medical Care Facility as defined by this Plan.

(j) Radiation or **chemotherapy** and treatment with radioactive substances. The materials and services of technicians are included.

(k) Routine patient care charges for **Clinical Trials.** Coverage is provided only for routine patient care costs for a Qualified Individual in an approved clinical trial for treatment of cancer or other life-threatening disease or condition. For these purposes, a Qualified Individual is a Covered Person who is eligible to participate in an approved clinical trial according to the trial protocol with respect to the treatment of cancer or another life-threatening disease or condition, and either: (1) the referring health care professional is a Network Provider and has concluded that the individual's participation in such trial would be appropriate; or (2) the Covered Person provides medical and scientific information establishing to the satisfaction of the Plan Administrator that the individual's participation in such trial would be appropriate. Coverage is not provided for charges not otherwise covered under the Plan, and does not include charges for the drug or procedure under trial, or charges which the Qualified Individual would not be required to pay in the absence of this coverage.

(l) Initial **contact lenses** or glasses required for treatment of keratoconus or glaucoma or following cataract surgery.

(m) Medical facility, anesthesia charges or any fees associated with **Dental Care** treatment that is determined to be medically necessary will be covered under the medical plan. Following are some examples of medical necessity:

(i) The patient is a child (up to 6 years old) with a dental condition that requires repairs of significant complexity (e.g., multiple restorations, pulpal therapy, extractions);

(ii) Patients with certain physical, intellectual or medically compromising conditions (e.g., mental retardation, cerebral palsy, epilepsy, cardiac problems, hyperactivity verified by appropriate medical documentation);

(iii) Extremely uncooperative, fearful, unmanageable, anxious or uncommunicative patients with substantial dental needs and no expectation that behavior will improve soon;

(iv) Patients with dental restorative or surgical needs for whom local anesthesia is ineffective (such as due to acute infection, anatomic variations or allergy);

(v) Patients who have sustained extensive orofacial or dental trauma, for which treatment under local anesthesia would be ineffective or compromised.

(n) **Diabetes Equipment and Supplies.** Benefits will be provided for the following Diabetes Equipment and Supplies:

- Blood glucose monitors, including monitors designed to assist the visually impaired, and blood glucose testing strips.
- Insulin pumps and related necessary supplies.
- Pen delivery systems for Insulin administration.
- Podiatric devices, such as therapeutic shoes and shoe inserts, to prevent and treat diabetes-related complications. These devices are covered under your Plan's benefits for Orthotics.

- Visual aids (but not eyeglasses) to help the visually impaired to properly dose Insulin.

(o) **Dialysis treatment.** Services for acute renal failure and chronic (end-stage) renal disease, including hemodialysis, home hemodialysis, home intermittent peritoneal dialysis (IPD), home continuous cycling peritoneal dialysis (CCPD), and home continuous ambulatory peritoneal dialysis (CAPD). Covered Services include dialysis treatments in an outpatient dialysis Facility. Covered Services also include home dialysis and training for you and the person who will help you with home self-dialysis. Coverage for equipment and medical supplies required for home hemodialysis and home peritoneal dialysis is limited to the standard item of equipment or supplies that adequately meets your medical needs.

(p) Rental of **durable medical or surgical equipment** if deemed Medically Necessary. These items may be bought rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase. Repair or replacement will be covered only when required due to growth or development of a dependent child, or deterioration from normal wear and tear if recommended by the attending physician.

(q) **Gender Dysphoria.** It is the intention of this Plan to comply with all applicable requirements of coverage regarding non-discrimination. Coverage and benefits are not affected by the sex, sexual orientation, or gender identification of the Covered Person.

Benefits for the following are covered at the same benefit levels as other services: mental health therapy; hormone therapy; and gender reassignment surgery which is medically necessary to treat the Covered Person's condition. Benefits for surgical services related to gender reassignment include: breast reduction, penectomy, orchiectomy, vaginoplasty, metoidioplasty, phalloplasty, and other related procedures.

The Plan's exclusions for services which are not medically necessary and/or cosmetic procedures are still applicable. For example, the Plan considers chondrolaryngoplasty procedures, electrolysis, rhinoplasty, cheek implantation, lip augmentation, breast enlargement, liposuction, and other facial surgeries to be cosmetic in nature and are therefore not covered benefits. (This is not an exhaustive list of excluded procedures.) If you have questions or concerns about coverage related to this benefit, please contact Member Services at the number listed on the back of your ID card for further information.

(r) **Gender Dysphoria Travel.** Certain travel expenses incurred in connection with an approved transgender surgery, when the hospital at which the surgery is performed is 75 miles or more from your place of residence, provided the expenses are authorized.

The following travel expenses incurred by you and one companion are considered Covered travel expenses:

- Ground transportation to and from the hospital when it is 75 miles or more from your place of residence.
- Coach airfare to and from the hospital when it is 300 miles or more from your residence.
- Lodging, limited to one room, double occupancy.
- Other reasonable expenses. Tobacco, alcohol, drug, and meal expenses are excluded.

(s) **Gene Therapy Services.** Your Plan includes benefits for gene therapy services, when precertified in advance. To be eligible for coverage, services must be Medically Necessary and performed by an approved Provider at an approved treatment center. Even if a Provider is an In-Network Provider for other services it may not be an approved Provider for certain gene therapy services.

(t) **Genetic testing** for the purpose of determining the need for fetal therapy or to determine a medically necessary intervention for the mother and when Medically Necessary for other conditions.

(u) **Habilitative** health care services and devices that help Covered Persons keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

(v) **Hearing Device.** Charges for cochlear implants, bone-anchored hearing aid, auditory brainstem implant, or any other surgically implantable device to correct hearing loss or surgery to implant such a device.

(w) Medically Necessary services for care and treatment of **jaw joint conditions, including Temporomandibular Joint syndrome (TMJ)**.

(x) **Laboratory studies.** Covered Charges for diagnostic and preventive lab testing and services.

(y) Treatment of **Mental Disorders and Substance Abuse** is payable as shown in the Schedule of Benefits.

(z) Injury to or care of **mouth, teeth and gums**. Charges for Injury within one year following injury or within one year of the Covered Persons effective date for care of the mouth, teeth, gums and alveolar processes. Covered Charges under Medical Benefits only if that care is for the following oral surgical procedures:

Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

Emergency repair due to Injury to sound natural teeth.

Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.

Excision of benign bony growths of the jaw and hard palate.

External incision and drainage of cellulitis.

Incision of sensory sinuses, salivary glands or ducts.

Reduction of dislocations and excision of temporomandibular joints (TMJs).

No charge will be covered under Medical Benefits for dental and oral surgical procedures involving extraction of teeth, surgery for impacted teeth, orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

(aa) **Occupational therapy** by a licensed therapist. Therapy must be ordered by a Physician, result from an Injury or Sickness and improve a body function. Covered Charges do not include recreational programs, maintenance therapy or supplies used in occupational therapy.

(bb) **Organ transplant** limits. Charges otherwise covered under the Plan that are incurred for the care and treatment due to an organ or tissue transplant are subject to these limits:

The transplant must be performed to replace an organ or tissue.

If the organ or tissue donor is a Covered Person and the recipient is not, then, the Plan will cover donor organ or tissue charges for:

evaluating the organ or tissue;

removing the organ or tissue from the donor, including complications from the donor procedure for up to six weeks from the date of procurement.

(cc) **Organ Transplant Travel.** Certain travel expenses incurred in connection with an approved, specified transplant (heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney, or bone marrow/stem cell and similar procedures) performed at a designated Center of Medical Excellence facility that is 75 miles or more from the recipient's or donor's place of residence are covered, provided the expenses are authorized in advance.

(dd) The initial purchase, fitting and repair of **orthotic appliances** such as braces, splints or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness.

(ee) Benefits are provided for behavioral health treatment for **Pervasive Developmental Disorder or autism**. Services covered under this Plan are payable as shown in the Schedule of benefits.

Behavioral Health Treatment

The behavioral health treatment services covered are those professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of an individual with Pervasive Developmental Disorder or autism and that meet all of the following requirements:

- The treatment must be prescribed by a licensed Physician and surgeon (an M.D. or D.O.) or developed by a licensed psychologist,

- The treatment must be provided under a treatment plan prescribed by a Qualified Autism Service Provider and administered by one of the following: (a) Qualified Autism Service Provider, (b) Qualified Autism Service Professional supervised by the Qualified Autism Service Provider, or (c) Qualified Autism Service Paraprofessional supervised by a Qualified Autism Service Provider or Qualified Autism Service Professional, and

- The treatment plan must have measurable goals over a specific timeline and be developed and approved by the Qualified Autism Service Provider for the specific patient being treated. The treatment plan must be reviewed no less than once every six months by the Qualified Autism Service Provider and modified whenever appropriate, and must be consistent with applicable state law that imposes requirements on the provision of applied behavioral analysis services and intensive behavioral intervention services to certain persons pursuant to which the Qualified Autism Service Provider does all of the following:

    - Describes the patient's behavioral health impairments to be treated,

    - Designs an intervention plan that includes the service type, number of hours, and parental participation needed (if any) to achieve the intervention

plan's goal and objectives, and the frequency at which the patient's progress is evaluated and reported,

- Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating Pervasive Developmental Disorder or autism, and

- Discontinues intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate.

- The treatment plan must not be used for purposes of providing or for the reimbursement of respite care, day care, or educational services, and must not be used to reimburse a parent for participating in the treatment program. The treatment plan must be made available to us upon request.

(ff) **Phenylketonuria (PKU).** Benefits for the testing and treatment of phenylketonuria (PKU) are paid on the same basis as any other medical condition. Coverage for treatment of PKU shall include those formulas and special food products that are part of a diet prescribed by a licensed Physician and managed by a health care professional in consultation with a Physician who specializes in the treatment of metabolic disease and who participates in or is authorized by the Plan. The diet must be deemed Medically Necessary to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU.

The cost of the necessary formulas and special food products is covered only as it exceeds the cost of a normal diet. “Formula” means an enteral product or products for use at home. The formula must be prescribed by a Physician or nurse practitioner, or ordered by a registered dietician upon Referral by a health care Provider authorized to prescribe dietary treatments, and is Medically Necessary for the treatment of PKU.

Formulas and special food products used in the treatment of PKU that are obtained from a Pharmacy are covered under your plan’s Prescription Drug benefits. Formulas and special food products that are not obtained from a Pharmacy are covered under this benefit.

“Special food product” means a food product that is all of the following:

- Prescribed by a Physician or nurse practitioner for the treatment of PKU, and

- Consistent with the recommendations and best practices of qualified health professionals with expertise in the treatment and care of PKU, and

- Used in place of normal food products, such as grocery store foods, used by the general population.

Note: It does not include a food that is naturally low in protein, but may include a food product that is specially formulated to have less than one gram of protein per serving.

(gg) **Physical therapy** must be administered in strict accordance with the referring Physician’s orders regarding type of therapy, frequency and duration. The condition treated must also be established as one which receives substantial benefit from short-term therapy.

(hh) Inpatient **Prescription** Drugs.

(ii) Routine **Preventive Care.** Covered Charges under Medical Benefits are payable for routine Preventive Care as described in the Schedule of Benefits. Standard Preventive Care shall be provided as required by applicable law if provided by a Network Provider. Standard Preventive Care for adults includes services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of Standard Preventive Care include:

- Screenings for: breast cancer, cervical cancer, colorectal cancer, high blood pressure, Type 2 Diabetes Mellitus, cholesterol, and obesity.
- Immunizations for adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and
- Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:
  -Breastfeeding support, supplies, and counseling.
  -Gestational diabetes screening.

Standard Preventive Care includes women's contraceptives, sterilization procedures, and counseling.

The list of services included as Standard Preventive Care may change from time to time depending upon government guidelines. A current listing of required preventive care can be accessed at:

- www.HealthCare.gov/center/regulations/prevention.html and
- www.cdc.gov/vaccines

Charges for Routine Well Adult Care. Routine well adult care is care by a Physician that is not for an Injury or Sickness.

Charges for Routine Well Child Care. Routine well child care is routine care by a Physician that is not for an Injury or Sickness. Standard Preventive Care shall be provided as required by applicable law if provided by a Network Provider. Standard Preventive Care for children includes services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of Standard Preventive Care include:

- Immunizations for children and adolescents recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. These may include:
  -Diphtheria,
  -Pertussis,
  -Tetanus,
  -Polio,
  -Measles,
  -Mumps,
  -Rubella,
  -Hemophilus influenza b (Hib),
  -Hepatitis B,
  -Varicella.
- Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration

The list of services included as Standard Preventive Care may change from time to time depending upon government guidelines. A current listing of required preventive care can be accessed at:

- www.HealthCare.gov/center/regulations/prevention.html and
- www.cdc.gov/vaccines

(jj) The initial purchase, fitting and repair of fitted **prosthetic devices** which replace body parts.

(kk) **Reconstructive Surgery.** Correction of abnormal congenital conditions and reconstructive mammoplasties will be considered Covered Charges.

This mammoplasty coverage will include reimbursement for:

(i) reconstruction of the breast on which a mastectomy has been performed,

(ii) surgery and reconstruction of the other breast to produce a symmetrical appearance, and

(iii) coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas,

in a manner determined in consultation with the attending Physician and the patient.

(ll) Care and treatment for **sleep disorders** when deemed Medically Necessary.

(mm) **Speech therapy** by a licensed therapist. Therapy must be ordered by a Physician and follow either: (i) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy) of a person; (ii) an Injury; or (iii) a Sickness. These provisions do not apply to habilitative care.

(nn) **Spinal Manipulation services** by a health care provider acting within the scope of his or her license.

(oo) **Surgical dressings**, splints, casts and other devices used in the reduction of fractures and dislocations.

(pp) Coverage of **Well Newborn Nursery/Physician Care**.

Charges for Routine Nursery Care. Routine well newborn nursery care is care while the newborn is Hospital-confined after birth and includes room, board and other normal well-baby care for which a Hospital makes a charge.

This coverage is only provided if the newborn child is an eligible Dependent and a parent (1) is a Covered Person who was covered under the Plan at the time of the birth, or (2) enrolls himself or herself (as well as the newborn child if required) in accordance with the Special Enrollment provisions with coverage effective as of the date of birth.

The benefit is limited to charges for routine well-baby nursery care for the newborn child while Hospital confined as a result of the child's birth.

Charges for covered routine nursery care will be applied toward the Plan of the covered parent.

This includes the circumcision of the newborn male during the initial hospital confinement.

Group health plans 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).

Charges for Routine Physician Care. The benefit is limited to charges for routine well-baby care made by a Physician for pediatric visits to the newborn child while Hospital confined as a result of the child's birth.

Charges for covered routine Physician care will be applied toward the Plan of the covered parent.

If the baby is ill, suffers an injury, premature birth, congenital abnormality or requires care other than routine care, benefits will be provided on the same basis as for any other eligible expense provided the child is added to the Plan and coverage is in effect.

(qq) Diagnostic **x-rays**.

COST MANAGEMENT SERVICES

Cost Management Services Phone Number

Please refer to the Member ID card for the Pre-Authorization Review phone number.

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.

UTILIZATION REVIEW

Utilization review is a program designed to help ensure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses.

The program consists of:

(a) Precertification of the Medical Necessity for the following non-emergency services before Medical and/or Surgical services are provided:

- **(i)** All inpatient Hospital and Skilled Nursing Facility stays.
- **(ii)** Facility based Treatment for Mental or Nervous Disorders or Substance Abuse.
- **(iii)** Home Health Care.
- **(iv)** All Organ and Tissue Transplants, peripheral stem cell replacement and similar procedures.
- **(v)** Infusion Therapy that includes Specialty Drugs in the specialty pharmacy program, and related services (for each Course of Therapy) in any setting, including, but not limited to: Physician's office, infusion center, outpatient Hospital or clinic, or your home or other residential setting.
- **(vi)** Certain surgical, diagnostic procedures, Durable Medical Equipment and/or prosthetics wherever rendered as specified by Anthem Blue Cross. For a list of current procedures, please contact Anthem Blue Cross toll free at (800) 274-7767.

(b) Retrospective review of the Medical Necessity of the listed services provided on an emergency basis;

(c) Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician; and

(d) Certification of services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

The purpose of the program is to determine what charges may be Medically Necessary. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care provider.

If a particular course of treatment or medical service is not certified, it means that either the Plan will not pay for the charges or the Plan will not consider that course of treatment as appropriate for the maximum reimbursement under the Plan. The patient is urged to find out why there is a discrepancy between what was requested and what was certified before incurring charges.

The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

In order to maximize Plan reimbursements, please read the following provisions carefully.

Here's how the program works.

Precertification. Before a Covered Person enters a Medical Care Facility on a non-emergency basis or receives other listed medical services, the utilization review administrator will, in conjunction with the attending Physician, certify the care. Precertification does not confirm or verify eligibility for coverage, nor is it a guarantee of payment. A non-emergency stay in a Medical Care Facility is one that can be scheduled in advance.

The utilization review program is set in motion by a telephone call from, or on behalf of, the Covered Person. Contact the utilization review administrator at the telephone number on your ID card **before** services are scheduled to be rendered with the following information:

- The name of the patient and relationship to the covered Employee
- The name, employee identification number and address of the covered Employee
- The name of the Employer
- The name and telephone number of the attending Physician
- The name of the Medical Care Facility, proposed date of admission, and proposed length of stay
- The proposed medical services

If there is an **emergency** admission to the Medical Care Facility, the patient, patient's family member, Medical Care Facility or attending Physician must contact the utilization review administrator **within 24 hours** or the first business day after the admission.

The utilization review administrator will precertify the number of days of Medical Care Facility confinement as determined by medical necessity. **Failure to follow this procedure may reduce reimbursement received from the Plan.**

If the Covered Person does not receive precertification as explained in this section, the benefit payment may be reduced by $500.

Concurrent review, discharge planning. Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are parts of the utilization review program. The utilization review administrator will monitor the Covered Person's Medical Care Facility stay or use of other medical services and coordinate with the attending Physician, Medical Care Facilities and Covered Person either the scheduled release or an extension of the Medical Care Facility stay or extension or cessation of the use of other medical services.

If the attending Physician feels that it is Medically Necessary for a Covered Person to receive additional services or to stay in the Medical Care Facility for a greater length of time than has been precertified, the attending Physician must request the additional services or days.

SECOND AND/OR THIRD OPINION PROGRAM

Certain surgical procedures are performed either inappropriately or unnecessarily. In some cases, surgery is only one of several treatment options. In other cases, surgery will not help the condition.

In order to prevent unnecessary or potentially harmful surgical treatments, the second and/or third opinion program fulfills the dual purpose of protecting the health of the Plan's Covered Persons and protecting the financial integrity of the Plan.

Benefits will be provided for a second (and third, if necessary) opinion consultation to determine the Medical Necessity of an elective surgical procedure. An elective surgical procedure is one that can be scheduled in advance; that is, it is not an emergency or of a life-threatening nature.

The patient may choose any board-certified specialist who is not an associate of the attending Physician and who is affiliated in the appropriate specialty.

While any surgical treatment is allowed a second opinion, the following procedures are ones for which surgery is often performed when other treatments are available.

Appendectomy	Hernia surgery	Spinal surgery
Cataract surgery	Hysterectomy	Surgery to knee, shoulder, elbow or toe
Cholecystectomy (gall bladder removal)	Mastectomy surgery	Tonsillectomy and adenoidectomy
Deviated septum (nose surgery)	Prostate surgery	Tympanotomy (inner ear)
Hemorrhoidectomy	Salpingo-oophorectomy (removal of tubes/ovaries)	Varicose vein ligation

PREADMISSION TESTING SERVICE

The Medical Benefits percentage payable will be for diagnostic lab tests and x-ray exams when:

(1) performed on an outpatient basis before a Hospital confinement;

(2) related to the condition which causes the confinement; and

(3) performed in place of tests while Hospital confined.

OUTPATIENT SURGERY

Certain surgical procedures can be performed safely and efficiently outside of a Hospital. Outpatient surgical facilities are equipped for many uncomplicated surgical operations, such as some biopsies, cataract surgeries, tonsillectomies and adenoidectomies, dilation and curettages, and similar procedures.

Charges for covered surgical procedures, when such procedures are performed on an outpatient rather than an inpatient basis, will be paid as shown in the Medical Benefits Schedule.

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.

DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

Active Employee is an Employee who is on the regular payroll of the Employer and who has begun to perform the duties of his or her job with the Employer on a full-time basis.

Allowable charge is a charge which is the network Provider's reduced fee; or the Recognized Charge for a service or supply; or the charge billed a Non-Network Providers during an emergency room visit; or the charge billed by Non-Network Providers for services rendered to a Covered Person who has no choice of a Network Provider while in a Network facility.

Ambulatory Surgical Center is a freestanding outpatient surgical facility. It must be licensed as an outpatient clinic according to state and local laws and must meet all requirements of an outpatient clinic providing surgical services. It must also meet accreditation standards of the Joint Commission on Accreditation of Health Care Organizations or the Accreditation Association of Ambulatory Health Care.

Approved Clinical Trials means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is described in any of the following:

(1) Federally-Funded Trials—The study or investigation is approved or funded (which include funding through in-kind contributions) by one or more of the following:

- **(a)** The National Institutes of Health;
- **(b)** The Centers for Disease Control and Prevention;
- **(c)** The Agency for Health Care Research and Quality;
- **(d)** The Centers for Medicare & Medicaid Services;
- **(e)** Cooperative group or center of any of the entities described in **(a)** through **(d)** or the Department of Defense or Department of Veterans Affairs; or
- **(f)** A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.

(2) The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.

(3) The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

Birthing Center means any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Brand Name means a trade name medication.

Calendar Year means January 1st through December 31st of the same year.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Covered Charge(s) means those Medically Necessary services or supplies that are covered under this Plan.

Covered Person is an Employee or Dependent who is covered under this Plan.

Custodial Care is care provided primarily to meet your personal needs. This includes help in walking, bathing or dressing. It also includes: Preparing food or special diets; feeding by utensil, tube or gastrostomy; suctioning and administration of medicine which is usually self-administered or any other care which does not require continuing services of medical personnel.

If Medically Necessary, benefits will be provided for feeding (by tube or gastrostomy) and suctioning.

Durable Medical Equipment means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

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.

Employee means a person who is classified by his Employer as an Active, common law employee.

Employer is 8x8 Inc.

ERISA is the Employee Retirement Income Security Act of 1974, as amended.

Essential Health Benefits include, to the extent they are covered under the Plan, ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Experimental procedures are those that are mainly limited to laboratory and/or animal research, but which are not generally accepted as proven and effective procedures within the organized medical community. The Utilization Manager has discretion to make this determination. However, if a Covered Person has a seriously debilitating condition and the Utilization Manager determines the requested treatment is not a Covered Service because it is Experimental, the Covered Person may request an Independent Medical Review.

Family Unit is the covered Employee and the family members who are covered as Dependents under the Plan.

Formulary means a list of prescription medications of safe, effective therapeutic drugs specifically covered by this Plan.

Generic drug means a Prescription Drug which has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Genetic Information means information about the genetic tests of an individual or his family members, and information about the manifestations of disease or disorder in family members of the individual. A "genetic test" means an analysis of human DNA, RNA, chromosomes, proteins or metabolites, which detects genotypes, mutations or chromosomal changes as defined by the *Genetic Information Nondiscrimination Act of 2008 (GINA)*.

Home Health Care Agency is a home health care provider which is licensed according to state and local laws to provide skilled nursing and other services on a visiting basis in your home, and recognized as home health providers under Medicare and/or accredited by a recognized accrediting agency such as the Joint Commission on the Accreditation of Healthcare Organizations.

Home Health Care Plan must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the Home Health Care is in place of Hospital confinement; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

Home Health Care Services and Supplies include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

Home Infusion Therapy provider is a provider licensed according to state and local laws as a pharmacy, and must be either certified as a home health care provider by Medicare, or accredited as a home pharmacy by the Joint Commission on Accreditation of Health Care Organizations.

Hospice Agency is an agency or organization providing a specialized form of interdisciplinary health care that provides palliative care (pain control and symptom relief) and alleviates the physical, emotional, social, and spiritual discomforts of a terminally ill person, as well as providing supportive care to the primary caregiver and the patient's family. A hospice must be: currently licensed as a hospice pursuant to Health and Safety Code section 1747 or a licensed home health agency with federal Medicare certification pursuant to Health and Safety Code section 1726 and 1747.1.

Hospice Care Plan is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

Hospice Care Services and Supplies are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

Hospice Unit is a facility or separate Hospital Unit that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

Hospital is a facility which provides diagnosis, treatment and care of persons who need acute inpatient hospital care under the supervision of physicians. It must be licensed as a general acute care hospital according to state and local laws. It must also be registered as a general hospital by the American Hospital Association and meet accreditation standards of the Joint Commission on Accreditation of Health Care Organizations.\

For limited purpose of inpatient care, the definition of hospital also includes: (1) psychiatric health facilities (only for the acute phase of a mental or nervous disorder or substance abuse), and (2) residential treatment centers.

Illness means a bodily disorder, disease, physical sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy.

Injury means an accidental physical Injury to the body caused by unexpected external means.

Intensive Care Unit is defined as a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special life saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

Investigational procedures (Investigational) are those:

(1) That have progressed to limited use on humans, but which are not generally accepted as proven and effective procedures within the organized medical community; or

(2) That do not have final approval from the appropriate governmental regulatory body; or

(3) That are not supported by scientific evidence which permits conclusions concerning the effect of the service, drug or device on health outcomes; or

(4) That do not improve the health outcome of the patient treated; or

(5) That are not beneficial as any established alternative; or

(6) Whose results outside the Investigational setting cannot be demonstrated or duplicated; or

(7) That are not generally approved or used by Physicians in the medical community.

Medical Care Facility means a Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

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.

Medical Non-Emergency Care means care which can safely and adequately be provided other than in a Hospital.

Medically Necessary procedures, supplies, equipment or services are those determined to be:

(1) Appropriate and necessary for the diagnosis or treatment of the medical condition;

(2) Provided for the diagnosis or direct care and treatment of the medical condition;

(3) Within standards of good medical practice within the organized medical community;

(4) Not primarily for your convenience, or for the convenience of your physician or another provider; and

(5) The most appropriate procedure, supply, equipment or service which can safely be provided. The most appropriate procedure, supply, equipment or service must satisfy the following requirements:

(a) there must be valid scientific evidence demonstrating that the expected health benefit from the procedure, supply, equipment or services are clinically significant and produce a greater likelihood of benefit, without a disproportionately greater risk of harm or complications, for you with the particular medical condition being treated than other possible alternatives; and

(b) generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable; and

(c) for hospital stays, acute care as an inpatient is necessary due to the kind of services you are receiving or the severity of your condition, and safe and adequate care cannot be received by you as an outpatient or in a less intensified medical setting.

The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary, and whether an exception to the Medical Necessity requirement is available.

Medicare is the Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Mental Disorder means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

No-Fault Auto Insurance is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

Outpatient Care and/or Services is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Outpatient Surgical Center, or the patient's home.

Outpatient Surgical Center is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

Pharmacy means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Occupational Therapist, Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Plan means 8x8 Inc. PPO with HSA, which is a benefits plan for certain Employees of 8x8 Inc. and is described in this document.

Plan Participant is any Employee or Dependent who is covered under this Plan.

Plan Year is the 12-month period beginning on January 1 and ending on the following December 31.

Pregnancy is childbirth and conditions associated with Pregnancy, including complications.

Prescription Drug means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of a Sickness or Injury.

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, and
- **(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.

Sickness is a Covered Person's Illness, disease or Pregnancy (including complications).

Skilled Nursing Facility is an institution that provides continuous skilled nursing services. It must be licensed according to state and local laws and be recognized as a skilled nursing facility under Medicare.

Spinal Manipulation/Chiropractic Care means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Substance Abuse is regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

Temporomandibular Joint (TMJ) syndrome is the treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint.

Total Disability (Totally Disabled) means: In the case of a Dependent, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and sex in good health.

Urgent Care Services means care and treatment for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room services.

PLAN EXCLUSIONS

Note: Exclusions related to Prescription Drugs are shown in the Prescription Drug Plan. Contact your Prescription Drug Administrator for additional information.

For all Medical Benefits shown in the Schedule of Benefits, a charge for the following is not covered:

(1) **Acupressure**, or massage to help alleviate pain, treat illness or promote health by putting pressure to one or more areas of the body.

(2) **Administrative Charges.**

- Charges to complete claim forms,
- Charges to get medical records or reports,
- Membership, administrative, or access fees charged by Doctors or other Providers. Examples include, but are not limited to, fees for educational brochures or calling you to give you test results.

(3) **Aids for Non-verbal Communication.** Devices and computers to assist in communication and speech except for speech aid devices and tracheoesophageal voice devices.

(4) **Alternative / Complementary Medicine.** Services or supplies for alternative or complementary medicine. This includes, but is not limited to the following:

Aquatic therapy and other water therapy except for other water therapy services that are part of a physical therapy treatment plan, Aroma therapy, Reiki therapy, Herbal, vitamin or dietary products or therapies, Thermography, Orthomolecular therapy, Contact reflex analysis, Bioenergial synchronization technique (BEST), Iridology-study of the iris, Auditory integration therapy (AIT), Colonic irrigation, Magnetic innervation therapy, Electromagnetic therapy, and Neurofeedback.

(5) **Biofeedback.**

(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.

(7) **Cosmetic Procedures.** Any surgery or procedure, the primary purpose of which is to improve or change the appearance of any portion of the body, but which does not restore bodily function, correct a disease state, or improve a physiological function. Cosmetic Procedures include cosmetic surgery, reconstructive surgery, pharmacological services, nutritional regimens or other services for beautification, or treatment relating to the consequences of, or as a result of, Cosmetic Surgery (including reimplantation). This exclusion includes, but is not limited to, surgery to correct gynecomastia and breast augmentation procedures, and otoplasties. This exclusion does not apply to surgery to restore function if the body area has been altered by injury, disease, trauma, congenital/developmental anomalies, or previous covered therapeutic processes.

(8) **Court Ordered Testing.** Court ordered testing or care unless Medically Necessary.

(9) **Custodial care.** Services or supplies provided mainly as a rest cure, maintenance, Custodial Care or domiciliary care consisting chiefly of room and board.

(10) **Educational or vocational testing.** Services for educational or vocational testing or training.

(11) **Excess charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Recognized Charge. This exclusion will not apply to charges billed by Non-Network Providers during an emergency room visit; or Non-Network Providers for services rendered to a Covered Person who has no choice of a Network Provider while in a Network facility.

(12) **Exercise programs.** Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy if covered by this Plan.

(13) **Experimental / Investigational or not Medically Necessary.** Care and treatment that is either Experimental/Investigational or not Medically Necessary. This exclusion shall not apply to routine patient costs to the extent that the cost is for a Qualified Individual who is a participant in an approved clinical trial with respect to the treatment of cancer or another life-threatening disease or condition. The Plan shall not deny, limit or impose additional conditions on routine patient costs for items and services furnished in connection with participation in the clinical trial.

The following are not included as routine patient costs:

(a) The investigational item, device, or service itself;

(b) Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or

(c) A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

This provision does not require the Plan to pay charges for services or supplies that are not otherwise Covered Charges (including, without limitation, charges which the Qualified Individual would not be required to pay in the absence of this coverage) or prohibit the Plan from imposing all applicable cost sharing and reasonable cost management provisions. For these purposes, a Qualified Individual is a Covered Person who is eligible to participate in an approved clinical trial according to the trial protocol with respect to the treatment of cancer or another life-threatening disease or condition, and either: (1) the referring health care professional is a Network Provider and has concluded that the individual's participation in such trial would be appropriate; or (2) the Covered Person provides medical and scientific information establishing that the individual's participation in such trial would be appropriate.

(14) **Eye care.** Radial keratotomy or other eye surgery, including LASIK to correct refractive disorders, including orthoptics and vision therapy. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages or as may be covered under the well adult or well child sections of this Plan.

(15) **Foot care.** Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations), and treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease).

(16) **Foot orthotics.** Charges in connection with over-the-counter foot orthotics or arch supports, except if used for a systemic illness affecting the lower limbs, such as severe diabetes.

(17) **Foreign travel.** Care, treatment or supplies out of the U.S. if travel is for the purpose of obtaining medical services.

(18) **Government coverage.** Care, treatment or supplies furnished by a program or agency funded by any government. This exclusion does not apply to Medicaid or when otherwise prohibited by applicable law.

(19) **Growth Hormone Treatment.**

(20) **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician.

(21) **Hearing aids and exams.** Charges for services or supplies in connection with hearing aids or exams for their fitting, except as may be covered under the well adult or well child sections of this Plan.

(22) Holistic medicine.

(23) Home births. Charges for services or supplies in connection with home births.

(24) Homeopathic medicine.

(25) Hospital employees. Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.

(26) Hyperhidrosis Treatment. Medical and surgical treatment of excessive sweating (hyperhidrosis).

(27) Hypnosis.

(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 of 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.

(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.

(30) Infertility. Care, supplies, services, testing and treatment for infertility, artificial insemination, or in vitro fertilization.

(31) Maintenance Therapy. Rehabilitative treatment or care that is provided when no further gains or improvements in your current level of function are clear or likely to occur. Maintenance therapy includes care that helps you keep your current level of function and prevents loss of that function, but does not result in any change for the better. This Exclusion does not apply to habilitative services.

(32) Massage and massage therapy, except for other massage therapy services that are part of a physical therapy treatment plan.

(33) Missed or Cancelled Appointments. Charges for missed or cancelled appointments, including Stand-by charges of a Doctor or other Provider.

(34) Naturopathy.

(35) No charge. Care and treatment for which there would not have been a charge if no coverage had been in force.

(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.

(37) Non-emergency Hospital admissions. Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.

(38) **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.

(39) **No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.

(40) **Not specified as covered.** Non-traditional medical services, treatments and supplies which are not specified as covered under this Plan.

(41) **Nutritional or Dietary Supplements.** Nutritional and/or dietary supplements, except as described in this Booklet or that we must cover by law. This Exclusion includes, but is not limited to, nutritional formulas and dietary supplements that you can buy over the counter and those you can get without a written Prescription or from a licensed pharmacist. This Exclusion does not apply to Medically Necessary services to treat Severe Mental Illness or Serious Emotional Disturbances of a Child as required by state law.

(42) **Obesity.** Screening and counseling for obesity will be covered to the extent required under Standard Preventive Care. Other care and treatment of obesity, weight loss or control whether or not it is, in any case, a part of the treatment plan for another Sickness is excluded. Medically necessary surgical and non-surgical charges for morbid obesity are covered.

(43) **Occupational.** Care and treatment of an Injury or Sickness that is occupational -- that is, arises from work for wage or profit including self-employment. This exclusion may apply even if the expenses for the illness or injury are not paid by Worker's Compensation or similar employer's liability insurance.

(44) **Personal comfort items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, over-the-counter humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, and first-aid supplies and nonhospital adjustable beds.

(45) **Plan design excludes.** Charges excluded by the Plan design as mentioned in this document.

(46) **Private Duty Nursing.** Private duty nursing services given in a Hospital or Skilled Nursing Facility. Private duty nursing services are a Covered Service only when given as part of the "Home Care Services" benefit.

(47) **Prosthetics.** Prosthetics for sports or cosmetic purposes.

(48) **Relative giving services.** Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

(49) **Self-Inflicted.** Any loss due to an intentionally self-inflicted Injury. 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.

(50) **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.

(51) **Sexual dysfunctions and inadequacies.** Care, treatment, services, or supplies in connection with treatment for sexual dysfunctions and inadequacies.

(52) **Speech devices.** Charges for computerized speech devices or other adaptive equipment that is not primarily restorative in nature.

(53) **Surgical sterilization reversal.** Care and treatment for reversal of surgical sterilization for men and women.

(54) **Surrogacy and surrogate mother.** Charges associated with surrogacy, a method of reproduction whereby a woman agrees to become pregnant and deliver a child for a contracted party.

(55) **Temporomandibular Joint Treatment.** Fixed or removable appliances which move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures).

(56) **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance, bariatric surgery, transgender surgery and organ transplant charges.

(55) **Travel vaccine.** Charges for services or supplies in connection with travel vaccinations.

(57) **Vein Treatment.** Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes.

(58) **War.** Any loss that is due to a declared or undeclared act of war.

PRESCRIPTION DRUG BENEFITS

Pharmacy Drug Charge

Copayments

The copayment is applied to each covered pharmacy drug or mail order drug charge and is shown in the schedule of benefits. The copayment amount is not a Covered Charge under the medical Plan. Any one pharmacy prescription is a 90-day supply when filled by a First Choice Pharmacy and 30-day supply when filled by a Non-First Choice Pharmacy. Any one mail order prescription is limited to a 90-day supply. The maximum Out-of-Pocket expense for Prescription Drug benefits includes the Prescription Drug deductible and includes copayments.

Contact the Prescription Drug Administrator for information regarding non-participating pharmacy benefits or benefits at a participating pharmacy when the Covered Person's ID card is not used.

Percentages Payable

The percentage payable amount is applied to each covered pharmacy drug or mail order drug charge and is shown in the schedule of benefits.

Mail Order Drug Benefit Option

The mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.) and for some specialty drugs.

Variable Copay Program (VCP)

Variable Copay Pharmacy-CRx: The plan has adopted the Prescription Drug Administrator's Variable Copay™ Program to help members who utilize manufacturer copay programs save money on prescription drugs. Under the Variable Copay™ Program, your out-of-pocket cost for prescription drugs may be reduced or eliminated by a drug manufacturer's copay subsidy. If you are eligible to receive a manufacturer copay subsidy for a drug, your copay obligation for that drug will be the maximum manufacturer copay subsidy for that drug.

Note: Any manufacturer copay subsidy obtained under the Variable Copay™ Program will not accumulate toward your deductible or out of pocket costs. If you are not eligible to receive a manufacturer copay subsidy, your copay obligation will be the copay amount listed for the drug in the standard formulary under the plan. If you are eligible for a manufacturer copay subsidy for a drug but fail to obtain the subsidy, your copay obligation – and the out-of-pocket cost you may be required to pay – will be the maximum manufacturer copay subsidy for that drug. A detailed schedule of subsidies available through manufacturer copay programs under the Variable Copay™ Program is available at www.crxspecialty.com.

Manufacturer Free Drug Initiative: The plan offers voluntary enrollment in **the Manufacturer Free Drug Initiative** to help members save money on prescription drugs. If you choose to enroll and receive a drug at no cost through a manufacturer free drug program, that drug will not be covered under the plan and you will have no cost sharing obligation to the plan for that drug. employer should have its own attorney or other qualified advisor review the sample language and ensure its SBC complies with applicable law.

Covered Prescription Drugs

(1) Drugs prescribed by a Physician that require a prescription either by federal or state law. This includes oral contraceptives unless otherwise specifically excluded, but excludes any drugs stated as not covered under this Plan.

(2) Compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity.

(3) Insulin, glucagon, and other Prescription Drugs and testing supplies for the treatment of diabetes, including syringes.

(4) Injectable drugs or any prescription directing self -administration by injection.

(5) Orally administered anti-cancer medications.

(6) FDA-approved smoking cessation products, including over the counter nicotine replacement products, when obtained with a Prescription for a Member age 18 or older. These products will be covered under the "Preventive Care" benefit.

Limits To This Benefit

This benefit applies only when a Covered Person incurs a covered Prescription Drug charge. The covered drug charge for any one prescription will be limited to:

(1) Refills only up to the number of times specified by a Physician.

(2) Refills up to one year from the date of order by a Physician.

Expenses Not Covered

This benefit will not cover a charge for any of the following:

(1) **Administration.** Any charge for the administration of a covered Prescription Drug.

(2) **Allergy desensitization products or allergy serum.**

(3) **Appetite suppressants.** A charge for appetite suppressants, dietary supplements or vitamin supplements, except for prenatal vitamins requiring a prescription or prescription vitamin supplements containing fluoride.

(4) **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.

(5) **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.

(6) **Drugs used for cosmetic purposes.** Charges for drugs used for cosmetic purposes, such as anabolic steroids, Retin A or medications for hair growth or removal, except drugs used to treat acne

(7) **Experimental.** Experimental drugs and medicines, even though a charge is made to the Covered Person.

(8) **FDA.** Any drug not approved by the Food and Drug Administration.

(9) **Gene Therapy.** Gene therapy that introduces or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material.

(10) **Growth hormones.** Charges for drugs to enhance physical growth or athletic performance or appearance.

(11) **Hyperhidrosis Treatment.** Prescription Drugs related to the medical and surgical treatment of excessive sweating (hyperhidrosis).

(12) **Immunization.** Immunization agents or biological sera, except as may be required under Standard Preventive Care.

(13) **Infertility.** A charge for infertility medication.

(14) **Investigational.** A drug or medicine labeled: "Caution - limited by federal law to investigational use".

(15) **Medical exclusions.** A charge excluded under Medical Plan Exclusions.

(16) **No charge.** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.

(17) **No prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin or to over the counter drugs that are prescribed by a Physician as required for Standard Preventive Care.

(19) **Onychomycosis Drugs.** Drugs for Onychomycosis (toenail fungus) except when we allow it to treat Members who are immuno-compromised or diabetic.

(20) **Refills.** Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.

(21) **Syringes.** Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.

HOW TO SUBMIT A CLAIM

When you receive care from a Network Provider, you do not need to file a claim because the Network Provider will do this for you. If you receive care from a Non-Network Provider, you will need to make sure a claim is filed. Many Non-Network Hospitals, Doctors and other Providers will file your claim for you, although they are not required to do so.
When a Covered Person has a Claim to submit for payment that person must:

(1) Obtain a HealthComp Group Medical Claim Form by calling Member Services or at: https://hconline.healthcomp.com/Resources/Member%20Forms/Claim%20Forms/Group%20Medical%20Claim%20form.pdf

(2) Complete the claim form. ALL CLAIM FORMS MUST SHOW:

- Policy and or Group number(s)
- Name and address of the Employer
- Name of the Employee (insured)
- Address of Employee
- Member's ID number
- Name of patient
- Attach an itemized bill from the provider of care. AN ITEMZED BILL MUST BE ATTACHED.

(3) Send the above to the Claims Administrator at this address:

Anthem Blue Cross
P.O Box 60007
Los Angeles, California 90060-0007
1(800) 442-7247

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 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.

APPEALS PROCEDURE

Following is a description of how the Plan processes claims for benefits and reviews the appeal of any claim that is denied. The terms used in this section are defined below.

A "Claim" is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant, which complies with the Plan's reasonable procedure for submitting claims and making benefit claims determinations.

A "Claim" does not include a request for a determination of an individual's eligibility to participate in the Plan.

If a Claim is denied, in whole or in part, or if Plan coverage is rescinded retroactively for fraud or misrepresentation, the denial is known as an "Adverse Benefit Determination."

A claimant has the right to request a review of an Adverse Benefit Determination. This request is an "Appeal." If the Claim is denied at the end of the Plan's internal Appeal process, as described below, the Plan's final decision is known as a "Final Adverse Benefit Determination." For certain types of Claims, the claimant has the right to request an independent external review of the Final Adverse Benefit Determination. The External Review procedures are described below.

The Claims and the Appeal procedures are designed to ensure that claimants are not unduly inhibited from making Claims; that claimants may appoint an authorized representative in accordance with Plan rules; that determinations will be made in accordance with the Plan documents and that Plan provisions are applied consistently. This means, among other things, that Claims and Appeals will be decided in a manner designed to ensure the independence and impartiality of the persons involved in making these decisions.

A claimant must follow all Claims and Appeal procedures both internal and external, before he or she can file a lawsuit. However, this rule may not apply if the Plan Administrator has not complied with the procedures described in this Section. If a lawsuit is brought, it must be filed within two years after the final determination of an Appeal.

The Plan may offer additional voluntary appeal and/or mandatory arbitration procedures other than those described here. If applicable, the Plan will not assert that a claimant has failed to exhaust administrative remedies for failure to use the voluntary procedures; any statute of limitations or other defense based on timeliness is tolled during the time a voluntary appeal is pending; and the voluntary process is available only after exhaustion of the appeals process described in this section. If mandatory arbitration is offered by the Plan, the arbitration must be conducted instead of the appeal process described in this section, and the claimant is not precluded from challenging the decision under ERISA section 501(a) or other applicable law.

Any of the authority and responsibilities of the Plan Administrator under the Claims and Appeal Procedures or the External Review Process, including the discretionary authority to interpret the terms of the Plan, may be delegated to a third party. If you have any questions regarding these procedures, please contact the Plan Administrator or delegated third party.

There are different kinds of Claims and each one has a specific timetable for each step in the review process. Upon receipt of the Claim, the Plan Administrator or delegated thrid party must decide whether to approve or deny the Claim. The Plan Administrator's or delegated thrid party’s notification to the claimant of its decision must be made as soon as practical and not later than the time shown in the timetable. However, if the Claim has not been filed properly, or if it is incomplete, or if there are other matters beyond the control of the Plan Administrator or delegated thrid party , the claimant may be notified that the period for providing the notification will need to be extended. If the period is extended because the Plan Administrator or delegated thrid party needs more information from the claimant, the claimant must provide the requested information within the time shown on the timetable. Once the Claim is complete, the Plan Administrator or delegated thrid party must make its decision as shown in the timetable. If the Claim is denied, in whole or in part, the claimant has the right to file an Appeal. Then the Plan Administrator or delegated thrid party must decide the Appeal and, if the Appeal is denied, provide notice to the claimant within the time periods shown on the timetable. The time periods shown in the timetable begin at the time the Claim or Appeal is filed in accordance with the Plan's procedures. Decisions will be made within a reasonable period of time appropriate to the circumstances, but within the maximum time periods listed in the timetables below. Unless otherwise noted, "days" means calendar days.

The definitions of the types of Claims are:

Urgent Care Claim

A Claim involving Urgent Care is any Claim for medical care or treatment where the Plan conditions receipt of benefits, in whole or in part, on approval in advance of obtaining the care or treatment, and using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the claimant; or the ability of the claimant to regain maximum function; or in the opinion of the attending or consulting Physician, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim. The Urgent Care Claim rules do not apply to claims involving urgent care where Plan benefits are not conditioned on prior approval. These claims are subject to the rules on Post-Service Claims described below.

A Physician with knowledge of the claimant's medical condition may determine if a Claim is one involving Urgent Care. The Claims Administrator will defer to the attending provider's determination that the Claim involves Urgent Care. If there is no such Physician, an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine may make the determination.

In the case of a Claim involving Urgent Care, responses must be made as soon as possible consistent with the medical urgency involved, and no later than the following times:

Notification to claimant of Claim determination	72 hours

Insufficient information on the Claim, or failure to follow the Plan's procedure for filing a Claim:

Notification to claimant, orally or in writing	24 hours
Response by claimant, orally or in writing	48 hours
Benefit determination, orally or in writing	48 hours
Notification of Adverse Benefit Determination on Appeal	72 hours

If there is an Adverse Benefit Determination on a Claim involving Urgent Care, a request for an expedited Appeal may be submitted orally or in writing by the claimant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the claimant by telephone, facsimile, or other similarly expeditious method. Alternatively, the claimant may request an expedited review under the External Review Process.

Concurrent Care Claims

A Concurrent Care Claim is a special type of Claim that arises if the Plan informs a claimant that benefits for a course of treatment that has been previously approved for a period of time or number of treatments is to be reduced or eliminated. In that case, the Plan must notify the claimant sufficiently in advance of the effective date of the reduction or elimination of treatment to allow the claimant to file an Appeal. This rule does not apply if benefits are reduced or eliminated due to Plan amendment or termination. A similar process applies for Claims based on a rescission of coverage for fraud or misrepresentation.

In the case of a Concurrent Care Claim, the following timetable applies:

Notification to claimant of benefit reduction	Sufficiently prior to scheduled termination of course of treatment to allow claimant to appeal
Notification to claimant of rescission	30 days
Notification of determination on Appeal of Claims involving Urgent Care	24 hours (provided claimant files Appeal more than 24 hours prior to scheduled termination of course of treatment)
Notification of Adverse Benefit Determination on Appeal for non-Urgent Claims	As soon as feasible, but not more than 30 days
Notification of Adverse Benefit Determination on Appeal for Rescission Claims	30 days

Pre-Service Claim

A Pre-Service Claim means any Claim for a benefit under this Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care. These are, for example, Claims subject to pre-certification. Please see the Cost Management section of this booklet for further information about Pre-Service Claims.

In the case of a Pre-Service Claim, the following timetable applies:

Notification to claimant of Benefit Determination (whether or not adverse)	15 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information on the Claim:	
Notification of	15 days
Response by claimant	45 days
Notification, orally or in writing, of failure to follow the Plan's procedures for filing a Claim	5 days
Notification of Adverse Benefit Determination on Appeal	15 days per benefit appeal

Post-Service Claim

A Post-Service Claim means any Claim for a Plan benefit that is not an Urgent Care Claim or a Pre-Service Claim; in other words, a Claim that is a request for payment under the Plan for medical services already received by the claimant.

In the case of a Post-Service Claim, the following timetable applies:

Notification to claimant of Adverse Benefit Determination	30 days
Extension due to matters beyond the control of the Plan	15 days
Extension due to insufficient information on the Claim	15 days
Response by claimant following notice of insufficient information	45 days
Notification of Adverse Benefit Determination on Appeal	30 days per benefit appeal

Notice to claimant of Adverse Benefit Determinations

If a Claim is denied in whole or in part, the denial is considered to be an Adverse Benefit Determination. Except with Urgent Care Claims, when the notification may be oral followed by written or electronic notification within three days of the oral notification, the Plan Administrator or delegated thrid party shall provide written or electronic notification of the Adverse Benefit Determination. The notice will state in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the claimant:

(1) Information sufficient to allow the claimant to identify the Claim involved (including date of service, the healthcare provider, and the claim amount, if applicable), and a statement that the diagnosis code and treatment code and their corresponding meanings will be provided to the claimant as soon as feasible upon request.

(2) The specific reason or reasons for the adverse determination, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the Claim. In the case of a Final Adverse Benefit Determination, the description must include a discussion of the decision.

(3) Reference to the specific Plan provisions on which the determination was based.

(4) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.

(5) A description of the Plan's internal and external Appeal procedures, incorporating any voluntary appeal procedures offered by the Plan. This description will include information on how to initiate the Appeal and the time limits applicable to such procedures. This will include a statement of the claimant's right to bring a civil action under section 502 of ERISA following a Final Adverse Benefit Determination.

(6) If the Adverse Benefit Determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was

relied upon in making the Adverse Benefit Determination and a copy will be provided free of charge to the claimant upon request.

(7) If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

(8) Information about the availability of and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and external review process.

Appeals

When a claimant receives notification of an Adverse Benefit Determination, the claimant generally has 180 days following receipt of the notification in which to file a written request for an Appeal of the decision. However, for Concurrent Care Claims, the Claimant must file the Appeal prior to the scheduled reduction or termination of treatment. For a claim based on rescission of coverage, the claimant must file the Appeal within 30 days. A claimant may submit written comments, documents, records, and other information relating to the Claim.

If the claimant so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim. The Plan Administrator or delegated thrid party shall provide the claimant, as soon as possible and sufficiently in advance of the time within which a final determination on Appeal is required to allow the claimant time to respond, any new or additional evidence that is relied upon, considered or generated by or at the direction of the Plan. This evidence shall be provided free of charge.

A document, record, or other information shall be considered relevant to a Claim if it:

(1) was relied upon in making the benefit determination;

(2) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;

(3) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or

(4) constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

The period of time within which a benefit determination on Appeal is required to be made shall begin at the time an Appeal is filed in writing in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

Before the Plan Administrator or delegated thrid party issues its Final Adverse Benefit Determination based on a new or additional rationale, the claimant must be provided, free of charge, with a copy of the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the time within which a final determination on Appeal is required to allow the claimant time to respond. If it is impossible under the circumstances to give the claimant a reasonable time to respond, the period for issuing the Final Adverse Benefit Determination will be delayed until the claimant has a reasonable opportunity to respond. After the claimant responds, or if the claimant fails to do so, the Plan Administrator or delegated thrid party will issue its Final Adverse Benefit Determiantion as soon as reasonably possible, taking into account the medical exigencies.

The review shall take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial Adverse Benefit Determination and

will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

If the determination was based 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 shall consult with a health care professional who was not involved in the original benefit determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified.

If the Appeal of a Claim is denied, in whole or in part, the Plan Administrator or delegated thrid party shall provide written notification of the Adverse Benefit Determination on Appeal. The notice will state, in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the claimant:

(1) Information sufficient to allow the claimant to identify the Claim involved (including date of service, the healthcare provider, and the claim amount, if applicable), and a statement that the diagnosis code and treatment code and their corresponding meanings will be provided to the claimant as soon as feasible upon request.

(2) The specific reason or reasons for the adverse determination, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the Claim.

(3) Reference to the specific Plan provisions on which the determination was based.

(4) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.

(5) A description of the Plan's internal and external review procedures, incorporating any voluntary appeal procedures offered by the Plan and the time limits applicable to such procedures. This will include a statement of the claimant's right to bring a civil action under section 502 of ERISA following an Adverse Benefit Determination on review.

(6) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

(7) If the Adverse Benefit Determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the Adverse Benefit Determination and a copy will be provided free of charge to the claimant upon request.

(8) If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

(9) Information about the availability of and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and external review process. In addition, a statement that "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office."

If the claimant disagrees with the Adverse Benefit Determination on Appeal, he or she may file a request for a second level of Appeal. This request must be made in writing within 180 days following receipt of the Adverse Benefit Determination on Appeal. The claimant may submit written comments, documents, records, and other information relating to the Claim. The second level of review will be conducted, and written notification of the decision, shall be made in accordance with all of the procedures that apply to the first level of review. If the

Claim is denied in whole or in part after this second level of Appeal, the written notification describing the Adverse Benefit Determination is the Final Adverse Benefit Determination.

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 nonquantitative treatment limitations), (2) a determination that a treatment is experimental or investigational, or (3) a rescission of coverage. The request for External Review must be filed in writing within four (4) months after receipt of the Final Adverse Benefit Determination.

The Plan Administrator or delegated thrid party will determine within five days of receipt whether the Claim is eligible for review under the External Review process. This determination is based on the criteria described above and whether:

(1) The claimant is or was covered under the Plan at the time the Claim was made or incurred;

(2) The denial relates to the claimant's failure to meet the Plan's eligibility requirements;

(3) The claimant has exhausted the Plan's internal Claims and Appeal Procedures; and

(4) The claimant has provided all the information required to process an External Review.

Within one business day after completion of this preliminary review, the Plan Administrator or delegated thrid party will provide written notification to the claimant of whether the claim is eligible for External Review.

If the request for review is complete but not eligible for External Review, the Plan Administrator or delegated thrid party will notify the claimant of the reasons for its ineligibility. The notice will include contact information for the Employee Benefits Security Administration at its toll free number (866-444-3272).

If the request is not complete, the notice will describe the information needed to complete it. The claimant will have 48 hours or until the last day of the 4 month filing period, whichever is later, to submit the additional information.

If the request is eligible for the External Review process, the Plan will assign it to a qualified independent review organization ("IRO"). The IRO is responsible for notifying the claimant, in writing, that the request for External Review has been accepted. The notice should include a statement that the claimant may submit in writing, within 10 business days, additional information the IRO must consider when conducting the review. The IRO will share this information with the Plan. The Plan may consider this information and decide to reverse its denial of the Claim. If the denial is reversed, the External Review process will end.

If the Plan does not reverse the denial, the IRO will make its decision on the basis of its review of all of the information in the record, as well as additional information where appropriate and available, such as:

(1) The claimant's medical records;

(2) The attending health care professional's recommendation;

(3) Reports from appropriate health care professionals and other documents submitted by the plan or issuer, claimant, or the claimant's treating provider;

(4) The terms of the Plan;

(5) Appropriate practice guidelines;

(6) Any applicable clinical review criteria developed and used by the Plan; and

(7) The opinion of the IRO's clinical reviewer.

The IRO must provide written notice to the Plan and the claimant of its final decision within 45 days after the IRO receives the request for the External Review. The IRO's decision notice must contain:

(1) A general description of the reason for the External Review, including information sufficient to identify the claim;

(2) The date the IRO received the assignment to conduct the review and the date of the IRO's decision;

(3) References to the evidence or documentation the IRO considered in reaching its decision;

(4) A discussion of the principal reason(s) for the IRO's decision;

(5) A statement that the determination is binding and that judicial review may be available to the claimant; and

(6) Contact information for any applicable office of health insurance consumer assistance or ombudsman established under the PPACA.

Generally, a claimant must exhaust the Plan's Claims and Procedures in order to be eligible for the External Review process. However, in some cases the Plan provides for an expedited External Review if:

(1) The claimant receives an Adverse Benefit Determination that involves a medical condition for which the time for completion of the Plan's internal Claims and Appeal Procedures would seriously jeopardize the claimant's life or health or ability to regain maximum function and the claimant has filed a request for an expedited internal review; or

(2) The claimant receives a Final Adverse Benefit Determination that involves a medical condition where the time for completion of a standard External Review process would seriously jeopardize the claimant's life or health or the claimant's ability to regain maximum function, or if the Final Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

Immediately upon receipt of a request for expedited External Review, the Plan must determine and notify the claimant whether the request satisfies the requirements for expedited review, including the eligibility requirements for External Review listed above. If the request qualifies for expedited review, it will be assigned to an IRO. The IRO must make its determination and provide a notice of the decision as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited External Review. If the original notice of its decision is not in writing, the IRO must provide written confirmation of the decision within 48 hours to both the claimant and the Plan.

COORDINATION OF BENEFITS

Coordination of the benefit plans. Coordination of benefits sets out rules for the order of payment of Covered Charges when two or more plans -- including Medicare -- are paying. When a Covered Person is covered by this Plan and another plan, or the Covered Person's Spouse is covered by this Plan and by another plan or the couple's Covered children are covered under two or more plans, the plans will coordinate benefits when a claim is received.

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.

Benefit plan. This provision will coordinate the medical benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

(1) Group or group-type plans, including franchise or blanket benefit plans.

(2) Blue Cross and Blue Shield group plans.

(3) Group practice and other group prepayment plans.

(4) Federal government plans or programs. This includes, but is not limited to, Medicare and Tricare.

(5) Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.

(6) No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

Allowable Charge. For a charge to be allowable it must be a Negotiated or Recognized Charge and at least part of it must be covered under this Plan.

In the case of HMO (Health Maintenance Organization) or other in-network only plans: This Plan will not consider any charges in excess of what an HMO or network provider has agreed to accept as payment in full. Also, when an HMO or network plan is primary and the Covered Person does not use an HMO or network provider, this Plan will not consider as an Allowable Charge any charge that would have been covered by the HMO or network plan had the Covered Person used the services of an HMO or network provider.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the Allowable Charge.

Automobile limitations. When medical payments are available under vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan deductibles. The Plan shall always be considered the secondary carrier regardless of the individual's election to file a claim under PIP (personal injury protection) coverage with the auto carrier.

Benefit plan payment order. When two or more plans provide benefits for the same Allowable Charge, benefit payment will follow these rules:

(1) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.

(2) Plans with a coordination provision will pay their benefits up to the Allowable Charge:

(a) The benefits of the plan which covers the person directly (that is, as an employee, member or subscriber) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").

(b) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or Retired Employee. The benefits of a benefit plan which covers a person as a Dependent of an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a Dependent of a laid off or Retired Employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

(c) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.

(d) When a child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:

(i) The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;

(ii) If both parents have the same birthday, the benefits of the benefit plan which has covered the parent for the longer time are determined before those of the benefit plan which covers the other parent.

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

(i) 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.

(ii) 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.

(iii) 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.

(iv) 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.

(v) For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.

(f) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. This includes situations in which a person who is covered as a dependent child under one benefit plan is also covered as a dependent spouse under another benefit plan. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of Allowable Charges when paying secondary.

(3) Medicare will pay primary, secondary or last to the extent stated in federal law. If a Plan Participant is Medicare entitled this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B regardless of whether or not the person was enrolled under any of these parts. The Plan Administrator will make this determination based on the information available through CMS. If CMS does not provide sufficient information to determine the amount Medicare would pay, the Plan Administrator will make reasonable assumptions based on published Medicare fee schedules.

(4) If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

(5) The Plan will pay primary to Tricare and a State child health plan to the extent required by federal law.

Claims determination period. Benefits will be coordinated on a Year basis. This is called the claims determination period.

Right to receive or release necessary information. To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of Allowable Charges.

Facility of payment. This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

Right of recovery. This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Covered Person. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

Exception to Medicaid. In accordance with ERISA, the Plan shall not take into consideration the fact that an individual is eligible for or is provided medical assistance through Medicaid when enrolling an individual in the Plan or making a determination about the payments for benefits received by a Covered Person under the Plan.

THIRD PARTY RECOVERY PROVISION

RIGHT OF SUBROGATION AND REFUND

When this provision applies. The Covered Person may incur medical or dental charges due to Injuries which may be caused by the act or omission of a Third Party. In such circumstances, the Covered Person may have a claim for payment of the medical or dental charges. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any rights the Covered Person may have to Recover payments from any Third Party or any other insurer or source, including but not limited to, "first party" underinsured or uninsured motorist coverage, worker's compensation, crime victim restitution funds, medical or disability payments, homeowner's plan, renter's plan, medical malpractice plan, or any other liability plan or any other source of coverage.

This Subrogation right allows the Plan to pursue any claim which the Covered Person has against any Third Party, or insurer, whether or not the Covered Person chooses to pursue that claim. The Plan may make a claim directly against the Third Party or insurer, but in any event, the Plan has a lien on any amount Recovered by the Covered Person whether or not designated as payment for medical expenses. This lien shall remain in effect until the Plan is repaid in full.

The Plan Administrator retains sole, full and final discretionary authority to construe, apply, and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights. The Plan Administrator also retains the right to delegate this discretionary authority to the Claims Administrator without notice.

The payment for benefits received by a Covered Person under the Plan shall be made in accordance with the assignment of rights by or on behalf of the Covered Person as required by Medicaid.

In any case in which the Plan has a legal liability to make payments for benefits received by a Covered Person, to the extent that payment has been made through Medicaid, the payment for benefits under the Plan shall be made in accordance with any state law that has provided that the state has acquired the rights of the Covered Person to the payments of those benefits.

The Covered Person:

(1) automatically assigns to the Plan his or her rights against any Third Party or insurer when this provision applies; and

(2) must repay to the Plan the benefits paid on his or her behalf out of the Recovery made from the Third Party or insurer.

Amount subject to Subrogation or Refund. The Covered Person agrees to recognize the Plan's right to Subrogation and Refund. These rights provide the Plan with a 100%, first dollar priority over any and all Recoveries and funds paid by a Third Party or insurer to a Covered Person relative to the Injury or Sickness, including a priority over any claim for non-medical or dental charges, attorney fees, or other costs and expenses, even if the Covered Person's Recovery is less than the amount claimed, and, as a result, the Covered Person is not made whole. The Covered Person further specifically agrees and acknowledges that the "made whole doctrine" and "common fund" doctrine are completely abrogated under this Plan, and will not affect the Plan's right to 100% Subrogation or Refund for any and all benefits paid. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any state prohibiting assignment of rights which interfere with or compromise in any way the Plan's equitable subrogation lien. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any and all rights the Covered Person may have to recover payments from any responsible third party or insurer. Further, accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan the Covered Person's Third Party Claims and/or the Covered Person's claims under any other policy of insurance or other coverage.

Notwithstanding its priority to funds, the Plan's Subrogation and Refund rights, as well as the rights assigned to it, are limited to the extent to which the Plan has made, or will make, payments for medical or dental charges as well as any costs and fees associated with the enforcement of its rights under the Plan. The Plan reserves the

right to be reimbursed for its court costs and attorneys' fees if the Plan needs to file suit in order to Recover payment for medical or dental expenses from the Covered Person.

When a right of Recovery exists, the Covered Person will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the Plan's right of Subrogation as a condition to having the Plan make payments. In addition, the Covered Person will do nothing to prejudice the right of the Plan to Subrogate.

Failure by the Covered Person(s) and/or his attorney to comply with any of these requirements may, at the Plan's discretion, result in forfeiture of payment by the Plan of medical benefits and any funds or payments due under this Plan may be withheld until the Covered Person(s) satisfies his or her obligation.

Conditions Precedent to Coverage. The Plan shall have no obligation whatsoever to pay medical or dental benefits to a Covered Person if a Covered Person refuses to cooperate with the Plan's reimbursement and Subrogation rights or refuses to execute and deliver such papers as the Plan may require in furtherance of its reimbursement and Subrogation rights. Further, in the event the Covered Person is a minor, the Plan shall have no obligation to pay any medical or dental benefits incurred on account of Injury or Sickness caused by a responsible Third Party until after the Covered Person or his authorized legal representative obtains valid court recognition and approval of the Plan's 100%, first dollar reimbursement and Subrogation rights on all Recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.

Defined terms: "Covered Person" means anyone covered under the Plan, including minor dependents.

"Recover," "Recovered," "Recovery" or "Recoveries" means all monies paid to the Covered Person or his designee by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injury or Sickness, whether or not said losses reflect medical or dental charges covered by the Plan. "Recoveries" further includes, but is not limited to, recoveries for medical or dental expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages and any other recovery of any form of damages or compensation whatsoever.

"Refund" means repayment to the Plan for medical or dental benefits that it has paid toward care and treatment of the Injury or Sickness.

"Subrogation" means the Plan's right to pursue and place a lien upon the Covered Person's claims for medical or dental charges against the other person.

"Third Party" means any Third Party including another person or a business entity.

Rights of Plan Administrator. The Plan Administrator has a right to request reports on and approve of all settlements.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Employees and their families covered under 8x8 Inc. PPO with HSA (the Plan) will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

COBRA continuation coverage under the Plan is administered by the COBRA Administrator. Please see Plan Contact Information on page ii for COBRA Administrator. Complete instructions on COBRA, as well as election forms and other information, will be provided by the COBRA Administrator to Plan Participants who become Qualified Beneficiaries under COBRA.

There may be other options available 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.

What is COBRA continuation coverage? COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

Who can become a Qualified Beneficiary? In general, a Qualified Beneficiary can be:

(1) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(2) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

The term "covered Employee" includes any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan (e.g., common-law employees (full or part-time), self-employed individuals, independent contractor, or corporate director). However, this provision does not establish eligibility of these individuals. Eligibility for Plan Coverage shall be determined in accordance with Plan Eligibility provisions.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason,

an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual.

A Domestic Partner and his or her children are not Qualified Beneficiaries and do not have an independent right to elect COBRA continuation coverage. However, if an Employee who is a Qualified Beneficiary elects COBRA continuation coverage for himself, he may also elect to continue coverage for his Domestic Partner and Children or Qualified Dependents if they are covered under the Plan on the day before the Qualifying Event.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

What is a Qualifying Event? A Qualifying Event is any of the following if the Plan provided that the Plan participant would lose coverage (i.e.: cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

(1) The death of a covered Employee.

(2) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.

(3) The divorce or legal separation of a covered Employee from the Employee's Spouse. If the Employee reduces or eliminates the Employee's Spouse's Plan 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 even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.

(4) A covered Employee's enrollment in any part of the Medicare program.

(5) A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).

If the Qualifying Event causes the covered Employee, or the covered Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event, the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993, as amended ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave. For non-FMLA leaves of absence, the COBRA Qualifying Event date will be the day the leave begins.

What factors should be considered when determining to elect COBRA continuation coverage? When considering options for health coverage, Qualified Beneficiaries should consider:

- **Premiums:** This plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive. Qualified Beneficiaries have special enrollment rights under federal law (HIPAA). They have the right to request special enrollment in another group health plan for which they are otherwise eligible (such as a plan sponsored by a spouse's employer) within 30 days after Plan coverage ends due to one of the Qualifying Events listed above.

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- **Provider Networks:** If a Qualified Beneficiary is currently getting care or treatment for a condition, a change in health coverage may affect access to a particular health care provider. You may want to check to see if your current health care providers participate in a network in considering options for health coverage.

- **Drug Formularies:** For Qualified Beneficiaries taking medication, a change in health coverage may affect costs for medication - and in some cases, the medication may not be covered by another plan. Qualified beneficiaries should check to see if current medications are listed in drug formularies for other health coverage.

- **Severance payments:** If COBRA rights arise because the Employee has lost his job and there is a severance package available from the employer, the former employer may have offered to pay some or all of the Employee's COBRA payments for a period of time. This can affect the timing of coverage available in the Marketplace. In this scenario, the Employee may want to contact the Department of Labor at 1-866-444-3272 to discuss options.

- **Medicare Eligibility:** You should be aware of how COBRA coverage coordinates with Medicare eligibility. If you are eligible for Medicare at the time of the Qualifying Event, or if you will become eligible soon after the Qualifying Event, you should know that you have 8 months to enroll in Medicare after your employment -related health coverage ends. Electing COBRA coverage does not extend this 8-month period. For more information, see medicare.gov/sign-up-change-plan.

- **Service Areas:** If benefits under the Plan are limited to specific service or coverage areas, benefits may not be available to a Qualified Beneficiary who moves out of the area.

- **Other Cost-Sharing:** In addition to premiums or contributions for health coverage, the Plan requires participants to pay copayments, deductibles, coinsurance, or other amounts as benefits are used. Qualified beneficiaries should check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

Are there other coverage options besides COBRA Continuation Coverage? Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for Qualified Beneficiaries through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

What is the procedure for obtaining COBRA continuation coverage? The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

What is the election period and how long must it last? The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

Note: If a covered Employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, as extended by the Trade Preferences Extension Act of 2015, and the Employee and his or her covered Dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Any person who qualifies or thinks that he and/or his family members may qualify for assistance under this special provision should contact the Plan Administrator for further information about the special second

election period. If continuation coverage is elected under this extension, it will not become effective prior to the beginning of this special second election period.

Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event? The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator has been timely notified that a Qualifying Event has occurred. The employer (if the employer is not the Plan Administrator) will notify the Plan Administrator of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

(1) the end of employment or reduction of hours of employment,

(2) death of the Employee,

(3) commencement of a proceeding in bankruptcy with respect to the employer, or

(4) entitlement of the employee to any part of Medicare.

IMPORTANT:

For the other Qualifying Events (divorce, termination of domestic partnership or legal separation of the Employee and Spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you or someone on your behalf must notify the COBRA Administrator within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any Spouse or Dependent child who loses coverage will not be offered the option to elect continuation coverage.

NOTICE PROCEDURES:

Any notice that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the COBRA Administrator.

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the **name of the plan or plans** under which you lost or are losing coverage,
- the **name and address of the Employee** covered under the plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a **divorce or legal separation**, your notice must include **a copy of the divorce decree or the legal separation agreement.**

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the COBRA Administrator receives *timely notice* that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage for their Spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If you or your Spouse or Dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights? If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the COBRA Administrator.

Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare? Qualified beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied).

When may a Qualified Beneficiary's COBRA continuation coverage be terminated? During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

(1) The last day of the applicable maximum coverage period.

(2) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.

(3) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any employee.

(4) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.

(5) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

(a) (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

(b) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

What are the maximum coverage periods for COBRA continuation coverage? The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below:

(1) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.

(2) In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries ends on the later of:

(a) 36 months after the date the covered Employee becomes enrolled in the Medicare program. This extension does not apply to the covered Employee; or

(b) 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.

(3) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

(4) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

Under what circumstances can the maximum coverage period be expanded? If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second Qualifying Event within 60 days of the second Qualifying Event. This notice must be sent to the COBRA Administrator in accordance with the procedures above.

How does a Qualified Beneficiary become entitled to a disability extension? A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice should be sent to the COBRA Administrator in accordance with the procedures above.

Does the Plan require payment for COBRA continuation coverage? For any period of COBRA continuation coverage under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Qualified beneficiaries will pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which Timely Payment is not made.

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments? Yes. The Plan is also permitted to allow for payment at other intervals.

What is Timely Payment for payment for COBRA continuation coverage? Timely Payment means a payment made no later than 31 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf,

the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

IF YOU HAVE QUESTIONS

If you have questions about your COBRA continuation coverage, you should contact COBRA Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

KEEP YOUR COBRA ADMINISTRATOR INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the COBRA Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the COBRA Administrator. .

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. 8x8 Inc. PPO with HSA is the benefit plan of 8x8 Inc., the Plan Administrator, also called the Plan Sponsor. It is to be administered by the Plan Administrator in accordance with the provisions of ERISA.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

Service of legal process may be made upon the Plan Administrator.

DUTIES OF THE PLAN ADMINISTRATOR.

(1) To administer the Plan in accordance with its terms.

(2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.

(3) To decide disputes which may arise relative to a Plan Participant's rights.

(4) To prescribe procedures for filing a claim for benefits and to review claim denials.

(5) To keep and maintain the Plan documents and all other records pertaining to the Plan.

(6) To appoint a Claims Administrator to pay claims.

(7) To perform all necessary reporting as required by ERISA.

(8) To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Sec. 609.

(9) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

FIDUCIARY. A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

FIDUCIARY DUTIES. A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Employees and their Dependent(s), and defraying reasonable expenses of administering the Plan. These are duties which must be carried out:

(1) with care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;

(2) by diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

(3) in accordance with the Plan documents to the extent that they agree with ERISA.

THE NAMED FIDUCIARY. A "named fiduciary" is the one named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

(1) the named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or

(2) the named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY. A Claims Administrator is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

FORCE MAJEURE. Should the performance of any act required by the Plan be prevented or delayed by reason of any act of nature, strike, lock-out, labor troubles, restrictive governmental laws or regulations, or any other cause beyond a party's control, the time for the performance of the act will be extended for a period equivalent to the period of delay, and non-performance of the act during the period of delay will be excused. In such an event, however, all parties will use reasonable efforts to perform their respective obligations under the Plan.

COMPLIANCE WITH HIPAA PRIVACY STANDARDS. Certain members of the Employer's workforce perform services in connection with administration of the Plan. In order to perform these services, it is necessary for these employees from time to time to have access to Protected Health Information (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these employees are permitted to have such access subject to the following:

(1) **General.** The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this HIPAA Privacy section is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, including genetic information and information about treatment or payment for treatment.

(2) **Permitted Uses and Disclosures.** Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities. However, Protected Health Information that consists of genetic information will not be used or disclosed for underwriting purposes.

(3) **Authorized Employees.** The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this HIPAA Privacy section, "members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer.

(a) **Updates Required.** The Employer shall amend the Plan promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.

(b) **Use and Disclosure Restricted.** An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.

(c) **Resolution of Issues of Noncompliance.** In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:

(i) Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

(ii) Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include, oral or written reprimand, additional training, or termination of employment;

(iii) Mitigating any harm caused by the breach, to the extent practicable; and

(iv) Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

(4) **Certification of Employer.** The Employer must provide certification to the Plan that it agrees to:

(a) Not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;

(b) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;

(c) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

(d) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law;

(e) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;

(f) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

(g) Make available the Protected Health Information required to provide any accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;

(h) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;

(i) If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and

(j) Ensure the adequate separation between the Plan and member of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards.

The following members of 8x8 Inc.'s workforce are designated as authorized to receive Protected Health Information from 8x8 Inc. PPO with HSA ("the Plan") in order to perform their duties with respect to the Plan: Privacy Officer, and other individuals trained and authorized by the Privacy Officer to receive Protected Health Information.

COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS. Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), the Employer agrees to the following:

(1) The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

(2) The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

(3) The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance With HIPAA Privacy Standards provisions (3) Authorized Employees and (4) Certification of Employers described above.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Employee and Dependent Coverage: Funding is derived from the funds of the Employer and contributions made by the covered Employees.

The level of any Employee contributions will be set by the Plan Administrator. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.

Benefits are paid directly from the Plan through the Claims Administrator.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract for or of employment.

CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount

of money. In the case of a Plan Participant, the amount of overpayment may be deducted from future benefits payable.

AMENDING AND TERMINATING THE PLAN

If the Plan is terminated, the rights of the Plan Participants are limited to expenses incurred before termination.

The Employer reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement (if any).

CERTAIN PLAN PARTICIPANTS RIGHTS UNDER ERISA

Plan Participants in this Plan are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA specifies that all Plan Participants shall be entitled to:

> Examine, without charge, at the Plan Administrator's office, all Plan documents and copies of 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.
>
> Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
>
> Continue health care coverage for a Plan Participant, Spouse, or other dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. Employees or dependents may have to pay for such coverage.
>
> Review this summary plan description and the documents governing the Plan or the rules governing COBRA continuation coverage rights.

If a Plan Participant's claim for a benefit is denied or ignored, in whole or in part, the participant has 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 a Plan Participant can take to enforce the above rights. For instance, if a Plan Participant requests a copy of Plan documents or the latest annual report from the Plan and does not receive them within 30 days, he or she may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and to pay the Plan Participant up to $110 a day until he or she receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the Plan Participant has a claim for benefits which is denied or ignored, in whole or in part, the participant may file suit in state or federal court.

In addition, if a Plan Participant disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, he or she may file suit in federal court.

In addition to creating rights for Plan Participants, ERISA imposes obligations upon the individuals who are responsible for the operation of the Plan. The individuals who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Plan Participants and their beneficiaries. No one, including the Employer or any other person, may fire a Plan Participant or otherwise discriminate against a Plan Participant in any way to prevent the Plan Participant from obtaining benefits under the Plan or from exercising his or her rights under ERISA.

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

If the Plan Participant has any questions about the Plan, he or she should contact the Plan Administrator. If the Plan Participant has any questions about this statement or his or her rights under ERISA, including COBRA or the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, that Plan Participant should contact either the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at www.dol.gov/ebsa/. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)