

PayPal Holdings, Inc. Health and Welfare Benefits Plan Plan Document and Summary Plan Description

Effective January 1, 2024

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1. Introduction

PayPal Holdings, Inc. (the “Company” or “PayPal”) maintains the PayPal Holdings, Inc. Health and Welfare Benefits Plan (the “Plan”) and the PayPal Section 125 Plan (the “Section 125 Plan”) to provide certain health and welfare benefits to the eligible employees (and their eligible dependents and beneficiaries) of PayPal and participating employers.¹ References to the “Plan” include the Section 125 Plan and each benefit program unless the context requires otherwise. References to employment with PayPal or the Company include employment with participating employers.

The Company is responsible for administering the Plan (the “Plan Administrator”).

This document, together with the benefit booklets (defined below) and other benefit program materials referenced in Appendix A, the provisions of the Section 125 Plan relating to Health Care Spending Accounts, any updates to this document (including any summary of material modifications (SMMs)) and the annual enrollment materials (collectively referred to herein as the “benefit program materials”) constitutes for the Plan a summary plan description and plan document for purposes of the Employee Retirement Income Security Act of 1974, as amended (ERISA). The “benefit booklets” are the evidences of coverage, schedules of benefits, summaries of benefits, plan documents, and the benefit descriptions provided by an insurance company, provider or third-party administrator in connection with a benefit program offered under the Plan. The benefit booklets can be found on PayPalBenefits.com or obtained from the benefits administrators listed in Appendix B.

Plan Details

More detailed information about the benefit programs under the Plan (each referred to herein as a “benefit program”) is provided in the benefit program materials, which are incorporated by reference into this document. For additional information, please refer to:

- Appendix A for a list of the benefit programs, including the insurance policy or contract number (if applicable) and benefit program materials associated with the benefit program;
- Appendix B for the benefits administrator and/or claims administrator address and contact information and for funding information about each benefit program; and
- Appendix C for Plan administration information.

Certain benefit programs offered under the Plan are currently provided under insurance contracts and administrative agreements entered into between the Company as the Plan Sponsor and various insurance carriers and third-party administrators.

For questions about this document, any provisions of the Plan, or to receive a paper copy of this document, please contact the Plan Administrator listed in Appendix C. For questions about any benefit plan material for a benefit program, please visit the HR Hub on the Bridge or contact the appropriate benefits administrator listed in Appendix B.

The Company offers the benefit programs listed below, which may change or be amended from time to time. Certain benefit programs (including the Health Reimbursement Arrangement) may be available for only a limited time and/or may not be available to all employees and/or dependents.

- Medical, including prescription drug coverage, virtual care, and fertility,
- Dental,
- Vision,
- Employee Assistance Program (EAP),
- Health Care Spending Account (HCSA) (please note that the Section 125 Plan refers to the HCSAs as the General Purpose Health Care Flexible Spending Account (General Purpose Health Care FSA) and the Limited Purpose Health Care Flexible Spending Account (Limited Purpose Health Care FSA)),
- Dependent Care Spending Account (DCSA),
- Health Reimbursement Arrangement (HRA),
- Life Insurance,

¹ A participating employer is an employer that adopts the Plan with the consent of PayPal and is designated in writing by PayPal as a participating employer. A complete list of the employers participating in the Plan is available for your review. You may obtain the list upon written request to the Plan Administrator.

- Accidental Death and Dismemberment Insurance (AD&D),
- Legal Assistance (Group Legal),
- Short-term Disability (STD),
- Long-term Disability (LTD),
- Business Travel Accident (BTA),
- Accident,
- Critical Illness,
- Hospital Indemnity,
- Optional Long-Term Care + Life Insurance
- Wellness
- Substance Use Treatment Helpline

Please note the following:

The DCSA and STD are not subject to ERISA and are not part of the Plan. However, descriptions of the DCSA and STD benefits are included in this document for your convenience.

Participants who enroll in certain medical benefit program options may be eligible to make contributions to a Health Savings Account (HSA). Although the HSA may be mentioned at times in this document and in benefit enrollment materials, the HSA is not subject to ERISA and is not a part of the Plan.

No Vested Benefits

There are no vested benefits under the Plan. To the maximum extent permitted by law, no person will acquire any right, title or interest in, or to any portion of, a contract under the Plan other than by the actual payment or distribution under the provisions of the Plan, or acquire any right, title or interest in, or to any component benefit programs referred to or provided for in, the Plan other than by actual payment of such benefit.

Important Note

Every effort has been made to ensure that the information in this document is complete and accurate. However, if there is a conflict or a difference between what is written here and the related benefit program materials, the related benefit program materials will govern with respect to the amounts payable, limitations and exclusions, claims procedures and other coverage aspects of the applicable benefit program, unless otherwise required by law. The SPD and the Plan document will govern with respect to eligibility, participation and other general Plan terms and conditions.

The Company or its authorized delegate, in its sole discretion, may amend, modify, suspend, or terminate in writing the Plan or any of the benefit programs or any provision of the Plan at any time for any reason.

This document does not create a contract nor guarantee employment between the Company and any individual. Your employment is always on an at-will basis. The Company or you may terminate your employment relationship without notice at any time and for any reason.

No participant or beneficiary in any benefit program will have any right to a benefit other than as specifically described in the Plan.

Keep Your Records Updated

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

To update your personal information, please review your Personal Profile with Employee Central. Terminated employees should notify the benefits administrator at the numbers listed in Appendix B with any updates.

2. Eligibility Requirements

Employees and their dependents are eligible for one or more of the benefit programs listed in Section 1 if they meet the requirements below. Please carefully read this section, as well as the benefit program materials for the benefit programs in which you participate, because each benefit program may define “dependent” in a different way (including, for example, the DCSA).

Employees

An employee of the Company is eligible for coverage under the Plan if he or she is on the U.S. payroll of the Company or a participating employer and is regularly scheduled to work 20 hours or more per week, provided that such employee is not an “excluded person” as described below (an “employee”). The Company may also designate other individuals and their dependents as being eligible for selected benefits under the Plan in its sole discretion.

Dependents

Unless specifically indicated otherwise in the benefit program materials, an eligible dependent (also referred to herein as a “family member”) for the benefit programs generally includes your:

- legally married spouse, unless you are legally separated;
- domestic partner (as defined below); and
- children through the month in which they attain age 26 or of any age under the medical benefit program if totally disabled (see “Continuing Health Coverage for Children with Disabilities” below), defined as:
 - biological or legally adopted children, as well as children placed with you for adoption,
 - stepchildren,
 - foster children,
 - children of enrolled domestic partners,
 - children for whom you are responsible to provide health coverage based on a qualified medical child support order (QMCSO), or
 - children for whom you have been appointed by a court as legal guardian.

Dependent Verification

Participants adding eligible dependent(s) to Company medical, dental or vision plans are required to verify dependent(s) eligibility by providing documentation substantiating the relationship to the covered participant.

Once enrollment has been successfully submitted and confirmed on the benefits administrator enrollment website, you must submit required documentation to the Dependent Verification Center, as directed by the Company. You have 45 days to submit required documents.

The online Dependent Verification Center will indicate required documentation, such as a birth or marriage certificate for each added dependent, verification deadline and verification status. Documents can be uploaded to the online portal.

You will receive a Verification Request Notice sent first class mail by the U.S. Postal Service. This notice is mailed to the address on file with the benefits administrator. The Verification Request Notice lists the dependent(s) covered under each plan and the documents required to verify eligibility for coverage. Documents can also be submitted by mail or fax. Throughout the verification process you will receive email reminders and a Reminder Notice by mail.

If you do not complete the dependent verification process within the stated deadline, coverage for the dependent(s) will end. You will receive a Final Results Notice by mail informing you which dependent(s) failed verification. The decision to terminate coverage is based on the information you did or did not provide. If you do not agree with this decision, you can start a claim and ask for review.

For assistance with dependent verification services or filing a claim, contact the applicable benefits administrator listed in Appendix B.

Domestic Partner Definition

Domestic partners of employees are eligible for certain Company benefits if the employee is eligible for Company benefits and if:

- they have a domestic partnership or civil union that is currently registered as such with any governmental body, pursuant to state or local law; or
- they are same- or opposite-sex domestic partners who have met all of the following criteria (as determined by the Company in its sole discretion):
 - are financially interdependent and are jointly responsible for each other's common welfare;
 - intend to remain in a committed relationship;
 - share the same living quarters and permanent address for six (6) months;
 - are at least age eighteen (18) years of age and capable of consenting to the domestic partnership;
 - are not so closely related by blood that a legal marriage would be otherwise prohibited by law; and
 - have not been in a different domestic partner relationship or marriage within the last six (6) months.

References to "spouses" in this Plan shall also include domestic partners, unless the context requires otherwise.

Continuing Health Coverage for Children With Disabilities

Your child will be allowed to continue Company health coverage if he or she is disabled and covered under the Plan prior to age 26 and meets the following criteria:

- incapable of self-sustaining employment because of mental or physical incapacity,
- chiefly dependent upon you for support and maintenance, and
- unmarried.

Coverage for such an eligible child will continue as long as the child remains incapacitated, dependent and unmarried. You must contact the benefits administrator at the numbers listed in Appendix B within 31 days after the child turns 26 in order to continue their coverage. You will be asked to provide written certification from the child's medical plan that he or she is disabled. You must provide such certification within the timeframe instructed by Your Benefits Resources (YBR). In order for such disabled child to continue coverage under the Plan, you must furnish written certification of continuing disability upon any request by the benefits administrator or the Plan Administrator thereafter.

Excluded Persons

The following persons are not eligible to participate in the Plan (unless they are eligible as a dependent of an eligible employee):

- Employees who are not on the U.S. payroll of the Company or a participating employer
- Employees who are regularly scheduled to work less than 20 hours per week
- Independent contractors (including any employee of an independent contractor or subcontractor)
- Leased workers
- Seasonal, casual, or temporary workers (e.g., individuals paid by an employment agency or temporary staffing firm)
- Individuals classified by the Company on its books and records as Interns (e.g., individuals who are students at an educational institution who are gaining supervised, practical work and educational experience at the Company for a limited period of time)
- Any person who is not treated as a common-law employee by the Company for income and employment tax withholding purposes, regardless of any subsequent determination of an individual's legal employment status
- Individuals who provide services pursuant to an agreement or arrangement (written or oral) that contains a waiver of participation in the Plan
- An individual classified by the Company as an ineligible individual

Qualified Medical Child Support Orders (QMCSOs)

In general, a QMCSO is any judgment, decree or order, including a court-approved settlement agreement, that:

- is issued by:
 - a domestic relations court or other court of competent jurisdiction, or
 - an administrative process established under state law which has the force and effect of law in that state,
- assigns to a child the right (or creates or recognizes the right of a child) to receive health benefits for which a participant or beneficiary is eligible under a group health plan that is a component of the Plan, and
- the Plan Administrator determines is qualified, in accordance with ERISA and applicable state law.

You can get a copy of the Plan's written QMCSO procedures upon request to the Plan Administrator listed in Appendix C at no cost to you.

In general, only children who meet the eligibility requirements as dependents—for example, by meeting the age requirements—can be covered under a QMCSO. However, a QMCSO can also apply to children who:

- were born out of wedlock,
- are not claimed as dependents on your federal income tax return, and
- do not live with you.

No Duplicate Coverage

You may not be covered as both an employee and a dependent under the Plan. For example, if you are married to another employee of the Company:

- you can both elect employee-only coverage, or
- one of you can elect employee-only coverage and the other can elect employee + one dependent (dependent cannot be your spouse), or
- one of you can elect employee + family coverage and the other must decline coverage.

If duplicate enrollment occurs, the Company will cancel the later enrollment. The Plan reserves the right to collect reimbursement for any duplicate premium payments and for any Plan benefits paid or provided due to the duplicate enrollment.

For additional information, refer to the applicable benefit program material listed in Appendix A.

Documentation

To verify eligibility for your family members, the Plan Administrator and the insurance carriers and benefits administrators may request documentation needed to verify your relationship, including but not limited to birth certificates, adoption records, marriage certificates, verification of domestic partnership or domestic partner registration, proof of adult dependent eligibility, disability, student status, and tax documentation. See Section 11, General Plan Provisions. Additionally, as noted in Section 2 under "Dependents," as of April 15, 2022, participants must provide verification for any newly added dependents. Please refer to that section for more details.

In addition, the Company, an insurance carrier, or a benefits administrator may request information from you regarding Medicare eligibility and enrollment, family member eligibility, address information, and more. You are required to promptly provide the requested information within the time frame specified by the Company, insurance carrier, or benefits administrator.

Enrolling or attempting to enroll a purported spouse, dependent, child, domestic partner, or other family member who does not actually have such relationship with you is an act, practice, or omission that constitutes fraud and/or an intentional misrepresentation of material fact. The Company reserves the right to de-enroll individuals and their family members for failing to provide documentation when requested. Individuals may be retroactively de-enrolled if their enrollment was due to fraud or intentional misinformation (for example, if an ineligible individual is enrolled in the Plan or if you fail to provide satisfactory proof of dependent status). In addition, the Company may seek disciplinary or legal action against you and/or reimbursement for employer contributions made to the Plan and benefits paid by the Plan for ineligible coverage.

These rights are in addition to, and not in lieu of, those set forth in any benefit program materials that address fraud, misrepresentation, and similar acts or omissions.

The Company has the sole and exclusive right to determine whether an individual satisfies the eligibility requirements under the Plan.

Loss of Family Member Eligibility

Whenever a family member loses eligibility to participate in a benefit program, it is your responsibility to de-enroll that family member from the benefit program within 31 calendar days using the benefits administrator numbers listed in Appendix B. If you do not, you will not be able to de-enroll that individual until the next annual enrollment period and you may be required to continue paying for the coverage of such individual even though he or she will not be able to receive any benefits under the Plan. You will be liable for any excess Company costs and for any benefit program expenses incurred by the ineligible family member (including any claims paid in respect of such family member).

Premiums will not be refunded if the employee does not cancel or de-enroll a family member within 31 days following the loss of eligibility. See Section 9, Continuation of Health Care Coverage, for information about continuing coverage under COBRA.

Fraud or Intentional Misrepresentation

The Plan Administrator or its designee (including any insurance company or benefits administrator) may seek reimbursement for all claims or expenses paid by the Plan as a result of acts of fraud or intentional misrepresentation of material fact (as determined by the Plan Administrator or its designee), and may reduce future benefits as an offset for amounts that should be reimbursed, or pursue legal action against the individual. Acts of fraud or intentional misrepresentation may include but are not limited to enrolling, or failing to de-enroll, an ineligible spouse, child, domestic partner, or dependent.

For example, if the Plan covers an ineligible dependent as a result of fraud or intentional misrepresentation of fact, you will be subject to the Company's disciplinary actions, which may include the retroactive termination of your and/or your dependent's coverage. If you intentionally misrepresent that a child meets the Plan's definition of eligible child in order to obtain coverage, your and your child's benefits may be terminated and/or you may be required to reimburse the Company for all expenses paid while the child was ineligible for coverage. Expenses may include but are not limited to expenses for premiums, claims, administrative fees, disciplinary action, civil action to recover any losses, and termination of your employment. This policy will be strictly enforced.

These rights are in addition to, and not in lieu of, those set forth in any benefit program materials that address fraud, misrepresentation, and similar acts or omissions.

3. How To Enroll

General Information

In order to receive benefits, some benefits programs require you to enroll. Others provide automatic coverage if you are eligible for the benefit.

Refer to your new-hire materials or annual enrollment material for further information, including information about default coverage and/or benefit program contributions.

Newly Eligible Employees

If you're a newly eligible employee, you will generally be sent an enrollment notification within seven (7) days of your enrollment eligibility. If you don't receive this notification within 10 days of your enrollment eligibility, contact the benefits administrator at the numbers listed in Appendix B.

Upon your benefits eligibility date and once you have met your eligibility requirements (as described in Section 2) or within 31 days of a Qualified Life Event (see Section 7), you must enroll yourself and eligible dependents by completing the enrollment process. If you have any questions regarding this process, contact the benefits administrator at the numbers listed in Appendix B. If you enroll in one or more benefit programs offered under the Plan, you are authorizing the Company to deduct your share of the cost of your coverage from your pay on a pre-tax or post-tax basis, as applicable, depending on the coverage. See the Section 125 Plan for more information.

You will be automatically enrolled in basic life insurance, basic AD&D, basic short-term disability (STD), basic long-term disability (LTD), and employee assistance program (EAP) benefits. **If you do not complete your enrollment within 31 days after you become eligible (generally, the thirty-first (31st) day following your first date of employment if you are a new hire), you will still be automatically enrolled in these benefits, and you will also be enrolled in "default" health, dental, and vision coverage if you do not actively decline such coverage within 31 days of your eligibility date. The "default" health coverage is the Copay Plan medical plan, the core dental plan, and the core vision plan with single (employee-only) coverage. You will be responsible for paying your share (if any) of the cost of coverages in which you are automatically enrolled, and you agree to pay such costs by being automatically enrolled.**

Required employee contributions for elected and default health coverage are deducted from your pay. If you don't enroll yourself and your eligible dependents within 31 days of the day you become eligible or a Qualified Life Event, or if you are enrolled in default health coverage, you must wait until the next annual enrollment period to enroll or change your enrollment, as applicable, unless a Special Enrollment Event or a Qualified Life Event occurs.

For example, if you are enrolled in a medical benefit program and later acquire a new dependent as a result of a marriage, birth, adoption or placement for adoption, you may enroll that dependent as long as you do so within 31 days following the event. For more information, refer to Section 7, Making Changes to Your Elections.

Evidence of Insurability (Good Health)

Note that certain benefits, such as optional (supplemental) life insurance, may require evidence of insurability (proof of good health) in various circumstances, such as if you do not enroll when initially eligible and wish to enroll at a later date or if you want to apply for an increase in the amount of coverage. You are solely responsible for ensuring that any evidence of insurability (proof of good health) is properly and timely completed and submitted. Contact the benefits administrator at the numbers listed in Appendix B for more information.

Annual Enrollment

Employees may enroll for coverage, change coverage elections, or waive coverage during the annual enrollment period, which will be announced each year. Note that certain non-health benefits require evidence of insurability if you do not enroll when initially eligible and wish to enroll later. Annual enrollment elections will be effective as of the first day of the following Plan Year. **If you do not change your elections during annual enrollment, your coverage levels will continue from the previous year with the exception of contributions to the HSA,**

HCSA, and DCSA, which require re-enrollment each year. This means that you will be deemed to have elected to continue coverage (and the same coverage levels) for the following Plan Year. You will be responsible for paying your share (if any) of the cost of coverages in which you are re-enrolled, and you agree to pay such costs by being re-enrolled.

COBRA-qualified beneficiaries are eligible to participate in the annual enrollment process if their maximum COBRA period has not expired. (See Section 9, Continuation of Health Care Coverage.)

Enrolling or Changing Coverage at Other Times

In general, you cannot enroll, drop coverage or change your or your dependent's coverage under the Plan except at annual enrollment. However, you may be able to drop or add coverage for yourself or a dependent in a benefit program during the Plan Year if you have a Qualified Life Event or become entitled to a Special Enrollment Right. The rules for changing your elections are described in Section 7, Making Changes to Your Elections.

If you want to make a change to your elections, you must request the change online by contacting the benefits administrator listed in Appendix B. You must request the change within 31 days following the event (or within 60 days if you or your dependent loses coverage under the Children's Health Insurance Program (CHIP) or Medicaid or becomes eligible for state premium assistance under Medicaid or CHIP). Otherwise, your next opportunity to enroll new dependents or make other program changes is the next annual enrollment period or the date you have another Qualified Life Event or Special Enrollment Right, whichever occurs first.

Note: An employee whose job level newly changes to Grades 15 to 19 (i.e., an employee who was previously not in Grades 15 to 19) will have 31 days from the effective date of the job level change to elect the Meritain Health Copay Plan with HRA plan coverage option (to the extent the employee is not already enrolled in that option), which is bundled with the PayPal Holdings, Inc. HRA Plan. PayPal provides credits under the PayPal Holdings, Inc. HRA Plan, which can be used toward reimbursing qualified medical expenses (as defined in that plan). To make this election change to your medical coverage, please call the Benefit Center at 844-474-6641.

When Coverage Begins

The date coverage begins will depend on when you enroll for coverage under a benefit program and the terms of the benefit program in which you are enrolled. In general, coverage begins on your date of hire or the date you enroll in the Plan (or such other date specified by the applicable benefit program(s)) following your becoming eligible under the Plan. For more information, review the applicable benefit program material listed in Appendix A.

If you are not initially eligible on the first day of your employment and later become eligible (for example, if you are scheduled to work less than 20 hours a week and your scheduled hours change and you become scheduled to work 20 hours or more per week), you and your eligible dependents' coverage will generally be effective on the date you enroll in the Plan (or such other date specified by the applicable benefit program(s)) as long as you enroll within 31 days after you become eligible. You may not, however, make any pre-tax contributions to pay for any coverage effective prior to the date you enroll.

If you enroll a new baby or adopted child, coverage will start on the date of birth, adoption, or placement for adoption as long as the child is enrolled within 31 days following the date of birth, adoption, or placement for adoption.

When Coverage Ends

Active Employees

Active employee coverage generally ends on the earliest of the following dates:

- the last day of the month in which you fail to make a required contribution;
- the last day of the month following layoff;
- the last day of the month in which you terminate employment with the Company;*
- the last day of the month in which you become ineligible for coverage;
- the last day of the Plan Year in which you elect to drop coverage during an annual enrollment period for the subsequent Plan Year;
- the date the Plan or benefit program terminates;

- the date you die;
- the date the employee and/or his or her dependent(s) commit any acts of fraud or make an intentional misrepresentation of material fact when applying for or obtaining coverage or obtaining benefits under the Plan; and
- as further described in the benefit program material.

* However, life and disability coverage ends on the date of termination. Please see the applicable benefits materials for more information, including portability, related to these coverages.

Dependents of Employees

Coverage for employees' dependents ends when the employee's coverage ends as provided above unless coverage ends sooner as a result of a Qualified Life Event.

In the event of an employee's death:

- Covered dependents will be offered federal COBRA continuation coverage, as provided in Section 9.
- For each covered dependent who is a COBRA-qualified beneficiary and elects COBRA continuation coverage, the Company will pay the cost of the COBRA coverage for a period of eighteen (18) months, starting with the first of the month following the employee's date of death. This Company payment applies only to COBRA continuation coverage with respect to the Plan's medical, dental, vision and EAP programs.
- After that period and for the remaining duration of the COBRA continuation period, the dependents will be responsible for paying the full cost of the COBRA coverage.

4. Paying for Coverage

You and the Company share the cost of coverage under certain benefit programs, as described in your enrollment materials. Your portion of the cost varies according to the benefits and coverage levels (i.e., single, family, etc.) you elect or are automatically enrolled or re-enrolled.

The cost of coverage does not include your costs for any applicable deductibles, coinsurance, copays, out-of-network charges, non-covered items, or similar costs.

Contributions for Health Benefits

Pre-Tax Payroll Contributions

Active employees generally pay their contributions for health benefits on a “pre-tax” basis, that is, before federal income and employment taxes are deducted from their paychecks. In addition, contributions to the HCSA and the DCSA are paid on a pre-tax basis.

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

If you are eligible for and elect medical coverage under a high-deductible health plan with HSA offered under the Plan (see Appendix A), the Company allows you to make pre-tax contributions to a Health Savings Account. The Company also has the discretion to make a contribution to your Health Savings Account for you if you are enrolled in this medical plan. Contributions to Health Savings Accounts are subject to annual limitations, and any contribution the Company makes to your Health Savings Account counts toward the annual limitation. You are solely responsible for ensuring that the total amount of contributions to your Health Savings Account do not exceed the applicable limits and taking any actions to correct excess contributions. Information about the Company contribution, if any, will be provided annually.

Contributions for Other Benefits

Employee contributions for accident, critical illness, hospital indemnity, group legal, optional life insurance, optional AD&D, and Optional Long-Term Care + Life Insurance are paid on an after-tax basis.

Unpaid Leave of Absence

Employees on Company-approved, unpaid leaves of absence can pay for their health benefit coverage on an after-tax basis and will be invoiced for coverage from the benefits administrator. Employees on a leave under the Family and Medical Leave Act of 1993 may arrange to pre-pay for health benefit coverage on a pre-tax basis. For more information on leaves of absence, refer to the Company’s leave of absence policy available on the Bridge (Company intranet).

Domestic Partner Benefits and Taxes

Because of federal and certain state tax laws, health coverage for domestic partners and the children of domestic partners is generally taxable. This means that the value of the coverage will be treated as taxable compensation or “imputed income.” Imputed income is taxable. If your domestic partner (and his or her children) is eligible for tax-favored coverage under the Internal Revenue Code (IRC), imputed income may not apply. In addition, depending on state tax laws that apply to you, you may not be subject to state income tax on the value of the coverage. For example, in California, if you enroll your “registered domestic partner” as defined under California law, the coverage is not subject to state taxes. If your domestic partner is eligible for tax-free coverage under federal or state law, contact the benefits administrator at the numbers listed in Appendix B to learn about the tax status certification process.

The Company and Plan Administrator do not provide tax or financial advice. You are solely responsible for the tax implications of the benefits and coverages you receive. Please contact your tax advisor for more information on the tax consequences of domestic partner coverage.

5. Health Benefit Information

The Plan includes health (medical, dental, vision, EAP, HCSA and HRA) benefits. For eligibility information for these programs, refer to Section 2.

Benefit Program Materials

The benefit program material for the health benefit program in which you are enrolled (listed in Appendix A) generally will be sent to you. If you would like to request this material, contact the benefits administrator at the numbers listed in Appendix B.

The benefit program materials listed in Appendix A describe the nature of covered services including but not limited to:

- coverage of prescription drugs, emergency care, preventive care, medical tests and procedures and durable medical equipment,
- eligibility to receive services,
- exclusions, limitations and terms for obtaining coverage (such as rules regarding preauthorization, medical management, and utilization review),
- cost sharing (including deductibles, copayment amounts, coinsurance amounts, and other out-of-pocket costs),
- annual and lifetime maximums and other caps or limits,
- circumstances under which services may be denied, reduced or forfeited,
- procedures to be followed in obtaining services, and
- procedures for submitting claims and the review of denied claims.

You may also obtain a copy of the benefit program material for the health benefit program in which you are enrolled by contacting the benefits administrator for the program directly at the address or phone number listed in Appendix B. Information about your health benefit program may also be available online (see Appendix B).

Health Savings Account (HSA)

If you are covered by a high-deductible health plan under the Plan, you may also be eligible to contribute to a Health Savings Account (HSA) made available in connection with the high-deductible health plan. The HSA is an account established for you by a written agreement between you and the HSA's trustee or custodian. The type and amount of benefits you will receive under the HSA, and the conditions and requirements for your benefits thereunder, are determined by your written agreement with the trustee or custodian of the HSA and by any other related administrative contract. In general, your HSA allows you to be reimbursed for qualified medical expenses on a tax-free basis. (Certain other HSA distributions may be permitted on a taxable basis.) The Company does not have authority or control over the funds deposited in your HSA. The HSA benefit consists solely of the ability to make contributions to the HSA on a pre-tax salary reduction basis and the right to receive Company contributions (if any) to the HSA on a pre-tax basis. The HSA is not a Company-sponsored employee benefits plan. It is a savings account that is established and maintained by an HSA trustee/custodian outside this Plan to be used primarily for reimbursement of "qualified eligible medical expenses" as set forth in Code Section 223(d)(2).

In general, you are eligible to contribute to an HSA if you are covered under a high-deductible health plan and you do not have any other health coverage that is not a high-deductible health plan (except for any benefit provided by "permitted insurance" or "permitted coverage" (e.g., dental, vision, preventive care, long-term care insurance, specific disease insurance, accident insurance, a hospital indemnity plan and Limited Purpose HCSA)), as described in Section 223(c)(2) of the IRC. If you are eligible to contribute to an HSA, you may elect to reduce your compensation by an amount to be credited to your HSA on a pre-tax basis and you may make prospective elections to increase, decrease, make or revoke your election to contribute to your HSA at least once per calendar month. The new election shall be effective as soon as administratively feasible but no later than the first day of the first full calendar month following the date that the election change is filed with the benefits administrator.

The maximum amount that may be contributed to your HSA in any year is based on the applicable IRS limit. In some circumstances the annual contribution may be prorated by the number of months that you are eligible to participate in the HSA. You may also be able to elect to contribute additional “catch-up” contributions if you are age 55 or older. The maximum amounts, for both employee-only coverage and family coverage, may be adjusted from time to time based on changes in the law or as decided by the Plan Administrator from time to time. You are solely responsible for ensuring that the total amount of contributions to your HSA does not exceed the applicable limits and for taking any actions to correct excess contributions.

The HSA is established and maintained outside of the Plan. The procedure for filing HSA claims is determined by the HSA custodian, not by this Plan. You, and not the Company, are ultimately responsible for selecting the HSA trustee/custodian to which you make HSA contributions. However, the Company may limit the number of HSA trustees/custodians to whom it will forward contributions that you make via pre-tax salary reductions, and such list is not and shall not be construed or interpreted as the endorsement of any particular trustee/custodian. The Plan Administrator shall maintain records regarding contributions to HSAs that eligible employees make via pre-tax salary reductions, but it will not create a separate fund or otherwise segregate assets for this purpose.

Further information about the HSA can be found in the Section 125 Plan.

Health Care Spending Account (HCSA)

An HCSA allows you to set aside money on a pre-tax basis to help pay for certain eligible health care expenses. This means you generally do not pay federal income or employment taxes on the amount you contribute to an HCSA. You may draw on an HCSA to reimburse yourself for eligible health care expenses you incur during the Plan Year.

There are two types of HCSAs—a General HCSA and a Limited Purpose HCSA—from which to choose, depending on the medical plan in which you are enrolled. If you participate in a General HCSA, you are not permitted to contribute to a Health Savings Account (but may be able to participate in a Limited Purpose HCSA). For additional information on the benefits and rules for the HCSAs, please refer to the Spending Account benefit program materials listed in Appendix A.

Health Reimbursement Arrangement (HRA)

An HRA is an employer-funded arrangement that can be used toward reimbursements for eligible health care expenses.

If you are an employee in job Grades 15-19 who elects the Meritain Health Copay Plan with HRA coverage option, you will be eligible to participate in the PayPal Holdings, Inc. HRA Plan. For additional information on the benefits and rules for the HRA, please refer to the HRA benefit program materials listed in Appendix A.

Provider Networks

If you are enrolled in a health benefit program that provides benefits through provider networks, a list of providers will be available to you without charge after your coverage takes effect. Provider directories are generally available online. If you need assistance, please contact the applicable benefits administrator at the address, phone number, or website listed in Appendix B.

Refer to the benefit program material for your health benefit program for a description of:

- how to use network providers,
- the composition of the network,
- the circumstances under which coverage will be provided for out-of-network services, and
- any conditions or limits on the selection of primary care providers or specialty medical providers that may apply.

If you participate in a health benefit program that provides benefits through a network of providers, in some cases benefits will be paid only if your provider participates in or is associated with a network that your health benefit program uses. In addition, some health benefit programs, such as a health maintenance organization (HMO), may require a referral from a primary care physician before a patient can be treated by a specialty provider. Contact your health plan benefits administrator at the numbers listed in Appendix B to determine your health benefit program’s rules regarding out of network benefits.

Maternity Hospital Stays (Newborns' and Mothers' Health Protection Act)

Federal law protects the benefit rights of mothers and newborns related to any hospital stay in connection with childbirth. In general, group health plans and health insurance issuers may not:

- restrict benefits for the length of hospital stay 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).
- require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay of up to 48 hours (or 96 hours as applicable).

For details on any state maternity laws that may apply to your medical benefit program, please refer to the benefit program material for the medical benefit program in which you are enrolled.

Benefits for Mastectomy-related Services (Women's Health and Cancer Rights Act)

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the medical benefit program.

For information on WHCRA benefits or details about any mastectomy-related state laws that may apply to your medical benefit program, please refer to the benefit program material for the medical benefit program in which you are enrolled.

Physician Designation Notice

Your group health plan may require or allow for the designation of a primary care provider for you, your spouse and your enrolled dependents. Refer to the benefit program materials for the applicable benefit program for more information.

To determine if these rules apply to your medical benefit program or to a medical benefit program that you are considering, for information on how to select a primary care provider, or for a list of participating primary care providers or health care professionals who specialize in obstetrics or gynecology, contact the applicable benefits administrator at the number listed in Appendix B.

Mental Health Parity and Addiction Equity Act

To the extent required by the Mental Health Parity and Addiction Equity Act of 2008, as amended (MHPAEA), the group health plans that are components of the Plan will provide mental health and substance use disorder benefits in accordance with the MHPAEA.

Genetic Information Nondiscrimination Act

The Plan will comply with the applicable provisions of the Genetic Information Nondiscrimination Act of 2008, as amended (GINA).

Patient Protection and Affordable Care Act and Health Care and Education Reconciliation Act

The Plan will comply with the applicable provisions of the Patient Protection and Affordable Care Act (PPACA) as amended by the Health Care and Education Reconciliation Act (HCERA).

Consolidated Appropriations Act, 2021 and Transparency-In-Coverage Regulations

The applicable benefit packages of the Plan will comply with the transparency, surprise billing and other applicable requirements in the relevant provisions of the Consolidated Appropriations Act, 2021 (CAA) and the Transparency-In-Coverage Regulations as they become effective, based on a good faith, reasonable interpretation of the statute, existing regulations and other official guidance.

Michelle's Law

Any health care coverage maintained under a benefit package that is a group health plan that requires a certification of student status for any period of dependent coverage shall comply with Michelle's Law, to the extent applicable.

Eligibility for such coverage for a dependent child who is enrolled in an institution of higher education at the beginning of a medically necessary leave of absence will be extended if the leave normally would cause the dependent child to lose eligibility for coverage under the group health plan due to loss of student status. This eligibility extension shall last up to one year beginning on the first day of the leave of absence or the date the coverage would otherwise terminate due to loss of student status, whichever is earlier, provided that the Plan (or the issuer of health insurance coverage offered in connection with the Plan) has received written certification by a treating physician of the dependent child which states that the child is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) is medically necessary. A dependent child whose benefits are continued under this Section shall be entitled to the same benefits as if (during the medically necessary leave of absence) the child continued to be a covered student at the institution of higher education and was not on a medically necessary leave of absence. To the extent applicable, the Plan shall comply with the continued application in case of changed coverage provisions of Michelle's Law. For this section, "Michelle's Law" refers to Pub. L. No. 110-381 (2008).

HIPAA Notice of Privacy Practices

You have been furnished a Notice of Privacy Practices describing the practices the Covered Components (as defined in Appendix D) will follow with regard to your personal health information that is protected by the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA). If you would like to obtain another copy of the Notice, go to the Plan Documents page on www.PayPalBenefits.com or contact the Plan Administrator.

Premium Assistance Under Medicaid and CHIP

If you or your children are eligible for Medicaid or CHIP and you are eligible for Company-sponsored health coverage, your state may have a premium assistance program that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for these programs but also have access to Company-sponsored health coverage. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov. You have been furnished with the Medicaid and Children's Health Insurance Program Employer Notice. If you would like to obtain a copy of the Notice, contact Alight Benefits Administrator.

6. Other Benefits

Benefit Program Materials

The benefit program materials for the non-health benefit programs in which you are enrolled generally will be sent to you. If you would like to request this material, please contact the benefits administrator at the numbers listed in Appendix B.

The benefit program materials listed in Appendix A describe the nature of covered services, including but not limited to:

- eligibility to receive services;
- exclusions, limitations, and terms for obtaining coverage;
- cost sharing;
- annual and lifetime maximums and other caps or limits;
- circumstances under which services may be denied, reduced, or forfeited;
- procedures to be followed in obtaining coverage; and
- procedures available for the review of denied claims.

You may also obtain a copy of the benefit program material for the benefit program in which you are enrolled by contacting the benefits administrator for the program directly at the address or phone number listed in Appendix B.

Life Insurance, Disability and Accident Benefits

Employees are eligible for life insurance, accidental death and dismemberment insurance (AD&D), short-term disability (STD), long-term disability (LTD), and business travel accident (BTA) benefits if they meet the requirements described in Section 2.

Employees who work in states where temporary disability benefits are *not* mandated under state law are eligible for Company-sponsored short-term disability benefits (STD).

Employees who work in states where short-term disability benefits are mandated under state law *are* covered by the "voluntary" short-term or temporary disability insurance programs that satisfy such state laws. Such benefits coordinate with the Company-sponsored STD.

Eligible employees may elect to cover their eligible dependents under optional life and optional AD&D benefit programs. **Note that an employee married to another employee may not cover his or her spouse as a dependent for these optional benefit programs. Also, only one parent can cover his or her child(ren) under the Plan.**

For more information, refer to the benefit program material listed in Appendix B.

Dependent Care Spending Account (DCSA)

The DCSA allows you to set aside money on a pre-tax basis to help pay for certain dependent care expenses to allow you and your spouse, if any, to work or look for work. This means you pay no taxes on the amount you contribute to your DCSA.

You may draw on the DCSA to reimburse yourself for eligible dependent care expenses you incur during the Plan Year for your eligible dependents (such as a child under age 13, a spouse or other dependent of any age who is physically or mentally unable to care for him or herself and satisfies certain other requirements).

For additional information on the benefits and rules for the DCSA, please refer to the Spending Account benefit program materials listed in Appendix A.

Important Note

In addition to the DCSA, another method of tax savings for dependent care expenses is a federal tax credit. Depending on your personal situation, you may be able to participate in the DCSA for certain expenses and still take a federal tax credit for certain remaining eligible expenses. However, you may not take both the federal tax credit *and* receive reimbursement from the DCSA for the same expenses. You may want to consult IRS Publication 503 and/or a tax advisor to help you decide whether the federal tax credit and/or the DCSA will result in better tax savings for you. The Company and Plan Administrator do not provide tax or financial advice. You are solely responsible for the tax implications of the benefits and coverages you receive.

7. Making Changes to Your Elections

If you experience a Qualified Life Event and you want to make a change in your benefit elections, you must request the change with YBR at <http://www.ybr.com/benefits/paypal> or call 1-844-474-6641 within 31 days following the event to request this change. Otherwise, your next opportunity to enroll new dependents or make other benefit changes is the next annual enrollment period or the date you have another Qualified Life Event, whichever occurs first. This section explains the Plan's rules for changing your elections.

For additional information about Qualified Life Events, see the Section 125 Plan.

Qualified Life Events

You will be eligible to make a change to your benefit elections during the Plan Year (as long as you meet the consistency requirements below) in the event of any of the following "Qualified Life Events," if such event impacts eligibility:

- **Legal marital status.** An event that changes your legal marital status, including marriage, divorce, death of a spouse, legal separation or annulment.
- **Domestic Partner status.** An event that changes the status of your domestic partnership, including establishment or termination of a domestic partnership or death of your domestic partner.
- **Number of children.** An event that changes your number of children, including birth, death, adoption and placement for adoption.
- **Employment status.** An event that changes your, your spouse's or your child's employment status, **resulting in a gain or loss of eligibility for coverage.** Examples include:
 - Beginning or terminating employment
 - Starting or returning from an unpaid leave of absence
 - Changing from part-time to full-time employment or vice versa
 - A change in worksite
 - A change in job level newly into or out of Grades 15 to 19, which would allow you to enroll in or disenroll from, respectively, the Meritain Copay Plan with HRA coverage option.
- **Dependent status.** An event that causes your child to become eligible or ineligible for coverage, including age or other circumstances.
- **Residence.** A change in your, your spouse's or your child's place of residence.
- **FMLA leave.** Beginning or returning from an FMLA leave.
- **Reduction in hours of service.** You may drop group health plan coverage under the Plan, even if you remain eligible for such coverage, if:
 - You were reasonably expected to work 30 hours per week and you experience a change in employment, after which you are reasonably expected to work less than 30 hours per week.
 - You intend to enroll yourself and any dependents dropping coverage in another health plan (satisfying the Affordable Care Act's definition of minimum essential coverage) effective no later than the first day of the second month after you drop the Company coverage.
 - You are not permitted to change your HCSA elections because of a reduction in hours of service.
- **Enrollment in a health plan offered through the public Marketplace.** If you are eligible for a special enrollment period to enroll in public Marketplace coverage, or you want to enroll in public Marketplace coverage during the public Marketplace's annual open enrollment period, you may drop group health plan coverage under this Plan, even if you remain eligible for coverage under this Plan. You (and any dependents whose coverage is dropped at this time) must intend to enroll in Marketplace coverage that is effective no later than the day immediately following the day your coverage under this Plan is dropped. You are not permitted to change your HCSA elections because you intend to enroll in a plan offered through the public Marketplace.

- **Family member enrollment in a health plan offered through the public Marketplace.** Beginning January 1, 2023, if one or more of your covered family members are eligible for a special enrollment period to enroll in public Marketplace coverage or intend to enroll in public Marketplace coverage during the public Marketplace's annual open enrollment period, you may drop group health plan family coverage under this Plan even if you remain eligible for coverage under this Plan. New Marketplace coverage must be effective no later than the day immediately following the day coverage under the Plan is dropped and you must elect self-only group health plan coverage (or family coverage including one or more already covered dependents) under this Plan. You are not permitted to change your HCSA elections because a family member intends to enroll in a plan offered through the public Marketplace.

Consistency Requirements

In general, the change you make to your benefit elections must be due to and consistent with the Qualified Life Event. To satisfy the "consistency rule," the Qualified Life Event and corresponding change in election must meet both of the following requirements:

- **Effect on eligibility.** Except for the DCSA, the Qualified Life Event must have an effect on eligibility for coverage under a Company-sponsored benefit program or under a program sponsored by the employer of your spouse or other dependent. For this purpose, eligibility for coverage is affected if you become eligible (or ineligible) for coverage or if the Qualified Life Event results in an increase or decrease in the number of your dependents who may benefit from coverage under the program.

For the DCSA, the Qualified Life Event must affect the amount of dependent care expenses eligible for reimbursement. (For example, your child reaches age 13 and dependent care expenses are no longer eligible for reimbursement.)

- **Corresponding election change.** The election change must correspond with the Qualified Life Event. For example, if your dependent loses eligibility for coverage under the terms of a medical benefit program, you may cancel medical coverage only for that dependent.

For life, dismemberment, and disability insurance coverages, an election to increase or decrease coverage in response to a Qualified Life Event is considered to correspond with the event.

Coverage and Cost Events

In some instances, you can make changes to your elections for other reasons, such as mid-year events affecting your cost or coverage, as described below. The coverage and cost event rules do not apply to the HCSA.

Coverage Events

If the Company adds or eliminates a benefit program option in the middle of the Plan Year, or if Company-sponsored coverage is significantly limited or ends, you can elect different available coverage for yourself and/or eligible dependents in accordance with IRS regulations (if the other program option permits). Coverage events may also include election opportunities allowed under other Company benefit programs. Here are some examples:

- If there is a significant reduction under a benefit program option that reduces coverage to participants overall, in general, participants enrolled in that program option may revoke their election and elect coverage under another option providing similar coverage.
- If the Company adds another benefit program option mid-year, participants can drop their existing coverage and enroll in the new program option. You may also enroll yourself and/or eligible dependents in the new program option even if not previously enrolled for coverage at all (if that program option permits).
- If another employer's program allows you, your spouse or your dependent child to make an election change during that program's annual enrollment period and such program has a different plan year than the Plan, you may make a corresponding mid-year election change.
- If another employer's program (for example, your spouse's employer) allows you, your spouse, or your dependent child to change his or her health program elections in accordance with IRS guidance, you may make a corresponding mid-year election change to your coverage.

Cost Events

If your cost for coverage increases or decreases significantly during the Plan Year, you may make a corresponding election change. For example, you may elect another benefit program option with similar coverage (if that program option permits) or drop coverage if no similar coverage is available. In addition, if there is a significant decrease in the cost of a benefit program option during the year, you may enroll in that program option, even if you previously declined to enroll in that program option. Any change in the cost of your benefit program option that is not significant will result in an automatic increase or decrease, as applicable, in your share of the total cost.

With respect to the DCSA, subject to applicable contribution limits, if you change your dependent care provider mid-year, you may change your DCSA contributions to correspond with the new provider's charges and if your dependent care provider (other than a provider who is your relative) raises or lowers its rates mid-year, you may increase or decrease your contributions. Additionally, if your dependent care provider reduces or increases the number of hours that it provides care, you may make a corresponding change to your DCSA election.

The Plan Administrator may from time to time establish and communicate a maximum number of changes that can be made to DCSA elections in a particular Plan Year.

Making Changes to Your Spending Account Plan Elections

Once you make your elections for participation in the HCSA and DCSA, you generally cannot change your elections until the next annual enrollment period. However, certain changes are permitted if they are made due to certain Qualified Life Events.

For additional information on the benefits and terms under the HCSA and DCSA, please refer to Section 125 Plan and the Spending Account benefit program materials listed in Appendix A.

Qualified Life Event: Special Enrollment Rights for Medical Coverage

You and your eligible dependents may also enroll for medical benefit program coverage outside of annual enrollment if you lose coverage or acquire newly eligible dependents, **as long as you enroll yourself and/or your dependents within 31 days (or 60 days for certain special enrollment events) following one of the "Special Enrollment Events" described below:**

Loss of other coverage. This rule applies if you meet both of the following conditions:

- You (or your dependents) were covered under other medical benefit program coverage (for example, under another employer's medical benefit program) when the Company coverage was offered to you; *and*
- You (or your dependents) lose other coverage because:
 - You or your dependents exhaust rights to COBRA coverage, or
 - The employer's contributions to the other coverage stop, or
 - You or your dependents are no longer eligible under that benefit program. Loss of eligibility does not include a loss due to a failure to timely pay premiums or termination of coverage for cause.

If you or your dependent loses other medical coverage and you meet the above conditions, you may enroll yourself and your eligible dependents in a Company-sponsored medical benefit program within 31 days following the loss of coverage.

Acquiring new dependents. When you acquire a newly eligible dependent (through marriage, birth, domestic partnership, adoption or placement for adoption), you may enroll yourself, your spouse and your eligible dependent children in a Company-sponsored medical benefit program. You must enroll within 31 days following the date you acquire the new dependent.

Coverage will start on the date of birth, adoption, or placement for adoption as long as the child is enrolled within 31 days following the date of birth, adoption, or placement for adoption.

CHIP/Medicaid/State Premium Assistance Special Enrollment Rights. Employees and/or dependents who are eligible for but not enrolled in a Company medical benefit program may request enrollment in a Company medical benefit program if they lose coverage under Medicaid or CHIP because they are no longer eligible. In

addition, they may *enroll* in a Company medical plan if they become eligible for state premium assistance under Medicaid or CHIP.

Specific restrictions may apply. Employees have *60 days* from the date of one of these events to request enrollment in a Company medical benefit program.

Other Qualified Life Events

Medicare or Medicaid Entitlement. You may change an election for health coverage mid-year if you, your spouse or your dependent child becomes entitled to coverage under Medicare or Medicaid. However, you are limited to reducing your medical coverage only for the person who becomes entitled to Medicare or Medicaid and to adding medical coverage only for the person who loses eligibility for Medicare or Medicaid.

Judgment, Decree, or Order. You may revoke an election for health coverage mid-year and make a new election if a judgment, decree, or order requires health coverage for your child, including a foster child. The order must have resulted from a divorce, legal separation, annulment or change in legal custody and must meet the requirements of a qualified medical child support order (QMCSO).

You may change your health benefit program election to provide coverage for the eligible child if the order requires coverage to be provided under the Plan. You may also cancel coverage for the child if the order requires your spouse, former spouse or other individual to provide coverage for the child, but only if coverage for the child is actually provided. Proof of that other coverage may be required.

Remember: To take advantage of the Qualified Life Event rules, you must make your election change within 31 days following the event (or within 60 days if you or your dependent has a CHIP/Medicaid/state premium assistance event).

Special Note Regarding Domestic Partner Coverage

The events qualifying you to make a mid-year election change described in this section generally also apply to events related to your domestic partner or your domestic partner's tax dependent. However, IRS rules generally do not permit you to make a mid-year change "on a *tax-favored* basis" for such events unless they involve tax dependents. See Section 2 for more information.

8. Claims and Appeals Procedures

Important Note

The following claims and appeals procedures apply to each benefit program that is subject to ERISA and offered under the Plan to the extent that the applicable benefit program material listed in Appendix A either lacks a claims and appeals procedure or the benefit program's claims and appeals procedure does not comply with ERISA Section 503. Generally, the insurance company or third-party administrator for the applicable benefit program reviews the claims under the benefit program and is referred to as the "claims administrator" for the program. See the applicable benefit program material listed in Appendix A for the specific process that the claims administrator for your benefit program will follow.

Any request for a specific benefit shall be made in accordance with the applicable insurance policy or administrative agreement directly to the claims administrator for that specific benefit. See Appendix B for claims administrator contact information.

In the event Appendix B identifies the Plan Administrator as the claims administrator, the claims procedures set forth in this Section 8 will apply.

A claim for benefits must generally be filed within twelve (12) months from the date the claim was incurred or as provided in the applicable insurance policy or administrative agreement. See your benefit program material for specific benefit program rules. In some cases, you must exhaust the applicable Plan claims and appeals procedures before seeking external review of the Plan's decision or filing a lawsuit about the decision. Generally, a legal action may not be brought if more than twelve (12) months have passed since the date a final decision has been rendered upon appeal or as provided in the applicable insurance policy or administrative agreement.

The claims procedures for each specific benefit program will be furnished automatically to you without charge as a part of the applicable benefit program material. If you would like to request the benefit program material, contact your claims administrator directly.

Health Benefit Claims and Appeals Procedures – Medical, Dental, Vision, EAP and HCSA

You must follow the claims and appeals rules established by the various health benefit programs in order to maximize your benefits under the Plan.

Filing an Initial Claim

If you are required to file an initial claim for benefits, you must do so within the time specified by the benefit program and in accordance with the program's established claim procedures. See the applicable benefit program material listed in Appendix A for details on filing claims. See Appendix B for a list of claims administrators. If you would like to request the claim procedures, contact your claims administrator directly.

Overview of Procedures

Health claims are divided into four categories: urgent care claims, pre-service claims, post-service claims and concurrent care decisions. Different rules and timeframes apply to each type of claim, as described below.

Note: Claims for HCSA benefits are always considered post-service claims.

Definitions

- **Claim.** Any request for benefit program benefits made by and to the proper person in accordance with the program's claims filing procedures, including any request for a service that must be pre-approved. Claims must be submitted in writing to the appropriate claims administrator listed in Appendix B.
- **Urgent Care Claim.** Any claim for medical care or treatment that has to be decided more quickly because the normal timeframes for decision-making could seriously jeopardize your life or health or your ability to regain maximum function or, in the opinion of a physician with knowledge of your condition, subject you to severe pain that cannot be adequately managed without the care or treatment addressed in the claim. A medical

benefit program must defer to physician with knowledge of the claimant's medical condition to determine if a claim is urgent. Claims relating to coverage under a dental or vision benefit program are not considered urgent care claims.

- **Pre-Service Claim.** Any claim for a benefit—other than an urgent care claim—that must be approved in advance of receiving medical care (for example, requests to pre-certify a hospital stay or for pre-approval under a utilization review program).
- **Post-Service Claim.** Any type of claim other than an urgent care claim or a pre-service claim, including a claim for reimbursement through the HCSA.
- **Concurrent Care Decision.** Any decision in which the benefit program—after having previously approved a claim for an ongoing course of treatment provided over a period of time or a specific number of treatments—later reduces or terminates coverage for treatments (other than by Plan amendment or termination) before the end of an approved period of time or number of treatments. Such decision constitutes an Adverse Decision.
- **Adverse Decision or Adverse Appeal Decision.** A denial, reduction, termination of or failure to provide or make payment (in whole or in part) for a benefit. An adverse decision includes a decision to deny benefits based on: (i) an individual's ineligibility to participate in the benefit program; (ii) utilization review; (iii) a service being characterized as experimental or investigational or not medically necessary or appropriate; (iv) a concurrent care decision; and (v) certain retroactive terminations of coverage—called “rescissions”—regardless of whether a benefit claim has been filed. An adverse decision includes a rescission of medical plan coverage under the Plan, regardless of whether the rescission has an adverse effect on any particular benefit at that time. (However, if the Plan retroactively cancels coverage for failure to pay required contributions, that is not an adverse decision.)
- **Final Adverse Decision.** An adverse decision of a medical claim that has been upheld by the appropriate claims administrator at the end of the internal appeals process or an adverse decision for which the internal appeals process has been exhausted under the “deemed exhaustion” rules described below.
- **Authorized Representative.** An individual authorized to act on your behalf in pursuing a claim or appeal in accordance with procedures established by the benefit program. For urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative. (A health care professional is a physician or other health care professional who is licensed, accredited or certified to perform specified health services consistent with state law.) For information about appointing an authorized representative, contact the claims administrator listed in Appendix B.

Insufficient Claims

Improperly Filed Pre-Service Claim. If a pre-service claim is not filed in accordance with the benefit program's claims procedures, you will be notified as soon as possible, but no later than five days after it is received by the claims administrator. If the claim is an urgent care claim, you will be notified within 24 hours. Notice of an improperly filed pre-service claim may be provided orally or in writing, upon your request. The notice will identify the proper procedures to be followed in filing the claim.

In order to receive notice of an improperly filed pre-service claim, you or your authorized representative must have communicated your request regarding the claim to the claims administrator listed in Appendix B. The request *must* include:

- the identity of the claimant,
- a specific medical condition or symptom, and
- a request for approval for a specific treatment, service or product for which approval is requested.

Incomplete Urgent Care Claims. If a properly filed urgent care claim is missing information needed for a coverage decision, you will be notified by the claims administrator as soon as possible, but no later than 24 hours after the claim has been received by the claims administrator. You will be notified of the specific information necessary to complete the claim.

You will have a reasonable amount of time considering the circumstances (but not less than 48 hours) to provide the specific information. The claims administrator will then provide notice of the claim decision as soon as possible, but no later than 48 hours after the earlier of:

- the date the claims administrator receives the specified information, or
- the end of the additional time period given for providing the information.

Notice of Benefit Determination

After your claim is reviewed by the claims administrator, you will receive a notice of benefit determination within the timeframes specified below. For urgent care and pre-service claims, you will receive a notice of benefit determination whether or not the claims administrator makes an adverse decision on your claim. For post-service and concurrent care claims, you are entitled to receive a notice of benefit determination if the benefit program makes an adverse decision on your claim.

The timeframes for providing notice of a benefit determination generally start when a written claim for benefits is received by the claims administrator. Notice of a benefit determination may be provided in writing by hand delivery, mail, or electronic delivery. However, in respect of certain urgent care claims, you may first be provided notice orally, which will be followed by written or electronic notice within three calendar (not business) days. The timeframes for providing a notice of benefit determination are as follows:

- **Urgent Care Claims.** As soon as possible considering the medical urgency; no later than 72 hours after the claims administrator receives your claim.
- **Pre-Service Claims.** Within a reasonable period of time appropriate to the medical circumstances; no later than 15 days after the claims administrator receives your claim. This timeframe may be extended for up to 15 days for matters beyond the claims administrator's control.
- **Post-Service Claims.** In the case of an adverse decision, within a reasonable period of time; no later than 30 days after the claims administrator receives your claim. This timeframe may be extended for up to 15 days for matters beyond the claims administrator's control.
- **Concurrent Care Decisions.** If an ongoing course of treatment will be reduced or terminated, you'll be notified sufficiently in advance to provide an opportunity to appeal and obtain an appeals decision before a benefit is reduced or terminated.

If you request an extension of ongoing treatment that is considered an urgent care claim, you will be notified as soon as possible given the medical urgency, but no later than 24 hours after the claims administrator receives your claim, provided the claim is submitted to the claims administrator at least 24 hours before the expiration of the prescribed time period or number of treatments.

If you request an extension of ongoing treatment that is not considered an urgent care claim, your request will be considered a new claim and decided according to post-service or pre-service claim timeframes, whichever applies.

For pre-service and post-service claims, the claims administrator may extend the timeframe for making a decision on your claim in certain cases. If an extension is necessary, you will be notified before the end of the initial timeframe (15 days for pre-service claims; 30 days for post-service claims) of the reasons for the delay and when the claims administrator expects to make a decision. Further, if an extension is necessary because certain information was not submitted with the claim, the notice will describe the required information that is missing, and you will be given an additional period of at least 45 days after you receive the notice to furnish the information. The claims administrator's extension period will begin when you respond to the request for additional information. The claims administrator will then notify you of the benefit determination within 15 days after your response is received.

An adverse benefit determination notice will include:

- The specific reason for the adverse benefit determination;
- Reference to the specific provisions of the benefit program on which the adverse benefit determination was based;
- Description of any additional material or information necessary to perfect the claim and an explanation of why this material or information is necessary;

- Description of the appeals procedures and the time limits that apply to such procedures, including a statement of your right to bring a civil action under ERISA Section 502(a) if the claim is denied on appeal;
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in deciding a claim, either (A) the specific rule, guideline, protocol, or other similar criterion, or (B) a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request;
- If the denial of a claim is based on a medical necessity or experimental treatment or similar exclusion or limit, either (A) an explanation of the scientific or clinical judgment for the determination, applying the terms of the benefit program to your medical circumstances, or (B) a statement that such explanation will be provided free of charge upon request; and
- If the adverse benefit determination relates to an Urgent Care Claim, a description of the expedited appeals procedures.

Appealing an Adverse Decision

If you disagree with the decision on your claim, you (or your authorized representative) may file a written appeal with the applicable claims administrator within 180 days after your receipt of the notice of adverse decision. For a list of claims administrators, see Appendix B. If you do not timely appeal, you may lose your right to later object to the decision, as you will not have exhausted your internal administrative claims and appeals procedures (which is generally a requirement before you can seek external review or sue in state or federal court).

You should include the reasons you believe the claim was improperly denied and all additional facts and documentation you consider relevant in support of your appeal. The decision on your appeal will consider all comments, documentation, records and other information you submit, even if they were not submitted or considered during the initial claim decision.

For appeals of adverse decisions involving urgent care claims, the claims administrator will accept either oral or written requests for appeals for an expedited review. All necessary information may be transmitted between the claims administrator and you or providers by telephone, fax or other available expeditious methods.

A medical benefit program will not terminate an ongoing course of treatment without giving you advance notice and an opportunity for review, so you may receive continued coverage pending the outcome of your appeal. If you appeal with respect to an urgent care claim, an ongoing course of treatment, or a claims administrator's failure to follow the benefit program's procedures, you may be able to initiate an external review while the benefit program's internal appeals process is underway.

A new decision-maker will review your denied claim. The appeal will not be conducted by the individual who initially denied the claim or that person's subordinate. The new decision-maker will not give deference to the original decision on your claim. That is, the reviewer will give the claim a "fresh look" and make an independent decision about the claim.

If your claim was denied based, in whole or in part, on medical judgment, the reviewer will consult with a health care professional who has appropriate training and experience in the field of medicine involved in your claim. The health care professional will not be the same person (or a subordinate of the person) who was consulted on the initial decision. (A medical judgment includes whether a treatment, drug, or other item is experimental, investigational or not medically necessary or appropriate.) Upon your request, the claims administrator will also identify any medical or other experts whose advice was obtained in considering the original decision on your claim, whether or not the claims administrator relied on their advice.

You will be able to review your file and other information related to your claim as part of the review, and you will receive any new or additional evidence considered or generated by the benefit program. You will have a reasonable opportunity to respond before the notice of the final adverse decision of a medical claim.

Notice of Appeal Decision

After your appeal is reviewed by the claims administrator, you will receive a notice of the appeal decision within the timeframes specified below. For medical claims, the notice will include:

- The specific reason for the appeal decision.
- Reference to the specific provisions of the benefit program on which the appeal decision was based.

- A statement that you are 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.
- A statement of your right to bring a civil action under ERISA Section 502(a).
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in deciding a claim, either (A) the specific rule, guideline, protocol, or other similar criterion, or (B) a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request.
- If the denial of a claim is based on a medical necessity or experimental treatment or similar exclusion or limit, either (A) an explanation of the scientific or clinical judgment for the determination, applying the terms of the benefit program to your medical circumstances, or (B) a statement that such explanation will be provided free of charge upon request.
- Information sufficient to identify the claim involved. This includes the date of service, the health care provider, the claim amount (if applicable), and the denial code. For medical claims, the notice will also include a statement that diagnosis and treatment codes (and their meanings) will be provided upon request and a description of the Plan's standard used in denying the claim. For example, a description of the "medical necessity" standard will be included.
- In addition to the description of the Plan's internal appeals procedures, a description of the external review processes and the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist enrollees with the internal claims and appeals and external review processes will also be included.

The timeframes for providing a notice of the appeal decision generally start when a written appeal is received by the claims administrator. Notice of the appeal decision may be provided in writing through in-hand, mail or electronic delivery. Decisions related to urgent care claims may be delivered by telephone, facsimile, or other expeditious methods. Note: "days" means calendar (not business) days. The timeframes for providing a notice of the appeal decision are as follows:

- **Urgent Care Appeals.** As soon as possible considering the medical urgency; no later than 72 hours after the claims administrator receives your appeal.
- **Pre-Service Appeals.** Within a reasonable period of time appropriate to the medical circumstances; no later than 30 days after the claims administrator receives your appeal.
- **Post-Service Appeals.** Within a reasonable period of time; no later than 60 days after the claims administrator receives your appeal.

You will be able to review your file and present evidence as part of the review. You will have the opportunity to submit written comments, documents, records, and other information relating to the claim; and you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits. Whether a document, record, or other information is relevant to the claim will be determined in accordance with the applicable Department of Labor (DOL) regulations. You also are entitled to the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse decision. The review will 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.

Deemed Exhaustion

If the Plan fails to strictly adhere to all the requirements of the medical claims and appeals process with respect to your medical benefit claim, you are deemed to have exhausted the internal claims and appeals process. In this case, you may seek an external review or pursue legal remedies without waiting for further Plan action.

External Review of the Plan's Decision – Medical Benefit Programs Only

In addition to the above internal Plan claims and appeals procedures, there is an opportunity for external review of denials based upon coverage rescissions (in whole or in part) or medical judgment or whether a plan issuer is complying with the surprise billing and cost-sharing protections set forth in Code Sections 9816 and 9817 and applicable regulations (and the parallel provisions in ERISA). As explained under "Important Note" in the beginning of this section, the claims administrators of benefit programs may have procedures that vary from the procedures

described in this section. See the applicable benefit program material listed in Appendix A for the specific process that your medical benefit program will follow.

Definitions

- **External Review.** Review of an adverse decision or final adverse decision by an Independent Review Organization/External Review Organization (ERO).
- **Final External Review Decision.** A determination by an ERO at the conclusion of an external review.

Requesting External Review

You must complete all of the levels of internal review described above before you can request external review for a medical benefit program claim, other than in a case of “deemed exhaustion.” If you are deemed to have exhausted the Plan’s internal claims and appeals procedures, you may (i) initiate an external review, and (ii) pursue any remedies available under state or federal law on the basis that the Plan has failed to provide reasonable internal claims and appeals procedures that would yield a decision on the merits of the claim. Your valid authorized representative may act on your behalf in filing and pursuing this voluntary appeal.

The notice of adverse decision or final adverse decision that you receive from the claims administrator will describe the process to follow if you wish to pursue an external review. You must submit the request for external review to the claims administrator within four months of the date you received the adverse decision or final adverse decision notice.

Filing an external review request will have no effect on your rights to any other benefits under the Plan. An external review request is voluntary; you are not required to undertake it before pursuing legal action.

External review is not automatic; you must request it. The external review is conducted by an independent organization and its decision is binding on you and the Plan, except to the extent other remedies are available under federal law.

Note that the external review process does not apply to an adverse decision or final internal adverse decision that relates to a participant’s or beneficiary’s failure to meet the requirements for eligibility under the terms of the Plan (for example, worker classification and similar issues).

The procedures for initiating an external review, as well as the review process, are outlined in the applicable benefit program material listed in Appendix A.

Preliminary Review

Within five business days following receipt of an external review request, the claims administrator will complete a preliminary review to determine that you were covered by the Plan at the time the service was requested or, provided your request does not relate to an eligibility matter, you have exhausted the internal appeals process (unless deemed exhaustion applies) and you have provided all paperwork necessary to complete the external review.

The claims administrator will issue a notification in writing to you within one business day after completion of the preliminary review that your request is not eligible for external review, eligible and ready for external review, or not complete because you have not provided all the information required. If your request is complete but not eligible for external review, the notice will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number: 866-444-EBSA (3272)). If your request is not complete, the claims administrator will describe the information or materials needed to make the request complete and allow you to perfect your external review request within the four-month filing deadline or within the 48-hour period following the receipt of the notice, whichever is later.

Referral to an External Review Organization (ERO)

If the claim is eligible and ready for external review, an ERO will be assigned to conduct the external review. Within five business days after assignment, the claims administrator will provide the ERO the documents and any information considered in deciding the initial claim and the internal appeal. The assigned ERO will timely notify you in writing of your request’s eligibility and acceptance for external review. The notice will provide an opportunity for you to submit in writing, within ten (10) business days following the date of receipt, additional information for the ERO to consider when conducting the external review.

The ERO will review all of the information and documents timely received. In reaching a decision, it will review the claim and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

The assigned ERO will provide its written notice of the final external review decision within 45 days after the ERO receives the request for the external review. The ERO will deliver the notice of final external review decision to you, the claims administrator and the Plan. The ERO's decision is binding on all parties unless and until there is a judicial decision otherwise.

Upon receipt of a notice of a final external review decision reversing the adverse decision or final adverse decision, the Plan will provide coverage or payment as required by law for the claim.

Expedited External Review

The Plan will allow you to request an expedited external review at the time you receive:

- An adverse decision on an initial claim if it involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or
- A final adverse decision, if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function or if the final adverse decision concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

A request for expedited external review must be accompanied by a written statement from your physician that your medical condition meets the above criteria. Upon receipt of the request for expedited external review, the claims administrator will determine whether your request meets the reviewability requirements discussed above with respect to standard external review and notify you of its determination.

Referral of Expedited Review to ERO

Upon a determination that a request is eligible for external review following preliminary review, the claims administrator will assign an ERO. The ERO will provide notice of its decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the ERO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the ERO will provide written confirmation of the decision to you, the claims administrator and the Plan.

Your Right to Information

Upon request to the applicable claims administrator listed in Appendix B and free of charge, you have a right to reasonable access to and copies of all documentation, records, and other information relevant to the claims administrator's denial of a claim or appeal. Information is "relevant" if it:

- was relied upon in making the decision on your claim or appeal,
- was submitted to, considered or generated by the claims administrator in considering your claim or appeal, or
- demonstrates compliance with the claims administrator's administrative processes for making claim decisions.

You are also entitled access to, and a copy of, any internal rule, guideline, protocol or other similar criteria used as a basis for a decision on your denied claim upon request, free of charge. Similarly, if your claim is denied based on a determination involving a medical judgment, you are entitled to an explanation of the scientific or clinical reasons for that determination free of charge upon request. (A medical judgment includes whether a treatment, drug or other item is experimental, investigational or not medically necessary or appropriate.) In addition, if voluntary appeals or alternative dispute resolution options are available under the benefit program, you are entitled to receive information about the procedures with respect to these options.

Non-Health Benefit Claims and Appeals Procedures – Life Insurance, Business Travel Accident, Disability, and AD&D Coverages

Filing an Initial Claim

You (or your beneficiaries) must follow the claims rules established by the various non-health benefit programs. If you are required to file an initial claim for benefits, you must do so within the time specified by the benefit program and in accordance with the program's established claims procedures. See the applicable benefit program material listed in Appendix A for details on filing claims. See Appendix B for a list of claims administrators and their contact information.

Definitions

- **Claim.** A request for benefit program benefits made in accordance with the claims administrator's claims filing procedures. Claims must be submitted in writing to the appropriate claims administrator listed in Appendix B.
- **Adverse Decision or Adverse Appeal Decision.** A denial, reduction, termination of or failure to provide or make payment (in whole or in part) for a benefit. An adverse decision includes a decision to deny benefits based on an individual's ineligibility to participate in the benefit program and, with respect to disability claims on or after April 1, 2018, certain retroactive terminations of coverage—called "rescissions"—regardless of whether a benefit claim has been filed. (However, if the Plan retroactively cancels coverage for failure to pay required contributions, that is not an adverse decision.)
- **Authorized Representative.** An individual authorized to act on your behalf in pursuing a claim or appeal with respect to benefits under a benefit program, based on reasonable procedures established by the claims administrator. For information about appointing an authorized representative, contact the claims administrator listed in Appendix B.
- **Deemed Exhaustion.** The Plan considers your claim or appeal to have completed all levels of internal review if the claims administrator fails to follow the benefit program's claims and appeals procedures (unless the error was minor).

Notice of Adverse Decision

If your claim is denied or reduced, you will be provided with a notice of adverse decision.

For the disability benefit programs, the notice of adverse decision will be provided within 45 days after the date your claim is received by the claims administrator. If more time is needed by the claims administrator to make a decision, you will be notified of the reasons for the delay before the end of the 45-day period. The claims administrator may extend the decision-making period for up to 30 days. If additional time is needed, the claims administrator may extend the decision-making period for an additional 30 days. You will be notified of the second extension before the end of the first extension period. The notice of extension may include a request for additional information from you.

You must provide the requested information to the claims administrator within 45 days. The claims administrator's 30-day extension period will begin when you respond to the request for additional information. If you do not comply with the request for information within the 45-day period, your claim may be denied. In the event of an adverse decision for a disability claim after April 1, 2018, the notice will also include:

- A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
 - the views of health care professionals treating the claimant and vocational professionals who evaluated the claimant;
 - the views of medical or vocational experts obtained by the Plan, without regard to whether the advice was relied upon for the adverse decision; and
 - any Social Security Administration disability determination regarding the claimant presented to the Plan;
- Either the specific rule, guideline, protocol, standards, or other similar criteria relied upon in making the adverse decision or a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist; and
- A statement that reasonable access to and copies of all documents, records, and other information relevant to the claimant's claim for benefits are available free of charge, upon request.

For the Life, AD&D, and Business Travel Accident insurance benefit programs, the notice of adverse decision will be provided within 90 days after the date your claim is received by the claims administrator. If more time is needed by the claims administrator to make a decision, you will be notified of the reasons for the delay before the end of the initial 90-day period. The claims administrator may extend the decision-making period for up to 90 days if the claims administrator determines that special circumstances require an extension.

Appealing an Adverse Decision

If you disagree with the decision on your claim, you (or your authorized representative) may file a written appeal with the applicable claims administrator. For a list of claims administrators, see Appendix B.

For the disability benefit programs, the appeal must be filed within 180 days after you receive the notice of adverse decision.

For the Life, AD&D and Business Travel Accident insurance benefit programs, the appeal must be filed within 60 days after you receive the notice of adverse decision.

You should include the reasons you believe the claim was improperly denied and all additional facts and documentation you consider relevant in support of your appeal. If you don't appeal on time, you may lose your right to file suit in a state or federal court, as you will not have exhausted your internal administrative appeals rights (which is generally a requirement before you can sue in state or federal court).

For the disability insurance benefit programs, a new decision-maker will reconsider your claim on appeal. The individual who initially denied the claim will not conduct the appeal. The new decision-maker will not give any deference to the original decision on your claim. That is, the reviewer will give the claim a "fresh look" and make an independent decision about the claim.

If your claim was denied based on medical judgment, the reviewer will consult with a health care professional who has appropriate training and experience in the field of medicine involved in your claim. The health care professional will not be the same person (or a subordinate of the person) who was consulted on the initial decision. (A medical judgment includes whether a treatment, drug or other item is experimental, investigational or not medically necessary or appropriate.) Upon your request, the claims administrator will also identify any medical or other experts whose advice was obtained in considering the original decision on your claim, whether or not the claims administrator relied on their advice.

Deemed Exhaustion

For disability claims on or after April 1, 2018, if the Plan fails to strictly adhere to all the requirements of the disability claims and appeals process with respect to your disability benefit claim, you are deemed to have exhausted the internal claims and appeals process. In this case, you may seek an external review or pursue legal remedies without waiting for further Plan action. However, this will not apply if the error was de minimis, if the error does not cause harm to the claimant, if the error was due to good cause or to matters beyond the Plan's control, if it occurs in context of good faith exchange of information, or if the error does not reflect a pattern or practice of non-compliance. If a court rejects your demand for immediate review based on the exceptions above, your claim will be considered as refiled on appeal upon receipt of the court's decision, and the Plan will notify you of the resubmission.

You will be able to review your file and present evidence as part of the review. You will have the opportunity to submit written comments, documents, records, and other information relating to the claim; and you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits. Whether a document, record, or other information is relevant to the claim will be determined in accordance with the applicable DOL regulations. You also are entitled to the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse decision. The review will 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.

For all non-health program claims, the decision will consider all comments, documentation, records and other information you submit, even if they were not submitted or considered during the initial claim decision.

Notice of Appeal Decision

For the disability programs, the claims administrator will provide notice of its decision within 45 days after the date you file the appeal. The claims administrator may extend the decision-making period for up to 45 days if special circumstances require extra time. You will be notified of an extension prior to the end of the first 45-day period.

For adverse decision on disability claims after April 1, 2018, the notice will also include:

- A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
 - the views of health care professionals treating the claimant and vocational professionals who evaluated the claimant;
 - the views of medical or vocational experts obtained by the Plan, without regard to whether the advice was relied upon for the adverse decision; and
 - any Social Security Administration disability determination regarding the claimant presented to the Plan;
- A description of any applicable contractual limitations period, including the date on which the claim expires;
- Either the specific rule, guideline, protocol, standards, or other similar criteria relied upon in making the adverse decision or a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist; and
- For adverse determinations based on medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision or a statement that an explanation will be provided free of charge upon request.

For the Life, AD&D, and Business Travel Accident insurance benefit programs, the claims administrator will provide notice of its decision within 60 days after the date you file the appeal. The claims administrator may extend the decision-making period for up to 60 days if special circumstances require extra time. You will be notified of an extension prior to the end of the first 60-day period.

The notice of extension will indicate the special circumstances requiring an extension and the date by which the claims administrator expects to render the determination on review.

Your Right to Information

Upon request to the applicable claims administrator listed in Appendix B and free of charge, you have a right to reasonable access to and copies of all documentation, records and other information relevant to the claims administrator's denial of a claim. Information is "relevant" if it:

- was relied upon in making the decision on your claim,
- was submitted to, considered or generated by the claims administrator in considering your claim, or
- demonstrates compliance with the claims administrator's administrative processes for making claim decisions.

If voluntary appeals or alternative dispute resolution options are available under the benefit program, you are entitled to receive information about the procedures with respect to these options.

If your claim or appeal is denied based on a determination involving a medical judgment, you are entitled to an explanation of the scientific or clinical reasons for that determination free of charge upon request. (A medical judgment includes whether a treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate.)

Section 12, Your Rights and Privileges Under ERISA, provides additional information on legal action you can take if you feel your right to a benefit has been improperly denied.

9. Continuation of Health Care Coverage

Coverage During Leaves of Absence

Approved Leaves of Absence

If you take a leave of absence that qualifies as a family or medical leave under the Family and Medical Leave Act of 1993 (FMLA leave) or California Pregnancy Disability Leave (PDL), or if you take any other leave of absence that is approved by PayPal Holdings, Inc., your elections will continue as long as you continue paying your portion of the cost of coverage. However, your contributions to, and participation in, the Dependent Care Flexible Spending Account will be terminated during a leave of absence. Please note that there may be a delay between when you apply for a leave of absence, when the leave is approved, and when your contributions, elections, and participation are adjusted. All changes are made as soon as administratively practicable. Should a contribution error occur, PayPal reserves the right to make corrections, including any payroll withholding corrections.

During a paid leave, your contributions will continue to be deducted from your pay on a pre-tax basis. During an unpaid leave, you will be invoiced for your contributions on an after-tax basis.

You may discontinue your coverage during an unpaid leave of absence. In this case, when you return to work after the leave and you re-enroll or your coverage is reinstated, your coverage will generally be the same as before the leave unless you have a Qualified Life Event or there is an intervening annual enrollment period.

For information about reinstatement in the Health Care Spending Account, see the Spending Account benefit program material listed in Appendix A. For additional information on leaves of absence, such as how to request a leave, your rights and obligations, and the impact on Plan benefits, review the information available on MyHR online.

Military Leaves of Absence (USERRA)

If you take a military leave of absence that qualifies as a leave under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), you may continue medical coverage for up to 24 months as long as you give the Company advance notice (with certain exceptions) of the leave.

If the entire length of the leave is 30 days or less, you will not be required to pay any more than the portion you paid before the leave. If the entire length of the leave is 31 days or longer, you may be required to pay up to 102% of the entire cost of the coverage. You can continue medical coverage for the lesser of 24 months, beginning on the date the absence begins or the length of the leave.

If you take a military leave but your medical coverage is terminated (for instance, because you do not elect the extended coverage), upon re-employment you will be treated as if you were actively employed during the military leave when determining whether an exclusion or waiting period applies upon your reinstatement into the applicable benefit program. Generally, no exclusions or waiting periods may be imposed upon reinstatement, except exclusions or waiting periods that would normally apply if you had not lost coverage due to your military leave.

Under circumstances in which COBRA continuation coverage rights also apply (see Federal COBRA Continuation Coverage below), an election for continuation coverage will be an election to take concurrent COBRA/USERRA medical coverage.

For additional information on military leave, such as how to request a leave, your rights and obligations, and the impact on Plan benefits, please contact the benefit program at the numbers listed in Appendix B.

Other Leaves of Absence

For questions regarding disability, workers' compensation and other leaves, please review the information available on the Bridge.

Federal COBRA Continuation Coverage

Under a federal law called the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Company employees and/or their dependents may be eligible to continue health benefit program coverage (called "COBRA coverage") at group rates. Health benefit program coverage available under COBRA includes medical, dental, vision, employee assistance program, Health Reimbursement Arrangement (HRA), and Health Care Spending Account (HCSA) benefits.

COBRA coverage is available in certain instances, called “qualifying events,” where coverage under the Plan would otherwise end. You may elect to continue coverage at your own expense on an after-tax basis when the coverage that you have through the Plan ends. The coverage described below may change as permitted or required by changes in any applicable law.

The following information is intended to inform you of your rights and obligations under the continuation coverage provisions of COBRA. In some states, state law provisions may also apply to the insurers and HMOs offering benefits under the Plan. For more information, contact the COBRA administrator listed in Appendix B.

You do not have to show that you are insurable to choose COBRA coverage. However, COBRA coverage is provided subject to your eligibility for coverage as described below. The Company reserves the right to terminate your COBRA coverage retroactively if it is determined that you are ineligible under the terms of the Plan.

There may be other coverage options for you and your family through the Health Insurance Marketplaces created as part of the Patient Protection and Affordable Care Act. By enrolling in coverage through the Marketplace, you could be eligible for lower premiums, deductibles, or out-of-pocket costs. Being eligible for COBRA does not limit your eligibility for coverage through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse’s plan), even if the plan generally does not accept late enrollees. Some of these options may cost less than COBRA coverage. You can learn more about many of these options at www.healthcare.gov.

Cost of COBRA Coverage

You will be required to pay up to 102% of the cost of COBRA coverage. If your coverage is extended from 18 months to 29 months for disability, you will be required to pay up to 150% of the cost of COBRA coverage beginning with the nineteenth (19th) month of coverage.

However, refer to the exception described in Section 3 where the Company will pay the cost of COBRA coverage for covered dependents when the qualifying event is an employee’s death.

The cost of group health coverage periodically changes. If you elect COBRA coverage, the COBRA administrator will notify you of any changes in the cost. Premiums are established in a 12-month determination period and will increase during that period if the Plan has been charging less than the maximum permissible amount, if the qualified beneficiary changes coverage level or in the case of a disability extension.

The initial payment for COBRA coverage is due 45 days from the date of your election. Thereafter, you must pay for coverage on a monthly basis. You have a grace period of 30 days to make COBRA coverage payments.

Contacting the COBRA Administrator

If you have any questions about COBRA coverage or the application of the law, contact the COBRA administrator listed in Appendix B. You may also 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.

Obligation To Notify the COBRA Administrator

You must notify the COBRA administrator in writing immediately at the address listed in Appendix B if:

- your marital status has changed,
- you, your spouse or a dependent has changed address, or
- a dependent loses eligibility for dependent coverage under the terms of the Plan.

All notices and other communications regarding COBRA coverage and your health benefit programs should be directed to the COBRA administrator.

Who Is Eligible for COBRA

If you are covered by the Plan on the day before a qualifying event, you have the right to choose COBRA coverage if you lose coverage under the terms of the Plan because of the following qualifying events: a reduction in your hours of employment or the termination of your employment (unless you are terminated because of your gross misconduct).

If you are enrolled in the Plan and do not return to work following an FMLA leave, your COBRA coverage will commence on the date that you indicate you will not be returning to work following the FMLA leave or the last day of the FMLA leave period, whichever is earlier.

If you are the spouse of an employee and you are covered by the Plan on the day before the qualifying event, you are considered a qualified beneficiary for purposes of COBRA coverage. That means you have the right to choose COBRA coverage for yourself if you lose group health coverage under the terms of the Plan because of the following qualifying events:

- your spouse dies;
- your spouse's employment is terminated (for reasons other than gross misconduct) or your spouse's hours of employment are reduced;
- you divorce or legally separate from your spouse (this includes a divorce or legal separation that occurs after the employee drops you from coverage, if the employee acted in anticipation of the divorce or legal separation); or
- your spouse becomes entitled to Medicare (Part A, Part B, or both).

If you are a dependent child of an employee and you are covered under the Plan on the day before the qualifying event, you are also considered a qualified beneficiary for purposes of COBRA coverage. This means you have the right to COBRA coverage if you lose coverage under the terms of the Plan for any of the following qualifying events:

- the parent-employee dies;
- the parent-employee's employment is terminated (for reasons other than the employee's gross misconduct) or the employee's hours of employment are reduced;
- the parent-employee becomes entitled to Medicare (Part A, Part B or both);
- the parents become divorced or legally separated; or
- you cease to be a "dependent child" under the Plan.

If the covered employee elects COBRA coverage and then has a child (either by birth, adoption or placement for adoption) during the period of COBRA coverage, the new child is a qualified beneficiary for purposes of COBRA coverage. In accordance with the terms of the Plan and the requirements of federal law, such a qualified beneficiary can be added to COBRA coverage by providing a written notice to the COBRA administrator of the new child's birth, adoption or placement for adoption at the address listed in Appendix B. This written notice should include information about the new child who will be receiving COBRA coverage. The COBRA administrator may ask for documentation supporting the occurrence of the birth, adoption or placement for adoption of the new child.

If the covered employee fails to notify the COBRA administrator about a new child within 31 days following the birth, adoption or placement for adoption, COBRA coverage cannot be elected for the new child. Newly acquired eligible dependents (such as a spouse) will not be considered qualified beneficiaries, but may be added as dependents.

Notify the COBRA administrator within 31 days if you acquire a new spouse and want to enroll them in COBRA coverage.

COBRA-like Continuation Coverage for Domestic Partners

Although domestic partners and civil union partners (Partners) are not qualified beneficiaries under COBRA, the Company currently provides COBRA-like continuation coverage to Partners and their dependent children who were covered under the health benefit programs when group coverage would otherwise have been lost.

In the description of federal COBRA above, whenever the term:

- "Spouse" is used and wherever "qualified beneficiary" when referring to a spouse is used, the term "Partner" as defined by the Plan also generally applies.

- Wherever the terms “dependent child” or “dependent children” are used, or wherever “qualified beneficiary(ies)” when referring to a dependent child or dependent children is used, the dependent child/children of a Partner also generally applies.
- Wherever the term “divorce” is used, termination of a domestic or civil union partnership also generally applies.
- Wherever the term “COBRA coverage” is used, COBRA-like continuation coverage also generally applies.

However, be aware that certain HMOs may not allow continuation coverage for Partners or the children of Partners. Contact the HMO directly for specific information.

Your Duties

You must, in writing, inform the COBRA administrator of a divorce, legal separation or child’s loss of dependent status under the Plan if you wish to preserve your right to elect COBRA coverage. You must provide notice within 60 days from the later of (1) the date of the divorce, legal separation or loss of dependent status and (2) the date coverage is lost because of the event.

Notice must be provided to the COBRA administrator on a form which can be obtained from the COBRA administrator. The notice should then be completed and provided to the COBRA administrator at the address shown in Appendix B.

The notice must identify the employee or qualified beneficiary requesting COBRA coverage and the qualifying event that gave rise to the individual’s right to COBRA coverage. In addition, the employee or qualified beneficiary may be required to provide the COBRA administrator with documentation supporting the occurrence of the qualifying event.

If you fail to notify the COBRA administrator within this 60-day period, the right to elect COBRA coverage will be lost.

When the COBRA administrator is notified that one of these events has happened, the COBRA administrator will in turn notify you about your right to choose COBRA coverage.

The COBRA Administrator’s Duties

Qualified beneficiaries will be notified of the right to elect COBRA coverage if they lose coverage under the terms of the Plan because of any of the following events:

- The covered employee dies;
- The covered employee’s employment is terminated (for reasons other than the employee’s gross misconduct) or the employee’s hours of employment are reduced; or
- The employee becomes covered by Medicare (Part A, Part B, or both).

Electing COBRA

To elect or inquire about COBRA coverage, contact the COBRA administrator listed in Appendix B.

Under the law, you have 60 days to elect COBRA coverage measured from the date you would lose your active coverage because of one of the qualifying events described above or, if later, 60 days after you receive notice of your right to elect COBRA coverage. An employee or family member who does not choose COBRA coverage within the 60-day time period described above loses the right to elect COBRA coverage. The employee and family members will be required to reimburse the Plan for any claims mistakenly paid after the date coverage would normally have ended.

If you choose COBRA coverage, your coverage will be the same coverage you had immediately before the event and the same coverage that is being provided to similarly situated beneficiaries. “Similarly situated” generally refers to a current employee or dependent who has not had a qualifying event.

You will have the same opportunity to change coverage as similarly situated active employees (for example, at annual enrollment or if you gain a new dependent). This also means that if the coverage for similarly situated employees or family members is modified, your coverage will be modified.

Separate Elections

Each qualified beneficiary has the right to elect COBRA coverage. This means that a spouse or dependent child can elect COBRA coverage even if the covered employee chooses not to. However, a covered employee or spouse may elect COBRA coverage on behalf of other qualified beneficiaries, and a parent or legal guardian may elect COBRA coverage on behalf of a minor child.

Length of COBRA Coverage

If elected, COBRA coverage begins on the date your active employee coverage ends. For dependents who no longer satisfy the requirements for dependent coverage, COBRA coverage begins the first day of the month following the date of the qualifying event. However, coverage will not take effect unless COBRA coverage is elected as described above and the required premium is received.

The maximum duration of COBRA coverage depends on the reason you or your covered dependents are eligible for COBRA coverage.

If group health coverage ends because of your termination of employment or reduction in hours, COBRA coverage may continue for you and your covered spouse and dependents for up to 18 months.

However, if termination of employment or reduction of hours follows Medicare enrollment, the COBRA coverage period for your spouse and dependent children is 36 months from the Medicare enrollment date or 18 months from the subsequent termination or reduction of hours, whichever is longer.

COBRA coverage for your covered spouse and dependents may continue for up to 36 months if coverage would otherwise end because:

- you die;
- you divorce or legally separate with your spouse; or
- your dependent child loses eligibility for coverage.

Note that COBRA coverage for the HCSA ends at the end of the Plan Year in which the qualifying event occurs.

Disability Extension

The 18 months of COBRA coverage may be extended to 29 months if an employee or covered family member is determined by the Social Security Administration to be disabled at any time during the first 60 days of an 18-month COBRA coverage period. This 11-month extension is available to all family members who have elected COBRA coverage due to the termination of employment or reduction in hours of the covered employee. It also applies to family members who are not disabled.

To benefit from the extension, the qualified beneficiary must provide the COBRA administrator with a copy of the disability determination within 60 days after the latest of (1) the Social Security Administration's determination of disability, (2) the date on which a qualifying event occurs or (3) the date coverage is lost because of the qualifying event. The notice regarding the Social Security Administration's determination of disability must also be furnished to the COBRA administrator before the end of the original 18-month COBRA coverage period.

During COBRA coverage, if the Social Security Administration determines that the qualified beneficiary is no longer disabled, the COBRA administrator must be informed within 30 days of such determination. The notice can be made by providing to the COBRA administrator a copy of the determination notice from the Social Security Administration or by other written means. The notice must properly identify the qualified beneficiary who is no longer disabled and the date the notice was received. The 11-month COBRA extension will end at the end of the month in which the notice from the Social Security Administration is received by the qualified beneficiary.

Second Qualifying Event Extensions

Your spouse and dependents may have additional qualifying events (called "second qualifying events") while they are covered by COBRA. These events can extend their 18- or 29-month continuation period to 36 months, but in no event will they have more than 36 months of COBRA coverage measured from the first day of the month following the first qualifying event that originally allowed them to elect coverage. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies or gets divorced or legally separated or if the dependent child stops being eligible under the Plan as a

dependent child. This occurs only if the additional event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

The law requires a qualified beneficiary to notify the COBRA administrator if any of these second qualifying events occur. This notice must be provided within 60 days from the later of (1) the date that the second qualifying event occurs, or (2) the date coverage would have been lost because of the event.

If your spouse and/or dependents experience a second qualifying event, the COBRA administrator must be informed. If a qualified beneficiary (or their representative) fails to provide the appropriate notice and supporting documentation, if required, to the COBRA administrator during the 60-day notice period, the qualified beneficiary will not be entitled to extended COBRA coverage.

Early Termination of COBRA Coverage

COBRA coverage will terminate before the expiration of the 18-, 29- or 36-month period, as applicable, for any of the following reasons:

- the Company no longer provides group health coverage to any of its employees; or
- the premium for COBRA coverage is not paid on time (within the applicable grace period).
you will be sent a termination notice to notify you of early termination of COBRA coverage due to the above events. COBRA coverage will also terminate early if:
- the qualified beneficiary becomes covered—after the date COBRA coverage is elected—under another group health program;
- the qualified beneficiary first becomes entitled to Medicare after the date COBRA coverage is elected; or
- coverage has been extended for up to 29 months due to disability, and the Social Security Administration has made a final determination that the individual is no longer disabled.

You are required to inform the COBRA administrator if you experience any of the above events.

COBRA and FMLA

Taking an approved leave under the Family and Medical Leave Act (FMLA) is not considered a qualifying event that would make you eligible for COBRA coverage. However, a COBRA-qualifying event occurs if:

- you, your spouse, or your dependent is covered by a benefit program on the day before the FMLA leave begins (or you or your dependent becomes covered during the FMLA leave); and
- you do not return to employment at the end of the FMLA leave or you terminate employment during your leave.

COBRA coverage begins on the earlier of the following:

- when you inform the COBRA administrator that you are not returning to work; or
- the end of the leave, if you do not return to work.

COBRA and Medicare

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an eight-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit <https://www.medicare.gov/medicare-and-you>.

Plan Changes During COBRA

While you or your dependents have COBRA coverage, there may be changes to the health benefit programs, such as new deductibles, covered expenses or changes to your premiums. All changes will also apply to your COBRA coverage.

State Continuation of Coverage Rights

Many states require insured medical benefit programs and HMOs to provide extended health coverage to participants after their group coverage ends. These rights generally supplement federal COBRA or provide continuation coverage to those who are ineligible for federal COBRA coverage. Because the laws vary from state to state, you should review your benefit program material listed in Appendix A and/or contact your medical benefit program directly to learn about any rights you may have under state law. That way, you can meet any election and premium requirements necessary to take advantage of these state continuation coverage rights.

Even if you are not enrolled in an insured medical benefit program or HMO, please review the section below as it may impact your enrollment decisions when you initially enroll or at annual enrollment. For example, you may want to switch from a self-funded medical plan to an insured medical benefit program or HMO during annual enrollment in order to take advantage of these continuation rights.

Participants in California HMOs or Insured Medical Plans

Cal-COBRA Extended Continuation Coverage. Insured medical benefit programs and HMOs regulated in California are required to offer COBRA-qualified beneficiaries who are enrolled in their programs an additional period of continuation coverage if they exhaust their 18 or 29 months of federal COBRA coverage (Cal-COBRA). Qualified beneficiaries must be offered up to a *total* of 36 months of combined federal and Cal-COBRA coverage, starting from the date federal COBRA began. The HMO or insurance company may charge up to 110% of the cost (disabled individuals may be charged up to 150% of the cost). Note that Cal-COBRA does not apply to the Company's dental benefit programs or the employee assistance program, whether insured or not.

Refer to the benefit program material listed in Appendix A or contact the California insured medical benefit program or HMO directly for further information on Cal-COBRA. The benefit program will be able to supply you with further information regarding how to enroll, deadlines for enrollment, premium amounts, deadlines for submitting premiums and how Cal-COBRA might be beneficial to you.

Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage.

Conversion and Portability Privileges

If medical coverage under an insured benefit program ends for you or any dependent under the Plan, you may be able to apply for an individual medical policy from that insurer.

The coverage and benefits may not be the same as those provided by the Company-sponsored medical benefit programs, and the rates will vary depending on your age, where you live, and other factors. For additional information on your conversion rights, you should check with your HMO or insurance carrier, or refer to the appropriate benefit program material listed in Appendix A.

Note: You may also be able to purchase an individual policy from a different HMO or insurance carrier than the HMO or carrier for a Company-sponsored benefit program that provides the group coverage that you are losing.

Conversion coverage and/or portability rights may be available for other benefits. Refer to your benefit program material listed in Appendix A for more information.

10. Coordination of Health Care Benefits

The procedures and timeframes described in this section are the general coordination of benefit rules applicable to Company-sponsored health benefits. The provisions in this Section 10 apply if the benefit program materials do not include a coordination of benefits provision.

The coordination of benefits rules, if any, that are applicable to the benefit program in which you are enrolled will be furnished automatically to you without charge as part of your benefit program material (see Appendix A).

If you do not receive the coordination of benefits procedures as part of your health benefit program summary, please contact your benefit program for a copy.

If you and your dependents are enrolled in a Company-sponsored health benefit program as well as another employer-sponsored program, such as your spouse's program at work, the Company-sponsored benefit program coordinates its coverage with the other program.

Here's how coordination of benefits works in general:

- When the Company-sponsored benefit program pays first (in other words, if the Company-sponsored benefit program is the "primary" program), it pays benefits as though no other program exists. The other program may or may not pay benefits.
- When the Company-sponsored benefit program pays second (in other words, if the Company-sponsored benefit program is the "secondary" program), it may or may not pay a benefit, depending on what the other program (the "primary" program) has paid. In most cases, the most an enrolled person can receive is a combined total of the amount that the secondary plan would have paid in the absence of other insurance.

Which Plan Pays First?

If you or your covered dependents are also covered under another health program, the first of the following rules which applies determines which program is primary:

1. A program without a coordination of benefits provision is considered primary.
2. A program in which you are covered as other than a dependent (for example, as an active employee) rather than as a dependent is primary. If you are a Medicare beneficiary, any program covering you as an active employee is primary, Medicare is secondary, and any program covering you as a retiree determines benefits and pays last. If you are covered as a dependent of an active employee and you are a Medicare beneficiary, the program covering you as a dependent is primary, Medicare is secondary, and any program covering you as a retiree (or as other than a dependent) determines benefits and pays last.
3. For a dependent child whose parents are married or are living together, whether or not they have ever been married, or if a court decree establishes joint custody of a dependent child without specifying which parent is responsible to provide health coverage, the Company uses the "birthday rule" to determine which program pays benefits first if the child is covered under both parent's programs. Under the birthday rule, the program covering the parent whose birthday falls first in the calendar year is primary. The program of the parent whose birthday falls later in the year is the secondary program.

If both parents share the same birthday, the primary program will be the program that has covered one parent the longest. The secondary program will be the program that has covered the other parent for a shorter period of time.

4. For a dependent child whose parents are divorced or separated or are not living together, whether or not they were ever married, and who is covered under both parent's programs, the birthday rule does not apply. Instead, the Company uses the following rules to determine which program pays benefits first:
 - First, the program of the parent to whom a court specifically assigns financial responsibility for health care expenses (for instance, through a qualified medical child support order),
 - Then, the program of the parent who has custody,
 - Then, the program of the spouse married to the parent who has custody,
 - Then, the program of the parent who does not have custody, and
 - Finally, the program of the spouse married to the parent who does not have custody.

5. A program in which you are enrolled as an active employee (or as that employee's dependent) rather than as a laid-off or retired employee is primary.
6. In most cases, a program in which you are enrolled as an active employee or subscriber rather than as a COBRA participant is primary.
7. The program covering the individual for the longest period of time is considered primary.
8. If none of the above rules determines which program is primary, the allowable expenses shall be shared equally between the programs.

Coordination of Benefits With Medicare

When Medicare is the primary payer, a group health plan will be the secondary payer. For purposes of this "Coordination of Benefits With Medicare" section, a spouse does not include a domestic partner.

When you, your spouse or your dependents (as applicable) are eligible for or entitled to Medicare and covered by a group health plan under this Plan, the Plan at all times will be operated in accordance with any applicable Medicare secondary payer and non-discrimination rules. These rules include, where applicable, but are not necessarily limited to, rules concerning individuals with end-stage renal disease, rules concerning active employees age 65 or over, and rules concerning working disabled individuals (as discussed below).

In accordance with federal law, the following rules apply in determining whether Medicare or group health plan coverage is primary health care coverage:

- (1) **The Working Aged Rule:** Medicare benefits are secondary to benefits payable under a group health plan for individuals entitled to Medicare due to being age 65 or over and who have group health plan coverage as a result of his or her current employment status (or the current employment status of a spouse of any age). When you or your spouse become entitled for Medicare due to the attainment of age 65, you or your spouse may still be eligible for benefits provided under the group health plan based on your current employment status.

If, as a result, you have or your spouse has primary coverage under the group health plan, the group health plan will pay the portion of your incurred expenses that are normally covered by the group health plan. All or part of the remaining amount, if any, may be paid by Medicare if the expenses are covered expenses under Medicare and the portion of the expenses covered by Medicare exceeds the portion covered by the group health plan. If the expenses are not covered by the group health plan but are Medicare-covered expenses, then Medicare will process its payment of the expenses as if you do not have group health plan coverage.

- (2) **The Working Disabled Rule:** Medicare benefits are secondary to benefits payable under a group health plan for covered individuals under age 65 entitled to Medicare on the basis of disability (other than end-stage renal disease) and who are covered under the group health plan as a result of his or her current employment status (or the current employment status of a family member). That is, if you or your dependents are covered by a group health plan based on your current employment status, Medicare benefits are secondary for you or your covered dependents entitled to Medicare on the basis of disability (other than end-stage renal disease). In this case the group health plan is primary.
- (3) **End-Stage Renal Disease Rule:** Medicare benefits are secondary to benefits payable under a group health plan for covered individuals eligible for or entitled to Medicare benefits on the basis of end-stage renal disease (ESRD), for a period not to exceed 30 months generally beginning the first day of the month of eligibility or entitlement to Medicare due to ESRD. (Special rules apply if you were entitled to Medicare based on age or disability prior to becoming eligible for Medicare due to ESRD.) Because an ESRD patient can have up to a three-month wait to obtain Medicare coverage, the group health plan's primary payment responsibility may vary up to three months, subject to applicable law. If the basis of your entitlement to Medicare changes from ESRD to age or disability, the group health plan's primary payment responsibility may terminate on the month before the month in which the change is effective and the rules set forth above, if applicable, will apply.
- (4) **Domestic Partners:** If an Employee's domestic partner is covered by a group health plan and the domestic partner is enrolled in Medicare, the group health plan is the secondary payer. The group health plan pays secondary to Medicare for any Medicare-eligible domestic partner, even if the domestic partner is not enrolled in Medicare.

11. General Plan Provisions

Administration of Plan

The Company has the power to appoint the Named Fiduciary and the Plan Administrator. The Plan Administrator is the Named Fiduciary of the Plan. The Company may appoint either an individual or a committee to serve as the Plan Administrator on its behalf. An individual appointed by the Company may resign by providing written notice to the Company. A committee appointed by the Company may act by a majority of its members at the time in office, either by vote at a meeting or in writing without a meeting. Such a committee may authorize any one or more of its members to execute any document or documents on behalf of the Plan Administrator.

The Plan Administrator has absolute discretionary authority to control and manage the operation and administration of the Plan, in accordance with its terms, for the exclusive benefit of participants and beneficiaries. Without limiting the foregoing, the Plan Administrator's discretionary authority includes but is not limited to correcting errors, construing and interpreting the Plan, determining eligibility, participation, and benefits, making and enforcing rules and regulations it deems necessary or proper for the administration of the Plan, and considering and deciding claims and appeals under the Plan. All decisions by the Plan Administrator or its delegate will be afforded the maximum deference permitted by law. Benefits will be paid under the Plan only if the Plan Administrator or its delegate decides in its sole discretion that the applicant is entitled to the benefits.

The Plan Administrator may delegate its duties and responsibilities under the Plan as it deems appropriate to facilitate the day-to-day administration of the Plan and, unless the Plan Administrator expressly provides to the contrary, any such delegation will carry with it the Plan Administrator's full discretionary authority to accomplish the delegation. In the case of such delegation, all references to the "Plan Administrator" in the Plan shall be deemed to refer to such delegate, as appropriate. Notwithstanding the foregoing, any insurance company or HMO issuing an insurance or HMO contract, or a third-party administrator issuing an administrative services agreement, shall have sole discretion with respect to the matters for which it is made responsible under such insurance or HMO contract or administrative services agreement.

The Plan Administrator may employ such counsel (who may be, but is not required to be, counsel for the Company), agents, accountants, consultants and other persons (regardless of whether they also provide services to the Company) and may arrange for such clerical or other services as it may require in carrying out the provisions of the Plan.

The Plan Administrator will not receive any compensation or fee from the Plan for services as the Plan Administrator. The Company will reimburse the Plan Administrator and any delegate thereof for any reasonable expenditures incurred in the discharge of their duties hereunder.

All decisions and interpretations of the Plan Administrator or its delegate will be final, conclusive and binding upon all persons and will be given the greatest deference permitted by law. The Company and each participating employer will, from time to time, upon request of the Plan Administrator, furnish to the Plan Administrator such data and information as the Plan Administrator shall require in the performance of its duties.

Indemnification

The Company and each participating employer will indemnify, defend, and reimburse, to the full extent permitted by law, all members of the Board of Directors of the Company and all employees of the Company who may be deemed fiduciaries of this Plan or otherwise have administrative responsibilities with respect to this Plan for all expenses, losses, claims, demands and liabilities arising from an act or omission in the management of the Plan, if the member or employee acted in good faith and did not act dishonestly or otherwise in willful violation of the law under which such liability, loss, cost, claim, demand, or expense arises. This indemnification obligation may be satisfied by insurance or otherwise.

Allocation of Responsibility

Except to the extent provided in Section 405 of ERISA, no fiduciary will have any liability for a breach of fiduciary responsibility of another fiduciary with respect to the Plan.

Plan Amendment and Termination

The Company or its authorized delegate reserves the right in its sole discretion to amend, modify, terminate, or suspend in writing the Plan (including any benefit provided under the Plan) or any benefit program, in whole or in part, and/or to completely discontinue the Plan (including any benefit provided under the Plan) or any benefit

program at any time for any reason. The Company or its authorized delegate may in writing terminate or partially terminate the Plan (including any benefit provided under the Plan) or any benefit program or discontinue contributions at any time for any reason. Any such amendment, modification, suspension, or termination will become effective on such date as the Company or its authorized delegate determines and will apply prospectively (or retroactively to the extent permitted by law) to employees and participants (and their dependents and beneficiaries). In the event that the Plan is terminated, the rights of persons covered under the Plan will be limited to benefit claims incurred as of the date of the Plan termination.

The right of the Company or its authorized delegate to amend, modify, suspend or terminate the Plan does not require the consent, concurrence or any other action by any participating employer. The Company's decision to amend, modify, suspend or terminate the Plan is not a fiduciary decision but a business decision that can be made solely in the Company's interest.

The Company or its authorized delegate may in writing terminate or partially terminate the Plan (including any benefit provided under the Plan) or discontinue contributions at any time. In addition, the Company reserves the right to amend or terminate in writing covered expenses, benefit copayments and lifetime maximums, and reserves the right to amend in writing the benefit programs to require or increase participant contributions. The Company also reserves the right to amend in writing the benefit programs to implement any cost control measures that it may deem advisable.

The Company has delegated to the Vice President, Global Benefits (or such other person holding an equivalent position), including any delegate of such individual, the authority to amend the Plan at any time and from time to time if such amendment (a) is required or advisable to satisfy or conform to any law or regulation, (b) is administrative in nature, or (c) is immaterial or would not significantly increase or decrease the benefits provided under the Plan.

Insured Benefits

Certain benefits under this Plan are fully insured. See Appendix A to learn which benefit programs are insured.

With respect to insured benefits, claims for benefits are sent to the insurance company. In this case, the insurance company is responsible for adjudicating and paying claims and adjudicating appeals, not the Company or the Plan Administrator.

The insurance company is responsible for and has full discretionary authority for:

- Determining eligibility for and the amount of any benefits payable under the applicable benefit program.
- Prescribing claims and appeals procedures to be followed and the claims and appeals forms to be used by program participants pursuant to the applicable benefit program.

The insurance company also has the authority to require program participants to furnish it with such information as it determines necessary for the proper administration of the applicable benefit program.

With respect to insured benefits, you (or, in the case of your death, your beneficiary as that term is defined in the applicable insurance policy or contract) will be entitled to receive only the insured benefit for which provision is actually made under the insurance policy or contract.

The Company does not assume liability or responsibility for any insured benefit and you will be able to look only to the insurance contracts for payment or any benefits. You will not have any claim for insured benefits against the Company, the Plan Administrator or any employee, officer or director of the Company or any participating employer.

Contributions and Premiums

Funding in General

The benefit provided under this Plan may be funded by an insurance policy or contract, by the Company's general assets, by employee contributions, or by some combination of thereof. Contributions are established by the Company. The Company reserves the right to modify the cost sharing of contributions between the Company and employees, in such amounts as the Company in its absolute discretion shall determine from time to time. Nothing in this Plan shall be construed to require the Company or the Plan Administrator to segregate any amount or to maintain any fund for the benefit of any participant, and no participant or other person shall have any claim against, right to, or security or other interest in any fund, account, or asset of the Company from which any

payment under this Plan may be made. There is no trust or other fund from which benefits are paid. The Company or Plan Administrator may hire an unrelated third-party paying agent to make benefit payments hereunder.

The Company's Contributions

The Company may fund benefits provided under the Plan in whole or in part. With respect to the insured and HMO benefit programs, the Company has purchased insurance contracts and policies from insurance companies and entered into contracts with HMOs to provide some of the Plan's benefits with respect to certain benefit programs. Contributions made by the Company will be made at the times and in the manner determined by the Company. No assets will be set aside for the purpose of providing benefits under the Plan. The Company will pay benefits (including any insurance premiums necessary for the purchase of benefits) required under the Plan out of the general assets of the Company. In no event shall the Company have any obligation to fund self-funded benefits provided under the Plan in advance of the date that such benefits are payable or pre-pay the premiums or other fees required in order to provide insured benefits under the Plan. The Company contribution, if any, may be paid directly to the insurance company or other provider under the Plan. Such payment shall constitute a complete discharge of the liability of the Plan. The Company assumes no liability or responsibility with respect to any obligor and does not guarantee that the benefits provided under a fully insured benefit program will be payable or paid.

Self-Funded Benefits

The Company's general assets are the sole source of self-funded benefits under the Plan. The Company has contracted with a third-party administrator to administer some of the Plan's self-insured benefit programs. The Company assumes no liability or responsibility for payment of such benefits beyond that which is provided in the self-funded benefit programs.

Participant Contributions

The amount of contributions, if any, required from participants under the benefit programs will be determined from time to time by the Company. The Company retains the right to change the amount of the required participant contribution for any benefit or coverage option at any time and for any reason. Participants will be advised of any changes in the amount of required contributions prior to the effective date of any such change. Participants and beneficiaries will not be entitled to any interest on any amounts contributed pursuant to the Plan.

No Right to Assets

No participant, dependent, or beneficiary of the Plan or any other person shall have any right to, interests in or claim for any particular assets of the Company, the Plan, any benefit program or any underlying contract, trust or other funding vehicle in connection with the Plan.

Acts of Third Parties

When you or your covered dependent ("you") are injured or become ill because of the actions or inactions of a third party, the Plan may cover your eligible health care (medical, vision, and dental) expenses. However, to receive coverage, you must immediately notify the Plan that your illness or injury was caused by a third party, and you must follow special Plan rules. This section describes the Plan's procedures with respect to subrogation and right of recovery. These rights are in addition to, and not in lieu of, those that are further described in the benefit program materials.

Subrogation means that if an injury or illness is someone else's fault, the Plan has the right to seek any expenses it pays in connection with that illness or injury directly from the at-fault party or any of the sources of payment listed later in this section. The Plan may take action against any party (including but not limited to an attorney or trust) in possession of property or funds awarded or paid as a result of your illness or injury, if such property or funds should be or should have been paid to the Plan under this Section 11. The Plan has the right to seek a temporary restraining order against such party to prevent disbursement of such property or funds. In addition, the Plan may seek restitution in equity (through the imposition of a constructive trust for the Plan's benefit) from such party for the full amount of benefits paid by the Plan or for which it may have future responsibility.

A right of recovery (sometimes referred to as a right of reimbursement) means the Plan has the right to recover such expenses indirectly out of any payment made to you by the at-fault party or any other party related to the illness or injury. The Plan shall legally succeed your right of recovery against a third party, up to the amount of benefits it has paid (or for which the Plan may have future responsibility) with respect to that illness or injury. The

Plan shall have first priority on any money recovered from the third party, including any amounts paid for medical costs over the uninsured or underinsured motorist's coverage, homeowner's or renter's coverage, medical malpractice or any liability plan. The Plan's contractual right to reimbursement is in addition to and separate from equitable subrogation and may be enforced under the same terms as discussed in this Section 11.

By accepting Plan benefits to pay for treatments, devices, or other products or services related to such illness or injury, you agree that the Plan:

- Has an equitable lien on any and all monies paid (or payable) to you or for your benefit by any responsible party or other recovery to the extent the Plan paid benefits for such illness or injury, without regard to whether you have been made whole or fully compensated for the injury or illness;
- May appoint you as constructive trustee for any and all monies paid (or payable) to you or for your benefit by any responsible party or other recovery to the extent the Plan paid benefits for such illness or injury; and
- May bring an action on its own behalf or on the covered person's behalf against any responsible party or third party involved in the illness or injury.

If you (or your attorney, estate, or other representative) receive any payment from the sources listed later in this section—through a judgment, settlement or otherwise—when an illness or injury is a result of a third party, you agree to place the funds in a separate, identifiable account and that the benefit program has an equitable lien on the funds, and/or you agree to serve as a constructive trustee over the funds to the extent that the Plan has paid expenses related to that illness or injury. This means that you will be deemed to be in control of the funds.

If a third party makes any payment to you, your attorney, or a trust for your benefit, such payment must first be used to provide equitable restitution to the Plan, to the full extent of benefits paid by or payable under the Plan. This priority of the Plan applies despite other legal doctrines or theories. You must pay the Plan back first, in full, out of such funds for any health care expenses the Plan has paid related to such illness or injury. You must pay the Plan back up to the full amount of the compensation you receive from the responsible party or other recovery, regardless of whether your settlement or judgment says that the money you receive (all or part of it) is for health care expenses.

Furthermore, you must pay the Plan back regardless of whether any third party admits liability and regardless of whether you have been made whole or fully compensated for your injury, and the Plan's rights of subrogation, reimbursement, and recovery will not be subject to, or affected, reduced, or eliminated by, the principles of unjust enrichment, the make-whole doctrine, the doctrine of comparative fault theory, assertion of a common fund doctrine or its equivalent or any other legal or equitable defenses, doctrines, or theories. The Plan and each benefit program expressly rejects the common fund doctrine with regard to attorneys' fees. The rights of the Plan shall not be affected, reduced, or eliminated by any allocation which purports to allocate recovery amounts in whole or in part to nonmedical damages. You may keep any money left over after paying back the Plan.

Additionally, the Plan is not required to participate in or contribute to any expenses or fees (including attorneys' fees and costs) you incur in obtaining the funds. At its option, the Plan may file suit or intervene in any pending lawsuit to secure and protect its rights on any third-party recovery.

The Plan's sources of payment through subrogation or recovery include (but are not limited to) the following:

- Money from a third party that you, your guardian or conservator, your estate, or other representatives receive or are entitled to receive;
- Any constructive or other trust that is imposed on the proceeds of any settlement, judgment or other amount that you, your estate, your guardian or conservator, or other representatives receive or are entitled to receive;
- Any equitable lien on the portion of the total recovery which is due the Plan for benefits it paid; and
- Any liability or other insurance (for example, uninsured motorist, underinsured motorist, medical payments, workers' compensation, no-fault, school, homeowners, or excess or umbrella coverage) that is paid or payable to you, your estate, your guardian or conservator, or other representatives.

As a Plan participant, you are required to:

- Cooperate with the Plan's efforts to ensure a successful subrogation or recovery claim, including setting funds aside in a particular account. This also includes doing nothing to impair or prejudice the Plan's subrogation or recovery rights outlined in this document.

- Notify the Plan immediately, but within no later than five (5) days of the date any notice is given by any party, including an attorney, of your intent to pursue or investigate a claim to recover damages or obtain compensation due to sustained injuries or illness. You must also notify the Plan immediately, but within no later than five (5) days, of any potential causes of action or claims for a recovery that you may have against a third party.
- Provide the Plan with a copy of any summons, complaint, or other process served in any lawsuit in which you seek a recovery. You must notify the Plan immediately, but no later than 5 days, of any settlement offer regarding a potential recovery.
- Provide all information requested by the Plan, the claims administrator and their representatives, and the Plan Administrator and its representatives. Without limiting the generality of the foregoing, this means that you must cooperate and assist the Plan in enforcing its subrogation and reimbursement rights and, upon request, must (i) provide details of the illness or injury; (ii) authorize the release of information, including the names of all providers from whom you received service or treatment; (iii) provide information about other insurance coverage and benefits; (iv) provide such other information as may be requested by the Plan; (v) assist the Plan in any action against the third party; and (vi) execute a subrogation agreement, assignment of recoveries, and reimbursement agreement in favor of the Plan.
- Execute and deliver such documents as may be required and do whatever else is needed to secure the Plan's rights.
- Reimburse the Plan the amount of any payments previously made to you by the Plan (or for which the Plan may have future responsibility) with respect to that illness or injury if a recovery is paid from a third party directly to you.
- Obtain written consent from the Plan Administrator before entering into any settlement agreement or release with a third party. If a settlement agreement or a judgment award includes payment for future medical expenses, a trust account may be established by the Plan Administrator or the Plan. In the absence of such a trust, the Plan has the right to exclude coverage for your future medical expenses, related to the illness or injury, up to the full amount of the settlement or award. The Plan Administrator has a right to request reports on all settlements. The Plan Administrator has full discretionary authority to approve all settlements.

The Plan may terminate your Plan participation and/or offset your future benefits for the value of benefits paid or advanced if the Plan does not recover its expenses or if you do not provide the requested information or authorizations, or otherwise cooperate in a manner that the Plan considers necessary to exercise its rights or privileges under the Plan. Should it be necessary for the Plan to institute proceedings against you for failure to reimburse the Plan or to otherwise honor the Plan's legal and equitable interests in obtaining amounts described in this section, you will be liable for the costs of collection relating to such failure, including reasonable attorneys' fees and costs.

If the person covered by the Plan is a minor, the Plan shall have no obligation to pay benefits related to the illness or injury caused by a third party until after the minor's legal representative obtains valid court recognition and approval of the Plan's 100%, first-dollar subrogation and reimbursement rights on all recoveries, as well as approval for the execution of any papers necessary for the enforcement of such rights.

If the subrogation and/or recovery provisions in these "Acts of Third Parties" provisions conflict with subrogation and/or recovery provisions in an insurance contract or policy governing the benefits at issue, the subrogation and/or recovery provisions in the insurance contract or policy will govern.

All Plan rights under this section remain enforceable against the heirs and estate of any covered person under the Plan.

No Estoppel of Plan

No person is entitled to any benefit under the Plan or any benefit program except and to the extent expressly provided under the Plan or the benefit program. The fact that payments have been made from the Plan or a benefit program in connection with any claim for benefits under the Plan or a benefit program does not (a) establish the validity of the claim, (b) provide any right to have such benefits continue for any period of time, or (c) prevent the Plan or benefit program from recovering the benefits paid to the extent that the Plan Administrator ultimately determines that there in fact was no right to payment of the benefits under the Plan or benefit program.

If benefits are paid more than once, are overpaid, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, are not paid according to the Plan's (or benefit program's) terms, conditions, limitations, or exclusions, or should otherwise not have been paid by the Plan (or a benefit program), the Plan may recover the amount of the overpayment from the source(s) to which it was paid, from primary payers, or from the party on whose behalf the charge(s) were paid. Thus, if a benefit is paid to a person under the Plan or a benefit program and it is thereafter determined by the Plan Administrator that such benefit should not have been paid (whether or not attributable to an error by such person, the Plan Administrator or any other person), then the Plan Administrator may take such action as it deems necessary or appropriate to remedy such situation, including, without limitation, by deducting the amount of any such overpayment from any succeeding payments to or on behalf of such person under the Plan or benefit program or from any amounts due or owing to such person by a participating employer or under any other program or arrangement, or otherwise recovering such overpayment from whomever has benefited from it. Whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator or its designee has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from other payers and/or the participant or dependent on whose behalf such payment was made. Upon any overpayment, the Plan will have a first right of reimbursement and restitution with an equitable lien by contract in such overpayment. Further, the holder of such overpayment is required to hold it as the Plan's constructive trustee. If any participant, dependent or beneficiary has cause to reasonably believe that an overpayment may have been made, the participant, dependent or beneficiary must promptly notify the Plan Administrator of the relevant facts. If the Plan Administrator determines (on the basis of any relevant facts) that an overpayment was made to any participant or dependent (or any other person), it will notify the participant, dependent or beneficiary in writing and the participant, dependent or beneficiary must promptly pay (or cause another person to pay) the amount of such overpayment to the Plan Administrator. A participant, dependent, provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan, or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the Plan. The Plan Administrator shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The Plan's right to subrogation, reimbursement, restitution, an equitable lien by contract, and as beneficiary of a constructive trust shall in no way be affected, reduced, compromised, or eliminated by any doctrines limiting its rights (equitable or otherwise) such as the make-whole doctrine, contributory or comparative negligence, the common fund doctrine, or any other doctrine, theory, or defense. The Plan's rights against the participant, dependent or beneficiary and the obligation of the participant, dependent or beneficiary to the Plan shall also not be affected if the overpayment was made to another person or entity on behalf of the participant, dependent or beneficiary.

For the avoidance of doubt, any offset of payments hereunder related to an overpayment will not be considered a denial or partial denial of any benefit claim under the Plan or other adverse decision that is subject to any applicable claims and appeals procedures under the Plan.

Responsibility for Benefit Programs

Please note that:

- All service providers (e.g., insurers and third-party administrators) are independent contractors of the applicable benefit program; the Company is not responsible for their actions.
- None of the Plan Administrator, the Company or any participating employer is responsible for the fiscal viability of service providers or for the continuing participation of doctors, hospitals, and others in their networks.
- None of the Plan Administrator, the Company or any participating employer can warrant or guarantee the quality or the length of service of service providers.

No Guarantee of Employment

By adopting and maintaining the Plan and these benefit programs, the Company has not entered into an employment contract with any person. Nothing in the Plan documents gives any employee the right to be employed by the Company or to interfere with the Company's right to discharge any program participant at any time. Similarly, these benefit programs do not give the Company the right to require any program participant to remain employed by the Company, or to interfere with an employee's right to terminate employment with the

Company at any time. The Company may terminate the employment of any employee as freely and with the same effect as if this Plan and any benefit programs were not in existence. Participation in this Plan or any benefit programs by an employee shall not constitute an express or implied contract of employment between the Company and the employee.

Assignment of Benefits

No rights, claims, causes of action or benefits under, or any interest in, the Plan or any benefit programs shall be assignable or transferable to any person or entity (including, but not limited to, any provider) in whole or in part, either directly or by operation of law or otherwise, including by contract, execution, levy, garnishment, attachment, pledge or bankruptcy, other than as required by law or permitted under the Plan. The Plan shall not be liable for any obligation or liability of any covered person under the Plan, including with respect to claims for alimony or the support of a spouse, other than as provided with respect to a qualified medical child support order (QMCSO). Any attempt to assign or transfer a right or interest in the Plan shall be void and of no effect. Notwithstanding the foregoing, the Plan Administrator shall have the right, in its sole discretion, to accept a purported assignment for payment of Plan benefits made by a covered person under the Plan to a hospital, doctor, dentist or other provider.

Payment of Benefits

The Plan reserves the unilateral right and discretion to pay a provider (or any other designated person or entity) directly for benefits under the Plan, with any such payment being made on a Plan participant's behalf (and not to such payment recipient in its, his or her own right). The Plan Administrator, an insurance company, a third-party administrator, or a claims administrator may, in its sole discretion, interact directly with a provider (or other designated person or entity). If the Plan makes a payment to a person or entity other than the Plan participant, or if the Plan Administrator and/or insurance company and/or claims administrator interacts directly with any such person or entity, such payment or interaction shall not constitute a waiver of any provision of "Assignment of Benefits" above or a consent to any assignment or transfer of any rights, claims, causes of action or benefits under, or any interest in, the Plan (unless otherwise provided by the Plan Administrator in its sole discretion). Any payment made under this Plan to any such person or entity discharges the Plan's responsibility to the Plan participant and any dependents for benefits under the Plan to which such payment relates. Payment of benefits under the Plan, if any, may be made to a Plan participant upon presentation of itemized "paid" bills.

If the Plan Administrator determines that an underpayment of benefits has been made, the Plan Administrator shall take such action as it deems necessary or appropriate to remedy such situation. However, in no event shall interest be paid on the amount of any underpayment.

Benefit Payment Limitation

The Plan shall have no obligation to make any payment with respect to any charges for services or expenses incurred by a Plan participant (or any dependents) with respect to which (i) the participant (or any dependents) has no obligation to pay, (ii) the participant (or any dependents) was not billed, or (iii) the participant (or any dependents) would not have been billed but for the coverage of such charges under the Plan. Therefore, if the Plan Administrator determines that a provider is waiving, reducing or forgiving (or has waived, reduced, or forgiven) all or any portion of its charges with respect to a participant (or any dependents) and/or all or any portion of any copay, deductible, coinsurance or other out-of-pocket amount(s) that the participant (or any dependent) is required to pay under the terms of the Plan, then the Plan Administrator shall have the unilateral right and discretion to wholly or partially reduce the benefits paid under the Plan in proportion to the amount of such charges or out-of-pocket amounts waived, reduced or forgiven, regardless of whether such provider represents or affirms that the participant (or any dependents) remains financially responsible for such amount(s). The Plan Administrator reserves the unilateral right and discretion to require that a participant provide satisfactory written proof that the participant (or any dependents) has paid the required copay, deductible, coinsurance or other out-of-pocket amount attributable to any benefits under the Plan, whether prior to or subsequent to any payment by the Plan for such benefits; provided, however, that the Plan Administrator's failure to request any such proof in any one or more instances shall not constitute any waiver or limitation of the exclusion of coverage under this section.

Minors or Disablement or Death

If the Plan Administrator determines in its sole discretion that any person to whom any amount is payable under the Plan is unable to care for his or her affairs or is incapacitated because of sickness or injury or is a minor or

has died, then any payment due to such person or such person's estate (unless a prior claim therefore has been made by a duly appointed legal representative) may, if the Plan Administrator so elects, be paid to such person's spouse, a domestic partner, a child, a relative, an institution maintaining or having custody of such person, or any other person deemed by the Plan Administrator to be a proper recipient on behalf of such person otherwise entitled to payment in accordance with the terms of the Plan and the applicable benefit program. The Plan Administrator shall, however, not be under any affirmative obligation to investigate whether a person is or is not capable of caring for his or her affairs. Any such payment shall be a complete discharge of the liability of the Plan and Plan Administrator.

Benefits of Unlocated Persons

Notwithstanding any contrary provision of the Plan and subject to applicable law, if a payment is due to any person under the Plan, and if notice of such payment due is mailed to the last known address of such person, as shown on the records of the Plan Administrator or service provider with respect to the Plan, and within six months (or, if a longer period is required by applicable law, such period) after such mailing such person has not made a written claim for such payment in accordance with the requirements of the Plan or cashed a written instrument for the payment due, the Plan Administrator or service provider, if it so elects, may direct that such payment and benefits (and subsequent payments and benefits) be forfeited and that such payment and any remaining payments otherwise due to such person be canceled, and upon such cancellation, the Plan and Plan Administrator shall have no further liability with respect to such payment.

Severability

If any provision of the Plan is determined to be unenforceable or invalid, such unenforceability or invalidity shall not affect any other provision of the Plan, and the Plan shall be interpreted, construed, administered, and enforced as if such provisions had not been included.

The Company's Use of Funds

The Company shall be entitled to retain, in accordance with applicable laws, any policy dividend, refund, or rebate, or portion thereof, it receives from any insurance company, administrative services organization, HMO, service program or any other organizations or individuals.

Plan's Use of Funds

All amounts paid to and held by the Plan (or any trust established in connection with the Plan) (if any), as well as any policy dividends and/or refunds not belonging to the Company, shall be available to fund the benefits provided by any benefit program included in the Plan. To the maximum extent permitted by applicable law, the Plan Administrator, at its sole and unfettered discretion, may use funds accumulated under this Plan for a benefit program (whether funds accumulated from insurance contract reserves, insurance company refunds or dividends, or administrative fees) to reduce the level of contributions that the Company would otherwise make to the Plan for a benefit program.

Workers' Compensation

The Plan is not in lieu of, and does not affect any requirement for coverage by, workers' compensation insurance.

Withholding of Taxes

Withholding and related tax reporting may be applied to amounts paid or payable pursuant to this Plan for all federal, state, local, or other taxes with respect to any amounts paid or payable under this Plan or any benefit program.

Statute of Limitations

Except for actions to which the statute of limitations prescribed by Section 413 of ERISA applies, no legal or equitable action relating to a claim under Section 502 of ERISA may be commenced later than one (1) year after the claimant receives a final decision pursuant to the Plan's claims and appeals procedures and no other legal or equitable action involving the Plan may be commenced later than two (2) years after the date the person bringing the action knew, or had reason to know, of the circumstances giving rise to the action. This provision shall not bar the Plan, the Plan Administrator, its delegates, or its representatives from recovering overpayments of benefits, initiating subrogation actions, initiating actions for reimbursements, or taking actions to recover, under any legal or

equitable theory, other amounts incorrectly paid to any person at any time or from bringing any legal or equitable action against any party.

For the avoidance of doubt, (i) if a benefit program contains a statute of limitations, such statute of limitations shall apply to actions thereunder, and (ii) nothing in this section will bar the Plan or its fiduciaries or other representatives or delegates from recovering overpayments of benefits or other amounts incorrectly paid to any person under the Plan at any time, or bringing any legal or equitable action against any party.

Governing Law; Venue; Forum

The Plan will be construed and enforced in accordance with the requirements of all applicable laws, including ERISA, and, to the extent it is not preempted by ERISA, with the laws of the State of California (without regard to principles of conflicts of law). Any ERISA action involving the Plan must be litigated in the United States District Court for the Northern District of California, and venue and forum shall be proper only in such court. Any action relating to, arising out of or involving the Plan that is not preempted by ERISA must be litigated in a state or federal court located in Santa Clara County, California and no other federal or state court unless otherwise provided by an HMO or insurer in an insurance policy or contract (if applicable). In consideration of participating in and receiving benefits under the Plan, employees, dependents, participants, beneficiaries, and other persons receiving benefits under the Plan agree to the provisions of this section.

Legal Fees

Any award of legal fees in connection with an action involving the Plan shall be calculated pursuant to a method that results in the lowest amount of fees being paid, which amount shall be no more than an amount that is reasonable. In no event shall legal fees be awarded for work related to (a) administrative proceedings under the Plan, (b) unsuccessful claims brought by any person, or (c) actions that are not brought under ERISA. In calculating any award of legal fees, there shall be no enhancement for the risk of contingency, nonpayment or any other risk nor shall there be applied a contingency multiplier or any other multiplier. In any action brought by any person against the Plan, the Company, any Plan fiduciary or the Plan Administrator or their respective affiliates or officers, directors, trustees, employees, or agents (the "Plan Parties"), legal fees of the Plan Parties in connection with such action shall be paid by the person bringing the action, unless the court specifically finds that there was a reasonable basis for the action.

Governing Provisions

If there is an inconsistency between the provisions contained in this Plan document and the provisions contained in benefit program materials listed in Appendix A, the provisions contained in this Plan document will govern with respect to eligibility, participation and other general Plan terms and conditions (including but not limited to Assignment of Benefits and Payment of Benefits in Section 11). Notwithstanding the foregoing, the benefit program materials will govern with respect to the amounts payable, required deductibles, copays, coinsurance, maximums and other out-of-pocket costs, conditions precedent to payment, limitations and exclusions, claims and appeals procedures, and other coverage-specific aspects of the benefit programs.

If the terms or provisions of any summary or description of this Plan are in any construction interpreted as being in conflict with the provisions of this Plan as set forth in this document, the provisions of this Plan shall be controlling. Except as required by applicable law, employees and other persons cannot rely on oral statements of Plan personnel, the Plan Administrator, the Employer, a third-party administrator, or any other individual. Although the Plan Administrator or its designee may respond orally to questions, oral communications are not binding on the Plan and cannot be relied upon in a benefits dispute. If an Employee requires an interpretation of a Plan provision, such request must be made in writing to the Plan Administrator or its designee.

No Guarantee of Tax Consequences

The Company, the Plan Administrator, and any participating employer do not make any commitment or guarantee that any amounts paid to or for the benefit of a participant (or his or her dependents or beneficiaries) under the Plan will be excludable from the participant's gross income for federal, state or local tax purposes or that any other favorable tax treatment will apply or be available to any participant (or his or her dependents or beneficiaries) with respect to such amounts. It shall be the obligation of each participant (or his or her dependents or beneficiaries) to determine whether any payment under this Plan or any benefit program is excludable from gross income for federal, state, or local tax purposes and to take appropriate action if there is reason to believe that any payment or amount withheld is not excludable. Neither the Company nor the Plan Administrator is liable

for any taxes or penalties owed by any participant (or his or her dependents or beneficiaries) with respect to such amounts. If there are any taxes or penalties payable by the Company on behalf of any participant (or his or her dependents or beneficiaries), such taxes or penalties shall be payable by the participant (or his or her dependents or beneficiaries) to the Company to the extent such taxes would have been originally payable by the participant (or his or her dependents or beneficiaries) had the Plan not been in existence.

12. Your Rights and Privileges Under ERISA

As a participant in the Plan, you are entitled to certain rights and protections under ERISA. The benefit programs maintained by the Company that are governed by ERISA include those described in this document, except for the Dependent Care Spending Account (which is a non-ERISA program).

ERISA provides that all Plan participants have the right to:

Receive Information About Your Plan and Benefits

- You can examine, without charge, at the Plan Administrator's office and at other specified locations (such as worksites), all documents governing the Plan. This includes insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA) of the U.S. Department of Labor.
- By submitting a written request to the Plan Administrator, you can obtain copies of documents governing the operation of the Plan, including insurance contracts, copies of the latest annual report (Form 5500 Series), and an updated summary plan description. (The Plan Administrator can charge you a reasonable fee for the copies.)
- You will receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to provide a copy of this summary annual report to each Plan participant.

Continue Group Health Plan Coverage

You can continue coverage under health benefit programs (medical, dental, vision, employee assistance program, HRA and HCSA) for yourself, your spouse and/or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You and your dependents may have to pay the cost of such coverage. For more details, review the COBRA information in this document, the relevant benefit program materials, and the COBRA Notice that was mailed to your home. If you need another copy of these documents, contact YBR.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a Plan benefit is denied or ignored, in whole or in part, you have a right (within certain time schedules) to:

- know the reason for the denial,
- obtain copies of documents relating to the decision without charge, and
- appeal any denial.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive your copies within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the requested materials and pay you up to a maximum of \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

After exhausting your appeal rights, you may file suit in a state or federal court if you have a claim for benefits which is denied or ignored, in whole or in part. After exhausting your appeal rights, you may file suit in a federal court if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or qualified medical child support order.

You may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court, if:

- Plan fiduciaries misuse the Plan's money, or
- You are discriminated against for asserting your rights.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (for example, if it finds your claim is frivolous).

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA or need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210, or www.askebsa.dol.gov. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 1-866-444-EBSA (3272) or on the internet at www.dol.gov/ebsa.

Additional Information

Additional information is attached as follows:

Appendix A: Benefit Program Materials

Appendix B: Benefit Program Contact and Funding Information

Appendix C: Plan Administration Information

Appendix D: HIPAA Privacy and Security

Appendix A: Benefit Program Materials

The following benefit program materials, together with this document, constitute the summary plan description (SPD) of benefits provided for eligible employees under the PayPal Holdings, Inc. Health and Welfare Benefits Plan. The following documents can be found on www.PayPalBenefits.com. Refer to the “Plan Details” heading in Section 1 regarding important information regarding the DCSA, STD, and HSA not being subject to ERISA.

Benefit Program/Policy or Contract No.	Benefit Program Material
Medical	
Meritain Health Copay Plan (18848)	Meritain Health Copay Plan Summary Plan Description
Meritain Health CDHP with HSA Plan (18848)	Meritain Health CDHP Summary Plan Description
Kaiser Northern (604762) and Southern California HMO (232527)	Kaiser Permanente Traditional Plan Evidence of Coverage
Progyny (available only to employees enrolled in the Meritain Health Copay or CDHP Plan)	Progyny Fertility Benefits
Hawaii Medical Service Association (122270-1) (available only to employees who live in Hawaii)	HMSA PPP PPO Guide to Benefits
Cigna Global Medical Plan (06752A)	Cigna Global Certificate of Coverage Cigna Global Benefits at a Glance
Prescription Drugs	
CVS Caremark (1166) (for participants in the Meritain Health Copay or CDHP Plan)	Caremark PPO Prescription Drug Benefits Summary Caremark CDHP Prescription Drug Benefits Summary
Hawaii Medical Service Association (122270-1) (available only to employees who live in Hawaii)	HMSA PPP PPO Guide to Benefits
Cigna Global Medical Plan (06752A)	Cigna Global Certificate of Coverage Cigna Global Benefits at a Glance
Dental	
Delta Dental (17690) Core Plan & Enhanced Plan	PayPal Holdings, Inc. Combined Evidence of Coverage and Disclosure Form
Hawaii Medical Service Association (122270-1) (available only to employees who live in Hawaii)	HMSA PPP PPO Guide to Benefits
Cigna Global Dental Care (06752A)	Cigna Global Certificate of Coverage Cigna Global Benefits at a Glance
Vision	
Vision Service Plan (30057214) Core Plan & Enhanced Plan	Group Vision Care Plan Evidence of Coverage
Hawaii Medical Service Association (122270-1) (available only to employees who live in Hawaii)	HMSA PPP PPO Guide to Benefits
Cigna Global Vision Care (06752A)	Cigna Global Certificate of Coverage Cigna Global Benefits at a Glance
Health Care Spending Accounts	
HealthEquity	PayPal Holdings, Inc. Spending Account Benefit Program Summary
Dependent Care Spending Account	
HealthEquity	PayPal Holdings, Inc. Spending Account Benefit Program Summary

Benefit Program/Policy or Contract No.	Benefit Program Material
Health Reimbursement Arrangement	
HealthEquity (available only to employee in Grades 15 to 19 enrolled in the Meritain Health Copay Plan with HRA)	PayPal Holdings, Inc. HRA Plan Document and Summary Plan Description
Employee Assistance Plan (EAP)	
Optum EAP	Optum EAP Brochure
Legal Assistance	
MetLife Legal Plan (6091045)	PayPal Holdings, Inc. Legal Services Plan Fact Sheet
Short-Term Disability (STD)	
Sedgwick STD (6371)	PayPal Holdings, Inc. Short Term Disability Plan Benefit Program Summary Overview
Long-Term Disability (LTD)	
Prudential (52853)	PayPal Holdings, Inc. – Group Disability Insurance LTD Certificate
Life	
Prudential (52853)	PayPal Basic Life, Dependent Life and Optional Life Certificate of Coverage
Business Travel Accident (BTA)	
ACE American Insurance Company (Business Travel: ADD N10892934, Business Medical: GLM N10892946)	Business Travel Class 1 Description of Coverage Business Travel Class 2 Description of Coverage Business Medical Class 1 Description of Coverage Business Medical Class 2 Description of Coverage
Accidental Death and Dismemberment (AD&D)	
AC Newman (Basic: ADD-123708, Voluntary: PAI-123707)	Basic AD&D Summary Plan Description Supplemental AD&D Summary Plan Description
Voluntary Supplemental Insurance	
Aflac	Aflac Group Accident Brochure Aflac Group Critical Illness Brochure Aflac Group Hospital Indemnity Brochure
Long-Term Care + Life Insurance	
Trustmark	Trustmark Long-Term Care + Life Insurance Program Underwritten by Trustmark – FAQs
Vida (Wellness Coaching)	Vida.com/paypal
Substance Use Treatment Helpline	855-780-5955
Substance Abuse Hotline	855-780-5955

Appendix B: Benefit Program Contact and Funding Information

Please direct all claims and claim appeals to the claims administrator for the benefit program in which you are enrolled. Refer to the "Plan Details" heading in Section 1 regarding important information regarding the DCSA, STD, and HSA not being subject to ERISA.

Benefit Programs	Claims Administrator	Self-funded or Insured	Employee Pre/After-Tax Contributions and/or Employer Contributions
Medical			
Meritain Health	Claims Office: Meritain Health P.O. Box 853921 Richardson, TX 75085- 3921 Phone: 866-406-1338 www.member.accolade.com	Self-funded	Pre-tax employee payroll deductions and employer contributions
Kaiser Northern California	Kaiser Foundation Health Plan, Inc. Claims Administration Department Non-Medicare Claims: P.O. Box 12923 Oakland, CA 94604-2923 Fax: 866-889-6021 Medicare Claims: Claims-Medicare P.O. Box 24010 Oakland, CA 94623-1010 www.kaiserpermanente.org	Insured	Pre-tax employee payroll deductions and employer contributions
Kaiser Southern California	Kaiser Foundation Health Plan, Inc. Claims Administration Department Initial Claims (Medicare and Non-Medicare) P.O. Box 7004 Downey, CA 90242-7004 Phone: 800-390-3510 www.kaiserpermanente.org	Insured	Pre-tax employee payroll deductions and employer contributions
Progyny	Progyny 245 Fifth Avenue, 4 th Floor New York, NY 10016 Phone: 877-762-5012 legalnotices@progyny.com Attention: Claims Appeals	Self-funded	Pre-tax employee payroll deductions (included in Meritain Health contributions) and employer contributions
Hawaii Medical Service Association	Hawaii Medical Service Association 818 Keeaumoku St. Honolulu, HI 96814 Phone: 800-776-4672 www.hmsa.com	Insured	Pre-tax employee payroll deductions and employer contributions
Cigna Global	Cigna Global Health Benefits 300 Bellevue Parkway Wilmington, DE 19809 Phone: 800-441-2668 www.cignaenvoy.com	Insured	Employer contributions only

Benefit Programs	Claims Administrator	Self-funded or Insured	Employee Pre/After-Tax Contributions and/or Employer Contributions
Pharmacy			
CVS Caremark (For Meritain Health medical plans)	CVS Caremark P.O. Box 52136 Phoenix, AZ 85072-2136 Phone: 844-287-1297 www.caremark.com	Self-funded	Pre-tax employee payroll deductions (included in Meritain Health contributions) and employer contributions
Hawaii Medical Service Association	Hawaii Medical Service Association 818 Keeaumoku St. Honolulu, HI 96814 Phone: 800-776-4672 www.hmsa.com	Insured	Pre-tax employee payroll deductions and employer contributions
Cigna Global	Cigna Global Health Benefits 300 Bellevue Parkway Wilmington, DE 19809 Phone: 800-441-2668 www.cignaenvoy.com	Insured	Employer contributions only
Dental			
Delta Dental PPO Core Plan Delta Dental PPO Enhanced Plan	Delta Dental P.O. Box 997330 Sacramento, CA 95899-7330 Phone: 800-765-6003 www.deltadentalins.com	Self-funded	Pre-tax employee payroll deductions and employer contributions
Hawaii Medical Service Association	Hawaii Medical Service Association 818 Keeaumoku St. Honolulu, HI 96814 Phone: 800-776-4672 www.hmsa.com	Insured	Pre-tax employee payroll deductions and employer contributions
Cigna Global	Cigna Global Health Benefits 300 Bellevue Parkway Wilmington, DE 19809 Phone: 800-441-2668 www.cignaenvoy.com	Insured	Employer contributions only
Vision			
VSP Vision Core Plan VSP Vision Enhanced Plan	Vision Service Plan 3333 Quality Drive Rancho Cordova, CA 95670 Phone: 1-800-877-7195 www.vsp.com	Self-funded	Pre-tax employee payroll deductions and employer contributions
Hawaii Medical Service Association	Hawaii Medical Service Association 818 Keeaumoku St. Honolulu, HI 96814 Phone: 800-620-4672 www.hmsa.com	Insured	Pre-tax employee payroll deductions and employer contributions
Cigna Global	Cigna Global Health Benefits 300 Bellevue Parkway Wilmington, DE 19809 Phone: 800-441-2668 www.cignaenvoy.com	Insured	Employer contributions only

Benefit Programs	Claims Administrator	Self-funded or Insured	Employee Pre/After-Tax Contributions and/or Employer Contributions
Health Care Spending Accounts			
HealthEquity	HealthEquity 15 W. Scenic Pointe Drive, Suite 100 Draper, UT 84020 Phone: 866-382-3510 www.healthequity.com/paypal	Self-funded	Pre-tax employee payroll deductions
Dependent Care Spending Account*			
HealthEquity	HealthEquity 15 W. Scenic Pointe Drive, Suite 100 Draper, UT 84020 Phone: 866-382-3510 www.healthequity.com/paypal	Self-funded	Pre-tax employee payroll deductions
Health Reimbursement Arrangement			
HealthEquity	HealthEquity 15 W. Scenic Pointe Drive, Suite 100 Draper, UT 84020 Phone: 866-382-3510 www.healthequity.com/paypal	Self-funded	Employer contributions only
Short-Term Disability (STD)*			
Sedgwick STD	Sedgwick Claims Management Services, Inc. Pasadena, CA Office P.O. Box 14435 Lexington, KY 40512 Phone: 855-233-7599 Fax: 877-393-0017 or 877-393-0019 www.sedgwickcms.com	Self-funded	Employer contributions only
Long-Term Disability (LTD)			
Prudential	Prudential Insurance Company of America Disability Management Services P.O. Box 13480 Philadelphia, PA 19176 Phone: 800-842-1718 Fax: 877-889-4885 www.prudential.com	Insured	Employer contributions only

Benefit Programs	Claims Administrator	Self-funded or Insured	Employee Pre/After-Tax Contributions and/or Employer Contributions
Life (Basic and Voluntary)			
Prudential	Prudential Insurance Company of America Group Life Claims P.O. Box 8517 Philadelphia, PA 19176 Phone: 800-524-0542 Fax: 888-227-6764 www.prudential.com	Insured	Basic Life: Employer contributions only Voluntary Life: After-tax employee payroll deductions
AC Newman AD&D	A.C. Newman & Company 7060 North Marks Avenue, Suite 108 Fresno, CA 93711 Phone: 559-252-2525 www.acnewman.com paypalclaims@acnewman.com	Insured	Basic AD&D: Employer contributions only Voluntary AD&D: After-tax employee payroll deductions
Legal			
MetLife Legal	MetLife Legal Plans, Inc. Director of Administration Eaton Center 1111 Superior Avenue Cleveland, OH 44114-2507 www.legalplans.com	Insured	After-tax employee payroll deductions
Business Travel Accident (BTA)			
ACE American Insurance Company	ACE USA P.O. Box 5124 Scranton, PA 18505-0556 Phone (Inside USA): 800-336-0627 Phone (Outside USA): 302-476- 6194 Fax: 302-476-7857	Insured	Employer contributions only
Employee Assistance Plan (EAP)			
Optum EAP	425 Market St. 14 th Floor San Francisco, CA 94105 Phone: 888-876-7830 www.liveandworkwell.com	Insured	Employer contributions only
Voluntary Benefits			
Voluntary Supplemental Insurance	Aflac 1-866-235-2211 Claims: groupclaimfiling@aflac.com	Insured	After-tax employee payroll deductions
Long-Term Care			
Optional Long-Term Care + Life Insurance	Trustmark 800-918-8877 www.gettci.com/paypal	Insured	After-tax employee payroll deductions
Substance Abuse Hotline	Optum liveandworkwell.com/recovery 855-780-5955	Self-funded	Employer Paid

Benefit Programs	Claims Administrator	Self-funded or Insured	Employee Pre/After-Tax Contributions and/or Employer Contributions
Wellness	Vida Vida.com/paypal Email: paypal_support@vida.com	Self-funded	Employer Paid

* The DCSA and STD are not subject to ERISA and are not part of the Plan. However, descriptions of the DCSA and STD are included in this document for your convenience.

OTHER CONTACTS

Alight Benefits Administrator	
For questions about health and welfare benefits, to update your personal information, new hire enrollment, initial enrollment information, or a copy of this Plan document/SPD	Employee Central Phone: 855-489-0343 employeecentralcases@paypal.com
For enrollment, disenrollment, changing benefit elections, or providing proof of eligibility	Alight Your Benefits Resources (YBR) Customer Service: 844-474-6641 http://www.ybr.com/benefits/PayPal
COBRA Administrator	
For questions, payments, submission of forms, notifications, updates to personal information, and all other matters related to COBRA continuation coverage	Alight Your Benefits Resources (YBR) Customer Service: 844-474-6641 http://www.ybr.com/benefits/PayPal COBRA payments should be sent to: PayPal, Inc. P.O. BOX 1380 Carol Stream, IL 60132-1380
Dependent Verification Center	
For questions about dependent verification, providing proof of eligibility and supporting documentation.	Phone: 844-474-6641 Fax: 877-965-9555 http://www.ybr.com/benefits/PayPal P.O. Box 1401 Lincolnshire, IL 60069-1401

Appendix C: Plan Administration Information

Official Plan Name	PayPal Holdings, Inc. Health and Welfare Benefits Plan
Employer/Plan Sponsor/Named Fiduciary	PayPal Holdings, Inc. 2211 North 1 st Street San Jose, CA 95131 1-855-489-0343
Employer I.D. Number	77-0510487
Plan Number	The Plan Number for the PayPal Holdings, Inc. Welfare Benefit Plan is 501. The benefit programs provided under this Plan do not have separate plan numbers.
Type of Plan	This Plan is an umbrella plan, also known as a wraparound plan, which provides the welfare benefits described in Appendix A. The benefit programs are welfare benefit plans, which include medical, dental, vision, health reimbursement, health flexible spending account, employee assistance program, legal services, disability, life insurance, business travel accident, voluntary benefits and accidental death and dismemberment benefits.
Type of Administration/ Insurance Issuers	The benefit programs are provided under both self-funded and insured arrangements. The insured plans (which include HMOs) are provided under group contracts between PayPal Holdings, Inc. and the carriers (including HMOs). The carriers—not PayPal Holdings, Inc.—are responsible for determining eligibility for benefits, the amount of any benefits payable and prescribing the claims procedures for the applicable benefit programs. The self-funded benefit programs are administered by third-party administrators.
Plan Funding	The insured arrangements are paid by insurance policies. The benefits and other plan costs (such as administrative costs) for the self-funded programs are paid from the general assets of PayPal Holdings, Inc.
Plan Administrator	PayPal Holdings, Inc. 2211 North 1 st Street San Jose, CA 95131 1-855-489-0343
Claims Administrator	See Appendix B
Agent for Service of Legal Process	PayPal Holdings, Inc. 2211 North 1 st Street San Jose, CA 95131 Legal process may be served on the Plan Administrator. Any legal process served in connection with the Plan will be deemed to be given if (1) it is in writing, (2) it is sent via messenger service, delivery service or U.S. mail with first class postage prepaid to the address specified above, and (3) the person serving legal process has written confirmation or evidence of delivery, as applicable, to the address specified above.
Plan Year	Calendar year ending December 31
Contribution Sources	Employer's general assets and participant contributions
No Trust	The Plan does not use a trust and therefore does not have any trustees.
Eligibility for Participation and Benefits	The Plan's requirements for participation and benefits are set forth in Sections 2 and 3 and/or in the benefit program materials for each benefit program.
Loss of Eligibility and Benefits	The circumstances which could result in disqualification, ineligibility, or denial, loss, forfeiture, suspension, offset, reduction, or recovery of benefits, are set forth in Sections 3 and 11 and in the benefit program materials for each benefit program.
Summary of Benefits	The benefits provided under this Plan are summarized in the benefit program materials for each benefit program. To the extent that any benefit program includes access to a provider network, the provider network is described generally in the applicable benefit program materials. The providers in the network may be listed on a separate document—if so, it will be provided to you automatically and free of charge.

QMCSOs	The procedures governing QMCSOs are available from the Plan Administrator upon written request, free of charge.
Claims and Appeals	Each benefit program (and/or its benefit program materials) describes the claims and appeals procedures applicable to benefits provided by the benefit program. If a benefit program does not have claims and appeals procedures, or if its claims and appeals procedures do not comply with ERISA Section 503, then the claims procedures set forth in Section 8 shall apply.
Further Information Inspection and Copy of Plan	You may obtain further information about the Plan by contacting the Plan Administrator. The Company will make the Plan and all related documents incorporated herein by reference available for inspection at its offices at no cost upon reasonable request. Upon reasonable notice and written request, a copy of this Plan may be obtained from the Plan Administrator. The Plan Administrator may make a reasonable charge for copies.

Appendix D: HIPAA Privacy and Security

1. Health Insurance Portability and Accountability Act of 1996

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended, imposes obligations on group health plans with respect to protected health information (PHI) and electronic protected health information (e-PHI) within the meaning of 45 CFR Parts 160 and 164 (the “HIPAA regulations”).

2. Plan Subject to HIPAA

The Plan is a “hybrid entity” within the meaning of HIPAA. The Plan elects to provide the privacy and security protections required by HIPAA only to the Covered Components. A “Covered Component” means each benefit program that, if it were a separate employee benefit plan, would be a “covered entity” within the meaning of HIPAA.

3. Uses and Disclosures of PHI

The Company may use or disclose PHI pursuant to this Section, which may be further limited by the Company’s HIPAA policies and procedures.

- (a) Permitted Uses and Disclosures. The Company may use and disclose any PHI obtained pursuant to this Appendix D only for the purposes of administrative functions that the Company performs for or on behalf of a Covered Component.
- (b) Required Uses and Disclosures. The Company is required to use and/or disclose PHI: (i) to an individual, when requested under and required by 45 C.F.R. § 164.524 in order to provide an individual with access to his or her own PHI; (ii) to an individual, when requested under and required by 45 C.F.R. § 164.528 in order to provide an individual with an accounting of disclosures of that individual’s PHI; and (iii) when required by the Secretary of the Department of Health and Human Services or those acting under the authority or at the direction of the Secretary to investigate or determine the Plan’s compliance with HIPAA.

4. Restriction on Plan Disclosure of PHI to the Plan Sponsor

Neither the Plan nor any of its business associates, health insurance issuers, or HMOs, will disclose PHI to the Company except upon the Plan’s receipt of the Company’s certification that the Plan has been amended to incorporate the agreements of the Company under Section 6 below, except as otherwise permitted or required by law. A copy of this Plan document may serve as such certification.

5. Privacy Agreements of the Plan Sponsor

- (a) The Company will not use or further disclose participants’ PHI other than (i) as permitted or required by the Plan document (which may be further limited by the provisions of a benefit package or by the Company’s HIPAA policies and procedures), or (ii) as required by law;
- (b) The Company will ensure that any of its agents, including a subcontractor, to whom it provides participants’ PHI agree to the restrictions and conditions that apply to the Company with respect to such information;
- (c) The Company will not use or disclose participants’ PHI (i) for employment-related actions and decisions, (ii) in connection with a non-Covered Component, or (iii) in connection with any employee benefit of the Company;
- (d) Promptly upon learning of any use or disclosure of participants’ PHI that is inconsistent with the uses or disclosures allowed under this Appendix D, the Company will report such inconsistent use or disclose to the applicable Covered Component;
- (e) The Company will make PHI available to the participant who is the subject of the information, in accordance with 45 C.F.R. § 164.524;
- (f) The Company will make participants’ PHI available for amendment, and will amend participants’ PHI, in accordance with 45 C.F.R. § 164.526;

- (g) The Company will make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. § 164.528;
- (h) The Company will make its internal practices, books, and records relating to the use and disclosure of participants' PHI available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance with 45 C.F.R. Parts 160-64;
- (i) If feasible, the Company will return or destroy all participants' PHI that the Company maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made; except that, if such return or destruction is not feasible, the Company agrees to limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
- (j) The Company agrees to require that there is adequate separation between the Plan and the Company by implementing the terms of (1) through (3), below:
 - (1) Employees With Access to PHI: The following employees or other members of the Company's workforce are the only individuals that may be given access to participants' PHI by the Company:
 - (a) PayPal Holdings, Inc. Employee Benefits Department (including the Vice President, Global Benefits or its equivalent position);
 - (b) Human Resource Managers or other staff responsible for referring participants to the PayPal Holdings, Inc. Employee Benefits Department for investigation of questions and assistance with resolution; and
 - (c) PayPal Holdings, Inc. Privacy Officer.
 - (2) Use Limited to Plan Administration: The access to and use of participants' PHI by the individuals described in (1) above is limited to Plan Administration functions as defined in HIPAA regulation 45 C.F.R. § 164.504(a) that are performed by the Company for the Covered Components of the Plan.
 - (3) Mechanism for Resolving Noncompliance: If the Company or any other person(s) responsible for monitoring compliance determines that any person described in (1) above has violated any of the restrictions of this Appendix D, of HIPAA, or of the Company's HIPAA policies and procedures, then such individual shall be subject to disciplinary action and sanctions in accordance with the Company's standard disciplinary policies and procedures, as those policies and procedures may be amended from time to time. The Company shall arrange to maintain records of such violations along with the persons involved, as well as sanctions, disciplinary, and corrective measures taken with respect to each incident. The Company will promptly report any such violation to the Covered Component, and will cooperate with the Covered Component in order to correct the violation, impose appropriate disciplinary action or sanctions on each person causing the violation, and mitigate any negative effect of the violation on any participant the privacy of whose PHI may have been compromised by the violation.

6. Security Agreements of the Plan Sponsor

The Company agrees it will:

- (a) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of a Covered Component;
- (b) Ensure that the adequate separation required by 45 C.F.R. § 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;
- (c) Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information;
- (d) Report to the Covered Component any security incident of which it becomes aware. "Security incident" has the meaning set forth in 45 C.F.R. § 164.304; and

- (e) Upon request from the Covered Component, provide information to the Covered Component on unsuccessful unauthorized access, use, disclosure, modification or destruction of e-PHI to the extent such information is available to the Company.

7. PHI and e-PHI not Subject to the Provisions of Appendix D

Notwithstanding the foregoing, the terms of this Appendix D shall not apply to uses or disclosures (i) of PHI released pursuant to an authorization that complies with 45 C.F.R. §§ 164.504(f)(1)(i) and 164.508; or (ii) in other circumstances as permitted by the HIPAA regulations.

8. Definitions

All capitalized terms within this Appendix D not otherwise defined by the provisions of this Appendix D shall have the meanings given them in the Plan or, if no other meaning is provided in the Plan, the term shall have the meaning provided under HIPAA. Terms that are defined in HIPAA and used in this Appendix D that are not capitalized shall have the meanings set forth in HIPAA.

9. Minimum Necessary

The Company will make reasonable efforts to limit its use or disclosure of PHI to the minimum information necessary to accomplish the intended purpose of the use or disclosure. When requesting PHI from another party, the Company will make reasonable efforts to limit its request to the minimum information necessary to satisfy the purpose of the request.

10. Employer's Certification of Compliance

Neither a Covered Component nor any health insurance issuer or business associate providing services to a Covered Component will disclose participants' PHI to the Company unless the Company certifies that the Plan includes the terms of this Appendix D and that the Company agrees to abide by this Appendix D.

11. Disclosure to Company

Any use or disclosure of PHI to the Company pursuant to this Section must be in accordance with the policies and procedures of the Covered Component and of the Company.

- (a) For the purpose of conducting administrative functions on behalf of a Covered Component, which functions must be consistent with HIPAA and the applicable Notice of Privacy Practices, the Company shall be entitled to receive PHI from: (i) a Covered Component; (ii) any business associate of a Covered Component; (iii) any person or entity that contracts with such business associate; (iv) any person or entity that contracts with the Company to provide services to or on behalf of the Covered Component; (v) any health insurer or health insurance issuer or HMO that provides health benefits coverage or services to or on behalf of the Covered Component; (vi) any health care clearinghouse that provides services to or on behalf of the Plan or with respect to participants; and (vii) any other person or entity that maintains, or has the authority to direct the disclosure of, PHI related to any participant.
- (b) Notwithstanding the foregoing, PHI shall not be disclosed to the Company: (i) for the purpose of employment related actions or decisions; (ii) in connection with a non-Covered Component; or (iii) in connection with any other employee benefit of the Employer that is not offered under the Plan.
- (c) A Covered Component may disclose PHI to the Company if the PHI summarizes the claims history, claims expenses, or types of claims experienced by individuals under the Covered Component, provided that the information described in 45 C.F.R. § 164.514(b)(2)(i) has been deleted (except that geographic information need only be aggregated to the level of a five-digit zip code).
- (d) A Covered Component may disclose to the Company information on whether an individual is participating in a Covered Component or is enrolled or has disenrolled from a particular coverage option within a Covered Component.