This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.paypalbenefits.com or by calling 1-855-489-0343.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: $1,300 Individual* / $2,600 Family Non-Network: $2,100 Individual* / $4,200 Family Per calendar year. Does not apply to services listed below as "No Charge". *Doesn't apply if policy covers 2+ people	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there other deductibles for specific services?	No, there are no other deductibles.	You don't have to meet deductibles for specific service, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Medical- Network: $3,000 Individual* / $6,000 Family Non-Network: $5,000 Individual* / $10,000 Family *Doesn't apply if policy covers 2+ people	The out-of-pocket limit is the most you could pay during a calendar year for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balanced-billed charges, health care this plan doesn't cover, penalties for failure to obtain pre-notification for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	This policy has no overall annual limit on the amount it will pay each year.	The chart starting on page 2 describes specific coverage limits, such as limits on the number of office visits.
Does this plan use a network of providers?	Yes, this plan uses network providers. If you use a non-network provider your cost may be more. For a list of network providers, see www.myuhc.com or call1-844-298-2737.	If you use a network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your network doctor or hospital may use a non-network provider for some services. Plans use the term network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	No	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on Page 4. See your policy or plan document for additional information about excluded services.

Questions: Call 1-844-298-2737 or visit us at www.myuhc.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call the number above to request a copy.

- Copayments are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- Coinsurance is *your* share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan's allowed amount for an overnight hospital stay is $1,000, your coinsurance payment of 20% would be $200. This may change if you haven't met your deductible.
- The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. (This is called balance billing.)
- This plan may encourage you to use network providers by charging you lower deductibles, copayments and coinsurance amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% Coinsurance After Deductible	30% Coinsurance After Deductible	None
	Specialist visit	10% Coinsurance After Deductible	30% Coinsurance After Deductible	None
	Other practitioner office visit	10% Coinsurance After Deductible	30% Coinsurance After Deductible	Cost Share applies for only Manipulative (Chiropractic) Care. Up to 24 non-combined visits per calendar year. Non-participating provider plan payment maximum is $25 per visit. Additional chiropractic visits as authorized by the claims administrator if medically necessary.
	Preventive care/screening/immunization	No Charge	30% Coinsurance After Deductible	Includes preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	10% Coinsurance After Deductible	30% Coinsurance After Deductible	None
	Imaging (CT/PET scans, MRIs)	10% Coinsurance After Deductible	30% Coinsurance After Deductible	Non-network Advance Notification required

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.caremark.com.	Tier 1 - Your Lowest-Cost Option	Retail 10% Coinsurance ($150 Max) After Deductible Mail Order 10% Coinsurance ($450 Max) After deductible	30% Coinsurance After Deductible	High blood pressure, cholesterol, diabetes medication, and diabetes supplies are covered at 100%. $150 (Retail) or $450 (Mail Order) maximum per script.
	Tier 2 - Your Midrange-Cost Option	Retail 10% Coinsurance ($150 Max) After Deductible: Mail Order 10% Coinsurance ($450 Max) After deductible	30% Coinsurance After Deductible	$150 (Retail) or $450 (Mail Order) maximum per script.
	Tier 3 - Your Highest-Cost Option	Retail 10% Coinsurance ($150 Max) After Deductible: Mail Order 10% Coinsurance ($450 Max) After deductible	30% Coinsurance After Deductible	$150 (Retail) or $450 (Mail Order) maximum per script.
	Tier 4 - Additional High-Cost Option	Retail: N/A Mail Order: N/A	Retail: N/A Mail Order: N/A	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% Coinsurance After Deductible	30% Coinsurance After Deductible	None
	Physician/surgeon fees	10% Coinsurance After Deductible	30% Coinsurance After Deductible	None
If you need immediate medical attention	Emergency room services	10% Coinsurance After Deductible	10% Coinsurance After Deductible	Non-network Advance Notification required
	Emergency medical transportation	10% Coinsurance After Deductible	10% Coinsurance After Deductible	Non-network Advance Notification required
	Urgent care	10% Coinsurance After Deductible	30% Coinsurance After Deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% Coinsurance After Deductible	30% Coinsurance After Deductible	Non-network Advance Notification required
	Physician/surgeon fee	10% Coinsurance After Deductible	30% Coinsurance After Deductible	None

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	10% Coinsurance After Deductible	30% Coinsurance After Deductible	None
	Mental/Behavioral health inpatient services	10% Coinsurance After Deductible	30% Coinsurance After Deductible	Non-network Advance Notification required
	Substance use disorder outpatient services	10% Coinsurance After Deductible	30% Coinsurance After Deductible	None
	Substance use disorder inpatient services	10% Coinsurance After Deductible	30% Coinsurance After Deductible	Non-network Advance Notification required
If you are pregnant	Prenatal and postnatal care	10% Coinsurance After Deductible	30% Coinsurance After Deductible	None
	Delivery and all inpatient services	10% Coinsurance After Deductible	30% Coinsurance After Deductible	Non-network Advance Notification required

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	10% Coinsurance After Deductible	30% Coinsurance After Deductible	Up to 120 visits per calendar year. Prior authorization is required. Non-network Advance Notification required
	Rehabilitation services	10% Coinsurance After Deductible	30% Coinsurance After Deductible	Up to 24 visits per calendar year for physical and occupational therapy, additional visits as authorized by the claims administrator if medically necessary. Up to 100 visits for speech therapy per calendar year applying for developmental delay; and an additional 60 visits applicable to injury or organic disease.
	Habilitation services	10% Coinsurance After Deductible	30% Coinsurance After Deductible	Up to 24 visits per calendar year for physical and occupational therapy, additional visits as authorized by the claims administrator if medically necessary. Up to 100 visits for speech therapy per calendar year applying for developmental delay; and an additional 60 visits applicable to injury or organic disease.
	Skilled nursing care	10% Coinsurance After Deductible	30% Coinsurance After Deductible	Up to 120 days per calendar year combined with Hospital Skilled Nursing Facility Unit. Non-network Advance Notification required
	Durable medical equipment	10% Coinsurance After Deductible	30% Coinsurance After Deductible	None
	Hospice service	10% Coinsurance After Deductible	30% Coinsurance After Deductible	Non-network Advance Notification required

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-network Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	None
	Glasses	Not Covered	Not Covered	None
	Dental check-up	Not Covered	Not Covered	Dental accidents are covered under your medical plan. For dental care call Delta Dental at 1-800-765-6003

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Child dental check-up
- Child routine vision exam (i.e. refraction)
- Child vision glasses
- Non-emergency care when traveling outside the U.S.

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture limitations may apply
- Bariatric Surgery limitations may apply
- Chiropractic care limitations may apply
- Hearing aids limitations may apply
- Infertility treatment limitations may apply
- Private-duty nursing limitations may apply
- Routine foot care limitations may apply

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.
For more information on your rights to continue coverage, contact the plan at 844-474-6641. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa , or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov .

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact us at 1-844-298-2737 or visit www.myuhc.com.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services:

- Spanish (Español): Para obtener asistencia en Español, llame al www.myuhc.com.
- Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa www.myuhc.com.
- Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** www.myuhc.com.
- Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' www.myuhc.com.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

If other than individual coverage, the Patient Pays amount may be more.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: $7,540
- Plan pays: $5,470
- Patient pays: $2,070

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	$7,540

Patient pays:

Deductibles	$1,300
Copays	$0
Coinsurance	$620
Limits or exclusions	$150
Total	$2,070

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: $5,400
- Plan pays: $2,320
- Patient pays: $3,080

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	$5,400

Patient pays:

Deductibles	$1,300
Copays	$0
Coinsurance	$1,700
Limits or exclusions	$80
Total	$3,080

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example Show

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ No. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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