PayPal Holdings, Inc.
UHC CDHP Plan w/HSA
Medical Benefit Summary

UnitedHealthcare

Effective: January 1, 2017

	Participating Providers	Non-Participating Providers
Calendar Year Medical Deductible	$1,300 per individual / $2,600 per family	$2,100 per individual / $4,200 per family
Calendar Year Out-of-Pocket Maximum	$3,000 per individual / $6,000 per family	$5,000 per individual / $10,000 per family
Lifetime Benefit Maximum	None	
Covered Services	**Member Coinsurance**	
OUTPATIENT PROFESSIONAL SERVICES	**Participating Providers**	**Non-Participating Providers**
Professional (Physician) Benefits		
Physician and specialist office visits	10% after the deductible	30% after the deductible
Outpatient diagnostic x-ray, imaging, pathology, laboratory and other testing services	10% after the deductible	30% after the deductible
Radiological and nuclear imaging (CT scans, MRIs, MRAs, PET scans and cardiac diagnostic procedures utilizing nuclear medicine)	10% after the deductible	30% after the deductible
Allergy Testing and Treatment Benefits		
Allergy testing, treatment and serum injections	10% after the deductible	30% after the deductible
Preventive Health Benefits		
Preventive health services (as required by applicable Federal law)	Plan covers 100% no deductible	30% after the deductible
OUTPATIENT FACILITY SERVICES		
Outpatient surgery performed at a free-standing ambulatory surgery center	10% after the deductible	30% after the deductible
Outpatient surgery performed in a hospital or hospital affiliated ambulatory surgery center	10% after the deductible	30% after the deductible
Outpatient services for treatment of illness or injury and necessary supplies (except as described under "Rehabilitation Benefits" and "Speech Therapy Benefits")	10% after the deductible	30% after the deductible
Outpatient diagnostic x-ray, imaging, pathology, laboratory and other testing services	10% after the deductible	30% after the deductible
Radiological and nuclear imaging (CT scans, MRIs, MRAs, PET scans and cardiac diagnostic procedures utilizing nuclear medicine)	10% after the deductible	30% after the deductible
Bariatric surgery (prior authorization is required; medically necessary surgery for weight loss, for morbid obesity only)	10% after the deductible	30% after the deductible
HOSPITALIZATION SERVICES		
Hospital Benefits (Facility Services)		
Inpatient physician services	10% after the deductible	30% after the deductible
Inpatient non-emergency facility services (semi-private room and board, and medically necessary services and supplies, including subacute care)	10% after the deductible	30% after the deductible
Bariatric surgery (prior authorization is required; medically necessary surgery for weight loss, for morbid obesity only)	10% after the deductible	30% after the deductible

Inpatient Skilled Nursing Benefits (Coverage limited to 120 days per member per benefit period, for hospital/free-standing skilled nursing facility services.)		
Free-standing skilled nursing facility	10% after the deductible	10% after the deductible
Skilled nursing unit of a hospital	10% after the deductible	30% after the deductible
EMERGENCY HEALTH COVERAGE		
Emergency room services not resulting in admission	10% after the deductible	10% after the deductible
Emergency room services resulting in admission (when the member is admitted directly from the ER)	10% after the deductible	10% after the deductible
Emergency room physician services	10% after the deductible	10% after the deductible
AMBULANCE SERVICES		
Emergency or authorized transport (ground or air)	10% after the deductible	10% after the deductible
PRESCRIPTION DRUG COVERAGE		
Outpatient Prescription Drug Benefits	**Carved out to Caremark 1- 844-287-1297**	
PROSTHETICS/ORTHOTICS		
Prosthetic equipment and devices	10% after the deductible	30% after the deductible
Orthotic equipment and devices	10% after the deductible	30% after the deductible
DURABLE MEDICAL EQUIPMENT		
Breast pump	Plan covers 100% no deductible)	30% after the deductible
Other durable medical equipment	10% after the deductible	30% after the deductible
Wigs	10% after the in-network deductible	10% after the in-network deductible
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES		
Inpatient hospital services	10% after the deductible	30% after the deductible
Residential care	10% after the deductible	30% after the deductible
Inpatient physician services	10% after the deductible	30% after the deductible
Routine outpatient mental health and substance abuse services (includes professional/physician visits)	10% after the deductible	30% after the deductible
Non-routine outpatient mental health and substance abuse services (includes electroconvulsive therapy, intensive outpatient programs, office-based opioid treatment, partial hospitalization program, psychological testing and transcranial magnetic stimulation)	10% after the deductible	30% after the deductible
Non-routine outpatient mental health and substance abuse services (includes behavioral health treatment)	10% after the deductible	30% after the deductible
HOME HEALTH SERVICES		
Home health care agency services (up to 120 visits per Calendar Year)	10% after the deductible	30% after the deductible
Home infusion/home injectable therapy and infusion nursing visits provided by a home infusion agency	10% after the deductible	30% after the deductible
HOSPICE PROGRAM BENEFITS		
Routine home care	10% after the deductible	30% after the deductible
Inpatient respite care	10% after the deductible	30% after the deductible
24-hour continuous home care	10% after the deductible	30% after the deductible
Short-term inpatient care for pain and symptom management	10% after the deductible	30% after the deductible
CHIROPRACTIC BENEFITS		
Chiropractic spinal manipulation (up to 24 visits per Calendar Year. Non-Participating provider plan payment maximum up to $25 per visit)	10% after the deductible	30% after the deductible
ACUPUNCTURE BENEFITS		
Acupuncture services (up to 24 visits per Calendar Year. Non-Participating provider plan payment maximum up to $25 per visit)	10% after the deductible	30% after the deductible
REHABILITATION and HABILITATION BENEFITS (Occupational, Physical, and Speech Therapy)		
Office location (24 visits per calendar year combined with physical therapy and speech therapy, Combined INN and OON. Additional visits may be granted with medical review.)	10% after the deductible	30% after the deductible

PREGNANCY AND MATERNITY CARE BENEFITS		
Prenatal and postnatal physician office visits (when billed as part of global maternity fee including hospital inpatient delivery services)	10% after the deductible	30% after the deductible
Abortion services(	10% after the deductible	30% after the deductible
FAMILY PLANNING BENEFITS		
Counseling and consulting (includes insertion of IUD, as well as injectable and implantable contraceptives for women)	Plan covers 100% no deductible)	30% after the deductible
Tubal ligation	Plan covers 100% no deductible)	30% after the deductible
Infertility services (Limited to a plan payment maximum of $10,000 per lifetime; Services to diagnose and treat the cause of infertility are covered under this benefit however are not included in the $10,000 plan payment maximum. Medical and Pharmacy benefits have separate lifetime maximums. Refer to your prescription drug plan for any prescription drug maximums.	10% after the deductible	30% after the deductible
Vasectomy (an additional facility copayment may apply when services are rendered in a hospital or outpatient surgery center)	10% after the deductible	30% after the deductible
HEARING AID BENEFITS		
Audiological evaluations	10% after the deductible	30% after the deductible
Hearing Aid instrument and ancillary equipment	10% after the deductible	30% after the deductible
DIABETES CARE BENEFITS		
Devices, equipment, and non-testing supplies (for testing supplies see Outpatient Prescription Drug Benefits)	10% after the deductible	30% after the deductible
Diabetes self-management training	10% after the deductible	30% after the deductible