

PayPal Section 125 Plan
Spending Accounts Benefits Program Summary
As of January 1, 2024

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Introduction

This is a summary plan description (“SPD”) as of January 1, 2024, for the PayPal Spending Accounts Benefits Program (“Program”) provided under the PayPal Section 125 Plan (“Plan”) sponsored by PayPal Holdings, Inc. (“PayPal”). The Program is comprised of:

- Two Health Care Spending Accounts (HCSAs):
 - 1) General HCSA - for employees who *do not* make or receive contributions toward a Health Savings Account. In the Plan, the General HCSA is referred to as the General Purpose Health Care Flexible Spending Account or the General Purpose Health Care FSA; and
 - 2) Limited Purpose HCSA - for employees who make or receive contributions toward a Health Savings Account, including employees who are enrolled in the Meritain Health CDHP with HSA Plan (CDHP). In the Plan, the Limited Purpose HCSA is referred to as the Limited Purpose Health Care Flexible Spending Account or the Limited Purpose Health Care FSA.
- The Dependent Care Spending Account (DCSA).

Throughout this SPD, these three accounts are collectively called “Spending Accounts”.

This SPD is a part of, and is meant to be read alongside, the PayPal Holdings, Inc. Health and Welfare Benefits Plan Document and Summary Plan Description (the “Welfare Plan”). Details regarding how the Plan and Program works are set forth in the Plan document, so for specific details regarding the Plan, refer to the Plan document. Note, however, that although the DCSA is described in this document for convenience, the DCSA is not subject to the Employee Retirement Income Security Act of 1974, as amended (“ERISA”) or ERISA’s summary plan description requirements. Additionally, please note that this SPD does not address the Plan’s Premium Conversion Benefit or Health Savings Account Benefit.

Read this SPD and the Welfare Plan SPD carefully so that you understand the provisions of the Plan and the benefits you will receive. This SPD describes the Plan’s HCSA and DCSA benefits and obligations as contained in the Plan document, which governs the operation of the Plan. The Plan document is written in more technical language. Please note that if the non-technical language in this SPD and the legal language of the Plan document conflict, the Plan document will always govern the Plan. If you wish to receive a copy of the Plan document or have any questions about the Plan, please contact the Plan Administrator. Please refer to the “**General Information About the Plan**” section of this SPD for the Plan Administrator’s contact information.

What Is A Spending Account?

The HCSAs and the DCSA are PayPal-sponsored programs that allow you to pay for eligible medical and dependent care expenses. Contributions to the Spending Accounts are deducted from your paycheck on a pre-tax basis – before federal income, payroll (Medicare and Social Security taxes), and in many cases state and local taxes, are taken out.

Amounts contributed to HCSAs may be used only for eligible medical expenses. Amounts contributed to the DCSA may be used only for eligible dependent care expenses.

How Do The Spending Accounts Save Me Money?

The Spending Accounts may save you money on payroll and income taxes. The tax savings, if any, are reflected in your pay and depend on your particular tax situation. For general information, you may want to refer to Internal Revenue Service (IRS) Publications 502 and 503 (at www.irs.gov (click on the “Forms and Publications” link)) or consult your tax advisor for more details.

The Spending Accounts may save you money on your taxes if you:

- Carefully estimate your health care and/or dependent care expenses.
- Adjust your annual Spending Account election(s) during Annual Enrollment to reflect your estimated expenses for the next Plan Year (January 1 – December 31).
- Submit claims on time. The deadline for filing Spending Account claims is April 30 of the following Plan Year. See “**How Do I File Claims?**”
- Please note that PayPal does not provide tax or financial advice. The example below is provided for illustrative purposes only, and you are solely responsible for the tax implications of the benefits and coverages you receive.

Example: How a Health Care Spending Account Can Help Save You Money

To illustrate how a HCSA can help save you money by reducing taxes, let's look at an example.

In this scenario, an unmarried PayPal employee named Leslie is enrolled in Kaiser and Delta Dental. She estimates that her combined out-of-pocket medical, dental and other health care expenses will be about \$200 per month in the next year. Thus, she elects to contribute \$2,400 (\$200 x 12 months) to the General HCSA in the next Plan Year in order to pay for these expenses on a pre-tax basis.

Leslie's Financials	With HCSA Contributions	Without HCSA Contributions
Monthly gross earnings	\$4,000.00	\$4,000.00
Monthly pre-tax HCSA contributions	-\$200.00	-\$0.00
Monthly taxable earnings	\$3,800.00	\$4,000.00
Monthly taxes*	\$1,544.70	\$1,626.00
Monthly earnings after taxes	\$2,255.30	\$2,374.00
Monthly after-tax expenses	-\$0.00	-\$200.00
Monthly spendable earnings	\$2,255.30	\$2,174.00
	\$81.30 per month (\$975.60 per year) more in spendable income with HCSA contributions	

*This example assumes 40.65% tax bracket (25% federal, 7.65% FICA and Medicare, and 8% California tax). Your actual tax savings amount will vary according to your tax rate and deductions.

As you can see, Leslie has more spendable income because her pre-tax Spending Account deductions lowered her taxable income and allowed her to pay for her eligible expenses with untaxed money.

How Do The Spending Accounts Affect My Social Security Benefits?

You do not pay Social Security taxes on the pre-tax dollars you use to pay for coverage under the Plan. As a result, the earnings used to calculate your Social Security benefits at retirement will not include these contributions. This could result in a small reduction in the Social Security benefit you receive at retirement. However, your savings on current taxes under the Plan may counteract any eventual reduction in Social Security benefits. Contact your qualified tax advisor for more information.

Who Can Participate In The Spending Accounts?

In general, you can participate in the Spending Accounts if you are regularly scheduled to work 20 hours or more per week for PayPal. Independent contractors, leased workers, seasonal, casual or temporary workers (e.g., individuals paid by an employment agency or temporary staffing firm), and interns are not eligible to participate in the Plan. Any person who is not treated as a common law employee of PayPal for income and employment tax withholding purposes, regardless of any subsequent determination of an individual's legal employment status, shall not be eligible to participate in the Plan. You are not eligible for the HCSA unless you are also eligible to participate in a group health plan sponsored by PayPal. For further information regarding who is eligible to participate in the Spending Accounts, please see the Plan document.

REMINDER: You must verify your spouse, domestic partner, and child(ren) if you enroll them in PayPal's medical, dental, or vision plans.

If you enroll or add your eligible spouse, domestic partner, or child(ren) to PayPal's medical, dental, or vision plans, you must timely provide documentation demonstrating the relationship. You will be provided a list of information you must provide to document the relationship. You have 45 days to submit the documentation. If you do not submit the required documentation by the stated deadline, or if you fail to demonstrate that the individual has the stated relationship, then coverage for the eligible spouse, domestic Partner, and/or Child(ren) will end on the last day of the month in which the verification failure occurs. For more information, contact Dependent Verification Center at 1-844-474-6641 or login to [YBR](#).

When Can I Enroll In A Spending Account?

Each year at Annual Enrollment (held in the fall), or when you otherwise become eligible to be covered under the Spending Accounts, you may enroll in a HCSA and/or the DCSA. At the time of enrollment, you decide what your annual contribution to the Spending Accounts will be, based on your personal circumstances and subject to the limitations discussed below.

Elections made during Annual Enrollment are effective the following January 1. You must re-enroll each year during the Annual Enrollment for the HCSA and/or DCSA. If you qualify for a carryover of HCSA funds from 2023 into 2024, you do not have to complete an election form to use carryover funds, but you must complete an election form to contribute additional amounts to your HCSA in 2024.

If you elect to participate in the HCSA for a Plan Year, have amounts available to carry over to the subsequent Plan Year, do not elect to participate in the HCSA for the subsequent Plan Year, but are otherwise eligible to participate in the HCSA, you will be deemed to have elected to participate in an applicable HCSA for the subsequent Plan Year solely for purposes of carrying over available unused HCSA contributions.

When Does Coverage Begin?

Coverage for eligible employees will begin on their hire date (provided that they enroll within 31 days of their hire date in accordance with the procedures described in the Plan); or if an eligible employee does not elect coverage at the time of initial eligibility, on the first day of the Plan Year or following a status change event with respect to which the eligible employee elects coverage in accordance with the procedures described in the Plan. Your first contribution will be deducted from your paycheck following the date you begin to participate in the Program.

When Does Coverage End?

Your coverage ends if one of the following events occurs:

1. Your employment with PayPal terminates or you otherwise cease to be an eligible employee (including as a result of your failure to timely submit the required contributions toward coverage).
2. You experience a status change event that allows you to cease being a participant in the General HCSA, the Limited Purpose HCSA, or the DCSA and you elect to terminate participation.
3. PayPal terminates the Plan, the General HCSA, the Limited Purpose HCSA, or the DCSA.
4. Your enrollment will automatically end at the end of the Plan Year (December 31). However, you will automatically carryover certain unused HCSA funds to the following Plan Year in accordance with the Plan document as long as you are an eligible employee on January 1 of the following Plan Year or have elected continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") with respect to your HCSA. For more information about the carry-over of HCSA funds see the HCSA section of this Summary.

Refer to "Who Can Participate In The Spending Accounts?" for information regarding terminations relating to failing to complete the verification process.

Participation in the Plan shall terminate on the earliest of:

- the last day of the month in which the Participant ceases to be an eligible employee or last satisfies the participation requirements;
- the final due date for the Participant's contributions for the cost of coverage, if not timely paid by the Participant;
- the end of the Plan Year for purposes of General Purpose Health Care FSA, the Limited Purpose Health Care FSA and Dependent Care FSA, unless a new election (or deemed election) is made in the time and manner provided by the Plan Administrator for the subsequent Plan Year;
- the end of the Plan Year, unless the Employee elects (or is deemed to elect) coverage under any Benefit Program;
- the date of termination of the Plan, the General HCSA, the Limited Purpose HCSA, or the DCSA;
- the date following a Status Event when an individual elects to discontinue participation in the General HCSA, the Limited Purpose HCSA, or the DCSA; or
- taking unapproved leave of absence: last day of the calendar month.

What Are The Rules For Changing My Elections?

You can generally change the amount of your annual Spending Account elections only during Annual Enrollment. In addition, certain status change events may allow you to start or stop participating or change the amount of your annual election during the Plan Year. In this circumstance, you must request an election change within 31 days (or 60 days for certain special enrollment events as described in the Welfare Plan and the Plan) of the event. Generally, mid-year election changes for your Spending Account elections are only allowed if you experience one of the following events and, for certain events, your requested change is consistent with that event:

- A change in legal marital status.
- A change in your number of dependents.
- A change in dependent's eligibility status.
- A change in residence.
- A change in your employment status.
- You receive a judgment, decree, or order requiring or relieving coverage.
- Your or one of your dependents become entitled to Medicare or Medicaid (applies only to the HCSA, not to the DCSA).
- For the DCSA, a change in dependent care service providers or significant cost increase imposed by a provider so long as the provider who is increasing the cost is not a relative of yours.

There are detailed requirements that must be met for you to change your elections during the Plan Year. Please see the Plan document and the Welfare Plan for more information on changing your elections.

If approved and permitted by the Plan, the election change will be effective on the date the change is received by the Plan Administrator, the date of birth, adoption, or placement for adoption if the Participant is exercising a HIPAA special enrollment right, or such earlier date as required under law. Any change in your deductions (if applicable) will be effective the first pay period following the change in election. You must request election changes in writing (or by electronic means in a manner acceptable to the Plan Administrator) within 31 days (60 days for a Participant exercising a HIPAA special enrollment right based on gain or loss of CHIP or Medicaid assistance) of the applicable event.

What If I Go On An Approved Paid Leave of Absence?

HCSA

If you go on an approved paid leave of absence, you will continue to participate in your HCSA and your pre-tax contributions will continue to be deducted from your pay for the current Plan Year. While on leave, you may continue to submit claims for eligible expenses to your HCSA through the claim filing deadline.

DCSA

Dependent care expenses are not eligible for reimbursement while you are on a leave (paid or unpaid). Any expenses you incur after you begin your leave will be ineligible for reimbursement. If you elected DCSA and you begin leave and return from leave during the same Plan Year, you will need to contact YBR within 31 days of your return from leave to have coverage under the DCSA. You will be able to resume participating in the DCSA upon return from leave. If you elect DCSA during the annual enrollment period but take a leave of absence prior to the new Plan Year in which your DCSA would go into effect, then you are treated as being ineligible for the DCSA, your DCSA election will be void, and you will need to contact YBR within 31 days of your return from leave to have coverage under the DCSA.

What If I Go On An Approved Unpaid Leave of Absence?

HCSA

If you go on an approved unpaid leave of absence, participation in your HCSA will continue unless you actively discontinue your coverage within 30 days of the commencement of the leave. If you discontinue your HCSA participation, any expenses incurred after your participation ends are not eligible for reimbursement, unless you are eligible for and elect COBRA.

You will be invoiced by YBR for any HCSA contributions due during an unpaid leave of absence. Your payments will be made on an after-tax basis. If you do not remit payment during the unpaid portion of your leave, your participation in the HCSA will end as of the date you last paid.

You will receive a letter outlining PayPal's process for administering benefits, and your options and obligations during leaves of absence when you begin a leave.

Note: if you are ordered or called to active military duty for a period in excess of 179 days or for an indefinite period of time, you may be able to elect a Qualified Reservist Distribution. Please contact YBR for more information.

DCSA

Dependent care expenses are not eligible for reimbursement while you are on a leave. Therefore, your coverage in your DCSA will end when you begin your leave. Any expenses you incur after you begin your leave will be ineligible for reimbursement. If you elected DCSA and you begin leave and return from leave during the same Plan Year, you will need to contact YBR within 31 days of your return from leave to have coverage under the DCSA. You will be able to resume participating in the DCSA upon return from leave. If you elect DCSA during the annual enrollment period but take a leave of absence prior to the new Plan Year in which your DCSA would go into effect, then you are treated as being ineligible for the DCSA, your DCSA election will be void, and you will need to contact the Benefits Administrator within 31 days of your return from leave to have coverage under the DCSA. You may continue to submit dependent care expenses incurred prior to your leave while you are on a leave of absence.

Adjustments for Leaves

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 (but not limited to) any payroll and tax withholding corrections.

What Happens When I Return To Work Following A Leave of Absence If My Participation Ended?

If your participation in a Spending Account was discontinued during a leave of absence and you return to work within the same Plan Year, the following rules generally apply:

- You must re-enroll in your HCSA or DCSA for the remainder of the Plan Year.

The length of your leave will affect your election options, as follows:

- If your leave is less than 30 days and you return to work during the same Plan Year, your HCSA annual election amount will remain the same. Your DCSA annual election will be recalculated as the annual election amount minus year-to-date contributions made for the current Plan Year divided by the remaining pay periods for the current Plan Year.
- If your leave is more than 30 days, you may make a new annual election (including an election not to participate) with a new monthly contribution amount for the remainder of the Plan Year.

In order to re-enroll in the Spending Accounts when you return from leave, you must notify YBR within 31 days of your return to active employment status, or you will not be able to re-enroll until the next Annual Enrollment.

If you experience certain status change events (e.g., you gain or lose a dependent) during your leave of absence, you may change your annual election under certain circumstances. There are detailed requirements that must be met for you to change your elections during the Plan Year. For more information, refer to the Plan document, as well as the "Making Changes to Your Elections" in the Welfare Plan.

Who Administers The Spending Accounts Program?

The PayPal Spending Accounts are administered by an outside claims administrator, HealthEquity:

HealthEquity
15 W Scenic Pointe Drive
Draper, UT 84020
1-866-346-5800
<https://my.healthequity.com>

When Can I Expect My Reimbursement?

The Plan includes detailed claims procedures and timelines for determining claims. However, in general, you can typically expect reimbursement within 7 business days of the date the claims administrator receives your reimbursement request. Please refer to the “**Health Care Spending Account**” and “**Dependent Care Spending Account**” sections for reimbursement methods.

How Do I Keep Track Of My Spending Account Claims?

You can check your Spending Account claims activity on the claims administrator’s website as well as sign up for email notification of all claims’ activity, including reimbursement status.

If The Spending Account Claims Administrator Accepts My Claims, Does This Assure The IRS Will, Too?

No. Although the Spending Account claims administrator makes an initial determination on eligibility for reimbursement, it is your responsibility to make sure that expenses you submit for reimbursement are eligible under the Spending Accounts. You are responsible for taxes and penalties associated with any ineligible expenses that may be discovered as a result of an IRS audit or other governmental actions.

Note that eligible expenses reimbursed from your Spending Accounts cannot be included in itemized deductions on your income tax return or reimbursed again by a health reimbursement account, including the PayPal Holdings, Inc. HRA Plan, or by any other group health plan. If you are a participant in the HRA Plan and have a balance in your HRA account, you must request reimbursement for medical care expenses from the HRA Plan first.

Nondiscrimination Requirements

In order to prevent the Program from being characterized as discriminatory under the Internal Revenue Code of 1986, as amended (“Code”) and therefore ineligible for favorable tax treatment, PayPal may reject or change any elections and/or may reduce contributions or benefits during the Plan Year. This means payroll deductions may be reduced, stopped, or reimbursements or contributions characterized as post-tax income as needed, as determined in PayPal’s sole discretion. You will be notified if your election requires an adjustment as a result of the Plan’s required nondiscrimination testing.

What If I Have Questions?

If you have questions, contact the Spending Account claims administrator or the Plan Administrator. Note that individual account information – such as contribution amounts, reimbursements, account balance, and claim status – is confidential.

Important Note

This SPD is not a guarantee of benefits. In particular:

- You may forfeit any Spending Account funds that remain in your account at the end of the Plan Year for which you have not submitted claims in accordance with the requirements described in this SPD (subject to any permissible carryover with respect to the HCSAs). Please refer to the “**Health Care Spending Accounts**” and “**Dependent Care Spending Account**” sections of this SPD for more information. Remember, this is only a summary of key provisions, so for full details you must consult the Plan document.
- PayPal may change the terms and conditions of the Spending Accounts at any time in its sole discretion.
- The Spending Accounts may be terminated by PayPal at any time in its sole discretion.

Health Care Spending Accounts

This section describes information specific to the Health Care Spending Accounts (HCSAs). There are two types of Health Care Spending Accounts:

- General HCSA.
- Limited Purpose HCSA.

The *General HCSA* allows you to pay on a pre-tax, salary reduction basis for eligible medical expenses incurred by you, your spouse, or your dependents that are not covered by your medical, dental, or vision plans or any other insurance or plan. Note that expenses for menstrual products, over-the-counter drugs and medicines without a prescription, as well as Personal Protective Equipment such as masks, hand sanitizer and sanitizing wipes for the primary purpose of preventing the spread of COVID-19, are reimbursable using your General HCSA funds.

The *Limited Purpose HCSA* is available to Meritain Health CDHP with HSA Plan (CDHP) participants and allows for reimbursement of eligible preventive care or dental and vision expenses not payable under the CDHP as well as post-deductible medical expenses including menstrual products, over-the-counter drugs and medicines without a prescription as well as Personal Protective Equipment such as masks, hand sanitizer and sanitizing wipes for the primary purpose of preventing the spread of COVID-19.

What Exclusions Apply To The General HCSA?

Due to federal rules, employees are not eligible to make or receive contributions to a Health Savings Account (HSA) if:

- they are enrolled in another “low deductible” plan that covers medical expenses; or
- they are covered by another plan, including a spouse’s medical plan, general purpose health care spending account, or a health reimbursement account that would cover or reimburse their medical expenses before the CDHP deductible is met.

Therefore, if you enroll in the CDHP with HSA, you may not enroll in the General HCSA. However, you may enroll in the Limited Purpose HCSA. Note: you may not participate in both the General HCSA and the Limited Purpose HCSA.

Before electing between the General HCSA and Limited Purpose HCSA, you should evaluate whether you are eligible to make contributions to an HSA. These rules are complex and this SPD does not include all the information you may need to consider in connection with HSA participation. For additional general information, you may want to refer to IRS Publication 969 available at www.irs.gov (click on the “Forms and Publications” link) or consult your personal tax advisor.

What Laws Govern The HCSAs?

The HCSAs are established under Code §§ 105 and 125, and the PayPal Section 125 Plan. The HCSAs are also group health plans under ERISA. It is the intention of PayPal that the HCSAs qualify as self-insured medical reimbursement plans within the meaning of Code § 105 and that the reimbursements which an employee receives under the HCSAs be eligible for exclusion from the employee’s income under Code §§ 105(b) and 125(a).

This document, together with the Welfare Plan, constitutes a summary plan description for the HCSAs as required under ERISA.

How Do The HCSAs Work?

After you enroll, the HCSAs generally work like this:

- The annual election that you specify when you enroll is deducted from your paychecks in equal amounts throughout the calendar year and credited to your HCSA.
- When you have an eligible medical expense, unless you use a debit card, you submit a claim form and an Explanation of Benefits (EOB), or detailed third-party receipt of services rendered, to the claims administrator. See “**How do I File Claims?**” for more information. The claims administrator sends you a reimbursement payment, either by direct deposit to your bank account, or by check.

What Are The Minimum And Maximum Contributions To A HCSA?

The maximum amount that you can contribute to the HCSA is subject to annual adjustments, in accordance with IRS guidance. You may contribute up to \$3,200 for the 2024 Plan Year; if both you and your spouse are PayPal employees, you may each contribute up to the annual limit per Plan Year. The maximum contribution is not reduced by any carryover amounts, as discussed further below. Although certain unused amounts may be carried over, it is still important that you estimate your health care expenses carefully. *You forfeit any contributions in excess of the permissible carryover amount that you don't claim for reimbursement* (See **“What is a Carryover And What Happens To HCSA Funds I Don't Use”**). The amount you elect to contribute to your HCSA for a Plan Year is available at all times during the Plan Year, properly reduced for prior reimbursements.

To participate in a HCSA, you must generally contribute a minimum of \$50 per year for the General HCSA and the Limited Purpose HCSA. A minimum contribution and carryover amount is not required to carryover funds.

Any adjustments to the maximum or minimum contribution amounts and to the carryover will typically be communicated during Annual Enrollment.

What Is A Carryover And What Happens To HCSA Funds I Don't Use?

For active employees or employees who have elected COBRA continuation coverage with respect to the current year HCSA, any HCSA balances as of the end of the 2024 Plan Year up to a maximum of \$640 (subject to future adjustments) will be carried over to your HCSA for the following year once the Plan's run-out period ends on April 30th, so long as a minimum of \$10 remains in your account as of the end of the 2024 Plan Year.

The amount remaining unused as of December 31 is the amount unused after medical expenses have been reimbursed at the end of the Plan's run-out period (April 30). A carryover does not count towards the maximum annual HCSA salary reduction election. Carryover amounts may not be cashed out or converted to any other taxable or nontaxable benefit. Because of the switch from Smart Choice to Health Equity, carryover amounts may not appear in your account until July 2024.

Unspent HCSA amounts of less than \$10 or in excess of the permissible carryover limit for the Plan Year will be forfeited.

If you have unspent General HCSA funds as of December 31 that would be carried over to the next Plan Year but elect to participate in the CDHP with HSA plan for that subsequent Plan Year, the carryover amount will be automatically credited to a Limited Purpose HCSA. However, you may continue to submit claims for general purpose medical expenses incurred during the preceding Plan Year until April 30 of the following Plan Year, to be reimbursed from your available General Purpose Health Care FSA amounts for the preceding Plan Year. In addition, you may elect prior to the beginning of a Plan Year to waive the carryover from the preceding Plan Year in accordance with procedures established by the Plan Administrator. If you waive the carryover, you may continue to submit claims for medical expenses incurred during the preceding Plan Year until April 30 of the following Plan Year, to be reimbursed from your available General Purpose Health Care FSA amounts. If you would like to waive the carryover, contact the Claims Administrator.

If you are otherwise eligible to participate in a HCSA for a Plan Year, and have amounts available for carryover from one Plan Year to the subsequent Plan Year, but do not make a HCSA election for that Plan Year, you will be deemed to have elected to participate in the HCSA for such subsequent Plan Year. Such deemed election is solely for and in the amount of the available carryover; you will not be able to make any contributions for such Plan Year. The deemed election is solely for the purpose of having carryover amounts available to reimburse you for medical expenses you incur as otherwise described in the Plan.

In accordance with the Code, PayPal may use forfeited funds to help pay administrative costs. Uncashed checks will also be treated as forfeitures after 6 months. The Plan document describes the ways forfeited amounts may be used.

You may not use money in your HCSA to pay dependent care expenses and vice versa. You may not switch money between the Spending Accounts.

Which Dependents' Expenses Are Eligible For Reimbursement?

HCSA reimbursement is available for the expenses of your eligible dependents as follows:

- Your legal spouse, unless legally separated.

- Your children up to age 26, or of any age if totally disabled (see Welfare Plan for more information on disabled children), including adopted children, children placed for adoption, stepchildren, and eligible foster children, if such individuals are eligible to receive tax-favored health benefits.
- Any other individual who qualifies as your tax dependent under federal law.

What General Rules Apply To The HCSAs?

Health care expenses must generally meet the statutory requirements for deductible medical expenses under Code § 213(d). General information about eligible expenses also can be found in IRS Publication 502 available at the IRS Website at www.irs.gov (click on the “Forms and Publications” link). However, IRS Publication 502 is not specific to this Plan or HCSAs, so you should consult your qualified tax advisor for specific questions, including the types of medical expenses that may be reimbursed.

Some basic guidelines for eligible HCSA expenses are:

- Expenses must be incurred during the Plan Year (January 1 through December 31) during which you have a HCSA account except as otherwise described in the section titled “What Is A **Carryover And What Happens To HCSA Funds I Don’t Use**”. You generally incur expenses when the care is provided, rather than when you are billed or when you pay for the care.
- If you enroll in a HCSA mid-year, expenses incurred before your effective date are not eligible for reimbursement.
- Expenses incurred after your participation in the HCSA ends aren’t eligible unless you have continued your HCSA coverage under COBRA. (See “**What If I Go on An Approved Unpaid Leave of Absence**” or “**What if I Terminate from PayPal**”.)

What Expenses Are Eligible Under The HCSAs?

The General HCSA may be used for medical expenses not paid or reimbursed by insurance or other sources, including deductibles, coinsurance, copays and expenses for drugs and medicines, as well as dental and vision expenses. The Limited Purpose HCSA may only be used for certain preventive care and post-deductible medical expenses as well as dental and vision expenses.

What HCSA Expenses Are Not Eligible For Reimbursement?

Health care expenses that do not meet the statutory requirements for medical care expenses under Code § 213(d) are not eligible for reimbursement. **Insurance premiums, including long-term care premiums, are not reimbursable under a HCSA.**

If your health care expenses are not clearly eligible, the claims administrator may ask you to submit additional information to help determine whether the reimbursement is allowed. In some cases, you may need a statement from your tax advisor verifying that the expense in question is eligible for reimbursement.

Note that there are differences in expenses that are eligible for tax deductions and expenses that are eligible under a HCSA. For additional information, consult your tax advisor. **You are responsible for making sure all expenses submitted for reimbursement under the HCSAs are eligible for reimbursement.**

How Do I File Claims?

You have access to your entire annual election amount and carryover amount (less prior reimbursements), regardless of your contributions to date during the Plan Year.

When you have incurred an eligible medical expense, you have two options:

1. You can use a General HCSA debit card (if provided to you) to pay for your eligible expense if you participate in the General HCSA; or
2. You can submit eligible claims to the claims administrator using a Health Care Claim Form, including a detailed third-party receipt of services rendered. Claims may be submitted online through the mobile app or website.

Once your claim form has been received and approved, the claims administrator will send you a reimbursement payment, either by direct deposit to your bank account or by check – depending on the reimbursement option you’ve selected. For more information, visit my.healthequity.com.

Order of Reimbursements

If you are a participant in the PayPal Inc. HRA Plan ("HRA"), a submitted claim will be processed and paid out of your HRA first. After you have used all of your HRA funds, claims will be processed and paid from your General HCSA or Limited Purpose HCSA, if funds are available in your General HCSA or Limited Purpose HCSA.

What If I Terminate From PayPal?

Your contributions to your HCSA continue as long as you remain on active pay status with PayPal unless you have a status change event that would permit you to discontinue your coverage. If you terminate employment with PayPal, participation in your HCSA ends as of the last day of the month in which you terminate from PayPal, unless you continue participation under COBRA. (See "**Can I Elect COBRA for a HCSA If I Stop Working for PayPal?**")

You may submit claims for HCSA eligible expenses incurred through the last day of the month in which you terminate. Expenses incurred after this date are not eligible for reimbursement unless you continue participation under COBRA.

For example, if you leave PayPal in August, your last contribution to your HCSA is taken from your final August paycheck. You can submit claims for HCSA eligible expenses incurred through August 31 (the date your participation ends).

What If I Return to Work at PayPal After Termination?

If you are rehired by PayPal and choose to re-enroll in a HCSA for the remainder of the Plan Year, you may do so within 30 days of your return to employment.

If you return to work within the same Plan Year, the length of your break in service from PayPal will affect your re-enrollment options, as follows:

- If you were terminated from PayPal less than 30 days prior to your re-hire date, your participation will be reinstated, and the monthly contribution must be the same as before your break in service*.
- If you were terminated from PayPal 31 days or more prior to your re-hire date, you may select a new annual contribution (or elect not to participate in the HCSA for the remainder of the Plan Year).

**If you experience certain status change events during your break in service that allow for a change in election (e.g., gain a new dependent) you may increase or decrease your election in accordance with the status change event.*

Can I Elect COBRA For A HCSA If I Stop Working for PayPal?

If your employment with PayPal terminates during the Plan Year, you may continue participation in a HCSA until the end of the Plan Year (December 31) if: (1) you have not filed claims against your entire annual elected contribution amount, and (2) you elect to continue coverage under COBRA. Note, however, that if you elect COBRA continuation coverage with respect to your HCSA and have a carryover balance as of December 31 of the year in which you terminate, you may continue to seek reimbursement from such carryover balance until such balance is depleted.

With COBRA, you make direct, after-tax payments to your HCSA. This provides the opportunity to be reimbursed for expenses incurred over the entire Plan Year.

You might consider COBRA if, for instance, you have a HCSA balance when you leave PayPal employment and you have surgery planned for later in the year. Remember, you can only claim expenses incurred while participating in a HCSA. So, for example, continuing participation through COBRA in this circumstance would allow you to claim eligible surgery-related expenses from a HCSA.

Following your termination of employment, the COBRA Administrator will send you a COBRA election notice explaining the procedure for continuing your participation under COBRA. If you don't receive this notice, please contact the COBRA Administrator. Please refer to the "**General Information About The Plan**" section of this SPD for the COBRA Administrator's contact information

For more information about COBRA, please see the Welfare Plan and the Plan.

HCSA Debit Card (General HCSA only)

The General HCSA features a debit card that you can use to pay for eligible medical expenses if you've chosen to contribute. As you use your prepaid debit card, eligible health care expenses will be deducted automatically from your account.

The debit card is not available to participants enrolled in the DCSA. Participants in the DCSA must submit Claim Forms or submit claims online to obtain reimbursements of qualifying expenses.

How the Debit Card Program Works

If you enroll in the HRA, HCSA, or Limited Purpose HCSA, you'll receive a package containing one debit card issued in your name, and information explaining the approved ways to use your card. You may request additional cards for your spouse and/or eligible dependent(s). The debit card for HRA, HCSA, and/or Limited Purpose HCSA is limited such that you are unable to use amounts contributed to one of those benefits to pay for expenses under another benefit.

The debit card remains active for up to three years as long as you are eligible to participate, you continue to participate in the HRA, HCSA, and/or Limited Purpose HCSA (including when you have carryover funds available in the HCSA), and you remain actively employed by PayPal.

Your card will be cancelled (deactivated) upon termination of your employment by PayPal or if you otherwise lose eligibility to participate, if you do not re-enroll in the HRA and General HCSA the following year and do not have any funds eligible for carryover to the General HCSA, or if your card has expired. The card can also be cancelled or deactivated for certain other reasons, such as if it is stolen or used for fraudulent purposes.

Important: Save your itemized receipts!

Because all HCSA debit card transactions must be verified as eligible health care expenses, you may be required to produce supporting documentation to validate your expenses. Regardless of how you pay for eligible health care expenses, make sure that you save all of your itemized receipts (including documentation evidencing the date of service, the name of the service provider, the name of the person receiving the service, the name of the product or service, and any amount paid by other coverage).

Validation of Debit Card Transactions

All debit card transactions must be validated electronically at the point of sale or by submitting paper documentation afterward. This process involves requesting itemized receipts or other supporting documentation from you to verify that the card transaction is for an eligible health care expense. You should retain your itemized receipts for all transactions, as they may be required for validation purposes.

Any ineligible expenses must be paid for with another form of payment. For a complete listing of eligible expenses and approved merchants, visit the HealthEquity website. If you use your debit card for any ineligible expenses, you will be required to repay the Plan for any improper payments made with your card.

Manual Claim Submission & Supporting Documentation

Manual claim submission and supporting documentation are sometimes required for the purchase of prescription drug or health care services or items that aren't validated automatically. These types of purchases are conditionally reimbursed, pending validation of the expenses.

What is the Claim and Appeal Process for Denied HCSA Claims?

After you submit your claim for reimbursement, the Claims Administrator will decide if the claim is eligible for reimbursement within a reasonable time. The Claims Administrator will determine whether your claim is payable or will be denied. The HCSA Claims Administrator will provide you with information about the appeals process if a claim is denied. Refer to Addendum 1 for information regarding the claims and appeals process. You should also refer to general claim and appeal procedures described in the Welfare Plan as well as the Plan document for complete details. All decisions and interpretations made by the Claims Administrator or Plan Administrator shall be final, conclusive and binding upon all persons and shall be given the greatest deference permitted by law.

Dependent Care Spending Account (DCSA)

This section describes information specific to the PayPal Dependent Care Spending Account (DCSA).

What Is The DCSA?

The DCSA allows you to pay on a pre-tax, salary reduction basis for eligible dependent care expenses, as described below.

The DCSA is established under Code §§ 129 and 125 and the PayPal Section 125 Plan. It is the intention of PayPal that the DCSA qualify as a self-insured dependent care assistance program within the meaning of Code § 129 and the reimbursements which an employee receives from the DCSA be eligible for exclusion from the employee's income under Code § 129(a). Although the DCSA is described in this document for convenience, it is not subject to ERISA.

How Does The DCSA Work?

After you enroll, the DCSA generally works like this:

- The amount you specify when you enroll is deducted from your pay in equal amounts throughout the calendar year and credited to your DCSA.
- When you have an eligible dependent care expense, you submit to the claims administrator a Dependent Care Claim Form and a detailed receipt of services rendered. See **“How Do I File Claims?”** for contact information.
- The claims administrator sends you a reimbursement payment, either by direct deposit to your bank account or by check.

What Is The Minimum Annual Contribution To The DCSA?

To participate in the DCSA, you must contribute a minimum of \$50.00 per year.

How Much Can I Contribute To My DCSA?

Your maximum annual contribution to the DCSA depends on your marital and income tax filing status, as indicated below. You are solely responsible for determining the amount you may contribute. For single participants, the maximum contribution is generally \$5,000 per year. For married participants, the maximum contribution is generally \$5,000 per year if filing tax returns jointly, and \$2,500 per year if filing tax returns separately. See the chart below for more information. *Note that spouses who both work (for PayPal or another employer) may contribute no more than \$5,000 per year in the aggregate to the DCSA and to any dependent care spending account maintained by another employer.* The table below is only a summary; the actual amount you may contribute will be determined pursuant to applicable law and the Plan document.

If You Are....	You May Contribute <i>the lesser of ...</i>
Single	\$5,000; or your annual income
Married, filing a joint tax return	\$5,000; your annual income; or your spouse's annual income
Married, filing separate tax returns	\$2,500; your annual income; or your spouse's annual income
Married and your spouse is physically or mentally incapable of caring for himself/herself <i>or</i> is a full-time student for at least 5 calendar months per year	\$250 per month (up to \$3,000 per year) for one qualifying dependent; or \$500 per month (up to \$5,000 per year) for <i>two or more</i> qualifying dependents

It's important that you estimate your dependent care expenses carefully, as you will forfeit any contributions you can't claim as described in the **“What Happens To DCSA Funds I Don't Use”** section below.

PayPal Contributions to the DCSA

If you are a non-exempt employee who elects to enroll in the DCSA, each pay period, PayPal will contribute an amount equal to 15% of the amount you elected to contribute to the DCSA. This contribution will be reflected in your DCSA account and will be reported on your Form W-2 for the year. The amount PayPal contributes is counted toward your maximum DCSA contribution for the year, outlined in the chart above, and your maximum contribution for the year will be reduced by the PayPal contribution attributable to the same year. Your payroll deductions and PayPal's contributions are made pro-rata based on your payroll schedule for the year. If both spouses or domestic partners are PayPal employees, each eligible employee receives the PayPal contribution.

For example, assume you are married filing jointly, elect a \$5,000 DCSA contribution for 2024, and are employed by PayPal for the entire year. PayPal will deduct \$4347 from your pay and you will receive a \$652 PayPal DCSA contribution for 2024.

PayPal will announce any change in the PayPal contribution levels during Open Enrollment for each upcoming Plan Year. PayPal reserves the right to modify, amend, or eliminate the PayPal DCSA contribution at any time and for any reason in its sole discretion.

If you move from a non-exempt to an exempt job classification, the PayPal DCSA contribution will cease as of the first pay period following your reclassification. If you move from an exempt to a non-exempt job classification, the PayPal DCSA contribution will begin as of the first pay period following your reclassification.

Who Can Participate In The DCSA?

In addition to the eligibility criteria outlined under “**Who Can Participate In The Spending Accounts?**”, to participate in the DCSA you must be:

- Single and working (or looking for work); or
- Married and:
 - Both you and your spouse work (or are looking for work);
 - You work and your spouse is a full-time student and attends classes outside the home at least five calendar months a year; or
 - You work and your spouse is mentally or physically disabled and unable to care for himself/herself.

Which Dependents' Expenses Are Eligible For Reimbursement?

The DCSA provides reimbursement for the eligible expenses of dependents who are, in general, your tax dependents and who:

- Live with you most of the time;
- Do not provide more than one-half of their own support; and
- Are under age 13, or are physically or mentally unable to care for themselves regardless of age, and live with you for more than half the tax year. This could include care for a disabled spouse or parent living with you that you are able to claim as a dependent on your tax return.

Special rules apply to children of divorced or separated parents. You can find more general information about the rules relating to children of divorced or separated parents in IRS Publication 503, available at www.irs.gov (click on the “Forms and Publications” link). Remember, you should consult with a qualified tax advisor if you have specific questions.

Which Expenses Are Eligible For Reimbursement?

Dependent care expenses must meet the statutory requirements of Code § 129. More general information about eligible expenses also can be found in IRS Publication 503 available at the IRS Website at www.irs.gov (click on the “Forms and Publications” link). Some basic general guidelines for eligible DCSA expenses are:

- Expenses must be incurred during the Plan Year (January 1 through December 31) or during the applicable grace period for that Plan Year (if applicable).

- For the 2023 Plan Year, qualifying dependent care expenses will be eligible for reimbursement using 2023 Plan Year DCSA funds if the expense is incurred during 2023 or between January 1, 2024 and March 15, 2024, which is the applicable grace period. Smart Choice can only accept claims for expenses incurred through December 31, 2023. Claims must be submitted to Smart Choice by April 30, 2024. All claims incurred during the grace period must be submitted to HealthEquity between July 1, 2024 and August 31, 2024.
- For the 2024 Plan Year and subsequent Plan Years, qualifying dependent care expenses will be eligible for reimbursement only if the expense is incurred on or before December 31 of the applicable Plan Year. Claims must be submitted by April 30 of the next Plan Year. For example, for the 2024 Plan Year, qualifying dependent care expense are eligible for reimbursement only if the expense is incurred on or before December 31, 2024, and the claim is submitted by April 30, 2025.
- You incur expenses when the care is provided, rather than when you are billed or when you pay for the care.
- If you enroll in the DCSA mid-year, expenses incurred before your effective date are not eligible.
- Expenses incurred after your participation ends aren't eligible. Note, however, that if you have funds remaining in your DCSA, you may continue to submit claims for reimbursement of eligible dependent care expenses incurred through the last day of the Plan Year in which you terminate employment, up to the amount you contributed. In order to be reimbursed, you must continue to meet the criteria listed under "**Who Can Participate In The DCSA?**". Additionally, please see "**What If I Go On An Approved Unpaid Leave of Absence**" above with regards to dependent care expenses when you are on an approved leave of absence.
- **NOTE: Expenses reimbursed under the DCSA may not be deducted on your income tax return.**

Eligible Expenses

The primary purpose of the DCSA is to set aside pretax dollars, which may then be used to reimburse yourself for qualifying dependent care expenses.

Some specific examples of expenses that might be eligible if they meet the requirements for reimbursement are:

- In-home services provided by a babysitter;
- The allocable portion of services provided by a housekeeper or maid during the day, in conjunction with the care of an eligible dependent during the day;
- Services provided by a day care facility for children, including summer day camp (the facility must be licensed if it provides care for more than six individuals who do not normally reside there);
- Services provided by a day care facility for adults (the facility must be licensed if it provides care for more than six individuals who do not normally reside there);
- Care provided outside your home (if the eligible dependent is age 13 or older, he or she must be unable to care for himself or herself and spend at least eight hours per day in your home); and
- Any taxes you pay as the employer of a dependent care provider.

Ineligible Expenses

Examples of ineligible DCSA expenses are:

- Payments to any individual who is your or your spouse's dependent under the age of 19 at the end of the calendar year in which the expense is incurred or paid;
- Payments to the parent of your dependent child;
- Expenses for which you have claimed the dependent care tax credit under Code § 21;
- Expenses incurred before you became a participant in the DCSA;
- Amounts paid to provide food, clothes or education (certain exceptions may apply);
- Services outside your home at a camp where your child, disabled spouse or dependent stays overnight;
- Transportation to and from the place where care is provided unless the transportation is provided by the dependent care provider;

- Expenses where the provider does not list their Social Security Number or Tax Identification Number;
- Educational expenses for dependent children in kindergarten or above; and
- Expenses incurred for care of your domestic partner or domestic partner's child unless such person is your tax dependent.

Be aware that expenses submitted for reimbursement to the DCSA must meet federal tax law requirements, as well as the Plan's requirements. If your dependent care expenses are not clearly eligible, the claims administrator may ask you to submit additional information to help determine whether the reimbursement is allowed. You should retain your itemized receipts for all transactions, as they may be required for validation purposes. In some cases, you may need a statement from your tax advisor verifying that the expense in question is eligible for reimbursement. For additional information, consult your tax advisor.

You are solely responsible for making sure all expenses submitted for payment under the DCSA are eligible for reimbursement.

Should I Use the Federal Tax Credit or the Dependent Care Spending Account?

Eligible expenses under the DCSA generally are the same expenses that may permit a dependent care tax credit on your federal income tax return. You cannot use the DCSA and the dependent care tax credit for the same expenses. It is up to you to decide which one would be more advantageous based on your personal situation. To help determine whether the federal child and dependent care tax credit or the DCSA would be more advantageous to you, you may wish to consult a qualified tax advisor.

How Do I File Claims?

With the DCSA, you have access to the total amount you have contributed year-to-date, less reimbursements previously made. *This is different from the HCSAs, which permit you to access your entire annual election amount (less prior reimbursements) regardless of your contributions to date.* To file a claim, go to my.healthequity.com. Claims may also be post-marked or faxed to the claims administrator.

What Happens to DCSA Funds I Don't Use?

You must file claims for reimbursement for dependent care expenses incurred during the Plan Year (including the applicable grace period, if any) no later than April 30 following the end of the Plan Year, or you will forfeit any funds remaining in your DCSA from the previous Plan Year. See "Which Expenses Are Eligible For Reimbursement?" above for more details.

With this "use or lose" rule, it is important that you carefully plan your contributions to your DCSA. You should set aside only as much as you expect to claim during the Plan Year because you will forfeit your unused contributions.

In accordance with the Code, PayPal may use forfeited funds to help pay administrative costs or for any other permitted purpose. Uncashed checks will also be treated as forfeitures after 6 months.

You may not use money in your HCSA to pay dependent day care expenses and vice versa. You may not switch money between a HCSA and a DCSA.

What If I Terminate From PayPal?

If your employment with PayPal terminates for any reason, contributions to your DCSA will stop with your final paycheck. Your participation will end as of the end of the month of your date of termination.

However, if you have funds remaining in your DCSA, you may continue to submit claims for reimbursement of eligible dependent care expenses incurred through the last day of the Plan Year in which you terminate employment, up to the amount you contributed. In order to be reimbursed, you must continue to meet the criteria listed under "**Who Can Participate In The DCSA?**"

What If I Return To Work At PayPal After Termination?

If you are rehired by PayPal and choose to re-enroll in the DCSA for the remainder of the Plan Year, you may do so within 30 days of your return to employment.

If you return to PayPal within the same Plan Year, the length of your break in service from PayPal will affect your re-enrollment options, as follows:

- If you were terminated from PayPal 30 days or fewer, your participation will be reinstated and the monthly contribution must be the same as before your break in service.*
- If you were terminated from PayPal for 31 days or more, you may select a new annual contribution (or elect not to participate in the DCSA for the remainder of the Plan Year).

**If you experience certain status change events during your break in service that allow for a change in election (e.g., gain a new dependent), you may increase or decrease your election in accordance with the status change event.*

Can I Elect COBRA Continuation For DCSA If I Stop Working For PayPal?

No. You cannot continue your participation in the DCSA through COBRA.

However, you may be reimbursed for unused amounts in your DCSA for eligible expenses incurred post-termination (for example, care to enable you to work for a new employer or actively look for work) through the remainder of the calendar year during which you terminated (no additional contributions to your account will be permitted).

What Is The Claim And Appeal Process For DCSA Claims?

After you submit your claim for reimbursement, the Claims Administrator will decide if the claim is eligible for reimbursement within a reasonable time. The Claims Administrator will provide you with information about the appeals process if a claim is denied. Refer to Addendum 2 for information regarding the claims and appeals process. You should also refer to general claim and appeal procedures described in the Welfare Plan, as well as the detailed claims and appeals procedures in the Plan document. All decisions and interpretations of the Claims Administrator or Plan Administrator shall be final, conclusive, binding upon all persons, and shall be given the greatest deference permitted by law.

General Information About the Plan

Refer to the PayPal Holdings, Inc. Health and Welfare Benefits Plan Document and Summary Plan Description for more information.

Plan Name: PayPal Section 125 Plan.

Plan Number: The General Purpose Health Care FSA and the Limited Purpose Health Care FSA portions of the PayPal Section 125 Plan are components of the PayPal Holdings, Inc. Health and Welfare Benefits Plan, which carries Plan Number 501.

Plan Year: January 1 to December 31.

Employer/Plan Administrator Information: PayPal Holdings, Inc. is the Employer, Plan Sponsor, and Plan Administrator of the Plan.

Company Name: PayPal Holdings, Inc

Business Address: 2211 North 1st Street
San Jose, CA 95131

Employer Tax ID #: 77-0510487

Claims Administrator Information:

HealthEquity
15 W Scenic Pointe Drive
Draper, UT 84020
1-866-346-5800

<https://my.healthequity.com>

Benefits Enrollment and COBRA Administrator Information:

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

Appeals should be sent to:

HealthEquity
15 W Scenic Pointe Drive
Draper, UT 84020
1-866-346-5800
<https://my.healthequity.com>

Refer to Addendum 1 and Addendum 2 for additional information.

Named Fiduciary (for the HCSAs) and Agent for Service of Legal Process: PayPal Holdings, Inc, 2211 North 1st Street, San Jose, CA 95131.

Qualified Medical Child Support Order ("QMCSO"): The HCSAs will provide benefits as required by any qualified medical child support order (QMCSO), as defined in ERISA §609(a). The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. Participants and beneficiaries can obtain, without charge, a copy of such procedures from the Plan Administrator.

Amendment and Termination: Although PayPal intends to continue the Plan indefinitely, it reserves the right to amend or terminate the Plan at any time for any reason. If either of these actions are taken, you will be notified.

No Contract of Employment: The Plan does not constitute a contract of employment between you and PayPal, nor does your participation in the Plan give you any rights to continue as an employee of PayPal. All employees remain subject to termination, layoff, or discipline as if the Plan had not been put into effect.

Your Rights and Privileges Under ERISA

As a participant in the HCSA, you are entitled to certain rights and protections under ERISA. The Dependent Care Spending Account is not an ERISA-covered program and the following explanation is not applicable to your participation in the DCSA.

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 the HCSA programs for yourself, 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 full 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 PayPal 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 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.

ADDENDUM 1

HCSA Claims and Appeals Procedures

1. *Initial Claims*

- (a) **Filing, Substantiation, and Deadline.** Except as provided below, any claims under the HCSA must be submitted pursuant to procedures established by the Plan Administrator (or its delegate) by April 30 following the close of the Plan Year in which the Qualifying Medical Expenses were incurred. Claims must be supported and substantiated by third-party documentation requested by the Claims Administrator, Plan Administrator, or its/their delegate. Section 8 of the Welfare Plan may include additional claims and appeals procedures.
- (b) All claims must be substantiated by bills, invoices, or other statements from an independent third party showing that the Medical Expenses were incurred and showing the amounts of such expenses, along with any additional documentation that the Plan Administrator may request.
- (c) **Approval of Initial Claim.** If a claim is approved, the Claims Administrator will provide the Participant with written or electronic notice of such approval. The notice will include: the amount of benefits to which the Participant is entitled; the duration of such benefit; the date the benefit is to commence; other pertinent information concerning the benefit; and any other information required by law.
- (d) **Notice of Denial of Initial Claim.** If a claim is denied (in whole or in part), the Claims Administrator will provide the Participant with written or electronic notification of such denial. The notice of denial of the claim will include: the specific reason that the claim was denied; a reference to the specific provisions of the Plan on which the denial was based; a description of any additional material or information necessary to perfect the claim and an explanation of why this material or information is necessary; a description of the appeal procedures and the time limits that apply to such procedures, including a statement of the Participant's right to bring a civil action under ERISA § 502(a) if a final internal adverse benefit determination is made after all appeals are exhausted; if an internal rule, guideline, protocol, or other similar criterion was relied upon in deciding the 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 the Participant upon request; and 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 Plan to the Participant's medical circumstances, or (B) a statement that such explanation will be provided free of charge upon request.
- (e) **Timing of Claims Decision.** The notice required by this Section will be provided within 30 days after receipt of the claim, unless special circumstances require an extension of time for processing the claim.

2. *Appeals*

- (a) **Filing an Appeal.** In the event that a claim is denied (in whole or in part), the Participant may appeal the denial by providing a written notice of appeal to the Claims Administrator within 180 days after the Participant receives the notice of denial of the claim. At the same time the Participant submits a notice of appeal, the Participant may also submit written comments, documents, records, and other information relating to the claim. The Participant is entitled to review and receive, free of charge, copies of all documents, records, and other information relevant to the initial claim.
- (b) **General Appeal Procedure.** The Claims Administrator may hold a hearing or otherwise ascertain such facts as it deems necessary and will render a decision which shall be binding upon both parties. In deciding the appeal, no deference will be given to the decision denying the initial claim; the appeal will be decided by an individual who did not decide the initial claim and who is not a subordinate of anyone who decided the initial claim; the individual deciding the appeal will review and consider all information submitted by the Participant, without regard to whether the information was submitted or considered in conjunction with the initial claim; if the appeal is based, in whole or in part, on a medical judgment, the individual deciding the appeal will consult with a health care professional who has appropriate training and experience in the relevant field; the health care professional will not be an individual who participated in the denial of the initial

claim and will not be the subordinate of any such individual; and if the Claims Administrator obtained advice from any medical or vocational experts in conjunction with the initial claim, such experts will be identified to the Participant (this identification must occur even if the Plan Administrator did not rely on the advice obtained).

- (c) **Notice of Decision on Appeal.** The appeal decision will be provided in written or electronic form to the Participant. If the appeal decision is adverse to the Participant, the written decision will include the following: the specific reason or reasons for the appeal decision; reference to the specific provisions of the Plan on which the appeal decision is based; a statement that the Participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the appeal decision; a statement describing any voluntary appeal procedures and the Participant's right to obtain the information about such procedures; and a statement of the Participant's right to bring an action under ERISA § 502(a) if a final internal adverse benefit determination is made; if an internal rule, guideline, protocol, or other similar criterion was relied upon in deciding the appeal, 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 the Participant upon request; if the denial of the appeal 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 Plan to the Participant's medical circumstances, or (B) a statement that such explanation will be provided free of charge upon request; and the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."
- (d) **Timing of Notice of Decision on Appeal.** The Claims Administrator will render a decision on appeal within 60 days after receipt of the appeal.

3. Extensions of Time

- (a) **Notice of Extension.** If the Claims Administrator requires an extension of time to review a claim, the Claims Administrator will provide the Participant with written or electronic notice of the extension before the first day of the extension. The notice of the extension will include: an explanation of the circumstances beyond the control of the Claims Administrator requiring the extension; the date by which the Claims Administrator expects to render a decision; the standard on which the Participant's entitlement to a benefit is based; and the unresolved issues, if any, that prevent a decision on the claim or appeal, and the information needed to resolve those issues. In the event such information is needed, the Participant will have at least 45 days from the date of the notice in which to provide the specified information. In addition, the time for determining an initial claim will be tolled from the date on which the notice of extension is sent to the Participant until the date on which the Participant responds to the request for additional information.
- (b) **Length of Extension.** For an initial claim, the Claims Administrator may obtain no more than one extension of 15 days. For an appeal, the Claims Administrator may not obtain an extension.

4. Legal Action. A claimant must exhaust his or her administrative remedies under these procedures prior to bringing any legal action with respect to a claim.

5. Deference. All decisions and interpretations made by the Claims Administrator or Plan Administrator shall be final, conclusive, and binding upon all persons and shall be given the greatest deference permitted by law.

ADDENDUM 2

DCSA Claims and Appeals Procedures

1. Initial Claims

- (a) **Filing, Substantiation, and Deadline.** Except as provided below, any claims under the DCSA must be submitted pursuant to procedures established by the Plan Administrator (or its delegate) by April 30 following the close of the Plan Year in which the eligible dependent care expenses were incurred. Claims must be supported and substantiated by third-party documentation requested by the Claims Administrator, Plan Administrator, or its/their delegate. Section 8 of the Welfare Plan may include additional claims and appeals procedures.
- (b) All claims must be substantiated by bills, invoices, or other statements from an independent third party showing that the eligible dependent care expenses were incurred and showing the amounts of such expenses, along with any additional documentation that the Plan Administrator may request.
- (c) **Approval of Initial Claim.** If a claim is approved, the Claims Administrator will provide the Participant with written or electronic notice of such approval. The notice will include: the amount of benefits to which the Participant is entitled; the duration of such benefit; the date the benefit is to commence; other pertinent information concerning the benefit; and any other information required by law.
- (d) **Notice of Denial of Initial Claim.** If a claim is denied (in whole or in part), the Claims Administrator will provide the Participant with written or electronic notification of such denial. The notice of denial of the claim will include: the specific reason that the claim was denied; a reference to the specific provisions of the Plan on which the denial was based; a description of any additional material or information necessary to perfect the claim and an explanation of why this material or information is necessary; and a description of the appeal procedures and the time limits that apply to such procedures, including a statement of the Participant's right to bring a civil action under ERISA § 502(a) (if applicable) if a final internal adverse benefit determination is made after all appeals are exhausted.
- (e) **Timing of Claims Decision.** The notice required by this Section will be provided within 30 days after receipt of the claim, unless special circumstances require an extension of time for processing the claim.

2. Appeals

- (a) **Filing an Appeal.** In the event that a claim is denied (in whole or in part), the Participant may appeal the denial by providing a written notice of appeal to the Claims Administrator within 180 days after the Participant receives the notice of denial of the claim. At the same time the Participant submits a notice of appeal, the Participant may also submit written comments, documents, records, and other information relating to the claim. The Participant is entitled to review and receive, free of charge, copies of all documents, records, and other information relevant to the initial claim.
- (b) **General Appeal Procedure.** The Claims Administrator may hold a hearing or otherwise ascertain such facts as it deems necessary and will render a decision which shall be binding upon both parties. In deciding the appeal, no deference will be given to the decision denying the initial claim; the appeal will be decided by an individual who did not decide the initial claim and who is not a subordinate of anyone who decided the initial claim; and the individual deciding the appeal will review and consider all information submitted by the Participant, without regard to whether the information was submitted or considered in conjunction with the initial claim.
- (c) **Notice of Decision on Appeal.** The appeal decision will be provided in written or electronic form to the Participant. If the appeal decision is adverse to the Participant, the written decision will include the following: the specific reason or reasons for the appeal decision; reference to the specific provisions of the Plan on which the appeal decision is based; a statement that the Participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the appeal decision; a statement describing any voluntary appeal procedures and the Participant's right to obtain the information about such procedures; and a statement of the Participant's right to bring an action under ERISA § 502(a) (if applicable) if a final internal adverse benefit determination is made.

- (d) Timing of Notice of Decision on Appeal. The Claims Administrator will render a decision on appeal within 60 days after receipt of the appeal.

3. Extensions of Time

- (a) Notice of Extension. If the Claims Administrator requires an extension of time to review a claim, the Claims Administrator will provide the Participant with written or electronic notice of the extension before the first day of the extension. The notice of the extension will include: an explanation of the circumstances beyond the control of the Claims Administrator requiring the extension; the date by which the Claims Administrator expects to render a decision; the standard on which the Participant's entitlement to a benefit is based; and the unresolved issues, if any, that prevent a decision on the claim, and the information needed to resolve those issues. In the event such information is needed, the Participant will have at least 45 days from the date of the notice in which to provide the specified information. In addition, the time for determining an initial claim will be tolled from the date on which the notice of extension is sent to the Participant until the date on which the Participant responds to the request for additional information.

- (b) Length of Extension. For an initial claim, the Claims Administrator may obtain no more than one extension of 15 days. For an appeal, the Claims Administrator may not obtain an extension.

4. Legal Action. A claimant must exhaust his or her administrative remedies under these procedures prior to bringing any legal action with respect to a claim.

5. Deference. All decisions and interpretations made by the Claims Administrator or Plan Administrator shall be final, conclusive, and binding upon all persons and shall be given the greatest deference permitted by law.