



Aetna International Health Plan Summary Plan

Description

Effective January 1, 2025

The Credit Suisse Aetna International Health Plan was terminated effective December 31, 2024. Please see the next page for additional information.

The Credit Suisse Aetna International Health Plan is Terminated

The Credit Suisse Aetna International Health Plan (the “Health Plan”) and all components thereof will terminate effective December 31, 2024. The Health Plan will pay for any claims incurred through December 31, 2024 (the “Termination Date”), even if filed at a later date, in accordance with the terms of the Health Plan. You must submit any claims incurred through the Termination Date before December 31, 2025.

Updated Plan Information

Plan Administrator The plan administrator is the UBS AG Benefits Committee (the “Benefits Committee”).

The Benefits Committee has delegated certain plan administration responsibilities to UBS Benefits Administration.

To contact either party, use the following information:

UBS AG
Attn. UBS Benefits Administration
9TH Floor
1000 Harbor Boulevard
Weehawken, NJ 07086

The Benefits Committee also has delegated claims administration and certain other responsibilities to the insurer listed below.

Agent for Service of Legal Process Legal process against the International Health Plan in the event of an unresolved dispute over benefit plan provisions can be served on the plan administrator.

If you need personal attention to answer a benefits question or issue related to the Health Plan, reach out to UBS Benefits Express (Alight Worklife) at 1-888-251-2500. Representatives are available Monday – Friday from 9:00 a.m. to 7:00 p.m. ET (excluding holidays).

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Important Information About the Aetna International Health Plan

Important Notice

This document includes important eligibility and participation information about your health coverage through a fully insured Aetna plan offered by Credit Suisse Securities (USA) LLC (Credit Suisse or the Bank).

Please note: This document, along with the Aetna International Health Plan Certificate of Coverage (the "Certificate"), serves as your Summary Plan Description (SPD), as required under the Employee Retirement Income Security Act of 1974, as amended (ERISA). These documents do not attempt to provide every detail of your benefits. Complete details are included in the Credit Suisse Securities (USA) LLC Group Health Care Plan document, which is the document that legally governs the plan. If there is any conflict between these documents and the plan document, the plan document will control. If there is any conflict between this document and the Certificate, the Certificate will control unless specifically provided otherwise in this document.

Who Is Eligible

You are eligible to participate in the Aetna International Health Plan (the International Health Plan or the plan) if you are:

- Classified as an employee of the Bank, meaning you are classified by and work for the Bank or a "Participating Affiliate," residing outside the United States or Bermuda as its employee;
- On a Credit Suisse U.S. payroll; and
- Regularly scheduled to work at least 20 hours a week.

OR

- You work for a division of Credit Suisse and are a U.S. citizen working in a country where local coverage prohibits coverage in the United States.

Participating Affiliates

The following Participating Affiliates have adopted the plan:

- Asset Management Finance LLC;
- Column Financial Inc.;
- Credit Suisse AG, New York Branch;
- Credit Suisse Alternative Capital LLC;
- Credit Suisse Asset Management LLC;
- Credit Suisse Services (USA) LLC;
- Credit Suisse Labs GmbH;
- Credit Suisse Holdings (USA), Inc; and
- Credit Suisse Loan Funding.

If You Are a Retiree

Please refer to the Aetna Retiree International Medical Plan Summary Plan Description for information about your retiree medical coverage.

Eligible Dependents

If you enroll in the International Health Plan, you also may enroll your eligible dependents which include your:

- Same- or opposite-sex spouse to whom you are legally married (including common-law marriage) determined in accordance with the laws of the state in which the marriage was entered into;
- Same- or opposite-sex domestic partner (see "Enrolling Your Domestic Partner");
- Children who are under age 26. Coverage continues until the end of the year in which the child turns age 26; and
- Mentally or physically disabled children over age 26, who are incapable of self-support.

Eligible children include your (or your spouse's or covered domestic partner's):

- Natural children;
- Stepchildren;
- Foster children;
- Legally adopted children (including children for whom legal adoption proceedings have begun); and
- Children related to you for whom you have a legal obligation in a parent-child relationship.

Married Credit Suisse Employees/Domestic Partners

If your spouse or domestic partner also works for Credit Suisse, you cannot be covered by the International Health Plan as an employee and as a dependent. In addition, only one of you can cover your eligible dependents.

Proof of Dependent Eligibility

The Bank reserves the right to ask for proof that the dependents you are covering are eligible for coverage. For example, you may be asked to provide a marriage certificate or birth certificate. If you are asked and you do not provide proof as requested, the Bank reserves the right to take appropriate action, which may include discontinuing your benefits.

Enrolling Your Domestic Partner

When you enroll your domestic partner, you will be asked to attest to certain requirements.

If you have a valid civil union and reside in a state that allows and recognizes civil unions or you are registered as domestic partners in a jurisdiction with such registry, you will be deemed a "domestic partner."

Alternatively, you can be deemed a domestic partner if you meet the requirements below:

- You and your domestic partner must live together in a serious committed relationship and must have done so for at least six months;
- You must be financially interdependent and be able to present two or more of the following as evidence of this:

- Joint mortgage or lease;
 - Designation of domestic partner under a durable power of attorney or health care proxy;
 - Joint wills or designation of domestic partner as executor or primary beneficiary;
 - Joint bank account, credit cards, or other evidence of joint financial responsibility;
 - Designation of domestic partner as beneficiary of life insurance or retirement benefits;
 - Driver's licenses or federally issued IDs listing current common address;
 - Common ownership of a motor vehicle; or
 - Other evidence that establishes economic interdependence.
- You must be each other's sole domestic partner;
 - You and your domestic partner must be at least age 18;
 - You and your domestic partner must not be legally married to another person; and
 - You and your domestic partner must not be related to each other by blood any closer than would prohibit legal marriage.

The insurance company may require documented proof that each of you is eligible.

Imputed Income Rules

Imputed Income Rules for Domestic Partners

The premium attributed to coverage for your domestic partner and his or her dependents will be deducted from your pay on an after-tax basis.

Under current federal income tax rules, the value of any additional premium that Credit Suisse pays to cover your domestic partner and his or her dependents is considered a taxable benefit and will be added to your taxable income and reported on your W-2.

Credit Suisse will "gross up" your pay to equalize the tax treatment on such imputed income.

You can obtain specific details by contacting the Credit Suisse Benefits Service Center.

Qualified Medical Child Support Orders (QMCSOs)

If required by a state domestic relations law, certain court orders could require that you provide health care coverage for your child(ren), even if you do not have custody. If the court order satisfies all of the applicable legal requirements and is determined to be a QMCSO, the Bank will make coverage available to the full extent provided by the law and in accordance with the terms and conditions of the QMCSO. Without such an order, benefits can be paid only to you or to the provider with your written consent. Contact the Credit Suisse Benefits Service Center for model QMCSO language at no cost.

Please note: You may obtain, without charge, a copy of the procedures governing QMCSOs directly from the plan administrator.

Who Is Not Eligible

You are not eligible to participate in the International Health Plan if you:

- Do not meet the requirements outlined under "Who Is Eligible";
- Are classified by and work for the Bank as an independent contractor or consultant or through an agency, consulting firm, payroll service, subcontractor, or other third-party provider; or
- Are classified by and work for the Bank as an intern.

Enrolling in the Plan

As a Transfer

When you first become an International Transfer, your coverage is automatically converted to the International Health Plan. If you wish to decline coverage under the International Health Plan, you must call the Credit Suisse Benefits Service Center at **1-888-325-2732** or **1-704-646-8768** outside the U.S. and Canada and speak with a representative.

As a New Hire

When you begin your employment with the Bank, you will receive instructions on how to enroll in your benefits through the Your Benefits Resources™ web site at <http://digital.alight.com/credit-suisse>.

Once you have been notified, you should enroll in your benefits within 30 days of your hire date. If you do not enroll in your benefits within 30 days, you will have no current health care coverage through Credit Suisse. Unless you have a qualified status change that allows you to enroll during the year (see "Changing Your Benefits During the Year"), your next opportunity to enroll will be the next Annual Enrollment period (generally held in the fall), with coverage taking effect the following January 1. Note that this paragraph applies regardless of any conflicting information in the Certificate.

During Annual Enrollment

Each year, you have the opportunity to enroll in or change your benefits for the following year during the Annual Enrollment period (generally held in the fall). You will receive an Annual Enrollment communication that outlines the enrollment dates and what you need to do to update your coverage through the Your Benefits Resources web site.

You Make One Election for Medical and Dental Coverage

If you are an active employee and you elect to enroll in the International Medical Plan, you and your enrolled covered dependents will automatically be covered under the Dental Plan. You cannot elect dental coverage only.

Coverage Categories

When you enroll, you will choose which, if any, eligible dependents to enroll for coverage. You may choose to enroll different eligible dependents for the Medical Plan and Dental Plan (active employees only). The number of dependents you enroll determines your coverage category in each plan. For active employees, the categories are:

- You Only;
- You + 1 Dependent; and
- You + Family (2 or more dependents).

When Participation Begins

As a Transfer

Your coverage under the International Health Plan becomes effective on the same day that your status changes to International Transfer.

As a New Hire

As long as you enroll within 30 days of your hire date, your participation in the plan takes effect retroactively to your date of hire. Deductions will be taken from your paycheck to cover this retroactive coverage. If you elect to enroll your eligible dependents, your dependents' participation begins at the same time as your own participation. Note that this paragraph applies regardless of any conflicting information in the Certificate.

Your benefit elections will last until the end of the year, unless you have a qualified status change, as described under "Changing Your Benefits During the Year."

During Annual Enrollment

If you enroll in or update your coverage during the Annual Enrollment period, your elections take effect on the following January 1.

Your benefit elections last the entire year, unless you have a qualified status change, as described under "Changing Your Benefits During the Year."

Additional Enrollment Rights

If you or your dependent is eligible, but not enrolled, for coverage under the International Health Plan, you are eligible to enroll for coverage if you meet any of the following conditions and you request enrollment in the International Health Plan within the time period specified below:

- The enrollment time period for the following events is the 30 days after the date of the event (regardless of any conflicting information in the Certificate):
 - You previously declined enrollment for yourself, your spouse, or your dependent(s) because you, your spouse, or your dependent(s) had other health insurance coverage and eligibility for the other coverage was subsequently lost; or
 - You gain a new dependent as the result of marriage, birth, adoption, or placement of adoption.

- The enrollment time period for the following events is the 60 days after the date of the event:
 - You or your dependent loses eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage; or
 - You or your dependent becomes eligible for premium assistance, with respect to coverage under the International Health Plan, due to coverage with Medicaid or CHIP.

To request special enrollment or obtain more information, contact the Credit Suisse Benefits Service Center at **1-888-325-2732** or **1-704-646-8768** outside the U.S. and Canada.

Changing Your Benefits During the Year

Generally, outside of the Annual Enrollment period or special enrollment rights described under “Additional Enrollment Rights,” the only time you may change your benefits during the year is if you have a qualified status change. Keep in mind that any changes made to your International Health Plan must be consistent with and correspond to the change in status you experience, and that the change in status you experience must result in the gain or loss of eligibility under an employer’s plan. Qualified status changes include:

- A change in your marital status or domestic partnership;
- A change in the number of your dependents, such as through birth, adoption, placement for adoption or legal guardianship, or death of a dependent;
- A change in your, your spouse's/domestic partner's, or your dependent's employment status that results in a loss or gain of benefits eligibility;
- When you become eligible for another employer's plan (for example, if you have a second job); or
- When you, your spouse/domestic partner, or your dependents start or return from a paid or unpaid leave of absence.

Please note: Surviving spouses and dependents covered under the plan may not add dependents.

If you experience a qualified status change during the year, you may change your International Health Plan elections through the Your Benefits Resources web site or call the Credit Suisse Benefits Service Center. Any changes in your International Health Plan elections must be made within 30 days of the event and must be consistent with the change in status.

Example: If you get married, you may add your new spouse to your Medical Plan coverage, change your option, or drop your Medical Plan coverage to enroll in your new spouse's coverage (through his or her employer's plan).

If you do not make a change in your International Health Plan elections during the 30-day period following the date of the qualified status change, you cannot make a change until the earlier of the next Annual Enrollment period or the date you experience another qualified status change. If requested by the Bank, you may have to provide proof of your qualified status change.

Proof of a Qualified Status Change or Dependent Eligibility

The Bank reserves the right to ask for proof of your qualified status change or that the dependents you are covering are eligible for coverage. For example, you may be asked to provide a marriage certificate, birth certificate, or death certificate. If you are asked and you do not provide proof as requested, the Bank reserves the right to take appropriate action, which may include not allowing you to make any changes to your benefits at this time, disciplinary action, or termination.

Benefits Compensation

For purposes of the Group Health Plan, your benefits compensation equals your base salary plus commissions and/or discretionary variable incentive awards averaged over the previous 36 months or, if less, the period of your Credit Suisse employment as of September 1 each year.

Please note: For Private Banking commissioned employees:

- During the first three years of employment, your benefits are calculated by taking the greater amount of either your hypothetical pay (which generally means estimated pay that is based on your title/job code) or your benefits compensation.
- After your first three years of employment, your benefits compensation is calculated by using your gross annual salary.

Please note: For purposes of benefits compensation, commissions and discretionary variable incentive awards are considered based on when they are paid, not awarded.

Benefits compensation does not include:

- Awards;
- Overtime pay;
- Credit Suisse contributions on your behalf to any deferred compensation arrangement or pension plan; or
- Any other compensation.

Cost of Coverage

Medical Plan

You and the Bank share in the cost of medical coverage. Your contributions are based on your benefits compensation and coverage category and will be adjusted to reflect any changes. Your contribution is deducted from your paycheck in equal amounts throughout the year on a "pre-tax basis."

Cost If You Are an Active Employee Over Age 65

If you are over age 65, Credit Suisse will pay the full cost of your medical and dental coverage for you and your spouse or domestic partner. If you have coverage for any eligible children, you will contribute, but the cost will be based on the You Only rate for your benefits compensation (see "Benefits Compensation") instead of the more expensive You + Family rate.

Tax Implications

Making contributions on a pre-tax basis means your contribution is taken from your paycheck before federal, Social Security, and in many cases, state and local taxes are withheld. This reduces your taxable income and, in turn, reduces the amount of taxes you have to pay.

Domestic Partner Benefits

As outlined under “Imputed Income Rules,” in certain situations the premium attributed to coverage of domestic partners and their dependents will be deducted on an after-tax basis. In addition, you will need to report imputed income in the amount of the additional premium that Credit Suisse pays to cover these dependents. Specific details can be obtained by contacting the Credit Suisse Benefits Service Center.

Military Leave

Employees going into or returning from military service will have plan rights mandated by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). These rights include up to 24 months of extended health care coverage for the employee and any family members covered under the plan immediately prior to leaving for military service upon payment of the entire cost of coverage plus a 2% administration fee and immediate reinstatement of coverage upon timely return from service. Only employees who are covered under the plan immediately prior to leaving for military service have rights mandated by USERRA. Please contact the plan administrator if you have questions regarding your rights under USERRA.

When Participation Ends

The Certificate describes the events that cause your participation under the International Health Plan to end. In addition to those events, coverage under the International Health Plan will end as described below.

Failure to Provide Information

Your coverage under the International Health Plan will end when you fail to provide plan-related information or documentation upon request.

Transfer to the United States

Your participation in the International Health Plan will end when you transfer back to employment in the United States. However, you will have the opportunity to obtain medical coverage under one of the Bank’s other health plan options. More information about these other health plan options will be provided to you in connection with your transfer.

Retirement

Your participation in the International Health Plan ends when you retire. However, if you qualify for retiree medical coverage, your coverage will be offered under the Aetna Retiree International Medical Plan.

As you prepare for your retirement date, you should call the Credit Suisse Benefits Service Center and notify a representative of your intent to retire. If you are eligible for the Retiree International Medical Plan, you are automatically enrolled in that plan when your coverage under the International Health Plan ends. Dependents you cover under the International Health Plan are also automatically covered under your retiree medical coverage. If you would like to drop coverage for yourself and/or your eligible dependents at your retirement, you must call the Credit Suisse Benefits Service Center within 30 days of your retirement date. For additional details regarding the Retiree International Medical Plan, please refer to the Retiree International Medical Plan Summary Plan Description. Credit Suisse reserves the right to modify, suspend, or terminate such plan.

Please note: If you decline retiree medical coverage when you retire, you permanently waive coverage and you will not be permitted to enroll in the Retiree International Medical Plan at a later date.

Continuing Your Coverage Under COBRA

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), created the right to continue your medical and dental coverage upon certain qualifying events.

This section:

- Contains important information about your right to COBRA coverage;
- Explains when COBRA coverage may become available; and
- Describes what you need to do to protect your right to receive COBRA coverage.

For additional information about your rights and obligations under the International Health Plan and under federal law, contact the Credit Suisse Benefits Service Center at **1-888-325-2732** or **1-704-646-8768** outside the U.S. and Canada.

Although federal law does not require employers to provide continuation coverage to domestic partners, your covered domestic partner has the right to elect continuation coverage similar to COBRA coverage. In this section, all references to a spouse also pertain to a domestic partner. In addition, the rights and obligations of spouses upon a divorce also apply to domestic partners when a domestic partnership terminates.

What COBRA Continuation Coverage Is

COBRA coverage is a temporary continuation of health care coverage when it otherwise would end because of a life event, known as a "qualifying event." (Specific qualifying events are listed later in this section.)

After a qualifying event, COBRA continuation coverage must be offered to each "qualified beneficiary." You, your spouse or domestic partner, and your dependent children could become qualified beneficiaries if coverage under the International Health Plan is lost because of the qualifying event. Qualified beneficiaries also include any children born to you or placed for adoption with you during the COBRA continuation period.

Qualified beneficiaries who elect COBRA continuation coverage must pay for it.

Qualifying Event

A qualifying event is an event, listed under "COBRA Qualified Beneficiaries and Qualifying Events," that results in a loss of coverage under the International Health Plan.

Qualifying Beneficiary

A qualified beneficiary is the benefit-eligible person affected by the qualifying event.

COBRA Qualified Beneficiaries and Qualifying Events

- **Employees.** You become a COBRA qualified beneficiary if you lose your coverage under the International Health Plan because of either of the following qualifying events:
 - Your hours of employment are reduced; or
 - Your employment ends for any reason (other than your gross misconduct).
- **Spouse of employee.** Your spouse becomes a COBRA qualified beneficiary if he or she loses coverage under the International Health Plan due to any of the following qualifying events:
 - Your hours of employment are reduced to the point where you would ordinarily lose coverage under the plan;
 - Your employment ends for any reason (other than gross misconduct) including death; or
 - You become divorced or legally separated from your spouse.
- **Dependent children.** Your dependent child will become a COBRA qualified beneficiary if the child loses dependent status due to any of the following qualifying events:
 - Your hours of employment are reduced to the point where you would ordinarily lose coverage under the plan;
 - Your employment ends for any reason (other than gross misconduct) including death;
 - You become divorced or legally separated from your spouse; or
 - The child no longer qualifies as a dependent, as defined (see "Eligible Dependents" under "Who Is Eligible").

When COBRA Coverage Is Available

The International Health Plan offers COBRA continuation coverage to qualified beneficiaries **only** after the Credit Suisse Benefits Service Center has been notified that a qualifying event has occurred.

Notification Procedures

Notification by the Bank

The Bank (either the plan administrator or the Human Resources department) will notify the COBRA administrator within 30 calendar days of the date coverage would otherwise be lost if your employment ends or your hours are reduced.

Notification by You, Your Qualified Beneficiary, or Your Qualified Beneficiary's Authorized Representative

You, your qualified beneficiary, or your or your qualified beneficiary's authorized representative must notify the Credit Suisse Benefits Service Center within 60 calendar days* after coverage would otherwise be lost as a result of any of the following qualifying events:

- You become divorced or legally separated from your spouse, or your domestic partnership ends;
- A dependent child ceases to be an eligible dependent (for example, he or she reaches the maximum age);
- The Social Security Administration determines that a qualified beneficiary, who was entitled to receive a maximum of 18 months of COBRA continuation coverage, was disabled during the first 60 calendar days of COBRA continuation coverage, as long as you provide notification of such determination, in writing, to the Credit Suisse Benefits Service Center within 60 days* of receiving the determination from the Social Security Administration and before the end of the initial 18 months of COBRA coverage;
- The Social Security Administration determines that a qualified beneficiary no longer is disabled.

Notification that the disability has ended must be provided, in writing, to the Credit Suisse Benefits Service Center within 30 days* of the date of the final determination; or

- A second qualifying event occurs during the first 18 months of COBRA continuation coverage.

*Due to the COVID-19 pandemic, if you or your qualified beneficiary would lose coverage due to a qualifying event during the Outbreak Period, the period for notifying the Credit Suisse Benefits Service Center of the qualifying event will end on the earlier of one year and 60 days after the date coverage would otherwise be lost due to the qualifying event or 60 days after the end of the Outbreak Period. The deadlines for providing notice of a disability or the end of a disability will also be similarly extended for up to one year. The Outbreak Period is the period beginning March 1, 2020 and ending 60 days after the end of the National Emergency.

Communications sent in writing should be mailed to:

Credit Suisse Benefits Service Center
P.O. Box 661074
Dallas, TX 75266-1074

Or, you, your qualified beneficiary, or your or your qualified beneficiary's authorized representative should notify the Credit Suisse Benefits Service Center at **1-888-325-2732** or **1-704-646-8768** outside the U.S. and Canada.

What the Notification Must Include

The notification should include the following information:

- Name of the International Health Plan;
- Your and your qualified beneficiary's(ies') names;
- Information concerning the qualifying event, including the date the event occurred;
- The date you and/or your qualified beneficiary(ies) loses (or would lose) coverage as a result of a qualifying event;
- If applicable, information concerning the disability determination; and
- If applicable, the date of the qualifying event of disability.

If you, your qualified beneficiary, or your or your qualified beneficiary's authorized representative does not provide the required information in the notice, the Credit Suisse Benefits Service Center may request the missing information. If you, your qualified beneficiary, or your or your qualified beneficiary's authorized representative does not respond to a request for more information or does not provide the requested information within a reasonable time, the plan will reject the notification of the qualifying event due to failure to provide the required information.

How COBRA Coverage Is Offered

After the Credit Suisse Benefits Service Center receives notice that a qualifying event has occurred, COBRA continuation coverage is offered to each qualified beneficiary.

The Credit Suisse Benefits Service Center will mail a COBRA continuation notice and a COBRA election notice within 14 calendar days* after receiving notice of the qualifying event. This information is sent to the most recent address we have on file.

Each qualified beneficiary has an independent right to elect COBRA continuation coverage. If your qualified beneficiary lives at another address, a separate information packet will be sent if that address is provided.

Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

Please note: Be sure that you (or anyone who may become a qualified beneficiary) maintain a current address with the Credit Suisse Benefits Service Center to ensure that you receive a COBRA continuation notice and a COBRA election notice following a qualifying event. To review your current information, log on to the Your Benefits Resources web site and select **Your Profile**. See "For More Information" for access information.

If you or a qualified beneficiary wishes to enroll in COBRA, you or your qualified beneficiary must follow the election instructions included in the COBRA continuation and election notices no later than 60 calendar days* after the later of the date those notices are provided to you or the date your coverage ends due to a qualifying event.

*Due to the COVID-19 pandemic, if you or your qualified beneficiary is provided with a COBRA election notice during the Outbreak Period, the period for following the election instructions will end on the earlier of one year and 60 days after the date the notice is provided (or 60 days after the date coverage ends, whichever is later) or 60 days after the end of the Outbreak Period. The Outbreak Period is the period beginning March 1, 2020 and ending 60 days after the end of the National Emergency.

If You Choose COBRA Continuation Coverage

If you or your dependent elects COBRA continuation coverage, you have the following options available to you:

- You or your dependent can keep the same level of coverage you had as an active employee or choose a lower level of coverage.
- Your or your dependent's coverage is effective immediately after coverage is lost as a result of the qualifying event, unless you or your dependent waives COBRA coverage and then revokes the waiver within the 60-day election period. (In this case, your elected coverage begins on the date you revoke your waiver.)
- You or your dependent may change coverage (if enrolled within the initial 60-calendar-day enrollment window):
 - During the Annual Enrollment period; or
 - If you or your dependent has a qualified change in status or another change in circumstance recognized by the IRS and the Bank.
- You may enroll any newly eligible spouse or dependent child under the International Health Plan rules.

What COBRA Coverage Costs

COBRA participants must pay monthly after-tax contributions for coverage.

Premiums are based on the full cost per covered person, set at the beginning of the year, plus 2% for administrative costs. Dependents making separate elections are charged the same rate as a single employee.

Payment is due at enrollment, but there is a 45-calendar-day* grace period from the date you mail your election form to make the initial payment. The initial payment includes coverage for the current month, plus any previous month(s), retroactively to the date coverage terminated under the International Health Plan.

Ongoing monthly payments are due on the first of each month, but there is a 30-calendar-day grace period (for example, the June payment is due June 1, but will be accepted if postmarked by June 30).

*Due to the COVID-19 pandemic, if you elect COBRA continuation coverage during the Outbreak Period, your initial payment is due on either (1) one year and 45 days after the date you elect COBRA coverage, if you elected COBRA continuation coverage within 60 days of the date the COBRA election notice was provided, or (2) one year and 105 days after the date the COBRA election notice was provided, if you elected COBRA continuation coverage outside of the initial 60-day period. If the Outbreak Period ends more than 45 days before this extended due date, your initial payment will instead be due 45 days after the end of the Outbreak Period. If your ongoing monthly payment would otherwise be due during the Outbreak Period, your ongoing monthly payment will instead be due by the earlier of (i) one year and 30 days after the original due date or (ii) 30 days after the end of the Outbreak Period. The Outbreak Period is the period beginning March 1, 2020 and ending 60 days after the end of the National Emergency.

Credit Suisse Subsidized COBRA Premiums

Under current federal income tax rules, the value of any Bank-paid premiums for COBRA coverage is considered a taxable benefit. This is called imputed income, and will be added to your taxable income and reported on your W-2 form.

How Long COBRA Coverage Lasts

COBRA continuation coverage is a temporary continuation of coverage.

COBRA continuation coverage generally lasts for up to a total of 18 months when the qualifying event is the end of employment or reduction of your hours of employment. This 18-month period of COBRA continuation coverage can be extended in two ways:

- **Disability extension of 18-month period of continuation coverage.** If a qualified beneficiary covered under the International Health Plan is determined by the Social Security Administration to be disabled and you, your qualified beneficiary, or your or your qualified beneficiary's authorized representative notifies the Credit Suisse Benefits Service Center in a timely fashion, you and all other qualified beneficiaries may be entitled to receive up to an additional 11 months of COBRA continuation coverage (for a total maximum of 29 months) if all of the following conditions are met:
 - Your COBRA qualifying event was a termination of employment or reduction in hours.
 - The disability started at some time before the 60th calendar day of COBRA continuation coverage and lasts at least until the end of the 18-month period of continuation coverage.
 - A copy of the Notice of Award from the Social Security Administration is provided to the Credit Suisse Benefits Service Center within 60 calendar days of the date of the notice and before the end of the initial 18 months of COBRA coverage. A copy of the Notice of Award from the Social Security Administration is provided to the Credit Suisse Benefits Service Center within 60 calendar days of receipt of the notice and before the end of the initial 18 months of COBRA continuation coverage.
- **Second qualifying event extension of 18-month period of continuation coverage.** If another qualifying event occurs during the first 18 months of COBRA continuation coverage, your spouse and dependent children can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Credit Suisse Benefits Service Center.

This extension may be available to your spouse and any dependent children receiving continuation

coverage if you die, divorce, or legally separate, or if your child no longer is eligible as a dependent child under the International Health Plan, but only if the event would have caused your spouse or child to lose coverage under the plan had the first qualifying event not occurred.

COBRA continuation coverage lasts for up to a total of 36 months when the qualifying event is:

- Your divorce or legal separation;
- Your death; or
- A dependent child losing eligibility as a dependent child.

If you enroll in Medicare within 18 months before your termination of employment or reduction in hours of employment, your covered spouse and/or dependent children may elect COBRA coverage for up to 36 months from the date you enrolled in Medicare.

Summary of Continuation Periods by COBRA Qualifying Event

Following is a summary of how long coverage can be continued under COBRA, based on the type of qualifying event.

Qualifying Event	Maximum Continuation Period (Months) [†] for:		
	You	Spouse	Covered Child
You lose coverage because of reduced work hours or taking unpaid leave, other than leave under the FMLA	18	18	18
You terminate employment for any reason (except gross misconduct)	18	18	18
You enroll in Medicare within 18 months before you lose coverage because of reduced hours or termination of employment	N/A	36	36
Your covered spouse and/or child has another qualifying event while on COBRA coverage due to your reduced hours or termination of employment	N/A	36	36
You or your covered dependent is disabled, as defined by the Social Security Act, at the time of the qualifying event or during the first 60 calendar days of COBRA continuation coverage	29 (initial 18 months, plus additional 11 months)	29 (initial 18 months, plus additional 11 months)	29 (initial 18 months, plus additional 11 months)
Your covered child no longer qualifies as a dependent	N/A	N/A	36
You and your spouse divorce or legally separate, or you die	N/A	36	36

[†]As mentioned, you and your eligible dependents have 60 calendar days from the date coverage ends due to a qualifying event or from the date of your COBRA notice, whichever is later, to elect continued participation under COBRA.

Situations When COBRA Coverage May End Earlier

COBRA coverage ends before the maximum continuation period if one of the following occurs:

- You or any of your covered dependents become covered under another health care plan not offered by the Bank (unless the other group health plan limits coverage for preexisting conditions that you or they may have).
- After you or your covered dependent have elected COBRA coverage, you or your covered dependent becomes enrolled in Medicare.
- After a disability extension starts, the Social Security Administration determines that the disabled person is no longer disabled.
- You or your covered dependent does not make timely premium payments or contributions as required.
- If any events occur that would lead to termination of coverage for similarly situated non-COBRA beneficiaries (for example, fraud).
- The Bank ceases to provide health care coverage to employees.
- Any other event that is listed in the Certificate as an event that would cause COBRA coverage to end.

If You Have Questions

Contact the Credit Suisse Benefits Service Center at **1-888-325-2732**, or **1-704-646-8768** outside the U.S. and Canada, if you have questions about COBRA.

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA web site at www.dol.gov/ebsa. (Addresses and telephone numbers of Regional and District EBSA Offices are available through EBSA's web site.)

Alternatives to COBRA Continuation Coverage

There may be other medical coverage options available through the Health Insurance Marketplace, Medicaid, or other group health plan coverages (such as a spouse's plan). You should compare your coverage options and choose the coverage that is best for you.

Marketplace Coverage

You can access the Marketplace for your state and learn more about eligibility, coverage and available tax credits at www.HealthCare.gov.

If you are eligible for coverage through a Marketplace, you have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. In addition, during a Marketplace open enrollment period, any eligible person can enroll in Marketplace coverage. If you sign up for COBRA continuation coverage, there are restrictions on when you can change to Marketplace coverage. If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage.

Medicare

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the initial enrollment period for Medicare Part A or B, you have an 8-month special enrollment period (these rules are different for persons with End Stage Renal Disease) to sign up,

beginning on the earlier of:

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

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

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

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

Plan Continuance

It is the intent of Credit Suisse to continue the Aetna International Health Plan indefinitely. However, Credit Suisse reserves the right to modify, suspend, or terminate it at any time by action of the Credit Suisse Holdings (USA), Inc. Executive Committee. In addition, the plan administrator may amend the plan at any time for minor changes.

Any such action would only be taken after careful consideration; however, plan modification, suspension, or termination is not contingent upon the financial condition of the Bank.

Plan Documents

This document and the Certificate contain important details about the Aetna International Health Plan. They do not create a contract of employment between Credit Suisse and any employee. As you review the information, keep in mind that it is meant as a summary only.

Plan Administration

International Health Plan Administration Chart

Here is some information about the International Health Plan and the people who have responsibility for its operation. This information applies regardless of any conflicting information in the Certificate.

The following information is applicable to the International Health Plan	
Plan Name	The International Health Plan is a component plan in the Credit Suisse Securities (USA) LLC Group Health Care Plan. You will need to use the group health care plan name if you ever need to correspond with a government agency about the plan.
Plan Sponsor	Credit Suisse Securities (USA) LLC Eleven Madison Avenue New York, NY 10010

The following information is applicable to the International Health Plan	
Plan Type	Under ERISA, the Aetna International Health Plan is a welfare plan providing medical benefits.
Plan Number	The number assigned to the Credit Suisse Securities (USA) LLC Group Health Care Plan is 517.
Plan Year	The plan year runs from January 1 through December 31.
Plan Administrator	<p>The plan administrator is the Benefits Committee of Credit Suisse. The Benefits Committee has delegated certain plan administration responsibilities to the Credit Suisse Benefits Service Center. To contact either party, use the following information:</p> <p>Credit Suisse Benefits Service Center P.O. Box 661074 Dallas, TX 75266-1074 1-888-325-2732</p> <p>The Benefits Committee also has delegated claims administration and certain other responsibilities to the insurer listed below.</p>
Insurer	<p>Aetna Life Insurance Company 151 Farmington Avenue Hartford, CT 06156</p> <p>The Employer collects and sends insurance premiums to the insurer. The insurer is responsible for investing the premiums and paying benefit claims, and it guarantees the payment of claims incurred before the group insurance contract terminates.</p>
Type of Administration	Insurer administration
Employer Identification Number	The Internal Revenue Service (IRS) has assigned Credit Suisse Employer Identification Number 05-0546650.
Type of Funding	The International Health Plan is funded through an insurance policy. Employees and Credit Suisse share the cost of coverage in the plan.
Agent for Service of Legal Process	<p>Legal process against the International Health Plan in the event of an unresolved dispute over benefit plan provisions can be served on the plan administrator. In addition, legal process may be served on Credit Suisse at the following address:</p> <p>Corporate Secretary Credit Suisse Securities (USA) LLC Eleven Madison Avenue New York, NY 10010 1-212-325-2000</p>

Reminder: It is your responsibility to notify the plan administrator of your current address so that you continue to receive updates about the plan. Any correspondence sent to your address on file will be

deemed to have been received by you for all plan purposes. Benefits can be forfeited after a certain amount of time if you do not provide updated contact information to the plan.

Your Rights Under ERISA

Overview

As a participant of the International Health Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all plan participants be entitled to the following:

Receive Information

- Receive information about the plan and benefits.
- Examine (without charge) at the plan administrator's office and at other specified locations—such as in the employee's local Human Resources department—all plan documents. These may include insurance contracts, and copies of all documents filed with the U.S. Department of Labor (for example, detailed annual reports [Form 5500 Series] available at the Public Disclosure Room of the Employee Benefits Security Administration [EBSA]).
- Obtain copies of documents governing the plan, including insurance contracts, copies of the latest Form 5500 annual report, and an updated summary plan description by writing to the plan administrator. The plan administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Care Plan Coverage

- Continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the plan as a result of a qualifying event as defined by law. You or your dependents may have to pay for such coverage.
- Review the SPD and the documents governing the plan for the rules that govern your Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the plan. The people who operate the plan, called "fiduciaries," have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries.

No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your ERISA rights.

Enforce Your Rights

If your claim for a benefit from the International Health Plan is denied or ignored—in whole or in part—you have a right to know why this was done, to obtain copies of documents relating to the decision (without charge), and to appeal any denial (all within certain time schedules).

Under ERISA, there are steps you can take to enforce your ERISA rights. For instance:

- If you request a copy of the plan documents or the latest annual report and do not receive them

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 materials and pay you up to \$110 a day until you receive the materials—unless the materials were not sent because of reasons beyond the plan administrator's control.

- If you have a claim for benefits that is denied or ignored—in whole or in part—you may file suit in a state or federal court.
- If you disagree with the plan's decision or if the plan does not respond to your request concerning the status of a Qualified Medical Child Support Order (QMCSO), you may seek resolution under the EDRP or file suit in a federal court.
- If it should happen that plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your ERISA rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.
- If you file suit against the plan, the court decides 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 your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the EBSA, 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.

You may also obtain certain publications about your rights and responsibilities under ERISA by:

- Calling the EBSA at **1-866-444-3272**;
- Logging on to the Internet at www.dol.gov/ebsa; or
- Contacting the EBSA field office nearest you.

Assignment of Rights

You cannot assign your rights under the plan. A direction to pay your health care provider directly is not an assignment of rights. This paragraph applies regardless of any conflicting information in the Certificate.

For More Information

Credit Suisse gives you access to resources to help you manage your benefits and get the most out of the programs the Bank offers.

The Your Benefits Resources web site should be your first stop for information about your benefits. You can log on to the web site from any computer with Internet access. Just enter the following web site address into your browser window: <http://digital.alight.com/credit-suisse>. (The first time you log on, you will be prompted to create a Benefits Access ID and password).

Log on to the web site to:

- Enroll for your benefits when newly hired or during the Annual Enrollment period in the fall;
- Download a claim form or this document;
- Review your current, personalized benefit information, and make changes as allowed by the Aetna International Health Plan; and
- Take advantage of the valuable tools and resources available to help you make the most of your benefits.

Protect your benefit information by following these basic rules:

- Use strong and unique passwords
- Use multi-factor authentication
- Keep personal contact information current
- Close or delete unused accounts
- Be wary of free Wi-Fi
- Beware of phishing attacks
- Use antivirus software and keep apps and software current
- Know how to report identity theft and cybersecurity incidents

The FBI and the Department of Homeland Security have set up valuable sites for reporting cybersecurity incidents: <https://www.fbi.gov/file-repository/cyber-incident-reporting-united-message-final.pdf/view>; <https://www.cisa.gov/reporting-cyber-incidents>.

The Credit Suisse Benefits Service Center is also available to answer a benefits question or assist with any issue. To reach the Credit Suisse Benefits Service Center, call **1-888-325-2732** or **1-704-646-8768** outside the U.S. and Canada. Representatives are available to assist you Monday through Friday, from 9:00 a.m. to 5:00 p.m., Eastern time.

The Aetna International Health Plan Certificate of Coverage, as modified by this document, serves as your summary plan description as required under ERISA. Its purpose is to provide you with a brief, clear, and meaningful description of the Aetna International Health Plan and to provide the administrative details of the plans, including your rights as a plan participant. Additional details about the Aetna International Health Plan are included in the Credit Suisse Group Health Plan, under which this plan is offered. If there is a discrepancy between anything in this document, the Aetna International Health Plan Certificate of Coverage, or the official plan document, the plan document will govern.

Additional terms and conditions applicable to the Aetna International Health Plan may be found in various documents and instruments, including:

- The Your Benefits Resources web site;
- Materials you may receive from the claims administrators; and
- The claims administrators' web sites.

If any of the terms and conditions in these other documents or instruments conflict with the terms and conditions of this insert and document, the plan administrator shall resolve the conflict in its sole discretion. Any such interpretation will be conclusive and binding on all persons unless the administrator's action is held to be arbitrary or capricious.