



**Retiree Group Medical and Group Life Plan  
Summary Plan Description**

**Effective January 1, 2025**

**The Credit Suisse Retiree Medical and Group Life Plan was terminated effective December 31, 2024. Please see the next page for additional information.**

## The Credit Suisse Retiree Group Medical and Group Life Plan is Terminated

The Credit Suisse Retiree Group Medical and Group Life Plan (the “Plan”) will terminate effective December 31, 2024. The 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 Plan.

### 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).

### Updated Claims and Appeal Procedure

How to File a Claim

Please note: Information regarding filing claims for fully insured plans are provided in the individual certificates of coverage that you receive from United Healthcare Medicare Solutions. You should follow the claims procedures in the applicable certificate of coverage for a fully insured plan.

The following information applies for filing self-insured medical claims.

If you receive care from a provider that participates in the carrier's network, you do not need to file a claim for benefits. The provider will do it for you.

If you receive care from a provider that does not participate in the carrier's network, you need to file a claim for benefits. To file a claim, you must obtain a claim form from the carrier's web site, or you may call the claims administrator to have a form mailed to you. Attach all bills, valid receipts, and documentation when you submit your claim to the carrier.

You must file a claim by the end of the calendar year following the year in which an expense is incurred. Otherwise, the claim will not be paid.

### Appealing a Denied Claim

In the event your claim is denied, there are two types of issues that you can appeal: eligibility issues and benefit issues.

#### **Eligibility Issues**

An eligibility issue relates to your ability to participate in a plan option or to change an election to participate during the year. You may want to start, add, or stop participation in the plan. You may want to challenge enrollment in a plan or eligibility for coverage in a plan. For instance, you may feel an error was made during the Annual Enrollment period that resulted in your being assigned incorrect coverage.

- Level 1: All eligibility issue appeals are reviewed by UBS Benefits Administration. The process by which the eligibility appeal can be filed and the timing of the review are determined by the type of appeal, as described under "Claim Appeal Categories."
- Level 2: All requests for review of denied eligibility appeals are reviewed by the UBS AG Employee Benefits Committee, or its designee. Requests for review of denied eligibility appeals must be filed within 180 days after receipt of your denial notice. Failure to file a request for review of a denied eligibility appeal within the 180-day period will be considered a failure to exhaust all administrative remedies under the Retiree Medical Plan. The process by which the request for review of the denied eligibility appeal can be filed and the timing of the review are determined by the type of appeal, as described under "Claim Appeal Categories."

#### **Benefit Issues**

A benefit issue relates to a claim for a particular benefit under a plan. It will typically include your initial request for benefits, if applicable.

Please note: For benefit issues, claims appeal procedures for your Medicare-eligible plans are provided in the individual certificates of coverage that you receive from United Healthcare Medicare Solutions. You must fully comply with the insurer's claims and appeals procedure if your benefit claim is denied. The complete claims procedure for fully insured benefit programs is contained in the respective coverage summaries or certificates of insurance that are provided to enrollees without charge as separate documents. You should refer to these documents for additional information about how and when to file an appeal. The insurer will also provide you with information on its voluntary external review process by an Independent Review Organization (IRO)/External Review Organization (ERO) or by the State Insurance Commissioner, if applicable. The insurer will describe the process to follow if you wish to pursue an external review of your claim.

#### **The following benefits claim appeal procedures apply to self-insured claims:**

- Level 1: All benefit issue appeals go directly to the claims administrator. Download a claim form from the claims administrator's web site, or call the claims administrator to have one mailed to you, and submit your appeal to the address on the form. Attach all supporting documentation, including receipts and explanations of benefits (EOBs) previously received.

- Level 2: Requests for review of denied medical benefit appeals are filed with the UBS AG Benefits Committee, or its designee. You must request a review of denied benefit appeals within 180 days after receipt of your denial notice. Failure to file a request for review of a denied appeal within the 180-day period will be considered a failure to exhaust all administrative remedies under the process by which the request for review of the denied appeal can be filed and the timing of the review are determined by the type of appeal, as described below.

Either type of issue will fall within one of four appeal sub-categories described below.

### **Review Procedures When an Appeal Is Denied**

Following are the review procedures to be followed when an appeal is denied:

- The Benefits Committee, or its designee, will provide a review that takes into account all comments, documents, records, and other information submitted by you without regard to whether such information was submitted or considered in the initial benefit determination.
- You will have the opportunity to submit written comments, documents, records, and other information relating to the appeal.
- You will be provided, upon request and free of charge, reasonable access to and copies of all relevant documents.
- The review of a denial will not defer to the initial determination made.
- The individual who will conduct the review process will not be the individual who made the initial denial nor the subordinate of such individual.
- In deciding an appeal of any denial that is based in whole or in part on a medical judgment, including determinations of whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment will be consulted. The health care professional will be an individual who was neither consulted in connection with the denial nor the subordinate of any such individual.
- The UBS AG Employee Benefits Committee, or its designee, will identify any medical or vocational experts whose advice was obtained on behalf of the plan in connection with your denial, without regard as to whether the advice was relied upon in making the benefit determination.
- In the case of an appeal involving urgent care, an expedited review process will be provided. You may request an expedited appeal orally or in writing and all necessary information may be transmitted between the plan and you by telephone, facsimile, or other available similarly expeditious method.

### **Claim Appeal Categories**

These sub-categories define the timing for the review of issue appeals and how those appeals can be submitted.

The four appeal sub-categories are:

**Post-Service:** A post-service appeal is an appeal for reimbursement of medical services already received. Claims related to prescription drug coverage are considered post-service claims. This is the most common type of appeal.

**Pre-Service:** A pre-service appeal is an appeal for a benefit for which a pre-treatment review is recommended or required by the plan.

**Concurrent Care:** A concurrent care appeal is an appeal for ongoing treatment over a period of time or a number of treatments. For example, if you have been authorized to receive seven treatments from a therapist and, during the

treatment, the therapist suggests 10 treatments; the appeal is a concurrent care appeal. Some concurrent care appeals also are urgent care appeals.

**Urgent Care:** An urgent care appeal is an appeal for medical care or treatment that, if the longer time frames for non-urgent care were applied, the delay could:  Seriously jeopardize the health of the patient or his or her ability to regain maximum function; or  In the opinion of a physician with knowledge of the patient's medical condition, would subject the patient to severe pain that could not be managed without the care or treatment that is the subject of the appeal.

The processes and timing for filing these appeals are described below.  
How to File Appeals

Whether you have an eligibility issue or a benefits issue, you are provided with two opportunities to challenge denied claims.

## **Filing Level 1 Eligibility Appeals**

### *Filing Pre-Service and Post-Service Eligibility Appeals*

In order for a communication from you to constitute a valid eligibility appeal, it must be in writing and delivered, along with any supporting comments, documents, records, and other information within 180 days of the original denial, by first-class mail postage paid, to:

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

Eligibility appeals may be pursued by you or your duly authorized representative.

## **Defective Appeals**

In the case of your failure to follow the plan's procedures for filing a valid urgent care or pre-service appeal, you will be notified of the failure and the proper procedures to be followed in filing an appeal. This notice will be provided to you as soon as possible.

### **Urgent and Concurrent Care Eligibility Appeals**

In the interest of time, all urgent or concurrent care eligibility appeals can be submitted orally. To file an urgent or concurrent appeal, call the UBS Benefits Express (Aight Worklife) at 1-888-251-2500. Representatives are available Monday – Friday from 9:00 a.m. to 7:00 p.m. ET (excluding holidays).

## **Filing Level 1 Benefit Appeals—Medical**

All Level 1 benefit appeals must be filed with the claims administrator within 180 days of the original denial. Refer to "Plan Administration" for the administrator contact information.

Timing for Level 1 Appeals

### **Timing to Review Post-Service Appeals**

In the case of an appeal filed after the medical care has been delivered, you will be notified of the determination within 30 days after receipt of the appeal.

If an extension is necessary due to your failure to submit the information necessary to decide the appeal, the notice of extension will describe the required information, you will be given at least 45 days from receipt of the notice within which to provide the specified information, and the 30-day period in which the decision is required to be made will be suspended from the date on which the notification is sent to you until the earlier of (1) the date you respond to the request for additional information, or (2) the due date established for furnishing the requested information.

### **Timing to Review Urgent Care Appeals**

In the case of an appeal involving urgent care, you will be notified of the benefit determination (whether adverse or not) no later than 72 hours after receipt of the appeal, provided that you provide sufficient information to determine whether, and to what extent, benefits are payable under the plan.

If you fail to provide sufficient information to determine whether, and to what extent, an appeal involving urgent care is covered by the plan, you will be notified within 24 hours after receipt of the appeal of the specific information necessary to complete the appeal. You will be given a reasonable amount of time, taking into account the circumstances but in no event less than 48 hours, to provide the specified information. You will be notified of the benefit determination no later than 48 hours following the earlier of:

- The receipt of the specified information; or
- The end of the period afforded to you to provide the specified additional information.

### **Timing to Review Concurrent Care Appeals**

In the case of a denial of coverage involving a course of treatment (other than by amendment or termination of the plan) before the end of such period of time or number of treatments, you will be notified of the denial in advance of the reduction or termination to allow you to appeal and obtain a determination on review of that denial before the benefit is reduced or terminated.

Where you want to extend the course of treatment beyond the period of time or number of treatments and it is an appeal involving urgent care, you will be notified of the benefit determination, whether adverse or not, within 24 hours after receipt of the appeal (provided that any such appeal is made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments).

### **Filing a Level 2 Appeal**

#### **Requesting Review of Denied Pre-Service and Post-Service Appeals—Eligibility, Medical Benefit**

In order for a communication from you to constitute a valid request for review of denied pre-service or post-service appeals, it must be in writing and delivered, within 180 days of the initial denial, along with any supporting comments, documents, records, and other information, by first-class mail postage paid, to:

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

#### **Requesting Review of Denied Concurrent and Urgent Care Appeals—Eligibility, Medical Benefit**

In the interest of time, requests for review of denied concurrent care and urgent care appeals can be submitted orally. All requests must be made within 180 days of the initial denial.

### **Timing to Review Denied Level 1 Appeals**

#### *Timing to Review Requests for Review of Denied Pre-Service Appeals*

In the case of a request for review of a denied appeal involving a pre-treatment review, you will be notified of the determination (whether adverse or not) within 15 days after receipt of the request for review.

#### *Timing to Review Requests for Review of Denied Post-Service Appeals*

In the case of a request for review of a denied appeal filed after the medical care has been delivered, you will be notified of the determination within 30 days after receipt of the request for review.

#### *Timing to Review Requests for Review of Denied Concurrent and Urgent Care Appeals*

In the case of a request for review of a denied appeal involving concurrent or urgent care, you will be notified of the determination (whether adverse or not) no later than 72 hours after receipt of the request for review.

### **Manner and Content of Notification of Denied Appeal**

You will be provided with written notice of any denial, in accordance with applicable U.S. Department of Labor regulations. The notification will include:

- Information to help you identify the claim that is being denied, including the date of service, provider's name, claim amount and denial codes and their meanings (treatment and diagnosis codes and their meanings will be provided to you upon request);
- The specific reason or reasons for the denial, including any standard used to deny the claim;
- Reference to the specific provision(s) of the medical plan on which the determination is based;
- A description of any additional material or information necessary for you to perfect the appeal and an explanation of why such material or information is necessary;
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, the notice will either (1) include the specific rule, guideline, protocol, or other similar criterion of the plan that was relied upon, or (2) provide a statement that such rule, guideline, protocol, or similar criterion was relied upon, and that a copy will be provided free of charge to you upon request;
- If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, the notice will provide either (1) an explanation of the scientific or clinical judgment relied upon for the determination, or (2) a statement that such explanation will be provided free of charge upon request;
- A description of the plan's internal and external review procedures and the time limits applicable to such procedures, and, if your appeal involves urgent care, of the expedited review process;
- A statement describing your right to bring a civil lawsuit under Section 502(a) of ERISA; and
- Contact information for any applicable office of health insurance consumer assistance or ombudsman.

For purposes of the Retiree Choice Plus CDHP (Post-94) plan option, if 10% or more of the population residing in the claimant's county are literate only in the same non-English language, as determined by the Department of Labor, then the plan will provide the following for written notice of a denial:

- Oral language services;
- A notice in any applicable non-English language, upon request; and
- A one-sentence statement in notices indicating how to access language services.

### **Discretionary Authority of Plan Administrator**

Although the UBS AG Employee Benefits Committee has delegated its authority to determine initial claims to the claims administrator, the Benefits Committee, or its designee, will have discretionary authority to determine for all parties claiming to have an interest in the plan, and in accordance with the terms of the documents and instruments governing the plan, any and all questions arising from or relating to the administration and interpretation of the plan. This authority includes, without limitation, determination of questions arising from or relating to the participation of eligible employees and eligibility for benefits, the relevant facts, the amount and type of benefits payable.

### **External Review**

Once you have pursued all of the internal claim and appeal rights described in this "How to File a Medical Claim" section in a timely manner (or you are deemed to have pursued them as described below), you can request that your claim be reviewed by an external independent review organization ("IRO"). You can also request an external review of your urgent care claim if exhaustion of the appeal process described earlier would seriously jeopardize your life or health or ability to regain maximum function.

The IRO is composed of persons who are not employed by Credit Suisse, the claims administrator, or any of their affiliates. Your decision to use this voluntary level of appeal will not affect your rights to any other benefits under the plan.

There is no charge for you to initiate this external review process. The plan will abide by the decision of the IRO.

To request an external review, you must notify the claims administrator within 120 days after you receive the final denial notice from the Benefits Committee. The claims administrator will then forward the file to the IRO, who will render an opinion within 45 days. When requested and when a delay would be detrimental to your medical condition, the review will be completed within three days.

You will be provided with written notice of the IRO's decision. The notification will include:

- A general description of the reason for the request for external review;
- The date the IRO received the request for review;
- The date of the IRO's decision;
- References to the evidence or documentation considered in the determination, including the specific coverage provisions and evidence-based standards;
- A discussion of the principal reason or reasons for the decision, including the rationale for the decision and any evidence-based standards relied upon;
- A statement that the determination is binding except to the extent that other relief is available under state or federal law;
- A statement regarding your right to file suit in federal court; and
- Current contact information, including phone numbers, for any applicable office of health insurance consumer assistance or ombudsman.

### **Employment Dispute Resolution Program**

Credit Suisse's Employment Dispute Resolution Program (EDRP) provides that if a claimant wishes to challenge a final determination by the Benefits Committee under the plan, the claim shall be submitted to external mediation. If mediation is not successful, the claimant may submit the claim to final binding arbitration.

You may elect to seek resolution of a denied appeal through the EDRP, through an external review, or through judicial review.

You must pursue all of the internal claim and appeal rights described above in a timely manner (or be deemed to have done so, as described below) before you seek resolution under the EDRP. You may not request that your claim be submitted to mediation until the appeal rights described above have been exercised and the benefits requested in such appeal have been denied in whole or in part (or there is any other adverse benefit determination). The request for mediation must be made within six months after the date on which all administrative remedies are exhausted—that

is, by the later of the date on which an adverse determination on review is issued or the last day on which a final decision should have been issued, or you will forever be prohibited from commencing mediation. A request for binding arbitration must be made within six months of the date Credit Suisse or the claimant gives notice to the other that the mediation proceedings are not likely to result in a resolution.

The EDRP is included in your employee handbook which may be accessed on the MyHR+ Intranet Homepage.

#### Deemed Exhaustion

If the plan does not comply with all of the internal claims and appeal processes described above, you will be treated as though you exhausted the internal appeals process. As a result, you may request an external review, you may request resolution under the EDRP, or you may bring a civil action—even though you have not completed both internal levels of appeal.

However, if the violation of an internal claims and appeal process is de minimus, you will not be treated as though you exhausted the internal appeals process. The violation will be considered de minimus if it is not likely to cause prejudice or harm to your claim, it was for a good cause or due to matters beyond the plan's control and was in the context of an ongoing, good faith exchange of information between you and the plan.

#### Legal Action

If you do not wish to submit your claim to external review or to mediation under the EDRP, you must pursue all of the internal claim and appeal rights described above in a timely manner before you may appeal in federal court. You may not bring any action at law or in equity to recover benefits unless and until the appeal rights described above have been exercised and the benefits requested in such an appeal have been denied in whole or in part (or there is any other adverse benefit determination).

If you wish to seek judicial review of any adverse benefit determination with respect to a claim, you must file a civil action under Section 502(a) of ERISA within one year after the date on which all administrative remedies are exhausted, that is, by the later of the date on which an adverse determination on review is issued or the last day on which a final decision should have been issued, or you will forever be prohibited from commencing such action. Any action must be brought in the New York State Supreme Court (Borough of Manhattan) or the United States District Court for the Southern District of New York and no other.

### **How to File a Life Insurance Claim Filing a Claim**

To initiate a claim occurring before December 31, 2024 under your retiree life insurance, your beneficiary(ies) should contact [sh-ushwoperations@ubs.com](mailto:sh-ushwoperations@ubs.com).

### **If a Claim Is Denied**

MetLife makes every effort to resolve disagreements quickly and informally. However, there are formal procedures in place should your beneficiary(ies) need to appeal a plan decision. MetLife has final determination of all appeals.

When your beneficiary(ies) files a claim, the claims administrator reviews the claim for benefits and makes a decision to either approve or deny the claim.

If the claim is denied, in whole or in part, your beneficiary(ies) will receive written or electronic notification from the claims administrator within 90 days after receipt of the claim by the plan. The notice will contain all of the following:

- The specific reasons for the denial.
- The specific plan provisions on which the denial is based.
- A description of any additional material or information needed and an explanation of why it is necessary.
- An explanation of the plan's claim review procedures, applicable time limits, and your beneficiary(ies)'s rights to bring a civil action under ERISA section 502(a) following a denial.

In some situations, the plan may need an additional 90 days to make a decision (for example, if the plan needs additional information). In these cases, your beneficiary(ies) will be notified before the end of the first 90-day period why the extension is necessary and when the plan expects to render a decision.

### **Request for Review if a Claim Is Denied**

Your beneficiary(ies), or his or her authorized representative, may ask for a full and fair review of the claim/benefit decision by writing to the claims administrator. All appeals of denied claims/benefits should be addressed to: MetLife Group Life Claims P.O. Box 6100 Scranton, PA 18505

Your beneficiary(ies) must make this request within 60 days of the date he or she receives notice of the denied claim. During the 60-day period, your beneficiary(ies) or his or her authorized representative will be given reasonable access to all documents and information relevant to the claim, and you may request copies free of charge. He or she can also submit written comments, documents, records, and other information relating to the claim to the claims administrator. Review of the claim will take into account all comments, documents, records, and other information, without regard to whether such information was submitted or considered in the initial benefit determination.

### **Additional Rights on Appeal**

If the claim/benefit is denied:

- Your beneficiary(ies) will have the opportunity to submit written comments, documents, records, and other information relating to the claim.
- Your beneficiary(ies) will be given reasonable access to and copies (free of charge) of all documents, records, and other information related to the claim.
- The review of the claim will take into account all the information submitted that relates to the claim, without regard to whether it was submitted for the initial claim.
- The claim will be reviewed *de novo*. That means "start fresh," and an independent plan fiduciary will review the claim. In reviewing the claim, he or she will not place deference upon the original decision. The claim will be reviewed by an appropriate named fiduciary who is not the individual who made the initial decision, and who is not subordinate to the initial reviewer, and who will give a full and fair review of the claim and the denial.
- If your beneficiary(ies) appeal is denied, he or she may file a suit under ERISA. (For more information, see "Your Rights Under ERISA.")

Your beneficiary(ies) and the claims administrator may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact the local office of the U.S. Department of Labor.

### **Decision on Review**

The claims administrator will then review the claim again and make a decision based on all comments, documents, records, and other information submitted. In most cases, your beneficiary(ies) will receive the claim administrator's decision within 60 days after receipt of the request for review by the plan. However, the period may be extended for an additional 60 days if a determination is made that such an extension is necessary due to matters beyond the control of the plan and if notification is given prior to the expiration of the initial 60-day period, of the circumstances requiring the extension of time and the date by which it expects to render a decision.

## **Discretionary Authority of Insurance Carrier and Plan Administrator**

The insurance carrier (MetLife) will make all final claim determinations as well as determine initial claims. The Benefits Committee or its designee will have sole and complete discretionary authority to determine conclusively for all parties all questions arising from or relating to the eligibility to participate in the benefits provided under the plan. The insurance carrier will have sole and complete discretionary authority to determine conclusively for all parties claiming to have an interest in the plan, and in accordance with the terms of the documents and instruments governing the plan, any and all questions arising from or relating to the eligibility of participants for benefits, the relevant facts, the amount and type of benefits payable to any participant or other claimant, and the construction of all terms of the plan. Decisions by the insurance carrier will be final, conclusive, and binding on all parties claiming to have an interest in the plan. Benefits will be paid under the plan only if the insurance carrier decides in its discretion that the participant or other claimant is entitled to them.

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# Retiree Group Medical Plan and Group Life Plan

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## Introduction

Credit Suisse Securities (USA) LLC (Credit Suisse or the Bank) offers group medical and group life insurance benefits to eligible employees during retirement under the Credit Suisse Securities (USA) LLC Group Health Care Plan. This document provides important details about the Retiree Group Medical Plan and Retiree Group Life Plan, including:

- Eligibility and participation;
- How the plans work;
- How to submit claims; and
- Legal and administrative information.

If you have any questions, please refer to "Resources."

**Note:** This SPD does not describe all of the retiree medical benefits under the Credit Suisse Securities (USA) LLC Group Health Care Plan. Separate certificates of coverage and/or summary plan descriptions have been prepared for the following groups of retirees:

- Eligible retirees who are part of a closed group of employees enrolled in one of several fully insured plans as of January 1, 2018 (the "Fully Insured Closed Retiree Medical Plans"). While this document generally applies to these retirees, the coverage provided under the Group Health Care Plan is described in the certificates of coverage issued for those plans.
- Eligible retirees who retire outside of the United States. Benefits for these retirees are provided under the Aetna Retiree International Medical Plan and are not described in this document.
- Retirees who are eligible for Medicare based on disability or who have dependents who are eligible for Medicare based on disability. Benefits for covered persons who are Medicare eligible based on disability are provided under the UHC Indemnity (Post-94) option and are not described in this document.

If you are a participant under the Aetna Retiree International Medical Plan, or you or your dependents are eligible for Medicare based on disability, call the Credit Suisse Benefits Service Center at **1-888-325-2732** for the separate summary plan description applicable to you.

If you are a participant under one of the Fully Insured Closed Retiree Medical Plans, call the Credit Suisse Benefits Service Center at **1-888-325-2732** for the certificate of coverage applicable to you.

Regardless of any conflicting information in the certificates of coverage, employees are eligible for the Fully Insured Closed Retiree Medical Plans if they were enrolled in coverage as of January 1, 2018 based on criteria that was established at the time the fully insured plans were implemented.

## Notice About This Document

This document along with the UnitedHealthcare Insurance Company of New York Certificates for the Fully Insured Closed Retiree Medical Plans and the Metropolitan Life Insurance Company Certificate for the Grandfathered July 1, 1988 First Boston Group (collectively, the "Certificates") serve 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 this document and the official plan document, the Plan document will control. If there is any conflict between this document and the Certificates, the Certificates will control unless specifically provided otherwise in this document.

Additional terms and conditions applicable to the Retiree Medical Plan and Retiree Life 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 (listed under "Resources").

If any of the terms and conditions in these other documents or instruments conflict with the terms and conditions of this SPD, 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.

## Overview of this SPD

This SPD describes the following retiree medical and life insurance benefits under the Credit Suisse Securities (USA) LLC Group Health Care Plan:

### ***Credit Suisse Retiree Group Medical Plan (Retiree Medical Plan)***

The Retiree Medical Plan provides an opportunity for eligible employees to participate in group health care coverage after retirement. Your coverage differs depending on your and/or your covered spouse's or domestic partner's eligibility for Medicare. Because of the variations in eligibility, coverage, and cost of coverage that exist, it is important for you to refer to the sections of this Summary Plan Description (SPD) that apply to you.

There are three main sections relevant to the Retiree Medical Plan. You should review the information below to determine which sections apply to your specific situation.

- I. **Standard Retiree Medical Plan:** This section is relevant for the four following groups:
  - All new hires and current employees and participants who meet the standard "Rule of 65" eligibility requirements as described under "Standard 'Rule of 65' Eligibility";
  - Grandfathered July 1, 1988 First Boston Group employees and retirees who retired on or after January 1, 1994 (specific eligibility and cost of coverage detailed under "Standard Plan: Grandfathered July 1, 1998 First Boston Group");
  - Former Credit Suisse Group employees and retirees (specific eligibility and cost of coverage is detailed under "Standard Plan: Former Credit Suisse Group Employees in the U.S."); and

- Grandfathered Donaldson Lufkin & Jenrette Group (“DLJ Group”) (call the Credit Suisse Benefits Service Center at 1-888-325-2732 for specific eligibility and cost of coverage information).

**NOTE:** The Standard Retiree Medical Plan **does not** apply to **Grandfathered July 1, 1988 First Boston Group retirees who retired on or before December 31, 1993.**

- II. Grandfathered July 1, 1988 First Boston Closed Groups:** This section **ONLY** applies to Grandfathered July 1, 1988 First Boston Group retirees who retired on or before December 31, 1993 (Grandfathered July 1, 1988 First Boston Closed Groups). If you fall into one of these Closed Groups, you should also read the "Medical and Prescription Drug Information for All Retirees" section of this SPD.

**NOTE:** This section does not apply to any current Credit Suisse employees or Grandfathered July 1, 1988 First Boston Group participants who retired on or after January 1, 1994.

- III. Medical and Prescription Drug Information for All Retirees:** This section is relevant for all employees and retirees.

### **Important**

Grandfathered, subsidy-eligible retirees and their spouses or domestic partners will have access to a Retiree Reimbursement (RRA) Account for eligible medical expenses and/or premium expenses as determined by Credit Suisse Securities USA LLC. The following groups of retirees are considered “grandfathered” for purposes of the RRA:

- Members of the Grandfathered July 1, 1988 First Boston Group (as defined in this Summary Plan Description) who retired on or after January 1, 1994.
- Members of the Grandfathered July 1, 1988 First Boston Closed Groups (as defined in this Summary Plan Description) who retired on or before December 31, 1993.
- Grandfathered retirees (as defined in this Summary Plan Description) and the Grandfathered Donaldson Lufkin & Jenrette Group.

If you would like a copy of the RRA Summary Plan Description, please contact the Credit Suisse Benefits Service Center.

### **Advocacy Services**

Get confidential assistance navigating health care issues. Knowledgeable professionals are just a phone call away to answer your medical questions, help you understand medical treatment options and diagnoses, and assist with claim issue resolution.

For clinical or claim advocacy services, call the Credit Suisse Benefits Service Center at **1-888-325-2732**.

### **Grandfathered Plans Under the Affordable Care Act**

This “Grandfathered Plans Under the Affordable Care Act” section applies regardless of any conflicting information in the Fully Insured Closed Group Retire Medical Plan Certificates.

With the exception of the Retiree Choice Plus CDHP (described within this SPD) and the Aetna Retiree International Medical Plan (not described within this SPD), all of the other medical options offered to Credit Suisse retirees (including but not limited to the Fully Insured Closed Retiree Medical Plans) are considered "grandfathered health plans" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans; for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act; for example, the elimination of lifetime limits on benefits.

### **Non-Grandfathered Plan under the Affordable Care Act**

The Retiree Choice Plus CDHP (described within this SPD) is a "non-grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). Being a non-grandfathered health plan means that the plan includes certain consumer protections of the Affordable Care Act that other grandfathered plans may not have. Questions regarding which protections apply and which protections do not apply to grandfathered health plans and non-grandfathered health plans, and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at:

Credit Suisse Benefits Service Center  
P.O. Box 661074  
Dallas, TX 75266-1074  
**1-888-325-2732**

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at **1-866-444-3272** or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). This web site has a table summarizing which protections do and do not apply to grandfathered health plans.

### ***Credit Suisse Retiree Group Life Plan (Retiree Life Plan)***

The Retiree Life Plan provides eligible employees with life insurance coverage during retirement. The Retiree Life Plan is **only** available to the Grandfathered July 1, 1988 First Boston Group. However, whether or not you are eligible for the Retiree Life Plan, you may be able to convert your active employee, supplemental, and/or spouse or domestic partner life insurance coverage to individual policies. See "The Retiree Life Plan" section.

# Standard Retiree Medical Plan

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## Overview

The information in this section describes, in general, how the Retiree Medical Plan works. Keep in mind, this section is relevant for all new hires and current employees and participants who meet the standard "Rule of 65" eligibility requirements as described under "Standard 'Rule of 65' Eligibility," as well as Grandfathered July 1, 1988 First Boston Group employees and retirees who retired on or after January 1, 1994 (specific eligibility and cost of coverage detailed beginning under " Standard Plan: Grandfathered July 1, 1988 First Boston Group"), Former Credit Suisse Group employees and retirees (specific eligibility and cost of coverage is detailed beginning under " Standard Plan: Former Credit Suisse Group Employees in the U.S."), and the Grandfathered DLJ Group. **This section does not apply to Grandfathered July 1, 1988 First Boston Closed Group retirees who retired on or before December 31, 1993.**

# Standard Retiree Medical Plan: Eligibility

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## Standard "Rule of 65" Eligibility

You are eligible for the plan if you meet the following requirements:

- You are classified as an employee of the Bank, meaning you are classified by and worked for the Bank or a "Participating Affiliate," or another entity that has adopted the Retiree Medical Plan with the consent of the Credit Suisse Benefits Committee as its employee (you can contact the Credit Suisse Benefits Service Center to help you determine if your employer participates in this plan);
- You are enrolled in a Credit Suisse medical option for active employees and on a U.S. payroll at the time of your retirement;
- You are age 55 or older when you retire;
- You have at least five years of service; and
- Your age plus years of service as defined under "Years of Service Defined" below equals 65 or more (the "Rule of 65").

### **Participating Affiliates**

The following Participating Affiliates have adopted the plan:

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

### **Years of Service Defined**

For the Retiree Medical Plan, service is calculated as all service with Credit Suisse and related companies according to the following rules:

- Service is counted as long as you are a full-time employee or part-time employee regularly scheduled to work 20 or more hours a week.
- Service is tracked to the nearest day and you can have a partial year of service.
- All partial years will be aggregated.

### ***How Service Is Counted During a Leave of Absence***

A paid or unpaid leave of absence counts toward years of service if it is for a period of one year or less, whether or not you return to work. If your paid or unpaid leave of absence is longer than one year, time during your leave is not counted.

### ***How Service Is Counted If You Have a Break in Service***

A break in service due to voluntary termination, retirement, or discharge counts toward years of service if it is for a period of one year or less. If your break in service is longer than one year, time during your break is not counted.

### ***How Service Is Counted If You Are on Long-Term Disability***

If you are receiving long-term disability benefits, you will receive up to one year of service during the time you are on disability, whether or not you return to work.

**Please note:** There are different eligibility requirements for Grandfathered July 1, 1988 First Boston Group participants as well as the Former Credit Suisse Group Retirees. Specific eligibility requirements and cost of coverage details are described starting under " Standard Plan: Grandfathered July 1, 1988 First Boston Group" and " Standard Plan: Former Credit Suisse Group Employees in the U.S.," respectively.

## **Eligible Dependents for the Retiree Medical Plan**

Upon retirement, when you are automatically enrolled in the Retiree Medical Plan, the dependents you covered as an active employee are automatically covered as well. Your eligible dependents 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 "Coverage for Your Domestic Partner");
- Children who are under age 26; coverage continues until December 31 of the year in which the child turns age 26; and
- Mentally or physically disabled children over age 26 who became disabled before age 26 while covered under the plan and 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.

### **Rules for Disabled Children**

Contact your claims administrator when your child becomes disabled to learn how to certify his or her disability status.

For your child's coverage to continue, you must notify the Credit Suisse Benefits Service Center when the claims administrator certifies your child's disability status.

## 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.

## Married Credit Suisse Retirees

Each Credit Suisse employee or retiree can only be covered by one Credit Suisse medical plan at a time. Therefore, if your spouse or domestic partner also works for or is retired from the Bank, keep in mind that you cannot be covered as both a dependent and the employee or retiree under the Bank's medical plans. Therefore:

- You can cover yourself as primary and your spouse or domestic partner as a dependent; or
- You may be covered as a dependent under your spouse's or domestic partner's plan; or
- You and your spouse or domestic partner can each choose You Only coverage.

Keep in mind, if you have eligible dependent children, only one of you can cover them as dependents under the plan.

Also keep in mind, if you do not elect retiree coverage, you cannot be enrolled at a later date unless you are rehired and subsequently retire. Existing spouses may not be added to coverage after retirement.

## Coverage for Your Domestic Partner

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

If you reside in a state that allows and recognizes a same-sex civil union, you may be asked to provide government documentation validating your civil union.

If you satisfy this requirement, 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 plan administrator and/or the insurance company, as applicable for certain insured medical benefits, may require documented proof that each of you is eligible.

## 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 Retiree Medical Plan if you:

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

# Standard Retiree Medical Plan: How the Standard Retiree Medical Plan Works

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## Enrolling in the Plan When You Retire

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.

At retirement, if you are eligible for the Retiree Medical Plan, pre-Medicare-eligible dependents are automatically enrolled in a pre-Medicare retiree medical option. If you and/or your spouse or domestic partner is eligible for Medicare, you and/or your spouse or domestic partner will have a choice of retiree medical plan options through United Healthcare® Medicare Solutions.

**Please note:** If you decline coverage when you retire, you permanently waive coverage and you will not be permitted to enroll yourself or your dependents in the Retiree Medical Plan at a later date unless you are a rehired employee as described below. If you decline coverage for a dependent when you retire, you permanently waive coverage for that dependent and you will not be permitted to enroll that dependent in the Retiree Medical Plan at a later date unless you are a rehired employee as described below.

### Rehired Retirees

If you are re-employed by Credit Suisse after your retirement and you are covered under the Credit Suisse Group Health Care Plan as an active employee at the time of your subsequent retirement, you and your covered dependents will be eligible for coverage under the Retiree Medical Plan in effect at that time.

### International Retirees

If you are a participant in the Aetna Retiree International Medical Plan when you move to the United States, and notify Credit Suisse of your address change, you will be automatically enrolled in a US Retiree Medical Plan. For more information about participation in the Retiree Medical Plan after participation in the Aetna Retiree International Medical Plan, please call the Credit Suisse Benefits Service Center at **1-888-325-2732**.

## When Coverage Begins

Your retiree medical coverage begins on the first of the month following your retirement date, unless you retire on the first of the month, in which case it begins on the same day. Your active medical coverage continues to the end of the month in which you retire, unless you retire on the first of the month, in which case it ends on that day.

Medical coverage for your dependents begins on the same day your coverage begins.

# Making Elections During Annual Enrollment

Each year, you have the opportunity to drop dependents or drop coverage during the Annual Enrollment period (generally held in the fall). Pre-Medicare retirees and dependents 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 (see "Resources").

Medicare-eligible retirees also have the option to make changes each year. They will receive enrollment materials from AARP/UHC.

**Please note: If you drop your Retiree Medical Plan coverage, you will not be permitted to re-enroll in the Retiree Medical Plan at a later date unless you are a rehired retiree as described above.**

## Coverage Categories

When you enroll, you will choose which, if any, eligible dependents to enroll for coverage. The number of dependents you enroll determines your coverage category. In general, the categories are:

- You Only;
- You + Spouse or Domestic Partner;
- You + Children; or
- You + Family.

# Changing Dependents to Your Standard Retiree Medical Plan During the Year

## If You Are a Pre-65 Medicare Retiree

Generally, outside of the Annual Enrollment period, the only time you may change your dependents during the year is if you have a permitted qualified status change. Keep in mind that any changes made to your Retiree Medical 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 the plan.

Except as described below, dependent coverage under the Retiree Medical Plan is available only to those persons who were covered as your dependents through the active plan at the time of your retirement.

Permitted qualified status changes include:

- Removing a spouse or domestic partner due to a change in your marital status or domestic partnership;
- Adding a spouse through marriage;
- Adding a spouse who lost coverage elsewhere;
- Adding a dependent due to birth, adoption, or placement for adoption, or removing a dependent due to the death of a dependent or a dependent who is no longer eligible for coverage;
- Removing a spouse, domestic partner or dependent due to a change in your, your spouse's or domestic partner's, or your dependent's employment status that results in a gain of benefits eligibility; and
- You may drop your coverage if you become eligible for another employer's plan (for example, if you have a job).

**Please note:** Surviving spouses and dependents covered under the plan may not add dependents. For more information about survivor coverage, see "When Retiree Medical Plan Participation Ends."

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

*Example 1:* If you get married, you may add your new spouse to your Retiree Medical Plan coverage, or you may drop your Retiree Medical Plan coverage to enroll in your new spouse's coverage (through his or her employer's plan). However, remember, if you drop your Retiree Medical Plan coverage, you cannot re-enroll at a later time unless you retire again after having been rehired as described above.

*Example 2:* If you have or adopt a child, you may add your new dependent to your Retiree Medical Plan coverage. However, you may not drop your coverage as a result of this change in status.

*Example 3:* If the retiree dies, the surviving spouse can continue to be covered under the Retiree Medical Plan. However, if the surviving spouse remarries, he or she will not be able to add his or her new spouse or any other eligible dependents to coverage.

If you do not make a change in your Retiree Medical 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**

The Bank reserves the right to ask for proof of your qualified status change. 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 that time or discontinuing your benefits.

### **If You Are a Post-65 Medicare-Eligible Retiree**

If you are a Medicare-eligible retiree who is age 65 or older, during the plan year you can move between AARP Medicare Supplement plans if you have a current AARP membership. Your change in coverage will become effective on the first of the following month.

However, if you are enrolled in a Medicare Part D Prescription Drug Plan or a Medicare Advantage Prescription Drug Plan, you cannot make any changes during the plan year unless you qualify for a special election period in accordance with Medicare. For additional information on special election periods, visit **Medicare.gov**.

# Standard Retiree Medical Plan: Coverage Options

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## Coverage Options

Your plan options for retiree medical coverage are based on whether or not you or your dependents are eligible for Medicare. The chart below shows how this works.

<b>You Are Non-Medicare-Eligible</b>		<b>You Are Medicare-Eligible</b>	
<b>You and Any Non-Medicare-Eligible Family Members Will Be Covered Under:</b>	<b>Any of Your Medicare-Eligible Family Be:</b>	<b>Any of Your Non-Medicare-Eligible Family Members Will Be Covered Under:</b>	<b>You and Any Medicare-Eligible Family Members age 65 or over will Be:</b>
UHC Choice Plus POS (Post-94) or Retiree Choice Plus CDHP (Post-94)	Able to choose a retiree medical plan option through United Healthcare Medicare Solutions	UHC Choice Plus POS (Post-94) or Retiree Choice Plus CDHP (Post-94)	Able to choose a retiree medical plan option through United Healthcare Medicare Solutions

### Split Family Coverage

When a family has members covered under both the non-Medicare-eligible and Medicare-eligible plans, this is referred to as "Split Family Coverage."

### Coverage for Non-Medicare-Eligible Participants Without A Subsidy – Retiree Choice Plus CDHP (Post-94)

If you are not eligible for Medicare and you are not a subsidy-eligible retiree, you and/or your non-Medicare-eligible dependents may be enrolled in the Retiree Choice Plus CDHP (Post-94) plan option. If you are Medicare-eligible but your dependents are non-Medicare-eligible, your dependents may be enrolled in the Retiree Choice Plus CDHP (Post-94) option.

The Retiree Choice Plus CDHP (Post-94) is not a grandfathered health plan option under the Affordable Care Act.

### Coverage for Non-Medicare-Eligible Participants With A Subsidy – UHC Choice Plus POS (Post-94)

If you are not eligible for Medicare and you are a subsidy-eligible retiree, you and/or your non-Medicare-eligible dependents may be enrolled in the UHC Choice Plus POS (Post-94) plan option. If you are Medicare-eligible but your dependents are non-Medicare-eligible, your dependents may be enrolled in the UHC Choice Plus (Post-94) option.

### Coverage for Medicare-Eligible Participants based on Age

Medicare-eligible retirees and/or their spouses or domestic partners will be able to choose a retiree medical plan option through United Healthcare Medicare Solutions. Through United Healthcare, participants have access to a wider choice of options at a variety of prices. United Healthcare offers Medicare Supplement plans, Medicare Advantage plans, and Medicare Part D prescription drug plans.

## Coverage for Medicare-Eligible Participants based on Disability

### Cost of Coverage

If you meet the "Standard Rule of 65" eligibility requirements, you pay the full cost of Retiree Medical Plan coverage. Current contributions for pre-Medicare retiree medical coverage are available on the Your Benefits Resources web site, or you may call the Credit Suisse Benefits Service Center at **1-888-325-2732**. Each year you will receive notification of the cost of coverage. If you enroll during the Annual Enrollment period or change your coverage at any time, you will receive a confirmation showing cost information.

Medicare-eligible retirees and their spouses or domestic partners are also responsible for the full cost of coverage of Medicare Supplement plans, Medicare Advantage Plans, and Medicare Part D prescription plans through United Healthcare Medicare Solutions. For questions on those coverages and costs, contact United Healthcare Medicare Solutions at **1-877-886-7309**.

See "Standard Plan: Grandfathered July 1, 1988 First Boston Group" and/or "Standard Plan: Former Credit Suisse Group Employees in the U.S." for cost of coverage information applicable to those populations.

See "Standard Plan: Former Credit Suisse Group Employees in the U.S." for cost of coverage information applicable to those populations.

Call the Credit Suisse Benefits Service Center at **1-888-325-2732** for cost of coverage information applicable to the DLJ group population.

**Please note:** Rates may change in the future. The Credit Suisse Benefits Service Center will notify pre-Medicare retirees of any change in the premium rate. Also, members of Grandfathered and Closed Groups will have a different cost of coverage described in each of the group's eligibility sections.

### Paying for Coverage

#### If You Are a Pre-Medicare Retiree

You will receive a monthly bill for the Retiree Medical Plan. Payment may be made through a direct debit from your bank account, electronic funds transfer, withdrawal from your Social Security check, or personal check. Visit the Your Benefits Resources web site to coordinate payment. You may also call the Credit Suisse Benefits Service Center at **1-888-325-2732** to have a form mailed to you. You will need to sign the form and mail it back.

#### If You Are a Medicare-Eligible Retiree

You may opt to pay your AARP Medicare Supplement Plan and Medicare Rx premiums on an annual or monthly basis. Instructions for each option are below. If you are eligible for the RRA, you may be able to reimburse yourself for payment of premiums. Refer to the RRA SPD for additional information.

#### ***AARP® Medicare Supplement Plans***

When you enroll in an AARP Medicare Supplement Plan, you will receive a coupon book. Annual payments

must be made by check, and should be mailed along with the first coupon of the book to the address noted on the coupon book. Monthly payments can be made by check or electronic funds transfer. If you pay by check, you must remit one coupon per month along with your check.

***AARP® Medicare RX***

When you enroll in an AARP Medicare Rx plan, you will receive a premium invoice. Annual payments must be made by check, and should be mailed to the address noted on the invoice. Monthly payments can be made by check or electronic funds transfer.

**The Retiree Medical Plan**

There is no retiree dental or vision plan. However, the Retiree Medical Plan may cover certain dental or vision expenses. These are described under "Standard Retiree Plan Design: What Is Covered."

# Standard Retiree Medical Plan: How the Non-Medicare-Eligible Options Pay Benefits

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## Plan Features

Following are some key definitions to help you understand how the Retiree Medical Plan works.

### Copayments

Under the non-Medicare **UHC Choice Plus POS (Post-94)** option, when you receive care from an in-network provider, you generally pay a small copayment at the time of service. Copayments do not apply to the Retiree Choice Plus CDHP. See "Standard Retiree Plan Design: What Is Covered" for copayment amounts.

### Coinsurance

You share the cost of medical services through coinsurance:

**For the Retiree Choice Plus CDHP (Post-94)**, coinsurance is the portion of the charges that you and the plan each pay for covered in- and out-of-network services. The amount the plan pays for out-of-network services are based on the plan's "reasonable and customary" (R&C) limits.

See "Standard Retiree Plan Design: What Is Covered" for specific coinsurance amounts.

### Reasonable and Customary (R&C) Limits

R&C rates are established by your carrier, and may vary by geography and type of service. If your provider's fee is higher than R&C, you are responsible for the full amount above R&C.

### Annual Deductibles

The annual deductible is the amount of covered medical expenses you are responsible for each year before the plan starts to pay benefits.

The following charges do **not** count toward meeting this deductible:

- Any copayments you pay for office visits, if applicable;
- Any charges you pay because the service or procedure is not covered by the plan;
- Any charges you pay because expenses exceed R&C limits;
- Any charges you pay because services are deemed not medically necessary;
- Any contributions you pay toward the cost of coverage; and
- Any expenses you pay through the prescription drug program.

There are different deductibles for individuals and families. Under the **UHC Choice Plus POS option (Post-94)**, once a covered person meets the individual deductible amount for the year, the plan starts paying medical benefits for that individual. Under the **Retiree Choice Plus CDHP option (Post-94)**, the individual deductible applies only if you elect "You Only" coverage. If you are covering one or more dependents, the "You + 1" or "You + Family" deductible must be met before the plan begins paying benefits for non-preventive services for any covered family member.

### **Annual Out-of-Pocket Maximum**

The Retiree Medical Plan places a maximum on the amount of money you have to pay out of pocket each year for your share of covered medical expenses. This is called the out-of-pocket maximum. The out-of-pocket maximum provides protection against large expenses from combined coinsurance and deductible payments during a year.

Under the **UHC Choice Plus POS (Post-94)** option, once you or a covered dependent reaches the individual out-of-pocket maximum, the plan pays 100% of most covered expenses for that person for the rest of the calendar year. For in-network services under the **Retiree Choice Plus CDHP (Post-94)** option, once you reach the individual out-of-pocket maximum for "You Only" coverage or you or a covered dependent reaches an individual out-of-pocket maximum of \$6,850 for "You + Family" coverage, the plan pays 100% of most covered expenses for that person for the rest of the calendar year. For out-of-network services under the **Retiree Choice Plus CHDP (Post-94) option**, the individual out-of-pocket maximum applies only if you elect "You Only" coverage. If you are covering one or more dependents, the "You + 1" or "You + Family" out-of-pocket maximum must be met before the plan will pay 100% of most covered expenses.

Amounts you pay toward meeting the annual medical deductible as well as out-of-pocket costs in the form of coinsurance (for the Retiree Choice Plus CHDP (Post-94) option) count toward the out-of-pocket maximum. However, the following charges do **not** count toward the annual out-of-pocket maximum:

- Any copayments you pay for office visits (other than for the Retiree Choice Plus CHDP), if applicable;
- Any charges you pay because the service or procedure is not covered by the plan;
- Any charges you pay because expenses exceed R&C limits;
- Any charges you pay because services are deemed not medically necessary;
- Any contributions you pay toward the cost of coverage; and
- Any expenses you pay through the prescription drug program, except under the Retiree Choice Plus CDHP.

### **How the Annual Deductibles and Out-of-Pocket Maximums Work When a Covered Individual Switches to Medicare-Eligible Coverage**

When any covered individual becomes eligible for Medicare (usually upon reaching age 65), Credit Suisse retiree medical coverage for that individual switches to a Medicare-eligible plan. Any amounts paid toward the non-Medicare plan's annual deductible or out-of-pocket maximum will reset and start over in the Medicare-eligible plan.

## Covered Charges

The Retiree Medical Plan pays benefits for services and supplies that are specifically covered by the plan. To be covered, a medical service must be "medically necessary" as determined by a physician and agreed to by the claims administrator. The claims administrator's criteria to determine medical necessity may change periodically. You may contact your claims administrator for additional information, or see the "Glossary" for a definition of "medically necessary." In addition, out-of-network expenses may be subject to R&C limits.

## More About Plan Features

The following chart provides additional details about certain plan features.

**Please note:** If you are in a Closed Group, please refer to the "Grandfathered July 1, 1988 First Boston Closed Groups" section.

Plan Feature	UHC Choice Plus POS (Post-94)		Retiree Choice Plus CDHP Plan Option (Post-94)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible	\$0	\$300 individual/\$600 family	\$3,500 individual/\$7,000 family	\$7,000 individual/\$14,000 family
Coinsurance	90%	70% after deductible	80% after deductible	60% after deductible
Reasonable and Customary (R&C) Limits	N/A	Services and supplies are subject to R&C	N/A	Services and supplies are subject to R&C
Medicare Allowable Charge	N/A	N/A	N/A	N/A
Out-of-Pocket Maximum	\$1,500 individual/\$3,000 family	\$3,000 individual/\$6,000 family	\$6,250 individual/\$6,850 individual enrolled in family/\$12,500 family	\$12,500 individual/\$25,000 family
Claim Forms	No claim forms are required	You pay for services and supplies at the time of care and submit a claim for reimbursement	No claim forms are required	You pay for services and supplies at the time of care and submit a claim for reimbursement

## Standard Retiree Plan Design: What Is Covered

This chart shows how benefits are paid by the UnitedHealthcare (UHC) plans.

For more information on coverage, visit the Your Benefits Resources web site. If you have a question about a specific type of coverage, call your claims administrator (see "Plan Administration" for contact information).

Plan Feature	UHC Choice Plus POS (Post-94)		Retiree Choice Plus CDHP Plan Option (Post-94)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
	Under the non-Medicare-eligible plan, you have the flexibility to choose between in-network and out-of-network care each time you need to visit a doctor or other health care provider. The network is a group of health care providers, including doctors, hospitals, labs, and other facilities, that has agreed to offer services to participants at a discounted rate. If you choose an in-network provider, you lower your out-of-pocket costs and the amount the Bank pays for your care.			
<b>Doctor's Office Visits</b>				
Doctor's office visit	\$25 regular doctor's office copayment/\$40 specialist copayment	70% after deductible	80% after deductible	60% after deductible
<b>Preventive Care</b>				
Annual physical exam	\$25 regular doctor's office copayment/\$40 specialist copayment	70% after deductible	The plan pays 100%	60% after deductible
<b>Limit:</b> One per calendar year, in- and out-of-network combined				
Well-woman exam (includes routine pap smear)	\$25 regular doctor's office copayment/\$40 specialist copayment	70% after deductible	The plan pays 100%	60% after deductible
<b>Limit:</b> One per calendar year, in- and out-of-network combined				
Mammogram	\$25 regular doctor's office copayment/\$40 specialist copayment	70% after deductible	The plan pays 100%	60% after deductible
Pediatric exams	\$25 regular doctor's office copayment/\$40 specialist copayment up to age 19	70% after deductible up to age 19	The plan pays 100%	60% after deductible up to age 19
Immunizations for children	\$25 regular doctor's office copayment/\$40 specialist copayment up to age 19	70% after deductible up to age 19	The plan pays 100%	60% after deductible up to age 19
Cancer screenings	\$25 regular doctor's office	70% after deductible	The plan pays 100%	60% after deductible

	copayment/\$40 specialist copayment			
One per calendar year over age 18				
Cardiovascular screenings	\$25 regular doctor's office copayment/\$40 specialist copayment	70% after deductible	The plan pays 100%	60% after deductible
Allergies	\$25 regular doctor's office copayment/\$40 specialist copayment for treatments and tests	70% after deductible	80% after deductible for treatments and tests	60% after deductible
<b>Outpatient Care</b>				
Outpatient surgery	\$25 regular doctor's office copayment/\$40 specialist copayment; then 90%	70% after deductible	80% after deductible	60% after deductible
Outpatient laboratory services	\$25 regular doctor's office copayment/\$40 specialist copayment; then 90%	70% after deductible	80% after deductible	60% after deductible
Outpatient X ray	90%	70% after deductible	80% after deductible	60% after deductible
Outpatient physical therapy	90%	70% after deductible	80% after deductible	60% after deductible
	<b>Limit:</b> Up to 30 visits per calendar year, in- and out-of-network combined		<b>Limit:</b> Up to 60 visits per calendar year, in- and out- of-network combined	
Outpatient occupational therapy	90%	70% after deductible	80% after deductible	60% after deductible
	<b>Limit:</b> Up to 30 visits per calendar year, in- and out-of-network combined		<b>Limit:</b> Up to 60 visits per calendar year, in- and out- of-network combined	
Outpatient speech therapy	90%	70% after deductible	80% after deductible	60% after deductible
	<b>Limit:</b> Up to 30 visits per calendar year, in- and out-of-network combined  Must be given to restore lost or impaired speech		<b>Limit:</b> Up to 60 visits per calendar year, in- and out- of-network combined  Must be given to restore lost or impaired speech	

<b>Family Planning/Maternity Care</b>				
Pre- and post-natal care doctor's office visits	\$25 regular doctor's office copayment/\$40 specialist copayment, initial visit only	70% after deductible	80% after deductible	60% after deductible
Hospital charges for delivery	90% after \$100 copayment	70% after deductible	80% after deductible; pre-authorization required	60% after deductible; pre-authorization required
Newborn nursery services	90%	70% after deductible	80% after deductible	60% after deductible
Fertility services	90% limited to \$10,000 per lifetime, in- and out-of-network combined	70% limited to \$10,000 per lifetime, in- and out-of-network combined	80% after deductible; limited to \$10,000 per lifetime for prescription drug fertility services and a \$25,000 annual maximum for medical fertility services , in- and out-of-network combined. Must use an Optum Fertility Center of Excellence.	60% after deductible; limited to \$10,000 per lifetime for prescription drug fertility services and a \$25,000 annual maximum for medical fertility services, in- and out-of-network combined. Must use an Optum Fertility Center of Excellence.
Female tubal ligation	90%	70% after deductible	The plan pays 100%	60% after deductible
Male vasectomy	90%	70% after deductible	80% after deductible	60% after deductible
<b>Please note:</b> Reversal of these procedures is not covered				
<b>Hearing</b>				
Hearing evaluations	Covered as part of preventive annual exam <b>Limit:</b> One exam per calendar year, in- and out-of-network combined			
Hearing aids	<b>Adults:</b> The plan pays up to \$2,000 over a 36-month period. <b>Children:</b> The plan pays up to \$2,000 over a 24-month period.			
<b>Vision</b>				
Routine vision exams	Routine services not covered; check with plan for details			
Eyeglasses and contact lenses	Not covered			
<b>Dental</b>				
Treatment of an accidental injury to teeth	\$25 regular doctor's office copayment/\$40 specialist copayment; then 90%	70% after deductible	80% after deductible	60% after deductible
	The dental damage is severe enough that initial contact with a physician or dentist occurred within 72 hours of the accident		Limited to sound natural teeth, must be within 12 months of the date of the accident	

Surgical extractions of impacted wisdom teeth	90%; limited to extractions of impacted wisdom teeth	70% after deductible	80% after deductible; limited to extractions of impacted wisdom teeth	60% after deductible
<b>Hospital Inpatient</b>				
Hospital admission	\$100 copayment; notification is required	70% after deductible; notification is required	80% after deductible; notification is required	60% after deductible; notification is required
Hospital semi-private room and board	90%	70% after deductible	80% after deductible	60% after deductible
<b>Please note: A private room is covered only when medically necessary</b>				
Inpatient lab and X ray	90%	70% after deductible	80% after deductible	60% after deductible
Inpatient physician and surgeon services	90%	70% after deductible	80% after deductible	60% after deductible
<b>Emergency Care</b>				
Emergency room (ER) charges	\$50 copayment; waived if admitted	\$50 copayment; waived if admitted	80% after deductible	80% after deductible
	Initial copayment waived if admitted. The plan does not cover ER charges for conditions that are not true emergencies.		The plan does not cover ER charges for conditions that are not true emergencies.	
Urgent care clinic visit	\$25 copayment	70% after deductible	80% after deductible	60% after deductible
Ambulance services	90%	90%	80% after deductible	60% after deductible
Charges covered for true emergencies				
<b>Mental Health Treatment</b>				
Outpatient mental health office visits	\$25 copayment	70% after deductible	80% after deductible	60% after deductible
Inpatient mental health treatment	90% covered after \$100 copayment for hospital admission	70% after deductible	80% after deductible	60% after deductible
Outpatient substance abuse detoxification	\$25 copayment	70% after deductible	Not covered	Not covered
Inpatient substance abuse detoxification	90% after \$100 copayment for hospital admission	70% after deductible; notification is required	80% after deductible; notification is required	60% after deductible; notification is required

Outpatient substance abuse rehabilitation	\$25 copayment	70% after deductible	80% after deductible	60% after deductible
Inpatient substance abuse rehabilitation	90% after \$100 copayment per admission	70% after deductible	80% after deductible; notification is required	60% after deductible; notification is required
<b>Alternative Care</b>				
Chiropractic services	90%	70% after deductible	80% after deductible	60% after deductible
<b>Limit:</b> Up to 24 visits per calendar year, in- and out-of-network combined				
Acupuncture	90%; must be performed by an MD or DO	70% after deductible; must be performed by an MD or DO	80% after deductible; must be performed by an MD or DO	60% after deductible; must be performed by an MD or DO
<b>Alternative Treatment Settings</b>				
Home health care	90%	70% after deductible	80% after deductible	60% after deductible
<b>Limit:</b> Up to 200 visits per calendar year, in- and out-of-network combined				
Hospice care	90%	70% after deductible	80% after deductible	60% after deductible
<b>Limit:</b> Up to 210 days per lifetime, in- and out-of-network combined				
Prescribed care in a skilled nursing facility	90% after \$100 copayment	70% after deductible	80% after deductible	60% after deductible
<b>Limit:</b> Up to 120 days per calendar year, in- and out-of-network combined				
Durable medical equipment	90%	70% after deductible	80% after deductible	60% after deductible
<b>Condition Management Programs</b>				
Condition management programs	UHC offers programs to help you manage existing health conditions. Contact the claims administrator of your plan for information on the programs available.			

## What Is Not Covered

The following list represents some of the items excluded from retiree medical coverage. This list may not capture all exclusions. If you have a question about a specific type of coverage, call your claims administrator.

Plan exclusions include, but are not limited to:

- Expenses for out-of-network services that exceed the reasonable and customary (R&C) limits;
- Services or supplies not deemed medically necessary;
- Services considered experimental or investigational;
- Expenses for out-of-network organ transplants;
- Routine vision exams;

- Routine foot care;
- Rental or use of non-durable medical equipment, even though recommended by a physician;
- Dental treatment (except as noted by your carrier for your option);
- Dental implants;
- Cosmetic surgery, procedures, or treatments;
- Occupational accidents or illnesses;
- Services rendered by non-qualified practitioners;
- Services of a private-duty nurse for inpatient hospital care;
- Services rendered in a freestanding facility that is not approved by the Joint Commission on Accreditation of Hospitals (JCAH);
- Custodial care or confinement in a nursing home;
- Charges made for the services of any person who is a member of your immediate family or who resides in your home;
- Charges for confinement in a place that is primarily a school or a place of rest;
- Charges incurred in a U.S. government hospital;
- Charges you would not be required to pay if there were no insurance;
- Sickness or loss covered by Workers' Compensation or automobile insurance;
- Personal hospital services such as radio, television, telephone, etc.;
- Weight-reduction programs (except when medically necessary);
- Herbal medicine or holistic or homeopathic care, including drugs;
- Acupuncture, except when services are provided by a medical doctor;
- Procedures to reverse voluntary sterilization;
- Services for mental health and/or substance abuse rendered in a residential treatment facility;
- Speech therapy due to a developmental delay (for Retiree Choice Plus CDHP (Post-94)); and
- Treatment of temporomandibular joint disorder (TMJ) (Note that the diagnosis of TMJ is a covered service)(for Retiree Choice Plus CDHP (Post-94)).

## Pre-Treatment Review and Preauthorization

Certain types of treatment are subject to either pre-treatment review or preauthorization. Although there is no penalty if you do not obtain pre-treatment review for certain services for which it is recommended, you should obtain pre-treatment review to ensure that the treatment is medically necessary and therefore covered by the plan.

For the Retiree Choice Plus CDHP Plan Option (Post-94), certain treatments, as described at the end of this section, require you to obtain preauthorization in order for the services to be covered by the plan. If you do not obtain preauthorization for these services, the services will not be covered.

Before you or a covered dependent receives certain types of treatment (such as any non-emergency hospital admission), you should call your claims administrator for a pre-treatment review. The claims administrator will review the proposed treatment to make sure the charges are medically necessary and within the plan's guidelines. The claims administrator will tell you what benefits the plan will pay and if there are any limitations or exclusions that may apply. It is your responsibility to contact the claims administrator to request a review.

Although there is no penalty if you do not call your claims administrator prior to receiving care for the services for which pre-treatment review is recommended, you run the risk of reduced or denied benefits if the claims administrator finds that the care you receive is not medically necessary.

## How to Request Pre-Treatment Review or Preauthorization

To request a pre-treatment review or preauthorization, you must call the claims administrator before you receive medical services. In an emergency, you or the hospital should call within 24 to 48 hours after an emergency admission.

<b>How Pre-Treatment Review May Affect Your Benefits</b>	
If you call and the plan determines that treatment is medically necessary	Plan pays benefits at regular rates
If you call and the plan determines that treatment is not medically necessary	No benefits are paid
If you do not call and the plan determines that treatment is medically necessary	Plan pays benefits at regular rates
If you do not call and the plan determines that treatment is not medically necessary	No benefits are paid

### Emergency Hospitalization—All Participants

In order to receive the maximum benefit allowed under the plan for emergency hospital admissions, you must contact the claims administrator for your option as soon as possible following the emergency admission. Note that you do not need a pre-treatment review of a hospital stay following the birth of a newborn, as long as it does not exceed 48 hours for a normal vaginal delivery or 96 hours for a cesarean section.

### Concurrent Review—All Participants

If a stay needs to be extended beyond the number of days originally reviewed, the additional days must be reviewed before your hospital stay that was originally agreed to ends. This is called concurrent review. You are responsible for making sure that concurrent review occurs.

### Important Information Regarding Preauthorization

Select imaging services which may include, but are not limited to, magnetic resonance imaging (MRI), computer tomography (CT) and positron emission tomography (PET), require preauthorization before services can be performed. If preauthorization isn't obtained, radiology services won't be covered. For additional information, contact your member Services Department (see the phone number on the back of your medical ID card).

## Receiving Care Outside Your Coverage Area

If you need medical care while traveling outside the network service area, you should contact the claims administrator:

- Prior to receiving any non-emergency care; and
- As soon as possible after you receive emergency care.

The claims administrator's telephone number is shown on your Medical Plan ID card.

## Plan Continuance

It is hoped that the Retiree Medical Plan will continue 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.

# Standard Plan: Medicare-Eligible Medical Plan Option Information

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## Information for Persons Eligible for Medicare Based on Age

If you and/or your spouse or domestic partner is Medicare-eligible based on age, or if you are non-Medicare-eligible but you have dependents who are eligible for Medicare based on age, you and/or your Medicare-eligible spouses or domestic partners will choose a retiree medical plan option through United Healthcare Medicare Solutions.

United Healthcare Medicare Solutions offers:

- A variety of plan options. You can choose a health care plan for your situation.
- Plans with low premiums. Some plan options have low or no premiums at all.
- The ability to change plan options. Some plan types allow changes as often as monthly, letting you make adjustments based on your needs.

United Healthcare provides detailed information about the various options available to you and/or your dependents. These summaries are available on [www.UHCretiree.com](http://www.UHCretiree.com) and can also be requested in print, free of charge, from United Healthcare. The coverage summaries will:

- Include any cost-sharing provisions, such as copayments, coinsurance, deductibles, and out-of-pocket maximum amounts.
- Include any applicable annual maximums or other limits.
- Define in-network health care providers, such as a doctor, physician, or hospital.
- Describe what preventive care services are covered and what other services and expenses are covered or not covered.

You or any Medicare-eligible dependents need to enroll in Medicare Part A and Part B in order to have coverage under the Credit Suisse Retiree Medical Plan. For prescription drug coverage, you will need to elect a Medicare Part D prescription plan.

Prior to your 65<sup>th</sup> birthday, you will receive a package from United Healthcare Medicare Solutions detailing your health care options and how to enroll.

You and/or your spouse or domestic partner should enroll in Medicare 90 days before turning age 65. You may do this by visiting [Medicare.gov](http://Medicare.gov) or by visiting your local Social Security office.

## Information for Persons Eligible for Medicare Based on Disability

Medicare-eligible disabled retirees, spouses or domestic partners, and children are not eligible for coverage through United Healthcare Medicare Solutions. Medicare-eligible disabled individuals may enroll in the UHC Indemnity (Post-94) option. The UHC Indemnity (Post-94) is a grandfathered health plan option under the Affordable Care Act. Once a disabled individual turns age 65, they may elect continued coverage through United Healthcare Medicare Solutions.

Call the Credit Suisse Benefits Service Center at **1-888-325-2732** for more information on the UHC Indemnity (Post-94) option or visit the Your Benefits Resources web site.

# How Your Non-Medicare Retiree Medical Benefits Coordinate With Other Plans

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## Coordination of Benefits

If you or your dependent is covered by more than one medical plan, your Retiree Medical Plan coordinates benefits with other group plans outside the program to help prevent duplicate payments for the same services. This section highlights the coordination of benefits (COB) feature.

## The Types of Plans That Coordinate

Certain types of plans normally coordinate benefits, including the following:

- Plans or coverages provided by an employer, union, trust, or other similar sponsor;
- Other group health care plans or coverages that cover you or your dependents, including student coverage provided through a school above the high school level;
- Government benefits programs provided or required by law, including Medicare or Medicaid; and
- In the case of accidents, automobile insurance plans.

These coordination provisions do not apply to individual or private insurance plans. Any benefits to which you may be entitled from other group plans are considered for possible coordination (even if you do not request payment from them).

### Requesting Coordination Information

From time to time, the Retiree Medical Plan will request information about other coverage you may have. Submit this information as soon as possible. If the information is not available when a claim is filed, claim processing will be delayed until the COB information is received.

## How Your Retiree Medical Benefits Coordinate With Medicare

**Please note:** If you are in a Closed Group, please refer to the "Grandfathered July 1, 1988 First Boston Closed Groups" section.

**It is extremely important that you and your spouse or domestic partner, if applicable, enroll in Medicare Part A and Part B as soon as either of you become eligible.** Your participation in the pre-retiree medical plan ends the first of the month in which you turn age 65.

## How Coordination Works With Other Group Plans

If you are covered by more than one group plan, one plan is **primary**. The primary plan considers benefit payment first without considering the other plans. Then, based on what the primary plan pays, the other plans may pay a reduced benefit (if any).

If your medical coverage under the Retiree Medical Plan is your primary plan, that plan considers benefit payment up to the limits described in this SPD.

If your coverage under the Retiree Medical Plan is **secondary**, the primary plan considers benefit payment first. Then, the Retiree Medical Plan considers paying the lesser of:

- The plan's benefit; or
- The balance left after the primary plan pays benefits.

When combined, the benefits that the plans pay will not exceed 100% of the eligible expense payable under the Retiree Medical Plan.

### **Determining the Order of Payment**

When benefits coordinate, the plans or coverages involved determine which considers benefit payment first (the primary plan), second (the secondary plan), etc. Here are the guidelines for determining which is primary:

- If one plan has no coordination of benefits (COB) provision, it is automatically primary.
- The plan covering the person as the retiree (for example, rather than as a dependent, or beneficiary under Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)) is primary and considers benefit payment first. The other coverage is secondary and only considers payment of any remaining eligible expenses.
- In the case of a divorce or separation, the plan of the parent who has not remarried and who has custody of the dependent child usually considers benefit payment first. If the parent with custody of the child remarries and the stepparent's plan also covers the child, the custodial parent's plan considers benefit payment first and the stepparent's (custodial parent's spouse's) plan considers benefit payment second. However, if there is a court order that requires a parent to take financial responsibility for health care coverage for the child, that parent's plan always is primary.
- If both parents' plans cover a dependent, the plans use the "birthday rule" to determine which parent's plan considers benefit payment first. Under the birthday rule, the plan of the parent whose birthday (month and day) falls earlier in the calendar year is the primary plan and the other parent's plan is secondary. If the other plan does not follow the birthday rule and, as a result, both plans would be considered either primary or secondary, then the rules of the other plan (not the Credit Suisse plan) determine which coverage is primary (the order of benefits).

If a determination cannot be made as to the order of payment, the plan that has covered the person longer is usually the primary plan.

# Standard Plan: Grandfathered July 1, 1988 First Boston Group

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## Specific Eligibility Requirements

You must meet the following specific eligibility requirements to be eligible for the **Grandfathered July 1, 1988 First Boston Group**.

- You are classified by and worked for the Bank or Credit Suisse Asset Management LLC, or another entity that has adopted the Retiree Medical Plan with the consent of the Benefits Committee as its employee (you can contact the Credit Suisse Benefits Service Center to help you determine if your employer participates in this plan);
- You were originally hired by First Boston (as defined under "First Boston Definition");
- Your hire date was before July 1, 1988; and
- You meet one of the following rules:
  - **The Rule of 65:** You are at least age 50, with at least 10 years of service with the Bank, and your age plus years of service are equal to or greater than 65;
  - **The 1992 Rule:** You were age 55 or older, with at least five years of service on January 1, 1992; or
  - **The Vice Chairman Rule:** As of December 31, 2005, you had the corporate title of a Vice Chairman (or above) at Credit Suisse First Boston LLC (the predecessor company to the Bank) and you have at least 20 years of service at retirement.

**Remember:** If you fall into this group and retired before December 31, 1993, you are in a Closed Group, and your plan details are described under "Grandfathered July 1, 1988 First Boston Closed Groups."

### Rehire Rule

You are also eligible for the Retiree Medical Plan if you meet all of the specific eligibility requirements in this section **and** all of the following apply:

- You accumulated at least 10 years of service (as defined under "Years of Service Defined" under "Eligibility") before you terminated your employment;
- You were later rehired within two years after your termination of employment or after you enrolled in the Retiree Medical Plan; and
- You remained with the Bank after your rehire date for at least two years before retiring.

**Please note:** If after termination, your length of separation from the Bank was one year or less, you are treated as if your termination had not occurred and your period of separation is included in your service.

### First Boston Definition

Where this document refers to "First Boston" it means the legal entity formerly known as The First Boston Corporation and the legal entity formerly known as Credit Suisse Financial Products LLC.

**Excluded** are: Barclay De Zoete Wedd (BZW); Guarantia; Donaldson Lufkin & Jenrette; or any other entity that became part of Credit Suisse as the result of a merger.

## Examples

The examples below show how the Grandfathered First Boston Group eligibility provisions are applied in determining eligibility. All examples assume that the employee in the example was enrolled in a Credit Suisse active medical option and on a U.S. payroll at the time of retirement. The examples are divided into two groups.

### ***Employees Who Are Eligible for the Retiree Medical Plan:***

#### **Employee 1**

Hiring entity: First Boston  
Hire date: January 1, 1988  
Retirement date: January 1, 2003  
Age at retirement: 50  
No breaks in service or leaves

This employee is eligible because he was hired by First Boston and meets the Rule of 65 because his age is at least 50, he has at least 10 years of service, and his age (50) plus service (in this case 15) is equal to 65.

#### **Employee 2**

Hiring entity: First Boston  
Hire date: January 1, 1987  
Retirement date: January 1, 1995  
Age at retirement: 58  
No breaks in service or leaves

This employee was hired by First Boston but she does not meet the Rule of 65, because even though she is at least 50, she does not have at least 10 years of service. However, the employee is still eligible to retire under the Rule of 1992 because her age was 55 and she had five years of service on January 1, 1992.

#### **Employee 3**

Hiring entity: First Boston  
Hire date: January 1, 1987  
Termination date: January 1, 2012  
Rehire date: June 1, 2013  
Retirement date: June 1, 2015  
Age at retirement: 65

This employee is eligible because he was hired by First Boston and meets the rehire eligibility provisions because he had at least 10 years of service upon his first termination date, was rehired within two years, and had at least two additional years of service after rehire and before retirement. Keep in mind, in order to be eligible to retire under the Rehire Rule, he must also satisfy all the "Specific Eligibility Requirements"; which he does, because he meets the Rule of 65 (age is at least 50 [in this case 65] and total years of service is at least 10 [in this case 27] and age plus service equals 92).

#### **Employee 4**

Hiring entity: First Boston  
Hire date: January 1, 1987  
Termination date: February 1, 1991  
Rehire date: March 1, 1991  
Retirement date: October 1, 2007  
Age at retirement: 65

This employee is eligible because he was hired by First Boston and meets the rehire eligibility provisions. Although he had only four years of service upon his first termination date, his period of separation was less than one year, and is therefore not considered in determining eligibility. After rehire, he worked an additional 16 years, thus exceeding the minimum requirement of 10 years of service. Keep in mind, in order to be eligible to retire under the Rehire Rule, he must also satisfy all the "Specific Eligibility Requirements"; which he does, because he meets the Rule of 65 (age is at least 50 [in this case 65] and total years of service is at least 10 [in this case 20] and age plus service equals 85).

#### ***Employees Who Are Not Eligible for the Retiree Medical Plan:***

#### **Employee 5**

Hiring entity: Donaldson Lufkin & Jenrette  
Hire date: January 1, 1988  
Retirement date: January 1, 2003  
Age at retirement: 50  
No breaks in service or leaves

This employee is not eligible to retire under the Grandfathered July 1, 1988 First Boston Group eligibility provision because he was not hired by First Boston. Age and years of service become irrelevant in this example so it does not matter that his age is at least 50 and age plus service equals 65. He will not be eligible to retire until he satisfies standard eligibility requirements described under "Standard 'Rule of 65' Eligibility" by meeting the Rule of 65; which for this participant will occur when he is age 55 and he has 15 years of service.

#### **Employee 6**

Hiring entity: First Boston  
Hire date: January 1, 1987  
Termination date: June 1, 1996  
Rehire date: June 1, 2004  
Retirement date: June 1, 2006  
Age at retirement: 65

This employee is not eligible because although he was hired by First Boston, he does not meet the rehire eligibility rules. When he terminated in 1996, he only had nine years and five months of service. The rehire eligibility rules require 10 years of service.

## Employee 7

Hiring entity: First Boston  
Hire date: January 1, 1987  
Termination date: January 1, 2012  
Age at termination: 60

Did not elect coverage under the Retiree Medical Plan following his termination date.

Rehire date: June 1, 2015  
Retirement date: June 1, 2017  
Age at retirement: 65

This employee is not eligible because he was not rehired within two years after his termination date and he did not elect coverage under the Retiree Medical Plan after his termination date. This employee was eligible to elect coverage under the Retiree Medical Plan after his termination date because he was hired by First Boston and met the Rule of 65 (his age was at least 50, he had at least 10 years of service, and his age [60] plus service [in this case 25] is greater than 65).

## Cost of Coverage

### If You Are a Non-Medicare-Eligible Participant

Each year you will receive notification of the cost of coverage. You may visit the Your Benefits Resources web site or call the Credit Suisse Benefits Service Center for information on your individual cost. If you enroll during the Annual Enrollment period or change your coverage at any time, you will receive a confirmation statement showing cost information.

If you retire under the specific eligibility requirements defined in this section, you will pay for coverage according to the following table:

<b>If You Have This Many Years of Service at Retirement:</b>	<b>You Pay This Percentage of the Cost:</b>
15 or more	0%
14	10%
13	20%
12	30%
11	40%
10	50%
Exception:	
The 1992 Rule	0%

**Please note:** The percentage of cost you pay does not change until you attain the actual number of years of service listed. For example, if you have 11 years and 364 days of service, you will pay 40% of the cost.

### **If You Are a Medicare-Eligible Participant**

Instead of a subsidized medical premium, Credit Suisse offers a Retiree Reimbursement Account (RRA), which is a non-taxable account that can be used for health care expenses, including premiums and eligible out-of-pocket expenses. In addition, you may also use the funds in this account to pay for other benefits such as dental or vision expenses that are not covered by Credit Suisse. For details on how the RRA works, please contact United Healthcare Medicare Solutions at **1-877-886-7309** or visit [www.uhcretireeaccounts.com](http://www.uhcretireeaccounts.com).

## Paying for Coverage

### **If You Are a Pre-Medicare Retiree**

You will receive a monthly bill for the Retiree Medical Plan. Payment may be made through a direct debit from your bank account, electronic funds transfer, withdrawal from your Social Security check, or personal check. Visit the Your Benefits Resources web site to coordinate payment. You may also call the Credit Suisse Benefits Service Center at **1-888-325-2732** to have a form mailed to you. You will need to sign the form and mail it back.

**Please note:** Rates may change in the future. The Credit Suisse Benefits Service Center will notify retirees of any change in the premium rate.

### **If You Are a Medicare-Eligible Retiree**

You may opt to pay your AARP Medicare Supplement Plan and Medicare Rx premiums on an annual or monthly basis. Instructions for each option are below. If you are eligible for the RRA, you may be able to reimburse yourself for payment of premiums. Refer to the RRA SPD for additional information.

#### ***AARP® Medicare Supplement Plans***

When you enroll in an AARP Medicare Supplement Plan, you will receive a coupon book. Annual payments must be made by check, and should be mailed along with the first coupon of the book to the address noted on the coupon book. Monthly payments can be made by check or electronic funds transfer. If you pay by check, you must remit one coupon per month along with your check.

#### ***AARP® Medicare RX***

When you enroll in an AARP Medicare Rx plan, you will receive a premium invoice. Annual payments must be made by check, and should be mailed to the address noted on the invoice. Monthly payments can be made by check or electronic funds transfer.

# Standard Plan: Former Credit Suisse Group Employees in the U.S.

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## If You Are a Former Credit Suisse Group Employee

This section applies to you if you were granted eligibility under the grandfathered provision for employees of the former entity known as Credit Suisse Group (prior to the 2006 Credit Suisse rebranding).

### Specific Eligibility Requirements

You were grandfathered into this group if you were:

- A U.S. employee of the legal entity formerly known as Credit Suisse Group and on active payroll as of December 31, 1997; and
- Age 50 as of January 1, 1998.

You are eligible for the Retiree Medical Plan as a part of this Grandfathered Group if you meet all of the following requirements. You must:

- Be an employee of the Bank or Credit Suisse Asset Management LLC, or another entity that has adopted the Retiree Medical Plan with the consent of the Benefits Committee (you can contact the Credit Suisse Benefits Service Center to help you determine if your employer participates in this plan);
- Be enrolled in a Credit Suisse active medical option and on a U.S. payroll at the time of your retirement;
- Have 15 years of service upon retirement; and
- Be at least age 55, but under age 65 when you retire.

**Please note:** If you are a member of this group, you are age 55 or older when you retire, have at least five years of service, and your age plus years of service equals 65 or more (the "Rule of 65"), you may qualify for the Retiree Medical Plan under the standard eligibility requirements listed under "Standard 'Rule of 65' Eligibility." If you do, you will automatically be covered under that plan because it provides better coverage and costs less than if you qualify under the special eligibility requirements listed here.

### When Coverage Ends

If you qualify under the specific eligibility requirements listed above, coverage ends:

#### For You

Your coverage ends on the earliest of the following:

- You die;
- The end of the month in which you reach age 65; or
- The Bank no longer offers the Retiree Medical Plan.

## For Your Covered Dependents

Coverage for your covered dependents ends on the earliest of the following:

- Your covered dependent dies;
- The end of the month in which you reach age 65 or would have reached age 65 (see "Special Rules If You Die Before Age 65" below);
- The end of the month in which that covered dependent reaches age 65; or
- The Bank no longer offers the Retiree Medical Plan.

## Special Rules If You Die Before Age 65

Your spouse or domestic partner who is under age 65 can continue coverage as long as he or she was covered at the time of your death. However, his or her coverage will cease at the end of the month in which you would have turned age 65. Your children can continue coverage until they would otherwise have lost eligibility, for example, by reaching the limiting age, or until the end of the month in which you would have turned age 65, whichever comes first.

## Cost of Coverage

If you retire under the specific eligibility rules listed in this section, you pay 2% more than if you retire under the standard eligibility rules listed under "Standard 'Rule of 65' Eligibility."

Each year you will receive notification of the cost of coverage. You may visit the Your Benefits Resources web site or call the Credit Suisse Benefits Service Center for information on your individual cost.

**Please note:** Rates may change in the future. The Credit Suisse Benefits Service Center will notify retirees of any change in the premium rate.

## Paying for Coverage

### If You Are a Pre-Medicare Retiree

You will receive a monthly bill for the Retiree Medical Plan. Payment may be made through a direct debit from your bank account, electronic funds transfer, withdrawal from your Social Security check, or personal check. Visit the Your Benefits Resources web site to coordinate payment. You may also call the Credit Suisse Benefits Service Center at **1-888-325-2732** to have a form mailed to you. You will need to sign the form and mail it back.

### If You Are a Medicare-Eligible Retiree

You may opt to pay your AARP Medicare Supplement Plan and Medicare Rx premiums on an annual or monthly basis. Instructions for each option are below. If you are eligible for the RRA, you may be able to reimburse yourself for payment of premiums. Refer to the RRA SPD for additional information.

***AARP® Medicare Supplement Plans***

When you enroll in an AARP Medicare Supplement Plan, you will receive a coupon book. Annual payments must be made by check, and should be mailed along with the first coupon of the book to the address noted on the coupon book. Monthly payments can be made by check or electronic funds transfer. If you pay by check, you must remit one coupon per month along with your check.

***AARP® Medicare RX***

When you enroll in an AARP Medicare Rx plan, you will receive a premium invoice. Annual payments must be made by check, and should be mailed to the address noted on the invoice. Monthly payments can be made by check or electronic funds transfer.

## Standard Plan: Grandfathered DLJ Group

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### If You Are a Grandfathered DLJ Group Employee

You were grandfathered into this DLJ Group if you were enrolled in coverage as of January 1, 2018 based on criteria that was established at the time of the merger of the former entity known as the Donaldson Lufkin & Jenrette Group.

See the plan administrator to determine when coverage ends, the cost of coverage and paying for coverage.

## Grandfathered July 1, 1988 First Boston Closed Groups

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### Grandfathered July 1, 1988 First Boston Closed Group Retirees

The information in this section describes, in general, how the Retiree Medical Plan works. Keep in mind, this section ONLY applies to **Grandfathered July 1, 1988 First Boston Group** retirees who retired on or before December 31, 1993. If you fall into one of these Closed Groups, you should also read the "Medical and Prescription Drug Information for Non-Medicare-Eligible Retirees" and "Medical and Prescription Drug Information for Medicare-Eligible Retirees" sections of this SPD. **This section does not apply to any current Credit Suisse employees or participants who retired on or after January 1, 1994.**

You are a member of one of the following **Closed Groups** if in addition to being hired by First Boston prior to July 1, 1988:

- **The 92-93 Group:** You retired on or after January 1, 1992, but on or before December 31, 1993.
- **The 82-91 Group:** You retired on or after January 1, 1982, but on or before December 31, 1991.
- **The Pre-1982 Group:** You retired before January 1, 1982.

The **Closed Groups** have a different plan design than other Credit Suisse Retirees. See "Grandfathered July 1, 1988 First Boston Closed Group Retirees: Coverage Options" for additional information.

# Grandfathered July 1, 1988 First Boston Closed Group Retirees: Three Closed Groups

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## Three Closed Groups

The Grandfathered July 1, 1988 First Boston Group includes three **Closed Groups** who retired on or before December 31, 1993. You are a member of one of the following **Closed Groups** if in addition to being hired by First Boston prior to July 1, 1988:

- **The 92-93 Group:** You are in this group if you retired on or after January 1, 1992, but on or before December 31, 1993.
- **The 82-91 Group:** You are in this group if you retired on or after January 1, 1982, but on or before December 31, 1991.
- **The Pre-1982 Group:** You are in this group if you retired before January 1, 1982.

The **Closed Groups** have a different plan design than other Credit Suisse Retirees. These differences are described in this section.

## Eligible Dependents for the Retiree Medical Plan

Upon retirement, when you were automatically enrolled in the Retiree Medical Plan, the dependents you covered as an active employee were automatically covered as well. Your eligible dependents include you:

- 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 "Coverage for Your Domestic Partner");
- Children who are under age 26; coverage continues until December 31 of the year in which the child turns age 26; and
- Mentally or physically disabled children over age 26 who became disabled before age 26 while covered under the plan and 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.

### ***Rules for Disabled Children***

Contact your claims administrator when your child becomes disabled to learn how to certify his or her disability status.

For your child's coverage to continue, you must notify the Credit Suisse Benefits Service Center when the claims administrator certifies your child's disability status.

### ***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.

### **Coverage for Your Domestic Partner**

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

If you reside in a state that allows and recognizes a same-sex civil union, you may be asked to provide government documentation validating your civil union.

If you satisfy this requirement, 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 plan administrator and/or the insurance company, as applicable for certain insured medical benefits, may require documented proof that each of you is eligible.

### ***Married Credit Suisse Retirees/Domestic Partners***

Each Credit Suisse employee or retiree can only be covered by one Credit Suisse medical plan at a time. Therefore, if your spouse or domestic partner also works for or is retired from the Bank, keep in mind that you cannot be covered as both a dependent and the employee or retiree under the Bank's medical plans. Therefore:

- You can cover yourself as primary and your spouse or domestic partner as a dependent; or
- You may be covered as a dependent under your spouse's or domestic partner's plan; or
- You and your spouse or domestic partner can each choose You Only coverage.

Keep in mind, if you have eligible dependent children, only one of you can cover them as dependents under the plan.

### ***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 Retiree Medical Plan if you:

- Do not meet the requirements outlined under "Eligibility" or do not fall into one of the Grandfathered or Closed Groups previously defined;
- Work for the Bank as an independent contractor or consultant or through an agency, consulting firm, or other third-party provider; or
- Work for the Bank as an intern.

# Grandfathered July 1, 1988 First Boston Closed Group Retirees: How the Plan Works

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## Making Elections During Annual Enrollment

Each year, you have the opportunity to drop dependents or drop coverage 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 (see "Resources").

**Please note:** If you drop your Retiree Medical Plan coverage, you will not be permitted to re-enroll in the plan at a later date.

### Coverage Categories

When you enroll, you will choose which, if any, eligible dependents to enroll for coverage. The number of dependents you enroll determines your coverage category. In general, the categories are:

- You Only;
- You + Spouse or Domestic Partner;
- You + Children; or
- You + Family.

## Changing Dependents To Your Retiree Medical Plan During the Year

Generally, outside of the Annual Enrollment period, the only time you may change your dependents during the year is if you have a permitted qualified status change. Keep in mind that any changes made to your Retiree Medical 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 the plan. Except as described below, dependent coverage is available only to those persons who were covered as your dependents at the time of your retirement. Permitted qualified status changes include:

- Removing a spouse or domestic partner due to a change in your marital status or domestic partnership;
- Adding a spouse through marriage;
- Adding a dependent due to birth, adoption, or placement for adoption, or removing a dependent due to the death of a dependent or a dependent who is no longer eligible for coverage;
- Removing a spouse, domestic partner, or dependent due to a change in your, your spouse's or domestic partner's, or your dependent's employment status that results in a gain of benefits eligibility; and
- You may drop your coverage if you become eligible for another employer's plan (for example, if you have a job).

**Please note:** Surviving spouses and dependents covered under the plan may not add dependents. For more information about survivor coverage, see "When Retiree Medical Plan Participation Ends."

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

*Example 1:* If you get married, you may add your new spouse to your Retiree Medical Plan coverage, or you may drop your Retiree Medical Plan coverage to enroll in your new spouse's coverage (through his or her employer's plan). If you drop your Retiree Medical Plan coverage, you cannot re-enroll at a later time.

*Example 2:* If you have or adopt a child, you may add your new dependent to your Retiree Medical Plan coverage. However, you may not drop your coverage as a result of this change in status.

*Example 3:* If the retiree dies, the surviving spouse can continue to be covered under the Retiree Medical Plan. However, if the surviving spouse remarries, they will not be able to add his or her new spouse or any other eligible dependents to coverage.

If you do not make a change in your Retiree Medical 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**

The Bank reserves the right to ask for proof of your qualified status change. 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 that time or discontinuing your benefits.

# Grandfathered July 1, 1988 First Boston Closed Group Retirees: Coverage Options

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## Coverage Options

Your retiree medical coverage is based on whether or not you or your dependents are eligible for Medicare. The chart below shows how this works.

### The Retiree Medical Plan

There is no retiree dental or vision plan. However, the Retiree Medical Plan may cover certain dental or vision expenses. These are described under "Closed Group Retiree Plan Design: What Is Covered if You Are a Non-Medicare-Eligible Participant."

### Split Family Coverage

When a family has members covered under both the non-Medicare-eligible and Medicare-eligible plans, this is referred to as "Split Family Coverage."

### Coverage for Non-Medicare-Eligible Participants

Non-Medicare-eligible retirees and/or dependents will be enrolled in the Choice Plus POS (Pre-94) medical plan. The UHC Choice Plus POS (Pre-94) is a grandfathered health plan option under the Affordable Care Act.

### Coverage for Medicare-Eligible Participants

Medicare-eligible retirees and/or spouses or domestic partners will be able to choose a retiree medical plan option through United Healthcare Medicare Solutions. Through United Healthcare, participants have access to a wider choice of options at a variety of prices. United Healthcare offers Medicare Supplement plans, Medicare Advantage plans, and Medicare Part D prescription drug plans. Some of the plan options allow changes as often as monthly, letting you make adjustments based on your needs.

You Are Non-Medicare-Eligible		You Are Medicare-Eligible	
You <i>and</i> Any Non-Medicare-Eligible Family Members Will Be Covered Under:	Any of Your Medicare-Eligible Family Members Will Be:	Any of Your Non-Medicare-Eligible Family Members Will Be Covered Under:	You <i>and</i> Any Medicare-Eligible Family Members Will Be:
UHC Choice Plus POS (Pre-94)	Able to choose a retiree medical plan option through United Healthcare Medicare Solutions	UHC Choice Plus POS (Pre-94)	Able to choose a retiree medical plan option through United Healthcare Medicare Solutions

## Cost of Coverage

### If You Are a Pre-Medicare Retiree

Each year you will receive notification of the cost of coverage. You may visit the Your Benefits Resources web site or call the Credit Suisse Benefits Service Center for information on your individual cost. If you enroll during the Annual Enrollment period or change your coverage at any time, you will receive a confirmation statement showing cost information.

If you retire under the specific Eligibility Requirements defined in this section, you will pay for coverage according to the following table:

<b>If You Have This Many Years of Service at Retirement:</b>	<b>You Pay This Percentage of the Cost:</b>
15 or more	0%
14	10%
13	20%
12	30%
11	40%
10	50%
<b>Exception:</b>	
The 1992 Rule	0%
<b>Please note:</b> The percentage of cost you pay does not change until you attain the actual number of years of service listed. For example, if you have 11 years and 364 days of service, you will pay 40% of the cost.	

### If You Are a Medicare-Eligible Participant

Instead of a subsidized medical premium, Credit Suisse offers a Retiree Reimbursement Account (RRA), which is a non-taxable account that can be used for health care expenses, including premiums and eligible out-of-pocket expenses. In addition, you may also use the funds in this account to pay for other benefits such as dental or vision expenses that are not covered by Credit Suisse.

Note: UHC will notify you of any plan premium changes each year, prior to the effective date.

## Paying for Coverage

### If You Are a Pre-Medicare Retiree

You will receive a monthly bill for the Retiree Medical Plan. Payment may be made through a direct debit from your bank account, electronic funds transfer, withdrawal from your Social Security check, or personal check. Visit the Your Benefits Resources web site to coordinate payment. You may also call the Credit

Suisse Benefits Service Center at **1-888-325-2732** to have a form mailed to you. You will need to sign the form and mail it back.

**Please note:** Rates may change in the future. The Credit Suisse Benefits Service Center will notify retirees of any change in the premium rate.

**If You Are a Medicare-Eligible Retiree**

You may opt to pay your AARP Medicare Supplement Plan and Medicare Rx premiums on an annual or monthly basis. Instructions for each option are below. If you are eligible for the RRA, you may be able to reimburse yourself for payment of premiums. Refer to the RRA SPD for additional information.

**AARP® Medicare Supplement Plans**

When you enroll in an AARP Medicare Supplement Plan, you will receive a coupon book. Annual payments must be made by check, and should be mailed along with the first coupon of the book to the address noted on the coupon book. Monthly payments can be made by check or electronic funds transfer. If you pay by check, you must remit one coupon per month along with your check.

**AARP® Medicare RX**

When you enroll in an AARP Medicare Rx plan, you will receive a premium invoice. Annual payments must be made by check, and should be mailed to the address noted on the invoice. Monthly payments can be made by check or electronic funds transfer.

**Special Provisions for the Closed Groups**

**Coinsurance, Deductible, and Out-of-Pocket Maximum Amounts for Retirees in Closed Groups Not Eligible for Medicare**

Members of the Closed Groups are eligible for special coinsurance, annual deductible and out-of-pocket maximum amounts for medical coverage as follows:

<b>If You Are a Non-Medicare-Eligible Member of...</b>	<b>Your Annual Deductible Is...</b>	<b>Your Out-of-Pocket Maximum Is...</b>	<b>In-Network Coinsurance</b>
<b>The 92-93 Group</b>	\$0 in-network; 1% of final base pay out-of-network	N/A in-network; two times the deductible; \$700 minimum out-of-network	100%
<b>The 82-91 Group</b>	\$0 in-network; 0.5% of final base pay out-of-network	N/A in-network; two times the deductible; \$700 minimum out-of-network	100%
<b>The Pre-1982 Group</b>	\$0 in-network; \$100 out-of-network	N/A in-network; \$700 per person out-of-network	100%

## More About Plan Features for Closed Groups Not Eligible for Medicare

The following chart provides additional details about certain plan features.

Plan Feature	UHC Choice Plus POS (Pre-94)	
	In-Network	Out-of-Network
Reasonable and Customary (R&C) Limits	N/A	Services and supplies are subject to R&C
Claim Forms	No claim forms are required	You pay for services and supplies at the time of care and submit a claim for reimbursement

## Closed Group Retiree Plan Design: What Is Covered if You Are a Non-Medicare-Eligible Participant

This chart shows how benefits are paid by the UnitedHealthcare (UHC) plans.

For more information on coverage, visit the Your Benefits Resources web site. If you have a question about a specific type of coverage, call your claims administrator (see "Plan Administration" for contact information).

Plan Feature	UHC Choice Plus POS (Pre-94)	
	In-Network	Out-of-Network
	Under the non-Medicare-eligible plan, you have the flexibility to choose between in-network and out-of-network care each time you need to visit a doctor or other health care provider. The network is a group of health care providers, including doctors, hospitals, labs, and other facilities, that has agreed to offer services to participants at a discounted rate. If you choose an in-network provider, you lower your out-of-pocket costs and the amount the Bank pays for your care.	
<b>Doctor's Office Visits</b>		
Doctor office visit	\$20 doctor's office copayment	70% after deductible
<b>Preventive Care</b>		
Annual physical exam	100% after \$20 copayment	70% after deductible
	<b>Limit:</b> One per calendar year for adults age 19 and over, in- and out-of-network combined	
Well-woman exam (includes routine pap smear)	100% after \$20 copayment	70% after deductible
	<b>Limit:</b> One per calendar year for covered individuals age 19 and over, in- and out-of-network combined	
Mammogram	100% after \$20 copayment	70% after deductible
	Baseline at ages 35-39; one per calendar year ages 40 and above	

Plan Feature	UHC Choice Plus POS (Pre-94)	
	In-Network	Out-of-Network
Pediatric exams	100% after \$20 copayment up to age 19	70% after deductible up to age 19
<b>Preventive Care</b>		
Immunizations for children	100% after \$20 copayment up to age 19	70% after deductible up to age 19
Cancer screenings	100% after \$20 copayment	70% after deductible
	One per calendar year over age 18	
Cardiovascular screenings	100% after \$20 copayment	70% after deductible
Allergies	100% after \$20 copayment for treatments and tests	70% after deductible
<b>Outpatient Care</b>		
Outpatient surgery	\$20 office copayment; 100% facility	70% after deductible
Outpatient laboratory services	\$20 office copayment; 100% facility	70% after deductible
Outpatient X ray	\$20 office copayment; 100% facility	70% after deductible
Outpatient physical therapy	\$20 office copayment; 100% facility	70% after deductible
	<b>Limit:</b> Up to 30 visits per calendar year, in- and out-of-network combined	
Outpatient occupational therapy	\$20 copayment	70% after deductible
	<b>Limit:</b> Up to 30 visits per calendar year, in- and out-of-network combined	
Outpatient speech therapy	\$20 copayment	70% after deductible
	<b>Limit:</b> Up to 30 visits per calendar year, in- and out-of-network combined	
	Must be given to restore lost or impaired speech	
<b>Family Planning/Maternity Care</b>		
Pre- and post-natal care doctor's office visits	\$20 copayment, initial visit only	70% after deductible
Hospital charges for delivery	100% after \$100 copayment	70% after deductible
Newborn nursery services	100%	70% after deductible
Fertility services	100%, outpatient facility; \$20 copayment then 100% covered, office services; procedures that may produce a pregnancy but do not correct the underlying	70% after deductible; procedures that may produce a pregnancy but do not correct the underlying cause of infertility are not covered

Plan Feature	UHC Choice Plus POS (Pre-94)	
	In-Network	Out-of-Network
	cause of infertility are not covered	
Female tubal ligation or male vasectomy	100%	70% after deductible
	<b>Please note: Reversal of these procedures is not covered</b>	
<b>Hearing</b>		
Hearing evaluations	Covered as part of preventive annual exam	70% after deductible
	<b>Limit:</b> One exam per calendar year, in- and out-of-network combined	
Hearing aids	<b>Adults:</b> The plan pays up to \$2,000 over a 36-month period. <b>Children:</b> The plan pays up to \$2,000 over a 24-month period.	
<b>Vision</b>		
Routine vision exams	One annual routine eye exam is covered either by a PCP or an eye doctor; does not include eye glasses, contact lenses, etc.	
Eyeglasses and contact lenses	Not covered	
<b>Dental</b>		
Treatment of an accidental injury to teeth	\$20 office copayment; 100% outpatient facility	70% after deductible
	The dental damage is severe enough that initial contact with a physician or dentist occurred within 72 hours of the accident	
Surgical extractions of impacted wisdom teeth	Not covered	Not covered
<b>Hospital Inpatient</b>		
Hospital admission	\$100 copayment	70% after deductible
Hospital semi-private room and board	100%	70% after deductible
	<b>Please note:</b> A private room is covered only when medically necessary	
Inpatient lab and X ray	100%	70% after deductible
Inpatient physician and surgeon services	100%	70% after deductible
<b>Emergency Care</b>		
Emergency room (ER) charges	\$25 copayment	\$25 copayment
	Copayment waived if admitted. The plan does not cover ER charges for conditions that are not true emergencies.	
Urgent care clinic visit	\$20 copayment	70% after deductible
Ambulance services	80%	80%
	Charges covered for true emergencies	
<b>Mental Health Treatment</b>		
Outpatient mental health office visits	\$20 copayment	70% after deductible
Inpatient mental health treatment	100%	70% after deductible
	Notification is required out-of-network	

Plan Feature	UHC Choice Plus POS (Pre-94)	
	In-Network	Out-of-Network
Outpatient substance abuse detoxification	\$20 copayment	70% after deductible
Inpatient substance abuse detoxification	100%	70% after deductible; notification is required
Outpatient substance abuse rehabilitation	100%	70% after deductible
Inpatient substance abuse rehabilitation	100%	70% after deductible
<b>Alternative Care</b>		
Chiropractic services	\$20 copayment	70% after deductible
	<b>Limit:</b> Up to 24 visits per calendar year, in- and out-of-network combined	
Acupuncture	\$20 copayment; must be performed by an MD or DO	70% after deductible; generally limited to 12 sessions over a 12-month period
		70% after deductible; must be performed by an MD or DO
<b>Alternative Treatment Settings</b>		
Home health care	100%	70% after deductible
	<b>Limit:</b> Up to 200 visits per calendar year, in- and out-of-network combined	
Hospice care	100% after \$100 copayment	70% after deductible
	<b>Limit:</b> Up to 210 days per lifetime, in- and out-of-network combined	
Prescribed care in skilled nursing facility	100%	70% after deductible
	<b>Limit:</b> Up to 120 days per calendar year, in- and out-of-network combined	
Durable medical equipment	100%	70% after deductible
<b>Condition Management Programs</b>		
Condition management programs	UHC offers programs to help you manage existing health conditions. Contact the claims administrator of your plan for information on the programs available.	

## Covered Charges

The Retiree Medical Plan pays benefits for services and supplies that are specifically covered by the plan. To be covered, a medical service must be "medically necessary" as determined by a physician and agreed to by the claims administrator. The claims administrator's criteria to determine medical necessity may change periodically. You may contact your claims administrator for additional information, or see the "Glossary" for a definition of "medically necessary." In addition, out-of-network expenses may be subject to R&C limits.

## What Is Not Covered

The following list represents some of the items excluded from retiree medical coverage. This list may not capture all exclusions. If you have a question about a specific type of coverage, call your claims administrator.

Plan exclusions include, but are not limited to:

- Expenses for out-of-network services that exceed the reasonable and customary (R&C) limits;
- Services or supplies not deemed medically necessary;
- Services considered experimental or investigational;
- Expenses for out-of-network organ transplants;
- Routine vision exams;
- Routine foot care;
- Rental or use of non-durable medical equipment, even though recommended by a physician;
- Dental treatment (except as noted by your carrier for your option);
- Dental implants;
- Cosmetic surgery, procedures, or treatments;
- Occupational accidents or illnesses;
- Services rendered by non-qualified practitioners;
- Services of a private-duty nurse for inpatient hospital care;
- Services rendered in a freestanding facility that is not approved by the Joint Commission on Accreditation of Hospitals (JCAH);
- Custodial care or confinement in a nursing home;
- Charges made for the services of any person who is a member of your immediate family or who resides in your home;
- Charges for confinement in a place that is primarily a school or a place of rest;
- Charges incurred in a U.S. government hospital;
- Charges you would not be required to pay if there were no insurance;
- Sickness or loss covered by Workers' Compensation or automobile insurance;
- Personal hospital services such as radio, television, telephone, etc.;
- Weight-reduction programs (except when medically necessary);
- Herbal medicine or holistic or homeopathic care, including drugs;
- Acupuncture, except when services are provided by a medical doctor;
- Procedures to reverse voluntary sterilization; and
- Services for mental health and/or substance abuse rendered in a residential treatment facility.

## Pre-Treatment Review

Certain types of treatment are subject to pre-treatment review. Although there is no penalty if you do not obtain pre-treatment review for certain services for which it is recommended, you should obtain pre-treatment review to ensure that the treatment is medically necessary and therefore covered by the plan.

Before you or a covered dependent receives certain types of treatment (such as any non-emergency hospital admission), you should call your claims administrator for a pre-treatment review. The claims administrator will review the proposed treatment to make sure the charges are medically necessary and within the plan's guidelines. The claims administrator will tell you what benefits the plan will pay and if there are any limitations or exclusions that may apply. It is your responsibility to contact the claims administrator to request a review.

Although there is no penalty if you do not call your claims administrator prior to receiving care, you run the risk of reduced or denied benefits if the claims administrator finds that the care you receive is not medically necessary.

### How to Request Pre-Treatment Review

To request a pre-treatment review, you must call the claims administrator before you receive medical services. In an emergency, you or the hospital should call within 24 to 48 hours after an emergency admission.

How Pre-Treatment Review May Affect Your Benefits	
If you call and the plan determines that treatment is medically necessary	Plan pays benefits at regular rates
If you call and the plan determines that treatment is not medically necessary	No benefits are paid
If you do not call and the plan determines that treatment is medically necessary	Plan pays benefits at regular rates
If you do not call and the plan determines that treatment is not medically necessary	No benefits are paid

### Emergency Hospitalization—All Participants

In order to receive the maximum benefit allowed under the plan for emergency hospital admissions, you must contact the claims administrator for your option as soon as possible following the emergency admission. Note that you do not need a pre-treatment review of a hospital stay following the birth of a newborn, as long as it does not exceed 48 hours for a normal vaginal delivery or 96 hours for a cesarean section.

### Concurrent Review—All Participants

If a stay needs to be extended beyond the number of days originally reviewed, the additional days must be reviewed before your hospital stay that was originally agreed to ends. This is called concurrent review. You are responsible for making sure that concurrent review occurs.

## Receiving Care Outside Your Coverage Area

If you need medical care while traveling outside the network service area, you should contact the claims administrator:

- Prior to receiving any non-emergency care; and
- As soon as possible after you receive emergency care.

The claims administrator's telephone number is shown on your Medical Plan ID card.

## Closed Groups: Medicare-Eligible Medical Plan Option Information

If you and/or your spouse or domestic partner is Medicare-eligible, you will choose a retiree medical plan option through United Healthcare Medicare Solutions.



United Healthcare Medicare Solutions offers:

- A variety of plan options. You can choose a health care plan for your situation.
- Plans with low premiums. Some plan options have low or no premiums at all.
- The ability to change plan options. Some plan types allow changes as often as monthly, letting you make adjustments based on your needs.

United Healthcare provides detailed information about the various options available to you and/or your dependents. These summaries are available on [www.UHCretiree.com](http://www.UHCretiree.com) and can also be requested in print, free of charge, from United Healthcare. The coverage summaries will:

- Include any cost-sharing provisions, such as copayments, coinsurance, deductibles, and out-of-pocket maximum amounts.
- Include any applicable annual maximums or other limits.
- Define in-network health care providers, such as a doctor, physician, or hospital.
- Describe what preventive care services are covered and what other services and expenses are covered or not covered.

You or any Medicare-eligible dependents need to enroll in Medicare Part A and Part B in order to have coverage under the Credit Suisse Retiree Medical Plan. For prescription drug coverage, you need to elect a Medicare Part D prescription plan.

Prior to your 65<sup>th</sup> birthday, you will receive a package from United Healthcare Medicare Solutions detailing your health care options and how to enroll.

You and/or your dependents should enroll in Medicare 90 days before turning age 65. You may do this by visiting [Medicare.gov](http://Medicare.gov) or by visiting your local Social Security office.

## Closed Groups: How Your Retiree Medical Benefits Coordinate With Medicare

When you or your spouse or domestic partner becomes eligible for Medicare, the Retiree Medical Plan automatically becomes the secondary payer of benefits for any Medicare-eligible participants, meaning the Retiree Medical Plan pays benefits as if you (or any Medicare-eligible dependents) are enrolled in Medicare Part A and Part B, regardless of whether or not you (or they) are actually enrolled.

When you or your Medicare-eligible spouse or domestic partner receives services or supplies, the amount for which you are responsible is based on whether the provider accepts Medicare assignment.

**It is extremely important that you and your spouse or domestic partner, if applicable, enroll in Medicare Part A and Part B as soon as either of you become eligible. The Retiree Medical Plan will not pay for any expenses that would have been covered by Medicare. If you receive services, and those services are not paid for by Medicare because you are not enrolled, you will remain responsible for the cost of those services.**

## Full Coordination of Benefits (COB): How Coordination Works

The Retiree Medical Plan will not reimburse a Medicare-eligible participant for expenses already covered by Medicare. The Retiree Medical Plan will reimburse you for expenses that were partially covered by Medicare. Total reimbursement from the Retiree Medical Plan and Medicare will never exceed the Medicare Allowable Charge.

Examples of how this works appear in the following charts. These examples assume that Medicare is your primary plan, the Retiree Medical Plan is your secondary plan, both plans have coinsurance of 80%, and you have already met the deductibles for both plans.

### ***When Your Provider Accepts Assignment***

Medicare Allowable Charge (based on fee schedule) and amount provider accepts as payment in full for services	\$150
Medicare coinsurance calculation	$\$150 \times 80\% = \$120$
Credit Suisse coinsurance calculation	$\$150 \times 80\% = \$120$
Amount payable from Medicare as primary plan	\$120
Amount payable from Credit Suisse as secondary plan	$\$150 - \$120 = \$30$
Total reimbursement amount (cannot exceed Medicare Allowable Charge)	\$150
Your out-of-pocket costs	\$0

### ***When Your Provider Does Not Accept Assignment***

Medicare Allowable Charge (based on fee schedule)	\$150
Minimum that providers can charge if they do not accept assignment is 95% of Medicare Allowable Charge; maximum is 115% of minimum	Minimum: \$142.50/maximum: \$163.88
This example uses maximum allowed	\$163.88
Medicare coinsurance calculation	$\$142.50 \times 80\% = \$114$
Credit Suisse coinsurance calculation	$\$163.88 \times 80\% = \$131.10$
Amount payable from Medicare as primary plan	\$114
Amount payable from Credit Suisse as secondary plan	$\$163.88 - \$114 = \$49.88$
Total reimbursement amount	\$163.88
Your out-of-pocket costs	\$0

### **When Expenses Are Not Covered by Medicare**

When expenses are **not** covered by Medicare, but **are** covered by the Retiree Medical Plan, you will need to meet the Retiree Medical Plan's annual deductible before receiving benefits.

There are some expenses that Medicare does not cover or limits coverage of, but that are covered under the Retiree Medical Plan's options, such as hospital stays over Medicare limits, and private duty nursing for medical treatment over Medicare limits.

If you have questions on coordinating with Medicare, call the Credit Suisse Benefits Service Center.

### **Medicare Terms**

The Medicare Allowable Charge is the fee Medicare sets as reasonable for a covered medical service. This is the amount a doctor or supplier is paid by you and Medicare for a service or supply. It may be less than the actual amount charged by a doctor or supplier. For example, a doctor's regular charge for a service may be \$200, but the Medicare Allowable Charge could be \$150.

The Medicare primary payment is the portion of the Allowable Charge paid by Medicare.

## **Plan Continuance**

It is hoped that the Retiree Medical Plan will continue 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.

# Medical and Prescription Drug Information for Non-Medicare-Eligible Retirees

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## Prescription Drug Coverage

You will continue to have access to prescription drug coverage through the Retiree Medical Plan during retirement. Prescription drug coverage is administered by Express Scripts (ESI).

## If You Participate in the Retiree Choice Plus CDHP (Post-94) Plan Option

You may fill your prescriptions at either a retail pharmacy or through the mail-order pharmacy. Under the Retiree Choice Plus CDHP (Post-94) Plan option, you must meet the annual deductible before prescription drug benefits are paid. The Retiree Medical Plan then pays 80% of all prescriptions, and you pay the remaining 20% at the time of purchase. Please note, however, that although your coinsurance is the same for all prescriptions, when you use generic or formulary brand drugs, you will see significant cost savings.

**Note:** If you choose a brand-name drug when a generic is available, you will pay your cost share for the brand drug, plus the difference in cost between the generic and the brand-name drug. This cost difference will accumulate toward your out-of-pocket maximum.

**Please note:** There is a \$10,000 lifetime maximum for prescription drug fertility services under this option.

## If You Participate in the UHC Choice Plus POS Option

You may fill your prescriptions at either a retail pharmacy or through the mail-order pharmacy. If you choose mail order, you can save money. For example, if you fill a generic prescription at a retail pharmacy, you will pay a \$5 copayment for a 30-day supply. If you fill a prescription for the same drug through mail order, you will pay a \$10 copayment for a 90-day supply.

If you choose to fill a prescription at a pharmacy that does not participate in the Retiree Medical Plan network, you will have to file a claim for reimbursement. Claim forms are available from Express Scripts; see "Plan Administration" for contact information.

The Retiree Medical Plan prescription drug coverage offers three tiers of coverage for prescriptions purchased at a retail pharmacy, and for prescriptions ordered through the mail-order pharmacy:

Prescription Tier	Retail (30-day supply)	Mail Order (up to 90-day supply)
Generic	\$5	\$10
Formulary Brand	\$30	\$60
Non-Formulary Brand	\$60	\$120

# How Your Prescription Drug Coverage Works

## **Retail Pharmacy**

You can purchase short-term prescriptions at retail pharmacies. For these prescriptions, you can purchase up to a 30-day supply each month. To purchase a prescription:

- Present your ID card when you pick up your prescription; and
- Pay any deductibles, copayments, or coinsurance required based on your Medical Plan option and on whether you purchase a generic, formulary brand, or non-formulary brand drug.

## **Home Delivery Service**

You can purchase up to a 90-day supply of maintenance medication through the mail-order program. The mail-order program may be convenient for you if you take maintenance medication for ongoing conditions like diabetes or high blood pressure. If you choose to use the mail-order program, your prescription will be mailed to your home. (It usually takes about 10 to 14 days to receive your prescription.)

## ***Planning Ahead***

Plan ahead to make sure you do not run out of your medicine before your refills arrive. Send in your order for maintenance refills at least two weeks before your supply runs out.

## **About Generic, Formulary Brand, and Non-Formulary Brand Drugs**

Your prescription drug coverage includes special coverage for generic drugs and drugs listed on the plan's formulary for both the retail and mail-order programs.

- A generic drug is a chemical copy of a brand-name prescription drug. It must contain the same active ingredients as and be equivalent in strength and dosage to its brand-name counterpart. It is subject to the same rigid U.S. Food and Drug Administration (FDA) standards for quality, strength, and purity as its brand-name counterpart. Generally, generic drugs cost 30% to 60% less than their brand-name counterparts because manufacturers of generic drugs do not have to pay for research and development or marketing and advertising.
- A formulary is a list of frequently prescribed preferred brand medications for which the plan has negotiated preferred pricing. As a result, prescriptions for formulary brand medications are more cost-effective for you and the plan. Physicians and pharmacists develop and evaluate the formulary list. Express Scripts' National Preferred Formulary applies to all Credit Suisse prescription drug options. The formulary is set by the prescription drug claims administrator and is subject to periodic review and change. It is available on the claims administrator's web site.
- A non-formulary drug is a drug for which the plan has not negotiated preferred pricing. Coverage for non-formulary drugs may be offered under the plan, but your share of the cost will be greater than if you were to receive a generic or formulary drug.

## What Is Covered

The prescription drug program covers the following drugs and medications that are medically necessary and prescribed by a physician:

- "Legend drugs," with the exception of those that are specifically excluded from coverage;
- Insulin;
- Compounded medication of which at least one ingredient is a legend drug;
- Any other drug that, under state law, may be dispensed only with a written prescription from a physician or other lawful prescriber; and
- Legend oral contraceptives and injectable contraceptives.

## Legend Drugs

Any drug that is not available without a physician's prescription.

## What Is Not Covered

The following list represents the items excluded from retiree prescription drug coverage. This list may not capture all exclusions. In addition to the exclusions listed here, many drugs have quantity limits or require authorization prior to filling a prescription. Contact the prescription drug carrier for information on a specific drug.

- Cosmetic-only indications, including photo-aged skin products;
- Contraceptive implants;
- Anorectics (any drug used for the purpose of weight loss) or weight-management agents;
- Dietary supplements, including legend supplemental vitamin and legend multi-vitamin;
- Implantable, time-released medication, unless otherwise noted;
- Legend homeopathic drugs;
- Allergy serums or injections;
- Immunizations;
- Over-the-counter (OTC) drugs (however, OTC contraceptives are covered with a valid prescription from your doctor);
- Prescription drugs with over-the-counter equivalents;
- Legend smoking-cessation products (however, Chantix and certain generic tobacco cessation drugs are covered);
- Hair-growth products;
- Non-legend drugs, other than insulin;
- Therapeutic devices or appliances, support garments, and other non-medicinal substances, regardless of their intended use;
- Prescriptions that an eligible person is entitled to receive without charge, including, but not limited to, those paid under Workers' Compensation laws;
- Experimental drugs or drugs labeled "Caution—limited by federal law to investigational use";
- Medication that is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended-care facility, convalescent hospital, nursing home, or similar institution that operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals; or
- Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician's original order.

# Medical and Prescription Drug Information for Medicare-Eligible Retirees

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## If You Are a Medicare-Eligible Participant

In order to continue having prescription coverage, you will need to elect a Medicare Advantage plan that includes a Medicare Part D prescription plan or a separate Medicare Part D prescription drug plan. United Healthcare Medicare Solutions representatives can help you choose a plan that is a good fit for your personal situation.

## About Medicare Part D

Medicare Part D is designed to help provide affordable prescription drug coverage to Medicare-eligible individuals who have minimal or no prescription drug benefits through their former employer. Medicare Part D became available to all Medicare beneficiaries as of January 1, 2006.

Medicare-eligible retirees should carefully review the benefits and costs of a Part D plan. If you would like to learn more about Medicare Part D, you can visit [Medicare.gov](https://www.medicare.gov) for general information on Medicare or [www.cms.hhs.gov](https://www.cms.hhs.gov) for details on Medicare and Medicaid services or consult the most recent version of the *Medicare & You* handbook, distributed by Medicare to all beneficiaries. You can also call Medicare at **1-800-MEDICARE (1-800-633-4227)**. For TTY/TDD assistance for the hearing-impaired, call **1-877-486-2048**.

For more information on Medicare Part D and how it affects your Credit Suisse retiree medical and prescription drug coverage, visit the Your Benefits Resources web site or call the Credit Suisse Benefits Service Center at **1-888-325-2732**.

## Contact Information

If you have general questions about your prescription drug coverage, call the Credit Suisse Benefits Service Center at **1-888-325-2732**.

If you are a non-Medicare-eligible retiree, contact Express Scripts at **1-866-210-4473** or [www.express-scripts.com](https://www.express-scripts.com) if you need to find a participating retail pharmacy, if you lose your ID card, if you want to check whether a drug is a formulary brand drug, or if you have questions about coverage.

If you are a Medicare-eligible retiree, contact United Healthcare Medicare Solutions at **1-877-886-7309** for information about your prescription drug coverage.

If you want to view summaries of the plans available to you, visit [www.UHCretiree.com](https://www.UHCretiree.com).

# When Retiree Medical Plan Participation Ends

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## When Coverage Ends

Coverage under the Retiree Medical Plan will end:

### **For you:**

- When you die;
- If you fail to provide plan-related information or documentation upon request;
- If you stop paying any required contributions; or
- If the Bank no longer offers the Retiree Medical Plan.

### **For your dependents:**

- For your spouse, if you become divorced or legally separated;
- For your domestic partner, if you dissolve your domestic partnership;
- For your dependents, when they are no longer eligible;
- If you or your dependent stops paying any required contributions; or
- If the Bank no longer offers the Retiree Medical Plan.

Note: If the Credit Suisse retiree fails to pay any premiums, coverage will be terminated for the retiree and any covered dependents.

Should you die while covered under the Retiree Medical Plan, coverage for any eligible surviving dependents who were covered at the time of your death will automatically be continued.

- Your spouse or domestic partner can continue coverage for himself or herself indefinitely, but he or she cannot add new dependents.
- Your children can continue coverage until they would otherwise lose eligibility, for example, by reaching the limiting age. However, they cannot add new dependents.

The Credit Suisse Benefits Service Center will provide information about this coverage to your surviving dependents upon your death.

When coverage ends for any reason other than your death, you, your spouse, or your dependents may be eligible to continue coverage for a specified period of time through COBRA. For more information, see "Continuing Your Coverage Under COBRA."

**Please note:** Special rules apply for the Grandfathered Group known as Former Credit Suisse Group Employees in the U.S. See "Standard Plan: Former Credit Suisse Group Employees in the U.S." for details.

## Coverage Information

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### Coverage Mandated by Law

Included in this section is information on certain types of coverages mandated by law. Additional information can be found on the Your Benefits Resources web site. If you have a question about a specific type of coverage, contact the claims administrator. The information in this section applies to all participants in the Retiree Medical Plan.

### Mental Health Parity Act

Under the Mental Health Parity and Addiction Equity Act of 2008, the financial requirements and treatment limitations applied to mental health and substance abuse services must not be more restrictive than those applied to other medical plan services.

### Newborns' and Mothers' Health Protection Act

Under the Newborns' and Mothers' Health Protection Act of 1996, benefits for you or your spouse for any hospital length of stay in conjunction with childbirth for the mother or newborn child may not be restricted to less than 48 hours following a normal delivery or less than 96 hours following a cesarean delivery. In addition, there can be no requirement that providers obtain authorization from the Retiree Medical Plan or the claims administrator for prescribing a length of stay within the above periods. Coverage for longer periods may be permitted with the prior authorization of the plan administrator.

A new mother may be released prior to 48 hours (or 96 hours) if she and her doctor agree to an earlier release date. However, the Retiree Medical Plan cannot offer financial incentives to either the mother or physician to prescribe a reduced hospital stay.

### Women's Health and Cancer Rights Act

Under the Women's Health and Cancer Rights Act of 1998, coverage will be provided in the manner determined by the attending physician and the patient for the following:

- Reconstruction of the breast on which surgery was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and physical complication at all stages of mastectomy, including lymphedema.

This coverage is subject to the same copayments and deductibles that apply to other medical benefits.

# How to File a Medical Claim

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## How to File a Claim

Please note: Information regarding filing claims for fully insured plans are provided in the individual certificates of coverage that you receive from United Healthcare Medicare Solutions. You should follow the claims procedures in the applicable certificate of coverage for a fully insured plan.

The following information applies for filing self-insured medical claims.

### *What Is a Fully Insured Benefit vs. a Self-Insured Benefit?*

***For fully insured benefits, the policyholder pays the insurer a premium in exchange for coverage under the insured option. The insurer or its delegate processes claims and makes all benefit determinations. Any benefit funded by the purchase of insurance will be payable solely by the insurer and the plan sponsor shall not have any further responsibility to pay such benefit.***

***For self-insured benefits, Credit Suisse pays a fee to the claims administrators in exchange for claim processing and customer service functions only. Claims are paid by Credit Suisse from Company general assets.***

If you receive care from a provider that participates in the carrier's network, you do not need to file a claim for benefits. The provider will do it for you.

If you receive care from a provider that does not participate in the carrier's network, you need to file a claim for benefits. To file a claim, you must obtain a claim form from the Your Benefits Resources web site or the carrier's web site, or you may call the claims administrator to have a form mailed to you. Attach all bills, valid receipts, and documentation when you submit your claim to the carrier.

You must file a claim by the end of the calendar year following the year in which an expense is incurred. Otherwise, the claim will not be paid.

### **Advocacy Services**

Questions about benefits or benefit amounts may arise. If you have a question or concern about health plan benefits or a benefit determination (how a claim was paid), you should informally contact the Credit Suisse Benefits Service Center to connect to Advocacy Services before submitting a formal appeal to the carrier.

If you have made at least one inquiry to resolve your issue directly with your health plan, Advocacy Services will research and work with your health plan in trying to resolve your issue before a formal appeal is filed. If Advocacy Services is unable to resolve your issue, there are formal appeals procedures in place, which are explained in this document.

# Appealing a Denied Claim

In the event your claim is denied, there are two types of issues that you can appeal: eligibility issues and benefit issues.

## Eligibility Issues

An eligibility issue relates to your ability to participate in a plan option or to change an election to participate during the year. You may want to start, add, or stop participation in the plan. You may want to challenge enrollment in a plan or eligibility for coverage in a plan. For instance, you may feel an error was made during the Annual Enrollment period that resulted in your being assigned incorrect coverage. In these situations, you should contact the Credit Suisse Benefits Service Center at **1-888-325-2732** to discuss your concerns.

- Level 1: All eligibility issue appeals are reviewed by Claims and Appeals Management. The process by which the eligibility appeal can be filed and the timing of the review are determined by the type of appeal, as described under "Claim Appeal Categories."
- Level 2: All requests for review of denied eligibility appeals are reviewed by the Benefits Committee, or its designee. Requests for review of denied eligibility appeals must be filed within 180 days after receipt of your denial notice. Failure to file a request for review of a denied eligibility appeal within the 180-day period will be considered a failure to exhaust all administrative remedies under the Retiree Medical Plan. The process by which the request for review of the denied eligibility appeal can be filed and the timing of the review are determined by the type of appeal, as described under "Claim Appeal Categories."

## Benefit Issues

A benefit issue relates to a claim for a particular benefit under a plan. It will typically include your initial request for benefits, if applicable.

Please note: For benefit issues, claims appeal procedures for your Medicare-eligible plans are provided in the individual certificates of coverage that you receive from United Healthcare Medicare Solutions. You must fully comply with the insurer's claims and appeals procedure if your benefit claim is denied. The complete claims procedure for fully insured benefit programs is contained in the respective coverage summaries or certificates of insurance that are provided to enrollees without charge as separate documents. You should refer to these documents for additional information about how and when to file an appeal. The insurer will also provide you with information on its voluntary external review process by an Independent Review Organization (IRO)/External Review Organization (ERO) or by the State Insurance Commissioner, if applicable. The insurer will describe the process to follow if you wish to pursue an external review of your claim.

## **The following benefits claim appeal procedures apply to self-insured claims:**

- Level 1: All benefit issue appeals go directly to the claims administrator. Download a claim form from the Your Benefits Resources web site or from the claims administrator's web site, or call the claims administrator to have one mailed to you, and submit your appeal to the address on the form. Attach all supporting documentation, including receipts and explanations of benefits (EOBs) previously received.
- Level 2: Requests for review of denied medical benefit appeals are filed with the Benefits Committee, or its designee. You must request a review of denied benefit appeals within 180 days after receipt of your denial notice. Failure to file a request for review of a denied appeal within the 180-day period will be considered a failure to exhaust all administrative remedies under the process by which the request for review of the denied appeal can be filed and the timing of the review are determined by the type of appeal, as described below.

Either type of issue will fall within one of four appeal sub-categories described below.

### **Review Procedures When an Appeal Is Denied**

Following are the review procedures to be followed when an appeal is denied:

- The Benefits Committee, or its designee, will provide a review that takes into account all comments, documents, records, and other information submitted by you without regard to whether such information was submitted or considered in the initial benefit determination.
- You will have the opportunity to submit written comments, documents, records, and other information relating to the appeal.
- You will be provided, upon request and free of charge, reasonable access to and copies of all relevant documents.
- The review of a denial will not defer to the initial determination made.
- The individual who will conduct the review process will not be the individual who made the initial denial nor the subordinate of such individual.
- In deciding an appeal of any denial that is based in whole or in part on a medical judgment, including determinations of whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment will be consulted. The health care professional will be an individual who was neither consulted in connection with the denial nor the subordinate of any such individual.
- The Benefits Committee, or its designee, will identify any medical or vocational experts whose advice was obtained on behalf of the plan in connection with your denial, without regard as to whether the advice was relied upon in making the benefit determination.
- In the case of an appeal involving urgent care, an expedited review process will be provided. You may request an expedited appeal orally or in writing and all necessary information may be transmitted between the plan and you by telephone, facsimile, or other available similarly expeditious method.

## **Claim Appeal Categories**

These sub-categories define the timing for the review of issue appeals and how those appeals can be submitted.

The four appeal sub-categories are:

- **Post-Service:** A post-service appeal is an appeal for reimbursement of medical services already received. Claims related to prescription drug coverage are considered post-service claims. This is the most common type of appeal.
- **Pre-Service:** A pre-service appeal is an appeal for a benefit for which a pre-treatment review is recommended or required by the plan.
- **Concurrent Care:** A concurrent care appeal is an appeal for ongoing treatment over a period of time or a number of treatments. For example, if you have been authorized to receive seven treatments from a therapist and, during the treatment, the therapist suggests 10 treatments; the appeal is a concurrent care appeal. Some concurrent care appeals also are urgent care appeals.
- **Urgent Care:** An urgent care appeal is an appeal for medical care or treatment that, if the longer time frames for non-urgent care were applied, the delay could:
  - Seriously jeopardize the health of the patient or his or her ability to regain maximum function; or
  - In the opinion of a physician with knowledge of the patient's medical condition, would subject the patient to severe pain that could not be managed without the care or treatment that is the subject of the appeal.

The processes and timing for filing these appeals are described below.

## How to File Appeals

Whether you have an eligibility issue or a benefits issue, you are provided with two opportunities to challenge denied claims.

### Filing Level 1 Eligibility Appeals

#### *Filing Pre-Service and Post-Service Eligibility Appeals*

In order for a communication from you to constitute a valid eligibility appeal, it must be in writing on the appropriate Appeal Initiation Review Form and delivered, along with any supporting comments, documents, records, and other information within 180 days of the original denial, by first-class mail postage paid, to:

Claims and Appeals Management  
P.O. Box 7105  
Rantoul, IL 61866-7105

You can receive the Appeal Initiation Review Form by calling the Credit Suisse Benefits Service Center at **1-888-325-2732**.

Eligibility appeals may be pursued by you or your duly authorized representative.

### Defective Appeals

In the case of your failure to follow the plan's procedures for filing a valid urgent care or pre-service appeal, you will be notified of the failure and the proper procedures to be followed in filing an appeal. This notice will be provided to you as soon as possible, and no later than 24 hours after the failure for urgent care appeals, or five days after the failure for pre-service appeals.

# Filing Urgent and Concurrent Care Eligibility Appeals

In the interest of time, all urgent or concurrent care eligibility appeals can be submitted orally. To file an urgent or concurrent appeal, call the Credit Suisse Benefits Service Center at **1-888-325-2732**.

## **Filing Level 1 Benefit Appeals—Medical**

All Level 1 benefit appeals must be filed with the claims administrator within 180 days of the original denial. Refer to "Plan Administration" for the administrator contact information.

## Timing for Level 1 Appeals

### **Timing to Review Pre-Service Appeals**

In the case of an appeal involving a pre-treatment review, you will be notified of the benefit determination (whether adverse or not) within 15 days after receipt of the appeal.

If an extension is necessary due to your failure to submit the information necessary to decide the appeal, the notice of extension will describe the required information, you will be given at least 45 days from receipt of the notice within which to provide the specified information, and the 15-day extension in which the decision is required to be made will be suspended from the date on which the notification is sent to you until the earlier of (1) the date you respond to the request for additional information, or (2) the due date established for furnishing the requested information.

### **Timing to Review Post-Service Appeals**

In the case of an appeal filed after the medical care has been delivered, you will be notified of the determination within 30 days after receipt of the appeal.

If an extension is necessary due to your failure to submit the information necessary to decide the appeal, the notice of extension will describe the required information, you will be given at least 45 days from receipt of the notice within which to provide the specified information, and the 30-day period in which the decision is required to be made will be suspended from the date on which the notification is sent to you until the earlier of (1) the date you respond to the request for additional information, or (2) the due date established for furnishing the requested information.

### **Timing to Review Urgent Care Appeals**

In the case of an appeal involving urgent care, you will be notified of the benefit determination (whether adverse or not) no later than 72 hours after receipt of the appeal, provided that you provide sufficient information to determine whether, and to what extent, benefits are payable under the plan.

If you fail to provide sufficient information to determine whether, and to what extent, an appeal involving urgent care is covered by the plan, you will be notified within 24 hours after receipt of the appeal of the specific information necessary to complete the appeal. You will be given a reasonable amount of time, taking into account the circumstances but in no event less than 48 hours, to provide the specified information. You will be notified of the benefit determination no later than 48 hours following the earlier of:

- The receipt of the specified information; or

- The end of the period afforded to you to provide the specified additional information.

### **Timing to Review Concurrent Care Appeals**

In the case of a denial of coverage involving a course of treatment (other than by amendment or termination of the plan) before the end of such period of time or number of treatments, you will be notified of the denial in advance of the reduction or termination to allow you to appeal and obtain a determination on review of that denial before the benefit is reduced or terminated.

Where you want to extend the course of treatment beyond the period of time or number of treatments and it is an appeal involving urgent care, you will be notified of the benefit determination, whether adverse or not, within 24 hours after receipt of the appeal (provided that any such appeal is made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments).

## **Filing a Level 2 Appeal**

### **Requesting Review of Denied Pre-Service and Post-Service Appeals—Eligibility, Medical Benefit**

In order for a communication from you to constitute a valid request for review of denied pre-service or post-service appeals, it must be in writing on the appropriate Denied Appeal Review Form and delivered, within 180 days of the initial denial, along with any supporting comments, documents, records, and other information, by first-class mail postage paid, to:

Credit Suisse Benefits Committee  
P.O. Box 7105  
Rantoul, IL 61866-7105

You can receive the Denied Appeal Review Form by calling the Credit Suisse Benefits Service Center at **1-888-325-2732**.

### **Requesting Review of Denied Concurrent and Urgent Care Appeals—Eligibility, Medical Benefit**

In the interest of time, requests for review of denied concurrent care and urgent care appeals can be submitted orally. To request a review of a denied concurrent or urgent appeal, call the Credit Suisse Benefits Service Center at **1-888-325-2732**. All requests must be made within 180 days of the initial denial.

### **Timing to Review Denied Level 1 Appeals**

#### ***Timing to Review Requests for Review of Denied Pre-Service Appeals***

In the case of a request for review of a denied appeal involving a pre-treatment review, you will be notified of the determination (whether adverse or not) within 15 days after receipt of the request for review.

#### ***Timing to Review Requests for Review of Denied Post-Service Appeals***

In the case of a request for review of a denied appeal filed after the medical care has been delivered, you will be notified of the determination within 30 days after receipt of the request for review.

### ***Timing to Review Requests for Review of Denied Concurrent and Urgent Care Appeals***

In the case of a request for review of a denied appeal involving concurrent or urgent care, you will be notified of the determination (whether adverse or not) no later than 72 hours after receipt of the request for review.

## **Manner and Content of Notification of Denied Appeal**

You will be provided with written notice of any denial, in accordance with applicable U.S. Department of Labor regulations. The notification will include:

- Information to help you identify the claim that is being denied, including the date of service, provider's name, claim amount and denial codes and their meanings (treatment and diagnosis codes and their meanings will be provided to you upon request);
- The specific reason or reasons for the denial, including any standard used to deny the claim;
- Reference to the specific provision(s) of the medical plan on which the determination is based;
- A description of any additional material or information necessary for you to perfect the appeal and an explanation of why such material or information is necessary;
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, the notice will either (1) include the specific rule, guideline, protocol, or other similar criterion of the plan that was relied upon, or (2) provide a statement that such rule, guideline, protocol, or similar criterion was relied upon, and that a copy will be provided free of charge to you upon request;
- If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, the notice will provide either (1) an explanation of the scientific or clinical judgment relied upon for the determination, or (2) a statement that such explanation will be provided free of charge upon request;
- A description of the plan's internal and external review procedures and the time limits applicable to such procedures, and, if your appeal involves urgent care, of the expedited review process;
- A statement describing your right to bring a civil lawsuit under Section 502(a) of ERISA; and
- Contact information for any applicable office of health insurance consumer assistance or ombudsman.

For purposes of the Retiree Choice Plus CDHP (Post-94) plan option, if 10% or more of the population residing in the claimant's county are literate only in the same non-English language, as determined by the Department of Labor, then the plan will provide the following for written notice of a denial:

- Oral language services;
- A notice in any applicable non-English language, upon request; and
- A one-sentence statement in notices indicating how to access language services.

## **Discretionary Authority of Plan Administrator**

Although the Benefits Committee has delegated its authority to determine initial claims to the claims administrator, the Benefits Committee, or its designee, will have discretionary authority to determine for all parties claiming to have an interest in the plan, and in accordance with the terms of the documents and instruments governing the plan, any and all questions arising from or relating to the administration and interpretation of the plan. This authority includes, without limitation, determination of questions arising from or relating to the participation of eligible employees and eligibility for benefits, the relevant facts, the amount and type of benefits payable.

## External Review

Once you have pursued all of the internal claim and appeal rights described in this "How to File a Medical Claim" section in a timely manner (or you are deemed to have pursued them as described below), you can request that your claim be reviewed by an external independent review organization ("IRO"). You can also request an external review of your urgent care claim if exhaustion of the appeal process described earlier would seriously jeopardize your life or health or ability to regain maximum function.

The IRO is composed of persons who are not employed by Credit Suisse, the claims administrator, or any of their affiliates. Your decision to use this voluntary level of appeal will not affect your rights to any other benefits under the plan.

There is no charge for you to initiate this external review process. The plan will abide by the decision of the IRO.

To request an external review, you must notify the claims administrator within 120 days after you receive the final denial notice from the Benefits Committee. The claims administrator will then forward the file to the IRO, who will render an opinion within 45 days. When requested and when a delay would be detrimental to your medical condition, the review will be completed within three days.

You will be provided with written notice of the IRO's decision. The notification will include:

- A general description of the reason for the request for external review;
- The date the IRO received the request for review;
- The date of the IRO's decision;
- References to the evidence or documentation considered in the determination, including the specific coverage provisions and evidence-based standards;
- A discussion of the principal reason or reasons for the decision, including the rationale for the decision and any evidence-based standards relied upon;
- A statement that the determination is binding except to the extent that other relief is available under state or federal law;
- A statement regarding your right to file suit in federal court; and
- Current contact information, including phone numbers, for any applicable office of health insurance consumer assistance or ombudsman.

## Employment Dispute Resolution Program

Credit Suisse's Employment Dispute Resolution Program (EDRP) provides that if a claimant wishes to challenge a final determination by the Benefits Committee under the plan, the claim shall be submitted to external mediation. If mediation is not successful, the claimant may submit the claim to final binding arbitration.

You may elect to seek resolution of a denied appeal through the EDRP, through an external review, or through judicial review.

You must pursue all of the internal claim and appeal rights described above in a timely manner (or be deemed to have done so, as described below) before you seek resolution under the EDRP. You may not request that your claim be submitted to mediation until the appeal rights described above have been exercised and the benefits requested in such appeal have been denied in whole or in part (or there is any other adverse benefit determination). The request for mediation must be made within six months after the date on which all administrative remedies are exhausted—that is, by the later of the date on which an adverse determination on review is issued or the last day on which a final decision should have been issued, or you will forever be prohibited from commencing mediation. A request for binding arbitration must be made within six months of the date Credit Suisse or the claimant gives notice to the other that the mediation proceedings are not likely to result in a resolution.

The EDRP is included in your employee handbook which may be accessed on the MyHR+ Intranet Homepage.

## Deemed Exhaustion

If the plan does not comply with all of the internal claims and appeal processes described above, you will be treated as though you exhausted the internal appeals process. As a result, you may request an external review, you may request resolution under the EDRP, or you may bring a civil action—even though you have not completed both internal levels of appeal.

However, if the violation of an internal claims and appeal process is de minimus, you will not be treated as though you exhausted the internal appeals process. The violation will be considered de minimus if it is not likely to cause prejudice or harm to your claim, it was for a good cause or due to matters beyond the plan's control and was in the context of an ongoing, good faith exchange of information between you and the plan.

## Legal Action

If you do not wish to submit your claim to external review or to mediation under the EDRP, you must pursue all of the internal claim and appeal rights described above in a timely manner before you may appeal in federal court. You may not bring any action at law or in equity to recover benefits unless and until the appeal rights described above have been exercised and the benefits requested in such an appeal have been denied in whole or in part (or there is any other adverse benefit determination).

If you wish to seek judicial review of any adverse benefit determination with respect to a claim, you must file a civil action under Section 502(a) of ERISA within one year after the date on which all administrative remedies are exhausted, that is, by the later of the date on which an adverse determination on review is issued or the last day on which a final decision should have been issued, or you will forever be prohibited from commencing such action. Any action must be brought in the New York State Supreme Court (Borough of Manhattan) or the United States District Court for the Southern District of New York and no other.

# Third-Party Liability and Subrogation

## Subrogation and Reimbursement Rules

The plan has a right to subrogation and reimbursement.

Subrogation applies when the plan has paid benefits on your behalf for a sickness or injury for which a third party is considered responsible. The right to subrogation means that the plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the benefits that the plan has paid that are related to the sickness or injury for which a third party is considered responsible.

The right to reimbursement means that if it is alleged that a third party caused or is responsible for a sickness or injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the plan 100% of any benefits you receive for that sickness or injury.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a sickness, injury, or damages, or who is legally responsible for the sickness, injury, or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the sickness, injury, or damages.
- The plan sponsor in a Workers' Compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners, or otherwise), Workers' Compensation coverage, other insurance carriers, or third-party administrators.
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the plan and its agents in protecting the legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
  - Notifying the plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused benefits to be paid or become payable.
  - Providing any relevant information requested by the plan or its agents.
  - Signing and/or delivering such documents as the plan or its agents reasonably request to secure the subrogation and reimbursement claim.
  - Responding to requests for information from the plan or its agents about any accident or injuries.
  - Making court appearances as requested by the plan or its agents.
  - Obtaining the plan's consent or the plan's agents' consent before entering into any settlement or releasing any party from liability or payment of medical expenses.
  - Complying with the terms of this section.

Your failure to cooperate with the plan is considered a breach of contract. As such, the plan has the right to terminate your benefits, deny future benefits, take legal action against you, and/or set off from any future benefits the value of benefits the plan has paid relating to any sickness or injury alleged to have been caused or caused by any third party to the extent not recovered by the plan due to you or your representative not cooperating with the plan. If the plan incurs attorneys' fees and costs in order to collect third-party settlement funds held by you or your representative, the plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the plan.

- The plan has a first priority right to receive payment on any claim against a third party before you receive payment from that third party. Further, the plan's first priority right to payment is superior to any and all claims, debts, or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- The plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages. The plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from the plan's recovery without the plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- Regardless of whether you have been fully compensated or made whole, the plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, "Made-Whole Doctrine" or "Make-Whole Doctrine" or similar doctrine, claim of unjust enrichment, nor any other equitable limitation shall limit the plan's subrogation and reimbursement rights.
- Benefits paid by the plan may also be considered to be benefits advanced.
- If you receive any payment from any party as a result of sickness or injury, and the plan alleges some or all of those funds are due and owed to the plan, you shall hold those funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the benefits the plan has paid.
- The plan's rights to recovery will not be reduced due to your own negligence.
- Upon request, you will assign to the plan all rights of recovery against third parties, to the extent of the benefits the plan has paid for the sickness or injury.
- The plan may take necessary and appropriate action to preserve the rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative, or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical benefits paid on your behalf out of any settlement, judgment, or other recovery from any third party considered responsible; and filing suit in your name, which does not obligate the plan in any way to pay you part of any recovery the plan might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund benefits as required under the terms of the plan is governed by a six-year statute of limitations.
- You may not accept any settlement that does not fully reimburse the plan, without its written approval.
- The plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

- In the case of your wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries.
- No allocation of damages, settlement funds, or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries, or any other person or party, shall be valid if it does not reimburse the plan for 100% of its interest unless the plan provides written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a dependent child who incurs a sickness or injury caused by a third party. If a parent or guardian brings a claim for damages arising out of a minor's sickness or injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If a third party causes or is alleged to have caused you to suffer a sickness or injury while you are covered under this plan, the provisions of this section continue to apply, even after you are no longer covered.

The plan and all administrators administering the terms and conditions of the plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the plan's subrogation and reimbursement rights; and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the plan.

## Right of Recovery

If, for any reason, the plan pays a benefit that is larger than the amount allowed, the plan has a right to recover the excess amount from the person or agency that received it. The person receiving the benefit must produce any instruments or papers necessary to dispute this right of recovery.

If the plan has already paid benefits, you must reimburse the plan. If you or any other covered person who was paid does not promptly refund the full amount, the plan may reduce the amount of any future benefits that are payable. The reductions will equal the amount of the required refund. The plan may have other rights in addition to the right to reduce future benefits.

## 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.

# Continuing Your Coverage Under COBRA

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## COBRA Information

COBRA, a federal law, created the right to continue your medical benefits under COBRA continuation coverage. This section:

- Contains important information about your right to COBRA continuation 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 Retiree Medical Plan and under federal law, contact the Credit Suisse Benefits Service Center **1-888-325-2732**.

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 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 below.)

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 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 below, that results in a loss of coverage under the Retiree Medical Plan.

### COBRA Qualified Beneficiaries

- **Spouse or domestic partner of retiree.** Your spouse or domestic partner becomes a COBRA qualified beneficiary if he or she loses coverage under the Retiree Medical Plan because you become divorced, legally separated, or dissolve a domestic partnership.
- **Dependent children.** Dependent children become COBRA qualified beneficiaries if they lose coverage under the Retiree Medical Plan because of any of the following qualifying events:
  - The parents become divorced, legally separated, or dissolve a domestic partnership; or
  - The child loses eligibility for coverage as a "dependent child" under the plan (for example, he or she attains the maximum age).

## Retirees in the Event of the Bank's Bankruptcy

Sometimes, the Bank's filing for bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy were to be filed with respect to the Bank and that bankruptcy resulted in the loss of coverage of any retired employee covered under the plan, the retired employee would become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse and dependent children also would become qualified beneficiaries if the bankruptcy resulted in the loss of their coverage under the Bank's group health plan.

## When COBRA Coverage Is Available

The Retiree Medical 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 (for example, the plan administrator or Human Resources) will notify the COBRA administrator within 30 calendar days of the date coverage would otherwise be lost in the event that the Bank files for bankruptcy.

#### ***Notification by You, Your Qualified Beneficiary, or Your 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:

- The divorce, legal separation, or dissolution of the domestic partnership of the retiree and spouse or domestic partner; or
- A child's loss of eligibility for coverage as a dependent child under the plan (for example, he or she reaches the maximum age).

### **What the Notification Must Include**

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** of the qualifying event. Written communications should be mailed to:

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

The notification should include the following information:

- Name of the Retiree Medical 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 retirees 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.

## 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 a participant in the Retiree Medical Plan 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 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 Internal Revenue Service (IRS) and the Bank.
- You may enroll any newly eligible spouse or dependent child under the Retiree Medical Plan rules.

## What COBRA Coverage Costs

COBRA participants must pay monthly after-tax premiums 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 retiree.

To enroll in COBRA coverage, call the Credit Suisse Benefits Service Center at **1-888-325-2732**. Once you are enrolled, the Credit Suisse Benefits Service Center will bill you for your initial payment. Your initial payment will include coverage for the current month and any previous months, retroactively to the date coverage terminated under the Retiree Medical Plan.

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 Retiree Medical 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).

## How Long COBRA Coverage Lasts

COBRA continuation coverage is a temporary continuation of coverage. It lasts for up to a total of 36 months.

The chart below provides a summary of how long coverage can be continued under COBRA based on the type of qualifying event.

Qualifying Event	Maximum Continuation Period* For:		
	You	Spouse	Covered Child
Bankruptcy	Death of covered retiree	Earlier of (i) date of death of spouse or (ii) date that is 36 months after death of covered retiree	Earlier of (i) date of death of spouse or (ii) date that is 36 months after death of covered retiree
Your covered child no longer qualifies as a dependent	N/A	N/A	36 months
You and your spouse or domestic partner divorce, legally separate, or dissolve your domestic partnership or you die	N/A	36 months	36 months

\*The maximum continuation period is measured from the date coverage would otherwise be lost as a result of the qualifying event.

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 may end 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.
- You or your covered dependent does not make timely premium payments or contributions as required.
- The Bank ceases to provide health care coverage to retirees.

Continuation coverage also may be terminated for any reason the Retiree Medical Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (for example, in the case of fraud).

## Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the plan administrator and the Credit Suisse Benefits Service Center informed of any changes in your address and the addresses of family members. Also, for your records, you should keep a copy of any notices you send to the plan administrator or to the Credit Suisse Benefits Service Center.

## If You Have Questions

Contact the Credit Suisse Benefits Service Center at **1-888-325-2732** if you have questions about COBRA.

## 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. You can access the Marketplace for your state and learn more about coverage and available tax credits at [www.HealthCare.gov](http://www.HealthCare.gov).

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, anyone 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.

# Your Rights Under HIPAA

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## About Your Privacy

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on employer health plans concerning the use and disclosure of individual health information. This information, known as Protected Health Information, includes virtually all individually identifiable health information held by any health plan, including health care flexible spending accounts—whether received in writing, through an electronic medium, or as an oral communication.

Credit Suisse has implemented policies and practices to appropriately protect the privacy of your Protected Health Information. Protected Health Information that you provide will be handled in accordance with the Credit Suisse HIPAA Privacy Policy. To obtain a copy of this notice, contact the Credit Suisse Benefits Service Center at **1-888-325-2732**.

# Plan Administration

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## Retiree Medical Plan Administration Chart

Here is some information about the Retiree Medical Plan and the people who have responsibility for its operation.

This “Retiree Medical Plan Administration Chart” applies regardless of any conflicting information in any of the Certificates.

<b>The following is applicable to the Retiree Medical Plan.</b>	
<b>Plan Name</b>	The official name of the plan is the Credit Suisse Securities (USA) LLC Group Health Care Plan. The Credit Suisse Retiree Group Medical Plan is a component of the 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.
<b>Plan Sponsor</b>	Credit Suisse Securities (USA) LLC Eleven Madison Avenue New York, NY 10010
<b>Plan Type</b>	Under ERISA, the UnitedHealthcare Retiree Choice Plus CDHP Plan Option and Choice Plus POS Option are considered welfare—self-insured group health plans.  The United Healthcare Medicare Solutions options are considered welfare—fully insured group health plans.
<b>Plan Number</b>	The number assigned to the Credit Suisse Securities (USA) LLC Group Health Care Plan is 517.
<b>Plan Year</b>	The plan year runs from January 1 through December 31.
<b>Plan Administrator</b>	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:  Credit Suisse Benefits Service Center P.O. Box 661074 Dallas, TX 75266-1074 <b>1-888-325-2732</b>  The Benefits Committee also has delegated claims and insurer responsibilities to the administrators listed below.
<b>Claims Administrators/Insurers</b>	Credit Suisse administers the Credit Suisse Retiree Medical Plan, but the Bank has delegated certain claims administration and insurer responsibilities:  Claims Administrators:

	<p>UnitedHealthcare Retiree Choice Plus CDHP Plan Option or Choice Plus POS Option  UnitedhealthCare Service LLC  2950 Expressway Drive South, Suite 240  Islandia, NY 11749-1412  <b>1-888-567-4654</b>  <a href="http://www.myuhc.com">www.myuhc.com</a></p> <p>Express Scripts  P.O. Box 66583  St. Louis, MO 63166  <b>1-866-210-4473</b>  <a href="http://www.express-scripts.com">www.express-scripts.com</a></p> <p><u><a href="#">Insurer</a></u>  UnitedhealthCare Medicare Solutions  2950 Expressway Drive South, Suite 240  Islandia, NY 11749-1412  <b>1-888-567-4654</b>  <a href="http://www.myuhc.com">www.myuhc.com</a></p>
<b>Employer Identification Number</b>	The Internal Revenue Service (IRS) has assigned Credit Suisse Employer Identification Number 05-0546650.
<b>Type of Funding</b>	<p>Retirees and Credit Suisse share the cost of the Credit Suisse Retiree Medical Plan.</p> <p>The fully insured retiree medical components are funded through an insurance policy. The self-insured retiree medical components are funded through the Bank's general assets.</p>
<b>Agent for Service of Legal Process</b>	<p>Legal process against the Credit Suisse Retiree Medical 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  Eleven Madison Avenue  New York, NY 10010  <b>1-212-325-2000</b></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.

## Plan Continuance

It is hoped that the Retiree Medical Plan will continue 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.

# The Retiree Life Plan

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## Who Is Eligible

This section applies regardless of any conflicting information in the Certificate.

You are eligible for the Retiree Life Plan only if you are a member of the Grandfathered July 1, 1988 First Boston Group (see "Standard Plan: Grandfathered July 1, 1988 First Boston Group").

## Who Is Not Eligible

You are not eligible for the Retiree Life Plan if you are not a member of the Grandfathered July 1, 1988 First Boston Group (see "Standard Plan: Grandfathered July 1, 1988 First Boston Group").

However, whether or not you are eligible for the Retiree Life Plan, you may be able to convert your active employee, supplemental, and/or spouse or domestic partner life coverage to individual policies (see "Converting Active Coverage to Individual Policies").

## Eligible Dependents for the Retiree Life Plan

Your dependents' life insurance coverage ceases at your retirement. You may convert spouse or domestic partner coverage to individual policies. See "Converting Active Coverage to Individual Policies" for more information.

# How Much Coverage the Plan Provides

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## Life Insurance Coverage

The amount of life insurance the plan provides at retirement is \$50,000. However, your coverage will be reduced by 20% on the anniversary date of your Retiree Life effective date, which is the first of the month following your retirement. Your coverage will be reduced by the same amount for each of the next three consecutive years.

**For example:** Assume you retire effective January 25, 2011. Your Retiree Life effective date would be February 1, 2011 (the first of the month following your retirement). Your life insurance coverage is reduced as follows:

- On February 1, 2012: \$40,000 [ $\$50,000 - (\$50,000 \times 20\%) = \$40,000$ ]
- On February 1, 2013: \$30,000 ( $\$40,000 - \$10,000$ )
- On February 1, 2014: \$20,000 ( $\$30,000 - \$10,000$ )
- On February 1, 2015: \$10,000 ( $\$20,000 - \$10,000$ )

Your life insurance coverage will not be reduced to less than the minimum amount, currently \$10,000.

### **Special Rules for Grandfathered Group of Employees Hired Prior to November 1, 1981**

If you were hired before November 1, 1981, and chose to remain under the provisions of the 1981 Grandfathered Coverage (for more details of this coverage, see the Life and Accident Summary Plan Description, which is located on the Your Benefits Resources web site), the life insurance plan after retirement is slightly different for you.

Your life insurance coverage under the 1981 Grandfathered Coverage is one and one-half times your salary on November 1, 1981, to a maximum of \$300,000. When you retire, this life insurance continues but a reduction schedule will apply. At the anniversary date of your Retiree Life effective date, the amount of insurance coverage will be reduced by 20% and then by the same dollar amount for each of the next three consecutive years. The minimum amount of life insurance you can have after retirement is \$4,000. There is no charge to you after retirement for this coverage.

# How the Retiree Life Plan Works

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## Enrolling in the Plan

If you are eligible for the Retiree Life Plan, you are automatically enrolled, but only for yourself. You may no longer cover your spouse, domestic partner, or dependent children.

### Review Your Beneficiary Information

As you prepare for retirement, take the time to visit the Your Benefits Resources web site to review and update your beneficiary information. Have circumstances changed such that you wish to name a new beneficiary? Is your beneficiary's current address on file? If you have not already input this information, you may want to do so now.

And, make sure your beneficiary is aware of your coverage and beneficiary designation so that he or she can file a claim as needed.

For Bank-provided coverage, you can review and change your beneficiary information online through the Your Benefits Resources web site. If you have not input your beneficiary information, you may call the Credit Suisse Benefits Service Center.

If you converted to an individual policy, contact the insurance carrier for beneficiary information.

## Cost of Coverage

If you are eligible, coverage under the Retiree Life Plan is available at no cost to you. Credit Suisse will pay the total cost of basic coverage for as long as you live.

## Converting Active Coverage to Individual Policies

Whether or not you are eligible for the Retiree Life Plan, you may be eligible to convert your active employee life insurance, your supplemental life insurance (the amount you contribute toward as an active employee), and your spouse or domestic partner life insurance to individual policies. For details, call MetLife at **1-800-638-6420** within 31 days of your retirement. You pay 100% of the cost for converted coverage.

In addition, you may be eligible to convert your personal accident insurance coverage up to the amount you have as an active employee immediately preceding your retirement. For details, call MetLife at **1-800-638-6420** within 30 days of your retirement.

Business travel accident coverage ceases on the day you retire. You cannot continue this coverage after you retire.

## When Retiree Life Insurance Coverage Ends

Your coverage under the Retiree Life Plan ends when you die.

# How to File a Life Insurance Claim

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## Filing a Claim

The Credit Suisse Benefits Service Center is responsible for maintaining records and assisting with all activities for the Retiree Life Plan. This responsibility includes assisting relatives or designated beneficiaries with filing a claim. To initiate a claim under your retiree life insurance, your beneficiary(ies) should contact the Credit Suisse Benefits Service Center at **1-888-325-2732**.

### If a Claim Is Denied

MetLife makes every effort to resolve disagreements quickly and informally. However, there are formal procedures in place should your beneficiary(ies) need to appeal a plan decision. MetLife has final determination of all appeals.

When your beneficiary(ies) files a claim, the claims administrator reviews the claim for benefits and makes a decision to either approve or deny the claim.

If the claim is denied, in whole or in part, your beneficiary(ies) will receive written or electronic notification from the claims administrator within 90 days after receipt of the claim by the plan. The notice will contain all of the following:

- The specific reasons for the denial.
- The specific plan provisions on which the denial is based.
- A description of any additional material or information needed and an explanation of why it is necessary.
- An explanation of the plan's claim review procedures, applicable time limits, and your beneficiary(ies)'s rights to bring a civil action under ERISA section 502(a) following a denial.

In some situations, the plan may need an additional 90 days to make a decision (for example, if the plan needs additional information). In these cases, your beneficiary(ies) will be notified before the end of the first 90-day period why the extension is necessary and when the plan expects to render a decision.

### Request for Review if a Claim Is Denied

Your beneficiary(ies), or his or her authorized representative, may ask for a full and fair review of the claim/benefit decision by writing to the claims administrator. All appeals of denied claims/benefits should be addressed to:

MetLife Group Life Claims  
P.O. Box 6100  
Scranton, PA 18505

Your beneficiary(ies) must make this request within 60 days of the date he or she receives notice of the denied claim. During the 60-day period, your beneficiary(ies) or his or her authorized representative will be given reasonable access to all documents and information relevant to the claim, and you may request copies free of charge. He or she can also submit written comments, documents, records, and other information relating to the claim to the claims administrator. Review of the claim will take into account all comments, documents, records, and other information, without regard to whether such information was submitted or considered in the initial benefit determination.

### **Additional Rights on Appeal**

If the claim/benefit is denied:

- Your beneficiary(ies) will have the opportunity to submit written comments, documents, records, and other information relating to the claim.
- Your beneficiary(ies) will be given reasonable access to and copies (free of charge) of all documents, records, and other information related to the claim.
- The review of the claim will take into account all the information submitted that relates to the claim, without regard to whether it was submitted for the initial claim.
- The claim will be reviewed *de novo*. That means "start fresh," and an independent plan fiduciary will review the claim. In reviewing the claim, he or she will not place deference upon the original decision. The claim will be reviewed by an appropriate named fiduciary who is not the individual who made the initial decision, and who is not subordinate to the initial reviewer, and who will give a full and fair review of the claim and the denial.
- If your beneficiary(ies) appeal is denied, he or she may file a suit under ERISA. (For more information, see "Your Rights Under ERISA.")

Your beneficiary(ies) and the claims administrator may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact the local office of the U.S. Department of Labor.

### **Decision on Review**

The claims administrator will then review the claim again and make a decision based on all comments, documents, records, and other information submitted. In most cases, your beneficiary(ies) will receive the claim administrator's decision within 60 days after receipt of the request for review by the plan. However, the period may be extended for an additional 60 days if a determination is made that such an extension is necessary due to matters beyond the control of the plan and if notification is given prior to the expiration of the initial 60-day period, of the circumstances requiring the extension of time and the date by which it expects to render a decision.

## **Discretionary Authority of Insurance Carrier and Plan Administrator**

The insurance carrier (MetLife) will make all final claim determinations as well as determine initial claims. The Benefits Committee or its designee will have sole and complete discretionary authority to determine conclusively for all parties all questions arising from or relating to the eligibility to participate in the benefits provided under the plan. The insurance carrier will have sole and complete discretionary authority to determine conclusively for all parties claiming to have an interest in the plan, and in accordance with the terms of the documents and instruments governing the plan, any and all questions arising from or relating to the eligibility of participants for benefits, the relevant facts, the amount and type of benefits payable to any participant or other claimant, and the construction of all terms of the plan. Decisions by the insurance carrier will be final, conclusive, and binding on all parties claiming to have an interest in the plan. Benefits will be paid under the plan only if the insurance carrier decides in its discretion that the participant or other claimant is entitled to them.

## **Subrogation**

If you suffer an injury or illness resulting from an allegedly negligent or wrongful act or omission by a third party, the plan has the right to pursue payment from the third party. This process is called subrogation.

## **Assignment of Rights**

Generally, you cannot assign your rights under the plan.

# Plan Administration

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## Retiree Life Plan Administration Chart

Here is some information about the Retiree Life Plan and the people who have responsibility for its operation.

The following is applicable to the Retiree Life Plan.

<b>Plan Name</b>	Credit Suisse Securities (USA) LLC Group Health Care Plan for which the Retiree Life Plan is a component. You will need to use the group health care plan name if you ever need to correspond with a government agency about the plan.
<b>Plan Sponsor</b>	Credit Suisse Securities (USA) LLC Eleven Madison Avenue New York, NY 10010
<b>Plan Type</b>	Under ERISA, life insurance benefits is a welfare—group insurance plan.
<b>Plan Number</b>	The number assigned to the Credit Suisse Securities (USA) LLC Group Health Care Plan is 517.
<b>Plan Year</b>	The plan year runs from January 1 through December 31.
<b>Plan Administrator</b>	<p>The plan administrator is the Benefits Committee of Credit Suisse. The Benefits Committee has delegated certain plan administration responsibilities with respect to eligibility for the Credit Suisse Securities (USA) LLC Life Insurance Plan 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 <b>1-888-325-2732</b></p> <p>In addition, the Benefits Committee has delegated all responsibilities for claims administration and determination of benefits to the insurer and payer of benefits.</p>
<b>Insurer/Payer of Benefits</b>	<p>The insurer and payer of benefits is:</p> <p>MetLife P.O. Box 6100 Scranton, PA 18505 <a href="http://www.metlife.com">www.metlife.com</a></p>
<b>Agent for Service of Legal Process</b>	<p>In the event of an unresolved dispute over benefit plan provisions, legal process can be served on the insurer and plan administrator. In addition, legal process may be served on Credit Suisse at the following address:</p> <p>Corporate Secretary Credit Suisse Eleven Madison Avenue</p>

	New York, NY 10010 <b>1-212-325-2000</b>
<b>Employer Identification Number</b>	The Internal Revenue Service (IRS) has assigned Credit Suisse Employer Identification Number 05-0546650.

**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.

## Plan Continuance

It is hoped that the Credit Suisse Securities (USA) LLC Life Insurance Plan will continue 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 plans 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.

# Your Rights Under ERISA

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## Overview

As a participant of the Credit Suisse Retiree Group Medical and Group Life Plans, you are entitled to certain rights and protections under ERISA. ERISA provides that all plan participants be entitled to the following:

### Receive Information

- 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 certificates, 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 plans, including insurance contracts, copies of the latest Form 5500 annual report, and an updated Summary Plan Description (SPD) by writing to the plan administrator. The plan administrator may make a reasonable charge for the copies.
- Receive a summary of the plans' 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 this SPD and the documents governing the plan for the rules that govern your 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 plans. The people who operate the plans, 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 Retiree Medical and Retiree Life Plans 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 a 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 for Retiree Medical claims or file suit in a federal court (all claims).
- If it should happen that plan fiduciaries misuse a 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 a 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 plans, 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, DC 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](http://www.dol.gov/ebsa); or
- Contacting the EBSA field office nearest you.

# Resources

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## Resources Offered by the Bank

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 access the web site in two ways:

- From the Credit Suisse HR Intranet: Link to the web site from the Credit Suisse HR Intranet. Go to the HR homepage, click **Benefits**, then click Your Benefits Resources. Re-enter your NT login ID and password.
- From outside the Credit Suisse HR Intranet: Enter the 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:

- Review your current, personalized benefit information, and make changes as allowed by the Retiree Medical Plan; and
- Take advantage of the valuable tools and resources available to help you make the most of your benefits.

The Credit Suisse Benefits Service Center is available when you need personal attention to answer a benefits question or issue. To reach the Credit Suisse Benefits Service Center, call **1-888-325-2732**. Representatives are available to assist you Monday through Friday, from 9:00 a.m. to 5:00 p.m., Eastern time. They will be glad to assist you in any way they can.

### Call the toll-free telephone number to:

- Speak with a Credit Suisse Benefits Service Center Representative;
- Connect to your health plan carrier; and
- Work with Advocacy Services to resolve an issue with your health plan.

## Resources Offered by the Claims Administrators

Each claims administrator offers a web site and toll-free telephone number. Contact the claims administrator for specific questions about coverage, to notify your claims administrator in advance of non-emergency procedures, and to ask questions on claims. Use the following contact information:

### Contact Information

#### Retiree Medical:

UnitedHealthcare Retiree Choice Plus CDHP Plan Option, Choice Plus POS Option, or Medicare Solutions Option

UnitedHealthcare Service LLC  
2950 Expressway Drive South, Suite 240  
Islandia, NY 11749-1412

**1-888-567-4654**

[www.myuhc.com](http://www.myuhc.com)

#### Prescription Drug Plan:

Express Scripts  
P.O. Box 66583  
St. Louis, MO 63166

**1-866-210-4473**

[www.express-scripts.com](http://www.express-scripts.com)

#### Retiree Life Insurance:

MetLife  
P.O. Box 6100  
Scranton, PA 18505

**1-800-638-6420**

[www.metlife.com](http://www.metlife.com)

## Information on Other Plans

For information on other Credit Suisse plans, please see the Summary Plan Descriptions (SPDs). SPDs for all Credit Suisse plans are posted on the Your Benefits Resources web site. Access the site through the HR Intranet's Benefits Page or directly at <http://digital.alight.com/credit-suisse>.

## Information on Your Rights

For more information about your rights under ERISA, including COBRA, HIPAA, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's EBSA in your area or visit the EBSA web site at [www.dol.gov/ebsa](http://www.dol.gov/ebsa). (Addresses and telephone numbers of Regional and District EBSA Offices are available through the EBSA web site.)

# Glossary

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## Terms to Know

### **Annual Deductible**

The amount you must pay out of pocket before the Retiree Medical Plan begins paying certain benefits.

### **Average Final Pay**

Annual salary immediately preceding retirement, plus an average of discretionary variable incentive awards and commissions for the three calendar years before retirement.

### **Beneficiary(ies)**

The person or people you designate to receive your life insurance benefit when you die.

### **Coordination of Benefits (COB)**

The Retiree Medical Plan will coordinate benefits with other group health plans to allow you to receive benefits equal to 100% of the cost of services and supplies.

### **Copayment**

A flat dollar amount you pay at the time you receive health care.

### **Formulary Brand**

A brand-name prescription drug on the formulary list. The formulary is a comprehensive list of all preferred brand-name drugs.

### **Generic**

A drug no longer patented and is usually produced and sold by many companies, driving the cost down.

### **In-Network**

Care you receive from a provider that participates in the carrier network.

### **Medicare Allowable Charge**

The amount Medicare sets that providers can charge for specific services and supplies.

### **Medicare Limiting Charge**

A provider can charge only 15% above the amount set by Medicare (the Medicare Allowable Charge).

## **Medicare Part A**

Provides automatic coverage at age 65 for hospital stays and services.

## **Medicare Part B**

Provides coverage for physician fees, X rays, lab tests, and much more. Individuals become eligible for Part B at age 65 but must choose to enroll. Coverage is not automatic.

## **Medicare Part D**

Provides coverage for prescription drugs for individuals who do not have access to affordable drug coverage. Individuals become eligible at age 65 but must choose to enroll. Coverage is not automatic. In addition, individuals should be aware that if they have employer-sponsored prescription drug coverage, they may lose it if they enroll in Part D.

## **Network**

A network is a group of doctors, hospitals, and other health care providers or facilities that contract with a carrier to offer medical services at negotiated rates. Because negotiated rates are lower than the rates charged by other providers, you typically receive higher plan benefits when you use an in-network provider. That means you pay less out of your pocket for covered expenses.

## **Network Gap**

A “network gap” occurs within an in-network area when an in-network provider (a physician/specialist or facility) is not available within 20 miles of your residence (the “Gap Area”) to perform or provide a specific service or procedure that is being requested. Therefore, a network gap exception may be warranted. Where a specific type of in-network provider is not available within the Gap Area, then obtaining a network gap exception from UnitedHealthcare will allow a claim to be paid as in-network while using an out-of-network provider in the Gap Area.

In order to obtain a network gap exception for an out-of-network provider in the Gap Area, you or the out-of-network provider should contact UnitedHealthcare at the number on the back of your card to request the approval of a network gap exception prior to the first date that services are to be rendered by the out-of-network provider. Once UnitedHealthcare approves the request for a network gap exception, the out-of-network provider can perform or provide the requested services, and your subsequent claim with respect to those services will be processed at the in-network benefit level, but you will be responsible for any charges above eligible expenses. If a network gap exception is not approved by UnitedHealthcare prior to the first date that services are to be rendered by the out-of-network provider, your subsequent claim with respect to those services will be processed at the out-of-network benefit level for an out-of-network provider.

## **Non-Formulary Brand**

A brand-name prescription drug not on the formulary list.

## **Out-of-Network**

Care you receive from a provider that does not participate in the carrier network.

## **Out-of-Pocket Maximum**

The maximum amount you will pay in one year toward health care expenses. Once you meet the out-of-pocket maximum, the Retiree Medical Plan pays 100% of all remaining eligible charges for the year.

## **Qualified Status Change**

As defined by the Internal Revenue Service (IRS), a qualified status change is a change within your family that necessitates a benefit change outside of the Annual Enrollment period. Not all of the IRS qualified status changes are permitted under the Retiree Medical and Life Plan.

## **Reasonable and Customary (R&C) Limits**

R&C rates are established by your carrier, and may vary by geography and type of service. You are responsible for charges above R&C. With respect to the UnitedHealthcare (UHC) self-insured medical options, the "reasonable and customary limit" is calculated as described below:

- For out-of-network providers who have agreed to discount their charges for covered health services, the reasonable and customary limit is the cost set by a Shared Savings Program that precludes Members from being balanced billed;
- For out-of-network physician/professionals who are not part of the Shared Savings Program, UHC sets the reasonable and customary limit by using the Fair Health database (90th percentile), which is owned and published by FAIR Health Inc. and maintains a website at [www.fairhealthconsumer.org](http://www.fairhealthconsumer.org); and
- For out-of-network facilities, UHC sets the reasonable and customary limit according to proprietary UHC facility databases as to reasonable and customary limits.