The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, http://digital.alight.com/credit-suisse. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at http://digital.alight.com/credit-suisse or call 1-888-325-2732 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network providers $2,500 individual / $5,000 family; for out-of-network providers $5,000 individual / $10,000 family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care and primary care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For network providers $5,000 individual/ $6,850 individual in Family/$10,000 family; for out-of-network providers $10,000 individual/$20,000 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out–of–pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, services deemed not medically necessary, balance-billing charges, and health care this plan doesn't cover	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See http://digital.alight.com/credit-suisse or call **1-888-325-2732** for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
	Specialist visit	20% coinsurance	50% coinsurance	
	Preventive care/screening/ Immunization	No charge; deductible does not apply	50% coinsurance	
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://digital.alight.com/credit-suisse	Generic drugs (Tier 1)	20% coinsurance	Not covered	Covers up to a 30-day supply at retail and update to a 90-day supply by mail; if a brand drug is received when a generic is available, the member will pay the difference; for certain drugs, if pre-authorization is not obtained, drug will not be covered. Up to a 90-day supply maintenance prescription drugs through mail order or at Walgreens or CVS pharmacy No Retail pharmacy fills allowed for most specialty drugs. All fills must go through Accredo Specialty pharmacy.
	Preferred brand drugs (Tier 2)	20% coinsurance	Not covered	
	Non-preferred brand drugs (Tier 3)	20% coinsurance	Not covered	
	Specialty drugs (Tier 4)	20% coinsurance	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	Failure to obtain pre-authorization will result in non-coverage if service is not medically necessary
	Physician/surgeon fees	20% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	Limited to true emergencies
	Emergency medical transportation	20% coinsurance	20% coinsurance	Limited to true emergencies
	Urgent care	20% coinsurance	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Failure to obtain pre-authorization will result in non-coverage if service is not medically necessary
	Physician/surgeon fees	20% coinsurance	50% coinsurance	Failure to obtain pre-authorization will result in non-coverage if service is not medically necessary

*For more information about limitations and exceptions, see the plan or policy document at http://digital.alight.com/credit-suisse

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	50% coinsurance	None
	Inpatient services	20% coinsurance	50% coinsurance	Failure to obtain pre-authorization will result in non-coverage if service is not medically necessary
If you are pregnant	Office visits	20% coinsurance	50% coinsurance	Pre-authorization is required if inpatient stays exceeds 48 hrs for normal delivery and 96 hrs after a cesarean delivery; failure to obtain pre-authorization will result in non-coverage if service is not medically necessary
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Must meet medical necessity; failure to obtain pre-authorization will result in non-coverage if service is not medically necessary
	Rehabilitation services	20% coinsurance	50% coinsurance	60 visits per calendar year combined in and out of network. After 60 visits would need to be submitted for medical necessity review. Includes physical therapy, speech therapy, and occupational therapy.
	Habilitation services	Not covered	Not covered	Coverage may be provided for specific services if clinical criteria are met
	Skilled nursing care	20% coinsurance	50% coinsurance	120 days per calendar year combined in and out of network
	Durable medical equipment	20% coinsurance	50% coinsurance	Failure to obtain pre-authorization will result in non-coverage if service is not medically necessary
	Hospice services	20% coinsurance	50% coinsurance	12 months per lifetime combined in and out of network
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

*For more information about limitations and exceptions, see the plan or policy document at http://digital.alight.com/credit-suisse

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (Adult), except for treatment of accidental injury
- Long-term care
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture, for certain conditions
- Bariatric surgery
- Chiropractic care limited to 24 visits per year; in- and out-of-network combined
- Hearing aids up to $2,000 per 24 months for children, and $2,000 per 36 months for adults, in- and out-of-network combined
- Infertility treatment up to $25,000 per calendar year for medical infertility treatment and $10,000 per lifetime for prescription drug infertility treatment, in- and out-of-network combined; member must enroll with Optum Fertility Solutions before receiving infertility treatment; Requires use of COE
- Most coverage provided outside the United States. See http://digital.alight.com/credit-suisse
- Non-emergency care when traveling outside the United States
- Private-duty nursing up to 200 visits per calendar year combined in- and out-of-network

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? **Yes**.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? **Yes**.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

*For more information about limitations and exceptions, see the plan or policy document at http://digital.alight.com/credit-suisse

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 1-888-325-2732.
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-325-2732.
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-888-325-2732.
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-325-2732.

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

*For more information about limitations and exceptions, see the plan or policy document at http://digital.alight.com/credit-suisse

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$2,500
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,500
Copayments	$0
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,560**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$2,500
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,500
Copayments	$0
Coinsurance	$600
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,120**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$2,500
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,500
Copayments	$0
Coinsurance	$60
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,560**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.