Thrive with Key

2027 Benefits Summary Chart

Medical Network

Plan Provisions	Surest (copay plan)	Plus HDHP (Key Medical 2)	Basic HDHP (Key Medical 3)
	Copay Plan/no deductible	High Deductible Health Plan	High Deductible Health Plan
Administrator: UnitedHealthcare	Network Benefits		
Deductible (combined medical/Rx deductible)	Employee-only: $0 Family: $0	Employee-only: $2,500 Family: $5,000	Employee-only: $4,000 Family: $8,000
Copay/Coinsurance	You pay copays for covered services. Costs vary based on the provider and service selected (see examples below).	You pay 20%[1] after deductible	You pay 30%[1] after deductible
Out-of-Pocket Maximum (includes deductible, coinsurance or copays, as applicable by plan)	Employee-only: $5,000 Family: $10,000	Employee-only: $5,000 Family: $10,000	Employee-only: $7,000 Family: $14,000 (Individuals in family coverage have an out-of-pocket maximum of $12,000)
Preventive Care: Includes Routine Well Exams, Screenings, Immunizations	$0	Plan pays 100%[2] (not subject to the deductible) Visit **uhc.com/health-and-wellness/preventive-care** for preventive care guidelines.	
Office Visit Exam Fee	$40 - $155	You pay 20%[1] after deductible	You pay 30%[1] after deductible
Urgent Care Centers	$100		
Emergency Room	$1,000		
Virtual Visits	$0-155		
Basic Labs, X-Rays and Ultrasounds	$0		
Inpatient stay	$3,500		
Outpatient hospital services	$400 - $1,400		
Maternity	$1,900 - $3,500		
Chiropractic (up to 25 visits annually)	$35		
Mental Health (Including Substance Use) Office Visit	$40		

Compare your 2027 plan options, search for network providers and more.
Surest (copay plan): **surest.care/keybank**
Plus HDHP (Key Medical 2) and Basic HDHP (Key Medical 3): **exploreuhcplans.com/keycorp**

HDHP = High Deductible Health Plan

[1]Subject to annual deductible and out-of-pocket maximum. Select preventive medications bypass the deductible. This means that you have the benefit of paying the applicable coinsurance without having to meet the deductible first. Although the coinsurance will not apply to the deductible, it does apply toward the out-of-pocket maximum. See the Prescription Drug Chart for more details.

[2]Is not subject to nor counts toward the deductible or out-of-pocket maximum.

Note, you may be eligible to earn a Wellness Incentive to be paid as a Health Savings Account contribution or a per pay premium credit based on your Plan enrollment and whether you earned by the deadline. Review all eligibility details and requirements to earn on the Medical Plan Wellness Incentive page on at **Thrive with Key.**

The information contained in this Benefit Summary Chart provides a very general overview of the KeyCorp Medical Plan coverages that will be in effect for the 2027 Plan year. For more specific Plan coverage information, please review the Medical Plan's Summary Plan Description (SPD), which can be found at **https://benefits.keybank.com.** Please be aware that the Medical Plan may not cover certain services and procedures that you wish to have performed. While these services will not be paid for by the Plan, you must always determine the medical care that is best for you.

If you use network providers, your Plan coinsurance costs are based on UnitedHealthcare's negotiated network fees. Plan coinsurance costs for out-of-network providers are determined as follows: (i) an amount negotiated by the Claims Administrator, (ii) a specific amount required by law (when required by law), or (iii) an amount the Claims Administrator has determined is typically accepted by a healthcare provider for the same or similar service or an amount that is greater than such rate when elected or directed by the Plan.

This information serves to update the medical coverage that is provided to eligible participants under the Key Medical Plan. If there is a disagreement between this overview and the Plan documents, including the Plan's SPD, the Plan documents always control. Also, please understand that Key reserves the right to amend or modify the Plan, including its prescription drug coverage, and to terminate the Plan at any time and for any reason.

Medical Out-of-Network

Plan Provisions	Surest (copay plan)	Plus HDHP (Key Medical 2)	Basic HDHP (Key Medical 3)
	Copay Plan/no deductible	High Deductible Health Plan	High Deductible Health Plan
Administrator: UnitedHealthcare	Out-of-Network Benefits		
Deductible (combined medical/Rx deductible)	Employee-only: $0 Family: $0	Employee-only: $5,000 Family: $10,000	Employee-only: $8,000 Family: $16,000
Copay/Coinsurance	You pay copays for covered services. Costs vary based on the provider and service selected (see below for details).	You pay 40%[1]	You pay 50%[1]
Out-of-Pocket Maximum (includes deductible, coinsurance or copays, as applicable by plan)	Employee-only: $10,000 Family: $20,000	Employee-only: $10,000 Family: $20,000	Employee-only: $14,000 Family: $28,000
Preventive Care: Includes Routine Well Exams, Screenings, Immunizations	Out-of-Network Preventive Care $220	Plan pays 100%[2] (not subject to the deductible) Visit **uhc.com/health-and-wellness/preventive-care** for preventive care guidelines.	
Office Visit Exam Fee	$220	You pay 40%[1]	You pay 50%[1]
Urgent Care Centers	$210		
Basic Labs, X-Rays and Ultrasounds	$0		
Inpatient stay	$9,000		
Outpatient hospital services	$3,500		
Maternity	$9,000		
Chiropractic (up to 25 visits annually)	$80		
Mental Health (Including Substance Use) Office Visit	$540		
Emergency	$1,000	Plan pays 80%[1]	Plan pays 70%[1]

Compare your 2027 plan options, search for network providers and more.
Surest (copay plan): **surest.care/keybank**
Plus HDHP (Key Medical 2) and Basic HDHP (Key Medical 3): **exploreuhcplans.com/keycorp**

HDHP = High Deductible Health Plan

[1]Subject to annual deductible and out-of-pocket maximum. Select preventive medications bypass the deductible. This means that you have the benefit of paying the applicable coinsurance without having to meet the deductible first. Although the coinsurance will not apply to the deductible, it does apply toward the out-of-pocket maximum. See the Prescription Drug Chart for more details.

[2]Is not subject to nor counts toward the deductible or out-of-pocket maximum.

Note, you may be eligible to earn a Wellness Incentive to be paid as a Health Savings Account contribution or a per pay premium credit based on your Plan enrollment and whether you earned by the deadline. Review all eligibility details and requirements to earn on the Medical Plan Wellness Incentive page on at **Thrive with Key.**

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If you use network providers, your Plan coinsurance costs are based on UnitedHealthcare's negotiated network fees. Plan coinsurance costs for out-of-network providers are determined as follows: (i) an amount negotiated by the Claims Administrator, (ii) a specific amount required by law (when required by law), or (iii) an amount the Claims Administrator has determined is typically accepted by a healthcare provider for the same or similar service or an amount that is greater than such rate when elected or directed by the Plan.

This information serves to update the medical coverage that is provided to eligible participants under the Key Medical Plan. If there is a disagreement between this overview and the Plan documents, including the Plan's SPD, the Plan documents always control. Also, please understand that Key reserves the right to amend or modify the Plan, including its prescription drug coverage, and to terminate the Plan at any time and for any reason.

Prescription Drug Coverage

Plan Provisions	Surest (copay plan)	Plus HDHP (Key Medical 2)	Basic HDHP (Key Medical 3)
	Copay Plan/no deductible	High Deductible Health Plan	High Deductible Health Plan
Administrator: Express Scripts®	Network Benefits[1]		
Generic[2]	No deductible	Subject to combined medical/Rx deductible	
Brand/Specialty[2]			
Select Preventive Medications (Go to **express-scripts.com/keycorp** for the preventive medication list.)	N/A	Not subject to deductible. Employee pays applicable coinsurance shown below. Coinsurance will not apply toward combined medical/Rx deductible; will apply to out-of-pocket maximum.	
	Surest (copay plan)	Plus HDHP (Key Medical 2)	Basic HDHP (Key Medical 3)
Generic	$10	20% after deductible	30% after deductible
Preferred Brand	$90	40% after deductible	50% after deductible
Non-Preferred Brand	$160	60% after deductible	70% after deductible
3-Month Supply – Express Scripts Mail Order or CVS Retail Pharmacy (required for maintenance meds)[3]	Employee Pays		
Generic	$25	20% ($10 minimum)	30% ($10 minimum)
Preferred Brand	$225	40%	50%
Non-Preferred Brand	$400	60%	70%

Compare drug costs by plan, view formulary exclusions and other authorization requirements at **express-scripts.com/keycorp** or call **1-800-849-9138**.

Surest (copay plan) – Specialty medication copays range from $440 to $530 for a 30-day supply.

Patient assistance funded by pharmaceutical manufacturers for specialty drugs will not be considered true out-of-pocket expenses for members and may not apply to the deductible and out-of-pocket maximum.

[1]If you go out of network, you will pay 100% of the pharmacy's retail charge and you must complete a prescription drug reimbursement form. You will be responsible for paying the coinsurance referenced above (Generic, Preferred Brand, Non-Preferred Brand), as well as the difference between the pharmacy's regular charge and the discounted cost that would have applied had you used a network pharmacy. Examples of out-of-network pharmacies include: Walgreens, Duane Reade, Happy Harry's and Kroger. Please always confirm current pharmacy network status by logging into your account at express-scripts.com or by calling Express Scripts at 1-800-849-9138.

[2]Some medications require a clinical review and/or participating in a program in order to be eligible for coverage under the Plan. Go to **express-scripts.com/keycorp** to view the clinical program and exclusion lists. These lists or requirements may change during the Plan year and if that occurs (with respect to a medication that is currently being covered by the Plan), Express Scripts will send you written communication. If you purchase a brand-name prescription drug that has an available generic equivalent, you will pay the generic drug cost share plus the cost difference between the brand-name prescription drug and the equivalent generic prescription drug (applies to both physician and patient requests for brand name instead of generic). The difference in cost does not apply to your deductible or out-of-pocket maximum.

[3]You must fill maintenance medications as a 90-day supply at CVS or through Express Scripts home delivery pharmacy.

- If you choose to fill maintenance medications at another pharmacy, or for less than a 90-day supply, you must contact Express Scripts to actively document that choice, or you will incur an increased cost.
- **You can obtain two 30-day courtesy fills before you must switch to 90 days at CVS or Express Scripts home delivery, or declare your decision to Express Scripts. Otherwise, after those 2 courtesy fills, you will be required to pay the full cost of the medication until you inform Express Scripts of your choice.**

The information contained in this Summary Chart provides a very general overview of the KeyCorp Medical Plan prescription drug coverages that will be in effect for the 2027 Plan year. For more specific Plan coverage information, please review the Medical Plan's Summary Plan Description (SPD), which can be found at **https://benefits.keybank.com.**

If you use network providers, your Plan coinsurance costs are based on Express Scripts' negotiated network fees. Mail-order benefits available only through Express Scripts mail order or participating CVS Retail Pharmacies. Please be aware that the Medical Plan may not cover certain products and procedures that you wish to have performed. While these services will not be paid for by the Plan, you must always determine the medical care that is best for you.

This information serves to update the medical coverage that is provided to eligible participants under the Key Medical Plan. If there is a disagreement between this overview and the Plan documents, including the Plan's SPD, the Plan documents always control. Also, please understand that Key reserves the right to amend or modify the Plan, including its prescription drug coverage, and to terminate the Plan at any time and for any reason.

Dental

Plan Provisions		
Administrator: Cigna®	**Network**	**Out-of-Network**
Reimbursement Levels	Based on contracted fees	Based on Reasonable & Customary (R&C) allowance
Maximum Annual Benefit	$1,500 per person (all services) except orthodontia	
Deductible	$50 per person/$100 per family	
Wellness and Diagnostic Care		
Oral Exams (2 per year)	Plan pays 100%	Plan pays 100% of the R&C allowance
Routine Cleanings (2 per year)		
Full Mouth X-rays (1 complete set every 3 years) **or Panoramic X-ray** (1 every 3 years)		
Bitewing X-rays (2 per year)		
Fluoride Application (2 per year under age 19)		
Sealants (limited to posterior tooth, 1 treatment per tooth every 3 years)		
Space Maintainers (limited to non-orthodontic treatment; 1 per tooth, per lifetime, to age 19)		
Emergency Care to Relieve Pain		
Basic Restorative Care[1]		
Fillings[2]	Plan pays 80%[3]	Plan pays 80% of the R&C allowance[3]
Root Canal Therapy		
Osseous Surgery		
Periodontal Scaling and Root Planing		
Denture Adjustments and Repairs		
Extractions		
Oral Surgery		
Major Restorative Care[1]		
Crowns	Plan pays 50%[3]	Plan pays 50% of the R&C allowance[3]
Dentures		
Bridges		
Implants		
Orthodontia[1]		
Orthodontia	Plan pays 50%[3]	Plan pays 50% of the R&C allowance[3]
Orthodontia Lifetime Maximum Paid by Plan	$1,500 per person[3]	

To contact Cigna, call **1-800-CIGNA24** or visit **myCigna.com.**

[1]Out-of-pocket costs may be lower if you see a network provider for these services.
[2]Amalgam (silver) or composite (white) fillings covered based on type of tooth and the alternative treatment provision. See Summary Plan Description (SPD) for details.
[3]Subject to annual deductible.

The information contained in this Summary Chart provides a very general overview of the KeyCorp Dental Plan coverages that will be in effect for the 2027 Plan year. For more specific Plan coverage information, please review the Dental Plan's SPD, which can be found at **https://benefits.keybank.com.**

If you use network providers, your Plan coinsurance costs are based on Cigna's negotiated network fees. Plan coinsurance costs for out-of-network providers are based on the reasonable and customary charges for the particular service received.

Please be aware that the Dental Plan may not cover certain services and procedures you wish to have performed. While these services will not be paid for by the Plan, you must always determine the dental care that is best for you. Pretreatment review is suggested when you are considering dental work in excess of $200.

This information serves to update the dental coverage that is provided to eligible participants under the Dental Plan. If there is a disagreement between this overview and the Plan documents, including the Plan's SPD, the Plan documents always control. Also, please understand that Key reserves the right to amend or modify the Plan and to terminate the Plan at any time and for any reason.

Vision

Plan Provisions

Administrator: VSP®	VSP Network	Out-of-Network
Routine Eye Exam (1 per calendar year)	$10 employee copay ($0 Premier Providers)	Up to $55 allowance
Retinal Imaging Benefit	Up to $39 copay ($0 Premier Providers)	NA
Vision Hardware (1 per calendar year: either frames/lenses OR contact lenses)		
Frames	$150 allowance; 20% off balance over $150 $200 allowance on Featured Brands	Up to $70 allowance
Standard Plastic Lenses		
Single Vision	No charge	Up to $70 allowance
Bifocal		Up to $80 allowance
Trifocal		Up to $100 allowance
Lenticular		Up to $110 allowance
Standard Progressive Lens	$0 employee copay	Up to $80 allowance
Premium Progressive Lens	$95–$105	
Lens Options		
Standard Progressive Lenses	No charge	Up to $80 allowance
Premium Progressive Lenses	$95–$105	
Custom Progressive Lenses	$150–$175	
Impact-Resistant Lenses	No charge	Employee pays 100%
Other Lens Enhancements	Average savings of 30%	
Contact Lenses		
Conventional	$150 allowance	Up to $115 allowance (Exam, Contacts, Fit and Follow-up)
Disposable	$150 allowance	
Contact Lens Fit and Follow-up	Employee pays up to $40	
Medically Necessary	No copay	Up to $200 allowance

Extra Savings:

Glasses and Sunglasses

- 40% savings on additional pairs of prescription glasses from same VSP Network provider who performed your well-vision exam within 12 months of your last exam.
- 20% savings on unlimited additional pairs of prescription glasses and/or non-prescription sunglasses from any VSP network doctor.

For information about featured frame brands, visit **vsp.com/framebrands.**

Laser Vision Correction

- Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities.



To contact VSP, call **1-800-877-7195** or visit **vsp.com.**

The information contained in this Summary Chart provides a very general overview of the KeyCorp Vision Plan coverages that will be in effect for the 2027 Plan year. For more specific Plan coverage information, please review the Vision Plan's Summary Plan Description (SPD), which can be found at **https://benefits.keybank.com.**

If you use network providers, your Plan coinsurance costs are based on VSP's negotiated network fees. Please be aware that the Vision Plan may not cover certain services and procedures that you wish to have performed. While these services will not be paid for by the Plan, you must always determine the medical care that is best for you.

This information serves to update the vision coverage that is provided to eligible participants under the Vision Plan. If there is a disagreement between this overview and the Plan documents, including the Plan's SPD, the Plan documents always control. Also, please understand that Key reserves the right to amend or modify the Plan, and to terminate the Plan at any time and for any reason.

Common health care terms

coinsurance: The percentage you pay of the cost of services after the deductible is met.

deductible: The amount you pay before your plan begins paying benefits for most covered services.

generic: You will pay the lowest coinsurance for generic drugs. Generics are equivalent to their brand-name counterparts, and are ensured by the Food and Drug Administration to be as safe and effective.

network providers: Doctors, hospitals and other health care professionals who have negotiated special rates with the medical, dental, vision or prescription drug administrators. If you use out-of-network providers, your costs may be higher.

non-preferred brand: These drugs have the highest coinsurance. Generally, these are higher-cost medications that have recently come on the market. In most cases, an alternative preferred medication is available.

out-of-pocket maximum: The most you will have to pay out of pocket each year for covered services. This includes your deductible and coinsurance. Premiums do not count toward your out-of-pocket maximum.

preferred brand: These are drugs for which generic equivalents are not available. They have been in the market for a time and are widely accepted. They cost more than generics but less than non-preferred brand-name drugs.

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