Thrive with Key

2020 Benefits Summary Chart

Medical In-Network

Plan Provisions	Key Medical 1	Key Medical 2	Key Medical 3
Administrator: UnitedHealthcare	**In-Network Benefits**		
Deductible	Employee-only coverage: $1,500 Family coverage: $3,000 (combined medical/Rx deductible)	Employee-only coverage: $1,500 Family coverage: $3,000 (combined medical/Rx deductible)	Employee-only coverage: $3,000 Family coverage: $6,000 (combined medical/Rx deductible)
Coinsurance (Plan pays/employee pays)[1]	100%/0%[1]	80%/20%[1]	70%/30%[1]
Out-of-Pocket Maximum (includes deductible and coinsurance)	Employee-only coverage: $1,500 Family coverage: $3,000	Employee-only coverage: $3,000 Family coverage: $6,000	Employee-only coverage: $5,000 Family coverage: $10,000 (Individuals in Family coverage have an out-of-pocket maximum of $7,900)
KeyBank Health Savings Account (HSA) Annual Employer Contribution (as part of the Wellness Incentive program)[2]	Applicable only if you earned the 2020 Wellness Incentive Employee-only coverage: $600[2] All other coverage levels: $1,200[2]		
Preventive Care: Includes Routine Well Exams, Screenings, Immunizations (General/Family Practitioner, Internist, Pediatrician, OB/GYN)	Preventive care services are covered at 100%, based on your age, gender and other health factors. To learn more about preventive care guidelines visit **uhcpreventivecare.com**, or call UnitedHealthcare at **1-866-201-0017** to confirm which services are covered for you.		
Other Office Visit Exam Fee – Primary Care (General/Family Practitioner, Internist, Pediatrician, OB/GYN)	Plan pays 100%[1]	Plan pays 80%[1]	Plan pays 70%[1]
Office Visit Exam Fee – Specialist			
Urgent Care Centers			
Emergency Room			
Hospitalization			
Surgery			
Outpatient Facilities			
X-rays/Lab Tests			
Chiropractic (up to 10 visits annually)			
Mental Health (Including Substance Use) Treatment – Inpatient			
Mental Health (Including Substance Use) Treatment – Outpatient			

[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]In addition to completing the required health actions to earn the Wellness Incentive, the employee and/or covered spouse/partner must continue to be enrolled in the Key Medical Plan for 2020. If the employee is no longer active at the time of the HSA contribution, does not have an HSA, or fails to open one before or during 2020, the employee may forfeit the Key contribution for 2020. If you are age 65 or older, your Wellness Incentive will be paid as a per-pay premium credit.

If you cover your spouse/partner and only one of you earns the Wellness Incentive, you will receive $600. Review details at HR Online and select "Wellness Incentive."

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

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 2020 Plan year. For more specific Plan coverage information, please review the Medical Plan's Summary Plan Description (SPD), which can be found at **hronline.keybank.com > Benefits References > Summary Plan Descriptions**. 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 based on the reasonable and customary charges for the particular service received. The above chart reflects only in-network coinsurance costs.

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.

To contact UnitedHealthcare, call **1-866-201-0017** (8 a.m. to 8 p.m. in all time zones, except Alaska) or visit **myuhc.com®** (pre-members, visit **keycorp.welcometouhc.com**).

Medical Out-of-Network

Plan Provisions	Key Medical 1	Key Medical 2	Key Medical 3
Administrator: UnitedHealthcare	Out-of-Network Benefits		
Deductible	Employee-only coverage: $3,000 Family coverage: $6,000 (combined medical/Rx deductible)	Employee-only coverage: $3,000 Family coverage: $6,000 (combined medical/Rx deductible)	Employee-only coverage: $6,000 Family coverage: $12,000 (combined medical/Rx deductible)
Coinsurance (Plan pays/employee pays)[1]	60%/40%[1]	60%/40%[1]	50%/50%[1]
Out-of-Pocket Maximum (per person/per family)	Employee-only coverage: $6,000 Family coverage: $12,000 (includes deductible and coinsurance)		Employee-only coverage: $10,000 Family coverage: $20,000 (includes deductible and coinsurance)
KeyBank Health Savings Account (HSA) Annual Employer Contribution (as part of the Wellness Incentive program)[2]	Applicable only if you earned the 2020 Wellness Incentive Employee-only coverage: $600[2] All other coverage levels: $1,200[2]		
Preventive Care: Includes Routine Well Exams, Screenings, Immunizations (General/Family Practitioner, Internist, Pediatrician, OB/GYN)	Preventive care services are covered at 100%, based on your age, gender and other health factors. To learn more about preventive care guidelines visit **uhcpreventivecare.com**, or call UnitedHealthcare at **1-866-201-0017** to confirm which services are covered for you.		
Other Office Visit Exam Fee – Primary Care (General/Family Practitioner, Internist, Pediatrician, OB/GYN)	Plan pays 60%[1]	Plan pays 60%[1]	Plan pays 50%[1]
Other Office Visit Exam Fee – Specialist			
Urgent Care Centers			
Hospitalization			
Surgery			
Outpatient Facilities			
X-rays/Lab Tests			
Chiropractic (up to 10 visits annually)			
Mental Health (Including Substance Use) Treatment – Inpatient			
Mental Health (Including Substance Use) Treatment – Outpatient			
Emergency	Plan pays 100%[1]	Plan pays 80%[1]	Plan pays 70%[1]

[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]In addition to completing the required health actions to earn the Wellness Incentive, the employee and/or covered spouse/partner must continue to be enrolled in the Key Medical Plan for 2020. If the employee is no longer active at the time of the HSA contribution, does not have an HSA, or fails to open one before or during 2020, the employee may forfeit the Key contribution for 2020. If you are age 65 or older, your Wellness Incentive will be paid as a per-pay premium credit.

If you cover your spouse/partner and only one of you earns the Wellness Incentive, you will receive $600. Review details at HR Online and select "Wellness Incentive."

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

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 2020 Plan year. For more specific Plan coverage information, please review the Medical Plan's Summary Plan Description (SPD), which can be found at **hronline.keybank.com > Benefits References > Summary Plan Descriptions**. 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 based on the reasonable and customary charges for the particular service received. The above chart reflects only in-network coinsurance costs.

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.

To contact UnitedHealthcare, call **1-866-201-0017** (8 a.m. to 8 p.m. in all time zones, except Alaska) or visit **myuhc.com** (pre-members, visit **keycorp.welcometouhc.com**).

Prescription Drug Coverage

Plan Provisions	Key Medical 1	Key Medical 2	Key Medical 3
Administrator: Express Scripts®	In-Network Benefits[1]		
Generic[2]	Subject to combined medical/Rx deductible		
Brand/Specialty[2]			
Select Preventive Medications (Go to **express-scripts.com/keycorp** for the preventive medication list.)	Not subject to deductible. Employee pays applicable coinsurance shown below without having to meet the deductible first. Coinsurance will not apply toward combined medical/Rx deductible; will apply to out-of-pocket maximum.		
Retail Pharmacy	Employee Pays		
Generic	20% ($4 minimum)	20% ($4 minimum)	30% ($4 minimum)
Preferred Brand	40%	40%	50%
Non-Preferred Brand	60%	60%	70%
Fertility[3]	50%	50%	50%
3-Month Supply - Express Scripts Mail Order or CVS Retail Pharmacy	Employee Pays		
Generic	20% ($10 minimum)	20% ($10 minimum)	30% ($10 minimum)
Preferred Brand	40%	40%	50%
Non-Preferred Brand	60%	60%	70%
Fertility[3]	50%	50%	50%

[1]Coinsurance is subject to combined medical/Rx deductible and out-of-pocket maximum.

— You will pay 100 percent 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, Fertility), 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. Walgreens, Duane Reade and Happy Harry's are out-of-network providers.

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

[2]Some medications require a clinical review or may be an exclusion on the Plan. Go to **express-scripts.com/keycorp** to view the clinical program and exclusion lists. These lists 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.

[3]Infertility medications are limited to a lifetime cap of $10,000 per covered person. Medical services for infertility are limited to a lifetime cap of $15,000 per covered person. You must participate in the Fertility Solutions program through UnitedHealthcare to be eligible for any infertility benefits under the Plan.

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 2020 Plan year. For more specific Plan coverage information, please review the Medical Plan's Summary Plan Description (SPD), which can be found at **hronline.keybank.com > Benefits References > Summary Plan Descriptions**.

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.

To contact Express Scripts, call **1-800-849-9138** (available 24/7) or visit **express-scripts.com/keycorp**.

Dental

Plan Provisions		
Administrator: Cigna®	**In-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 (two per year)	Plan pays 100%	Plan pays 100% of the R&C allowance
Routine Cleanings (two per year)		
Full Mouth X-rays (one complete set every three years) **or Panoramic X-ray** (one every three years)		
Bitewing X-rays (two per year)		
Fluoride Application (two per year under age 19)		
Sealants (limited to posterior tooth, one treatment per tooth every three years)		
Space Maintainers (limited to non-orthodontic treatment; one 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		
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]	

[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 2020 Plan year. For more specific Plan coverage information, please review the Dental Plan's SPD, which can be found at **hronline.keybank.com > Benefits References > Summary Plan Descriptions**.

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. Pre-treatment 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.

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

Vision

Plan Provisions

Administrator: EyeMed™	In-Network[1]	Out-of-Network[2]
Routine Eye Exam (one per calendar year)	$10 employee copay	Up to $55 allowance
Retinal Imaging Benefit	Up to $39 copay	NA
Vision Hardware (one per calendar year: either frames/lenses OR contact lenses)		
Frames	$150 allowance; 20% off balance over $150	Up to $60 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	$65 employee copay	Up to $80 allowance
Premium Progressive Lens	See Vision Summary Plan Description	
Lens Options		
Standard Polycarbonate	No charge	Up to $20 allowance
UV Treatment	$15 employee copay	Employee pays 100%
Tint (Solid and Gradient)		
Standard Plastic Scratch Coating		
Standard Anti-Reflective Coating	$45 employee copay	
Photochromic/Transitions Plastic	$75 employee copay	
Polarized	Employee receives 20% discount off retail	
Premium Anti-Reflective	See Vision Summary Plan Description	
Contact Lenses		
Conventional	$150 allowance; 15% off balance over $150	Up to $115 allowance
Disposable	$150 allowance; Employee pays balance over $150	
Medically Necessary	$250 allowance; Employee pays balance over $250	Up to $200 allowance
Fit and Follow-Up		
Standard Contact Lens	Employee pays up to $40	NA
Premium Contact Lens	Employee receives 10% discount off retail	

[1]Members receive a 20 percent discount on any items not covered by the Plan at network providers (excluding exams or contact lenses). Members also receive a 40 percent discount on any complete pair of glasses once their benefit has been exhausted.

[2]Out-of-network — One claims submission per year permitted. Submission may include claims for both an eye exam and eye hardware. Allowance indicated is the maximum reimbursement which can be obtained for this benefit by submitting a claim form to EyeMed.

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 2020 Plan year. For more specific Plan coverage information, please review the Vision Plan's Summary Plan Description (SPD), which can be found at **hronline.keybank.com > Benefits References > Summary Plan Descriptions**.

If you use network providers, your Plan coinsurance costs are based on EyeMed'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.

To contact EyeMed, call **1-877-863-9282** (7:30 a.m. to 11 p.m. ET, Monday through Saturday; 11 a.m. to 8 p.m. ET, Sunday) or visit **eyemedvisioncare.com/keybank**.

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. So-called "designer" drugs also fall into this category. 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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