Key Advantage Expanded Benefits At-A-Glance

Effective July 1, 2025 or October 1, 2025

Key Advantage Expanded Benefits At-A-Glance

	Benefit	In-Network	Out-of-Network
Plan Year Deductible *(applies as indicated)*	One Person	$100	$200
	Family (two or more people)	$200	$400
Plan Year Out-Of-Pocket Expense Limit	One Person	$2,000	$3,000
	Family (two or more people)	$4,000	$6,000
Out-of-network benefits	Yes. Once you meet the out-of-network deductible, you pay 30% coinsurance for medical and behavioral health services. Copayments do not apply to out-of-network medical and behavioral health services. Copayments and coinsurance for routine vision, outpatient prescription drugs and dental services will still apply.		
Lifetime maximum	Unlimited		

Covered Services	You Pay In-network		
Ambulance Travel *No Plan Year limit*	20% coinsurance, after deductible		
Autism Spectrum Disorder	Copayment/coinsurance determined by service received		
Behavioral Health			
Inpatient treatment	$300 copayment per stay[1]		
Residential Treatment	$300 copayment per stay[1]		
Partial Hospitalization (Day) Program	$100 copayment per stay[1]		
Intensive Outpatient Treatment Program (IOP)	$100 copayment per episode of care		
Outpatient Treatment Program			
Facility Services	$100 copayment		
Professional Provider Services	$15 copayment		
Chiropractic, Spinal Manipulations and Other Manual Medical Interventions 30-Visit Plan Year limit per member			
Primary Care Physicians	$15 copayment		
Specialty Care Providers	$25 copayment		
Dental Care (Delta Dental)			
Preventive Dental Option *(diagnostic and preventive services only for lower premium)*	$0		
Comprehensive Dental Option (for higher premium)			
Dental Plan Year Deductible	One Person $25	Two People $50	Family $75
Plan Year Maximum (Except Orthodontics)	$1,500		
Preventive Dental Care	$0		
Primary Dental Care	20% coinsurance, after dental deductible		
Major Dental Care	50% coinsurance, after dental deductible		
Orthodontic Services (Includes Adult Ortho)	50% coinsurance, no dental deductible, with $1,500 lifetime maximum		
Dental Services (non-routine Medical)	20% coinsurance, after deductible		
Diabetic Education	$0		
Diabetic Equipment	20% coinsurance, after deductible		

[1] A stay is the period from the admission to the date of discharge from a Facility. All hospital stays less than 90 days apart for the same diagnosis are considered the same stay, and a new hospital inpatient copayment will not apply. If you are readmitted within 90 days for a different diagnosis, a copayment will apply. For Behavioral Health Partial Day Program or Intensive Outpatient Treatment Program (IOP), the copayment is also waived if you are admitted within 15 days if an inpatient stay is for the same diagnosis.

Covered Services	You Pay In-network
Diagnostic Tests, Labs and X-rays	
Outpatient Surgery	20% coinsurance, no deductible
Outpatient Diagnostic Services Only	20% coinsurance, no deductible
Outpatient Emergency Room	20% coinsurance, no deductible
Dialysis Treatments	
Facility Services	$0
Doctor's Office	$0
Doctor's Visits *(On an Outpatient basis)*	
Primary Care Physicians (in-person or online)	$15 copayment
Specialty Care Providers (in-person or online)	$25 copayment
Employee Assistance Program (EAP) Up to four Visits per issue *(per plan year)*	$0
Early Intervention Services (Birth to 3 years)	Copayment/coinsurance determined by service received
Emergency Room Visits	
Facility Services	$250 copayment per visit (waived if admitted to hospital)
Professional Provider Services	
Primary Care Physicians	$15 copayment
Specialty Care Providers	$25 copayment
Diagnostic Tests, Labs and X-rays	20% coinsurance, no deductible
Home Health Services *90-Visit Plan Year limit per member*	$0
Home Private Duty Nurse's Services	20% coinsurance, after deductible
Hospice Care Services	$0
Hospital Services	
Inpatient Care	
Facility Services	$300 copayment per stay[1]
Professional Provider Services	
Primary Care Physicians	$0
Specialty Care Providers	$0
Diagnostic Services	$0
Outpatient Care	
Facility Services	$100 copayment per visit
Professional Provider Services	
Primary Care Physicians	$15 copayment
Specialty Care Providers	$25 copayment
Diagnostic Tests, Labs and X-rays	20% coinsurance, no deductible
Maternity	
Professional Provider Services	
Prenatal and Postnatal Care	
Primary Care Physicians	$15 copayment
Specialty Care Providers	$25 copayment
Delivery	
Primary Care Physicians	$0
Specialty Care Providers	$0
Hospital Services for Delivery Delivery room, anesthesia, routine nursing care for newborn	$300 copayment per stay
Diagnostic Tests, Labs and X-rays	20% coinsurance, no deductible
Medical Equipment (durable), Appliances, Formulas, Prosthetics and Supplies	20% coinsurance, after deductible

Key Advantage Expanded Benefits At-A-Glance (continued)

Covered Services	You Pay In-network
Outpatient Prescription Drugs (mandatory generic)	
Retail Pharmacy Covered drugs per 34-day supply	
Tier 1	$10 copayment
Tier 2	$30 copayment
Tier 3	$45 copayment
Tier 4	$55 copayment
Home Delivery Services (Mail Order) Covered drugs for up to a 90-day supply	
Tier 1	$20 copayment
Tier 2	$60 copayment
Tier 3	$90 copayment
Tier 4	$110 copayment
Diabetic Supplies	20% coinsurance, no deductible
Shots – allergy & therapeutic injections At a doctor's office, Emergency room or Outpatient hospital department	20% coinsurance, no deductible
Skilled Nursing Facility Stays 180-day per Stay limit per member[2]	
Facility Services	$0
Professional Provider Services	$0
Surgery	
Inpatient	
Facility Services	$300 copayment per stay
Professional Provider Services	
Primary Care Physicians	$0
Specialty Care Providers	$0
Diagnostic Services	$0
Outpatient	
Facility Services	$100 copayment per visit
Professional Provider Services	
Primary Care Physicians	$15 copayment
Specialty Care Providers	$25 copayment
Therapy – Outpatient Services	
Cardiac Rehabilitation Therapy	20% coinsurance, after deductible
Chemotherapy	20% coinsurance, after deductible
Infusion (includes IV therapy and injected chemotherapy)	20% coinsurance, after deductible
Therapy – Outpatient Services *(continued)*	
Occupational Therapy	20% coinsurance, after deductible
Physical Therapy	20% coinsurance, after deductible
Radiation Therapy	20% coinsurance, after deductible
Respiratory Therapy	20% coinsurance, after deductible
Speech Therapy	20% coinsurance, after deductible

[2] A stay is the period from the admission to the date of discharge from a Facility. If there is less than a 90 day break between two admissions, the days allowable for the subsequent admission are reduced by the days used in the first. If there are more than 90 days between the two admissions, the days available for the subsequent admission start over for a full 180 days.

Covered Services	You Pay In-network
Vision Correction *After surgery or accident*	20% coinsurance, after deductible
Wellness and Preventive Care Services	
Well Child (Birth to 18 years)	
Office Visits at specified intervals	
Primary Care Physicians	No copayment, coinsurance, or deductible
Specialty Care Providers	No copayment, coinsurance, or deductible
Immunizations	
Primary Care Physicians	No copayment, coinsurance, or deductible
Specialty Care Providers	No copayment, coinsurance, or deductible
Screening Tests	No copayment, coinsurance, or deductible
Routine Wellness (18 years and older)	
Check-up Visit (one per Plan Year)	
Primary Care Physicians	No copayment, coinsurance, or deductible
Specialty Care Providers	No copayment, coinsurance, or deductible
Immunizations	
Primary Care Physicians	No copayment, coinsurance, or deductible
Specialty Care Providers	No copayment, coinsurance, or deductible
Routine Lab and X-ray Services	No copayment, coinsurance, or deductible
Wellness and Preventive Care Services (one of each per Plan Year)	
Gynecological Exam	
Primary Care Physicians	No copayment, coinsurance, or deductible
Specialty Care Providers	No copayment, coinsurance, or deductible
Pap Test	No copayment, coinsurance, or deductible
Mammography Screening	No copayment, coinsurance, or deductible
Prostate Exam (digital rectal exam)	
Primary Care Physicians	No copayment, coinsurance, or deductible
Specialty Care Providers	No copayment, coinsurance, or deductible
Prostate Specific Antigen Test	No copayment, coinsurance, or deductible
Colorectal Cancer Screenings	No copayment, coinsurance, or deductible

Key Advantage Expanded Benefits At-A-Glance (continued)

Routine Vision

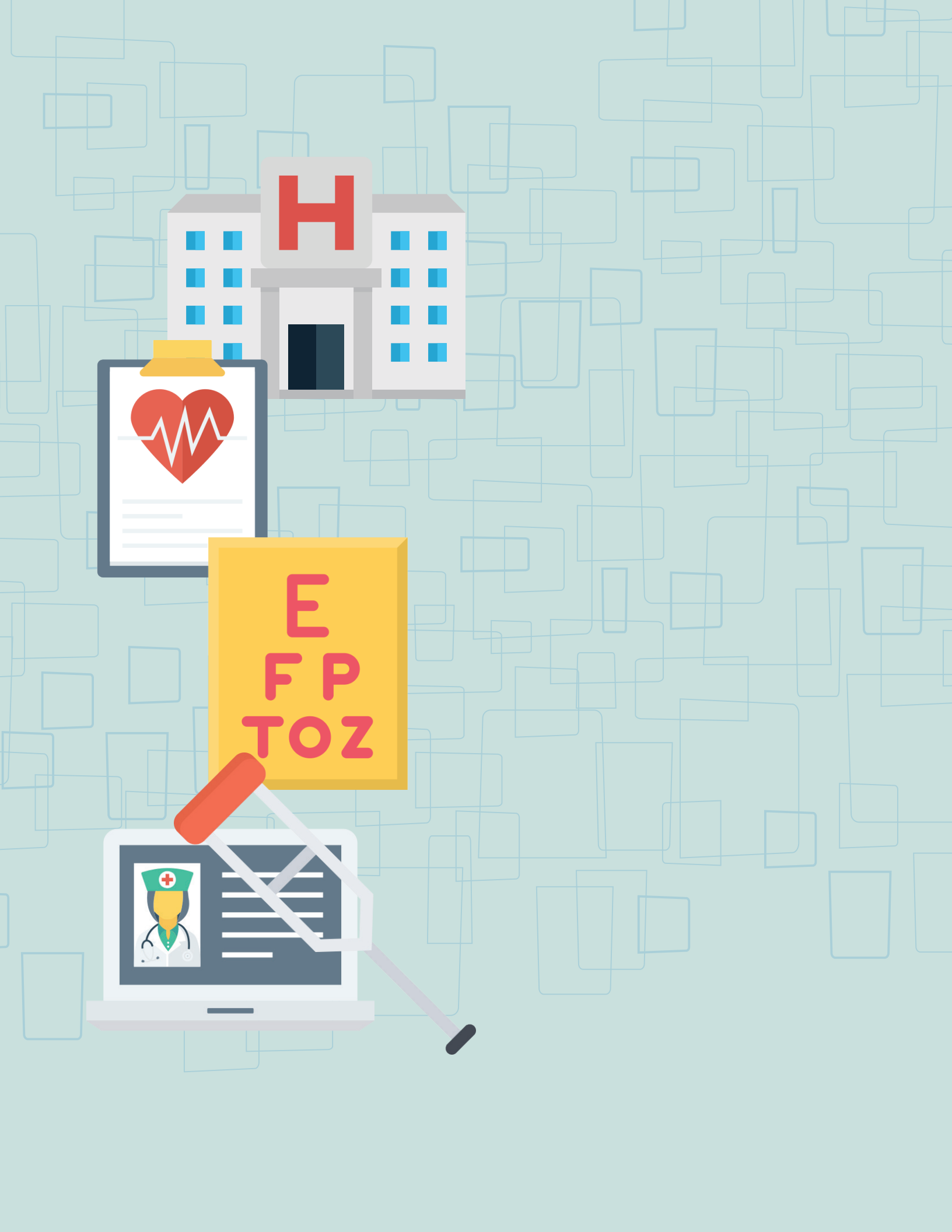
An allowance for eyeglass lenses or contact lenses every plan year. You pay the remaining cost for frames and lenses after Your Health Plan's Reimbursement.

Covered Services	**In-Network** (once per plan year)	Out-of-Network
Routine eye exam	You pay $25 copayment	Plan pays up to to $50
Standard eyeglass lenses *(in lieu of eyeglass lenses)* Polycarbonate lenses included at no additional cost for children under 19 years old	You pay $20 copayment	Plan pays up to: $50 single lenses; $75 bifocal; $100 trifocal
Eyeglass frames	Plan pays up to $100* retail allowance	Plan pays up to $80
Contact lenses[1] *(in lieu of eyeglass lenses)*		
Elective Conventional[2]	Plan pays up to $100 allowance then 15% discount off remaining balance	Plan pays up to $80
Elective Disposable[2]	Plan pays up to $100 allowance (no additional discount)	Plan pays up to $80
Non-Elective[2]	Covered in full	Plan pays up to $210
Retinal Imaging At member's option can be performed at time of eye exam	Not more than $39	
Lens options		
UV coating, tints, standard scratch-resistant	You pay $15	Not available
Standard polycarbonate (Adult)	You pay $40	Not available
Standard progressive *(in addition to bifocal copayment)*	You pay $65	Not available
Standard anti-reflective	You pay $45	Not available
Other add-ons (i.e. high index lenses, anti-fog coating)	You pay 20% off retail	Not available

*You may select a frame greater than the covered allowance and receive a 20% discount for any additional cost over the allowance.

[1] Declining Balance. Your plan has a declining balance allowance. This means if you do not use your allowance all at once, the remainder will be available for you to use at a later time. However, any remaining balance will not carry over to the next benefit year. All services or supplies using the declining balance for a benefit period must be received In-Network based on where the first paid claim is incurred..

[2] Elective contact lenses are typically elected in lieu of eyeglass lenses. Non-Elective contact lenses are medically necessary contacts when glasses are not an option for vision.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