Brown & Brown, Inc.

Choice Plus Copay

Administrative services provided by UnitedHealthcare

The Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine your coverage. If this Benefit Summary conflicts in any way with the Summary Plan Description (SPD), the SPD shall prevail. It is recommended that you review your SPD for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage. This document is provided as a summary of benefits and does not detail all the terms, conditions, restrictions and exclusions contained in the Summary Plan Description. This summary merely summarized the employee benefit plan and does not create any contractual rights for any current or former employee of Brown & Brown, Inc., and its subsidiaries.

PLAN HIGHLIGHTS

Types of Coverage	Network Benefits	Non-Network Benefits
Annual Deductible		
Individual Deductible **Family Deductible**	$500 per year $1,500 per year	$1,500 per year $4,500 per year
• Member In-Network Copays do not accumulate towards the Deductible unless otherwise notated within the specific benefit category below.		
Out-of-Pocket Maximum		
Individual Out-of-Pocket Maximum **Family Out-of-Pocket Maximum**	$8,000 per year $16,000 per year	$12,000 per year $24,000 per year
• The Out-of-Pocket Maximum includes the Annual Deductible. • Copays, Coinsurance and Deductibles accumulate towards the Out-of-Pocket Maximum. • Prescription Drug cost shares are included in the Medical Out-of-Pocket Maximum.		
Benefit Plan Coinsurance – The Amount the Plan Pays		
	80% after Deductible has been met.	60% after Deductible has been met.
In-Network Copays		
• Primary Care Provider: $20 (in-person or telemedicine visits) • Virtual Visits Provider: $0 (Doctor on Demand, Teladoc or AmWell) • Specialist: $40 (in-person or telemedicine visits) • Urgent Care: $40 (in-person or telemedicine visits) • Pharmacy Benefits (see details below)		
Information on Benefit Limits		
• The Annual Deductible, Out-of-Pocket Maximum and Benefit limits are calculated on a calendar year basis. • Refer to your Summary Plan Description for a definition of Eligible Expenses and information on how benefits are paid. • When Benefit limits apply, the limit refers to any combination of Network and Non-Network Benefits unless specifically stated in the Benefit category. • In order to obtain the highest level of Benefits, you should confirm the Network status of all providers prior to obtaining Covered Health Services. • Out-of-Pocket maximum excludes non-covered services and charges in excess of the plan's allowance.		

BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Ambulance Services – Emergency and Non-Emergency		
Prior Authorization is required for Non-Emergency Ambulance.	Emergency: 80% after Deductible has been met. Non-Emergency: 80% Network, 60% Non-Network after Deductible has been met.	
Dental Services – Accident Only		
	80% after Deductible has been met.	

Durable Medical Equipment (DME)		
Benefits are limited as follows: *A single purchase of a type of Durable Medical Equipment (including repair and replacement) every three years. This limit does not apply to wound vacuums.*	80% after Deductible has been met.	60% after Deductible has been met.
	Prior Authorization is required for Non-Network Durable Medical Equipment that costs more than $1,000.	
Emergency Health Services - Outpatient		
	80% after Deductible has been met. If you are admitted as an inpatient to a Network Hospital directly from the Emergency room, the Benefits for an Inpatient Stay in a Network Hospital will apply instead.	
Home Health Care		
Benefits are limited as follows: *60 visits per calendar year network and non-network combined.*	80% after Deductible has been met.	60% after Deductible has been met.
	Prior Authorization is required for certain services.	
Hospice Care		
	80% after Deductible has been met.	60% after Deductible has been met.
	Prior Authorization is required for Inpatient Stay.	
Hospital – Inpatient Stay		
	80% after Deductible has been met.	60% after Deductible has been met. There is a $250 copay per admission.
	Prior Authorization is required.	
Lab, X-Ray and Diagnostics - Outpatient		
For Preventive Lab, X-Ray and Diagnostics, refer to the Preventive Care Services category.	80% after Deductible has been met.	60% after Deductible has been met.
	Prior Authorization is required for Non-Network sleep studies.	
Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine - Outpatient		
	80% after Deductible has been met.	60% after Deductible has been met.
Mental Health Services		
In-Patient	80% after Deductible has been met.	60% after Deductible has been met.
Out-Patient Facility	80% after Deductible has been met.	60% after Deductible has been met.
Office Visit	100% after you pay a $20 Copay per visit.	60% after Deductible has been met.
	Prior Authorization is required for certain services.	
Pharmaceutical Products – Outpatient		
This includes medications administered in an outpatient setting, in the Physician's Office or in a Covered Person's home.	80% after Deductible has been met.	60% after Deductible has been met.
Physician Fees for Surgical and Medical Services		
	80% after Deductible has been met.	60% after Deductible has been met.
Physician's Office Services – Sickness and Injury		
Primary Physician Office Visit	100% after you pay a $20 Copay per visit.	60% after Deductible has been met.
Specialist Physician Office Visit	100% after you pay a $40 Copay per visit.	60% after Deductible has been met.
	Prior Authorization *is required for Non-Network Breast Cancer Genetic Test Counseling (BRCA) for women at higher risk for breast cancer.*	

- In addition to the office visit Copay stated in this section, the Coinsurance and any deductible applies when these services are done: Lab, X-Ray; CT, PET, MRI, MRA, Nuclear Medicine; Pharmaceutical Products, Scopic Procedures; Surgery; Therapeutic Treatments.

Pregnancy – Maternity Services		
	• Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each covered Health Service category in this Benefit Summary. • Prior Authorization *is required if Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.*	
Prescription Drug – Retail and Mail Order		
Prescription Drug Deductible **Individual Deductible** **Family Deductible**	None None	No Benefit
Retail Drugs up to 30-day supply	Tier 1 (Preventative): $0 copay Tier 1 (Non-Preventative): $5 copay Tier 2: $40 copay Tier 3: $80 copay Tier 4: $200 copay	No Benefit
Retail Drugs Extended Supply Network; 90-day supply	Tier 1 (Preventive): $0 copay Tier 1 (Non-Preventative): $15 copay Tier 2: $120 copay Tier 3: $240 copay	
Maintenance Drugs through Mail Order; 90-day supply	Tier 1 (Preventive): $0 copay Tier 1 (Non-Preventative): $15 copay Tier 2: $120 copay Tier 3: $240 copay	
Preventive Care Services		
Covered Health Services include but are not limited to:		
Primary Physician Office Visit	100% Deductible does not apply.	60% after Deductible has been met. Adult Preventive Care is subject to $750 paid maximum out of network per calendar year. No maximum in-network.
Specialist Physician Office Visit	100% Deductible does not apply.	
Lab, X-Ray or other preventive tests	100% Deductible does not apply.	
Prosthetic Devices		
Benefits are limited as follows: *A single purchase of each type of prosthetic device every three years.*	80% after Deductible has been met.	60% after Deductible has been met.
	Prior Authorization is required for Non-Network Prosthetic Devices that costs more than $1,000.	
Reconstructive Procedures		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
	Prior Authorization for Non-Network is required for certain services.	
Rehabilitation Services – Outpatient Therapy and Manipulative Treatment		
Benefits are as follows: *physical therapy* *occupational therapy* *speech therapy* *pulmonary rehabilitation* *cardiac rehabilitation* *cognitive rehabilitation therapy* *Includes habilitative services and* *Spinal manipulative treatment.*	80% after Deductible has been met.	60% after Deductible has been met.

Scopic Procedures – Outpatient Diagnostic and Therapeutic		
Diagnostic scopic procedures include, but are not limited to: Colonoscopy; Sigmoidoscopy; Endoscopy *For Preventive Scopic Procedures, refer to the Preventive Care Services category.*	80% after Deductible has been met.	60% after Deductible has been met.
	Prior Authorization for Non-Network is required for certain services.	
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services		
Benefits are limited as follows: *60 days per calendar year*	80% after Deductible has been met.	60% after Deductible has been met.
	Prior Authorization is required for certain services.	
Substance Use Disorder Services		
In-Patient	80% after Deductible has been met.	60% after Deductible has been met.
Out-Patient Facility	80% after Deductible has been met.	60% after Deductible has been met.
Office Visit	100% after you pay a $20 Copay per visit.	60% after Deductible has been met.
	Prior Authorization is required for certain services.	
Surgery – Outpatient		
	80% after Deductible has been met.	60% after Deductible has been met.
	Prior Authorization is required for certain services.	
Transplantation Services		
For Network Benefits, services may be received at a Designated Facility.	80% after Deductible has been met.	60% after Deductible has been met.
	Prior Authorization is required for certain services.	
Urgent Care Center Services		
	100% after you pay a $40 Copay per visit.	60% after Deductible has been met.
• In addition to the Copay stated in this section, the Coinsurance and any deductible applies when these services are done: Lab, X-Ray; CT, PET, MRI, MRA, Nuclear Medicine; Pharmaceutical Products, Scopic Procedures; Surgery; Therapeutic Treatments.		
Virtual Visits		
Network Benefits are available only when services are delivered through a Designated Virtual Visit Network Provider. Find a Designated Virtual Visit Network Provider Group at myuhc.com or by calling Advocate4Me at the telephone number on your ID card.	100% Deductible does not apply.	Non-Network Benefits are not available.
	Access to Virtual Visits and prescription services may not be available in all states or for all groups.	