Brown & Brown, Inc.

Choice Plus HDHP (HSA Qualified)

This 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 summarizes the employee benefit plan and does not create any contractual rights for any current or former employee of Brown & Brown, Inc., and its subsidiaries. Where eligible, this HDHP Coverage is intended to be a Health Savings Account qualified Plan.

MEDICAL PLAN HIGHLIGHTS – ADMINISTERED BY UNITEDHEALTHCARE

Types of Coverage	Network Benefits	Out-of-Network Benefits
Annual Deductible		
Single Coverage Only Deductible **Family Deductible**	$1,750 per year $3,500 per year	$3,500 per year $7,000 per year
• When Family Coverage is elected, the Family Deductible applies and must be met before applying coinsurance. • Annual Deductible amounts apply to Medical and Prescription Drug Coverage.		
Out-of-Pocket Maximum		
Individual Out-of-Pocket Maximum **Family Out-of-Pocket Maximum**	$6,000 per year $12,000 per year	$12,000 per year $24,000 per year
• The Out-of-Pocket Maximum includes the Annual Deductible. • Individual Out-of-Pocket maximum apply when Family coverage is elected. • 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.	50% after Deductible has been met.
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 Out-of-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	Out-of-Network Benefits
Ambulance Services – Emergency and Non-Emergency		
• Emergency	80% after Deductible has been met.	
• Non-Emergency	80% after Deductible has been met.	50% after Deductible has been met.
	Prior Authorization is required for Non-Emergency Ambulance.	
Dental Services – Accident Only		
	80% after Deductible has been met; Network or Out-of-Network.	
Durable Medical Equipment (DME)		
Benefits are limited as follows: *A single purchase of a type of Durable Medical Equipment (including repair*	80% after Deductible has been met.	50% after Deductible has been met.

Types of Coverage	Network Benefits	Out-of-Network Benefits
and replacement) every three years. This limit does not apply to wound vacuums.	*Prior Authorization is required for Out-of-Network Durable Medical Equipment*.	
Emergency Health Services - Outpatient		
	80% after Deductible has been met; Network or Out-of-Network.	
Home Health Care		
Benefits are limited as follows: 60 visits per calendar year network and Out-of-Network combined.	80% after Deductible has been met.	50% after Deductible has been met.
	Prior Authorization is required for certain services.	
Hospice Care		
	80% after Deductible has been met.	50% after Deductible has been met.
	Prior Authorization is required for Inpatient Stay.	
Hospital – Inpatient Stay		
	80% after Deductible has been met.	50% after Deductible has been met. There is an additional $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.	50% after Deductible has been met.
	Prior Authorization is required for Out-of-Network sleep studies.	
Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine - Outpatient		
	80% after Deductible has been met.	50% after Deductible has been met.
	Prior Authorization is required for certain services.	
Mental Health Services		
• **In-Patient**	80% after Deductible has been met.	50% after Deductible has been met. There is an additional $250 copay per admission
• **Out-Patient & Intensive Outpatient Therapy**	80% after Deductible has been met.	50% after Deductible has been met.
• **Office Visit (*in person or virtual*)**	100% after Deductible has been met.	50% 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.	50% after Deductible has been met.
Physician Fees for Surgical and Medical Services		
	80% after Deductible has been met.	50% after Deductible has been met.
Physician's Office Services – Sickness and Injury		
• **Primary Physician Office Visit**	80% after Deductible has been met.	50% after Deductible has been met.
• **Specialist Physician Office Visit**	80% after Deductible has been met.	50% after Deductible has been met.
	Prior Authorization is required for Out-of-Network Breast Cancer Genetic Test Counseling (BRCA) for women at higher risk for breast cancer.	

In addition, the Deductible and Coinsurance applies when these services are done: Lab, X-Ray; CT, PET, MRI, MRA, Nuclear Medicine; Pharmaceutical Products, Scopic Procedures; Surgery; Therapeutic Treatments.

Types of Coverage	Network Benefits	Out-of-Network Benefits
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.*	
Preventive Care Services		
Covered Health Services include but are not limited to:		
• **Primary Physician Office Visit** • **Specialist Physician Office Visit** • **Lab, X-Ray or other preventive tests**	100% Deductible does not apply. 100% Deductible does not apply. 100% Deductible does not apply.	50% after Deductible has been met. Adult Preventive Care is subject to $750 paid maximum out of network per calendar year. No maximum in-network.
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.	50% after Deductible has been met.
	Prior Authorization is required for Out-of-Network Prosthetic Devices.	
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 Out-of-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.	50% 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.	50% after Deductible has been met.
	Prior Authorization for Out-of-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.	50% after Deductible has been met.
	Prior Authorization is required for certain services.	
Substance Use Disorder Services		
• **In-Patient**	80% after Deductible has been met.	50% after Deductible has been met. There is an additional $250 copay per admission
• **Out-Patient & Intensive Outpatient Therapy**	80% after Deductible has been met.	50% after Deductible has been met.
• **Office Visit (*in person or virtual*)**	100% after Deductible has been met.	50% after Deductible has been met.
	Prior Authorization is required for certain services.	

Types of Coverage	Network Benefits	Out-of-Network Benefits
Surgery – Outpatient		
	80% after Deductible has been met.	50% after Deductible has been met.
	Spine and Joint Surgeries require second surgical opinions prior to treatment.	
	Prior Authorization is required for certain services.	
Transplantation Services		
For Network Benefits, use of a designated transplant provider may be required. Please refer to the Summary Plan Description for details.	80% after Deductible has been met.	50% after Deductible has been met.
	Prior Authorization is required for certain services.	
Urgent Care Center Services		
	80% after Deductible has been met.	50% after Deductible has been met.
In addition, the Deductible and Coinsurance applies when these services are done: Lab, X-Ray; CT, PET, MRI, MRA, Nuclear Medicine; Pharmaceutical Products, Scopic Procedures; Surgery; Therapeutic Treatments.		
Virtual Visits		
• *AmWell, Doctor on Demand or Teladoc Consultations* • *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 the telephone number on your ID card.*	100% after Deductible has been met. 80% after Deductible has been met.	Out-of-Network Benefits are not available.
	Access to Virtual Visits and prescription services may not be available in all states or for all groups.	

PRESCRIPTION DRUG HIGHLIGHTS – ADMINISTERED BY EXPRESS SCRIPTS

Mandatory Generic. When a covered Prescription Brand Drug that has a generic equivalent available, is dispensed at your, or your provider's request, you are responsible for the applicable Non-Preferred Brand cost-share described below, plus any cost difference between the generic and the brand product. This ancillary charge does not apply to any Out-of-Pocket expense.

Types of Coverage	Network Benefits	Out-of-Network Benefits
Annual Deductible		
Prescription Drug Deductible • **Individual Deductible** • **Family Deductible**	Medical Deductible Applies Medical Deductible Applies	No Benefit
Affordable Care Act Preventive Drugs		
Examples Include: Aspirin products, fluoride products, folic acid products, contraceptive methods, smoking cessation products, vaccines, bowel preps and primary prevention of breast cancer.		
• **Generic Retail or Home Delivery**	$0 Copay; 100% (no applied Annual Deductible)	No Benefit

Types of Coverage	Network Benefits	Out-of-Network Benefits
Expanded Preventive Drugs		
Maintenance drugs to treat conditions such as high blood pressure, high cholesterol, diabetes[1], asthma and more.		
• **Generic Retail or Home Delivery**	$0 Copay; 100% (no applied Annual Deductible)	No Benefit
Non-Preventive, Non-Specialty Prescription Drugs		
All other covered non-specialty drugs		
Retail Drugs up to 30-day supply • **Generic** • **Preferred Brand** • **Non-Preferred Brand**	 $15 Copay, after Annual Deductible $50 Copay, after Annual Deductible $90 Copay, after Annual Deductible	No Benefit
Retail Drugs Extended Supply Network; 90-day supply or Home Delivery • **Generic** • **Preferred Brand** • **Non-Preferred Brand**	$45 Copay, after Annual Deductible $150 Copay, after Annual Deductible $270 Copay, after Annual Deductible	No Benefit
Specialty Prescription Drug		
• **Specialty Medications (***filled by Accredo***)**	$200 Copay, after Annual Deductible	No Benefit
	Cost Share Assistance Program provided by PillarRx	

[1] Diabetic insulin medications include Generic and Preferred Brand drugs.