Brown & Brown INSURANCE®

Choice Plus Copay
Harvard Pilgrim

Brown & Brown, Inc.

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.

MEDICAL PLAN HIGHLIGHTS – ADMINISTERED BY UNITEDHEALTHCARE

Types of Coverage	Network Benefits	Out-of-Network Benefits
Annual Deductible		
Individual Deductible **Family Deductible**	$750 per year $1,500 per year	$3,000 per year $6,000 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**	$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. • 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		
• $0 Office and Virtual Visit for Mental Health and Substance Abuse Disorder • $0 UHC Designated 24/7 Virtual Care • Primary Care Provider: $25 (in-person, telemedicine, virtual or UHC Virtual Primary Care) • Specialist: $50 (in-person, UHC Designated Virtual Specialty Care or telemedicine visits/virtual care) • Urgent Care: $40 (in-person or telemedicine visits) • Emergency Visit: $400, waived if admitted • 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 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.	60% after Deductible has been met.
	Prior Authorization is required for Non-Emergency Ambulance.	

Types of Coverage	Network Benefits	Out-of-Network Benefits
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 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 Out-of-Network Durable Medical Equipment.	
Emergency Health Services - Outpatient		
	100% after you pay a $400 Copay per visit. 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.	
Fertility		
Conditional annual and lifetime limits and treatment limits apply, see Summary Plan Description for complete details. Enrollment and participation in the UHC Fertility Solutions program is required.	80% after Deductible has been met.	Out-of-Network Benefits are not available.
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.	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 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.	60% 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.	60% after Deductible has been met.
	Prior Authorization is required for certain services.	
Mental Health Services		
• **In-Patient**	80% after Deductible has been met.	60% after Deductible has been met. There is an additional $250 copay per admission.
• **Out-Patient & Intensive Outpatient Therapy**	80% after Deductible has been met.	60% after Deductible has been met.
• **Office Visit *(in person or virtual)***	100%, Deductible and copay do not apply	60% after Deductible has been met.
	Prior Authorization is required for certain services.	

Types of Coverage	Network Benefits	Out-of-Network Benefits
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 $25 Copay per visit.	60% after Deductible has been met.
• **Specialist Physician Office Visit**	100% after you pay a $50 Copay per visit.	60% 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 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.*	
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 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* • *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, and 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 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.	60% after Deductible has been met.
	Prior Authorization is required for certain services.	
Substance Use Disorder Services		
• **In-Patient**	Platinum Preferred Network Substance Abuse Provider: 100%, deductible and coinsurance do not apply. Other In-Network Provider: 80% after deductible.	60% after Deductible has been met. There is an additional $250 copay per admission.
• **Out-Patient Outpatient Therapy**	80% after Deductible has been met.	60% after Deductible has been met.
• **Office Visit *(in person or virtual)***	100%, Deductible and copay do not apply	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.
	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.	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.		

PRESCRIPTION DRUG HIGHLIGHTS – ADMINISTERED BY EXPRESS SCRIPTS

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

Step Therapy. Helps you and your doctor choose a clinically effective lower cost medicine as the first step in treating certain health conditions. Plan Participants try less expensive clinically appropriate options before "stepping up" to more expensive medications. If you try (or have tried) a first line drug and it does not work for you, you may receive coverage for a non-preferred drug that your doctor prescribes.

Generic Diabetic Drugs. Covered at 100% with no required copayment.

Types of Coverage	Network Benefits	Out-of-Network Benefits
Annual Deductible		
Prescription Drug Deductible • **Individual Deductible** • **Family Deductible**	 None None	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.
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 $50 Copay $90 Copay	No Benefit.
Retail Drugs Extended Supply Network; 90-day supply or Home Delivery • **Generic** • **Preferred Brand** • **Non-Preferred Brand**	 $45 Copay $150 Copay $270 Copay	No Benefit.
Specialty Prescription Drug		
• **Specialty Medications (***filled by Accredo***)**	$200 Copay	No Benefit.
	Cost Share Assistance Program provided by PillarRx.	