2019 Medical Plan Comparison Summary

Your share of covered expenses

MEDICAL COVERAGE	HSA SILVER PLAN[1]	HSA GOLD PLAN[1]	POS PLATINUM PLAN[1]
Medical coverage under all three medical plans is administered by a single carrier in each state: **Aetna**, **BlueCross BlueShield of Illinois**, or **UnitedHealthcare**. "Network" = that carrier's network.			
In-Network Preventive Care[2]	$0 (no deductible)	$0 (no deductible)	$0 (no deductible or copay)
Annual Deductible[3] *In-Network*	• $1,750 Individual • $3,500 Family	• $1,500 Individual • $3,000 Family	• $300 Individual • $600 Family
Out-of-Network	• $1,750 Individual • $3,500 Family	• $1,500 Individual • $3,000 Family	• $600 Individual • $1,200 Family
Coinsurance *In-Network* *Out-of-Network*	20% after deductible 40% after deductible	20% after deductible 40% after deductible	20% after deductible 40% after deductible
Annual Out-of-Pocket Maximum[3] *In-Network*	• $4,000 Individual • $7,350 Family (includes deductible)	• $3,000 Individual • $6,000 Family (includes deductible)	• $2,250 Individual • $4,500 Family (includes deductible)
Out-of-Network	• $4,000 Individual • $7,350 Family	• $3,000 Individual • $6,000 Family	• $6,000 Individual • $12,000 Family
Lifetime Plan Maximum	Unlimited	Unlimited	Unlimited
Physician Services Primary care/office visits, diagnostic and lab, specialist visit *In-Network*	20% after deductible	20% after deductible	Office: $25 copayment Specialist visit: $50 copay Laboratory facility: 20% after deductible
Out-of-Network	40% after deductible	40% after deductible	40% after deductible
Hospital Services Facility fee, physician/surgeon fees *In-Network* *Out-of-Network*	20% after deductible 40% after deductible	20% after deductible 40% after deductible	20% after deductible 40% after deductible
Emergency Room Services *In-Network* *Out-of-Network*	20% after deductible[4] 20% after deductible	20% after deductible[4] 20% after deductible	$150/visit copay (waived if admitted)
Fertility Treatment *In-Network* *Out-of-Network*	20% after deductible 40% after deductible $25,000 lifetime medical maximum	20% after deductible 40% after deductible $25,000 lifetime medical maximum	20% after deductible 40% after deductible $25,000 lifetime medical maximum
Other Services Hospice care, home health care and outpatient surgery *In-Network* *Out-of-Network*	20% after deductible 40% after deductible	20% after deductible 40% after deductible	20% after deductible 40% after deductible

New in 2019

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2019 Medical Plan Comparison Summary *continued*

PRESCRIPTION DRUG COVERAGE	Your share of covered expenses		
	HSA SILVER PLAN[1]	**HSA GOLD PLAN[1]**	**POS PLATINUM PLAN[1]**
Administered by: **Express Scripts** (ESI). "Network" = ESI network			
Annual Deductible *In- and Out-of-Network*	Combined with medical plan deductible	Combined with medical plan deductible	None
Retail Pharmacy *In-Network* Generics	• **Preventive maintenance:** $5 copay (no deductible[5]) • **Non-preventive:** $5 copay after medical plan deductible	• **Preventive maintenance:** $0 (no deductible[5]) • **Non-preventive:** $5 copay after medical plan deductible	• **Preventive maintenance:** $5 copay (no deductible[5]) • **Non-preventive:** $5 copay
Brand Formulary	25% of cost or $20 minimum copay after medical plan deductible	25% of cost or $20 minimum copay after medical plan deductible	25% of cost ($20 minimum)
Brand Non-Formulary	25% of cost or $45 minimum copay after medical plan deductible	25% of cost or $45 minimum copay after medical plan deductible	25% of cost ($45 minimum)
Retail Pharmacy *Out-of-Network* Generics	70% of cost or $5 minimum copay after medical plan deductible	70% of cost or $5 minimum copay after medical plan deductible	70% of cost ($5 minimum)
Brand Formulary	70% of cost or $20 minimum copay after medical plan deductible	70% of cost or $20 minimum copay after medical plan deductible	70% of cost ($20 minimum)
Brand Non-Formulary	70% of cost or $45 minimum copay after medical plan deductible	70% of cost or $45 minimum copay after medical plan deductible	70% of cost ($45 minimum)
Home Delivery *In-Network* Generics	• **Preventive maintenance:** $10 copay (no deductible[5]) • **Non-preventive:** $10 copay after medical plan deductible	• **Preventive maintenance:** $0 (no deductible[5]) • **Non-preventive:** $10 copay after medical plan deductible	• **Preventive maintenance:** $10 copay (no deductible[5]) • **Non-preventive:** $10 copay
Brand Formulary	20% of cost or $40 minimum copay after medical plan deductible	20% of cost or $40 minimum copay after medical plan deductible	20% of cost or ($40 minimum)
Brand Non-Formulary	20% of cost or $90 minimum copay after medical plan deductible	20% of cost or $90 minimum copay after medical plan deductible	20% of cost or ($90 minimum)
Fertility Prescription Drugs	$15,000 lifetime maximum	$15,000 lifetime maximum	$15,000 lifetime maximum
Annual Out-of-Pocket Maximum *In- and Out-of-Network*	Combined with medical plan out-of-pocket maximum	Combined with medical plan out-of-pocket maximum	• $2,250 per person retail and home delivery combined (up to four times the maximum amount) • $9,000 Family

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2019 Medical Plan Comparison Summary *continued*

BEHAVIORAL HEALTH SERVICES	Your share of covered expenses		
	HSA SILVER PLAN[1]	**HSA GOLD PLAN[1]**	**POS PLATINUM PLAN[1]**
Administered by: **OptumHealth Behavioral Solutions**. "Network" = Optum's network			
Annual Deductible *In- and Out-of-Network*	Combined with medical plan deductible	Combined with medical plan deductible	Combined with medical plan deductible
Outpatient *In-Network* *Out-of-Network*	20% after deductible 40% after deductible	20% after deductible 40% after deductible	$25 copay (no deductible) 40% after deductible
Inpatient *In-Network* *Out-of-Network*	20% after deductible 40% after deductible	20% after deductible 40% after deductible	20% after deductible 40% after deductible
Annual Out-of-Pocket Maximum *In- and Out-of-Network*	Combined with medical plan out-of-pocket maximum	Combined with medical plan out-of-pocket maximum	Combined with medical plan out-of-pocket maximum

VIRTUAL MEDICINE	Your share of covered expenses		
	HSA SILVER PLAN[1]	**HSA GOLD PLAN[1]**	**POS PLATINUM PLAN[1]**
Administered by: Your medical plan carrier			
Aetna	Approximately $40/visit, then 80% after deductible is met	Approximately $40/visit, then 80% after deductible is met	$25
BlueCross BlueShield of Illinois	Approximately $44/visit, then 80% after deductible is met	Approximately $44/visit, then 80% after deductible is met	$25
UnitedHealthcare	Approximately $49/visit, then 80% after deductible is met	Approximately $49/visit, then 80% after deductible is met	$25

HEALTH SAVINGS ACCOUNT (HSA)	HSA SILVER PLAN[1]	HSA GOLD PLAN[1]	POS PLATINUM PLAN[1]
Administered by: **Alight Smart-Choice Accounts** (formerly named Your Spending Account)			
Grainger's Annual Health Savings Account (HSA) Contribution (pro-rated and based on pay schedule)	Not applicable	• $500 Individual • $750 Individual + Spouse/ Partner or Individual + Child(ren) • $1,000 Family	Not applicable
Your Maximum Annual HSA Contribution (includes Grainger's contribution)	• $3,500 Individual • $7,000 Family Age 55+ can make an additional $1,000 catch-up contribution	• $3,000 Individual • $6,250 Individual + Spouse/ Partner or Individual + Child(ren) • $6,000 Family Age 55+ can make an additional $1,000 catch-up contribution	Not applicable

New in 2019

2019 Medical Plan Comparison Summary *continued*

FLEXIBLE SPENDING ACCOUNT (FSA)

Administered by: **Alight Smart-Choice Accounts** (formerly named Your Spending Account)

Your Maximum Annual Dental & Vision FSA Contribution	$250 – $2,650

New in 2019

[1] Team members outside the continental U.S. have one medical plan option.

[2] Preventive Care includes visits such as your annual physical, well woman exam, checkups for your dependent children and flu shots. Flu shots are available at your doctor or in-network pharmacy through Express Scripts for covered team members or on-site at some Grainger locations. Preventive care received from out-of-network providers is not covered under the HSA Silver and Gold Plans. Certain restrictions apply to out-of-network preventive care under the POS Platinum Plan.

[3] If you cover one or more dependents under the HSA Silver Plan or HSA Gold Plan, the family Annual Deductible / Annual Out-of-Pocket Maximum must be satisfied; individual limits do not apply.

[4] If not an emergency, benefits reduced to 50%.

[5] Grainger's medical plans cover: 100% of in-network preventive care services and 100% of preventive generic drugs (per health care reform), the plans also cover preventive maintenance generic drugs used to avoid acute episodes from chronic conditions at 100% under the Gold plan and with a $5 copay under the Silver and Platinum plans, with no deductible.

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