Click for 2019 Plan Comparison

2020 Medical Plan Comparison Summary

MEDICAL COVERAGE	HSA SILVER PLAN[1]	HSA GOLD PLAN[1]	POS PLATINUM PLAN[1]
	Your share of covered expenses		
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)
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*	20% after deductible	20% after deductible	20% after deductible
Out-of-Network	40% after deductible	40% 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*	20% after deductible	20% after deductible	20% after deductible
Out-of-Network	40% after deductible	40% after deductible	40% after deductible
Emergency Room Services *In-Network*	20% after deductible[4]	20% after deductible[4]	20% after deductible[4]
Out-of-Network	20% after deductible	20% after deductible	$150 copay (waived if admitted)
Fertility Treatment *In-Network*	20% after deductible	20% after deductible	20% after deductible
Out-of-Network	No out-of-network coverage	No out-of-network coverage	No out-of-network coverage
Other Services Hospice care, home health care and outpatient surgery *In-Network*	20% after deductible	20% after deductible	20% after deductible
Out-of-Network	40% after deductible	40% after deductible	40% after deductible

2020 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 after medical plan deductible
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 copay (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 copay after medical plan deductible
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

2020 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
	Applied Behavioral Analysis (ABA) Therapies Coverage: For team members and family members with Autism Spectrum Disorder who are enrolled in the Silver, Gold or Platinum medical plan, Applied Behavioral Analysis (ABA) therapies will now be covered under Optum's Behavioral Health program.		
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

New in 2020

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

2020 Medical Plan Comparison Summary *continued*

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	• $3,550 Individual • $7,100 Family Age 55+ can make an additional $1,000 catch-up contribution	• $3,050 Individual • $6,350 Individual + Spouse/ Partner or Individual + Child(ren) • $6,100 Family Age 55+ can make an additional $1,000 catch-up contribution *Your maximum reflects Grainger's contribution to your account*	Not applicable

New in 2020

FLEXIBLE SPENDING ACCOUNT (FSA)

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

Your Maximum Annual Dental & Vision FSA Contribution	$250 – $2,700

New in 2020

[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.