2021 Medical Plan Comparison Chart

Click for 2020 Plan Comparison

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. Behavioral health services are now administered by your medical plan carrier.

MEDICAL COVERAGE	Silver Plan[1]	Gold Plan[1]	Platinum Plan[1]
	Your share of covered expenses		
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* *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 Benefit Maximum	Eligible plan benefits are unlimited	Eligible plan benefits are unlimited	Eligible plan benefits are unlimited
Physician Services Primary care/office visits (including behavioral health therapy, diagnostic and lab, specialist visits) *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[4]	20% after deductible[4] 20% after deductible[4]	20% after deductible[4] $150 copay (waived if admitted)[4]
Fertility Treatment *In-Network (Subject to $25,000 lifetime benefit maximum)* *Out-of-Network*	20% after deductible No out-of-network coverage	20% after deductible No out-of-network coverage	20% after deductible No out-of-network coverage
Other Services Behavioral health 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

GRAINGER

2021 Medical Plan Comparison Chart *continued*

PRESCRIPTION DRUG COVERAGE	Silver Plan[1]	Gold Plan[1]	Platinum Plan[1]
Administered by: **Express Scripts** (ESI). "Network" = ESI network			
	Your share of covered expenses		
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 benefit maximum	$15,000 lifetime benefit maximum	$15,000 lifetime benefit 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

2021 Medical Plan Comparison Chart *continued*

VIRTUAL MEDICINE	Silver Plan[1]	Gold Plan[1]	Platinum Plan[1]
Administered by: **Doctor On Demand®** Online: DoctorOnDemand.com/Grainger			
	Your share of covered expenses		
Your share of covered expenses	$10/visit, after deductible is met (Before the deductible is met, costs generally range $49 – $229 per visit, depending on the type of visit)	$10/visit, after deductible is met (Before the deductible is met, costs generally range $49 – $229 per visit, depending on the type of visit)	$10/visit

HEALTH SAVINGS ACCOUNT (HSA)	Silver Plan[1]	Gold Plan[1]	Platinum Plan[1]
Administered by: **Alight Smart-Choice Accounts**			
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	• $3,600 Individual • $7,200 Family Age 55+ can make an additional $1,000 catch-up contribution	• $3,100 Individual • $6,450 Individual + Spouse/ Partner or Individual + Child(ren) • $6,200 Family Age 55+ can make an additional $1,000 catch-up contribution *Your maximum reflects Grainger's contribution to your account*	Not applicable

FLEXIBLE SPENDING ACCOUNT (FSA)	
Administered by: **Alight Smart-Choice Accounts**	
Your Maximum Annual Dental & Vision FSA Contribution	$250 – $2,750

[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.