2018 Medical Plan Options Summary

MEDICAL COVERAGE	Your share of covered expenses 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 *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 *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 40% after deductible	20% after deductible 40% after deductible	$150/visit copay (waived if admitted)
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
Administered by: OptumHealth Behavioral Solutions. "Network" = their network.			
Behavioral Health Services[3] 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
Behavioral Health Services[3] Inpatient *In-Network* *Out-of-Network*	20% after deductible 40% after deductible	20% after deductible 40% after deductible	20% after deductible 40% after deductible

GRAINGER

2018 Medical Plan Options 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 health plan deductible[4]	Combined with health plan deductible[4]	None
Retail Pharmacy *In-Network* Generics	• **Preventive maintenance:** $5 copay (no deductible[5]) • **Non-preventive:** $5 copay after health plan deductible	• **Preventive maintenance:** $0 (no deductible[5]) • **Non-preventive:** $5 copay after health plan deductible	• **Preventive maintenance:** $5 copay (no deductible[5]) • **Non-preventive:** $5 copay
Brand Formulary	25% of cost or $20 minimum copay after health plan deductible	25% of cost or $20 minimum copay after health plan deductible	25% of cost ($20 minimum)
Brand Non-Formulary	25% of cost or $45 minimum copay after health plan deductible	25% of cost or $45 minimum copay after health plan deductible	25% of cost ($45 minimum)
Retail Pharmacy *Out-of-Network* Generics	70% of cost or $5 minimum copay after health plan deductible	70% of cost or $5 minimum copay after health plan deductible	70% of cost ($5 minimum)
Brand Formulary	70% of cost or $20 minimum copay after health plan deductible	70% of cost or $20 minimum copay after health plan deductible	70% of cost ($20 minimum)
Brand Non-Formulary	70% of cost or $45 minimum copay after health plan deductible	70% of cost or $45 minimum copay after health plan deductible	70% of cost ($45 minimum)
Home Delivery *In-Network* Generics	• **Preventive maintenance:** $10 copay (no deductible[5]) • **Non-preventive:** $10 copay after health plan deductible	• **Preventive maintenance:** $0 (no deductible[5]) • **Non-preventive:** $10 copay after health plan deductible	• **Preventive maintenance:** $10 copay (no deductible[5]) • **Non-preventive:** $10 copay
Brand Formulary	20% of cost or $40 minimum copay after health plan deductible	20% of cost or $40 minimum copay after health plan deductible	20% of cost or ($40 minimum)
Brand Non-Formulary	20% of cost or $90 minimum copay after health plan deductible	20% of cost or $90 minimum copay after health plan deductible	20% of cost or ($90 minimum)
Annual Out-of-Pocket Maximum *In- and Out-of-Network*	Combined with health plan deductible	Combined with health plan deductible	• $2,250 per person retail and home delivery combined (up to four times the maximum amount) • $9,000 Family

2018 Medical Plan Options Summary *continued*

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[6]	Approximately $40[6]	$25
BCBS of Illinois	Approximately $40[6]	Approximately $40[6]	$25
UnitedHealthcare	Approximately $40[6]	Approximately $40[6]	$25

HEALTH SAVINGS ACCOUNT (HSA)	HSA SILVER PLAN[1]	HSA GOLD PLAN[1]	POS PLATINUM PLAN[1]
Administered by: Your Spending Account			
Grainger's Annual Health Savings Account (HSA) Contribution[7]	Not applicable	• $500 Individual • $750 Individual + Spouse/ Domestic Partner or Individual + Child(ren) • $1,000 Family	Not applicable
Your Maximum Annual HSA Contribution (includes Grainger's contribution)	• $3,450 Individual • $6,900 Family Age 55+ can make an additional $1,000 catch-up contribution	• $2,950 Individual • $6,150 Individual + Spouse/ Domestic Partner or Individual + Child(ren) • $5,900 Family Age 55+ can make an additional $1,000 catch-up contribution	Not applicable

DENTAL & VISION FLEXIBLE SPENDING ACCOUNT	
Administered by: Your Spending Account	
Your annual contribution	$250 – $2,600

[1] The HSA Silver Plan, HSA Gold Plan and POS Platinum Plan do not apply to team members in Hawaii (Kaiser Permanente), Puerto Rico (Triple-S) or Guam (SelectCare).
[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] For Behavioral Health Services, the deductible and out-of-pocket maximum is combined with the health plan amounts.
[4] The health plan deductible includes medical, prescription drug and behavioral health costs.
[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 at 100% under the Gold plan and with a $5 copay under the Silver and Platinum plans, with no deductible.
[6] Varies by provider state. Contact the medical plan carrier regarding certain state and service exclusions. The cost will count toward your deductible.
[7] Grainger's contribution will be pro-rated during the year based on your pay schedule.