2021 Medical Plan Comparison Chart

MEDICAL COVERAGE	Silver Plan[1]	Gold Plan[1]	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. Behavioral health service providers are now available through your medical plan network. However, free EAP and Work/Life services are still provided through Optum, whether or not you have Grainger medical coverage.			
	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 unless stated otherwise	Eligible plan benefits are unlimited unless stated otherwise	Eligible plan benefits are unlimited unless stated otherwise
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]	$150 copay
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

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

EXPERT MEDICAL OPINION			
Administered by: **2nd.MD**			
Your share of covered expenses	$0	$0	$0

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.

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