A COMPARISON OF NATIONAL GRID HEALTH BENEFITS FOR EMPLOYEES REPRESENTED BY LOCAL 101: Corporate Utility, Customer Operations & NG Energy Management

This is a summary of the major benefits offered by each health care plan and also provides employee contributions/costs effective January 1, 2017 to December 31, 2017.

MEDICAL PLAN COMPARISON: HOW PLANS COVER SERVICES

	Consumer Driven Health Plan** (Blue Cross Blue Shield)		GHI Premier PPO Plan		GHI Standard PPO Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
GENERAL PROVISIONS						
Annual deductible	$1,550/individual $3,100/family	$3,100/individual $6,200/family	$250/individual $500/family	$500/individual $1,000/family	$400/individual $800/family	$800/individual $1,600/family
Benefit level (what the plan pays for most eligible expenses)	Plan pays services at 90% after you satisfy the deductible, you pay 10%	Plan pays services at 70% after you satisfy the deductible, you pay 30%	Plan pays services at 95% after you pay the deductible, you pay 5% or 100% after your co-payment	Plan pays services at 70% after you satisfy the deductible, you pay 30%	Plan pays services at 90% after you satisfy the deductible, you pay 10%	Plan pays services at 70% after you satisfy the deductible, you pay 30%
Annual out-of-pocket maximum (including deductible, medical & Rx co-payments and coinsurance)	$2,700/individual $5,400/family	$5,400/individual $10,800/family	$1,900/individual $3,800/family	$3,800/individual $7,600/family	$2,400/individual $4,800/family	$4,800/individual $9,600/family
Maximum lifetime benefit per individual	None	None	None	None	None	None
Dependent coverage	Until December 31 of the year in which the child attains age 26					
Inpatient covered services	90%*	70%*	95%*	70%*	90%*	70%*
Health Savings Account Contribution from National Grid	$750/individual $1,500/family		N/A		N/A	
OUTPATIENT COVERED SERVICES						
Preventive care visits	100% (subject to schedule)	70%*	100%(subject to schedule)	70%*	100% (subject to schedule)	70%*
Primary care office visits	90%*	70%*	100% after $30 co-payment per visit	70%*	100% after $40 co-payment per visit	70%*
Telehealth* **	90%*		Telehealth not available			
Specialist office visits, including urgent care	90%*	70%*	100% after $40 co-payment per visit	70%*	100% after $60 co-payment per visit	70%*
Outpatient surgery and pre-admission testing	90%*	70%*	95%*	70%* of the average in-network hospital payment	100% after $100 co-payment	70%*
Routine vision (one per calendar year)	100%	70%*	100%	100% of in-network payment covered; responsible for any charge exceeding this payment	100%	Member reimbursed 100% of in-network payment. Member is responsible for any excess of this payment
Routine hearing exams	100%	70%*	100%	70%*	100%	70%*
Diagnostic lab, X-ray and advanced radiology	90%*	70%*	95%*	70%*	95%*	70%*
MENTAL HEALTH AND SUBSTANCE ABUSE						
Inpatient	90%*	70%*	95%*	70%*	90%*	70%*
Outpatient	90%*	70%*	100% after $30 co-payment	70%*	100% after $40 co-payment	70%*

MATERNITY BENEFITS						
Prenatal care	100%	70%*	100% after $30 co-payment for initial visit	70%*	100% after $40 co-payment for initial visit	70%*
In-hospital delivery and well-baby visit	90%* Well-Baby 100%	70%*	95%*	70%*	90%*	70%*
EMERGENCY ROOM CARE						
	90%*	90%*	95%*	95%*	90%*	90%*

*After you satisfy the deductible.
** The deductibles and out-of-pocket maximums cross accumulate across in- and out-of-network.
*** Telehealth is only available to BCBS members.

Prescription Drug Coverage

When you enroll in medical coverage through National Grid you will automatically receive prescription drug coverage through CVS Caremark.

PRESCRIPTION DRUG COVERAGE

Note: Your prescription drug carrier uses a formulary drug list of approved medications. Consult with your physician regarding the use of the formulary.

	RETAIL (30-DAY SUPPLY)	MAIL ORDER (90-DAY SUPPLY)
GHI PREMIER PPO PLAN		
Generic (Tier I)	$10	$20
Formulary Brand (Tier II)	$35	$70
Non-Formulary Brand (Tier III)	$60	$120
GHI STANDARD PPO PLAN		
Generic (Tier I)	$10	$20
Formulary Brand (Tier II)	$35	$70
Non-Formulary Brand (Tier III)	$60	$120
BCBS CONSUMER DRIVEN HEALTH PLAN		
Generic (Tier I)	10% after deductible	10% after deductible
Formulary Brand (Tier II)	10% after deductible	10% after deductible
Non-Formulary Brand (Tier III)	10% after deductible	10% after deductible

Mandatory mail order (picked up at retail or via mail) for maintenance drugs, generic step therapy and specialty preferred drug therapy applies to all plans.
Note: Prior Authorization may be required for certain medications.

MEDICAL PLAN COSTS*

MEDICAL COSTS (Including Prescription Drug Coverage)	CONSUMER DRIVEN HEALTH PLAN (Blue Cross Blue Shield)		GHI PREMIER PPO PLAN		GHI STANDARD PPO PLAN	
	Individual	Family	Individual	Family	Individual	Family
Monthly Cost Summary						
Employee pays	$65.00	$173.33	$186.33	$416.00	$117.00	$238.33
Weekly Cost Summary						
Employee pays	$15.00	$40.00	$43.00	$96.00	$27.00	$55.00

* Deducted in pre-tax dollars.

A COMPARISON OF NATIONAL GRID HEALTH BENEFITS FOR EMPLOYEES REPRESENTED BY LOCAL 101: Corporate Utility, Customer Operations & NG Energy Management

This is a summary of the major benefits offered by each health care plan and also provides employee contributions/costs effective January 1, 2017 to December 31, 2017.

MEDICAL PLAN CONTACT INFORMATION

If you need more information about each plan, contact the plan directly at the phone numbers and websites listed below.

CUSTOMER SERVICE TELEPHONE NUMBERS AND WEBSITES FOR EACH PLAN			
	BCBS Consumer Driven Health Plan	**Health Equity for Health Savings Account**	**GHI PPO**
For a provider directory, service area map or more information call:	1-800-287-8757	1-866-346-5800	1-800-624-2414
Or visit their Web site at:	www.bluecrossma.com	www.healthequity.com	www.emblemhealth.com
For Telehealth, call American Well:	1-888-247-2583		Telehealth not available
Or visit their Web site at:	www.bluecrossma.com/wps/portal/members/home/		
For CVS Caremark, call 1-800-378-8826 or go to www.caremark.com			

DENTAL PLAN

Each time you need care, you choose to receive care from an in- or out-of-network provider.

DENTAL PLAN: HOW THE PLAN PAYS BENEFITS		
General Provisions	In-Network*	Out-of-Network
Annual Deductible (per individual/family)	$25	$25
Maximum Annual Benefit**	$2,000 per individual	$2,000 per individual
Type I: Diagnostic and Preventive Care • Exams and cleanings (once every 6 months) • X-rays (up to 4 bitewings per calendar year, 1 panoramic film every 3 years) • Fluoride for children under 19 (once per calendar year) • Space maintainers (1 per child per lifetime up to age 19)	Plan pay 100% Preferred Schedule (not subject to deductible)	Plan pay 100% Preferred Schedule (not subject to deductible)
Type II: Basic Restorative Services • Fillings • Oral surgery • Extractions • Root canal therapy • Treatment of gum disease (periodontal treatment)	Plan pay 100% Preferred Schedule	Plan pay 100% Preferred Schedule
Type III: Major Restorative Services • Crowns • Dentures • Bridgework	Plan pay 100% Preferred Schedule	Plan pay 100% Preferred Schedule
Dependent coverage	Dependents covered to age 19	
Children's Orthodontia		
Orthodontia (coverage for dependent children up to age 19 and to age 25 for a sponsored dependent)***	100% Preferred Schedule, $1,998 lifetime maximum per individual	

* Member is reimbursed the applicable percentage (%) of the Preferred Schedule. Member is responsible for any dental charges that exceed this payment.
** Combined in and out-of-network services cannot exceed $2,000 per individual in a calendar year.
*** Combined in and out-of-network services cannot exceed $1,998 per individual per lifetime.

DENTAL PLAN COSTS*

GHI DENTAL			
	Individual	Family	Sponsored Dental - Individual
Monthly Cost Summary			
Employee pays	$0	$0	$17.07
Weekly Cost Summary			
Employee pays	$0	$0	$3.94

* Deducted in pre-tax dollars.

DENTAL PLAN CONTACT INFORMATION

For more information about dental plan benefits, contact GHI directly at 1-800-624-2414, or visit www.emblemhealth.com.