nationalgrid

Empowered Decisions. Healthy Outcomes.

OPEN ENROLLMENT **2017**

2017 **Benefits** Enrollment Guide

FOR NATIONAL GRID REPRESENTED EMPLOYEES

Local 101

What's Inside

Welcome to 2017 Open Enrollment!

As an employee of National Grid, you have access to a range of quality benefit options so you can get the coverage you need for yourself and your eligible family members. Open Enrollment is your annual opportunity to reassess your health care, life insurance and other benefit needs — by considering how you used your benefits in 2016 and how your needs may change in 2017.

Open Enrollment will begin on Tuesday, October 11 at 8 a.m. and end on Tuesday, October 25 at 6 p.m. Eastern Time (ET) via phone and 12 midnight via Web.

This Benefits Enrollment Guide describes the benefits available to you in 2017 as well as important information on how to enroll in your benefits. Read it carefully so that you can make informed decisions that are right for you and your family. To the extent the benefits are subject to the Employee Retirement Income Security Act (ERISA), the Guide is also a Summary of Material Modifications that describes the changes in those benefits that are effective in 2017. Please keep this Guide for future reference.

BE AN ACTIVE HEALTH CARE CONSUMER

Health consumerism is an approach to health care that focuses on understanding and advocating for your own health. When you're an **active health care consumer**, *you* can play a significant role in getting the care you need to help ensure your wellbeing and quality of life. Active health care consumers:

- Understand their overall health and take steps to prevent the onset of disease
- Seek out early intervention for illness
- Ask questions, and seek opinions, about their diagnosis and treatment options
- Talk regularly, and openly, with their doctors.

As an active health care consumer, you'll find you have a better understanding of how the body works, risk factors for various medical issues and even steps you can take to improve your quality of life. You're likely to be better prepared for any aftercare needs and *less likely* to be disappointed about treatment outcomes. Most of all, you'll know **you're making informed medical decisions about all aspects of *your* health**.

For all these reasons and more, **we encourage you to be an active health care consumer and engage in your own health.** Be proactive about your health care needs, make informed lifestyle choices, seek early screening for health care issues and work with health providers to address specific concerns. National Grid's Commitment to Health and Wellbeing provides additional resources for you and your family (see page 29).

YOUR BENEFITS ENROLLMENT KIT INCLUDES:

1. This *2017 Benefits Enrollment Guide*, which describes the benefit options and how the programs work.

2. *A Comparison of National Grid Health Benefits*, a chart that summarizes how the medical plan options and the dental plan pay benefits and your cost for coverage.

Note that you will be receiving a Summary of Benefits Coverage (SBC) separately (via mail to the mailing address on file). The SBC is an easy-to-understand summary about your health plan's benefits including coverage examples.

In addition, your *2017 Personalized Enrollment Worksheet* will be mailed separately to your home (Management employees please log on to: **www.nationalgridbenefitservices.com** to access your worksheet). This worksheet includes your current coverage, your available options and your costs for 2017. If you do not receive your *2017 Personalized Enrollment Worksheet* by October 11, 2016, please contact the National Grid Benefit Services Center at 1-888-483-2123.

As in past years, after you've enrolled in your 2017 benefits, you will receive a written confirmation of your choices, and you'll have the chance to make changes before your coverage becomes effective on January 1, 2017.

Beginning October 11, please log on to: **www.nationalgridbenefitservices.com** during the Open Enrollment period to review your 2016 coverage and to make any 2017 benefit election decisions.

Got a mobile device? Your benefit information is at your fingertips.
www.nationalgridbenefitservices.com is NOW mobile friendly!

Don't Wait Until the Last Minute to Enroll!

- Look at your enrollment tools and resources as soon as possible to make your decision easy and timely.
- Avoid peak hours — during Open Enrollment, 8 a.m. to 11 a.m. ET is the busiest time for the National Grid Benefit Services Center. The best way to get your questions answered quickly is to call mid-week in the afternoon.
- Don't wait until the last minute to enroll — the last day of the enrollment period is a busy time for the online enrollment Web site and the National Grid Benefit Services Center!

What's New

The health and wellbeing of our workforce is integral to the work we do at National Grid and the service we provide to our customers. The work we do depends on your physical and mental wellbeing, which is why we strive to provide high quality, market competitive benefits to our employees and their families that are affordable, easy to access, and provide services we need to stay healthy.

As a nation, we are experiencing a shift in how the health care industry provides value to consumers due to the rising cost of health care, coupled with the requirements imposed by the Affordable Care Act (ACA). National Grid remains committed to providing you with a comprehensive and sustainable program of health and wellbeing benefits that support you and your family.

In 2017, you will continue to have access to comprehensive benefit programs along with new plan features that incorporate elements of consumerism to encourage awareness in the use, and cost of health care, along with coverage that supports National Grid's dedication to inclusion and diversity of our workforce. These services include Telehealth for Blue Cross Blue Shield members and the addition of coverage for transgender surgery across all health plans. Additional details about plan changes are included below and in the pages that follow. By continuing to work together, we can make a greater impact on future health care costs.

You will find details on your 2017 plan coverage and employee contributions in the *A Comparison of National Grid Health Benefits*.

The following is a summary of the health and welfare benefit plan modifications that become effective January 1, 2017 as negotiated under the collective bargaining agreement or as a result of regulatory and/or administrative changes.

- **Changes to the GHI Premier PPO**
  - Employee weekly contributions will increase from $38 individual/$86 family to $43 individual/$96 family

  In-Network

  - Increase annual deductible to $250 individual/$500 family
  - Decrease annual out-of-pocket maximum to $1,900 individual/$3,800 family (includes deductible, co-insurance and medical/prescription co-payments)
  - Implement 95% co-insurance after deductible for non-copayment based services, except preventive care services which will continue to be covered at 100% per the Patient Protection and Affordable Care Act (PPACA)
  - Increase office visit co-payments to $30 for primary care and $40 for specialist visits
  - Change emergency room from co-payment to 95% co-insurance after deductible
  - Increase Urgent Care Center co-payment to $40
  - Change inpatient hospital from co-payment to 95% co-insurance after deductible
  - Diagnostic testing, lab, x-ray and advanced imaging co-payment eliminated and will be covered at 95% co-insurance after deductible

  Out-of-Network

- Increase annual deductible to $500 individual/$1,000 family
- Decrease annual out-of-pocket maximum to $3,800 individual/$7,600 family
- Change emergency room from co-payment to 95% co-insurance after deductible

Change in prescription co-payment

- Increase retail prescription co-payment to $10 generic/$35 formulary/$60 non-formulary; increase mail-order prescription co-payment to $20 generic/$70 formulary/$120 non-formulary

- **Changes to the GHI Standard PPO Plan**
  - Employee weekly contributions will increase from $23 individual/$49.50 family to $27 individual/$55 family

  In-Network

  - Increase office visit co-payments to $40 for primary care and $60 for specialist visits
  - Increase urgent care center co-payment to $60
  - Diagnostic testing, lab, x-ray and advanced imaging co-payment will be eliminated and will be covered at 90% co-insurance after deductible

  Change in prescription co-payment

  - Increase retail prescription co-payment to $10 generic/$35 formulary/$60 non-formulary; increase mail-order prescription co-payment to $20 generic/$70 formulary/$120 non-formulary
- **Changes to the BCBS Consumer Driven Health Plan**

  Health Savings Account (HSA) Annual Maximum Contribution

  - HSA maximum contribution limit increases to $3,400 for individual, family maximum remains at $6,750

  Telehealth Services Offered Through BCBS Partnership with AmericanWell

  - Introduce Telehealth services for BCBS participants. Telehealth visits will be covered consistent with the in-network primary care office visit coverage level

  Fitness Reimbursement Benefit

  - Reimbursement of up to $600 (note, this is taxable) every rolling 6 months for health club membership and fitness classes at qualified health clubs (available to covered employees and spouses). Proof of 50 visits within the 6 month period will be required
- **Gender Reassignment Surgery**
  - All medical plans will include coverage for gender reassignment surgery along with prescription drugs that aid in the transition
- **Implementation of the following Prescription Drug Programs with CVS Caremark (refer to the Prescription Drug Benefits section for further information):**

  Introducing Exclusive Specialty Pharmacy Program: all specialty medications will be processed through, and delivered by the CVS Caremark Specialty Pharmacy Program. Members who receive specialty medications from another pharmacy will be contacted by Caremark to transition their medications prior to 1/1/2017.

Important Enrollment Information

You will enroll through the National Grid Benefit Services Center either online or via phone (see page 38 for instructions). You will need to enroll if you want to:

- Change your current medical and/or dental coverage
- Enroll in the Consumer Driven Health Plan (CDHP)
- Enroll in the Health Savings Account (HSA) for 2017 (CDHP participants only)
- Waive medical coverage
- Waive dental coverage
- Change the dependents you cover in the medical and/or dental plans
- Enroll in the Health Care Flexible Spending Account (HCFSA) for 2017
- Enroll in the Dependent Care Reimbursement Account (DCRA) for 2017
- Enroll in the Long-Term Disability plan
- Enroll in or change your parking and/or transit benefits
- Enroll in Legal Services.

If You Waived Medical Coverage in 2016

If you elected to waive medical coverage in 2016, and you do not enroll in medical coverage for 2017, you will have no medical coverage for 2017.

Making Changes During the Year

You can change your elections during the year only when you have a qualifying change in status even if you opt out of medical coverage during Open Enrollment. Otherwise, you will not be able to make a change until the next Open Enrollment period.

Contact the carrier directly to:

- Purchase or increase optional life insurance coverage for you, your spouse, or your children. If you would like to enroll in optional life insurance, contact MetLife at 1-866-492-6983.
- Enroll in supplemental cancer coverage for the first time. Contact Aflac by calling 1-917-532-3011.

If you do not take any action before October 25, 2016 and you are already eligible for and enrolled in subsidized medical and dental coverage, you will default into the following plan elections:

Default Benefit Plans	
Medical (If enrolled in 2016)	The coverage you had in 2016
Health Savings Account (If enrolled in 2016)	The annual contribution amount you chose in 2016
Supplemental Cancer Coverage (If enrolled in 2016)	The coverage you had in 2016
Dental (If enrolled in 2016)	The coverage you had in 2016
Flexible Spending Accounts Health Care Dependent Care	 Waive-No Coverage Waive-No Coverage
Optional Life Insurance	The coverage you had in 2016

Default Benefit Plans	
Long-Term Disability	The coverage you had in 2016
Transit Benefits	The coverage you had in 2016
Legal Services	Waive-No Coverage

WHO IS ELIGIBLE?

You are eligible to choose coverage under one of the medical plan options and to enroll in dental coverage if you are an active employee who is represented by Local 101 and you have completed the required months of service as per the governing collective bargaining agreement. Please refer to page 9.

MEDICAL

In addition to yourself, the following family members are eligible to enroll in the medical plan:

- Your legally married spouse.
- Your child(ren) who are under the age of 26, married or unmarried regardless of full-time student or tax dependent status. A child includes:
  - Natural child(ren), legally adopted child(ren) or child(ren) placed with you pending legal adoption, child(ren) for whom you or your spouse serve as legal guardian, step-child(ren), eligible foster child(ren) and child(ren) of a legally married spouse. **You must elect coverage for your legally married spouse if you want to elect coverage for his/her dependent child(ren).**
  - ***Note: Grandchild(ren) are not eligible for coverage unless adopted by you or under your legal guardianship.***
- Tax-qualified dependents as determined by the provision of the most recent required tax returns confirming federal tax dependent status as per IRS regulations.
  - Tax-qualified dependents are subject to annual re-verification based on the submission of the most recent federal tax filing confirming ongoing eligibility for coverage. Therefore, please be prepared to submit the required documentation upon request to confirm your ongoing eligibility to receive health coverage.

Medical coverage for dependent children ceases at midnight on December 31 of the year in which age 26 is attained. Coverage may be extended indefinitely if the child has been certified as disabled by your medical plan prior to his/her 26th birthday.

Important Note Regarding Dependent Eligibility

If you add dependents to your coverage, you will be required to provide documentation that verifies their eligibility. You will be contacted separately after Open Enrollment with instructions for submitting the appropriate documentation to verify eligibility. Additionally, you will be separately contacted to complete a full-time student verification form for coverage to continue for your dependents under the dental plan.

If You Want to Opt Out of Medical Coverage

If you elected to opt out of medical coverage in 2016 and you do not enroll in a medical plan during Open Enrollment, you will not receive medical benefits for 2017.

If you are adding new dependents to your 1/1/2017 coverage, you will be required to provide documentation by November 28, 2016. You can find the documentation requirements on the website at www.nationalgridbenefitservices.com under Resources.

Note: Parents and/or spouses of married dependents and child(ren) of dependents are NOT eligible for coverage.

DENTAL

In addition to yourself, the following family members are eligible to enroll:

- Your legally married spouse.
- Your dependent child(ren) including your unmarried natural child(ren), legally adopted child(ren) or child(ren) placed with you pending legal adoption, child(ren) for whom you or your spouse serve as legal guardian, eligible foster child(ren), child(ren) of a legally married spouse. **You must elect coverage for your legally married spouse if you want to elect coverage for his/her dependent child(ren).**

  Note: Grandchild(ren) are not eligible for coverage unless adopted by you or under your legal guardianship.

- Dependent child(ren) are covered until December 31 of the year in which the child attains age 19.
- Coverage for your child(ren) as defined above may be extended beyond age 19, until the end of the year in which the child reaches age 25, as long as the child is a full-time student, and you enroll the child as a “Sponsored Dependent” for coverage.
- Annual certification is required to confirm a child’s continuing full-time student status.

If you are adding new dependents to your 1/1/2017 coverage, you will be required to provide documentation by November 28, 2016. You can find the documentation requirements on the website at www.nationalgridbenefitservices.com under Resources.

WHEN YOUR COVERAGE BEGINS

The elections you make during this Open Enrollment period will take effect on January 1, 2017 and will remain in effect through December 31, 2017. Your elections are irrevocable and you can only make a change during the year if you have a qualified life event as described on page 11 of this guide.

Choose Well

Choose well means enrolling in the right benefits for you and your family. It is important for you to consider your/your family's own needs for the upcoming year when making your elections for eligible benefits. The information in this guide together with your comparison chart provides a summary overview of many benefits and highlights what's new and changing in 2017.

NEW HIRES

All full-time regular new hires are required to call 1-888-483-2123 within 31 days of first becoming eligible for either full cost or subsidized health benefits or voluntary benefits in order to make elections and ensure adequate coverage. See the chart on the next page for more information about the eligibility for certain benefits.

If you do not make a medical benefit election when you first become eligible for subsidized coverage, you will be defaulted into the GHI Standard PPO with Employee Only coverage. If you do not make a dental benefit election when you first become eligible for subsidized coverage, you will be defaulted into the dental plan with Employee Only coverage. Additionally, you will be automatically defaulted into LTD coverage upon becoming eligible. If you decide that you do not want LTD coverage, you may opt out at any time. If you do not initially enroll in coverage within 31 days of first becoming eligible, you will be subject to Evidence of Insurability if you later decide you want this coverage.

If you elect to waive medical and/or dental coverage you must contact the National Grid Benefit Services Center at 1-888-483-2123, please follow the prompts to enroll in Medical/Dental elections.

Benefit	Eligibility	
	NGEM Direct Hires	Utility & Customer Ops Employees Hired On or Before 10/15/11
Medical Plan	**Full cost** First of the month following or coincident with your date of hire **Subsidized cost** First of the month following or coincident with the completion of 60-days of employment	
Health Savings Account (HSA)	Available to those who enroll in CDHP Employee must elect the HSA in order to contribute towards the account If elected, a one-time employer contribution will be applied to the HSA (pro-rated for mid-year enrollments) See page 16 for details	
Dental Plan	**Full cost** First of the month following or coincident with your date of hire **Subsidized cost** After completion of six months of service	
Supplemental Cancer Coverage	Enroll in a supplemental policy through Aflac You must be enrolled in medical coverage to purchase this additional cancer coverage policy. Cash benefits payable under this policy are in addition to what your medical plan covers. Different policy benefit levels are available, with different premiums.	
Health Care Flexible Spending Account	After six months of service	
Dependent Care Reimbursement Account	After six months of service	
Basic Life Insurance	After six months of service: One times base salary, up to $100,000	After one year of service: $5,000 After two years of service: Two times base salary, up to $500,000 For Customer Operations Employees hired on or after October 16, 2010: One times base salary
Optional Life Insurance **Spousal Life Insurance** **Dependent Life Insurance**	After six months of service	
Basic Accidental Death and Dismemberment Coverage	After six months of service: One times annual base up to $200,000, with an additional $50,000 benefit available for an occupational loss	After six months of service: One times base salary up to $200,000, with an additional $50,000 benefit available for an occupational loss

Benefit	Eligibility	
	NGEM Direct Hires	Utility & Customer Ops Employees Hired On or Before 10/15/11
Long-Term Disability	First of the month following or coincident with the completion of three months of service	
Transit Benefits	First of the month following three months of service	
Legal Services	Available at Open Enrollment only	

PAYING FOR COVERAGE

Your *2017 Personalized Enrollment Worksheet* and *A Comparison of National Grid Health Benefits* chart include the cost for each of your medical and dental benefit options, as well as the coverage levels available to you. Optional life insurance coverage is provided through a separate enrollment with MetLife. During Open Enrollment, you may contact MetLife directly if you want to confirm your current coverage, enroll in optional life or change current elections. If you are a newly hired employee, you will receive your MetLife information with your other enrollment information and new hire documentation.

Depending on the type of benefit, your contributions will be deducted from your paycheck on a pre-tax or after-tax basis as shown in the chart below.

Pre-Tax Contributions Apply to These Benefits:	After-Tax Contributions Apply to These Benefits:
Medical Coverage	Optional Life Insurance
Health Savings Account (HSA)	Dependent Life Insurance
Supplemental Cancer Coverage	Long-Term Disability Coverage
Dental Coverage	Legal Services
Health Care Flexible Spending Account (HCFSA)	Auto/Homeowners Insurance
Dependent Care Reimbursement Account (DCRA)	
Transit Benefits	

Paying With Pre-Tax Dollars: What It Means
Paying with pre-tax dollars means that you pay less in taxes because your income is lower for tax calculation purposes. It's important to note that because you don't pay Social Security taxes on pre-tax contributions, your Social Security benefits at retirement or disability may be slightly reduced. Any reduction, however, will be minimal and will probably be offset by your current tax savings. Conversely, for tax purposes, any contributions you make for optional life insurance coverage for yourself, your spouse or your child(ren) will be deducted on an after-tax basis. As a result, any benefits received will be tax-free.

MAKING CHANGES DURING THE YEAR

The benefit elections you make during this Open Enrollment period will stay in effect throughout the 2017 calendar year. You can only make changes to your pre-tax benefits coverage outside of the Open Enrollment period if you experience one of the qualified life events listed below. Documented proof of the qualified life event(s) will be required.

Qualified life events include:

- Marriage, legal separation, divorce, birth, adoption or death of a spouse or child, or a change in the eligibility of a covered dependent
- Your spouse gains or loses employment
- You or your spouse changes from part-time to full-time employment status or vice versa
- You or your spouse takes an unpaid leave of absence
- You or your spouse experiences a significant change in health coverage due to your spouse's employment (For example, his/her employer changes payroll withholding, or he/she chooses a different medical plan or coverage during the year.)
- You move out of your medical plan's service area

The benefit change you make must reflect the change in status that you experience. For example, if you get married mid-year, you may add your spouse to your current coverage, but you may not change medical plans. **If you experience a qualifying life event, you must contact the National Grid Benefit Services Center at 1-888-483-2123 within 31 days of the event to make the change**.

Transit benefit enrollment/changes can be made on a monthly basis. See page 36 for more information.

Your 2017 Benefit Choices

National Grid's benefits program offers a broad choice of quality, affordable coverage for you and your family. This chart highlights the 2017 choices available to employees represented by Local 101. More details about each benefit follow.

Your 2017 Benefit Choices	
Medical Plan Options All plans include prescription drug coverage through CVS Caremark	• A choice between the BCBS Consumer Driven Health Plan (CDHP) with Health Savings Account (HSA), the GHI Premier PPO and the GHI Standard PPO Ability to waive medical coverage These plans cover in-network preventive care at 100% and pay for a wide range of other medically necessary services and supplies, including prescriptions, office visits, specialist visits, hospitalization and behavioral health.
Health Savings Account	• Enrollment available to CDHP participants only • Contribute up to $3,400 annually for individual coverage, and $6,750 annually for family coverage. These limits can be reached through a combination of employee and employer contributions (see *A Comparison of National Grid Health Benefits* chart for 2017 Company contribution to the HSA)
Supplemental Cancer Coverage	• Enroll in a supplemental policy through Aflac You must be enrolled in a medical coverage to purchase this supplemental policy. Cash benefits payable under this policy are in addition to what your Company-sponsored medical plan covers. Policies with various coverage types and premiums are available.
Dental Plan	• One plan option through GHI • Ability to waive dental coverage The plan pays the full cost of preventive care and other services, including fillings, crowns, periodontal care and orthodontia (for children up to age 19 only).
Flexible Spending Accounts	• **Health Care**: Contribute up to $2,550 pre-tax for eligible health care expenses. • **Dependent Care**: Contribute the following amounts pre-tax for eligible dependent care expenses; o Up to $5,000 a year if you're single or married and filing a joint tax return o Up to $2,500 if you're married and filing separately, or married and your spouse also works at National Grid and is contributing to his/her own Dependent Care Spending Account

Your 2017 Benefit Choices	
Life Insurance for Employees	**Company-Paid Basic Life Insurance** For NGEM direct hires: • One times base salary up to $100,000 For Corporate Utility employees: • $5,000 after one year of service • Two times base salary up to $500,000 after two years of service For Customer Operations employees hired on or after October 16, 2010: • One times base salary **Optional Life Insurance** • Purchase coverage up to five times your annual salary rounded to the next highest $10,000 or $250,000
Dependent Life Insurance Check with carrier for further details on eligibility and evidence of insurability requirements	• For your spouse: Purchase in increments of $10,000, cannot exceed the employee's coverage or $100,000 whichever is less ($10,000 minimum) • For your child(ren): $2,000 or $4,000
Accidental Death and Dismemberment	Basic: one times base salary up to $100,000; for Occupational-related loss, additional coverage of $50,000 is provided The Company pays the full cost of basic AD&D coverage; you are automatically enrolled.
Long-Term Disability	Monthly benefit equals 60% of your monthly base earnings. Maximum monthly benefit is $8,000; minimum is $100 or 10% of the gross benefit, whichever is greater.
Transit Benefits	Save pre-tax dollars to pay for work-related commuting expenses, including parking and mass transit fares.
Auto and Homeowners Insurance	Purchase insurance at discounted group rates.
Legal Services	Purchase access to legal services through Hyatt Legal Plans, including telephone advice and office consultations for services including will preparation and real estate closings.

Medical Plan Options

For 2017, National Grid will continue to offer the Consumer Driven Health Plan (CDHP) with Blue Cross Blue Shield (BCBS) and the choice of two Preferred Provider Organization (PPO) plans administered through GHI. Each plan covers the same wide range of health care services, and each includes prescription drug coverage.

What to Consider When Choosing Your Plan

When thinking about which plan to enroll in, it's important to consider both cost and coverage levels. Here are some questions that may help you decide:

- What do you think your health care needs will be in 2017? What are your typical health care needs? Do you or a covered family member have any chronic health conditions?
- What are your total costs under each option–including the contributions, deductibles, co-insurance, co-payments and non-covered services?
- How does your National Grid coverage compare to any other coverage you might have, such as through your spouse's plan?

Here's a Tip: Wash Up

To fend off colds, washing your hands well and often is the best step you can take. Use plain soap and water and scrub for at least 20 seconds.

THE GHI PREFERRED PROVIDER ORGANIZATION ("PPO") MEDICAL PLAN OPTIONS

You will have a choice of two medical plan options in 2017 administered by EmblemHealth – the GHI Standard PPO and the GHI Premier PPO.

Both of the GHI PPO options offer you the opportunity to choose to receive care from a provider who is part of the GHI network or from a provider outside of the network. You pay less when you use a GHI network provider.

When you use the GHI network, you do not need a referral nor do you need to choose a primary care physician (PCP). To access in-network care, simply select any provider from within GHI's network of physicians. You choose whether you need to see a specialist or generalist.

GENERALISTS AND PCPS

When you visit a participating GHI medical provider or mental health care provider, you will pay a $30 co-payment per visit in the GHI Premier Plan or a $40 co-payment in the GHI Standard Plan.

SPECIALISTS

When you visit a participating GHI specialist, you will pay a $40 co-payment per visit in the GHI Premier Plan or a $60 co-payment in the GHI Standard Plan. Specialists include dermatologists, surgeons and surgical subspecialties, including providers who practice Cardiothoracic and Thoracic Surgery, Colon and Rectal Surgery, General Surgery, Neurological Surgery, Ophthalmology, Oral Surgery, Orthopedic and Hand Surgery, Otolaryngology, Plastic Surgery, Podiatry and Podiatric Surgery, Traumatic Surgery, Urology, Vascular and Veno Surgery.

COVERAGE WHEN YOU ARE AWAY FROM HOME

Emergency treatment is covered on an in-network basis as long as you follow the guidelines of the GHI PPO option in which you are enrolled.

If you are traveling within the GHI PPO service area, simply call your Member Services to connect with a provider in your temporary location. If you are traveling outside the GHI PPO service area, you can see the doctor of your choice and receive coverage at the out-of-network level.

CONSUMER DRIVEN HEALTH PLAN (CDHP)

The CDHP provides comprehensive coverage for your medical and prescription drug needs, the flexibility of going to an in or out-of-network provider, and the benefit of saving for future health care costs. When and how you pay for services differentiates this plan from the others, including the use of a companion Health Savings Account.

With any plan, you are in charge of your health care choices and choose how best to spend your income on the health care that you need. Payroll contributions for the CDHP are lower than the PPO plans, allowing you the opportunity to contribute the cost savings to a Health Savings Account (or HSA). Through the HSA, you are saving those dollars to pay for health care expenses when they occur rather than overpaying for coverage you may or may not need.

Purchasing Power of a CDHP

The concept of "consumerism", where you take a more active role in managing your health care needs and expenses, is the driving force of the CDHP with HSA.

Awareness of the cost and quality of services matters when it comes to your health and your wallet.

How do you become a better consumer of health care?

By contributing less to your health plan through lower paycheck contributions and putting those saved contributions into an HSA – *the tool to help you save for and pay for future eligible health care expenses.*

By using your health care savings wisely through choosing high quality, cost effective health care providers.

You can find out more about the CDHP and HSA, including additional FAQs and how to make the most of your HSA, at www.bluecrossma.com/CDHPnationalgrid

A CDHP typically includes higher deductibles and out-of-pocket maximums than a traditional PPO plan. Although your out-of-pocket costs look a little different, the plan still covers the same medical and pharmacy services you would get under a tradition plan. For example:

When you join a CDHP:

- You can receive care from any doctor or specialist. By choosing a preferred provider (also called an in-network provider) for a covered service, your out-of-pocket costs will be lower than if you choose a non-preferred provider (also called an out-of-network provider).
- Some differences include when and how the plan begins to pay for your coverage:
    - Certain in-network annual preventive visits, related routine tests, and immunizations subject to a schedule are covered at 100% and no deductible or co-insurance is applied to these services.
    - For all non-preventive care services and the cost for most prescription drugs, you pay 100% of the cost up to the **annual deductible**.

- After you satisfy the deductible, you and National Grid share in the cost of medical services AND prescription drugs through co-insurance. Those in a family plan must meet the family deductible before the plan starts paying co-insurance.
- If your total expenses (deductible plus co-insurance) for in-network medical services and prescription drugs reach your in-network **out-of-pocket maximum**, National Grid will cover all eligible expenses at 100% for in-network services for the rest of the plan year.
  - The individual out-of-pocket maximum does not apply to those in a family plan. The family out-of-pocket maximum must be met by one or more family members before the plan plays 100% of future claims costs through the end of the plan year.

- If you use a non-preferred provider (doctors that do not participate in the BCBS network):
  - Your deductible and co-insurance cost will be based on allowed charges. You may be responsible for any amount that exceed allowed charges even if you hit the plan's out-of-pocket maximum.
  - You will use a BCBS claim form to submit a claim for reimbursement.

CDHP participants benefit from access to providers nationwide in the BCBS BlueCard network. Nearly all the providers National Grid employees currently use are in this network. In fact, the CDHP utilizes a larger network than the PPO plans. You can confirm that your doctor participates by checking the BCBS Web site at: **https://www.bluecrossma.com/wps/portal/members/using-my-plan/doctors-hospitals/findadoctor** and searching in the BlueCard network.

HEALTH SAVINGS ACCOUNT (HSA)

The HSA is a valuable tool to help you save for and pay for health care expenses with tax-free dollars. Not only can you use the HSA to offset current health care costs, it can be used to build savings for future health care costs (such as in retirement). Contributions to an HSA can be made by the employee, employer, or both.

The HSA is administered by HealthEquity. You must enroll in the CDHP and meet certain eligibility requirements to open an HSA. You can choose an annual contribution amount that will be prorated over the course of the year. The proration of this annual amount protects you from exceeding the pre-tax limit in the event you are no longer eligible for a CDHP during the course of the year. Contributions to the HSA will be automatically deducted from each paycheck on a pre-tax basis. You can change your contribution amount to the HSA at any time during the year.

You can also contribute amounts outside of the payroll process entirely. These contributions are tax deductible and can be filed with your income tax return.

Contributions made to the HSA roll over from year to year — unlike other tax-advantaged health care accounts, the HSA has no IRS "use it or lose it" rule. The dollars are yours until you decide to use them.

In 2017, National Grid will make a one-time contribution to your HSA. Those enrolled in the CDHP with individual coverage will receive $750, those enrolled in the CDHP with family coverage will receive $1,500. Those enrolling mid-year will receive a pro-rated amount of the employer contribution (subject to the enrollment date in the HSA). **The employer and employee**

contributions will be accessible in the HSA only after your account has been set up with HealthEquity.

BENEFITS OF THE HSA

1. **You can use your HSA for 2017 eligible health care expenses – even after you incur them.** You can put your HSA dollars toward your deductible and other eligible medical, prescription, dental and vision expenses.

   Unlike a Flexible Spending Account (FSA), you can contribute to your HSA *after you incur out-of-pocket costs* and then use those tax-free dollars to reimburse yourself. So, even if you have unexpected health care costs in 2017, you can contribute additional money to your HSA to pay for those expenses.
2. **You can roll over dollars you don't use.** Unused money rolls over from year to year, which helps you build savings for future eligible health care expenses. You can also use dollars in your HSA to pay for eligible expenses in future years even if you're not enrolled in the CDHP at the time.
3. **You can take it with you.** The money in your HSA is always yours, so you can take your unused balance when you retire or leave National Grid.
4. **Triple-tax advantages.** You will not pay taxes on your HSA dollars as long as you use them to pay for eligible health care expenses. You won't be taxed when you make contributions, as your account grows with interest, or when you withdraw the money to pay for eligible expenses. If you choose to invest your HSA dollars, your investment earnings grow tax free.
5. **It's convenient.** The HSA Debit Card from HealthEquity makes it easy to pay for expenses at the point of service if required, and you can pay providers through the HSA member portal (just like online banking).
6. **Increase your health care savings through investments.** HealthEquity provides the opportunity to invest your health care dollars. More information is available at www.bluecrossma.com/nm/cdhp-national-grid

HSA Contribution Limits

The IRS limits your maximum annual HSA contribution. For 2017, the annual limits are $3,400 for individual coverage and $6,750 for family coverage. Once you are age 55, and each year thereafter, you are eligible to make an additional annual "catch up" contribution of up to $1,000 to your HSA for that year.

Contribution limits can be met through the combination of employer and employee contributions. The one-time contribution to your HSA from National Grid counts towards the total IRS maximum annual contribution. It is your responsibility to make sure that your total contributions for the year do not exceed this limit.

HSA Tools & Resources can be found on the Heatlh Equity education site: http://www.healthequity.com/ed/bcbsma/

FREQUENTLY ASKED QUESTIONS

Who is eligible to open and contribute to an HSA?

"Eligible individuals" are any individuals who are:

- Covered under a Consumer Driven Health Plan (CDHP).
- Not covered by any other health plan that is not a CDHP (with certain exceptions for plans providing certain limited types of coverage). This means you cannot be covered under your spouse's medical coverage unless it too is a CDHP.

- Not enrolled in Medicare, including Part A.
- Not claimed as a dependent on another person's tax return.
- Veterans who have not received treatment through the Veteran's Administration other than preventive care, within the last 3 months.

How are prescription drug costs paid under the CDHP?

Prescription drug coverage for the CDHP is administered by CVS Caremark. Prescription drug expenses also count toward your annual deductible and out-of-pocket maximum. This means that you will pay the full cost of most prescriptions until you meet your plan's annual deductible. Co-insurance applies after the deductible is met.

Will the health FSA impact employees' HSA eligibility?

Individuals enrolled in a traditional FSA in 2016 who wish to participate in a CDHP with HSA in 2017 may be required to delay their enrollment in, and contributions to, the HSA.

If you are enrolled in the National Grid 2016 FSA plan and have an outstanding balance in your FSA account as of January 1, 2017, you are subject to the 2 ½ month grace period. You must wait to enroll and contribute to the HSA until the end of the FSA grace period. The earliest you can attempt to enroll in the HSA is April 1. National Grid will provide 100% of the employer seed for the 2017 plan once your HSA enrollment has been completed.

If you are enrolled in the National Grid 2016 FSA plan and do not have an outstanding balance in your FSA account as of January 1, 2017 you can enroll and contribute to the HSA effective January 1. National Grid will provide 100% of the employer seed contribution for the 2017 plan year once your HSA enrollment has been completed. If your enrollment in the HSA is effective January 1, 2017, the employer seed will be sent to HealthEquity by the end of January.

If you are eligible to be reimbursed by your spouse's FSA plan, the same rules apply.

The IRS tax code governs the rules around the administration of flexible spending accounts and health savings accounts when both are made available to employees. For more details about this topic please refer to the HealthEquity HSA Guidebook (http://healthequity.com/ed/resources/docs/HSA_guidebook.pdf)

How do I enroll in the HSA?

By electing the CDHP plan you will be defaulted into the HSA. You have the choice to remain in the HSA or elect to waive this plan option. By agreeing to the default option during the Open Enrollment process (i.e. enrollment in the HSA plan) you will be authorizing HealthEquity to open an HSA. However if you choose to enroll in the HSA you can do so at any time of the year. Please note: the employer seed ($750 individual/$1,500 family) will be pro-rated from the day of the HSA election not the CDHP default date.

For details about the terms of the account you can access HealthEquity's HSA Custodial Agreement at http://healthequity.com/en/Site/EducationCenter/Forms.aspx. In compliance with the USA PATRIOT Act, HealthEquity must verify the identity of all customers seeking to open an HSA. As part of this identity verification process, you may be asked to provide additional information and/or documentation before your account can be established. In addition, your

enrollment and health information will be shared with HealthEquity for the purpose of administering and coordinating payments under the health savings account.

Tools and Resources

You can find out more about the CDHP and HSA, including additional FAQs and how to make the most of your HSA, at www.bluecrossma.com/nm/cdhp-national-grid. You can also access the HealthEquity Member Guide: http://www.healthequity.com/hsamemberguide/

TELEHEALTH FOR PARTICIPANTS OF BLUE CROSS BLUE SHIELD PLANS

Participants on the Blue Cross Blue Shield health plans will have access to Telehealth services through AmericanWell starting January 1, 2017. Telehealth services provide immediate face to face access to board certified physicians through your smartphone, computer, or tablet device. In general, Telehealth services are used for acute medical care for minor illnesses and injuries for adults and children, for managing symptoms from chronic conditions, and for support of behavioral healthcare needs along with any other general health and wellness concerns you may have.

Use Telehealth services as an alternative to emergency room or urgent care, when your doctor's office is closed, while at work in the office or in the field, or after business hours or on weekends. Face to face visits can take from 10 to 30 minutes, depending on the care you need, at the cost of a primary care visit under your health plan (see comparison chart for PCP cost).

Register on-line before your first time use to speed up access to physicians when you need one. To register, you'll need to create a username and password, and enter the information on your plan ID card and the service key "BCBSMA" in order to get the BCBS negotiated rate for those physicians.

To learn more about Telehealth visit www.bluecrossma.com/telehealth.

Women's Health and Cancer Rights Act of 1998 (the "Act")

This Act, signed into law on October 21, 1998, requires all group health plans that provide medical and surgical benefits related to a mastectomy to also provide coverage for:

- Reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatment of physical complications of all stages of mastectomy, including lymphedema.

These services must be provided in a manner determined in consultation with the attending physician and patient. This coverage may be subject to annual deductibles and co-insurance provisions applied to other medical and surgical benefits provided under the plan. Please refer to *A Comparison of National Grid Health Benefits* chart for the deductibles and co-insurance information applicable to the plan in which you choose to enroll.

COVERAGE LEVEL OPTIONS

You can choose from the following coverage options:

- Employee Only
- Employee Plus Family (includes spouse and/or eligible dependents)
- Waive

If your spouse is also employed by National Grid, you have several enrollment options:

- You and your spouse may both choose Employee Only coverage under the same or different plans.
- If you and your spouse have other eligible dependents, you may choose Employee Only coverage and your spouse may choose Employee Plus Family coverage (or vice versa). In this case the employee choosing Employee Plus Family coverage will be covering him/herself and the eligible dependents while the spouse choosing Employee Only coverage is simply covering him/herself.
- You or your spouse may also elect the National Grid Spouse Medical and/or Dental option. Under this option, one employee (you or your spouse) elects Employee Plus Family coverage for the entire family. The other employee chooses the National Grid Spouse option, which means this employee is electing to be covered as a dependent under his or her spouse's plan.

Remember: A National Grid employee cannot be covered both as an employee and a dependent under a National Grid medical plan, so if National Grid also employs your spouse, you must choose to be covered by either your spouse's plan or yours.

WAIVING MEDICAL COVERAGE

If you have coverage under another medical plan (for example, through your spouse's employer), you may elect to waive coverage through the Company. If you choose to waive medical coverage, you will have no medical coverage for yourself or your family through National Grid for 2017.

To certify that you have coverage under another employer-provided medical plan and waive medical coverage through National Grid for 2017, contact the National Grid Benefit Services Center online at www.nationalgridbenefitservices.com and select "no coverage" under the medical benefit plan option. You may also call the National Grid Benefit Services Center at 1-888-483-2123.

Remember, if you voluntarily waive medical coverage, you waive your rights to elect medical coverage under COBRA (Consolidated Omnibus Budget Reconciliation Act) if you terminate employment.

Prescription Drug Benefits

When you enroll in a National Grid medical plan, you will automatically receive prescription drug coverage. This coverage is provided through CVS Caremark for all plan participants. New participants will receive a CVS Caremark ID card for use at a participating pharmacy. To see if your pharmacy is in the network, either contact the pharmacy directly or log on to **www.caremark.com**. Please refer to the enclosed *A Comparison of National Grid Health Benefits* for prescription drug co-payment information.

Specialty Pharmacy Update:

All specialty medications will be exclusively processed by CVS Caremark Specialty Pharmacy. Notifications to those who do not currently use CVS Caremark Specialty pharmacy to obtain their prescriptions will be sent 45 days prior to the new year and clinical support will be available to help you with the transition.

FILLING PRESCRIPTIONS THROUGH CVS CAREMARK

- **You can fill a 30-day supply of medication at a network pharmacy.** Show your prescription drug ID card and you can purchase prescription drugs at participating CVS Caremark network pharmacies (including national chains like CVS, Walgreens, Rite-Aid, and most other retail pharmacies).
- **You can fill a 90-day supply of a maintenance (long-term) medication through the Maintenance Choice Program.** The program is an easy, convenient way to get the maintenance medications you need at the lowest possible cost. It is to your advantage to fill your long-term prescriptions with a 90-day supply because this prescription is priced more competitively than a retail prescription. To take advantage of this program, you must ask your provider for a 90-day prescription and choose to fill the prescription either:
  - *Through the mail order.* With mail order you can choose where to have the order delivered—your home, office or another location.
  - *At a CVS Pharmacy.* Simply go to any CVS Pharmacy to pick up your 90-day supply of medication.

Mandatory mail order for maintenance (long-term) medication. Once you receive a prescription and two refills for the same maintenance medication, you are required to use the CVS Caremark mail order plan. You will have two options for filling your maintenance medication prescriptions:

- Receiving your 90-day supply of maintenance medication through the CVS Caremark Mail Service Pharmacy
- Receiving your 90-day supply of maintenance medication at the local retail CVS/participating network pharmacy

The mail order co-payment will be the same, regardless of which method you use: home delivery or CVS retail pick-up. For those on the CDHP, you can expect to pay the same discounted amount for 90 day supply at retail and at mail order.

Here's a Tip: Choose Generic Drugs and Save!

When the patent protection for a brand-name drug expires, generic versions of the drug can be offered for sale with FDA approval. Generic drugs are generally less expensive than brand-name drugs. If you're not already using a generic equivalent for any prescription medications you take, talk with your doctor to see if one may be right for you.

Failure to fill maintenance medications through either option will result in your being charged 100% of the cost at the retail point of sale. We strongly urge you to take advantage of the convenience of submitting a mail order request through CVS Caremark's Mail Service Program or by bringing your 90-day prescription to your local CVS or participating network pharmacy.

GENERIC STEP THERAPY

Generic Step Therapy requires that a cost-effective generic alternative is tried before a brand name is covered This program is intended to actively educate members and prescribers with regards to clinically appropriate medications, and to guide them to more cost-effective options.

Here is how it works:

When a new prescription for a single-source brand is presented (at the retail or mail pharmacy), the CVS Caremark system will check for previous generic use. If the history shows generic use, the single source brand claim will be approved and the Plan will pay its cost share responsibility.

If there is no history of a generic trial, the pharmacist will receive a message from CVS Caremark that step therapy is required before the single-source brand is dispensed. The patient and prescriber will be informed to call CVS Caremark for more information. In the event that the prescriber advises CVS Caremark that a generic alternative is not right for the member, they will be instructed to undergo the prior authorization and medical review process to request approval for the single source brand to bypass the step therapy requirement.

A prior authorization review is not a guarantee that a single-source brand will be approved. In cases where there is a denial even after prior authorization review, the member can still obtain the single source brand but at 100% of the cost.

IMPORTANT INFORMATION THAT APPLIES TO SPECIALTY MEDICATIONS

Specialty medications are those that are often used to treat chronic, complex medical conditions that require additional patient support to ensure optimal adherence. Many specialty drugs require special handling, storage, and administration and follow very specific FDA guidelines to ensure the product is clinically effective. These drugs can come in generic or brand name form, are taken for a long period of time, and are often more expensive than non-specialty medications.

Programs for specialty medications under the National Grid plan are designed to help prescribers select the most clinically effective therapy through well-supported treatment options and clinical support.

Specialty medications will be subject to a prior authorization process, ***and new this year,*** all specialty medications will be dispensed by CVS Specialty pharmacy. If you currently obtain your specialty medications through another specialty pharmacy, CVS Caremark will reach out to you by letter and via phone to discuss transition of your medications to be processed exclusively through CVS Caremark.

In addition, medications for the following conditions will be reviewed for their preferred or non-preferred status within the plan's formulary prior to being dispensed: Multiple Sclerosis, autoimmune, fertility, Hepatitis C (interferons), growth hormone, pulmonary arterial hypertension,

osteoarthritis, hematology, osteoporosis, chronic myeloid leukemia, and transplant. When/if you present a new prescription for a preferred specialty medication under one of these drug classes, the prescription will automatically be approved. When/if you present a prescription for a non-preferred specialty medication under these drug classes, you will have the opportunity to have your doctor prescribe a preferred drug or submit a request for a prior authorization review. Once a request is received, CVS Caremark will contact the prescriber to complete the clinical exception review. CVS Caremark will ask the prescriber if one of the preferred medications is acceptable. If the physician agrees, the preferred drug will be approved for coverage.

CVS Caremark will notify both the prescriber and member of the approval. If there is not a medical reason to use the non-preferred medication, the request for an exception will not be approved. Please note that if a member is currently using a specialty preferred drug, they will be exempt from this program at this time. If a prescriber does not agree with CVS Caremark's recommendation to prescribe the preferred specialty medication (first prescription for a new utilizing member) – the clinical review process would apply.

COMPOUNDED DRUGS PRIOR AUTHORIZATION

Medically necessary compounded drugs will continue to be covered, however prior authorization for compounded drugs over $300 is required. Compounding is the combining, mixing, or altering of ingredients to create a customized medication that is not otherwise commercially available and in final form do not meet FDA standards. The cost of these combinations dramatically increase plan costs.

Supplemental Cancer Coverage

You have the option to purchase a voluntary personal supplemental cancer protection plan offered through the American Family Life Assurance Company (Aflac). You must be enrolled in medical coverage offered by National Grid in order to apply for enrollment in this voluntary benefit.

If you elect coverage and you or a family member is diagnosed with cancer, you will be eligible to receive benefits through Aflac:

- The plan protects individuals against having to bear the entire financial burden for expenses, such as experimental treatment, second surgical opinions, radiation, chemotherapy, hospital stays, skin cancer surgery benefit, lump sum first occurrence benefit, lodging, rent and utilities expenses, and bone marrow transplants.
- Cash benefits paid directly to the insured with no coordination of benefits with health insurance, disability insurance or other types of insurance.
- Cancer Screening Wellness – a $75 or $100 annual benefit (depending on level of coverage) paid to a covered person for a cancer screening exam.
- Favorable group-discounted premiums.
- Smokers and people with family histories of cancer are eligible for coverage at the same rates.[1]
- Policies are individually owned and portable at the same payroll rate.
- Policies are guaranteed renewable for life.
- Depending on the benefit level elected, employees participating in this supplemental plan will have a pre-tax contribution deducted from each paycheck.

Once enrolled, employees are subject to the same rules that govern participation in the medical plan options. Therefore, enrolled Aflac policy holders must have a documented qualifying life event (see page 11) to amend or drop this benefit.

Employees who are on an unpaid leave of absence are responsible for remitting premiums to Aflac until they return to active duty. Unpaid premiums may cause a lapse or cancellation in coverage. For more information about this plan visit **www.aflac.com**. To enroll in this benefit, please email Kimberly_demetri@us.aflac.com or call 1-917-532-3011.

Reminder to ALL Aflac Policyholders!

Remember to claim your annual $75 benefit from Aflac upon completion of appropriate cancer screenings (based on your personal history) as part of your/your family's annual physical exam and preventive care regimen. The Wellness fax number is 1-877-844-0201. Refer to your policy or **www.aflac.com** for more details.

CONTINUING PARTICIPATION IF YOU TERMINATE EMPLOYMENT

The coverage is fully portable and is available through age 75. It is guaranteed renewable for life as long as premiums are paid.

[1]Please refer to the policy for complete details limitations and exclusions. Coverage is not available to persons presently diagnosed with internal cancer, or those who have not been cancer free for a period of at least five years from the date of application. Applicants must have health insurance at the time of the application in order to be eligible for coverage.

Dental Plan

National Grid offers competitive dental coverage through GHI, administered by EmblemHealth. The GHI Preferred Dental option provides benefits for covered services, including preventive and diagnostic services, restorative services, basic services, and orthodontics, when you use a GHI participating dentist. GHI reimburses participating dentists directly, and you do not need to submit a claim form. You must show your GHI Dental ID card to your participating dentist. Please call GHI to obtain the names of GHI Preferred Participating Dentists. Contact GHI at **1-800-624-2414** or **www.emblemhealth.com**.

Medical and Dental Plan Coverage Levels

You can choose the plan and coverage levels that best meet your family's needs. So, for example, if you elect Employee Plus Family coverage for your medical plan to cover yourself and your spouse, you may elect a different coverage level (such as Employee Only) for your dental coverage.

The GHI Preferred Dental Plan also allows you the freedom to choose a non-participating provider while still receiving benefits for covered services. If you use a non-participating provider, then you must pay that provider directly when services are rendered. You must then file a claim form with GHI and you will be reimbursed according to the GHI Preferred Schedule of Allowances. You are responsible for paying the non-participating provider any difference between the provider's charge and GHI's payment.

COVERAGE LEVEL OPTIONS

You can choose from the following coverage options:

- Employee Only
- Employee Plus Family (includes spouse and/or dependent child(ren))
- Waive

You or your spouse may also elect the National Grid Spouse Dental Option. Under this option, one employee (you or your spouse) elects Employee Plus Family coverage for the entire family. The other employee chooses the National Grid Spouse Option, which means this employee is electing to be covered as a dependent under his/her employed spouse's plan.

Flexible Spending Accounts

National Grid offers two Flexible Spending Accounts:

- The **Health Care Flexible Spending Account** (HCFSA) which allows you to pay for eligible health care expenses and
- The **Dependent Care Reimbursement Account** (DCRA) which allows you to pay for eligible child and elder care expenses.

You may contribute to one or both flexible spending accounts. However, you must enroll each year to participate. Participation does not automatically continue from year to year. With a flexible spending account, you save because the money in your account is never taxed — when it goes into your account, or when you withdraw it to reimburse yourself for eligible expenses.

Using Your HCFSA

Your total annual contribution is available for reimbursement on January 1, 2017. Your annual contribution election will be deducted in equal installments each pay period before applicable payroll taxes are deducted.

Participants in the Consumer Driven Health Plan are not eligible to enroll in the Health Care Flexible Spending Account (HCFSA).

HEALTH CARE FLEXIBLE SPENDING ACCOUNT

With the HCFSA, you can set aside up to $2,550 each year through pre-tax payroll deductions to help you save to pay for eligible health care expenses which are not otherwise covered by your health care plans.

The $2,550 cap applies on a per-employee basis. If an employee and his/her spouse are both employees of National Grid and are eligible to make contributions to the HCFSA, each person may elect to contribute up to the $2,550 limit.

Eligible Health Care Flexible Spending Account Expenses

- Office visit and prescription drug co-payments
- Vision care, including eye exams, eyeglasses and contact lenses
- Dental care, including dentures, dental implants and orthodontia
- Hearing exams and aids
- Deductibles and co-insurance

For a complete list of eligible and ineligible expenses, contact WageWorks (see page 44 for contact information), contact the IRS toll-free at 1-800-829-3676 and ask that Publication 502 be sent to you free of charge, or visit **www.irs.gov.**

DEPENDENT CARE REIMBURSEMENT ACCOUNT

The DCRA helps you lower the cost of eligible dependent care expenses by reducing the amount you pay in taxes. With the DCRA, you can set aside up to $5,000 a year (minimum $100) through pre-tax payroll deductions to pay for eligible out-of-pocket expenses for child and other dependent care needed so you (and your spouse, if you're married) can work, look for work, or attend school full-time. Limitations apply if you are married, but file separate tax returns, or if your spouse is a full-time student or is disabled.

Eligible Dependent Care Reimbursement Account Expenses

- Day care facilities, family day care homes, preschools and nursery schools
- Before- and after-school programs for children up to age 13
- Summer day camps
- Senior citizen centers
- Babysitters
- In-home care for dependents incapable of self-care
- Any other expenses that qualify as dependent care under IRS regulations

For a complete list of eligible and ineligible expenses, contact WageWorks (see page 44 for contact information), contact the IRS toll-free at 1-800-829-3676 and ask that Publication 503 be sent to you free of charge, or visit **www.irs.gov**.

USING YOUR DCRA

You are eligible to be reimbursed up to the amount in your account at the time you submit your reimbursement form. Your annual contribution election will be deducted in equal installments each pay period before applicable payroll taxes are deducted.

To receive reimbursement for expenses paid for dependent care, you must be an active participant in an account at the time the expense is incurred. For example, if you are required to pay a deposit in advance of your dependent attending a day camp, you must be contributing at the time the expense is incurred to receive reimbursement of that cost. The dependent care provider's Social Security or federal tax ID number must also be provided on the claim form.

Dependent Care Tax Credit

The Federal dependent care tax credit can be applied to up to $3,000 in expenses for one child and $6,000 in expenses for two or more children.

If you plan to take the tax credit, you cannot use the DCRA for that portion of your expenses. You may want to speak with a financial planner or tax advisor before the Open Enrollment period to help you decide whether you should enroll in the DCRA or take the federal dependent care tax credit, based on your needs.

ADDITIONAL FLEXIBLE SPENDING ACCOUNT RULES

- **Contributions.** Once you enroll in either (or both) the health or dependent care account, you may not change or stop your contributions until the next Open Enrollment period (unless you experience a qualified life event as indicated on page 11).

- **Reimbursement.** To be reimbursed for eligible health or dependent care expenses incurred between January 1, 2017 and March 15, 2018, obtain the applicable reimbursement claim form by visiting **https://www.wageworks.com/employees/support-center/important-forms.aspx**. Submit your completed form along with a receipt or proof of payment (including the Explanation of Benefits (EOB) if provided by a health plan). WageWorks will then reimburse you for your eligible out-of-pocket expenses up to the total amount of your HCFSA contribution election or your DCRA balance.

If You Have Questions

If you have any questions regarding your flexible spending accounts during Open Enrollment, please contact WageWorks at 1-877-924-3967 between 8 a.m. and 8 p.m. ET, Monday through Friday.

- **Use It or Lose It.** If you do not use the dollars you have set aside by the appropriate deadlines, you lose them! You have until May 31, 2018 to submit claims for all eligible expenses incurred between January 1, 2017 and March 15, 2018. That's why it's important to carefully consider the amount you will use over the course of the year before contributing to either account. Those who are considering enrolling in the Consumer Driven Health Plan (CDHP) should refer to page 18 to learn about how the CDHP Health Savings Account is affected by the HCFSA 2 ½ month grace period.

Note: The above submission dates apply only if you continue to be actively employed with the Company. Participants who retire or otherwise end employment with National Grid have only 90 days from the effective termination date to file eligible claims incurred while actively enrolled in the plan(s).

CONTINUING PARTICIPATION IF YOU TERMINATE YOUR EMPLOYMENT

Terminated or retired employees may choose to continue funding their HCFSA on an after-tax basis by electing continued coverage through COBRA. Details will be included in the CONEXIS package mailed at the time your employment ends.

National Grid's Commitment to Health and Wellbeing

National Grid's Safety, Health and Environment Department offers targeted programs and services free of charge for employees, with the intent to create healthier and happier personal and working lives.

HEALTH & WELLNESS RESOURCE CENTER

www.bluecrossma.com/nationalgrid

A one-stop shop where employees can get tips on a variety of health and wellness topics, including:

- Increasing physical activity
- Managing weight
- Learning stress management techniques
- Maintaining work-life balance
- Improving office ergonomics
- Quitting smoking

Health & Wellbeing Information is also available from Emblem Health at: **www.emblemhealth.com**

Here's a Tip: Physical Activity

Exercise is a major contributor to a healthy lifestyle; people are made to use their bodies, and disuse leads to unhealthy living. Unhealthy living may manifest itself in obesity, weakness, lack of endurance, and overall poor health that may foster disease development.

Regular exercise can prevent and reverse age-related decreases in muscle mass and strength, improve balance, flexibility, and endurance. Regular exercise can help prevent coronary heart disease, stroke, diabetes, obesity, and high blood pressure.

QUITNET — SMOKING CESSATION

Quintet is an online comprehensive smoking cessation program offering a variety of resources for a smoke-free life.

National Quitline

1-800-QUIT NOW (1-800-784-8669) (English and Spanish)
This hotline is staffed by professional counselors who provide support and give referrals to local tobacco treatment centers.
http://smokefree.gov/

Here's a Tip: Stop Smoking

Tobacco use is the most important preventable illness and cause of death in the U.S., according to the National Cancer Institute. Tobacco use was estimated to be the cause of 480,000 deaths in 2015 in the U.S.

- Stop smoking tobacco; start to stop today (it takes about 15 years of nonsmoking behavior to achieve a "normal" risk level for heart disease for those that smoke).
- Stop using chewing tobacco to avoid oral cancers.
- Tobacco use causes or contributes to a large number of cancers in the U.S. In men, 90% of lung cancer deaths are attributable to smoking; 80% in women. Tobacco use causes cancers of the lung, mouth, lip, tongue, esophagus, kidney, and bladder.

CORPORATE COUNSELING ASSOCIATES (CCA) — WORK/LIFE ASSISTANCE

National Grid's Employee Assistance Program, CCA, can be reached at 1-800-833-8707 or online at www.ccainc.com. (Company code: National Grid)

INJURY PREVENTION FOR FIELD EMPLOYEES

National Grid offers an interactive injury prevention program developed specifically for field employees to reduce and control on the job injuries. The training helps employees to recognize and utilize better body mechanics and ergonomics on the job and is supported by customized video for both basic training, and task specific.

For more information please go to **http://infonet2/OurOrganisation/USHumanResources/LearningDevelopment/Pages/VVL.aspx** to link to Learning and Development's virtual video library to see the video content.

Life Insurance and AD&D Benefits

National Grid provides basic life insurance and accidental death and dismemberment (AD&D) coverage at no cost to you. You can also buy optional life insurance coverage for you and your family through the Company's life insurance administrator, MetLife. MetLife manages the enrollment for all life insurance.

Medical Evidence of Insurability (EOI)

Evidence of Insurability is medical information you may need to provide about the condition of your health before you can be approved for certain levels of life insurance coverage. MetLife will notify you if you make an election that requires EOI.

BASIC COVERAGE

IF YOU ARE A NGEM DIRECT HIRE:

You are eligible for a basic life insurance benefit equal to one times your base salary, up to $100,000, on the first day of the month coincident with or next following six months of active full-time service. The Company pays the full cost of this group life insurance coverage.

You are eligible for AD&D insurance equal to one times your base salary, up to $200,000, on the first day of the month coincident with or next following one month of service. If you experience an occupational-related loss, you will receive an additional benefit of $50,000. The Company pays the full cost of this coverage.

IF YOU ARE A CORPORATE UTILITY EMPLOYEE:

You are eligible for a basic life insurance benefit equal to $5,000, on the first day of the month coincident with or next following one year of service. Your benefit will increase to two times your base salary, up to $500,000, on the first day of the month coincident with or next following two years of service. The Company pays the full cost of this group life insurance coverage.

You are eligible for AD&D insurance equal to one times your base salary, up to $200,000 on the first day of the month coincident with or next following six month of service. If you experience an occupational-related loss, you will receive an additional benefit of $50,000. The Company pays the full cost of this coverage.

IF YOU ARE A LOCAL 101 MEMBER HIRED INTO CUSTOMER OPERATIONS ON OR AFTER OCTOBER 16, 2010:

You are eligible for a basic life insurance benefit equal to one times your base salary.

You are eligible for AD&D insurance equal to one times your base salary, up to $500,000, on the first day of the month coincident with or next following six months of service. If you experience an occupational-related loss, you will receive an additional benefit of $50,000. The Company pays the full cost of this coverage.

OPTIONAL LIFE INSURANCE COVERAGE

FOR YOURSELF

If you want additional life insurance for yourself, you can purchase it on an after-tax basis through the optional life insurance program administered through MetLife. The maximum optional life insurance you can purchase is five times your annual salary rounded to the next highest $10,000 or $250,000, whichever is less (minimum coverage is $10,000).

If you enroll within 31 days of your initial eligibility date, you are guaranteed coverage up to two times annual salary or $100,000, whichever is less. You are required to submit evidence of insurability to purchase more than that amount. You must be actively at work on the date coverage begins in order to be eligible.

When you enroll in optional life insurance, you become eligible for two special provisions:

- You can receive up to 50% of your life insurance coverage face amount due to terminal illness through the Accelerated Benefit Option (ABO).
- You can increase coverage due to a special event (e.g., birth, marriage).

You can generally increase your coverage once each year during Open Enrollment by one times annual salary without medical evidence of insurability.

About Optional Life Insurance

In order to enroll your spouse or child for coverage, you must be enrolled in employee optional life insurance coverage.

Optional life insurance coverage is portable through MetLife. This means you are eligible to continue your coverage if you leave or retire from National Grid.

FOR YOUR SPOUSE

Dependent life insurance is available for your legally married spouse in $10,000 increments to a maximum of the lesser of your basic and optional life coverages combined or $100,000. (Up to $30,000 of coverage is available without providing medical EOI.) The cost of coverage for your legally married spouse is based on his/her age and the level of coverage you elect. Rates will be included in the MetLife enrollment materials you will receive separately.

The amount of spouse coverage cannot exceed the lesser of your coverage or $100,000. If both you and your spouse work for National Grid, you cannot buy coverage for your spouse, but your spouse may have his/her own coverage as an employee.

FOR YOUR CHILD(REN)

You may also make a single election to cover your dependent child(ren) at either $2,000 or $4,000. Your dependent must be at least 15 days old and less than 21 years old, unmarried (or under the age of 25, if a full-time student).

Imputed Income

Under law, the value of any Company-provided amount of basic life insurance coverage that exceeds $50,000 is considered “imputed income.” This means the value of life insurance that exceeds $50,000 will be considered part of your annual compensation for federal income tax and Social Security purposes. You’ll be taxed on this amount according to special age-based rates set by the IRS. Your imputed income will continue to be included on your W-2 form and will appear on your pay stub, just as it does now.

Naming a Beneficiary

It is important that you name a beneficiary for life insurance and AD&D coverage. Your beneficiary is the person who will receive benefits from these plans if you die. You may choose to name more than one beneficiary, and you can change your beneficiary designations as often as you want. You elect your beneficiary directly through MetLife. Follow directions in the MetLife enrollment materials that will be mailed to your home address or contact MetLife directly.

By October 11, you should receive a direct home mailing from MetLife which describes how you can enroll in these optional programs. If you need assistance, please call the MetLife Call Center at 1-866-492-6983.

Long-Term Disability

You become eligible to participate in the Long-Term Disability (LTD) Plan on the first day of the month coincident with or next following three months of continuous full-time service. You will be automatically enrolled in this coverage and may choose to dis-enroll at any time. However, if you waive automatic coverage or dis-enroll from current coverage, you will be required to submit Medical Evidence of Insurability if you wish to elect this coverage in the future.

About Your Payroll Contributions

If you are enrolled in the LTD Plan, your payroll contributions are made on an after-tax basis. Thus, the LTD benefit you receive will be tax-free.

WHEN BENEFITS BEGIN

Benefits begin after 90 consecutive days of disability or at the end of your paid sick days, whichever is later. However, you will receive the minimum benefit described below beginning on the 91st day of your disability, regardless of the number of sick days to which you are entitled. The amount of your monthly benefit equals 60% of your monthly base earnings. The maximum monthly benefit you can receive from the Plan is $8,000 and the minimum is $100 or 10% of the gross benefit whichever is greater. Your benefits will be offset by benefits paid from your pension or other sources.

For example, let's assume that your annual salary for purposes of the Plan is $48,000 a year or $4,000 a month. Now let's assume that you are totally disabled for more than 90 consecutive days and have used all your paid sick leave days. Your monthly payments from the LTD Plan will be $2,400 ($4,000 x 60%) less any other benefits you are receiving from other sources (e.g., Social Security, your pension, Workers' Compensation or other benefits).

We strongly recommend that you consider electing LTD coverage in order to insure your earnings (i.e., protect your income) for both you and your family. Benefits continue until recovery or age 65 if you become disabled prior to age 60. If you become disabled on or after age 60, then:

Age When Disability Begins	Duration of Benefit Payments During LTD
Less than 60	To age 65, but not less than 5 years
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 and over	12 months

The LTD benefit also provides a survivor benefit equal to three times your gross monthly benefit.

THE COST OF LONG-TERM DISABILITY COVERAGE

Contributions for LTD coverage are based on the amount of income protection you will receive based on your annual salary.

As a new hire, your annual salary for purposes of the Plan is your base salary.

Your annual cost is $1.241per $100 of coverage. Again assuming that your annual salary for purposes of the Plan is $48,000 a year, your annual cost would be $595.68 per year (i.e., $48,000 multiplied by $1.241 divided by $100) or $11.46 per week (i.e., $595.68 divided by 52 weeks). Your contributions will be re-calculated at the beginning of each year to adjust for salary increases.

If you decide you do not want LTD coverage after January 1, 2017, you can cancel your coverage at any time. However, you will not receive a refund for LTD deductions that have been already taken from your pay.

Transit Benefits

With National Grid's transit benefits, you can set aside pre-tax dollars to pay for work-related commuting expenses (excluding tolls). You make separate elections to the commuter (mass transit) benefit component and the parking component. Each of these benefits has a monthly maximum which is set annually by the IRS. Currently, the monthly maximum is $255 for parking and $255 for transit. Limits may change for 2017 depending on the maximum set by the IRS.

You can change your commuter benefit election each month, if necessary, by logging on to the National Grid Benefit Services Center Web site and adjusting your transit election. Changes to the transit/parking election will become effective the first of the month following the date of the election or change.

Reimbursement of these expenses will be managed by WageWorks. To receive reimbursement for your expenses, you can obtain and submit your claims online by accessing the WageWorks Web site: **https://www.wageworks.com/employees/support-center/important-forms.aspx**. You will be asked to submit receipts showing proof of payment. You can also submit a claim form via fax to 1-877-353-9236 or mail to WageWorks CLAIMS ADMINISTRATOR, P.O. Box 14053, Lexington, KY, 40512. Claim forms can also be accessed by visiting the Infonet Spending Accounts section under My Rewards & Benefits: **http://infonet2/OurOrganisation/USHumanResources/Pages/SpendingAccounts.aspx.** Claims must be submitted within 180 days of the date the expense was incurred.

Auto and Homeowners Insurance

You are eligible for auto and home insurance at special discounted group rates through MetLife Home & Auto. Contact MetLife to receive information regarding auto and home insurance programs through payroll deductions.

This insurance option provides a variety of coverage in most geographic areas: automobile, renters, boat owners, recreational vehicles, homeowners, condominium, mobile home, fire and personal excess liability. Payments can be conveniently deducted directly from your paycheck over the term of the policy without any interest fees or service charges.

You can enroll, change coverage or file claims via phone. For more information, contact MetLife directly at 1-800-438-6388 or visit www.metlife.com/NationalGrid.

Legal Services

All eligible full-time employees who are represented by Local 101 and were directly hired into a National Grid subsidiary can elect to participate in a comprehensive legal services plan. Services include telephone advice and office consultations with a plan attorney of your choice on a range of services as shown in the chart below. The plan excludes employment and business-related matters.

The plan is administered by Hyatt Legal Plans, a MetLife subsidiary. Over 14,000 attorneys nationwide participate. Fees for covered services provided by a plan attorney are fully covered and paid. Out-of-network options are also available through this plan.

The cost of this benefit is $3.46 per week. The rate includes coverage for you, your spouse and dependent child(ren). You may not disenroll from the program until the next Open Enrollment period.

What's Covered Under the Legal Services Plan	
Documentation Preparation/Review: • Wills, Codicils, Living Trusts/Wills • Powers of Attorney, Affidavits, Deeds • Demand Letters, Notes, Mortgages • Elder Law Matters **Legal Assistance/Advice:** • Immigration • Small Claims • Probate • Personal Injury	**Legal Representation for:** • Primary Home – Purchase, Sale, Refinance • Debt Collection Defense, Identity Theft • Personal Bankruptcy, Tenant Negotiations • Eviction Defense (tenant only), Tax Audits • Premarital Agreements, Name Change • Uncontested Adoption, Guardianship • Conservatorship, Consumer Protection • Traffic Ticket Defense (no DUI) • Juvenile Court Defense • Civil Litigation Defense, Incompetency Defense, Administrative Hearings

CONTINUING PARTICIPATION IF YOU TERMINATE YOUR EMPLOYMENT

Terminated or retired employees who were enrolled in this coverage as of their termination date may continue participation in this pre-paid Legal Services program by contacting Hyatt Legal Plans and pre-paying 30 months of premiums at the unsubsidized rate.

Within 30 days of their termination date, former employees must contact Hyatt Legal Plans' Client Service Center at 1-800-821-6400 and request to port the plan/continue coverage. Remember, legal matters open and pending at the time of termination are completed under the plan even if the former employee does not opt for portability.

Enrolling in Your Benefits

Once you've reviewed your benefit options and the information on your *2017 Personalized Enrollment Worksheet*, it's time to get online and enroll! **Remember, you have until October 25, 2016 by 6 p.m. ET via phone and 12 midnight via Web to elect your benefits for 2017**. If you don't enroll, you will automatically receive default coverage (see page 5 for more details). If you want to keep your default benefit elections and you do not plan to participate in the flexible spending accounts, you do not need to enroll. If you do not enroll in another Medical plan or waive coverage, you will be defaulted into the GHI Standard PPO with Employee Only coverage. Please note your elections are irrevocable and you can only make a change during the year if you have a qualified life event as described on page **Error! Bookmark not defined.**1.

To Enroll or Make Changes by Phone

You are encouraged to enrol online. However, if you do not have access to the Web you can enroll by contacting the National Grid Benefit Services Center at **1-888-483-2123**. Be sure to have your *2017 Personalized Enrollment Worksheet* in front of you when you call.

TO ENROLL OR MAKE CHANGES ONLINE/BY PHONE

There are two ways to enroll:

1. Through the Web at **www.nationalgridbenefitservices.com**. This is the fastest and easiest way to enroll or view your benefits. The secure web site is available 24 hours a day, so you can make your benefit elections during the Open Enrollment period, at a time that is convenient for you.

Please note – you will be prompted to enter your:

- User ID — this is your Employee ID.
- Password
    - **If this is your first time logging into the site**, your temporary password is the first letter of your first name in upper case, followed by the first letter of your last name in lower case, followed by the last four digits of your SSN, followed by the year of your birth in the format of YYYY. For example, if your name is Jane Doe, and the last 4 digits of your SSN are 1234, and the year of your birth is 1970, then your temporary password would be Jd12341970.
    - **If you have logged in previously**, please enter the password you created when you first accessed your account. If you have already registered and have forgotten your password, you can click on the 'Forgot Password' link on the main login page and immediately reset your password. OR

Mobile access?

Got a mobile device? Your benefit information is at your fingertips, literally! **www.nationalgridbenefitservices.com** is NOW mobile friendly!

2. By calling the National Grid Benefit Services Center toll-free at **1-888-483-2123.** The National Grid Benefit Services Center is available Monday through Friday, from 8 a.m. to 6 p.m. ET. You may speak with a Benefits Specialist who will walk you through the enrollment process.

Step-By-Step Web Enrollment Instructions

1. Visit the National Grid Benefit Services Web site at: **www.nationalgridbenefitservices.com**. You will be prompted to enter your User ID and Password.
2. **If this is the first time that you login:**
   - You will be prompted to read and accept the user agreement.
   - You will also be prompted to change your password (must be at least 8 digits with one upper case, one lower case and one number).
   - You will also be prompted to complete a security question to be used in the event you forget your password.
3. **Start your enrollment:** By clicking on the 'Open Enrollment' Notification or Tile.
4. **Review your personal profile information:** If you would like to update your telephone number or email preferences, click on the 'Edit' button.
5. **Change/Add New Dependents:** The dependent screen displays dependent information currently on file. If you need to add dependents click the 'Add New Dependent' button to begin. If you need to make changes to your dependents, click on the pencil icon to the left of the dependent's name. It is your responsibility to make sure that all enrolled dependents are eligible to participate in the National Grid benefit plans.
   - In order for new family members to be eligible for coverage, you must submit proof of their eligibility. Any elections for the dependent will be pending until documentation is received and approved.
6. **Enrollment Acknowledgement:** You will be prompted to read and confirm your understanding that any changes made to your benefit elections will be saved even if you do not submit your final elections at the end of the enrollment event.
7. **Select Your Benefits:** All of your eligible benefits are displayed on this screen. To begin making elections click on the benefit name and then click on the 'Change' button. If a benefit does not have a "Change" button then that benefit cannot be changed or waived.
8. **Select Your Benefit Options:** The change screen allows you to review the options for that benefit and choose an option. When you click on next, it will bring up a screen to assign dependents to that coverage if applicable.
9. **Review Elections:** The review election screen shows a snapshot of your elections at a glance including costs. You will need to click on 'Save Elections' to finalize your selections.
10. **Save Elections Confirmation:** You will be asked to confirm that you are ready to save your elections. Click 'Yes' to submit your elections or click 'No' to go back and make changes.

11. **Enrollment Confirmation:** The Enrollment Confirmation screen shows your elections at a glance once they have been saved. There are two options, you can print the page and/or download it for your records.

You will be able to change your elections as many times as you like until the enrollment period ends on October 25, 2016. If you would like to make a change before the close of Open Enrollment and after receiving your confirmation number, you will need to restart the enrollment process from the beginning. Your changed elections, which become effective January 1, 2017, will be saved even if you do not receive a new confirmation number.

CONFIRMATION OF ENROLLMENT

You will receive a confirmation statement when the Open Enrollment period ends, even if you did not make an affirmative election. If any information on the confirmation statement is incorrect, you will have another opportunity to make changes during the Open Enrollment Correction Period scheduled from November 14, 2016 through November 18, 2016.

Enrollment Deadline

You can enroll between October 11, 2016 and October 25, 2016. **You must enroll by October 25 at 6 p.m. ET via phone and 12 midnight via Web.** If you have any questions about benefits or the enrollment process, call the National Grid Benefit Services Center at 1-888-483-2123.

PERSONAL AND EMERGENCY CONTACT INFORMATION

While thinking about your and your family's health, this is a good time to check your personal as well as emergency contact information in SAP. To access your personal information:

- Go to the Infonet Home Page, select the US tab at the top of the screen, and scroll down and click the SAP Portal link.
- In the portal, select the "Employee Self-Service" link on the top bar and then "Personal Information."
- Once you are in the "Personal Information" section, click on the "Addresses" link. Here you will find your home address, mailing address, and emergency contact information.
- If the current information showing needs to be updated, please click the edit button, update the necessary information, review the entries, and then save.
- If there is no emergency contact information on file, you can go to the bottom of the screen and click on the "New Emergency Address" button to add the information to your record.

If you do not have access to the SAP Portal, changes can be submitted to Employee Services via the Personal Data Change form. This form can be found on the SDC forms center. This can be accessed by going to www.NationalgridSDC123.com, sign in with your 8 digit Personnel number and password, and then click the SDC Form Centers Link to navigate to the Personal Data Change form. Please note that your password will be the last 4 digits of your Social Security Number when you log in for the first time. This form can be completed and submitted to Employee.Services@nationalgrid.com to update your record.

Should you have any questions, please contact the Services Delivery Center (SDC) at 1-888-483-2123.

Reminder: False or Misleading Information

An important component of managing the cost of our benefit programs is ensuring we provide coverage only to eligible employees and dependents. It is your responsibility to provide accurate information about your eligibility for, and participation in, Company benefit plans. If any of the information you provide is found to be false or misleading, you may be required to reimburse the plans for any costs incurred and you will be subject to disciplinary action, up to termination of employment.

The information in this booklet is an abbreviated summary of the actual plan documents. If there is a discrepancy between the information summarized here and the actual plan documents, the actual plan documents govern.

Glossary

Co-insurance – The amount you pay after a plan pays benefits and you satisfy any required deductibles, up to your annual out-of-pocket maximum. Expressed as a percentage.

Consumer Driven Health Plan (also known as a high deductible health plan) – CDHP plans give you access to a network of providers and health services and the flexibility to choose where to obtain those services, either in- or out-of-network. There is no requirement to choose a primary care physician to coordinate your care. The plan features of a CDHP include a deductible and co-insurance when accessing services both in and out-of-network. The participant is responsible for 100% of the costs of most covered health services and prescription drugs up to the deductible amount and a cost sharing through co-insurance. The plan is responsible for 100% cost of covered health services after reaching the plans out-of-pocket maximum. Deductibles, co-insurance, and out-of-pocket maximums differ for in- and out-of-network services. A unique feature of the CDHP includes access to a health savings account. Participants can contribute to a health savings account in order to save for and pay for qualified medical expenses (defined by the IRS).

Co-payment – The fee you pay for outpatient services, such as office visits and prescriptions. Expressed as a dollar amount.

Covered services – Medically necessary health care services for which benefits are paid under a particular medical plan.

Deductible - The annual dollar amount for covered services that you must pay before the plan pays benefits. For those in the PPO plan, each individual in a family plan must reach their own individual deductible before the plan begins to pay for a portion of the covered services (co-insurance) for that one individual. Co-payments do not apply to the deductible in the PPO plans. For those in the CDHP plan with family coverage, you must reach the family deductible before the plan begins to pay a portion of covered services (co-insurance) for both medical services and pharmacy for any one individual in that plan.

Healthcare Reform (also known as PPACA) – President Obama signed the Affordable Care Act into law in March 2010. This law is intended to make sweeping changes to health care in the United States. Many of the law's provisions are already in effect, while others will come in the next few years.

Health Savings Account (HSA) – A tax-advantaged account you can use to save money tax free to pay eligible health care expenses now and in the future.

In-network care – Care you receive from network providers. Most in-network services require a co-payment or co-insurance amount.

Out-of-network care – Care you receive from providers outside of the network. In general, you pay more for out-of-network care.

Out-of-pocket maximum – The maximum amount you will pay for covered medical expenses during the year under the plan (including deductibles, co-insurance and co-payments for medical, pharmacy, and mental health/substance abuse treatments). Any covered medical or

pharmacy expenses above the maximum will be covered at 100% by the plan, up to the allowed amount, for the rest of the calendar year. CDHP participants in a family plan must meet the family out-of-pocket maximum before the plan pays 100% for any individual in that plan.

Preferred Provider Organization (PPO) – With this plan, you can choose to receive care either within or outside the GHI network. You can see any provider within the network without a referral from a primary care physician. If you receive care in the network, you pay less because the network providers have negotiated special rates and the plan covers more. If you receive care outside the network, you pay more and the plan pays less.

Pre-tax payroll deductions – Your payroll deductions for medical, dental, supplemental cancer coverage and/or transit benefits, which are made before federal and state income and FICA (Social Security) taxes are withheld. Your contributions to the Health Care Flexible Spending Account, Dependent Care Reimbursement Account and Health Savings Account are also pre-tax. Pre-tax payroll deductions lower your taxable income, allowing you to save on taxes and increase your take-home pay.

Contact Information

For Information On:	Call:	Or Visit the Web Site:
Medical Plans		
GHI Blue Cross Blue Shield (CDHP)	1-800-624-2414 1-800-287-8757	www.emblemhealth.com www.bluecrossma.com/nm/cdhp-national-grid
HealthEquity (Health Savings Account)	1-866-346-5800	www.healthequity.com
Prescription Drug Benefits		
CVS Caremark	1-800-378-8826	www.caremark.com
Supplemental Cancer Coverage		
Aflac	1-917-532-3011	www.aflac.com
Dental Plan		
GHI	1-800-624-2414	www.emblemhealth.com
Flexible Spending Accounts		
WageWorks	1-877-924-3967	www.wageworks.com
Life Insurance and AD&D		
MetLife	1-866-492-6983	www.metlife.com/mybenefits
Transit Benefits		
WageWorks	1-855-774-7441	www.wageworks.com
Auto and Homeowners Insurance		
MetLife	1-800-438-6388	www.metlife.com/mybenefits
Legal Services		
Hyatt Legal Plans	1-800-821-6400	www.legalplans.com If not yet a member, click “Thinking About Enrolling” and enter password 3990010
Enrollment		
National Grid Benefit Services Center	1-888-483-2123 Follow the phone prompt for benefits/medical and dental	www.nationalgridbenefitservices.com
General Benefit Questions		
National Grid Services Delivery Center	1-888-483-2123	www.nationalgridsdc123.com

STEPS YOU MUST TAKE BY OCTOBER 25, 2016 AT 6 P.M. ET VIA PHONE OR 12 MIDNIGHT VIA WEB	
If you want to...	
• Enroll in, change or waive your medical coverage for 2017 • Enroll in the Health Savings Account for 2017 (for CDHP participants only) • Enroll in, change or waive your dental coverage for 2017 • Enroll or re-enroll in the Health Care Flexible Spending Account and/or Dependent Care Reimbursement Account for 2017 • Enroll or re-enroll in Legal Services for 2017	You must enroll online at: www.nationalgridbenefitservices.com or call the National Grid Benefit Services Center at 1-888-483-2123.
• Purchase or change optional life insurance for 2017	You must call the MetLife Call Center at 1-866-492-6983

Don't forget: If the coverage listed on your *2017 Personalized Enrollment Worksheet* meets your needs for 2017, you do not need to enroll.

The information in this booklet is an abbreviated summary of the actual plan documents. If there is a discrepancy between the information summarized here and the actual plan documents, the actual plan documents govern.

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