LIVE
BRIGHTER

nationalgrid

YOUR 2019 BENEFITS
CHOICES FOR A HEALTHY LIFE

Open Enrollment is
October 15 – 26, 2018

Benefits for Local 101

New hires must enroll in benefits within 31 days. See page 1.

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GET READY!

Open Enrollment for your 2019 benefits begins soon

nationalgrid

Services Delivery Center, Employee Services

nationalgrid
300 Erie Boulevard West, C-1
Syracuse, NY 13202

Let's live healthy together

Your National Grid benefits are here to help you and your family live well, today and tomorrow. By working in partnership, we are creating a community of healthier people and a brighter future for all of us.

USE YOUR BENEFITS TO BE YOUR BEST

National Grid offers many benefits to support your health, finances, and personal wellbeing. We want you to choose and use your benefits wisely, so you can make the most of the moments that matter in your life.

Your choices make a difference! Simple actions — like calling your health plan for guidance or looking up the cost of a procedure before you access it — give you more control over your health and spending. And that helps build a stronger future for all of us at National Grid.

Helping you decide

To support your decision-making, we provide tools and resources to help you understand your options, choose the right coverage, and make informed decisions as you use your benefits throughout the year (see page 4).

2019 BENEFITS OVERVIEW

While most of your benefits will stay the same for 2019, there are a few changes you should know about. Please read this brochure to learn more, then visit **NGBenefitsLiveBrighter.com** for complete details about your 2019 benefits.

NEW HIRES: ENROLL WITHIN 31 DAYS

Visit **NGBenefitsLiveBrighter.com** for complete benefits information, including tools to help you learn about your options. Then, take action — you must enroll in your 2019 benefits at **nationalgridbenefitservices.com** within 31 days of hire. If you don't, you will receive default benefits coverage for 2019 (for details, visit **NGBenefitsLiveBrighter.com** and refer to the "New hires" section on the "Eligibility" page of your digital benefits guide).*

Tip: Find helpful benefits information just for you, including 401(k) and stock purchase, on the "New Hire Resources" page of your digital benefits guide.

EASY ENROLLMENT

You can elect your 2019 benefits on our mobile-friendly enrollment website, **nationalgridbenefitservices.com**.

LIFE HAPPENS: NEW AND AVAILABLE NOW!

If you have a qualified life event during the year and need to change your benefits, visit the new "Life Happens" page of your digital benefits guide at **NGBenefitsLiveBrighter.com**. Remember, once Open Enrollment is over, you can only change your benefits if you have a life event.

THIS OPEN ENROLLMENT, YOU MAY NEED TO TAKE ACTION

Open Enrollment for your 2019 benefits is October 15 – 26, 2018. This is your opportunity to review your benefit options and choose the coverage that will best fit your needs and budget in 2019.

If you do not take action during Open Enrollment, your current benefits will continue into 2019, with a few exceptions. **You must re-enroll in the following benefits if you want to participate in 2019** — your current elections in these benefits will not automatically carry over:

- Health Care Flexible Spending Account (HCFSA)
- Dependent Care Reimbursement Account (DCRA)
- Legal Services plan

You also must take action if you want to make benefit changes or newly enroll in any plans (and receive the upfront HSA contribution from National Grid in 2019, if **newly enrolling** in the CDHP and HSA). See page 4 for the steps you may need to take this Open Enrollment.

*Note: If you are hired in 2018, you will need to enroll in benefits for 2018 and 2019. Please contact the National Grid Services Delivery Center at 1-888-483-2123 for assistance.

Benefit changes for 2019

The following changes will take effect on January 1, 2019, unless otherwise noted. You'll find medical and dental plan coverage details starting on page 5. For complete benefits information, visit **NGBenefitsLiveBrighter.com**.

New BCBS Enhanced Care Management for CDHP members

- If you're enrolled in the Consumer Driven Health Plan (CDHP), you and your family now have access to on-demand concierge support from Blue Cross Blue Shield (BCBS) to help improve your care and make your life easier. It's called Enhanced Care Management, and it's a new, expanded version of the Care Concierge service offered to you today.
- With Enhanced Care Management — available now — you have one phone number to call for all your health care needs. This free service can help you with appointment scheduling, finding doctors, benefits and claims issues, chronic conditions, behavioral health, and much more. Dial 1-800-287-8757 to be connected with:
  - Registered nurses
  - Behavioral health case managers
  - Nutritionists
  - Certified wellness coaches
  - The BCBS member service team

New CVS/Caremark Specialty Copay Card Program for CDHP members

- If you are enrolled in the CDHP and take a specialty medication, CVS/Caremark is developing a Specialty Copay Card Program for 2019. Here's how it will work:
  - As a reminder, under the CDHP, the amount you spend on prescriptions counts toward your deductible and out-of-pocket maximum.
  - As you may know, some drug manufacturers offer copay assistance cards to help CDHP members satisfy their deductible and out-of-pocket maximum.
  - Currently, copay assistance card dollars paid by the drug manufacturer count toward your deductible and out-of-pocket maximum. With the Specialty Copay Card Program, only the portion that you pay for the prescription — not the amount that the drug manufacturer pays through copay assistance — will be credited toward your deductible and out-of-pocket maximum.
- If you are currently using a copay assistance card, you will be contacted by CVS/Caremark with more information about the program when it becomes available.

Aflac Supplemental Cancer Plan no longer available

- The Aflac Supplemental Cancer Plan is no longer available. If you were enrolled in the Aflac plan in 2018 and wish to continue, you need to move your coverage to a direct-bill basis by calling Aflac at 1-866-632-4638.

REDBRICK HEALTH®

EARN HEALTHY REWARDS

With National Grid's Wellbeing Program, you can earn rewards for taking steps to take care of your health! When you complete the healthy activities with RedBrick and earn a total of 50 stars by November 1, 2018, you will earn a $50 gift card. Any RedBrick activities you complete between June 1 and November 1, 2018, will count toward earning your gift card. Why wait? Get started today!

For details and to get started, log in to **NGWellbeing.RedBrickHealth.com**. If you have any questions, email **Redbrickwellbeing@healthyemail.com**.

TIP: DRUG FORMULARIES CAN CHANGE OFTEN

CVS/Caremark continually reviews its Standard Formulary (a list of preferred drugs, based on effectiveness and cost) and will either add new drugs or exclude those that do not meet clinical requirements. You can find drugs on the current formulary and see your prescription costs by logging in to your member account at **caremark.com** or by using the CVS/Caremark mobile app.

Health Savings Account (HSA) limits increasing

- The IRS is increasing the amount that CDHP members may save in an HSA. In 2019, the total amount that you **and** National Grid may contribute to your HSA is:
  - $3,500 if you enroll in individual medical coverage (up from $3,450).
  - $7,000 if you enroll in family medical coverage (up from $6,900).
  - Add $1,000 to these limits if you are age 55 or older in 2019.
- **Important:** If you are **newly enrolling** in the CDHP and HSA, you must select an HSA contribution amount for 2019 (it can be $0.00, if you don't want to contribute) in order to receive the upfront Company contribution to your account in 2019. **If you waive HSA enrollment for 2019, you will also be waiving the 2019 upfront HSA contribution from National Grid.**

Note: Per state laws, if you live in CA or NJ, you will owe taxes on your HSA contributions.

ENROLL IN THE CDHP, GET HSA FUNDING

In 2019, National Grid will make an upfront contribution to your HSA if you are enrolled in the CDHP — $750 for individual coverage or $1,500 for family coverage. You can spend your HSA money on eligible health expenses anytime, even in retirement.

Health Care Flexible Spending Account (HCFSA) limit increasing

- The amount you may contribute to your HCFSA in 2019 is increasing to $2,650 (up from $2,600). The HCFSA is a tax-advantaged account available to those who are not enrolled in the HSA.
- **Important: If you want to contribute to the HCFSA in 2019, you must actively elect it during Open Enrollment, even if you currently participate.** Your FSA elections do not roll over to the next year.

LEARN MORE ABOUT THE HSA

Access a wealth of resources to get familiar with the HSA, including videos, an HSA contribution calculator, future balance calculator, and more. Go to **healthequity.com/ed/nationalgrid**.

Optional dependent life insurance rates increasing

- The rates for optional dependent life insurance (spouse and children) through MetLife will increase in 2019. The cost of coverage is based on age and the amount of coverage chosen for dependent spouses. See your coverage options and rates on the MetLife website in the Book of Options — visit **https://Metlife-ekits.kittrak.com**. Enter NATIONAL GRID LOCAL 101 and use code NGPLAN101.
- **Tip:** Take this opportunity to check your beneficiary on file with MetLife and make sure it's up to date. To make changes, use the beneficiary designation form on MetLife's website.

Long-Term Disability (LTD) rates increasing

The cost of employee-paid LTD coverage is based on the amount of income protection you will receive based on your annual salary. Rates for LTD coverage will increase from $1.241 to $1.396 per $100 of coverage. Questions can be directed to the National Grid Benefit Services Center at 1-888-483-2123.

2019 coverage costs

You can see your costs for medical and dental coverage on pages 7 and 8 of this brochure. Benefit costs are also in your digital benefits guide at **NGBenefitsLiveBrighter.com** and in the *2019 Personalized Enrollment Worksheet* you'll receive by mail.

Learn more

For more details about these changes, as well as complete information about your National Grid benefits, access your digital benefits guide at **NGBenefitsLiveBrighter.com**.

Tools and resources

We want to make it easier for you to connect with your benefits so you can be healthy and make decisions with confidence. National Grid has pulled together resources to give you a clearer picture of how your benefits work, what to expect when you use your coverage, and where to go for more info.

YOUR ENROLLMENT CHECKLIST

It's important that you and your family members understand the benefits and resources available to you so you can make informed, healthy choices during Open Enrollment and all year long. Follow these steps!

- ☐ **Think about how your needs have changed** and consider if you may find more value and/or better coverage by selecting a different plan.
- ☐ **Explore your options at NGBenefitsLiveBrighter.com** where you'll find your benefits information in one place. We have updated the site to help you learn about your 2019 options. You'll find:
  - **Your 2019 digital benefits guide** with complete plan details.
  - **New interactive tools** to help you and your family understand your benefits better.
- ☐ **Review your dependents.** Open Enrollment is the time to review National Grid's benefits eligibility requirements and make sure your dependents still qualify for coverage. To review the requirements, visit **NGBenefitsLiveBrighter.com** and go to the "Eligibility" page of your digital benefits guide. You will still be required to provide documentation for any new dependents you add to your coverage. Note: You may be asked to provide student verification for children over the age of 19 if you have dependents enrolled in dental benefits.
- ☐ **Watch your mailbox.** You will receive your *2019 Personalized Enrollment Worksheet* by mail, which shows your current coverage as well as your benefit options and costs for next year. If you do not receive your *Personalized Enrollment Worksheet*, you can log in to **nationalgridbenefitservices.com** to view your current elections.
- ☐ **Enroll beginning October 15** by logging on to **nationalgridbenefitservices.com**. Enrolling online is the fastest and easiest way to enroll in your 2019 benefits! You have until 11:59 p.m. ET on October 26 to enroll online.
- ☐ **After you enroll,** you'll receive a confirmation statement; please review it for accuracy. If you have any questions or need to make changes to your elections before the enrollment deadline, call the National Grid Benefit Services Center at **1-888-483-2123**. Benefits Specialists are available 8 a.m. to 6 p.m. ET, Monday through Friday.

PARKING AND TRANSIT BENEFITS

You can enroll in or change your parking and transit benefits at any time during the year by logging in to the WageWorks portal at **wageworks.com**.

HOW TO ENROLL

Use the tools and resources at **NGBenefitsLiveBrighter.com** to learn about your 2019 benefits, then enroll at **nationalgridbenefitservices.com** by the deadline.

Note: We encourage you to enroll online, but if you do not have access to the internet, you can enroll by contacting the National Grid Benefit Services Center at 1-888-483-2123. If possible, please have your *2019 Personalized Enrollment Worksheet* in front of you when you call.

Open Enrollment is October 15 – 26, 2018

Many, but not all, of your current benefits will carry over to 2019 if you do not take action during Open Enrollment. **You must take action October 15 – 26, 2018, if you want to:**

- Newly enroll in any plans or make benefit changes for 2019.
- Receive the upfront HSA contribution if you are **newly enrolling** in the CDHP and HSA for 2019: You must select an HSA contribution amount for 2019 (it can be $0.00, if you don't want to contribute) in order to receive the upfront Company HSA contribution in 2019. **If you waive HSA enrollment for 2019, you will also be waiving the 2019 HSA contribution from National Grid.**
  - Note: If you are enrolled in the HSA now and you do not take action during Open Enrollment, your current HSA contribution amount will continue.
- Participate in the Health Care Flexible Spending Account and/or Dependent Care Reimbursement Account in 2019.
- Participate in the Legal Services plan in 2019.
- Purchase or change optional life insurance for 2019 through MetLife.*

The elections you make this Open Enrollment will take effect on January 1, 2019. Elections are final and cannot be changed until the next Open Enrollment unless you experience a qualified life event.

New hires must enroll within 31 days

Be sure to enroll in your 2019 benefits within 31 days of hire. If you don't, you will receive default benefits coverage for 2019 (for details, visit **NGBenefitsLiveBrighter.com** and refer to the "New hires" section on the "Eligibility" page of your digital benefits guide). Your next opportunity to enroll will be the next annual Open Enrollment, unless you experience a qualified life event.

Note: If you are hired in 2018, you will need to enroll in benefits for 2018 and 2019. Please contact the National Grid Services Delivery Center at 1-888-483-2123 for assistance.

* Optional life insurance coverage is available through a separate enrollment with MetLife. You will automatically be enrolled in Company-paid basic life insurance and AD&D insurance through MetLife.

2019 medical and dental plans

Here's a look at your medical and dental options for 2019. Complete plan details are also available on **NGBenefitsLiveBrighter.com**.

A COMPARISON OF NATIONAL GRID PLAN BENEFITS FOR EMPLOYEES REPRESENTED BY LOCAL 101

This chart summarizes major benefits offered by each health plan and also provides employee contributions/costs effective January 1, 2019, to December 31, 2019. If you need more information about each plan, you may call the plan's Customer Service Department directly, or visit their website (phone numbers and website addresses are listed on page 7).

MEDICAL BENEFITS COMPARISON						
	CONSUMER DRIVEN HEALTH PLAN** (Blue Cross Blue Shield)		GHI PREMIER PPO PLAN		GHI STANDARD PPO PLAN	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
GENERAL PROVISIONS						
Annual deductible • Individual • Family	$1,550 $3,100***	$3,100 $6,200***	$250 $500	$500 $1,000	$400 $800	$800 $1,600
Benefit level / coinsurance (what the plan pays for most eligible expenses)	Plan pays services at 90% after you satisfy the deductible, you pay 10%	Plan pays services at 70% after you satisfy the deductible, you pay 30%	Plan pays services at 95% after you satisfy the deductible, you pay 5%	Plan pays services at 70% after you satisfy the deductible, you pay 30%	Plan pays services at 90% after you satisfy the deductible, you pay 10%	Plan pays services at 70% after you satisfy the deductible, you pay 30%
Annual out-of-pocket max. (includes deductible, medical & Rx copays, and coinsurance) • Individual • Family	$2,700 $5,400***	$5,400 $10,800***	$1,900 $3,800	$3,800 $7,600	$2,400 $4,800	$4,800 $9,600
Maximum lifetime benefit per individual	None	None	None	None	None	None
Dependent coverage	Until December 31 of the year in which the child attains age 26					
Inpatient covered services	90%*	70%*	95%*	70%*	90%*	70%*
Health Savings Account (HSA) contribution from National Grid	$750/individual $1,500/family		N/A		N/A	
OUTPATIENT COVERED SERVICES						
Preventive care	100% (subject to schedule)	70%*	100% (subject to schedule)	70%*	100% (subject to schedule)	70%*
Primary care office visits	90%*	70%*	100% after $30 copay per visit	70%*	100% after $40 copay per visit	70%*
Telehealth	90%*		Telehealth not available			
Specialty office visits, including urgent care	90%*	70%*	100% after $40 copay per visit	70%*	100% after $60 copay per visit	70%*

Continued on next page ...

MEDICAL BENEFITS COMPARISON						
	CONSUMER DRIVEN HEALTH PLAN** (Blue Cross Blue Shield)		GHI PREMIER PPO PLAN		GHI STANDARD PPO PLAN	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
OUTPATIENT COVERED SERVICES *(continued)*						
Outpatient surgery and pre-admission testing	90%*	70%*	95%*	70%*	100% after $100 copay	70%*
Routine vision	100% Once every 12 months	70%* Once every 12 months	100% Once per calendar year	Not covered	100% Once per calendar year	Not covered
Routine hearing exams	100%	70%*	100%	70%*	100%	70%*
Diagnostic lab, X-ray	90%*	70%*	100%	70%*	90%*	70%*
Advanced radiology	90%*	70%*	95%*	70%*	90%*	70%*
MENTAL HEALTH AND SUBSTANCE ABUSE						
Inpatient	90%*	70%*	95%*	70%*	90%*	70%*
Outpatient	90%*	70%*	100% after $30 copay	70%*	100% after $40 copay	70%*
MATERNITY BENEFITS						
Prenatal care	90%* (100% covered after initial visit)	70%*	100% after $30 copay for initial visit	70%*	100% after $40 copay for initial visit	70%*
In-hospital delivery and well-baby visit	Delivery: 90%* Well-baby: 100%	70%*	Delivery: 95%* Well-baby: 100%	70%*	Delivery: 90%* Well-baby: 100%	70%*
EMERGENCY ROOM CARE						
Emergency room visits	90%*	90%*	95%*	95%*	90%*	90%*

* After you satisfy the deductible.
** The deductibles and out-of-pocket maximums accumulate across in- and out-of-network.
*** If you are enrolled in the CDHP with family coverage, you must meet the family deductible for coinsurance to apply, and then meet the family out-of-pocket maximum to have the plan pay 100%.

PRESCRIPTION DRUG COVERAGE

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

PRESCRIPTION DRUGS* (administered by CVS/Caremark) Note: Your prescription drug carrier uses a formulary drug list of approved medications. Consult with your physician regarding the use of the formulary.		
	RETAIL (30-DAY SUPPLY)	**MAIL ORDER** (90-DAY SUPPLY)
BCBS CONSUMER DRIVEN HEALTH PLAN		
Generic	You pay 10% after deductible	You pay 10% after deductible
Formulary brand	You pay 10% after deductible	You pay 10% after deductible
Non-formulary brand	You pay 10% after deductible	You pay 10% after deductible
GHI PREMIER PPO PLAN		
Generic	$10	$20
Formulary brand	$35	$70
Non-formulary brand	$60	$120
GHI STANDARD PPO PLAN		
Generic	$10	$20
Formulary brand	$35	$70
Non-formulary brand	$60	$120

* Certain CVS/Caremark pharmacy programs apply to prescription coverage under all of the medical plans. Learn about these programs at **NGBenefitsLiveBrighter.com**.

MEDICAL COSTS* (including prescription drug coverage)						
	CONSUMER DRIVEN HEALTH PLAN (Blue Cross Blue Shield)		**GHI PREMIER PPO PLAN**		**GHI STANDARD PPO PLAN**	
	Individual	Family	Individual	Family	Individual	Family
MONTHLY COST SUMMARY						
Employee pays	$73.67	$195.00	$203.67	$459.33	$143.00	$325.00
WEEKLY COST SUMMARY						
Employee pays	$17.00	$45.00	$47.00	$106.00	$33.00	$75.00

* Deducted in pre-tax dollars.

MEDICAL PLAN CONTACT INFORMATION If you need more information about each plan, contact the plan directly at the phone number and website listed below. **CUSTOMER SERVICE TELEPHONE NUMBERS AND WEBSITES FOR EACH PLAN**			
	CONSUMER DRIVEN HEALTH PLAN (Blue Cross Blue Shield)	**HEALTHEQUITY HSA**	**GHI PPOs**
For a provider directory, service area map, or more information, call:	1-800-287-8757	1-866-346-5800	1-800-624-2414
Or visit their website at:	bluecrossma.com	healthequity.com	emblemhealth.com
For telehealth, visit the Well Connection website:	wellconnection.com		Telehealth not available

For CVS/Caremark, call **1-800-378-8826** or go to **caremark.com**.

DENTAL BENEFITS

Each time you need care, you choose to receive care from an in- or out-of-network provider.
For more information about dental plan benefits, contact GHI directly at 1**-800-624-2414**, or visit **emblemhealth.com**.

DENTAL PLAN: HOW THE PLAN PAYS BENEFITS

GHI DENTAL		
	In-Network*	Out-of-Network
GENERAL PROVISIONS		
Annual deductible	$25	$25
Maximum annual benefit**	$2,000 per individual	$2,000 per individual
Type I: diagnostic and preventive services • Exams and cleanings (once every 6 months) • X-rays (up to 4 bitewings per calendar year, 1 panoramic film every 3 years) • Fluoride for children under 19 (once per calendar year) • Sealants • Space maintainers (1 per child per lifetime up to age 19)	Plan pays 100% Preferred Schedule (not subject to deductible)	Plan pays 100% Preferred Schedule (not subject to deductible)
Type II: basic restorative services • Fillings • Oral surgery • Extractions • Root canal therapy • Treatment of gum disease (periodontal treatment) • Repair of dentures	Plan pays 100% Preferred Schedule	Plan pays 100% Preferred Schedule
Type III: major restorative services • Crowns • Dentures • Bridgework	Plan pays 100% Preferred Schedule	Plan pays 100% Preferred Schedule
Dependent coverage	Until December 31 of the year the dependent attains age 19	
CHILDREN'S ORTHODONTIA		
Orthodontia (coverage for dependent children until December 31 of the year the dependent attains age 19; sponsored dependents to age 25)***	100% Preferred Schedule, $1,998 lifetime maximum per individual	

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

DENTAL COSTS*

GHI DENTAL			
	Individual	Family	Sponsored Dental - Individual
MONTHLY COST SUMMARY			
Employee pays	$0	$0	$17.76
WEEKLY COST SUMMARY			
Employee pays	$0	$0	$4.10

* Deducted in pre-tax dollars.

Notes

Notes

The information in this brochure 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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IMPORTANT BENEFITS INFORMATION

See what's NEW for 2018 and be ready to enroll October 11th–24th.

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HEALTHY CHOICES START HERE

Benefits for New England Unions

UWUA 369
UWUA, BUW 310, 310B, 317, 322, 329, 330
IBEW 326, 486, 1465

YOUR 2018 BENEFITS ENROLLMENT GUIDE

Open Enrollment is October 11 – 24, 2017

WHAT'S INSIDE?

Need help?

If you have any questions or prefer to enroll by phone, please contact the National Grid Benefit Services Center to speak with a Benefits Specialist. Be sure to have your *2018 Personalized Enrollment Worksheet* in front of you when you call.

National Grid Benefit Services Center
1-888-483-2123
Monday through Friday
8 a.m. – 6 p.m. ET

Welcome to Open Enrollment

National Grid is proud to offer valuable, sustainable benefits to help you and your family live well — and help us create a community of healthy people. By working in partnership, we can all live brighter, individually and as a company.

PARTNERING TO LIVE HEALTHY TOGETHER

When you focus on living healthy, keeping up with preventive care, and thinking like a consumer, you're able to better manage your health and your spending. That helps build a stronger future for all of us at National Grid.

To support you, we are providing new tools and resources that are just a click away through your new benefits decision website at **NGBenefitsLiveBrighter.com**. We've created this site to help you connect with your benefits easily so you can get the most out of them and make healthy, thoughtful choices. Turn to page 37 to learn more about the decision support resources available to you.

Go to NGBenefitsLiveBrighter.com:

- *Before Open Enrollment begins on October 11*, this website will include interactive tools and resources to learn more about your benefits, including educational videos and an interactive brochure that explains how the Consumer Driven Health Plan (CDHP) and Health Savings Account (HSA) work.
- *Starting October 11,* the site will be updated to include a digital version of this benefits guide, where you'll find additional resources and direct links for more information.

WHAT'S CHANGING FOR 2018

Many of your benefits will stay the same in 2018, but there are some important changes coming next year, including some new benefit options. To learn about these changes, see page 2.

WHAT YOU NEED TO DO

Open Enrollment for your 2018 benefits is October 11 – 24, 2017. This is your opportunity to review your current benefits and make sure they are still a good fit for your needs. You also have new benefit options to consider. After Open Enrollment ends, you will only be able to make a change to your benefits during the year if you have a qualified life event, such as getting married or having a baby (learn more on page 42).

We encourage you to take the time to learn about your options, using the tools and resources available, so you can enroll in the plans that will be best for you and your family next year.

3 STEPS TO A SUCCESSFUL ENROLLMENT

1. **READ** this guide to learn about your benefit options for 2018 and see what's changing.
2. **ACCESS** additional resources on your new benefits decision website, **NGBenefitsLiveBrighter.com**.
3. **ENROLL** in your benefits at **nationalgridbenefitservices.com** between October 11 and October 24, 2017.

DO YOU NEED TO ENROLL?

Many, but not all, of your current benefits will carry over to 2018 if you do not take action during Open Enrollment. **You must take action October 11 – 24 if you want to**:

- Enroll in, change, or opt out of your medical coverage for 2018
- Receive an upfront contribution to your HSA (CDHP participants only)
- Enroll or re-enroll in the Health Care Flexible Spending Account and/or Dependent Care Reimbursement Account for 2018
- Enroll in, change, or decline your dental coverage for 2018
- Purchase vacation time
- Enroll in one or more of the new voluntary benefit plans for 2018
- Purchase or change optional life insurance and/or voluntary AD&D for 2018 through MetLife*

For details about the default coverage you will receive if you do not enroll, please turn to page 34.

* Optional life insurance and voluntary AD&D coverage available through a separate enrollment with MetLife. You will automatically be enrolled in Company-paid basic life insurance and AD&D insurance through MetLife.

SAME ENROLLMENT PROCESS THAT YOU KNOW

You'll still elect your benefits on our mobile-friendly enrollment site, **nationalgridbenefitservices.com**, between October 11 and October 24, 2017. Before Open Enrollment begins, you will also receive your *2018 Personalized Enrollment Worksheet* in the mail, showing your current benefits as well as your options and costs for 2018.

Changes for 2018

As part of our ongoing benefits strategy, we remain committed to providing a competitive, sustainable benefits program that meets our employees' diverse needs. We are pleased to offer you similar benefit options for 2018 with a few changes and enhancements.

WHAT'S CHANGING

MEDICAL PLANS

Consumer Driven Health Plan (CDHP) changes:

- The CDHP will have higher deductibles in 2018; however, the increase will be offset by the new upfront HSA contribution ($750 for employee only coverage and $1,500 if you are covering dependents).
  - In-network deductibles are increasing to $1,550 for employee only coverage and $3,100 if you cover dependents (currently $1,500/$3,000).
  - Out-of-network deductibles are increasing to $3,100 for employee only coverage and $6,200 if you cover dependents (currently $1,500/$3,000).
- CDHP out-of-pocket maximums are decreasing for 2018 to offer you additional financial protection against significant medical expenses.
  - In-network out-of-pocket maximums are decreasing to $2,700 for employee only coverage and $5,400 if you cover dependents (currently $3,200/$6,400).
  - Out-of-network out-of-pocket maximums are decreasing to $5,400 for employee only coverage and $10,800 if you cover dependents (currently $6,000/$12,000).
  - For complete CDHP coverage details and costs, turn to page 6.

Preferred Provider Organization (PPO) plan changes:

- An annual deductible and coinsurance will now apply to certain services in the PPO plan through BCBS. You will continue to pay a flat copay for doctor's visits and prescriptions. For other services, such as emergency room visits and hospital care, you pay the full cost up to the plan's annual deductible; then you and National Grid share any costs that exceed the deductible for the rest of the year until you hit your out-of-pocket maximum. You pay a small percentage of coinsurance, while the plan pays the majority of the costs. To learn more about how the deductible and coinsurance work in the PPO plan, see page 10.

Point of Service (POS) plan changes:

- POS plans through Fallon Community Health Plan and Harvard Pilgrim are still being offered for 2018.
- **The other regional POS plans (Blue Choice 2 New England (NH & RI), Health New England, Nantucket, and MVP Select) will no longer be available**. If you are currently in a POS plan that is being discontinued, you must elect another medical plan during Open Enrollment or you will automatically be enrolled in the PPO at the same coverage level you have now effective January 1, 2018.
- An annual deductible and coinsurance will now apply to certain services in the POS plans through Fallon Community Health Plan and Harvard Pilgrim. You will continue to pay a flat copay for doctor's visits and prescriptions. For other services, such as emergency room visits and hospital care, you pay the full cost up to the plan's annual deductible; then you and National Grid share any costs that exceed the deductible for the rest of the year until you hit your out-of-pocket maximum. You pay a small percentage of coinsurance, while the plan pays the majority of the costs. To learn more about how the deductible and coinsurance work in the POS plan, see page 11.
- For complete POS plan details and costs, see page 6.

HEALTH SAVINGS ACCOUNT (HSA)

Upfront contribution to your HSA

- If you enroll in the Consumer Driven Health Plan (CDHP), you will receive HSA funding — that's health care spending money, just for enrolling! In 2018, you will receive an upfront HSA contribution of $750 for employee only medical plan coverage or $1,500 if you cover dependents.
- This contribution to your HSA is tax-free and yours to keep — use it, along with your own pre-tax contributions, to pay for your eligible health care expenses in 2018 and beyond. Any unused balance carries forward year after year.

IRS annual contribution limits increasing

- In 2018, the total amount that can be contributed to your HSA is $3,450 if you enroll in employee only medical coverage or $6,900 if you cover dependents. Add $1,000 to these limits if you are age 55 or older.

NEW VOLUNTARY BENEFITS

Introducing three voluntary plan options

- To give you more options for protecting your health and finances, we are introducing three new voluntary plan options, all offered through MetLife: Accident, Hospital Indemnity, and Critical Illness insurance. These plans are designed to supplement your primary medical plan by providing cash payments in the event of a significant unexpected medical expense. See page 23 for details.

FITNESS REIMBURSEMENT FOR BCBS MEMBERS

Changes to fitness reimbursement benefit

- In addition to our definition of qualified health clubs, coverage will now include fitness studios and facilities that offer the following exercise activities taught by a certified instructor: yoga, pilates, zumba, aerobic/group classes, indoor cycling/spinning classes, kickboxing, crossfit, strength training, tennis, indoor rock climbing, and personal training. A qualified health club is one that has cardiovascular and strength training equipment and facilities for exercising and improving physical fitness.
- In 2018, if you are enrolled in a Blue Cross Blue Shield medical plan, you are eligible for a $600 reimbursement every six months (on a rolling six-month basis) for membership fees at eligible facilities after attainment of 50 visits. The $600 reimbursement limit is new for 2018.

PRESCRIPTION DRUG

New prescription programs from Caremark

CVS/Caremark will continue to provide prescription coverage for all of our medical plans. Several new prescription programs are being introduced for 2018 to help you access the most appropriate medication for your needs in the most cost-effective way. You'll find an overview of these programs below. For complete details, turn to page 14.

- **PPACA vaccine coverage:** As part of the Patient Protection and Affordable Care Act (health care reform law), the list of fully covered vaccines will be expanded to include both seasonal strains of influenza and common preventable diseases at no cost to you.
- **Glumetza, Fortamet, Zegerid, and their high-cost generics require authorization:** You will be required to get prior authorization from your doctor before receiving Type 2 diabetes medications Glumetza, Fortamet, and the associated high-cost Metformin ER generics. Members will be instructed to try Glucophage and its generic medication before being allowed to use one of the alternative antidiabetics. In addition, there is a similar process for Proton Pump Inhibitor medication Zegerid and its generics. Generic proton pump inhibitors such as omeprazole and lansoprazole are the preferred lower cost alternatives. Your prescribing doctors will be made aware of the upcoming changes about the prior authorization requirement on Glumetza, Fortamet, Zegerid, and their respective generics.
- **Opioid management program:** This program is designed to help ensure safe and appropriate use of opioids by limiting the use of pain medication and controlled substances to FDA-approved amounts.
- **Periodic formulary updates:** CVS/Caremark continually reviews drugs on the formularies and will either add newly available products or exclude products that do not meet clinical requirements. If you are impacted by a formulary change, you will be contacted by CVS/Caremark.

DENTAL

New dental plan option

- In 2018, you will have a second dental plan option: Dental Plan Without Orthodontia. This new plan does not include orthodontia coverage, and offers a less expensive alternative for employees who do not need that extra coverage. We will continue to offer the same plan we currently offer, called the Dental Plan With Orthodontia. Learn about the dental plans on page 25.

SHORT-TERM AND LONG-TERM DISABILITY

New contribution formula

- Starting January 1, 2018, your current contribution for Short-Term Disability (STD) and Long-Term Disability (LTD) benefits is changing from a flat rate to a percent base. The company will contribute 80% of the cost and employees pay 20%. As your base salary changes, the contribution will be adjusted. Most employees will experience a decrease in contribution for this benefit.

Medical

Nothing is more important than the health of you and your family. National Grid is proud to offer benefits that help you live well today and help us create a community of healthy people, together.

For 2018, you have a choice of three medical plans with a range of coverage levels and costs, giving you the flexibility to choose what's best for your needs and budget. Learn about your options here, then visit **nationalgridbenefitservices.com** to enroll in (or waive) coverage. If you enroll in a medical plan for 2018, you will receive a new medical ID card in the mail.

Important: The POS plans through Fallon Community Health Plan and Harvard Pilgrim are still being offered for 2018; however, the other regional POS plans (Blue Choice 2 New England (NH & RI), Health New England, Nantucket, and MVP Select) will no longer be available. If you are currently in a POS plan that is being discontinued, you must elect another medical plan during Open Enrollment or you will automatically be enrolled in the PPO at the same coverage level you have now effective January 1, 2018.

2018 MEDICAL PLAN OPTIONS

- Consumer Driven Health Plan (CDHP)
- Preferred Provider Organization (PPO)
- Point of Service Plan (POS)

KEY FEATURES

All of National Grid's medical plans offer:

- **Comprehensive, affordable coverage** that fulfills the requirements of the health care reform law. **Tip:** If you need extra protection from large or unexpected medical expenses, you may also choose to enroll in voluntary benefit coverage (see page 23).
- **Fully covered in-network preventive care** — you pay nothing for services such as annual physicals, recommended immunizations, and routine cancer screenings when received from network providers. See more covered preventive services at **healthcare.gov/coverage/preventive-care-benefits**.
- **Prescription drug coverage** included with each medical plan. Prescription benefits are provided by CVS/Caremark. Turn to page 14 for details.
- **Financial protection** through annual out-of-pocket maximums that limit the amount you'll pay each year.
- **Choice of three coverage levels:** Employee only, 2-person, or Family.

Consumer Driven Health Plan (CDHP)

A plan that puts you in charge of your spending through lower paycheck contributions, higher deductibles, and a tax-free Health Savings Account (HSA), which now includes an upfront tax-free contribution. All the money in your HSA is yours for life and rolls over year to year.

Offered through: Blue Cross Blue Shield

Compatible with: Health Savings Account (HSA)

Preferred Provider Organization (PPO)

A traditional PPO plan that offers cost sharing after you meet the deductible; a flat copay is offered for certain services and prescriptions. It reduces your out-of-pocket responsibility when you need care through a lower deductible and higher paycheck contributions.

Offered through: Blue Cross Blue Shield

Compatible with: Health Care Flexible Spending Account (FSA)

Point of Service Plan (POS)

The regional POS plan is similar to the PPO, except you must choose a primary care physician (PCP) to coordinate your in-network care. As with all of National Grid's medical plans, you can see in-network or out-of-network providers, but you'll pay less when you stay in network.

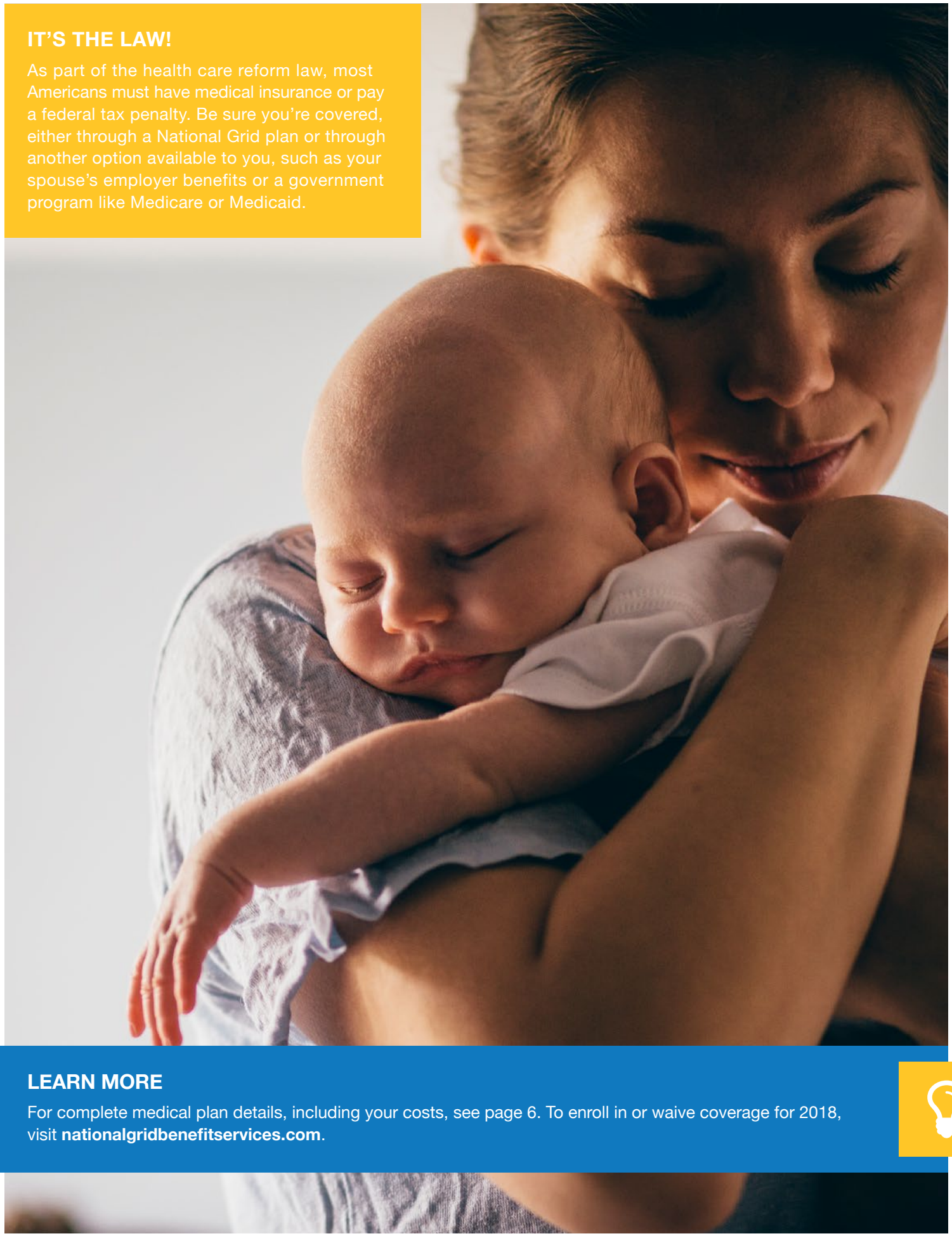
Offered through: Fallon Community Health Plan or Harvard Pilgrim

Compatible with: Health Care Flexible Spending Account (FSA)

Note: Fallon and Harvard are not available everywhere. Refer to your *2018 Personalized Enrollment Worksheet* to see which plans are available to you. Then, visit **fchp.org** for more information about Fallon Community Health Plan and **harvardpilgrim.org/members** for more information about Harvard Pilgrim.

IT'S THE LAW!

As part of the health care reform law, most Americans must have medical insurance or pay a federal tax penalty. Be sure you're covered, either through a National Grid plan or through another option available to you, such as your spouse's employer benefits or a government program like Medicare or Medicaid.



LEARN MORE

For complete medical plan details, including your costs, see page 6. To enroll in or waive coverage for 2018, visit **nationalgridbenefitservices.com**.

Medical

COMPARE THE PLANS

This chart summarizes major benefits offered by each health care plan (Consumer Driven Health Plan, Preferred Provider Organization Plan, and Point of Service Plan) and also provides employee contributions/costs effective January 1, 2018, to December 31, 2018. If you need more information about each plan, you may call the plan's Customer Service Department directly, or visit their website.

Please note: Diagnostic labs, X-rays, and advanced radiology services remain subject to the deductible and coinsurance under the CDHP and PPO plans. Under the POS plan, diagnostic labs, X-rays, and advanced radiology services are subject to the deductible and coinsurance, but you will pay only a copay for MRI/CT/PET scans and nuclear imaging.

	MEDICAL BENEFITS COMPARISON: HOW PLANS COVER SERVICES					
	Consumer Driven Health Plan (CDHP) (Blue Cross Blue Shield)		**Preferred Provider Organization (PPO)** (Blue Cross Blue Shield)		**Point of Service (POS)** (Fallon Community Health Plan, Harvard Pilgrim)	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
GENERAL PROVISIONS						
Annual deductible • Employee only • Covering dependents	$1,550 $3,100**	$3,100 $6,200**	$250 $500	$500 $1,000	$250 $500	$500 $1,000
Benefit level / Coinsurance (what the plan pays for most eligible expenses)	Plan pays services at 90% after deductible is satisfied; you pay 10%	Plan pays services at 70% after deductible is satisfied; you pay 30%	Plan pays services at 95% after deductible is satisfied; you pay 5%	Plan pays services at 75% after deductible is satisfied; you pay 25%	Plan pays services at 95% after deductible is satisfied; you pay 5%	Plan pays services at 75% after deductible is satisfied; you pay 25%
Annual out-of-pocket max. (includes deductible, medical and Rx copays, and coinsurance) • Employee only • Covering dependents	$2,700 $5,400**	$5,400 $10,800**	$1,900 $3,800	$3,800 $7,600	$1,900 $3,800	$3,800 $7,600
Maximum lifetime benefit per individual	None	None	None	None	None	None
Dependent coverage	Until December 31 of the year in which the child attains age 26					
Inpatient covered services	90%*	70%*	95%*	75%*	95%*	75%*
Health Savings Account (HSA) upfront contribution	$750/employee only $1,500/covering dependents		N/A			

* After you satisfy the deductible.

** If you are enrolled in the CDHP with dependents, you must meet the family deductible for coinsurance to apply, and then meet the family out-of-pocket maximum to have the plan pay 100%.

	MEDICAL BENEFITS COMPARISON: HOW PLANS COVER SERVICES					
	Consumer Driven Health Plan (CDHP) (Blue Cross Blue Shield)		**Preferred Provider Organization (PPO)** (Blue Cross Blue Shield)		**Point of Service (POS)** (Fallon Community Health Plan, Harvard Pilgrim)	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
OUTPATIENT COVERED SERVICES						
Primary care office visits	90%*	70%*	$30 copay per visit	75%*	$30 copay per visit	75%*
Telehealth	90%*		$30 copay		$30 copay (Harvard Pilgrim only)	
Outpatient surgery and pre-admission testing	90%*	70%*	95%*	75%*	95%*	75%*
Preventive care (subject to schedule)	100%	70%*	100%	75%*	100%	75%*
Routine vision	100% (once every 12 months)	70%* (once every 12 months)	100% once every 24 months)	75%* (once every 24 months)	100% (once every 12 months)	75%* (once every 12 months)
Routine hearing exams	100%	70%*	100%	75%*	100%	75%*
Specialty office visits, including urgent care	90%*	70%*	$40 copay per visit	75%*	$40 copay per visit	75%*
Diagnostic lab, X-ray, and advanced radiology	90%*	70%*	95%*	75%*	95%*	75%*
MRI/CT/PET scans and nuclear imaging	90%*	70%*	95%*	75%*	$40 copay per visit; Authorization required	75%*; Authorization required
MATERNITY BENEFITS						
Prenatal care	90%* (covered 100% after first visit)	70%*	$30 copay (first visit only)	75%*	$30 copay (first visit only)	75%*
In-hospital delivery and well-baby visit	Delivery: 90%* Well-baby: 100%	70%*	Delivery: 95%* Well-baby: 100%	75%*	Delivery: 95%* Well-baby: 100%	75%*
EMERGENCY ROOM CARE						
Emergency room visits	90%*	90%*	95%*	95%*	95%*	95%*

* After you satisfy the deductible.

Medical

COMPARE THE PLANS (Continued)

	MENTAL HEALTH AND SUBSTANCE ABUSE			
	Consumer Driven Health Plan (CDHP)	**Preferred Provider Organization (PPO)**	**Point of Service (POS)**	
	Blue Cross Blue Shield	Blue Cross Blue Shield	Harvard Pilgrim	Fallon Community Health Plan
Inpatient – In-network	90%*	95%*	95%*	95%*
Inpatient – Out-of-network	70%* Prior authorization required	75%*	75%* Prior authorization required	75%* Prior authorization required
Outpatient – In-network	90%*	$30 copay per visit	$30 copay per visit	$30 copay per visit
Outpatient – Out-of-network	70%*	75%*	75%*	75%*

* After you satisfy the deductible.

	MEDICAL COSTS* (Including Prescription Drug Coverage)								
	Consumer Driven Health Plan (CDHP) (Blue Cross Blue Shield)			**Preferred Provider Organization (PPO)** (Blue Cross Blue Shield)			**Point of Service (POS)** (Fallon Community Health Plan, Harvard Pilgrim)		
	Employee only	2-Person	Family	Employee only	2-Person	Family	Employee only	2-Person	Family
Total monthly cost	$765.17	$1,530.34	$2,182.97	$814.89	$1,629.79	$2,324.83	$835.79	$1,671.58	$2,384.44
National Grid pays monthly	$688.65	$1,377.31	$1,964.67	$668.21	$1,336.43	$1,906.36	$668.63	$1,337.26	$1,907.55
New England Union employees pay monthly	$76.52	$153.03	$218.30	$146.68	$293.36	$418.47	$167.16	$334.32	$476.89
True-up Surcharge	$2.54	$5.08	$7.25	$5.66	$11.32	$16.15	$5.91	$11.82	$16.87
Full-time employees pay monthly	$79.06	$158.11	$225.55	$152.34	$304.68	$434.62	$173.07	$346.14	$493.76
Full-time employees pay weekly	$18.24	$36.49	$52.05	$35.16	$70.31	$100.30	$39.94	$79.88	$113.94
80% part-time employees pay weekly	$49.91	$99.82	$142.39	$65.73	$131.47	$187.54	$70.53	$141.05	$201.21
60% part-time employees pay weekly	$81.58	$163.16	$232.73	$96.31	$192.63	$274.78	$101.11	$202.23	$288.47

* Deducted in pre-tax dollars.

Medical

CONSUMER DRIVEN HEALTH PLAN (CDHP)

The CDHP combines low-premium, high-deductible coverage with a Health Savings Account (HSA) that lets you save for and pay for eligible health care expenses with tax-free dollars. **As an added benefit**, you will receive an upfront HSA contribution of $750 for employee only coverage or $1,500 if you cover dependents. Learn more about the HSA on page 18.

HOW THE CDHP WORKS

You can see any provider you wish, but:

- Staying in-network will save you money. It offers access to providers nationwide, so you can likely receive in-network care no matter where you are. See how to find in-network providers on page 13.
- In-network **preventive care** is fully covered, so you pay nothing. For **non-preventive care**, you pay for your initial **medical and prescription costs** until you meet your annual **deductible**. Remember, the upfront contribution to your HSA, as well as your own pre-tax HSA contributions, will help you pay for your out-of-pocket costs.
- Once the deductible is met, you'll pay a percentage of your covered medical expenses (with your plan covering the majority); this amount is called your **coinsurance**. If you are covering dependents, you must meet the family deductible before the plan starts paying coinsurance.
- If your share of medical expenses reaches an amount called the **out-of-pocket maximum**, the plan pays 100% of your eligible expenses for the rest of the 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 pays 100% of future claims costs through the end of the plan year.

HOW PRESCRIPTION DRUG COSTS ARE PAID UNDER THE CDHP

Prescription drug coverage for the CDHP is administered by CVS/Caremark. Here's how it works:

- Prescription drug expenses 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. After you meet the deductible, you pay only the coinsurance and your plan pays the rest.
- The Patient Protection and Affordable Care Act (PPACA) makes certain preventive medications and supplements available to you at no cost, including certain women's contraceptives, pediatric multivitamins, and smoking cessation medications. You pay $0 for qualifying PPACA preventive medications regardless of which medical plan you choose. The preventive drug list is available by calling CVS/Caremark at **1-800-378-8826**.

HOW DOES A CDHP GIVE YOU MORE CONTROL OVER YOUR HEALTH SPENDING?

With any plan, you are in charge of your health care choices and how best to spend your income on the health care that you need. Your payroll contributions for the CDHP are lower than the PPO and POS plans, giving you the opportunity to contribute the cost savings to an HSA. Through the HSA, you're saving those dollars to pay for health care expenses when they occur rather than overpaying for coverage you may or may not need. You can spend the money now, 10 years from now, even in retirement.

- CDHP members have access to a list of preventive prescription drugs that are available without having to meet the deductible. You will only pay the coinsurance for these medications, even if you have not yet met your annual plan deductible. The Preventive Drug List for CDHP participants is available by visiting **caremark.com/portal/asset/preventive_dl.pdf** or calling CVS/Caremark at **1-800-378-8826**. Preventive drugs as defined by the PPACA (health care reform law) will continue to be covered in full ($0 cost) and are not subject to the deductible.

USE YOUR CDHP AND HSA WISELY

Here are ways to make the most of your CDHP all year long.

- **Track your stats.** Log in to **bluecrossma.com** to see how much of your deductible you've met, what you've accumulated toward your out-of-pocket maximum, review medical claims, use helpful tools, and more. Likewise, keep tabs on your HSA by logging in to your HSA provider's website at **healthequity.com** to view your balance, submit claims, and more.
- **Think about your costs.** You pay lower paycheck contributions in exchange for assuming more financial responsibility when you receive care, so it's smart to plan ahead. Try to contribute enough to your HSA to cover your expected out-of-pocket costs, such as your annual deductible and coinsurance.
- **Change your contributions anytime.** Adjust your contributions as necessary during the year to make sure you have money available when you need it. Note: You can only spend HSA money that's actually been deposited into your account.
- **Look long term.** You will never forfeit any money left in your HSA — it rolls over year after year. If you know about future expenses, or want to save for your health care costs in retirement, set aside a little extra each paycheck so your balance can grow over time.

Medical

PREFERRED PROVIDER ORGANIZATION (PPO) PLAN

The PPO charges higher paycheck contributions in exchange for lower out-of-pocket costs as you receive care throughout the year. With this plan, your costs are more predictable, but you'll still have out-of-pocket expenses — either copays or a deductible and coinsurance, depending on the service received.

Participants in the PPO are not eligible to participate in the HSA, by law, but may participate in the Health Care Flexible Spending Account (HCFSA), which still offers tax savings but does not allow you to keep or carry over your money each year.

HOW THE PPO PLAN WORKS

- You can see any provider you wish, but staying in-network will save you money. It offers access to providers nationwide, so you can likely receive in-network care no matter where you are. See how to find in-network providers on page 13. You do not need referrals from a primary care physician (PCP).
- In-network **preventive care** is covered at 100%. For certain in-network **non-preventive** services — including primary care and specialist office visits, urgent care, prescriptions, and many outpatient services — you pay a flat **copay** without needing to meet the **deductible**. For all other health care services, you pay 100% of the costs until you meet the annual deductible.
- Once the deductible is met, you'll pay a percentage of your covered medical expenses (with your plan covering the majority); this amount is called your **coinsurance**.
  - If you need specialty care (bariatric surgery, cardiac care, rare cancers, knee and hip replacement, maternity care, spine surgery, and transplants), go to a BCBS Blue Distinction Plus Center (visit **bcbs.com/about-us/capabilities-initiatives/blue-distinction/blue-distinction-specialty-care** for details).
- If your share of expenses reaches an amount called the **out-of-pocket maximum**, the plan pays 100% of your eligible expenses for the rest of the year.

USE YOUR PPO PLAN WISELY

Here are ways to make the most of your PPO all year long.

- **Track your stats.** Log in to **bluecrossma.com** to see how much of your deductible you've met, review claims, use helpful tools, and more.
- **Pair it with a Health Care FSA.** If you enroll in the Health Care FSA when enrolling in the PPO, you can set aside pre-tax dollars to help pay for your out-of-pocket costs. Keep in mind, with this account, you have 2½ months into the following year to spend any remaining balance; after that, any unused funds will be forfeited as part of the "use it or lose it" rule.
- **Be cost-conscious.** Log in to **bluecrossma.com**, where you can search for in-network providers, get cost estimates for over 1,600 medical procedures, read physician reviews, compare doctors, and more.

POINT OF SERVICE (POS) PLAN

The POS plan, offered through your choice of Fallon Community Health Plan or Harvard Pilgrim, is similar to the PPO. You pay higher paycheck contributions in exchange for lower out-of-pocket costs as you receive care throughout the year. This means your costs are more predictable, but you'll still have out-of-pocket expenses — either copays or a deductible and coinsurance, depending on the service received.

Unlike the PPO, with a POS plan you must choose a primary care physician (PCP) to coordinate your in-network care.

Participants in the POS plan are not eligible to participate in the HSA, by law, but may participate in the Health Care Flexible Spending Account (HCFSA), which still offers tax savings but does not allow you to keep or carry over your money each year.

HOW THE POS PLAN WORKS

- You can see any provider you wish, but staying in-network will save you money. You must follow the plan's procedures for filing claims when you receive out-of-network care or you may be subject to a penalty. See how to find in-network providers on page 13.
- You are required to choose a PCP to coordinate your in-network care.
- In-network **preventive care** is covered at 100%. For certain in-network **non-preventive** services — including primary care and specialist office visits, urgent care, prescriptions, and many outpatient services — you pay a flat **copay** without needing to meet the deductible. For all other health care services, you pay 100% of the costs until you meet the annual **deductible**.
- Once the deductible is met, you'll pay a percentage of your covered medical expenses (with your plan covering the majority); this amount is called your **coinsurance**.
- If your share of expenses reaches an amount called the **out-of-pocket maximum**, the plan pays 100% of your eligible expenses for the rest of the year.

USE YOUR POS PLAN WISELY

Here are ways to make the most of your POS plan all year long.

- **Track your stats.** Log in to the Fallon Community Health Plan website at **fchp.org** or the Harvard Pilgrim website at **harvardpilgrim.org/members** to see how much of your deductible you've met, review claims, use helpful tools, and more.
- **Pair it with a Health Care FSA.** If you enroll in the Health Care FSA when enrolling in the POS plan, you can set aside pre-tax dollars to help pay for your out-of-pocket costs. Keep in mind, with this account, you have 2½ months into the following year to spend any remaining balance; after that, any unused funds will be forfeited as part of the "use it or lose it" rule.
- **Be cost-conscious**. On the Fallon Community Health Plan website at **fchp.org**, you can search for in-network providers and use the Fallon SmartShopper tool to get real-time cost comparisons and find the right health care providers for you. Through the Harvard Pilgrim website at **harvardpilgrim.org/members**, you can search for in-network providers, take advantage of member discounts and savings, and use the Prescription Drug Lookup tool to see how different drugs are covered (and potentially find less expensive generic alternatives).

MASSACHUSETTS RESIDENTS WHO OPT OUT

National Grid provides medical benefits deemed creditable by the Commonwealth of Massachusetts. If you do not have creditable health insurance coverage (as defined by the Commonwealth), you will be subject to tax penalties of up to 50% of the lowest cost premium for health insurance through the Massachusetts Health Connector for each month you go without coverage (after a 63-day grace period).

To avoid tax penalties, you are required to file proof of creditable health insurance coverage annually along with your personal income tax return. You provide your proof of creditable coverage in the form of a tax form, Form MA 1099-HC. In early 2018, you will receive the Form MA 1099-HC that will indicate you have creditable coverage. Use this form when filing your 2017 taxes.

For more information, visit **mahealthconnector.org** or call the National Grid Benefit Services Center at **1-888-483-2123**.

Medical

CARE CONCIERGE

Employees enrolled in a medical plan with Blue Cross Blue Shield can take advantage of the Care Concierge service, offered by National Grid at no cost to you. The Care Concierge team of dedicated nurses is ready to help you learn more about health conditions, give you ideas for healthier habits, and let you know about programs and resources available to make the most of your plan.

With a simple phone call, a Care Concierge nurse can help you:

Take control of your health through:

- Advice on healthy lifestyle changes
- Proper use of medications
- Understanding a diagnosis
- Guidance on complex medical issues

Get more from your medical plan:

- Specialty care programs
- Wellness coaching services
- Prevention and wellness programs
- Online tools and resources

Choose the right care:

- Through education on quality care centers
- Based on your doctor's recommendation
- With decision-making support regarding a surgery or procedure

To access Care Concierge, call **1-800-287-8757**.

TELEHEALTH

With our convenient telehealth benefits, you and your covered family members can see the doctor without leaving your house. Telehealth gives you 24/7/365 access to U.S. board-certified physicians, online or by phone. It's an affordable alternative to urgent care and Emergency Room visits for non-emergency medical care. In fact, a telehealth visit costs the same as an in-network primary care visit. To see your primary care visit costs, turn to page 7.

Be sure to register for telehealth through your medical plan carrier so you'll be ready when you need care in a hurry! Please note: Telehealth is not currently available to POS plan members with Fallon Community Health Plan.

TELEHEALTH (CDHP AND PPO PLAN MEMBERS WITH BLUE CROSS BLUE SHIELD):

- **Go to bluecrossma.com/telehealth**. 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. You can also download the *AmWell Live Doctor Video Visits* app for free on most mobile devices.

DOCTOR ON DEMAND (POS PLAN MEMBERS WITH HARVARD PILGRIM)

- **Go to doctorondemand.com**. Click "Join Now" and enter your email address, password, and date of birth. Next, set up your profile by providing a few basic details, selecting "Harvard Pilgrim Health Care" as your insurance provider, and entering your Member ID to receive the negotiated rate for those physicians. You can also download the *Doctor On Demand* app for free on most mobile devices.

WHEN SHOULD YOU USE TELEHEALTH?	
Use it for …	Use it when…
A wide variety of common medical conditions in adults and children, including: ✔ Acute care for minor illnesses and injuries ✔ Managing symptoms from chronic conditions ✔ Support of behavioral health care needs ✔ Any other general health and wellbeing concerns	You need an alternative to the emergency room or urgent care in these types of situations: ✔ Your doctor's office is closed ✔ Your child has a fever at 2 a.m. ✔ You think you have the flu, but you're feeling too ill to leave the house ✔ You're at work in the office or in the field ✔ It's after business hours or on weekends

FIND A DOCTOR & ESTIMATE COSTS

Blue Cross Blue Shield (BCBS)

- Visit **bluecrossma.com**.
- On the homepage, click the "Find a Doctor & Estimate Costs" box.
- From here, you can either log in to your BCBSMA account to search, or you can find a doctor without logging in. Choose the "PPO or EPO" network and enter your search criteria.

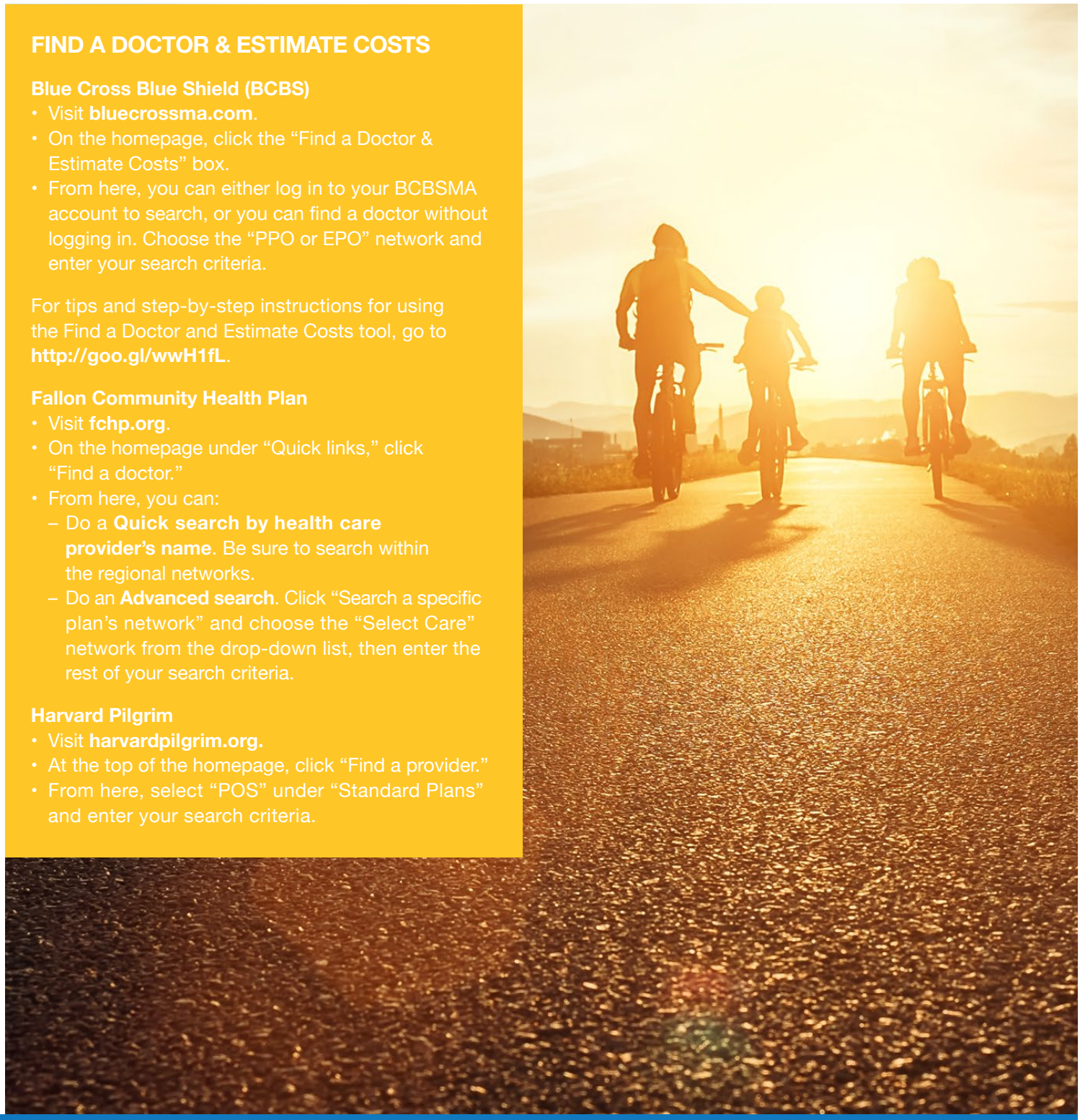
For tips and step-by-step instructions for using the Find a Doctor and Estimate Costs tool, go to **http://goo.gl/wwH1fL**.

Fallon Community Health Plan

- Visit **fchp.org**.
- On the homepage under "Quick links," click "Find a doctor."
- From here, you can:
  - Do a **Quick search by health care provider's name**. Be sure to search within the regional networks.
  - Do an **Advanced search**. Click "Search a specific plan's network" and choose the "Select Care" network from the drop-down list, then enter the rest of your search criteria.

Harvard Pilgrim

- Visit **harvardpilgrim.org.**
- At the top of the homepage, click "Find a provider."
- From here, select "POS" under "Standard Plans" and enter your search criteria.



DON'T HAVE A PERSONAL DOCTOR? YOU SHOULD. HERE'S WHY.

- **Better health**. Getting the right health screenings each year can reduce your risk for many serious conditions. In-network preventive care is **100% covered** under each of National Grid's medical plans, so there's no excuse to skip it.
- **A healthier wallet**. Having a doctor you can call helps you avoid costly trips to the emergency room and decide when you really need to see a specialist.
- **Peace of mind.** Advice from someone you trust ... it means a lot when you're healthy, but it's even more important when you're sick. Your personal doctor gets to know you and your health history and can help coordinate any care you need.

Medical

PRESCRIPTION DRUG

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

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 **caremark.com**. Learn how prescriptions are covered under each plan in the table below.

	PRESCRIPTION DRUG COVERAGE (administered by CVS/Caremark)			
			Point of Service (POS)	
	Consumer Driven Health Plan (CDHP) (Blue Cross Blue Shield)	**Preferred Provider Organization (PPO)** (Blue Cross Blue Shield)	**Harvard Pilgrim**	**Fallon Community Health Plan**
RETAIL (30-DAY SUPPLY)				
Generic	You pay 10% after deductible	$10 copay	$10 copay	$10 copay
Formulary Brand	You pay 10% after deductible	$35 copay	$35 copay	$35 copay
Non-Formulary Brand	You pay 10% after deductible	$60 copay	$60 copay	$60 copay
MAIL ORDER (90-DAY SUPPLY)				
Generic	You pay 10% after deductible	$20 copay	$20 copay	$20 copay
Formulary Brand	You pay 10% after deductible	$70 copay	$70 copay	$70 copay
Non-Formulary Brand	You pay 10% after deductible	$120 copay	$120 copay	$120 copay

Certain CVS/Caremark pharmacy programs apply to prescription coverage under all of the medical plans. See the next page for details.

FILLING PRESCRIPTIONS THROUGH CVS/CAREMARK

There are two ways to fill prescriptions: at a network retail pharmacy or using the mail-order service.

At a network pharmacy (30-day supply)

Show your prescription drug ID card and you can purchase prescription drugs at participating CVS/Caremark network pharmacies (including national chains such as CVS, Walgreens, Rite Aid, and most other retail pharmacies).

Mandatory mail order for maintenance (long-term) medication (90-day supply)

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 have two options for filling your maintenance medications:

1. Receive your 90-day supply of maintenance medication through the CVS/Caremark Mail Service Pharmacy.
   - **Advantages:** Enjoy convenient home delivery; receive medication in confidential, tamper-resistant and (when necessary) temperature-controlled packaging; talk to a pharmacist by phone.
2. Receive your 90-day supply of maintenance medication at the local retail CVS/participating network pharmacy.
   - **Advantages:** Pick up your long-term medication from the pharmacy at a time that's convenient for you; enjoy same-day prescription availability; talk face-to-face with a pharmacist.

The mail-order copayment is the same for PPO and POS participants, regardless of which method you use: home delivery or CVS retail pick-up. For those in the CDHP, you can expect to pay the same discounted amount for a 90-day supply at retail and at mail order.

Failure to fill maintenance medications through either option will result in you 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.

EXTRA DISCOUNTS FOR CVS/CAREMARK MEMBERS

Use your CVS® card, which entitles you to a 20% discount on all CVS-brand Health Care Flexible Spending Account (HCFSA)-eligible products.

DRUG TIERS

The cost of your prescription drugs under each medical plan depends on the tier of the medication:

- **Generic drugs** contain the same active ingredients as their brand-name equivalents and meet the same federal standards for safety, but typically cost significantly less.
- **Formulary drugs** are brand-name medications that are preferred by a prescription plan based on drug effectiveness and cost.
- **Nonformulary drugs** are brand-name medications that are not on a prescription plan's preferred list (or formulary) based on drug effectiveness and cost. They may still be covered, but may require prior authorization and cost more.

CHOOSE GENERICS AND SAVE!

When patent protection for a brand-name drug expires, generic versions of the drug can be offered for sale with FDA approval. Generic medications must pass the same quality tests as brand-name medicines and are identical in strength, dosage, safety, quality, and administration. Yet, the cost of generics is substantially lower — between 30% and 75% less than brand names. 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.

PHARMACY PROGRAMS

STANDARD FORMULARY

A formulary is a prescription plan's list of preferred drugs based on effectiveness and cost. Medications on the formulary are covered; those not on the formulary may still be covered but may require prior authorization and may cost more. If you are prescribed a medication not on the formulary, you and your prescriber will need to obtain prior authorization before the prescription is filled.

EXCLUSIVE SPECIALTY PHARMACY PROGRAM

What are specialty drugs?

- They 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 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. Here's how it works:

- Specialty medications will be subject to a prior authorization process.
- All specialty medications will be processed through and delivered by the CVS/Caremark Specialty Pharmacy Program.
- 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.

GENERIC STEP THERAPY

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

Here's 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 instructed 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.

PRIOR AUTHORIZATION FOR COMPOUNDED DRUGS

Medically necessary compounded drugs are 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 does not meet FDA standards. The cost of these combinations dramatically increases plan costs.

Note: Bulk Powders are excluded from coverage for compound drugs. Bulk Powder represents an ingredient(s) for which the effectiveness and safety are unknown or have not been adequately studied based on their route of administration by the FDA.

PPACA VACCINE COVERAGE

As part of the Patient Protection and Affordable Care Act (health care reform law), the list of fully covered vaccines will be expanded to include both seasonal strains of influenza and common preventable diseases at no cost to you or your family.

GLUMETZA, FORTAMET, ZEGERID, AND THEIR HIGH-COST GENERICS REQUIRE AUTHORIZATION

You will be required to get prior authorization from your doctor before receiving Type 2 diabetes medications Glumetza, Fortamet, and the associated high-cost Metformin ER generics. Members will be instructed to try Glucophage and its generic medication before being allowed to use one of the alternative antidiabetics. In addition, there is a similar process for Proton Pump Inhibitor medication Zegerid and its generics. Generic proton pump inhibitors such as omeprazole and lansoprazole are the preferred lower cost alternatives. Your prescribing doctors will be made aware of the upcoming changes about the prior authorization requirement on Glumetza, Fortamet, Zegerid, and their respective generics.

OPIOID MANAGEMENT PROGRAM

This program is designed to help ensure safe and appropriate use of opioids by limiting the use of pain medication and controlled substances to FDA-approved amounts. You will be able to fill a prescription for the amount approved by the FDA, but not for a higher quantity. If there is a medical necessity to increase the quantity beyond the FDA limit, you and your physician may apply for **post-limit prior authorizatio**n to obtain additional medication. **Note:** These limits do not apply to individuals diagnosed with cancer or end-of-life hospice or palliative care.

PERIODIC FORMULARY UPDATES

CVS/Caremark continually reviews drugs on the formularies and will either add newly available products or exclude products that do not meet clinical requirements. If you are impacted by a formulary change, you will be contacted by CVS/Caremark.

Spending and Savings Accounts

You can save money on health care and dependent care expenses by paying for them with tax-free accounts. To enroll for 2018, log on to **nationalgridbenefitservices.com**.

2018 ACCOUNTS

- **Health Savings Account (HSA):** Available only to employees who enroll in the Consumer Driven Health Plan (CDHP).
- **Flexible Spending Accounts (FSAs):**
  - **Health Care FSA (HCFSA):** Available to employees who enroll in a PPO or POS plan or do not elect medical coverage through National Grid.
  - **Dependent Care Reimbursement Account (DCRA):** Available to all employees.

Important:

- Your HSA will carry over into 2018 (the money is always yours to keep), but you must be actively enrolled in a Consumer Driven Health Plan (CDHP) in order to continue contributing to your HSA.
- Your 2017 HSA contribution amount will carry over to your 2018 benefit elections. You may change it or even select a $0.00 contribution if you would prefer not to contribute, but you cannot waive HSA participation if you want to receive the upfront HSA contribution to your Health Equity account in 2018. This contribution will be deposited into your account by the end of January.
- You must enroll in the Health Care Flexible Spending Account and/or Dependent Care Reimbursement Account if you want to contribute to these accounts in 2018, even if you currently participate. Your enrollment in these accounts does not carry over.

KEY FEATURES

- **Tax-free money** — Money goes in tax-free and comes out tax-free when it's used for eligible expenses.
- **Convenient payroll deductions** — Contribute to your accounts easily and effortlessly.
- **Helpful budgeting tool** — Plan for upcoming expenses by setting aside money each paycheck.

Read the following pages to learn more about these tax-free accounts.

HOW MUCH COULD YOU SAVE?

Here's an example. Let's say Tom decides to set aside $2,000 in an HSA or FSA for the year. Normally, on that money, he'd pay $560 in federal income tax, $100 in state income tax, and $153 in FICA tax. So, by contributing that $2,000 to his HSA or FSA, he'll get an $813 tax savings for the year.

Without an HSA or FSA, Tom would pay …	Savings
28% in federal income tax	$560
5% in state income tax	$100
7.65% in Federal Insurance Contributions Act (FICA) tax	$153
His total tax savings for the year with an HSA or FSA	**$813**

This hypothetical illustration is for educational purposes only. Dollar amounts or savings will vary depending on income, state and city tax rules, and other factors. Please consult a tax, legal, or financial advisor about your own personal situation.

Spending and Savings Accounts

HEALTH SAVINGS ACCOUNT

With the Consumer Driven Health Plan (CDHP), you're eligible to open and contribute money to a Health Savings Account (HSA) through HealthEquity. The HSA is a tax-free savings account you can use to pay for eligible health expenses anytime, even in retirement. To learn more about the HSA, visit HealthEquity's HSA education website at **healthequity.com/ed/nationalgrid**. To enroll, log on to **nationalgridbenefitservices.com**.

Important: During Open Enrollment, you must select an HSA contribution amount for 2018 in order to receive the upfront HSA contribution to your account — if you don't want to contribute, you can select a contribution amount of $0.00, but you cannot waive coverage.

HSA FEATURES

PUT MONEY IN TAX-FREE.

- Contribute to your HSA through pre-tax payroll deductions (up to annual limits).
- Change your contribution amount anytime.

GET AN UPFRONT CONTRIBUTION.

- **NEW:** You will automatically receive an upfront contribution to your HSA in 2018:
  - **$750** for employee only medical plan coverage
  - **$1,500** if you cover dependents
- Employees enrolling mid-year will receive a prorated contribution based on their HSA enrollment date.

PAY FOR CARE TAX-FREE.*

- Pay for eligible medical, prescription, dental, and vision expenses for you and your family by using your HealthEquity HSA debit card (provided sufficient funds are in your account), accessing your funds online, or requesting reimbursement.
- To see a complete list of eligible expenses, refer to IRS Publication 502 at **irs.gov/publications/p502/index.html**.
- Track your spending, check your balance, reimburse yourself, and more on the HealthEquity website at **healthequity.com**.

CARRY UNUSED MONEY OVER.

- All the money in your HSA is yours to keep, year after year. There is no "use it or lose it" rule.
- You can build up savings to pay for future health care expenses. You can even invest your money once it reaches a minimum balance, which gives you the potential for tax-free earnings growth and a way to plan ahead for your medical costs in retirement.

* Money in an HSA can be withdrawn tax-free as long as it is used to pay for qualified health-related expenses. If money is used for ineligible expenses, you will pay ordinary income tax on the amount withdrawn, plus a 20% penalty tax if you withdraw the money before age 65.

CONTRIBUTION LIMITS

In 2018, the limits on **total** contributions to your account (both your contributions and the upfront contribution) are:

- Up to $3,450 for employee only medical coverage
- Up to $6,900 if you cover dependents
- Add $1,000 to these limits if you're age 55 or older

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.

Note: Your contributions and the upfront contribution will be accessible in the HSA only after your account has been set up with HealthEquity.

DID YOU KNOW?

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

HEALTH SAVINGS ACCOUNT

BENEFITS OF THE HSA

1. **You can use your HSA for 2018 eligible medical, prescription, dental, and vision expenses — even after you incur them.** 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 at a later date. So, even if you have unexpected health care costs in 2018, you can contribute additional money to your HSA in 2019 to pay for those expenses.
2. **You roll over dollars you don't use.** Unused money automatically rolls over from year to year, which helps you build savings for future eligible health care expenses. You can also use your HSA to pay for eligible expenses in future years even if you're not enrolled in a 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.** Your money goes in tax-free, builds earnings tax-free, and comes out tax-free when used on eligible expenses. Use your HSA funds to pay for expenses in retirement rather than your savings from a 401(k) or Roth IRA, which tax you somewhere along the line.
5. **It's convenient.** You will receive an HSA Debit Card from HealthEquity, which 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 allows you to invest your health care dollars in select Vanguard fund options. Learn more at **healthequity.com**.

HOW THE HSA WORKS WITH THE CDHP

- Show your BCBSMA medical ID card to your provider at the time of service.
- The provider bills BCBSMA for medical services.
- BCBSMA will process the claim and send "eligible medical expenses" to HealthEquity each week.
- BCBSMA will send a Summary of Health Plan Payments to you and your provider with any amounts you owe toward your eligible medical expenses.
- Access your HSA funds online to pay for eligible medical expenses. You will also receive a HealthEquity Debit Card to spend HSA funds at the point of sale, or you can upload your receipts to HealthEquity's website and be reimbursed.
- Some providers may ask for payment toward the deductible upfront. You can reimburse yourself with HSA funds if available.
- Pharmacy costs will be immediately determined at the point-of-sale; this way you can use your HealthEquity Debit Card to pay for your medications at the pharmacy. You can also use your HealthEquity Debit Card to pay for medications that you receive through mail order rather than using your personal credit card and submitting for reimbursement at a later date.

Additional details can be found on HealthEquity's HSA education website at **healthequity.com/ed/nationalgrid**.

MAKE SURE YOU'RE ELIGIBLE

Eligible individuals are those who are:

- Covered under a Consumer Driven Health Plan (CDHP) like National Grid's.
- Not covered by any other medical 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 Veterans Administration other than preventive care, within the past three months.

Spending and Savings Accounts

HEALTH SAVINGS ACCOUNT

ENROLLING IN THE HSA

- You will be defaulted into the HSA when you elect a CDHP through the National Grid Benefit Services Center website at **nationalgridbenefitservices.com**. It's important that you do not waive the HSA option; you must actively select an HSA contribution for 2018 during Open Enrollment in order to receive the upfront HSA contribution next year. You may elect a contribution amount of $0.00 if you would prefer not to contribute to the HSA and you will still receive the upfront contribution.
- New hires who are defaulted into the CDHP will not be automatically enrolled in the HSA. However, if you choose to enroll in the HSA, you can do so at any time of the year. Please note: the upfront HSA contribution ($750 employee only/$1,500 if covering dependents) will be prorated from the day of the HSA election, not the CDHP default date (dates subject to change in subsequent plan years). It's best to enroll in the HSA immediately upon election into the CDHP to receive the full upfront contribution for which you are eligible.
- For account terms, review the HealthEquity HSA Custodial Agreement at **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 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 HSA.

FLEXIBLE SPENDING ACCOUNTS

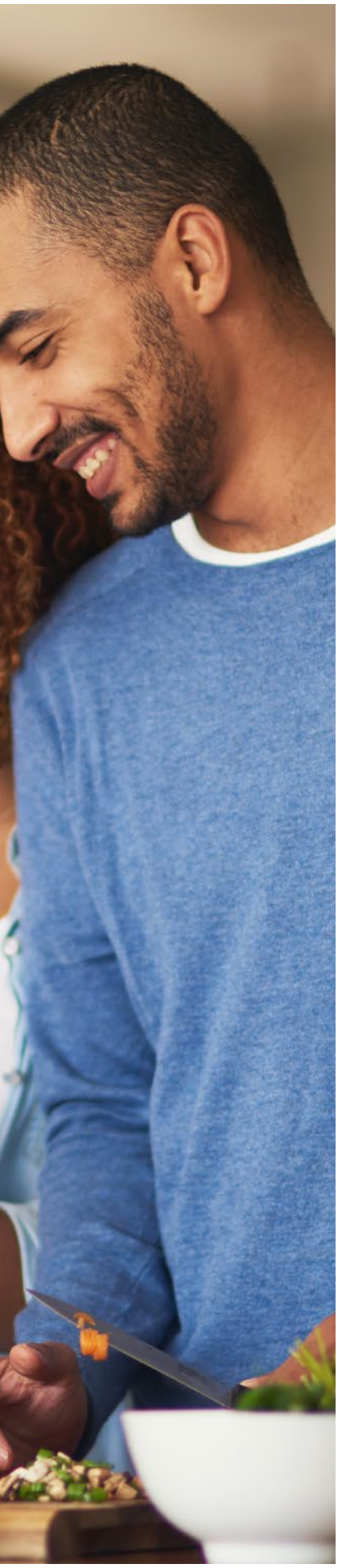
Using a Flexible Spending Account, or FSA, is like getting a discount on everyday health and/or dependent care expenses because you're paying with tax-free money. There are separate FSAs for health care and dependent care. To enroll for 2018, log on to **nationalgridbenefitservices.com**.

Important: You must enroll if you want to contribute to an FSA in 2018, even if you currently participate.

HEALTH CARE FLEXIBLE SPENDING ACCOUNT (HCFSA)

Available to employees who enroll in a PPO or POS plan or do not elect medical coverage through National Grid.

- Contribute up to $2,600 annually through pre-tax payroll deductions to pay for eligible medical, prescription, dental, and vision expenses. For a list of eligible expenses, refer to IRS Publication 502 at **irs.gov/publications/p502/index.html**.
- Choose your contribution amount during Open Enrollment. Your annual contribution election will be deducted in equal installments each pay period before applicable payroll taxes are deducted. You can only change your contribution amount during the year if your personal situation changes (see page 42 for details).
- Manage your account at **wageworks.com**.
- Spend your money and request reimbursement for payments you've made.
- Your entire annual contribution is available to you from the beginning of the plan year.
- You will have 2½ months into the following year to spend any remaining balance; after that, any unused funds will be forfeited as part of the "use it or lose it" rule. Claims must be submitted to WageWorks by May 31, 2018.



HCFSA: WHAT'S ELIGIBLE?

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

For a complete list of eligible and ineligible expenses, refer to IRS Publication 502 at **irs.gov/publications/p502/index.html**.

DEPENDENT CARE REIMBURSEMENT ACCOUNT (DCRA)

Available to all employees

- Contribute up to $5,000 (minimum $100) annually through pre-tax payroll deductions to pay for eligible dependent care needed so you (and your spouse, if you're married) can work, look for work, or attend school full-time. For a list of eligible expenses, refer to IRS Publication 503 at **irs.gov/publications/p503/index.html**.
- Manage your account at **wageworks.com** and request reimbursement for payments you've made.
- Choose your contribution amount during Open Enrollment. You can only change your contribution amount during the year if your personal situation changes (see page 42 for details).
- You will have 2½ months into the following year to spend any remaining balance; after that, any unused funds will be forfeited as part of the "use it or lose it" rule. Claims must be submitted to WageWorks by May 31, 2018.

DCRA: WHAT'S ELIGIBLE?

- 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, refer to IRS Publication 503 at **irs.gov/publications/p503/index.html**.

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 to help you decide whether you should enroll in the DCRA or take the federal dependent care tax credit, based on your needs.

Spending and Savings Accounts

FLEXIBLE SPENDING ACCOUNTS

ADDITIONAL FSA 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 — see page 42).

Reimbursement

To be reimbursed for eligible health or dependent care expenses incurred between January 1, 2018, and March 15, 2019, obtain the applicable reimbursement claim form at **wageworks.com/employees/support-center/important-forms.aspx** and submit your completed form along with a receipt or proof of payment (including the Explanation of Benefits, or EOB, if provided by your medical 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.

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, 2019, to submit claims for all eligible expenses incurred between January 1, 2018, and March 15, 2019. That's why it's important to carefully consider the amount you will use over the course of the year before deciding how much to contribute to either account.

Note: If you are currently enrolled in the Health Care Flexible Spending Account (HCFSA) and you're considering enrolling in the Consumer Driven Health Plan (CDHP) for 2018, please read the "Important note for current Health Care FSA participants" section below to learn how the HSA is affected by the HCFSA 2 ½ month grace period.

Continuing participation

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.

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).

IMPORTANT NOTE FOR CURRENT HEALTH CARE FSA PARTICIPANTS

If you're enrolled in a Health Care FSA (HCFSA) in 2017 and you want to enroll in the CDHP with HSA for 2018, you may be required to delay your enrollment in, and contributions to, the HSA.

- **If you are enrolled in the 2017 HCFSA and have a balance remaining in your account on January 1, 2018, you are subject to the 2 ½ month FSA grace period.** You must wait to enroll and contribute to the HSA until the end of the grace period. You will elect the HSA contribution amount during Open Enrollment, but this amount will not go into effect until April 1. By the end of April, you will receive your upfront HSA contribution into your account ($750 for employee only medical plan coverage or $1,500 if you are covering dependents).
- **If you are enrolled in the 2017 HCFSA and you do not have a balance remaining in your account on January 1, 2018**, you can enroll in and contribute to the HSA effective January 1. National Grid will deposit the upfront contribution into your account once your HSA enrollment has been completed. If your enrollment in the HSA is effective January 1, 2018, the upfront contribution 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.**

COMPARE HEALTH ACCOUNTS

	Health Savings Account (HSA)	Health Care Flexible Spending Account (HCFSA)
Available with	Consumer Driven Health Plan (CDHP)	Preferred Provider Organization (PPO) plan Point of Service (POS) plan Also available if you waive medical coverage
Receive upfront contribution into your account	Yes: $750 for employee only coverage; $1,500 if you cover dependents	No
Change your contribution amount anytime	Yes	No
Access your entire annual contribution amount starting January 1, 2018	No	Yes
Access only funds that have been deposited	Yes	No
"Use it or lose it" by the end of the grace period	No	Yes
Money is always yours to keep	Yes	No

Voluntary Plans

To give you more options for protecting your health and finances, we are introducing three new voluntary plan options to choose from, all offered through MetLife: Accident, Critical Illness, and Hospital Indemnity. These plans are designed to supplement your primary medical plan by providing cash payments in the event of a significant unexpected medical expense. They are not intended to replace Accidental Death and Dismemberment (AD&D) coverage.

For 2018, you may choose to enroll in any combination of the three voluntary benefit plans on **nationalgridbenefitservices.com** during Open Enrollment.

KEEP IN MIND

On their own, these voluntary plans don't provide the minimum level of medical coverage needed to meet health care reform requirements. Rather, they're intended to supplement the coverage provided by your medical plan. Be sure to consider your anticipated medical needs for the coming year — for example, a major surgery — when deciding if voluntary benefit coverage is right for you.

ACCIDENT INSURANCE

Accident insurance, available through MetLife, helps protect you from unexpected financial stress if you or a covered family member has an accident. You are eligible to enroll in accident insurance only if you elect a medical plan. Accident insurance supplements your primary medical plan by providing cash benefits in cases of accidental injuries. You can use this money to help pay for medical expenses not paid by your medical plan (such as your deductible or coinsurance) or for anything else (such as everyday living expenses). Contributions are deducted post tax through payroll deductions.

BENEFITS ARE PAID:

- Directly to you, unless assigned to someone else
- In addition to any other coverage, like your primary medical plan or an Accidental Death & Dismemberment (AD&D) plan

YOU RECEIVE A CASH BENEFIT UP TO A SPECIFIC AMOUNT FOR:

- Accidental death
- Dismemberment
- Dislocation or fracture
- Initial hospital confinement
- Intensive care
- Ambulance
- Medical expenses
- Outpatient physician's treatment

The actual benefit amounts depend on the type of injuries you have and the medical services you need.

Voluntary Plans

CRITICAL ILLNESS INSURANCE

When a serious illness strikes, Critical Illness insurance — available through MetLife — can provide financial support to help you through a difficult time. It protects against the financial impact of certain illnesses, such as a heart attack, cancer, or stroke.

You receive a lump-sum benefit to cover out-of-pocket expenses for your treatment, to pay your coinsurance, or to take care of your everyday living expenses such as housekeeping services, special transportation services and child care. Contributions can be made post-tax through payroll deductions.

BENEFITS ARE PAID:

- Up to a maximum annual benefit of $15,000 directly to you, unless assigned to someone else

CONTINUING PARTICIPATION IF YOU LEAVE EMPLOYMENT

If you leave National Grid, you can "port," or move, your coverage to a direct-bill basis with MetLife if you want to continue coverage at that time. Your premiums will remain unchanged.

HOSPITAL INDEMNITY INSURANCE

A trip to the hospital can be stressful, and so can the bills. Even with a major medical plan, you may still be responsible for copays, deductibles, and other out-of-pocket costs. Offered through MetLife, the Hospital Indemnity plan can help offset your share of the cost associated with a covered sickness or accident.

Use this money to help cover hospital stays, ambulance service, surgery, and certain inpatient or outpatient treatments. The plan pays benefits in addition to any other insurance. Contributions can be made post-tax through payroll deductions.

YOUR BENEFIT COVERAGE OPTION INCLUDES:

- A $1,000 hospital admission and $200 daily hospital confinement benefit, up to 31 days

BENEFITS ARE PAID:

- Directly to you, unless assigned to someone else
- As a lump sum or on a benefit schedule

DOWNLOAD THE APP!

With MetLife's mobile app, you can:

- View policy details such as coverage amount and coverage effective date
- Review designated beneficiaries and dependents
- Access the MetLife Claim Center
- And more

Download the app by visiting the iTunes App Store ® or Google Play and searching "MetLife."

Dental

Healthy teeth and gums are important to your overall health. That's why it's important to have regular dental checkups and maintain good oral hygiene.

To offer you more flexibility to choose dental coverage that best fits your needs, we are introducing a second dental plan option for 2018: the Dental Plan Without Orthodontia. We will continue to offer the same plan we have today, called the Dental Plan With Orthodontia. Both plans are offered through Delta Dental. Learn more at **deltadentalma.com**.

With these plans, you can visit in-network or out-of-network providers. The plans pay the same level of benefits no matter where you get care, but the cost of services is typically lower in the network since those providers have negotiated discounted rates.

To enroll for 2018, log on to **nationalgridbenefitservices.com**.

2018 DENTAL PLAN OPTIONS

- Dental Plan With Orthodontia
- Dental Plan Without Orthodontia

KEY FEATURES

- Fully covered in-network preventive care
- Affordable coverage that helps you manage the cost of dental treatment
- Wide network of providers that have agreed to negotiated rates, which helps you save money
- Choice of three coverage levels: Employee only, 2-Person, or Family

FIND A NETWORK DENTIST

You'll generally pay less when you use a dentist in the Delta Dental network. To search for in-network providers, visit **deltadentalma.com** and search the Delta Dental PPO Plus Premier network.

COVERAGE DETAILS

DENTAL BENEFITS
Each time you need care, you choose to receive care from an in- or out-of-network provider. When you receive care from an in-network provider, your cost will generally be lower because Delta Dental negotiates discounted rates with those providers. For more information about dental plan benefits, contact Delta Dental directly at **1-800-872-0500**, or visit **deltadentalma.com**.

DENTAL PLANS: HOW THE PLANS PAY BENEFITS		
DELTA DENTAL		
	Delta Dental With Orthodontia	**Delta Dental Without Orthodontia**
GENERAL PROVISIONS		
Annual Deductible (employee only/covering dependents)	$50/$150	$50/$150
Maximum Annual Benefit (per calendar year per person)	$2,000 excluding orthodontia	$2,000
Type I: Diagnostic and Preventive Services • Periodic exams and routine cleanings (2 times per year) • Panoramic or full mouth X-rays (once every 60 months) • Bitewing X-rays (once every 6 months) • Single tooth X-rays (as needed) • Fluoride for children under 19 (once every 6 months) • Space maintainers for children under 14 limited to once per child per lifetime up to age 19	Plan pays 100%; not subject to deductible	Plan pays 100%; not subject to deductible

DENTAL PLANS: HOW THE PLANS PAY BENEFITS		
DELTA DENTAL		
	Delta Dental With Orthodontia	**Delta Dental Without Orthodontia**
Type II: Basic Restorative Services • Fillings (once every 24 months) multi-surface white fillings on back teeth will be processed as silver fillings • Protective restoration (once per tooth) • General anesthesia and IV sedation – allowed with covered surgical impacted teeth only (up to one hour) • Periodontal cleanings (once every 3 months following active periodontal treatment) • Extractions (once per tooth) • Palliative treatment (3 occurrences in 12 months) • Root canal retreatment (once per tooth after 24 months have elapsed from initial treatment) • Periodontal treatment – on natural teeth: periodontal surgery (1 surgical procedure per quadrant in 36 months); scaling and root planning (once in 24 months per quadrant, only 2 quadrants are allowed per date of service) • Prosthetic maintenance: bridge or denture repair (once per bridge/denture per 12 months after 24 months of initial insertion), crown or onlay repairs (once per tooth per 12 months after 24 months of initial treatment), rebase or reline of dentures (once within 36 months) • Recement of crowns, onlays and bridges (once per tooth/bridge)	Plan pays 80% after deductible; you pay 20%	Plan pays 80% after deductible; you pay 20%
Type III: Major Restorative Services • Crowns or onlays – when teeth cannot be restored with regular fillings, once within 60 months per tooth (age 12 and older) • Dentures – once within 60 months (age 16 and older) • Implants – covered to replace 1 missing tooth and when adjacent teeth are healthy and do not require crowns (once per 60 months) • Implant abutments once per implant when surgical implant is benefited • Fixed bridges – once within 60 months (age 16 and older) • Repair or maintenance of implants (once per 60 months per implant) • Cast posts/buildups – once per tooth per 60 months, only benefitted to retain a crown	Plan pays 50% after deductible; you pay 50%	Plan pays 50% after deductible; you pay 50%
Orthodontia (for children up to age 19, or if a full-time student, age 25)	Plan pays 50% up to $1,500 lifetime maximum per child	Not covered
Dependent Coverage	Dependents covered to the end of the calendar year the dependent attains age 19; full-time students to age 25	

When you and your family receive care from a participating dentist, no claim forms are necessary. Your dentist files claims for you. Ask your dentist to submit a pretreatment estimate to Delta Dental for any procedure that exceeds $300. This will help you estimate any out-of-pocket expenses you may incur and will confirm that the procedure is covered under your dental plan.

	DENTAL COSTS*		
	DELTA DENTAL		
	Employee only	2-Person	Family
DELTA DENTAL WITH ORTHODONTIA			
Total monthly cost	$44.45	$88.91	$126.70
National Grid pays monthly	$35.56	$71.13	$101.36
New England Union employees pay monthly	$8.89	$17.78	$25.34
Full-time employees pay weekly	$2.05	$4.10	$5.85
80% part-time employees pay weekly	$3.69	$7.39	$10.53
60% part-time employees pay weekly	$5.33	$10.67	$15.20
DELTA DENTAL WITHOUT ORTHODONTIA			
Total monthly cost	$42.23	$84.46	$120.37
National Grid pays monthly	$33.78	$67.57	$96.30
New England Union employees pay monthly	$8.45	$16.89	$24.07
Full-time employees pay weekly	$1.95	$3.90	$5.56
80% part-time employees pay weekly	$3.51	$7.02	$10.00
60% part-time employees pay weekly	$5.07	$10.14	$14.44

*Deducted in pre-tax dollars.

USE YOUR DENTAL BENEFITS WISELY

Here's how to make the most of your dental benefits:

- **Stay in network.** Each time you need dental care, you have a choice of providers. Selecting a participating dentist in the Delta Dental network will ensure you receive the highest benefits from your plan. To find a provider, go to **deltadentalma.com** and search the Delta Dental PPO Plus Premier network.
- **If your service will exceed $300, submit for a pretreatment estimate.** You should always submit a request for a pretreatment estimate for procedures and services your dentist believes will exceed $300 (procedures such as crowns, inlays, bridges, and periodontics). For more information about pretreatment estimates, call Delta Dental at **1-800-872-0500** or visit **deltadentalma.com**.
- **Check your claim status and other information at deltadentalma.com.** You can review Explanation of Benefits (EOB) statements, check if claims have been paid, and more.

Wellbeing

In addition to the medical, dental, and other plans you elect, National Grid offers valuable wellbeing resources to help you manage and maintain your health.

FITNESS REIMBURSEMENT FOR BCBS MEMBERS

We are expanding our fitness benefit to give you additional ways to stay fit while saving money. In addition to our definition of qualified health clubs, coverage will now include fitness studios and facilities that offer the following exercise activities taught by a certified instructor: yoga, pilates, zumba, aerobic/group classes, indoor cycling/spinning classes, kickboxing, crossfit, strength training, tennis, indoor rock climbing, and personal training. A qualified health club is one that has cardiovascular and strength training equipment and facilities for exercising and improving physical fitness. A qualified health club is one that has cardiovascular and strength training equipment and facilities for exercising and improving physical fitness.

In 2018, if you are enrolled in a Blue Cross Blue Shield medical plan, you are eligible for a $600 reimbursement every six months (on a rolling six-month basis) for membership fees at eligible facilities after attainment of 50 visits. This benefit is available to you and your covered spouse.

This benefit is paid through Blue Cross Blue Shield. For more information, contact Blue Cross Blue Shield at 1-800-287-8757 or visit **bluecrossma.com**.

THE ROLE OF REGULAR EXERCISE

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, mental stress, and overall poor health that may foster disease development.

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

SMOKING CESSATION

Go to **smokefree.gov** to access support, tips, tools, and expert advice right now to help you or someone you love quit smoking.

- **Online chat:** Get immediate information and answers about quitting smoking. Connect with a National Cancer Institute LiveHelp information specialist, in English at **livehelp.cancer.gov/app/chat/chat_launch** or in Spanish at **livehelp-es.cancer.gov/app/chat/chat_launch**.
- **By phone:**
  - Call **1-877-44U-QUIT (1-877-448-7848)** to speak with the National Cancer Institute's trained counselors who provide information and support for quitting in English and Spanish. Call Monday through Friday, 8:00 a.m. to 8:00 p.m. ET.
  - Call **1-800-QUIT-NOW (1-800-784-8669)** to connect directly to your state's quitline.

TIME TO QUIT

On average, nonsmokers can expect to live 13 years longer than smokers. Here's how quitting can improve your health — and extend your life.

- 24 hours after quitting: Your risk of heart attack decreases.
- 1 year after quitting: Your risk of heart disease reduces by 50%.
- 10 years after quitting: Lung cancer risks reduce.
- 15 years after quitting: Health risks finally return to normal.

It takes the average person seven attempts to quit before succeeding. Don't give up!

Sources: Centers for Disease Control and Prevention, American Lung Association, and American Cancer Society.

CORPORATE COUNSELING ASSOCIATES (CCA)

National Grid's Employee Assistance Program, CCA, can be reached at **1-800-833-8707** or online at **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 basic and task-specific training. For details, 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.

TAKE ADVANTAGE

Use these resources, along with your fully covered in-network preventive care (included with all our medical plans), to be your healthiest.

Consumer Tips

When it comes to purchasing products, we almost always look at the price tag. Yet, with all the money we spend on health care — from paycheck contributions to prescriptions to doctor's office visits — we rarely think about the price of these services. And as health care prices continue to rise, that ends up costing more for you and National Grid. Fortunately, you have more control over your health spending than you may think.

6 WAYS TO TAKE CONTROL OF YOUR HEALTH SPENDING

1. **Use in-network providers.** They've agreed to charge only up to negotiated rates and bill your insurance company directly, which saves you money and time. Also, check with your insurance company to ensure that the services you and your dependents require are covered before you receive care.

2. **Keep up with preventive care.** It's covered in full by all of our medical plans and can help detect and prevent potentially costly health issues early. You pay nothing for annual physicals, recommended immunizations, routine cancer screenings, and more when you see in-network providers. To see a list of covered preventive care services, go to **healthcare.gov/coverage/preventive-care-benefits**.

3. **Use tax-free money to pay for eligible health expenses.** Contributing to a Health Savings Account (HSA) or a Health Care Flexible Spending Account (HCFSA) is easy and saves you money on expenses you'd have to pay anyway.

4. **Shop smart for prescriptions.** Using generic alternatives will almost always save you money — and they're proven just as effective as brand-name prescriptions. It's also a good idea to call a few local pharmacies to compare prices before deciding where to fill a prescription. For your ongoing prescriptions, use the mail-order service to save money and time.

5. **Compare costs.** If you're in the CDHP or PPO, use the cost comparison tools through the BCBS website at **bluecrossma.com** to make informed choices before getting health care services. If you're in the POS plan through Fallon Community Health Plan, go to **fchp.org** and use the Fallon SmartShopper tool to get real-time cost comparisons and find the right health care providers for you. And if you're in the POS plan through Harvard Pilgrim, go to **harvardpilgrim.org/members** to take advantage of member discounts and savings.

6. **Take advantage of telehealth.** This convenient, affordable benefit provides 24/7/365 access to board-certified physicians online or by phone. It's a less expensive alternative to urgent care and ER visits for non-emergency medical care. Learn more about telehealth benefits on page 12. **Note:** Telehealth is not available to employees enrolled in the POS plan with Fallon Community Health Plan.

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.

Life and AD&D Insurance

It's important to protect your family's financial security in case the unexpected happens. That's why National Grid automatically provides basic life insurance and accidental death and dismemberment (AD&D) coverage at no cost to you. There's no need to enroll.

During Open Enrollment (October 11 – 24, 2017) you can also buy additional coverage for yourself and your family through the Company's life insurance administrator, MetLife. MetLife manages the enrollment for all optional life insurance and voluntary AD&D coverage. **Before Open Enrollment begins, you should receive a direct home mailing from MetLife, which describes how you can enroll in these optional programs.** Please contact MetLife directly at **1-866-492-6983** if you want to enroll in optional life or voluntary AD&D, confirm your current coverage, or change your current elections. You can find rates for optional insurance on the MetLife website in the Book of Options — visit **https://Metlife-ekits.kittrak.com**. Enter **NATIONAL GRID NE UNIONS** and use code **NGPLAN3**.

BASIC COVERAGE

BASIC LIFE INSURANCE

The National Grid basic life insurance program pays a benefit to your designated beneficiary if you die. You automatically receive Company-provided life insurance coverage equal to two times your base annual salary rounded to the next higher multiple of $2,000, up to a maximum of $200,000.

BASIC AD&D

The Company also provides basic accidental death and dismemberment (AD&D) coverage, which pays you a benefit if you receive certain injuries as a result of an accident, or pays a benefit to your beneficiary if you die in an accident. Benefits are equal to:

- **Non-occupational coverage** equal to one times base annual salary, rounded to the next higher multiple of $2,000
- **Occupational coverage** equal to six times base annual salary, rounded to the next higher multiple of $2,000, up to a maximum of $600,000

HOW THE AD&D PLAN PAYS BENEFITS	
100% benefit for accidental loss of:	50% benefit for accidental loss of:
• Life • Both hands • Both feet • Sight of both eyes • One hand and one foot • One hand and sight of one eye • One foot and sight of one eye	• One hand • One foot • Sight of one eye

WHAT IS *BASE ANNUAL SALARY* FOR LIFE INSURANCE PURPOSES?

For the purpose of life insurance benefits, including AD&D, base annual salary is strictly your base wages. It does not include annual incentives, overtime, or any other compensation.

OPTIONAL COVERAGE

EMPLOYEE LIFE INSURANCE

If you want additional life insurance for yourself, you can purchase it on an after-tax basis and take advantage of discounted group rates through the optional life insurance program:

- The maximum optional life insurance amount you can purchase is five times your base annual salary, rounded to the next higher multiple of $2,000, to a maximum of $1,000,000.
- You will be required to show medical evidence of insurability, also called EOI, if you elect to increase more than one times pay or if you elect more than three times pay.

DEPENDENT LIFE INSURANCE

You can also purchase optional life insurance for your legal spouse, child(ren), or both at discounted group rates. In order to enroll in life insurance for your dependents, you must either (a) already be enrolled in supplemental life insurance for yourself or (b) enroll at the same time in supplemental life insurance for yourself.

For your legally married spouse:

- You may purchase either $25,000 or $50,000 in optional life insurance for your spouse.
- You will be required to show medical EOI if you elect more than $25,000 for your spouse.

For your child(ren):

- You may purchase $2,500, $4,000, or $10,000 of optional life insurance for your dependent child(ren). Eligible children are at least 15 days old, unmarried and under age 21 (up to age 25 if unmarried and a full-time student), including handicapped or disabled children.

To reduce your level of optional life insurance or remove dependent children no longer eligible, you must contact the MetLife Call Center to initiate the cancellation.

YOU CAN TAKE IT WITH YOU

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

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.

VOLUNTARY AD&D COVERAGE

You may buy additional AD&D coverage for yourself, your spouse, and/or your children. Any contributions you make for voluntary AD&D coverage will be deducted from your pay on an after-tax basis.

For you:

- Purchase coverage at one, two, or three times your base annual salary, rounded to the next higher multiple of $2,000, up to a maximum of $625,000.

For your family:

- If you have elected voluntary AD&D for yourself, you can purchase coverage for your spouse and/or child(ren) in amounts expressed as a percentage of your coverage:
  - For your spouse only: 50% of your coverage
  - For your child(ren) only: 15% of your coverage for each child
  - For both:
    - Spouse: 40% of your coverage
    - Child(ren): 10% of your coverage for each child

The cost of voluntary AD&D coverage is based on the coverage level you select and your base annual salary. If your salary increases or decreases during the year, the amount you pay each pay period for this coverage will change accordingly.

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.

HAVE YOU NAMED 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.

Vacation Purchase Program

You have the option to purchase up to five additional days of vacation for the year. You must get approval from your manager and/or supervisor to purchase additional vacation days. Managers and/or supervisors have full discretion over authorizing you to purchase vacation days, and can limit the number of days you can purchase.

To purchase vacation days, you must take action during Open Enrollment (October 11 – 24, 2017). Log on to **nationalgridbenefitservices.com** or call the National Grid Benefit Services Center at **1-888-483-2123**.

YOUR COSTS

- The cost of this program is determined by two factors: your **daily salary rate** and the **number of days you purchase**. Your daily rate multiplied by the number of days you want to purchase will equal your total annual cost of vacation purchase.
- The total annual cost is then deducted from your paycheck in equal installments throughout the calendar year.
- Your daily salary rate for vacation purchase is based on your salary effective August 2, 2017, and will not change during the year, regardless of any increases or decreases in your salary.
- You must be an active employee (that is, not on a leave of absence) on the payroll as of August 2017 to be eligible to purchase additional vacation days.

TAKE NOTE

- Managers will approve employee vacation purchase requests electronically. If you elect to participate in the program, you will be notified of your election approval status once the approval window closes.
- You must use your standard vacation time (including any days carried over from a prior year) before you can use any purchased vacation days, per IRS regulations.
- You cannot carry over any unused purchased vacation days. You must use all vacation (both earned and purchased) by the end of the year. You will lose any days that you buy and do not use by December 31, 2018.
- One purchased day of vacation is equal to 8 hours (less for part-timers).
- If you leave National Grid or go on disability before the end of the year (2017), and have not used your purchased days, you can request to be reimbursed for the amount that you have paid for those days. You must notify the National Grid Services Delivery Center at **1-888-483-2123** before December 15, 2017, in order to receive reimbursement.

How to Enroll

YOU MAY NEED TO TAKE ACTION

Open Enrollment for your 2018 benefits is October 11 – 24, 2017. This is your opportunity to review your current benefits and make sure they are still a good fit for your needs.

Many of your current benefits will roll into 2018 if you do not take action, but **some require you to enroll or re-enroll**. You also have new benefit options to consider. The elections you make during Open Enrollment will take effect on January 1, 2018. Elections are final and cannot be changed until the next Open Enrollment unless you experience a qualified life event (see page 42).

STEPS YOU MUST TAKE BY OCTOBER 24, 2017, AT 11:59 p.m. ET (if enrolling online) or 6 p.m. ET (if enrolling by phone)	
If you want to…	You must…
• Enroll in, change, or waive your medical coverage for 2018 • Newly enroll in the Health Savings Account for 2018 (CDHP participants only) • Receive the upfront HSA contribution in 2018 (CDHP participants only): **You must select an HSA contribution amount for 2018 in order to receive the upfront HSA contribution to your account** — if you don't want to contribute, you can select a contribution amount of $0.00, but you cannot waive coverage • Participate in the Health Care Flexible Spending Account and/or Dependent Care Reimbursement Account for 2018 • Enroll in, change, or waive your dental coverage in 2018 • Purchase vacation time • Enroll in one or more of the new voluntary plan options for 2018 (Accident, Critical Illness, and Hospital Indemnity insurance)	Go to **nationalgridbenefitservices.com** or call **1-888-483-2123**
• Purchase or change optional life insurance and/or voluntary AD&D for 2018	Call MetLife at **1-866-492-6983**

REVIEW YOUR DEPENDENTS

Open Enrollment is the time to review National Grid's benefits eligibility requirements (see page 39) and make sure your dependents still qualify for coverage. Reminder: You will still be required to provide documentation for any new dependents you add to your coverage.

WHAT IF YOU DON'T ENROLL?

If you don't take action during Open Enrollment, you will receive automatic coverage as shown in the following table.

TAKE NOTE:

- If you do not want to enroll in a medical plan through National Grid, you will need to actively waive medical coverage.
- If you do not enroll in any of the new voluntary plan options — Accident, Critical Illness, and Hospital Indemnity insurance — you will default to no voluntary coverage in 2018.

WHAT HAPPENS IF YOU DON'T ENROLL?	
If you are currently enrolled in	You will automatically default into
CDHP	CDHP at same coverage level
PPO plan	PPO at same coverage level
POS plan with Fallon Community Health Plan or Harvard Pilgrim	POS with same carrier at same coverage level
POS plan with Blue Choice 2 New England (NH & RI), Health New England, Nantucket, or MVP Select	PPO at the same coverage level you have now
No medical coverage (waived)	No medical coverage (waived)
Health Savings Account (HSA)	Current enrollees default to 2017 contribution level **You must actively select an HSA contribution amount for 2018 in order to receive the upfront HSA contribution to your account** — if you don't want to contribute, you can select a contribution amount of $0.00, but you cannot waive coverage
Dental	Current dental plan at the same coverage level
Flexible Spending Accounts (FSAs)	No Health Care FSA (HCFSA) or Dependent Care Reimbursement Account (DCRA) enrollment
Voluntary benefits (optional life, voluntary AD&D)	No voluntary benefits coverage

STEP-BY-STEP ENROLLMENT INSTRUCTIONS

The Open Enrollment process is the same this year — just log on to our benefits enrollment website at **nationalgridbenefitservices.com** and follow the steps below.

If you have any questions or prefer to enroll by phone, please call the National Grid Benefit Services Center at **1-888-483-2123**. A Benefits Specialist will be available to assist you Monday through Friday, from 8 a.m. to 6 p.m. ET. Be sure to have your *2018 Personalized Enrollment Worksheet* in front of you when you call.

1. Visit the National Grid Benefit Services website at **nationalgridbenefitservices.com**. You will be prompted to enter your User ID (your Employee ID) and your Password:
   - **If this is this is your first time logging in**, 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 four digits of your SSN are 1234, and the year of your birth is 1970, then your temporary password would be Jd12341970. Once you have logged in, you'll be prompted to read and accept the user agreement, change your password, and complete a security question in case you ever forget your password.
   - **If you have logged in previously**, enter the password you created when you first accessed your account. If you've forgotten your password, click "Forgot Password" on the main login page to immediately reset your password.
2. **Start your enrollment:** By clicking on the "Open Enrollment" Notification or Tile.
3. **Review your personal profile information:** If you would like to update your telephone number or email preferences, click on the "Edit" button.
4. **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.
5. **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.
6. **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.
7. **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.
8. **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.
9. **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.
10. **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 can change your elections as many times as you like until the enrollment period ends on October 24, 2017. 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, 2018, 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 must call the National Grid Benefit Services Center at **1-888-483-2123** by 11:59 p.m. EST on November 21 to change your elections.

DON'T WAIT UNTIL THE LAST MINUTE!

We highly recommend you enroll early. Use the educational tools and resources we're providing to help you make your decisions, then take action beginning October 11 or as close to that date as possible. A couple of suggestions:

- **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 (October 24) is a busy time for the online enrollment website and the National Grid Benefit Services Center.

Decision Support

TOOLS TO HELP YOU CHOOSE

Choosing the right plans matters to your health and your financial wellbeing. Use the resources on your new benefits decision website, **NGBenefitsLiveBrighter.com**, to learn about your benefits and select the best options for you and your family.

On **NGBenefitsLiveBrighter.com**, you will find:

- **Master Your CDHP + HSA** — Click through this interactive brochure and learn five winning strategies for using your CDHP and HSA like a pro.
- **Consumer Driven Health Plan (CDHP) video** — Learn how this plan works together with the Health Savings Account (HSA) to give you more control over your health and spending.
- **Health Savings Account (HSA) video** — Take a closer look at this triple-tax-advantaged account and how you can use it to build savings for future health expenses.

Additional resources available to you include:

- **HealthEquity education site** — Access a wealth of resources to get familiar with the HSA, including videos, an HSA contribution calculator, future balance calculator, and more. Go to **healthequity.com/ed/nationalgrid**.
- **nationalgridbenefitservices.com** — Log in to our mobile-friendly enrollment website to make your benefit elections this Open Enrollment.
- ***2018 Personalized Enrollment Worksheet*** — Watch your mailbox for this worksheet showing your current coverage, available options, and costs for 2018.

ENROLLMENT CHECKLIST

Use this checklist to help you make informed decisions this Open Enrollment.

- **Learn about your benefit options**, paying special attention to the changes coming next year (see page 2).
- **Think about your coverage needs**, including how much health care you anticipate needing and whether your current life and disability insurance provide enough protection.
- **Make sure your dependent information is correct** and all your dependents are still eligible. See eligibility requirements on page 39.
- **Consider how FSAs and/or an HSA could help you save money** — they allow you to pay for eligible health care and/or dependent care expenses with tax-free money! Learn more about these accounts starting on page 17.
  - If you enroll in the CDHP, you must elect an HSA contribution amount in order to receive the upfront HSA contribution to your HealthEquity account in 2018. Your 2017 HSA contribution amount will carry over to your 2018 benefit elections if you don't change it. If you would prefer not to contribute to an HSA, you may select a $0.00 contribution amount, but do not waive HSA participation.
  - You must enroll in the Health Care Flexible Spending Account and/or Dependent Care Reimbursement Account if you want to contribute to these accounts in 2018, even if you currently participate. Your enrollment in these accounts does not carry over.
- **Review your beneficiaries** – Review your beneficiary information during the enrollment process (especially if your personal circumstances have changed) and take this opportunity to make updates as needed.
- **Complete your benefits enrollment** by October 24, 2017.

TIP: THINK ABOUT THE WHOLE COST

When choosing a medical plan, it's important to think about the whole cost of coverage — the amount you'll spend out of your paycheck, as well as out of your pocket (copays, deductibles, and coinsurance). To view your current contributions, go to **nationalgridbenefitservices.com**.

TOP 5 QUESTIONS ABOUT OPEN ENROLLMENT

1. DO I NEED TO ENROLL? WHAT HAPPENS IF I DON'T?

If you do not take action during Open Enrollment, your current benefits will continue into 2018, with a few exceptions:

- If you are in one of the Point of Service (POS) medical plans being eliminated for 2018 (see page 2 for details), you will default into the Preferred Provider Organization (PPO) plan for 2018, at the same coverage level you have now.
- You must enroll or re-enroll in the following benefits if you want to participate in 2018 — your current elections in these benefits will not automatically carry over:
  - Health Care Flexible Spending Account (HCFSA)
  - Dependent Care Reimbursement Account (DCRA)

Please note: Your 2017 HSA contribution amount will carry over to your 2018 benefit elections if you don't change it. If you would prefer not to contribute to an HSA, you may select a $0.00 contribution amount, but you must actively elect HSA participation in order to receive the upfront HSA contribution to your Health Equity account in 2018; do not waive HSA coverage.

You also must take action if you want to enroll in any newly offered benefits for 2018, including the three voluntary plans and the new dental plan. For more details about the default coverage you will receive if you don't enroll, turn to page 34.

2. HOW ARE THE MEDICAL PLANS DIFFERENT?

The key difference between the plans is how much you pay in paycheck contributions and how you pay for services throughout the year. Consider how you prefer to handle costs:

- Would you rather pay extra from your paycheck for a medical plan that covers more of your costs when you need care? If so, you may want to consider the PPO or POS plans.
- Would you rather pay as little as possible from your paycheck — even if that means bigger bills when you need care? Are you looking for a tax-free way to save for future health expenses? If so, the CDHP may be a good choice.

Of course, there are many other points to consider when choosing a medical plan. Compare the plans on page 6.

3. WHAT'S INCLUDED IN MY FULLY COVERED PREVENTIVE CARE?

In-network preventive care is fully covered under all of National Grid's medical plans, so you pay nothing. These services include:

- Well-baby care
- Immunizations
- Annual checkups
- Pap tests
- Tests for cholesterol and blood pressure
- Mammograms
- Prostate screenings
- Colorectal screenings
- Bone density (over 60)

See a full list of covered services at **healthcare.gov/coverage/preventive-care-benefits**.

4. WHAT'S THE DIFFERENCE BETWEEN THE HEALTH CARE FLEXIBLE SPENDING ACCOUNT (HCFSA) AND THE HEALTH SAVINGS ACCOUNT (HSA)?

The way the HCFSA and the HSA work is largely the same — you contribute to your account through automatic, pre-tax payroll deductions, then use the money to pay for eligible medical, prescription, dental, and vision expenses.

However, there are some important differences. For example, all the money in an HSA rolls over year after year and is always yours to keep, while the FSAs have a "use it or lose it" rule. Compare the accounts on page 23.

5. I HAVE QUESTIONS ABOUT MY BENEFITS. WHOM DO I CONTACT?

For general questions, call the National Grid Benefit Services Center at **1-888-483-2123**. Benefits Specialists are available 8 a.m. to 6 p.m. ET. To contact one of our benefit carriers, turn to the Benefit Contacts section.

Benefits Eligibility

All regular full-time employees and regular part-time employees scheduled to work at least 20 hours per week are eligible for the benefits described in this guide. In addition to yourself, you may also enroll additional family members in some of the benefit options available to you.

IMPORTANT NOTE ABOUT DEPENDENT CHILDREN

You must elect coverage for your legally married spouse if you want to elect coverage for his/her dependent child(ren).

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 serves as legal guardian, stepchild(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. If you are adding new dependents to your January 1, 2018, coverage, you will be required to provide documentation within 45 days from the date of your enrollment. You'll find the documentation requirements at **nationalgridbenefitservices.com** under Resources.

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

DENTAL AND LIFE INSURANCE

In addition to yourself, the following family members are eligible for dental and life insurance:

- Your legally married spouse.
- Your dependent child(ren), including your unmarried natural child(ren), stepchild(ren), eligible foster child(ren), legally adopted child(ren), child(ren) placed with you pending legal adoption, child(ren) for whom you or your spouse serves as a legal guardian, and child(ren) of your 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 the end of the year in which the child attains age 19 (21 for life insurance) or until midnight prior to age 25 if a full-time student (or December 31 of the year in which the child is no longer a full-time student, whichever is earlier).
- Annual certification is required to confirm a child's continuing full-time student status. If you are adding new dependents to your January 1, 2018, coverage, you will be required to provide documentation within 45 days from the date of your enrollment. You'll find the documentation requirements at **nationalgridbenefitservices.com** under Resources.

VERIFY YOUR DEPENDENT ELIGIBILITY

If you add dependents to your medical and/or dental 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. You must submit this documentation within 45 days from the date of your enrollment. You'll also be contacted separately to complete a full-time student verification form for coverage to continue for your dependents under the dental plan.

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.

WHEN YOUR COVERAGE BEGINS

The elections you make during this Open Enrollment period will take effect on January 1, 2018, and will remain in effect through December 31, 2018. Your elections are irrevocable and you can only make a change during the year if you have a qualified life event (see page 42).

If you are a new employee enrolling in your benefits for the first time, your coverage will begin on the first day of the month following your date of hire (unless you were hired on the first business day of the month, in which case coverage is effective as of your date of hire).

PAYING FOR COVERAGE

To compare plan details and see your costs for 2018 medical and dental coverage, review this guide (remember, you can access an online version of this guide containing additional resources at **NGBenefitsLiveBrighter.com**). You will also see the 2018 costs displayed for each of your medical, dental, and vacation purchase benefit options — as well as the coverage levels available to you — when you log on to **nationalgridbenefitservices.com** to enroll.

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

BENEFITS WITH PRE-TAX PAYCHECK CONTRIBUTIONS	BENEFITS WITH AFTER-TAX PAYCHECK CONTRIBUTIONS
• Medical coverage • Health Savings Account (HSA) • Dental coverage • Purchased vacation days (if eligible) • Health Care Flexible Spending Account (HCFSA) • Dependent Care Reimbursement Account (DCRA)	• Optional life insurance • Dependent life insurance • Voluntary AD&D coverage • Accident • Critical Illness • Hospital Indemnity

BENEFITS FOR PART-TIME EMPLOYEES

Part-time employees, scheduled to work at least 20 hours per week, are eligible for the same benefits as regular full-time employees. Generally, your cost will be prorated based on your normal work schedule. The Company contributions toward medical and/or dental coverage are:

WEEKLY WORK SCHEDULE	COMPANY CONTRIBUTION (% OF EMPLOYER PORTION)
20 – 24 hours	60%
25 – 31 hours	80%

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. 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. For example, any contributions you make for optional life insurance or voluntary AD&D 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 Benefit Changes

The benefit elections you make during this Open Enrollment period will stay in effect throughout the 2018 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 into or out of your regional POS medical plan's service area

If you experience a qualified 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.

* Your Health Savings Account (HSA) contributions can be changed anytime.

KEEP IN MIND

When changing your benefit elections due to a qualified life event, the 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.

PERSONAL AND EMERGENCY CONTACT INFORMATION

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

- Go to the Infonet homepage, 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 **NationalgridSDC123.com**, signing in with your eight-digit Personnel number and password, and then clicking the "SDC Forms Center" link to navigate to the Personal Data Change form. Please note that your password will be the last four 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. If you have any questions, please contact the National Grid Services Delivery Center (NGSDC) at **1-888-483-2123**.

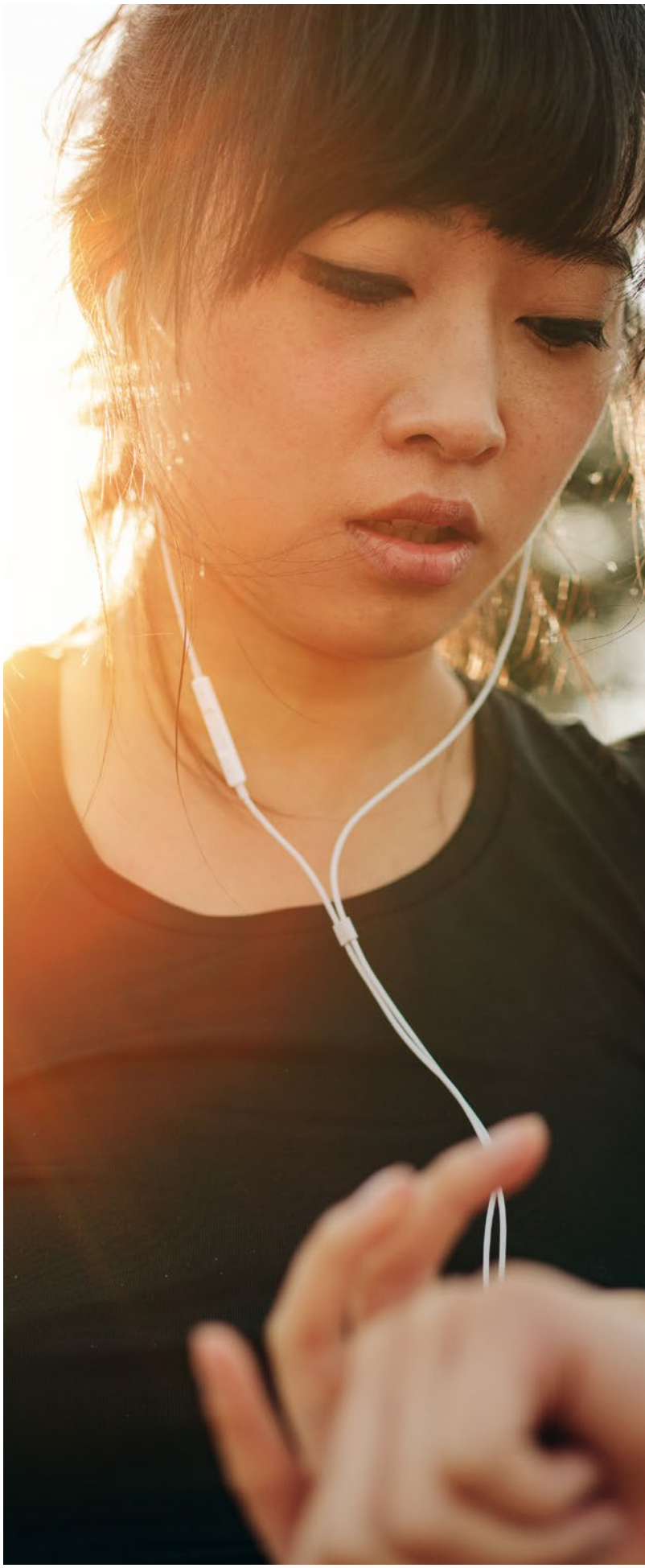
Benefit Contacts

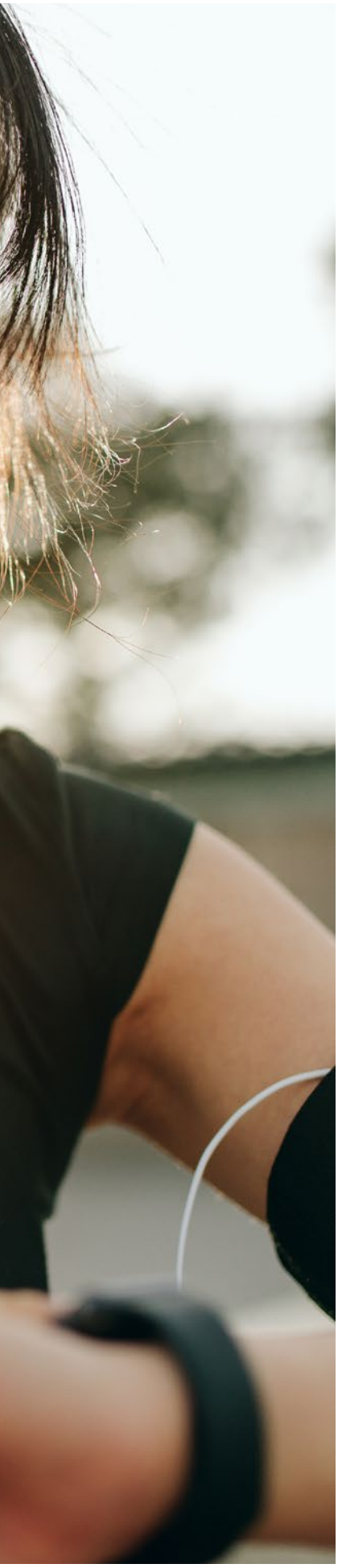
When you need to reach one of our benefit providers, please refer to the table below.

BENEFIT/TOPIC	ADMINISTRATOR	WEBSITE	PHONE NUMBER
Benefits enrollment	National Grid Benefit Services Center	nationalgridbenefitservices.com	1-888-483-2123
General benefit questions	National Grid Services Delivery Center	nationalgridsdc123.com	1-888-483-2123
2018 benefits decision website	National Grid	NGBenefitsLiveBrighter.com	1-888-483-2123
Medical – CDHP and PPO plans	Blue Cross Blue Shield	bluecrossma.com	1-800-287-8757
Medical – POS plan	Fallon Community Health Plan Harvard Pilgrim	fchp.org harvardpilgrim.com/members	1-800-868-5200 1-888-333-4742
Prescription drug	CVS/Caremark	caremark.com	1-800-378-8826
Telehealth – CDHP and PPO plans	AmericanWell	bluecrossma.com/telehealth	1-844-SEE-DOCS (1-844-733-3627)
Telehealth – POS plan with Harvard Pilgrim	Doctor On Demand	doctorondemand.com	1-800-997-6196
Health Savings Account (HSA)	HealthEquity	healthequity.com	1-866-346-5800
Flexible Spending Accounts (FSAs)	WageWorks	wageworks.com	1-877-924-3967
Voluntary plans (Accident, Critical Illness, Hospital Indemnity)	MetLife	NGBenefitsLiveBrighter.com	1-866-492-6983
Dental	Delta Dental	deltadentalma.com	1-800-872-0500
Optional life insurance and AD&D	MetLife	metlife.com/mybenefits	1-866-492-6983

Glossary

- **Coinsurance:** How you and your medical plan share costs after you meet the plan's annual deductible (if applicable). For example, your plan may cover 80% of charges for a covered hospitalization, leaving you responsible for the other 20%. This 20% is known as your coinsurance.
- **Consumer Driven Health Plan (CDHP):** A CDHP is designed to give you more control over your health care spending. CDHPs have higher deductibles and out-of-pocket maximums compared to traditional PPO/POS plans — but your payroll contributions are significantly lower, giving you the opportunity to contribute the cost savings to a tax-free **Health Savings Account (HSA)**. You'll also receive an upfront tax-free contribution to your HSA. Through the HSA, you can plan ahead to have money available to pay for your health care expenses when they occur, rather than overpaying for coverage you may or may not need. All the money in your HSA is yours for life and rolls over year to year.
- **Copay:** A fixed amount (for example, $50) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of service you receive.
- **Covered services:** Medically necessary health care services for which benefits are paid under a particular medical plan.
- **Deductible:** The amount you owe for health care services before your plan begins to pay. For example, if your annual deductible is $250, your plan won't pay anything until you've reached that amount first. The exception is in-network preventive care, which is fully covered so you pay nothing.
- **Dependent Care Reimbursement Account (DCRA):** You may choose to enroll in this account to pay for eligible dependent care expenses — including child and elder care — with tax-free dollars. You contribute to your FSA through automatic, pre-tax payroll deductions. You will have 2½ months into the following year to spend any remaining balance; after that, any unused funds will be forfeited as part of the "use it or lose it" rule. For a full list of eligible expenses, refer to **irs.gov/publications/p503/index.html**.
- **Health Care Flexible Spending Account (HCFSA):** You may choose to enroll in this account to pay for eligible health care expenses — including deductibles, coinsurance, and copays for medical, dental, and vision care — with tax-free dollars. You contribute to your HCFSA through automatic, pre-tax payroll deductions. You will have 2½ months into the following year to spend any remaining balance; after that, any unused funds will be forfeited as part of the "use it or lose it" rule. By law, you cannot participate in an HCFSA and a Health Savings Account (HSA) at the same time. For a full list of eligible expenses, refer to IRS Publication 502 at **irs.gov/publications/p502/index.html**.





- **Health Savings Account (HSA):** A tax-free savings account that is only available to participants in a qualified high-deductible health plan, such as the Consumer Driven Health Plan (CDHP) offered by National Grid. You contribute to your HSA through automatic, pre-tax payroll contributions and can use the money to pay for eligible medical expenses — including deductibles, coinsurance, and copays for medical, dental, and vision care. In addition, you'll receive an upfront contribution to your account in 2018. Unlike a Flexible Spending Account (FSA), all of the money in your HSA rolls over from year to year and is always yours to keep. For example, you may use the money in your HSA to pay for eligible health expenses in retirement. For a full list of eligible expenses, refer to IRS Publication 502 at **irs.gov/publications/p502/index.html**.
- **Out-of-pocket maximum:** Protects you financially by capping the amount you'll pay in a plan year for covered health expenses. If you reach your medical plan's out-of-pocket maximum, your plan pays 100% of covered services for the rest of the year.
- **Paycheck contributions:** A fixed amount that you automatically contribute from each paycheck for coverage under a medical plan. Paycheck contributions can vary widely based on the type of plan you choose. To see your contribution rates, visit **nationalgridbenefitservices.com**.
- **Point of Service (POS) plan:** The POS plan, offered through your choice of Fallon Community Health Plan or Harvard Pilgrim, is similar to the PPO — except you must choose a primary care physician (PCP) to coordinate your in-network care. You pay higher paycheck contributions in exchange for lower out-of-pocket costs as you receive care throughout the year. This means your costs are more predictable, but you'll still have out-of-pocket expenses — either copays or a deductible and coinsurance, depending on the service received. As with all of National Grid's medical plans, you can see in-network or out-of-network providers, but you'll pay less when you stay in network.
- **Post-tax paycheck deductions:** Your voluntary benefit plan coverage, including Accident, Critical Illness and Hospital Indemnity insurance, are made after federal and state income and FICA (Social Security) taxes are withheld.
- **Preferred Provider Organization (PPO) plan:** A traditional PPO medical plan that offers cost sharing after you meet the deductible for most services; however, you pay a flat copay for in-network primary care, specialist, and urgent care visits, as well as prescriptions. The PPO reduces your out-of-pocket responsibility when you need care through a lower deductible and higher paycheck contributions. It covers both in-network and out-of-network benefits, but you will pay less when you stay in the BCBS network.
- **Pre-tax paycheck deductions:** Your paycheck deductions for medical, dental, and any purchased vacation days 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 paycheck deductions lower your taxable income, allowing you to save on taxes and increase your take-home pay.
- **Preventive care:** In-network preventive care is fully covered under all of National Grid's medical plans, so you pay nothing. Preventive care includes routine care designed to prevent illness or disease, including annual physicals, recommended immunizations, and routine cancer screenings. If the same tests are done to diagnose an illness or treat a known condition, they are not considered preventive care and your plan's normal charges will apply.

Legal Notices

Please visit **NGBenefitsLiveBrighter.com** starting October 11, 2017, to view these important legal notices.

- HIPAA Special Enrollment Rights Notice
- HIPAA Privacy Notice Reminder
- Women's Health & Cancer Rights Act Notice (WHCRA)
- The Newborns' and Mothers' Health Protection Act
- Notice of Grandfather Status
- CHIP Medicaid Notice
- HIPAA Privacy Notice
- Medicare Part D Notice
- Physician Designation Notice
- SBCs
- Exchange Notice
- USERRA (Uniformed Services Employment and Reemployment Rights Act)
- FMLA
- Group Hospital Indemnity On-Ballot Language (MetLife)
- Group Hospital Indemnity Insurance Regulatory Disclosure (MetLife)
- Group Critical Illness Insurance Ballot Language (MetLife)
- Critical Illness Insurance Disclaimer (MetLife)
- Group Accident On-Ballot Language (MetLife)
- Group Accident Insurance Disclaimer (MetLife)
- National Grid USA Service Co., OOC Disclosure (MetLife)
- National Grid USA Service Co., Accident AD&D (MetLife)
- National Grid USA Service Co., Hospital Indemnity (MetLife)

The information in this guide 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.

Notes

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GET READY!

Open Enrollment is October 11–24, 2017

Let's live brighter together

Choose your benefits

We're offering new resources to help you take care of your health, save money, and choose the right benefits for you and your family. Visit **NGBenefitsLiveBrighter.com** to learn more today.

SEPTEMBER 18–NOVEMBER 1:

Complete your Wellbeing Program requirements*

National Grid has partnered with RedBrick Health to help you take steps toward improving your health. By completing the Wellbeing Program requirements, you can:

- Save $50/month on your 2018 medical plan contributions (all plans eligible)
- Gain the full upfront Health Savings Account (HSA) contribution from National Grid if you enroll in a Consumer Driven Health Plan (CDHP)

OCTOBER 11–OCTOBER 24:

Enroll in your 2018 benefits

Enroll at **nationalgridbenefitservices.com** by October 24. Learn about your benefits so you can choose wisely. Access information, tools, and resources to help you make your benefit decisions at **NGBenefitsLiveBrighter.com**.

* Currently applies to Management employees only.

Use these resources

REDBRICK HEALTH

Wellbeing Program*

NGWellbeing.RedBrickHealth.com

MetLife

MetLife voluntary plans

1-866-492-6983

Learn about Accident, Critical Illness, and Hospital Indemnity insurance

HealthEquity
Building Health Savings

HSA with HealthEquity

healthequity.com/ed/nationalgrid

Learn all about the HSA using videos, calculators, and more

GET READY!

Open Enrollment is October 15–26, 2018

Let's live brighter together

Your pathway to health and wellbeing includes taking advantage of the benefits offered by National Grid. Choose the benefits that make sense for you in 2019.

Follow these steps

1. **LEARN** about your benefits and see what's changing for 2019 at **NGBenefitsLiveBrighter.com**.

NEW BENEFIT TOOLS
Use clickable infographics, quizzes, videos, and more!

2. **ENROLL** in your 2019 benefits by October 26 at **nationalgridbenefitservices.com**.

3. **COMPLETE** the Wellbeing Program activities by November 1 to earn rewards! Activity since June 1 will count. Go to **NGWellbeing.RedBrickHealth.com**.

IMPORTANT
Activities will take more time this year, so start early!

Resources for your health and your wallet

REDBRICK HEALTH®

Wellbeing Program

NGWellbeing.RedBrickHealth.com

Complete your healthy activities by November 1 to earn rewards

MetLife

MetLife voluntary plans

1-800-438-6388

Learn about Accident, Critical Illness, and Hospital Indemnity insurance

HealthEquity
Building Health Savings℠

HSA with HealthEquity

healthequity.com/ed/nationalgrid

Learn all about the HSA using videos, calculators, and more

nationalgrid

Create your path! Go to
NGBenefitsLiveBrighter.com
to learn more.