PUC 1-38

Request:

Please provide a breakdown of the year-end 2015 and 2016 expenses, for all non-pension benefits available to employees. For each benefit, include a detailed description of the benefit and the conditions that each employee must meet to be entitled to the benefit.

Response:

Please refer to the Company's response to PUC 1-31 for expenses for all non-pension benefits available to employees in 2015 and 2016.

For descriptions of the benefits available to management employees, please see the following attachments:

- Attachment PUC 1-38-1 – 2015 Benefit Plans for National Grid New Hires - Management Employees
- Attachment PUC 1-38-2 – 2016 Benefit Plans for National Grid New Hires - Management Employees
- Attachment PUC 1-38-3 – 2015 Comparison of Health Benefits for Management Employees
- Attachment PUC 1-38-4 – 2016 Comparison of Health Benefits for Management Employees

For descriptions of the benefits available to union employees, please see the following attachments:

- Attachment PUC 1-38-5 – 2015 Open Enrollment Guide Local 101
- Attachment PUC 1-38-6 – 2016 Open Enrollment Guide Local 101
- Attachment PUC 1-38-7 – 2015 Open Enrollment Guide for Local 12003, 318, 350, 369, and 13507
- Attachment PUC 1-38-8 – 2016 Open Enrollment Guide for Local 12003, 318, 350, 369, and 13507

Prepared by or under the supervision of: Maureen P. Heaphy

- Attachment PUC 1-38-9 – 2015 New England Union Guide Locals 310, 310B, 317, 322, 326, 329, 330, 369, 486, 1465, and 12431

- Attachment PUC 1-38-10 – 2016 New England Union Guide Locals 310, 310B, 317, 322, 326, 329, 330, 369, 486, 1465, and 12431

- Attachment PUC 1-38-11 – 2015 Comparison of Health Benefits for Local 101

- Attachment PUC 1-38-12 – 2016 Comparison of Health Benefits for Local 101

- Attachment PUC 1-38-13 – 2015 Comparison of Health Benefits for Local 12003

- Attachment PUC 1-38-14 – 2016 Comparison of Health Benefits for Local 12003

- Attachment PUC 1-38-15 – 2015 Comparison of Health Benefits for New England Unions Locals 310, 310B, 317, 322, 326, 329, 330, 369, 486, 1465, and 12431

- Attachment PUC 1-38-16 – 2016 Comparison of Health Benefits for New England Unions Locals 310, 310B, 317, 322, 326, 329, 330, 369, 486, 1465, and 12431

Descriptions of all other benefits offered to union employees are included in the collective bargaining agreement for each union. The collective bargaining agreements were provided in the Company's response to PUC 1-33.

Prepared by or under the supervision of: Maureen P. Heaphy

9/24/2015

2015 Benefit Plans for National Grid New Hires* - Non-Union Employee

Benefit Program	Description	Eligibility Begin Date	Action Required or Automatic Enrollment	Pre-tax, Post-tax, No Cost	Additional Information
Medical Plan	You have the option to enroll in a PPO Plan (Preferred Provider Organization), an EPO Plan (Exclusive Provider Organization) or you can decline coverage. The coverage levels available are for Individual, 2-Person or Family.	First of the month following date of hire or day of hire if you begin work on the first business day of the month.	Employee action required. If you do not make a medical plan election, you will be defaulted into the BCBS PPO with employee only coverage.	Deductions are withheld pre-tax	National PPO and EPO are provided by Blue Cross Blue Shield. Regional PPO carriers are also available based on home & work location. If you elect to waive medical you **must** contact the National Grid Benefit Services Center at 888-483-2123.
Dental Plan	You have the option to enroll in the dental plan or you can decline coverage. The coverage levels available are for Individual, 2-Person or Family.	First of the month following date of hire or day of hire if you begin work on the first business day of the month.	Employee action required	Deductions are withheld pre-tax	Coverage is provided by Delta Dental.
Prescription Drug Benefit	When you enroll in a medical plan, you automatically receive prescription drug coverage which includes both retail and mail-order prescription drug program options.	First of the month following date of hire or day of hire if you begin work on the first business day of the month.	Automatic enrollment with election of a medical plan	Included in cost of medical plan	Coverage is provided by CVS Caremark.
Health Care Spending Account	You have the option to set aside up to $2,500 pre-tax to pay for certain unreimbursed health-related expenses incurred while enrolled in this benefit, including; co-payments, deductibles, coinsurance, vision care.	First of the month following date of hire or day of hire if you begin work on the first business day of the month.	Employee action required	Deductions are withheld pre-tax	Benefit is administered by WageWorks.
Dependent Care Reimbursement Account	You have the option to set aside up to $5,000 pre-tax to pay for certain dependent care expenses (incurred while enrolled in this benefit) for eligible children or elderly parents. National Grid contributes 10% towards the amount you set aside to an overall maximum of $5,000.	First of the month following date of hire or day of hire if you begin work on the first business day of the month.	Employee action required	Deductions are withheld pre-tax	Benefit is administered by WageWorks.
Life Insurance Coverage	National Grid provides you with basic life insurance coverage equal to one times your base annual salary rounded to the next even $2,000. National Grid also provides you with Accidental Death and Dismemberment coverage (AD&D).	First of the month following date of hire or day of hire if you begin work on the first business day of the month.	Automatic enrollment	No cost up to $50,000. Value of benefit over $50,000 is subject to tax.	Basic life insurance and AD&D coverage are provided by MetLife.
Optional Life Insurance Coverage	You have the option to purchase additional life insurance coverage for yourself of up to five times your annual base salary. You also may purchase life insurance coverage for your spouse/qualified same sex domestic partner and your children. Additional AD&D coverage for yourself and your family is also available.	Must enroll within 31 days of hire, otherwise enrollment is contingent upon medical evidence of insurability.	Employee action required	Deductions are withheld post-tax	Optional life insurance and AD&D coverage is provided by MetLife. Medical evidence of insurability required for elections exceeding 3x base salary.
401(K) Plan	You can contribute on a pre-tax basis from 1% to 50% of base pay or "all pay" (including base pay, overtime, premium pay, commissions and incentive pay) up to federal limits and/or on a post-tax basis up to 15% of base pay or all pay. On the first of the month following 3 months of employment, the Company will match 50% of the first 8% you contribute (pre-tax and post-tax contributions) to the Plan subject to limits set by the IRS.	After 45-days of employment you are automatically enrolled at 6% of all pay. Unless you choose otherwise, contributions will be invested in the Vanguard Target Retirement Fund based on the year in which you turn age 65.	Automatic enrollment	Deductions are withheld pre-tax and/or post-tax	Plan is administered by Vanguard. Company Match vests after 3 years of service.
	In addition to the Company match, National Grid will contribute a supplemental Core Contribution into your account regardless if you contribute to the 401(k) plan or not. You receive this contribution each pay period for which you receive compensation. This represents a percentage (between 4% and 8%) of your "all pay" based on the sum of your age and years of service.	First of the month following 3 months of service. Contributions are invested in the same investments as your payroll contributions. Unless you choose otherwise, your core contributions will be invested in the Vanguard Target Retirement Fund based on the year in which you turn age 65.	Automatic enrollment	Core contributions require no employee contribution or action	Core Contribution vests after 3 years of service.

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9/24/2015

2015 Benefit Plans for National Grid New Hires* - Non-Union Employee

Benefit Program	Description	Eligibility Begin Date	Action Required or Automatic Enrollment	Pre-tax, Post-tax, No Cost	Additional Information
Post-Retirement Medical	You may be eligible for post-retirement medical coverage.	You must be at least 60 years old and have at least 10 years of service at retirement.	Employee action required	Deductions are withheld post-tax	Pre-65 Coverage: fixed company subsidy equal to 50% of the cost, determined at retirement; retiree pays remainder, including any increases. Post-65 Coverage: retiree pays full cost.
Paid Holidays	National Grid provides 10 paid holidays and 2 personal days per year.	Personal days are pro-rated in the year of hire.	Automatic	No cost	The scheduling of personal days must be approved by your supervisor or manager.
Paid Vacation	National Grid provides you with paid vacation days. You are eligible for 3 weeks vacation for the first fourteen full years of service, 4 weeks in years 15 through 19 and 5 weeks for 20 years or more.	Pro-rated in first calendar year of employment.	Automatic	No cost	Vacation scheduling must be approved by your supervisor or manager.
Vacation Buy and Sell	You have the option to purchase up to an additional 5 days of vacation per calendar year or sell up to 3 vacation days per calendar year.	Election to purchase or sell vacation is only available during the Annual Open Enrollment period. You must have completed 1 full year of service in order to sell vacation days.	Employee action required	Pre-tax deductions to buy. Taxable reimbursement of sold days	Vacation sell is based on your base annual salary as of 8/1 of the previous year, up to a maximum of $350/day.
Sickness in Family Leave	You are allowed to take up to two (2) days off per calendar year with full pay to care for sick members of your immediate family.	After one full year of service.	None	No cost	Sickness In Family Leave must be approved by your supervisor or manager.
Sick Leave	National Grid provides you with a sick leave allowance of 1 week (5 days) of full sick leave for every year of continuous service after completing one year of continuous service. At a minimum, you will be eligible to receive a sick leave allowance of 13 weeks payable at a rate of 60% of base pay after completing 3 full months of continuous service.	Eligible for full sick leave after completing one year of continuous service. Eligible for sick leave at 60% of base pay to a maximum of 13 weeks after completing 3 months of service. There is no paid sick time during the first 90 days of employment.	None	No cost	Administered by AonHewitt
Long-Term Disability (LTD)	LTD benefits provide you 60% of base pay with a maximum monthly benefit of $15,000. LTD begins following the expiration of your sick leave benefits and continues for as long as you remain disabled as defined in the plan.	First of the month following date of hire or day of hire if you begin work on the first business day of the month.	Automatic enrollment	Premium associated with LTD is included in taxable income to employees.	Administered by the Hartford. 90 day elimination period. Employees who are on extended sick leave for a period of 90 consecutive days may be eligible for long-term disability benefits.
Annual Performance Plan (APP)	The APP is integral to the way we manage performance and is also a key tool to align everyone on Performance for Growth (P4G) with our Line of Sight priorities. The plan is comprised of the Elevate 2015 measurements which include: Safety and Reliability, Customer Responsiveness, Stewardship and Cost Competitiveness as well as Individual Objectives. Employees may earn an award based on the achievement of these goals and their performance rating.	Award is calculated as a percentage of eligible base pay earnings for the fiscal year. You must be employed with the company at of the end of the performance year to be eligible to receive an award. Awards are payable in June.	None	No cost	Employees hired on or after March 1st are not eligible for an award for that fiscal year. The award is calculated as a percentage of eligible base pay earnings during the performance year which begins in April and ends on March 31.
Employee Stock Purchase Plan	You have the option to purchase National Grid American Depository Shares on a monthly basis at a 15% discount.	Following three (3) months of employment.	Employee action required	Deductions are withheld post-tax	Administered by Computershare.
Educational Aid	National Grid provides you with tuition assistance for Company related undergraduate (annual maximum of $8,000) and graduate degree (annual maximum of $10,000) programs.	First semester that begins after your employment	Employee action required	Taxable status can vary based on IRS limits	Upon completion of a Bachelor's or Master's degree, you will be eligible for a $2,500 award.
Supplemental Cancer Protection Plan	You may purchase the cancer protection plan which will provide you with supplemental cash benefits in the event you or a family member is diagnosed with cancer.	Must enroll within 31 days of hire, otherwise enrollment is available only during Annual Open Enrollment.	Employee action required	Deductions are withheld pre-tax	Benefit is administered by Aflac.

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9/24/2015

2015 Benefit Plans for National Grid New Hires* - Non-Union Employee

Benefit Program	Description	Eligibility Begin Date	Action Required or Automatic Enrollment	Pre-tax, Post-tax, No Cost	Additional Information
Legal Services Plan	You have the option to participate in a comprehensive legal services program. Services include telephone advice and office consultations.	Election to participate is only allowed during the Annual Open Enrollment period.	Employee action required	Deductions are withheld post-tax	Monthly contribution of $5.00. Administered by Hyatt Legal Plans, a subsidiary of MetLife.
Transit Benefit	You have the option to set aside pre-tax dollars to pay for work-related commuting expenses, including parking (up to $3,000/year) and mass transit fares (up to $1,560/year).	Election or enrollment change available monthly	Employee action required	Deductions are withheld pre-tax	Benefit is administered by WageWorks.
Scholarships	15 scholarships are awarded each year to children of employees – 12 undergraduate and 3 graduate awards.	After 1 year of continuous service as of January 1 of the award year.	Employee's child must apply	No cost	Scholarship application deadline is February 1.
Employee Assistance Program (EAP)	You and your family are able to obtain confidential, professional counseling. Services are available for personal, financial or legal matters.	Date of Hire	Automatic	No cost	Coverage is made available through Corporate Counseling Associates (CCA).
Adoption Assistance	National Grid provides you with reimbursement for certain adoption expenses up to $8,000 per adoption.	Date of Hire	Employee must apply for reimbursement	Deductions for Social Security and Medicare taxes only.	Adopted child must be under 18 when the adoption is finalized.

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3/28/2017

2016 Benefit Plans for National Grid Management New Hires*

Benefit Program	Description	Eligibility Begin Date	Action Required or Automatic Enrollment	Pre-tax, Post-tax, No Cost	Additional Information
Medical Plan	You have the option to enroll in a PPO Plan (Preferred Provider Organization), an EPO Plan (Exclusive Provider Organization), a CDHP (Consumer Driven Health Plan) or you can decline coverage. The coverage levels available are for Individual, 2-Person or Family.	First of the month following date of hire or day of hire if you begin work on the first business day of the month.	Employee action required. If you do not make a medical plan election, you will be defaulted into the BCBS PPO with employee only coverage.	Deductions are withheld pre-tax	National PPO, EPO & CDHP are provided by Blue Cross Blue Shield. Regional PPO carriers are also available based on home & work location. If you elect to waive medical you **must** contact the National Grid Benefit Services Center at 888-483-2123.
Health Savings Account	Enrollment available to CDHP participants only. You can contribute up to $3,350 annually for individual coverage, and $6,750 annually for family coverage. These limits can be reached through a combination of employee and employer contributions.	First of the month following date of hire or day of hire if you begin work on the first business day of the month.	Employee action required.	Deductions are withheld pre-tax	National Grid will contribute up to $750 for individual coverage and $1,500 for family coverage (prorated based on date of hire).
Dental Plan	You have the option to enroll in the dental plan or you can decline coverage. The coverage levels available are for Individual, 2-Person or Family.	First of the month following date of hire or day of hire if you begin work on the first business day of the month.	Employee action required	Deductions are withheld pre-tax	Coverage is provided by Delta Dental.
Prescription Drug Benefit	When you enroll in a medical plan, you automatically receive prescription drug coverage which includes both retail and mail-order prescription drug program options.	First of the month following date of hire or day of hire if you begin work on the first business day of the month.	Automatic enrollment with election of a medical plan	Included in cost of medical plan	Coverage is provided by CVS Caremark.
Health Care Spending Account	You have the option to set aside up to $2,550 pre-tax to pay for certain unreimbursed health-related expenses incurred while enrolled in this benefit, including; co-payments, deductibles, coinsurance, vision care.	First of the month following date of hire or day of hire if you begin work on the first business day of the month.	Employee action required	Deductions are withheld pre-tax	Benefit is administered by WageWorks.
Dependent Care Reimbursement Account	You have the option to set aside up to $5,000 pre-tax to pay for certain dependent care expenses (incurred while enrolled in this benefit) for eligible children or elderly parents. National Grid contributes 10% towards the amount you set aside to an overall maximum of $5,000.	First of the month following date of hire or day of hire if you begin work on the first business day of the month.	Employee action required	Deductions are withheld pre-tax	Benefit is administered by WageWorks.
Life Insurance Coverage	National Grid provides you with basic life insurance coverage equal to one times your base annual salary rounded to the next even $2,000. National Grid also provides you with Accidental Death and Dismemberment coverage (AD&D).	First of the month following date of hire or day of hire if you begin work on the first business day of the month.	Automatic enrollment	No cost up to $50,000. Value of benefit over $50,000 is subject to tax.	Basic life insurance and AD&D coverage are provided by MetLife.
Optional Life Insurance Coverage	You have the option to purchase additional life insurance coverage for yourself of up to five times your annual base salary. You also may purchase life insurance coverage for your legally married spouse and your children. Additional AD&D coverage for yourself and your family is also available.	Must enroll within 31 days of hire, otherwise enrollment is contingent upon medical evidence of insurability.	Employee action required	Deductions are withheld post-tax	Optional life insurance and AD&D coverage is provided by MetLife. Medical evidence of insurability required for elections exceeding 3x base salary.
401(K) Plan	You can contribute on a pre-tax basis from 1% to 50% of base pay or "all pay" (including base pay, overtime, premium pay, commissions and incentive pay) up to federal limits and/or on a post-tax basis up to 15% of base pay or all pay. On the first of the month following 3 months of employment, the Company will match 50% of the first 8% you contribute (pre-tax and post-tax contributions) to the Plan subject to limits set by the IRS.	After 45-days of employment you are automatically enrolled at 6% of all pay. Unless you choose otherwise, contributions will be invested in the Vanguard Target Retirement Fund based on the year in which you turn age 65.	Automatic enrollment	Deductions are withheld pre-tax and/or post-tax	Plan is administered by Vanguard. Company Match vests after 3 years of service.
	In addition to the Company match, National Grid will contribute a supplemental Core Contribution into your account regardless if you contribute to the 401(k) plan or not. You receive this contribution each pay period for which you receive compensation. This represents a percentage (between 4% and 8%) of your "all pay" based on the sum of your age and years of service.	First of the month following 3 months of service. Contributions are invested in the same investments as your payroll contributions. Unless you choose otherwise, your core contributions will be invested in the Vanguard Target Retirement Fund based on the year in which you turn age 65.	Automatic enrollment	Core contributions require no employee contribution or action	Core Contribution vests after 3 years of service.

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3/28/2017

2016 Benefit Plans for National Grid Management New Hires*

Benefit Program	Description	Eligibility Begin Date	Action Required or Automatic Enrollment	Pre-tax, Post-tax, No Cost	Additional Information
Post-Retirement Medical	You may be eligible for post-retirement medical coverage.	You must be at least 60 years old and have at least 10 years of service at retirement.	Employee action required	Deductions are withheld post-tax	Pre-65 Coverage: fixed company subsidy equal to 50% of the cost, determined at retirement; retiree pays remainder, including any increases. Post-65 Coverage: retiree pays full cost.
Paid Holidays	National Grid provides 10 paid holidays and 2 personal days per year.	Personal days are pro-rated in the year of hire.	Automatic	No cost	The scheduling of personal days must be approved by your supervisor or manager.
Paid Vacation	National Grid provides you with paid vacation days. You are eligible for 3 weeks vacation for the first fourteen full years of service, 4 weeks in years 15 through 19 and 5 weeks for 20 years or more.	Pro-rated in first calendar year of employment.	Automatic	No cost	Vacation scheduling must be approved by your supervisor or manager.
Vacation Buy and Sell	You have the option to purchase up to an additional 5 days of vacation per calendar year or sell up to 3 vacation days per calendar year.	Election to purchase or sell vacation is only available during the Annual Open Enrollment period. You must have completed 1 full year of service in order to sell vacation days.	Employee action required	Pre-tax deductions to buy. Taxable reimbursement of sold days	Vacation sell is based on your base annual salary as of 8/31 of the previous year, up to a maximum of $350/day.
Sickness in Family Leave	You are allowed to take up to two (2) days off per calendar year with full pay to care for sick members of your immediate family.	After one full year of service.	None	No cost	Sickness In Family Leave must be approved by your supervisor or manager.
Sick Leave	National Grid provides you with a sick leave allowance of 1 week (5 days) of full sick leave for every year of continuous service after completing one year of continuous service. At a minimum, you will be eligible to receive a sick leave allowance of 13 weeks payable at a rate of 60% of base pay after completing 3 full months of continuous service.	Eligible for full sick leave after completing one year of continuous service. Eligible for sick leave at 60% of base pay to a maximum of 13 weeks after completing 3 months of service. There is no paid sick time during the first 90 days of employment.	None	No cost	Administered by AonHewitt
Long-Term Disability (LTD)	LTD benefits provide you 60% of base pay with a maximum monthly benefit of $15,000. LTD begins following the expiration of your sick leave benefits and continues for as long as you remain disabled as defined in the plan.	First of the month following date of hire or day of hire if you begin work on the first business day of the month.	Automatic enrollment	Premium associated with LTD is included in taxable income to employees.	Administered by the Hartford. 90 day elimination period. Employees who are on extended sick leave for a period of 90 consecutive days may be eligible for long-term disability benefits.
Annual Performance Plan (APP)	The APP is integral to the way we manage performance and is also a key tool to align everyone on Performance for Growth (P4G) with our Line of Sight priorities. The plan is comprised of the Elevate 2018 measurements which include: Safety and Reliability, Customer Responsiveness, Stewardship and Cost Competitiveness as well as Individual Objectives. Employees may earn an award based on the achievement of these goals and their performance rating.	Award is calculated as a percentage of eligible base pay earnings for the fiscal year. You must be employed with the company at the end of the performance year to be eligible to receive an award. Awards are payable in June.	None	No cost	Employees hired on or after March 1st are not eligible for an award for that fiscal year. The award is calculated as a percentage of eligible base pay earnings during the performance year which begins in April and ends on March 31.
Employee Stock Purchase Plan	You have the option to purchase National Grid American Depository Shares on a monthly basis at a 15% discount.	Following three (3) months of employment.	Employee action required	Deductions are withheld post-tax	Administered by Computershare.
Educational Aid	National Grid provides you with tuition assistance for Company related undergraduate (annual maximum of $8,000) and graduate degree (annual maximum of $10,000) programs.	First semester that begins after your employment	Employee action required	Taxable status can vary based on IRS limits	Upon completion of a Bachelor's or Master's degree, you will be eligible for a $2,500 graduation award.
Supplemental Cancer Protection Plan	You may purchase the cancer protection plan which will provide you with supplemental cash benefits in the event you or a family member is diagnosed with cancer.	Must enroll within 31 days of hire, otherwise enrollment is available only during Annual Open Enrollment.	Employee action required	Deductions are withheld pre-tax	Benefit is administered by Aflac.
Legal Services Plan	You have the option to participate in a comprehensive legal services program. Services include telephone advice and office consultations.	Election to participate is only allowed during the Annual Open Enrollment period.	Employee action required	Deductions are withheld post-tax	Monthly contribution of $5.00. Administered by Hyatt Legal Plans, a subsidiary of MetLife.

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3/28/2017

2016 Benefit Plans for National Grid Management New Hires*

Benefit Program	Description	Eligibility Begin Date	Action Required or Automatic Enrollment	Pre-tax, Post-tax, No Cost	Additional Information
Transit Benefit	You have the option to set aside pre-tax dollars to pay for work-related commuting expenses, including parking (up to $250/month) and mass transit fares (up to $130/month).	Election or enrollment change available monthly	Employee action required	Deductions are withheld pre-tax	Benefit is administered by WageWorks.
Scholarships	15 scholarships are awarded each year to children of employees – 12 undergraduate and 3 graduate awards.	After 1 year of continuous service as of January 1 of the award year.	Employee's child must apply	No cost	Scholarship application deadline is February 1.
Employee Assistance Program (EAP)	You and your family are able to obtain confidential, professional counseling. Services are available for personal, financial or legal matters.	Date of Hire	Automatic	No cost	Coverage is made available through Corporate Counseling Associates (CCA).
Adoption Assistance	National Grid provides you with reimbursement for certain adoption expenses up to $8,000 per adoption.	Date of Hire	Employee must apply for reimbursement	Deductions for Social Security and Medicare taxes only.	Adopted child must be under 18 when the adoption is finalized.

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A COMPARISON OF NATIONAL GRID HEALTH BENEFITS FOR MANAGEMENT EMPLOYEES UNDER AGE 65 MANAGEMENT RETIREES FOR NEW ENGLAND AND UPSTATE NEW YORK (RETIRED ON OR AFTER JANUARY 1, 2003) AND FORMER KEYSPAN (RETIRED ON OR AFTER JANUARY 1, 2009)

This is a summary of the major benefits offered by each health care plan and also provides costs for 2015.

MEDICAL PLAN COMPARISON: HOW PLANS COVER SERVICES

	National PPO (Blue Cross Blue Shield) and Regional PPOs (Harvard Pilgrim, Independent Health, MVP, Oxford)		National EPO (Blue Cross Blue Shield)
	In-Network	Out-of-Network	In-Network Only
GENERAL PROVISIONS			
Annual deductible	$400/individual $800/family	$400/individual $800/family	None
Benefit level (what the plan pays for most eligible expenses)	Plan typically pays services at 90% after you satisfy the deductible, you pay 10%	Plan typically pays services at 70% you satisfy the deductible, you pay 30%	Plan typically pays services at 100% after you pay your co-payment
Annual out-of-pocket maximum (including deductible, medical and Rx co-payments and coinsurance)	$2,000/individual $4,000/family	$2,800/individual $5,600/family	$6,350/individual $12,700/family
Maximum lifetime benefit per individual	No limit	No limit	No limit
Dependent coverage	To the end of the year in which the dependent turns age 26		
Inpatient covered services	Plan pays 90%*; you pay 10%	Plan pays 70%*; you pay 30%	You pay $150 co-payment
OUTPATIENT COVERED SERVICES			
Preventive care visits	Plan pays 100%; no deductible	Plan pays 70%*; you pay 30%	Plan pays 100%
Other office visits	You pay $20 Primary Care/ $30 Specialist per visit	Plan pays 70%*; you pay 30%	You pay $20 Primary Care/ $30 Specialist per visit
Outpatient surgery and pre-admission testing	Plan pays 90%*; you pay 10%	Plan pays 70%*; you pay 30%	Plan pays 100%
Routine vision (one per calendar year)	Plan pays 100%, no deductible	Plan pays 70%*; you pay 30%	Plan pays 100%
Routine hearing exams	Plan pays 100%, no deductible	Plan pays 70%*; you pay 30%	Plan pays 100%
Diagnostic lab and X-ray	Plan pays 100%; no deductible	Plan pays 70%*; you pay 30%	Plan pays 100%
MENTAL HEALTH AND SUBSTANCE ABUSE			
Inpatient	Plan pays 90%*; you pay 10%	Plan pays 70%*; you pay 30%	You pay $150 per admission
Outpatient	You pay $20 per visit, no deductible	Plan pays 70%*; you pay 30%	You pay $20 per visit
MATERNITY BENEFITS			
Prenatal care	$20 co-payment for first visit	Plan pays 70%*; you pay 30%	$20 co-payment for first visit
In-hospital delivery	Plan pays 90%*; you pay 10%	Plan pays 70%*; you pay 30%	You pay $150 per admission
EMERGENCY ROOM CARE			
	Plan pays 90%; you pay 10%	Plan pays 90%; you pay 10%	You pay $100 co-payment (waived if admitted or held 24 hours)

* After you satisfy the deductible

Prescription Drug Coverage

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

PRESCRIPTION DRUG COVERAGE*

Note: CVS Caremark 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)*
Generic (Tier I)	$10	$20
Preferred Brand (Tier II)	$30	$60
Non-Preferred Brand (Tier III)	$45	$90

*Mandatory mail order (picked up at retail or via mail) for maintenance drugs, generic step therapy and specialty preferred drug therapy applies to all plans.

Medical Plan Costs* +

MEDICAL COSTS (Including Prescription Drug Coverage)	NATIONAL PPO			NATIONAL EPO			REGIONAL PPO		
	Individual	2-Person	Family	Individual	2-Person	Family	Individual	2-Person	Family
MONTHLY COST SUMMARY:									
Full-time employees pay	$120.00	$240.00	$340.00	$160.00	$320.00	$455.00	$140.00	$280.00	$395.00
80% part-time employees pay	$222.04	$444.08	$631.90	$263.84	$527.67	$752.55	$238.04	$476.08	$675.90
60% part-time employees pay	$324.08	$648.16	$923.80	$367.67	$735.35	$1,050.09	$336.08	$672.16	$956.80
WEEKLY COST SUMMARY:									
Full-time employees pay	$27.69	$55.38	$78.46	$36.92	$73.85	$105.00	$32.31	$64.62	$91.15
80% part-time employees pay	$51.24	$102.48	$145.82	$60.89	$121.77	$173.66	$54.93	$109.86	$155.98
60% part-time employees pay	$74.79	$149.58	$213.18	$84.85	$169.70	$242.33	$77.56	$155.11	$220.80

* Deducted in pre-tax dollars

\+ For applicable **retirees**, rates will be provided under separate cover. Please refer to your confirmation statement

Medical Plan Contact Information

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

Customer Service Telephone Numbers and Websites for Each Plan					
	National PPO and National EPO (BCBS)	Harvard Pilgrim PPO	Independent Health PPO	MVP PPO	Oxford PPO
For a provider directory; service area map or more information call:	1-800-287-8757	1-888-333-4742	1-800-501-3439	1-800-229-5851	1-800-444-6222
Or visit their website at:	www.bluecrossma.com	www.harvardpilgrim.org/member	www.independenthealth.com	www.mvphealthcare.com	www.oxfordhealth.com

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

Dental Plan (Dental benefits are available only to certain retirees based on retirement date)

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.

DENTAL PLAN: HOW THE PLAN PAYS BENEFITS	
GENERAL PROVISIONS	
Dependent Coverage	To age 19 or age 25 if full-time student*
Annual Deductible (individual/family)	$50/$150 (applies to Type II and Type III services)
Maximum Annual Benefit	Plan pays up to $2,500 per individual
Type I – Diagnostic and Preventive Care • Exams and cleanings, 2x/yr (3x/yr for specific conditions) • X-rays • Fluoride for children under 19 (once every six months) • Space maintainers for children under 19	Plan pays 100%; no deductible applies
Type II: Basic Restorative Services • Fillings • Oral surgery • Anesthesia • Extractions • Root canal therapy • Treatment of gum disease (periodontal treatment) • Repair or maintenance of dentures	Plan pays 80% after deductible; you pay 20%
Type III: Major Restorative Services • Crowns • Dentures (once within 60 months) • Implants • Bridgework • Repair or maintenance of crowns or implants	Plan pays 50% after deductible; you pay 50%
CHILDREN'S ORTHODONTIA	
Orthodontia (coverage for dependent children up to age 19)*	Plan pays 100%; no deductible applies Up to lifetime maximum for orthodontia benefits: $2,000

*Dependent eligibility may vary for **retiree** plan offering.

Dental Plan Costs * +

DENTAL COSTS			
	Individual	2-Person	Family
Monthly Cost Summary:			
Full-time employees pay	$19.00	$38.00	$53.00
80% part-time employees pay	$24.80	$49.59	$69.75
60% part-time employees pay	$30.59	$61.18	$86.50
Weekly Cost Summary:			
Full-time employees pay	$4.38	$8.77	$12.23
80% part-time employees pay	$5.72	$11.44	$16.10
60% part-time employees pay	$7.06	$14.12	$19.96

* Deducted in pre-tax dollars
+ For applicable **retirees**, rates will be provided under separate cover. Please refer to your confirmation statement.

Dental Plan Contact Information

For more information about dental plan benefits, contact Delta Dental directly at 1-800-872-0500, or visit www.deltadentalma.com.

A COMPARISON OF NATIONAL GRID HEALTH BENEFITS FOR MANAGEMENT EMPLOYEES

This is a summary of the major benefits offered by each health care plan and also provides costs for 2016

MEDICAL PLAN COMPARISON: HOW PLANS COVER SERVICES

	National PPO (Blue Cross Blue Shield) and Regional PPOs (Harvard Pilgrim, Independent Health, MVP, Oxford)		National EPO (Blue Cross Blue Shield)	Consumer Driven Health Plan (Blue Cross Blue Shield)	
	In-Network	Out-of-Network	In-Network Only	In-Network	Out-of-Network
GENERAL PROVISIONS					
Annual deductible	$400/individual $800/family	$400/individual $800/family	$200/individual $400/family	$1,550/individual $3,100/family	$3,100/individual $6,200/family
Benefit level (what the plan pays for most eligible expenses)	Plan typically pays services at 90% after you satisfy the deductible, you pay 10%	Plan typically pays services at 70% after you satisfy the deductible, you pay 30%	Plan typically pays services at 90% after you satisfy the deductible, you pay 10%	90% after deductible	70% after deductible
Annual out-of-pocket maximum (including deductible, medical & Rx co-payments and coinsurance)	$2,000/individual $4,000/family	$2,800/individual $5,600/family	$1,500/individual $3,000/family	$2,700/individual $5,400/family	$5,400/individual $10,800/family
Maximum lifetime benefit per individual	No limit	No limit	No limit	No limit	No limit
Dependent coverage	To end of the year in which the dependent turns age 26				
Inpatient covered services	Plan pays 90%*; you pay 10%	Plan pays 70%*; you pay 30%	Plan pays 90%*; you pay 10%	Plan pays 90%*; you pay 10%	Plan pays 70%*; you pay 30%
Health Savings Account Contribution from National Grid	N/A		N/A	$750/individual $1,500/family	
OUTPATIENT COVERED SERVICES					
Preventive care visits	Plan pays 100%; no deductible	Plan pays 70%*; you pay 30%	Plan pays 100%, no deductible	Plan pays 100%, no deductible	Plan pays 70%*; you pay 30%
Other office visits	You pay $20 Primary Care/ $30 Specialist per visit	Plan pays 70%*; you pay 30%	You pay $20 Primary Care/ $30 Specialist per visit	Plan pays 90%*; you pay 10%	Plan pays 70%*; you pay 30%
Outpatient surgery and pre-admission testing	Plan pays 90%*; you pay 10%	Plan pays 70%*; you pay 30%	Plan pays 90%*; you pay 10%	Plan pays 90%*; you pay 10%	Plan pays 70%*; you pay 30%
Routine vision (one per calendar year)	Plan pays 100%; no deductible	Plan pays 70%*; you pay 30%	Plan pays 100%; no deductible	Plan pays 100%; no deductible	Plan pays 70%*; you pay 30%
Routine hearing exams	Plan pays 100%; no deductible	Plan pays 70%*; you pay 30%	Plan pays 100%; no deductible	Plan pays 100%; no deductible	Plan pays 70%*; you pay 30%
Diagnostic lab and X-ray	Plan pays 100%; no deductible	Plan pays 70%*; you pay 30%	Plan pays 100%; no deductible	Plan pays 90%*; you pay 10%	Plan pays 70%*; you pay 30%
MENTAL HEALTH AND SUBSTANCE ABUSE					
Inpatient	Plan pays 90%*; you pay 10%%	Plan pays 70%*; you pay 30%	Plan pays 90%*; you pay 10%	Plan pays 90%*; you pay 10%	Plan pays 70%*; you pay 30%
Outpatient	You pay $20 per visit, no deductible	Plan pays 70%*; you pay 30%	You pay $20 per visit	Plan pays 90%*; you pay 10%	Plan pays 70%*; you pay 30%
MATERNITY BENEFITS					
Prenatal care	$20 co-payment for first visit	Plan pays 70%*; you pay 30%	$20 co-payment for first visit	Plan pays 100%; no deductible	Plan pays 70%*; you pay 30%
In-hospital delivery	Plan pays 90%*; you pay 10%	Plan pays 70%*; you pay 30%	Plan pays 90%*; you pay 10%	Plan pays 90%*; you pay 10%; Well-Baby plan pays 100%	Plan pays 70%*; you pay 30%
EMERGENCY ROOM CARE					
	Plan pays 90%*; you pay 10%	Plan pays 90%*; you pay 10%	You pay $100 co-payment (waived if admitted or held 24 hours)	Plan pays 90%*; you pay 10%	Plan pays 90%*; you pay 10%

* After you satisfy the deductible

Prescription Drug Coverage

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

PRESCRIPTION DRUG COVERAGE

Note: CVS Caremark 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)**
EPO/PPO PLAN		
Generic (Tier I)	$10	$20
Preferred Brand (Tier II)	$30	$60
Non-Preferred Brand (Tier III)	$45	$90
CONSUMER DRIVEN HEALTH PLAN		
Generic (Tier I)	Plan pays 90%*; you pay 10%	Plan pays 90%*; you pay 10%
Preferred Brand (Tier II)	Plan pays 90%*; you pay 10%	Plan pays 90%*; you pay 10%
Non-Preferred Brand (Tier III)	Plan pays 90%*; you pay 10%	Plan pays 90%*; you pay 10%

* After you satisfy the deductible

**Mandatory mail order (picked up at retail or via mail) for maintenance drugs, generic step therapy and specialty preferred drug therapy applies to all plans.

NOTE: Medically necessary compounded drugs will continue to be covered, however prior authorization for compounded drugs over $300 will be required.

MEDICAL PLAN COSTS*

MEDICAL COSTS (Including Prescription Drug Coverage)	NATIONAL PPO			NATIONAL EPO			REGIONAL PPO			CONSUMER DRIVEN HEALTH PLAN		
	Individual	2-Person	Family	Individual	2-Person	Family	Individual	2-Person	Family	Individual	2 - Person	Family
	Monthly Cost Summary											
Full-time employee pays	$120.00	$240.00	$340.00	$150.00	$300.00	$430.00	$140.00	$280.00	$395.00	$60.00	$120.00	$170.00
80% part-time employee pays	$225.72	$451.43	$642.12	$251.72	$503.43	$719.98	$241.72	$483.43	$ 686.12	$168.20	$336.41	$479.01
60% part-time employee pays	$331.44	$662.87	$944.24	$ 353.43	$706.86	$ 1009.96	$ 343.44	$686.87	$ 977.24	$276.41	$552.82	$788.02
	Weekly Cost Summary											
Full-time employee pays	$27.69	$55.38	$78.46	$ 34.62	$ 69.23	$ 99.23	$32.31	$64.62	$91.15	$13.85	$27.69	$39.23
80% part-time employee pays	$ 52.09	$ 104.18	$ 148.18	$ 58.09	$116.18	$ 166.15	$ 55.78	$111.56	$ 158.34	$38.82	$77.63	$110.54
60% part-time employee pays	$76.49	$152.97	$217.90	$81.56	$163.12	$233.07	$79.25	$158.51	$225.52	$63.79	$127.57	$181.85

* Deducted in pre-tax dollars

MEDICAL PLAN CONTACT INFORMATION

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

CUSTOMER SERVICE TELEPHONE NUMBERS AND WEB SITES FOR EACH PLAN							
	NATIONAL PPO AND NATIONAL EPO (BCBS)	HARVARD PILGRIM PPO	INDEPENDENT HEALTH PPO	MVP PPO	OXFORD PPO	CONSUMER DRIVEN HEALTH PLAN (BCBS)	HEALTH EQUITY FOR HSA
For a provider directory, service area map or more information call:	1-800-287-8757	1-888-333-4742	1-800-501-3439	1-800-229-5851	1-800-444-6222	1-800-287-8757	1-866-346-5800
Or visit their Web site at:	www.bluecrossma.com	www.harvardpilgrim.org/member	www.independenthealth.com	www.mvphealthcare.com	www.oxfordhealth.com	www.bluecrossma.com	www.healthequity.com

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

DENTAL PLAN

Each time you need care, you choose to receive care from an in- or out-of-network provider. When you receive care from an in-network provider your cost will generally be lower because Delta Dental negotiates discounted rates with those providers.

DENTAL PLAN: HOW THE PLAN PAYS BENEFITS	
GENERAL PROVISIONS	
Annual Deductible (individual/family)	$50/$150 (applies to Type II and Type III services)
Maximum Annual Benefit	Plan pays up to $2,500 per individual (limitations do apply)
Type I: Diagnostic and Preventive Care • Exams and cleanings, 2 times per year (3 times per year for specific conditions) • X-rays • Fluoride for children under 19 (once every 6 months) • Space maintainers for children under 19	Plan pays 100%; no deductible applies
Type II: Basic Restorative Services • Fillings • Oral surgery • Anesthesia • Extractions • Root canal therapy • Treatment of gum disease (periodontal treatment) • Repair or maintenance of dentures	Plan pays 80% after deductible; you pay 20%
Type III: Major Restorative Services • Crowns • Dentures (once within 60 months) • Implants • Bridgework • Repair or maintenance of crowns or implants	Plan pays 50% after deductible; you pay 50%
Dependent coverage	To age 19 or age 25 if full-time student
Children's Orthodontia	
Orthodontia (coverage for dependent children up to age 19)	Plan pays 100%; no deductible applies Up to a lifetime maximum for orthodontia benefits: $2,000

DENTAL PLAN COSTS*

DENTAL COSTS			
	Individual	2-Person	Family
Monthly Cost Summary			
Full-time employee pays	$19.00	$38.00	$53.00
80% part-time employee pays	$24.84	$49.68	$69.87
60% part-time employee pays	$30.68	$61.35	$86.74
Weekly Cost Summary			
Full-time employee pays	$4.38	$8.77	$12.23
80% part-time employee pays	$5.73	$11.46	$16.12
60% part-time employee pays	$7.08	$14.16	$20.02

* Deducted in pre-tax dollars

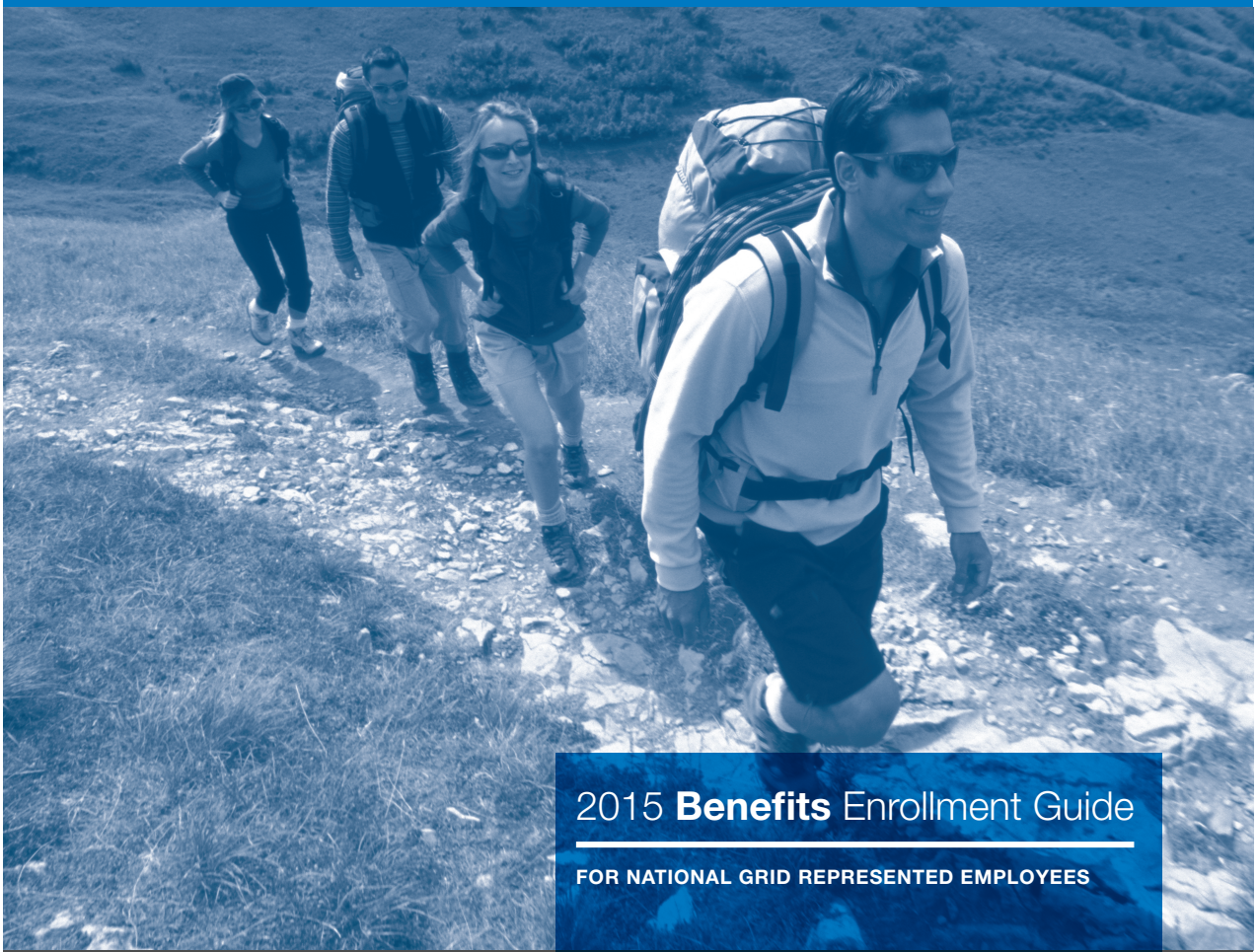
Dental Plan Contact Information

For more information about dental plan benefits, contact Delta Dental directly at 1-800-872-0500, or visit www.deltadentalma.com.

nationalgrid

Benefits Connection:
Choose well
Be well
Live well

OPEN ENROLLMENT **2015**



2015 **Benefits** Enrollment Guide

FOR NATIONAL GRID REPRESENTED EMPLOYEES

Local 101

What's Inside

Local 101

Welcome to 2015 Open Enrollment!

As an employee of National Grid, you have access to a range of quality benefit options so you can get the coverage you need for yourself and your eligible family members. Open Enrollment is your annual opportunity to reassess your health care, life insurance and other benefit needs — by considering how you used your benefits in 2014 and how your needs may change in 2015.

When to Enroll

The Open Enrollment period will begin on **Wednesday, December 3** at 8 a.m. and end on **Wednesday, December 10** at 5 p.m. Eastern Time (ET) via phone and 12 midnight via Web.

This Benefits Enrollment Guide describes the benefits available to you in 2015 as well as important information on how to enroll in your benefits. Read it carefully so that you can make informed decisions that are right for you and your family. To the extent the benefits are subject to the Employee Retirement Income Security Act, the Guide is also a Summary of Material Modifications that describes the changes in those benefits that are effective in 2015. Please keep this Guide for future reference.

You will find detailed instructions about how to enroll starting on page 33

BE AN ACTIVE HEALTH CARE CONSUMER

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

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

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

For all these reasons and more, **we encourage you to be an active health care consumer and engage in your own health.** Be proactive about your health care needs, make informed lifestyle choices, seek early screening for health care issues and work with health providers to address specific concerns. National Grid's Commitment to Health and Wellbeing provides additional resources for you and your family (see page 24).

WHAT'S IN YOUR BENEFITS ENROLLMENT KIT?

YOUR BENEFITS ENROLLMENT KIT INCLUDES:

1. This *2015 Benefits Enrollment Guide*, which describes the benefit options and how they work.

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

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

You will receive a *Personalized Enrollment Worksheet* at your home separate from this communication package. The worksheet shows the options available to you as well as your costs for 2015. If you do not receive your *2015 Personalized Enrollment Worksheet* by December 3, 2014, please contact the Mercer Benefits Service Center at 1-866-294-8052.

After you've enrolled in your 2015 benefits, you will receive a written confirmation of your choices.

Don't Wait Until the Last Minute to Enroll!

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

What's New

You will continue to have access to comprehensive benefit programs in 2015.

The following is a summary of the health and welfare benefit plan modifications that become effective January 1, 2015 as negotiated under the collective bargaining agreement or as a result of regulatory and/or administrative changes. The health benefits and wellness programs offered by National Grid—combined with more employees taking an active role in managing their health—are helping to manage the pace of health care cost increases. **As a result, 2015 contributions for the medical plans will not increase for full-time employees. Contributions will remain the same as 2014 (assuming you remain at your current coverage level for 2015). Employees assigned to Customer Operations will have a decrease in contributions.** You will find details on your 2015 cost for coverage in the enclosed *A Comparison of National Grid Health Benefits chart*.

- **Change in dental contribution share**
  - Effective January 1, 2015, employee contributions towards the dental plan have been eliminated. National Grid will pay 100% of the contribution. The Sponsored Dependent Dental plan will remain in effect with a small contribution increase to $3.76 per week. The employee pays the full cost for this coverage.
- **Change in Flexible Spending Accounts and Commuter Benefits Administrator**
  - Beginning January 1, 2015, administration of the Health Care Spending and Dependent Care Reimbursement Accounts as well as the Transit Benefit will transition from Ceridian to WageWorks.
- **Due to new Health Care Reform requirements, the following changes will become effective January 1, 2015:**
  - Comprehensive in-network out-of-pocket maximum to include Prescription drug costs.
    - Effective January 1, 2015, prescription drug co-payments will accrue to the in-network out of pocket maximum. A combined maximum has been set to which both medical and prescription drug costs will accrue. The out of pocket maximum now includes deductible, medical co-payments and co-insurance, mental health/substance abuse treatments and prescription co-payments. Please refer to the *A Comparison of National Grid Health Benefits* chart to see changes to your current in-network out of pocket maximum levels.
  - Expanded treatments for tobacco cessation, when prescribed by a health care provider
  - Enhanced coverage for Breast Cancer Preventive Medications for women with increased risk
  - BRCA risk assessment and genetic testing for women
  - Lung cancer screening for adults aged 55 to 80 years with a 30 pack per year smoking history and currently smoke or quit within the past 15 years.

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- **Changes to the GHI Premier PPO**
  - Change primary care office visit co-payment from $20 to $25
  - Change specialist office visit co-payment from $30 to $35
  - Change in retail prescription co-payment from $5 generic/$25 formulary/$35 non-formulary to $10/$30/$50
  - Change in mail order prescription co-payment from $10 generic/$50 formulary/$70 non-formulary to $20/$60/$100.
- **Changes to the GHI Standard PPO Plan**
  - Change in-network deductible from $250 individual/$500 family to $300/$600
  - Change in Emergency Room co-payment from $150 to $250
- **Implementation of the following Prescription Drug Programs with CVS Caremark (refer to the Prescription Drug Benefits section for further information):**
  - **Compounded Drugs Prior Authorization**. Compounded drugs often contain three to five drugs along with expensive bases and solvents in the preparation that dramatically increases the cost. Compounded drug claims over $300 will require prior authorization
  - **Generic Step Therapy.** This is a strategy to encourage the use of generics and requires that a member has either tried or chosen a generic or preferred brand product when filling his or her prescription
  - **Specialty Preferred Drug Therapy**. This program encourages the use of preferred specialty medications for specific therapeutic classes. The preferred drugs are well-supported treatment options and represent the most cost-effective medications for a given condition. Current utilizing members are grandfathered from this program requirement.

Important Enrollment Information

You will enroll through the Mercer Benefits Service Center either online or via phone. You will need to enroll if you want to:

- Change your current medical and/or dental coverage.
- Waive medical coverage.
- Waive dental coverage.
- Change the dependents you cover in the medical and/or dental plans.
- Enroll in a Health Care Spending Account (HCSA) and/or a Dependent Care Reimbursement Account (DCRA) for 2015.
- Enroll in the Long-Term Disability plan.
- Enroll in or change your parking and/or transit benefits.
- Enroll in Legal Services.

If You Waived Medical Coverage in 2014

If you elected to waive medical coverage in 2014, and you do not actively elect medical coverage for 2015, you will have no medical coverage for 2015.

Making Changes During the Year

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

Contact the carrier directly to:

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

If you do not take any action before **December 10**, and you are already eligible for and enrolled in subsidized medical and dental coverage, you will default into the following plan elections:

Default Benefit Plans	
Medical (If enrolled in 2014)	The coverage you had in 2014
Supplemental Cancer Coverage (If enrolled in 2014)	The coverage you had in 2014
Dental (If enrolled in 2014)	The coverage you had in 2014
Flexible Spending Accounts • Health Care • Dependent Care	Waive-No Coverage Waive-No Coverage
Optional/Supplemental Life Insurance	The coverage you had in 2014
Long-Term Disability	The coverage you had in 2014
Transit Benefits	The coverage you had in 2014
Legal Services	Waive-No Coverage

WHO IS ELIGIBLE?

You are eligible to choose coverage under one of the medical plan options and to enroll in dental coverage if you are an active employee who is represented by Local 101 and you have completed the required months of service as per the governing collective bargaining agreement. Please refer to the *When Your Coverage Begins* section on page 8.

MEDICAL

In addition to yourself, the following family members are eligible to enroll in some of the benefit options available to you:

- Your legally married spouse, including same-sex spouse (if you were married in a state that recognizes same-sex marriage, regardless of where you actually reside).
- Your child(ren) who are under the age of 26, married or unmarried regardless of full-time student or tax dependent status. A child includes:
  - Natural child(ren), legally adopted child(ren) or child(ren) placed with you pending legal adoption, child(ren) for whom you or your spouse serve as legal guardian, eligible foster child(ren), stepchild(ren), child(ren) of a same-sex spouse. **You must elect coverage for your same-sex spouse if you want to elect coverage for his/her dependent child(ren)**.

    **Note: Grandchild(ren) are not eligible for coverage unless adopted or legal guardian.*
- 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 required documentation upon request to confirm your ongoing eligibility to receive health coverage.

Important Note Regarding Dependent Eligibility

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

If You Want to Opt Out of Medical Coverage

If you elected to opt out of medical coverage in 2014, and received the opt-out credit and want to opt out again in 2015, you must make an active election to opt out of medical coverage during Open Enrollment. If you do not actively elect to opt out and you do not enroll in a medical plan during Open Enrollment, you will not receive medical benefits for 2015 and you will not receive an opt-out credit (if eligible). (See page 16 for more information.)

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

Spouses of married dependents and child(ren) of dependents are NOT eligible for coverage.

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DENTAL

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

- Your legally married spouse, including same-sex spouse (if you were married in a state that recognizes same-sex marriage, regardless of where you actually reside).
- Your dependent child(ren) including your unmarried natural child(ren), legally adopted child(ren) or child(ren) placed with you pending legal adoption, child(ren) for whom you or your spouse serve as legal guardian, eligible foster child(ren), step-child(ren), child(ren) of a same-sex spouse. **You must elect coverage for your same-sex spouse if you want to elect coverage for his/her dependent child(ren)**.

  **Note: Grandchild(ren) are not eligible for coverage unless adopted or legal guardian.*

  – Coverage for your child(ren) as defined above may be extended beyond age 19, until the end of the year in which the child reaches age 25, as long as the child is a full-time student, and you enroll the child as a "Sponsored Dependent" for coverage.

  – Certification is required annually to confirm a child's continuing full-time student status.

Local 101

WHEN YOUR COVERAGE BEGINS

The elections you make during this Open Enrollment period will take effect on January 1, 2015 and will remain in effect through December 31, 2015. You can only make a change during the year if you have a qualified life event as described on page 11 of this guide.

Choose Well

Choose well means enrolling in the right benefits for you and your family. It is important for you to consider your/your family's own needs for the upcoming year when making your elections for eligible benefits. The information in this guide together with your comparison chart provides a summary overview of many benefits and highlights what's new and changing in 2015.

NEW HIRES

All full-time regular new hires are required to call 1-888-4TDC-123 (1-888-483-2123) within 31 days of first becoming eligible for either full cost or subsidized health benefits or voluntary benefits in order to make elections and ensure adequate coverage. See the chart on the next page for more information about the eligibility for certain benefits.

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

If you elect to waive medical and/or dental coverage you must contact the Mercer Benefits Service Center at 1-866-294-8052.

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Benefit	Eligibility	
	NGEM Direct Hires	Utility & Customer Ops Employees
Medical Plan	**Full cost** First of the month following or coincident with your date of hire **Subsidized cost** First of the month following or coincident with the completion of 60-days of employment	
Dental Plan	**Full cost** First of the month following or coincident with your date of hire **Subsidized cost** After completion of six months of service	
Supplemental Cancer Coverage	Available at Open Enrollment only; not available to those who waived National Grid medical coverage	
Health Care Spending Account	After six months of service	
Dependent Care Reimbursement Account	After six months of service	
Basic Life Insurance (Auto-Enrollment)	After six months of service: Two times base salary, up to $200,000	• After one year of service: $5,000 • After two years of service: Two times base salary, up to $500,000 For Customer Operations • Employees hired on or after October 16, 2010: One times base salary
Optional Life Insurance **Spousal Life Insurance** **Dependent Life Insurance**	After six months of service	
Basic Accidental Death and Dismemberment Coverage (Auto-Enrollment)	After six months of service: One times annual base up to $200,000	After six months of service: One times base salary up to $200,000, with an additional $50,000 benefit available for an occupational loss
Long-Term Disability	First of the month following or coincident with the completion of three months of service	
Transit Benefits	First of the month following three months of service	
Legal Services	Available at Open Enrollment only	

Local 101

PAYING FOR COVERAGE

Your *2015 Personalized Enrollment Worksheet* and *A Comparison of National Grid Health Benefits* chart include the cost for each of your medical and dental benefit options, as well as the coverage levels available to you. Optional life insurance coverage is provided through a separate enrollment with MetLife. During Open Enrollment, you may contact MetLife directly to review your options. If you are a newly hired employee, you will receive your MetLife information with your other enrollment information and new hire documentation. Depending on the type of benefit, your contributions will be deducted from your paycheck on a pre-tax or after-tax basis as shown in the chart below.

Pre-Tax Contributions Apply to These Benefits:	After-Tax Contributions Apply to These Benefits:
• Medical Coverage • Supplemental Cancer Coverage • Dental Coverage • Health Care Spending Account (HCSA) • Dependent Care Reimbursement Account (DCRA) • Transit Benefits	• Optional Life Insurance • Dependent Life Insurance • Voluntary AD&D • Long-Term Disability Coverage • Legal Services

Paying With Pre-Tax Dollars: What It Means

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

MAKING CHANGES DURING THE YEAR

The benefit elections you make during this Open Enrollment period will stay in effect throughout the 2015 calendar year. You can only make changes to your coverage during the year if you experience a qualified life event — a significant change in your life that has a direct impact on your coverage. 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/same-sex spouse or child, or a change in the eligibility of a covered dependent.
- Your spouse/same-sex spouse gains or loses employment.
- You or your spouse/same-sex spouse changes from part-time to full-time employment status or vice versa.
- You or your spouse/same-sex spouse takes an unpaid leave of absence.
- You or your spouse/same-sex spouse experiences a significant change in health coverage due to your spouse's/same-sex spouse's employment. (For example, his/her employer changes payroll withholding, or he/she chooses a different medical plan or coverage during the year.)
- You move out of your medical plan's service area.

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

How are you spending time?

People spend an average of 6.8 hours researching buying a car, 4.9 hours holiday shopping, and 1.3 hours buying a pair of shoes, according to Guardian Life industry data. And on average, people are spending about 1.4 hours reviewing their benefits plans.

It takes time to make sure your needs are covered. Smart benefits decisions may not have that "new car smell"—but peace of mind is an accessory that doesn't wear off quickly. The choices you make—or don't make—during Open Enrollment will impact you and your family for the next year. Take the time to give your benefits a thorough check-up this year.

Your 2015 Benefit Choices

National Grid's benefits program offers a broad choice of quality, affordable coverage for you and your family. This chart highlights the 2015 choices available to employees represented by Local 101. More details about each benefit follow.

Your 2015 Benefit Choices	
Medical Plan Options All plans include prescription drug coverage	• A choice between the GHI Premier PPO and the GHI Standard PPO • Ability to waive medical coverage (if you have coverage elsewhere) These plans cover preventive care at 100% and pay for a wide range of other medically necessary services and supplies, including prescriptions, office visits, specialist visits, hospitalization and behavioral health.
Supplemental Cancer Coverage	• Enroll in a supplemental policy through Aflac You must be enrolled in medical coverage to purchase this supplemental policy. Cash benefits payable under this policy are in addition to what your Company-sponsored medical plan covers. Different policy levels are available, with different premiums.
Dental Plan	• One plan option through GHI • Ability to waive dental coverage The plan pays the full cost of preventive care and other services, including fillings, crowns, periodontal care and orthodontia (for children up to age 19 only).
Flexible Spending Accounts	• **Health Care**: Contribute up to $2,500 pre-tax for eligible health care expenses. • **Dependent Care**: Contribute the following amounts pre-tax for eligible dependent care expenses; – Up to $5,000 a year if you're single or married and filing a joint tax return – Up to $2,500 if you're married and filing separately

Your 2015 Benefit Choices	
Life Insurance for Employees	**Company-Paid Basic Life Insurance** • For NGEM direct hires: — One times base salary up to $200,000 • For Corporate Utility employees: — $5,000 after one year of service — Two times base salary up to $500,000 after two years of service • For Customer Operations employees hired on or after October 16, 2010: — One times base salary **Optional Life Insurance** • Purchase coverage up to five times your annual salary rounded to the next highest $10,000 or $250,000
Dependent Life Insurance Check with carrier for further details on eligibility and evidence of insurability requirements	• For your spouse/same-sex spouse: Purchase in increments of $10,000, cannot exceed the employee's coverage or $100,000 whichever is less ($10,000 minimum) • For your child(ren): $2,000 or $4,000
Accidental Death and Dismemberment	• Basic: one times base salary up to $100,000; for Occupational-related loss, additional coverage of $50,000 is provided The Company pays the full cost of basic AD&D coverage; you are automatically enrolled.
Long-Term Disability	Monthly benefit equals 60% of your monthly base earnings. Maximum monthly benefit is $8,000; minimum is $100 or 10% of the gross benefit, whichever is greater
Transit Benefits	Save pre-tax dollars to pay for work-related commuting expenses, including parking and mass transit fares
Auto and Homeowners Insurance	Purchase insurance at discounted group rates
Legal Services	Purchase access to legal services through Hyatt Legal Plans, including telephone advice and office consultations for services including will preparation and real estate closings

Medical Plan Options

For 2015, National Grid will continue to offer the choice of two Preferred Provider Organization (PPO) plans administered through GHI. Each plan covers the same wide range of health care services, and each includes prescription drug coverage.

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

You will have a choice of two medical plan options in 2015 administered by EmblemHealth – the GHI Standard PPO and the GHI Premier PPO.

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

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

What to Consider When Choosing Your Plan

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

- What do you think your health care needs will be in 2015? What are your typical health care needs? Do you or a covered family member have any chronic health conditions?
- What are your total costs under each option–including the contributions, deductibles, co-insurance, co-payments and non-covered services?
- How does your National Grid coverage compare to any other coverage you might have, such as through your spouse's plan?

Here's a Tip: Play an Active Role

Patients who ask questions are more satisfied with their care and see more of an improvement in their health than patients who do not.

GENERALISTS AND PCPS

When you visit a participating GHI medical provider or mental health care provider, you will pay a $25 co-payment per visit in the GHI Premier Plan or a $30 co-payment in the GHI Standard Plan. These include providers who practice: Allergy, Audiology, Bacteriology, Cardiology, Certified Nurse Midwife, Chiropractor, Endocrinology, Family Practice, Gastroenterology, General Practice, Geriatric Medicine, Gynecology and Obstetrics, Hematology, Infectious Diseases, Internal Medicine, Medical Genetics, Neonatology, Nephrology, Neurology, Nuclear Medicine, Nurse Practitioner, Oncology, Pain Management, Pathology, Pediatrics, Physical Medicine and Rehabilitation, Physical Therapy, Preventive Medicine, Pulmonary Diseases, Reproductive Endocrinology, Rheumatology, Screening Centers, Speech Pathology and Therapeutic Radiology.

SPECIALISTS

When you visit a participating GHI specialist, you will pay a $35 co-payment per visit in the GHI Premier Plan or a $50 co-payment in the GHI Standard Plan. Specialists include dermatologists, surgeons and surgical subspecialties, including providers who practice Cardiothoracic and Thoracic Surgery, Colon and Rectal Surgery, General Surgery, Neurological Surgery, Ophthalmology, Oral Surgery, Orthopedic and Hand Surgery, Otolaryngology, Plastic Surgery, Podiatry and Podiatric Surgery, Traumatic Surgery, Urology, Vascular and Veno Surgery.

COVERAGE WHEN YOU ARE AWAY FROM HOME

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

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

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

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

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

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

COVERAGE LEVEL OPTIONS

You can choose from the following coverage options:

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

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

- You and your spouse may both choose Employee Only coverage under the same or different plans.

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

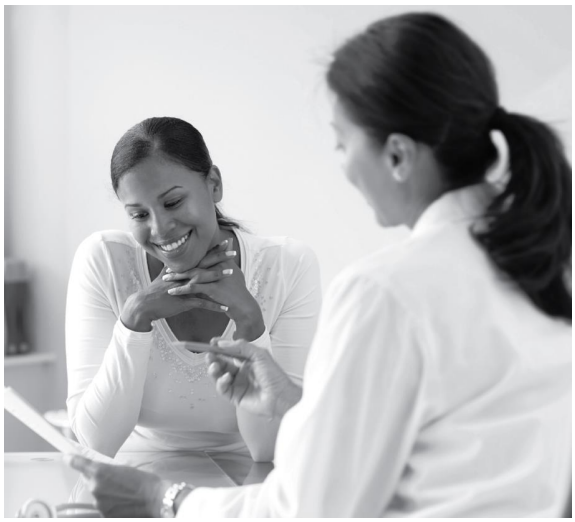
Remember: A National Grid employee cannot be covered both as an employee and a dependent under a National Grid medical plan, so if National Grid also employs your spouse, you must choose to be covered by either your spouse's plan or yours.

WAIVING MEDICAL COVERAGE

If you have coverage under another medical plan (for example, through your spouse's employer), you may elect to waive coverage through the Company. If you choose to waive medical coverage, you will have no medical coverage for yourself or your family through National Grid for 2015.

To certify that you have coverage under another employer-provided medical plan and waive medical coverage through National Grid for 2015, contact the Mercer Benefits Service Center online at **www.NationalGridEmployeeServices.MercerHRS.com** and select "no coverage" under the medical benefit plan option. You may also call the Mercer Benefits Service Center at 1-866-294-8052.

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



Prescription Drug Benefits

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

Here's a Tip: Use Generic Drugs Whenever Possible

Generic drugs are as effective as brand-name drugs but almost always cost less. If you take a brand-name drug, talk with your health care provider to determine if a generic equivalent might be a smarter choice for you.

FILLING PRESCRIPTIONS THROUGH CVS CAREMARK

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

Note: If you take a maintenance (long-term) medication, you can get up to three 30-day fills of the same medication at a participating retail pharmacy. After the third fill, you are required to order up to a 90-day supply of your prescription either through the mail order or at a CVS Pharmacy. **Failure to fill maintenance medications as outlined above will result in you being charged for 100% of the cost at 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 Pharmacy to avoid paying full cost for your prescriptions.

Compounded Drugs Prior Authorization

Compound drugs often contain three to five drugs along with expensive bases and solvents in the preparation that dramatically increases the cost. The drugs contained in the topical products are not in an FDA approved topical formulation. Claims over $300 will require prior authorization.

Generic Step Therapy

This new prescription program encourages members to utilize more cost effective first-line generics and provides coverage for one preferred select brand in most classes. The preferred select brand is determined by clinical effectiveness based on FDA approved indications, lowest net cost and/or shortest remaining patent life. For some classes, such as the PPI class where sufficient generics are available, a generic trial is required before any single source brand is covered.

Generic Step Therapy requires that a cost-effective generic alternative is tried first before a single-source brand is covered. Here is how it works:

When a prescription for a targeted 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 will be paid. If there is no history of a generic trial, the pharmacist will receive a message for the prescriber to call a toll-free number for more information. In the event that the prescriber advises CVS Caremark that a generic alternative is not right for the member, he or she can call the Prior Authorization Department.

This program is intended to actively educate members and prescribers with regards to clinically appropriate medications, and to guide them to more cost-effective options.

Specialty Preferred Drug Program

Another new prescription drug program is designed to help prescribers select the most clinically effective therapy, at the lowest cost in specific specialty therapeutic categories. The preferred medication is a well-supported treatment option and represents the most cost-effective medication. The Specialty Preferred Drug Program will apply to the following specialty medication categories: multiple sclerosis, auto-immune medications (medications used to treat Crohn's disease, psoriasis, rheumatoid arthritis).

When/if you present a prescription for preferred specialty medication, the prescription will automatically be approved. When/if you present a prescription for a non-preferred specialty medication, 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, he or she 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.

Note: Current utilizing members are grandfathered from this program requirement.

Supplemental Cancer Coverage

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

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

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

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

For more information about this plan visit **www.aflac.com**. To enroll in this benefit, please call 1-917-532-3011.

CONTINUING PARTICIPATION IF YOU TERMINATE EMPLOYMENT

The coverage is fully portable and is available through age 70. It is guaranteed renewable for life as long as premiums are paid.

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

Dental Plan

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

Medical and Dental Plan Coverage Levels

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

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

COVERAGE LEVEL OPTIONS

You can choose from the following coverage options:

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

Here's a Tip: Get a Regular Dental Check-up

Did you know that getting a preventive dental check-up can help detect early signs of dental disease? Schedule a dental appointment and help reduce future cost and stress.

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

Flexible Spending Accounts

National Grid offers two flexible spending accounts:

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

Using Your HCSA

Your total annual contribution is available for reimbursement on January 1, 2015. Your annual contribution election will be deducted in equal installments each pay period before applicable payroll taxes are deducted.

You may contribute to one or both flexible spending accounts. However, you must enroll each year to participate. Participation does not automatically continue from year to year. Beginning January 1, 2015, WageWorks will replace Ceridian as the administrator for both spending accounts on behalf of National Grid. See page 36 for contact information.

With a flexible spending account, you save because the money in your account is never taxed — when it goes into your account, or when you withdraw it to reimburse yourself for eligible expenses.

HEALTH CARE SPENDING ACCOUNT

With the HCSA, you can set aside up to $2,500 each year through pre-tax payroll deductions to help you save to pay for eligible health care expenses which are not otherwise covered by your health care plans.

The $2,500 cap applies on a per-employee basis. If an employee and his/her spouse are both employees of National Grid and are eligible to make contributions to the HCSA, each person may elect to contribute up to the $2,500 limit.

Eligible Health Care Spending Account Expenses

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

For a complete list of eligible and ineligible expenses, contact Ceridian (see page 36 for contact information), contact the IRS toll-free at 1-800-829-3676 and ask that Publication 502 be sent to you free of charge, or visit **www.irs.gov.**

DEPENDENT CARE REIMBURSEMENT ACCOUNT

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

Eligible Dependent Care Reimbursement Account Expenses

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

For a complete list of eligible and ineligible expenses, contact Ceridian (see page 36 for contact information), contact the IRS toll-free at 1-800-829-3676 and ask that Publication 503 be sent to you free of charge, or visit **www.irs.gov**.

USING YOUR DCRA

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

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

Dependent Care Tax Credit

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

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

ADDITIONAL FLEXIBLE SPENDING ACCOUNT RULES

If you have any questions regarding your flexible spending accounts during Open Enrollment, please contact the Ceridian Claim Administration Department at 1-877-799-8820 between 8 a.m. and 8 p.m. ET, Monday through Friday.

Beginning January 1, 2015, please contact WageWorks at 1-855-774-7441.

- **Contributions.** Once you enroll in either (or both) the health or dependent care account, you may not change or stop your contributions until the next Open Enrollment period (unless you experience a qualified life event as indicated on page 11).
- **Reimbursement.** To be reimbursed for eligible health or dependent care expenses incurred between January 1, 2015 and March 15, 2016, obtain the applicable reimbursement claim form by visiting **https://www.wageworks.com/employees/support-center/important-forms.aspx**. Submit your completed form along with a receipt or proof of payment (including the Explanation of Benefits (EOB) if provided by a health plan). WageWorks will then reimburse you for your eligible out-of-pocket expenses up to the total amount of your HCSA contribution election or your DCRA balance. (Note: your account balance on December 31, 2014 will be transferred to WageWorks effective January 1, 2015.) Additional information regarding online reimbursement will be available in December 2014 via a separate announcement.
- **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, 2016 to submit claims for all eligible expenses incurred between January 1, 2015 and March 15, 2016. That's why it's important to carefully consider the amount you will use over the course of the year before contributing to either account.

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.

CONTINUING PARTICIPATION IF YOU TERMINATE YOUR EMPLOYMENT

Terminated or retired employees may choose to continue funding their Health Care Spending Account on an after-tax basis by electing continued coverage through COBRA. Details will be included in the Ceridian COBRA package.

National Grid's Commitment to Health and Wellbeing

Our Integrated Health Management Department offers targeted programs and services free of charge for employees, with the intent to create healthier and happier personal and working lives.

HEALTH & WELLNESS RESOURCE CENTER

www.bluecrossma.com/nationalgrid

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

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

Live Well

Live well includes taking control of your/your family's physical, mental and financial health. Take the time to put wellness into your daily activities. Taking advantage of the various health/wellness programs offered by our health providers, and maintaining appropriate optional life insurance can help to positively influence your physical and mental wellbeing.

PERSONAL HEALTH ASSESSMENT

www.bluecrossma.com/nm/national-grid/healthy-weight.html

You can take the first step to better health by taking a personal health assessment. Upon completion of the confidential questionnaire, you will receive a personalized report and recommendations for appropriate health improvement goals.

QUITNET — SMOKING CESSATION

www.bluecrossma.com/nm/national-grid/quitting-smoking.html

Quitnet is an online smoking cessation program offering resources for a smoke-free life.

CORPORATE COUNSELING ASSOCIATES (CCA) — WORK/LIFE ASSISTANCE

National Grid's Employee Assistance Program, CCA, can be reached at 1-800-833-8707 or online at **www.powerflexweb.com/1073/login.html**. (Company code: National Grid)

GLOBAL FIT

https://www.globalfit.com/club/gyms.asp

Get discounts on gyms and information on exercise, weight loss and nutrition.

INJURY PREVENTION FOR FIELD EMPLOYEES

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

Did You Know?

56% of all injuries reported at National Grid are soft tissue related. Soft tissue injury is the damage of muscles, ligaments and tendons throughout the body. Stretching and flexing before work can significantly reduce your risk of soft tissue injury.

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

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Life Insurance and AD&D Benefits

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

Medical Evidence of Insurability (EOI)

Evidence of Insurability is medical information you may need to provide about the condition of your health before you can be approved for certain levels of life insurance coverage.

BASIC COVERAGE

IF YOU ARE A NGEM DIRECT HIRE:

You are eligible for a basic life insurance benefit equal to one times your base salary, up to $200,000, on the first day of the month coincident with or next following six months of active full-time service. The Company pays the full cost of this group life insurance coverage.

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

IF YOU ARE A CORPORATE UTILITY EMPLOYEE:

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

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

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

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

OPTIONAL LIFE INSURANCE COVERAGE

FOR YOURSELF

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

If you enroll within 31 days of your initial eligibility date and have not been hospitalized within the past 90 days, you are guaranteed coverage up to two times annual salary or $100,000, whichever is less. You are required to submit evidence of insurability to purchase more than that amount. You must be actively at work on the date coverage begins in order to be eligible.

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

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

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

About Optional Life Insurance

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

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

FOR YOUR SPOUSE

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

The amount of spouse coverage cannot exceed the lesser of your coverage or $100,000.You and your spouse must be under 65. If both you and your spouse work for National Grid, you cannot buy coverage for your spouse, but your spouse may have his/her own coverage as an employee.

FOR YOUR CHILD(REN)

You may also make a single election to cover your dependent child(ren) at either $2,000 or $4,000. Your dependent must be at least 14 days old and less than 21 years old (or under the age of 25, if a full-time student).

Imputed Income

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

Naming a Beneficiary

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

By December 3, you should receive a direct home mailing from MetLife which describes how you can enroll in these optional programs. If you need assistance, please call the MetLife Call Center at 1-866-492-6983.

Local 101

Long-Term Disability

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

About Your Payroll Contributions

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

WHEN BENEFITS BEGIN

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

For example, let's assume that your annual salary for purposes of the Plan is $48,000 a year or $4,000 a month (note: your annual salary is defined as your previous year's August 31 base salary). Now let's assume that you are totally disabled for more than 90 consecutive days and have used all your paid sick leave days. Your monthly payments from the LTD Plan will be $2,400 ($4,000 x 60%) less any other benefits you are receiving from other sources (e.g., Social Security, your pension, Workers' Compensation or other benefits).

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

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

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

THE COST OF LONG-TERM DISABILITY COVERAGE

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

As a new hire, your annual salary for purposes of the Plan is your base salary. In subsequent years, your annual salary will be your previous year's August 31 base salary.

Your annual cost is $0.906 per $100 of coverage. Again assuming that your annual salary for purposes of the Plan is $48,000 a year, your annual cost would be $434.88 per year (i.e., $48,000 multiplied by $0.906 divided by $100) or $8.36 per week (i.e., $434.88 divided by 52 weeks). Your contributions will be re-calculated at the beginning of each year to adjust for salary increases.

If you decide you do not want LTD coverage after January 1, 2015, you can cancel your coverage at any time. However, you will not receive a refund for LTD deductions that have been already taken from your pay.

Transit Benefits

With National Grid's transit benefits, you can set aside pre-tax dollars to pay for work-related commuting expenses (excluding tolls). You make separate elections to the commuter (mass transit) benefit component and the parking component. Each of these benefits has a monthly maximum which is set annually by the IRS. Currently, the monthly maximum is $250 for parking and $130 for transit.

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

Beginning January 1, 2015, the reimbursement of these expenses will be managed by WageWorks. To receive reimbursement for your expenses, you can obtain and submit your claims online by accessing the WageWorks Web site: **https://www.wageworks.com/employees/support-center/important-forms.aspx**. You will be asked to submit receipts showing proof of payment. You can also submit a claim form via fax to 1-877-353-9236 or mail to WageWorks CLAIMS ADMINISTRATOR, P.O. Box 14053, Lexington, KY, 40512. Claim forms can also be accessed by visiting the Infonet Spending Accounts section under My Rewards & Benefits: **http://infonet2/OurOrganisation/USHumanResources/Pages/SpendingAccounts.aspx.** Claims must be submitted within 180 days of the date the expense was incurred.

Auto and Homeowners Insurance

National Grid has contracted with MetLife to allow employees to insure their cars, homes and other personal property at special discounted group rates via payroll deduction.

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

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

Legal Services

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

The plan is administered by Hyatt Legal Plans, a MetLife subsidiary. Over 13,000 attorneys nationwide participate. Fees for covered services provided by a plan attorney are fully covered and paid. Out-of-network options are also available through this plan.

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

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

CONTINUING PARTICIPATION IF YOU TERMINATE YOUR EMPLOYMENT

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

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

Enrolling in Your Benefits

Once you've reviewed your benefit options and the information on your *2015 Personalized Enrollment Worksheet*, it's time to get online and enroll! Remember, you have until December 10, by 5 p.m. ET via phone and 12 midnight via Web to elect your benefits for 2015. If you don't enroll, you will automatically receive default coverage (see page 5 for more details). If you want to keep your default benefit elections and you do not plan to participate in the flexible spending accounts or Legal Services Plan, you do not need to enroll.

To Enroll or Make Changes by Phone

You can enroll by contacting the Mercer Benefits Service Center at 1-866-294-8052. Be sure to have your *2015 Personalized Enrollment Worksheet* in front of you when you call.

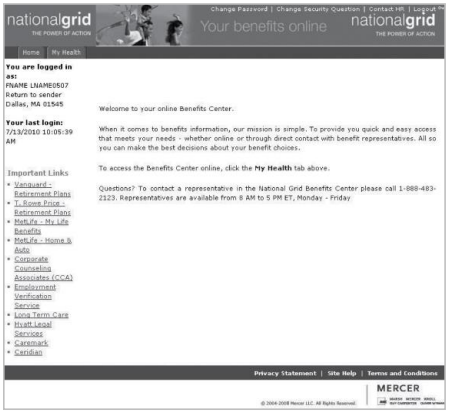
TO ENROLL OR MAKE CHANGES ONLINE

Step 1: Log on to the Mercer Benefits Service Center Web site at **www.NationalGridEmployeeServices.MercerHRS.com**.

Step 2: You will need your User ID and Personal Identification Number (PIN) to log on to the Mercer Benefits Service Center Web site.

- Your User ID is your Employee ID number, which can be located on your *2015 Personalized Enrollment Worksheet* as well as on your pay advice.
- If you do not remember your PIN, you have the ability to reset it by clicking ***Click here to reset your PIN*** from the log on page. If this is the first time you are using the Web site, your PIN has been set to the last four digits of your Social Security Number. Once you log on, you will be asked to reset your PIN and select a series of security questions. Please keep this information for future access.

Step 3: Click on the ***My Health*** link at the top of the page to begin. From this page, you may review your current 2014 elections, personal data and dependent data or you can enroll in your 2015 benefits.



Confirmation of Enrollment

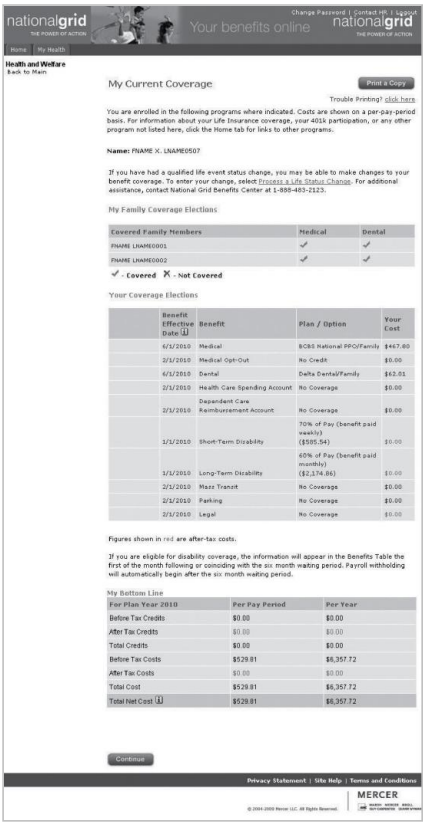
You will receive a confirmation statement when the Open Enrollment period ends, even if you did not make an affirmative election. If any information on the confirmation statement is incorrect, please contact the Mercer Benefits Service Center at 1-866-294-8052 immediately (Monday through Friday, between 8 a.m. and 5 p.m. ET).

Step 4: Review your information on each of the tabs described here:

- **My Cost** — Review your cost for your 2015 benefits.
- **About Me** — Review your personal information. If any of the information on this page is not correct, please call the Transaction Delivery Center at 1-888-483-2123.
- **My Dependents** — Review and update your dependent information listed on this page before electing coverage. If assistance is needed with changing dependent data (name, SSN, etc.), you can call Mercer at 1-866-294-8052.

Click ***Complete Your 2015 Open Enrollment***. You will reach the Enrollment Summary page. Choose the benefits you would like to change by clicking on the ***Change*** button. The Web site will guide you through choosing your plan, selecting which dependents to cover and/or entering a contribution amount for a flexible spending account.

If you want to opt out of medical coverage for 2015, you must click on the ***Change*** button to the left of the medical line and select ***No Coverage***.



Step 5: Once you have made your elections, click ***Submit My Elections***.

Step 6: Your elections are not final until you receive your confirmation number. Once you receive your confirmation number, you will have an opportunity to print a copy of your elections. Click ***Continue*** to complete a quick online survey.

You will be able to change your elections as many times as you like until the enrollment period ends on December 10. If you would like to make a change after receiving your confirmation number, you will need to restart the enrollment process from the beginning. Your changed elections, which become effective January 1, 2015, will not be saved until you receive a new confirmation number.

Local 101

Glossary

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

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

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

Deductible – The annual dollar amount for covered services that you must pay before a PPO plan pays out-of-network benefits.

Healthcare Reform - President Obama signed the Affordable Care Act into law in March 2010. This law is intended to make sweeping changes to healthcare in the United States. Many of the law's provisions are already in effect, while others will come in the next few years.

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

Out-of-network care – Care you receive from providers outside of a PPO network. Under a PPO, you pay more for out-of-network care.

Out-of-pocket maximum – The maximum amount you will pay for covered medical expenses during the year under the plan (including deductibles, co-insurance and co-payments for medical, pharmacy, and mental health/substance abuse treatments for in-network treatment). Any covered medical or pharmacy expenses above the maximum will be covered at 100% by the plan, up to the reasonable and customary limit, for the rest of the calendar year.

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

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

Contact Information

For Information On:	Call:	Or Visit the Web Site:
Medical Plan GHI	1-800-624-2414	www.emblemhealth.com
Prescription Drug Benefits CVS Caremark	1-800-378-8826	www.caremark.com
Supplemental Cancer Coverage Aflac	1-917-532-3011	www.aflac.com
Dental Plan GHI	1-800-624-2414	www.emblemhealth.com
Flexible Spending Accounts Ceridian through December 31, 2014 WageWorks beginning January 1, 2015	1-877-799-8820 1-855-774-7441	www.ceridian-benefits.com www.wageworks.com
Life Insurance and AD&D MetLife	1-866-492-6983	www.metlife.com/mybenefits
Transit Benefits Ceridian through December 31, 2014 WageWorks beginning January 1, 2015	1-877-548-7788 1-855-774-7441	www.ceridian-benefits.com www.wageworks.com
Auto and Homeowners Insurance MetLife	1-800-438-6388	www.metlife.com/mybenefits
Legal Services Hyatt Legal Plans	1-800-821-6400	www.legalplans.com If not yet a member, click “Thinking About Enrolling” and enter password 3990010
Enrollment Mercer Benefits Service Center	1-866-294-8052	www.NationalGridEmployeeServices.MercerHRS.com
General Benefit Questions Transactions Delivery Center	1-888-4TDC-123 (1-888-483-2123)	www.nationalgridtdc123.com

STEPS YOU MUST TAKE BY DECEMBER 10 AT 5 P.M. ET VIA PHONE OR 12 MIDNIGHT VIA WEB	
If you want to... • Enroll in, change or waive your medical coverage for 2015 • Enroll in, change or waive your dental coverage for 2015 • Enroll or re-enroll in the Health Care Spending Account and/or Dependent Care Reimbursement Account for 2015 • Enroll or re-enroll in Legal Services for 2015 • Purchase or change optional life insurance for 2015	You must enroll online at: **www.NationalGridEmployeeServices.MercerHRS.com** or call the Mercer Benefits Service Center at 1-866-294-8052. • You must call the MetLife Call Center at 1-866-492-6983

Don't forget: If the coverage listed on your *2015 Personalized Enrollment Worksheet* meets your needs for 2015, you do not need to enroll.

Reminder: False or Misleading Information

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

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

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Engage in Your Benefits

OPEN ENROLLMENT **2016**

2016 **Benefits** Enrollment Guide

FOR NATIONAL GRID REPRESENTED EMPLOYEES

Local 101

What's Inside

Welcome to 2016 Open Enrollment!

As an employee of National Grid, you have access to a range of quality benefit options so you can get the coverage you need for yourself and your eligible family members. Open Enrollment is your annual opportunity to reassess your health care, life insurance and other benefit needs — by considering how you used your benefits in 2015 and how your needs may change in 2016.

When to Enroll

The Open Enrollment period will begin on Monday**,** October 26 at 7 a.m. and end on Friday, November 6 at 6 p.m. Eastern Time (ET) via phone and 12 midnight via Web.

This Benefits Enrollment Guide describes the benefits available to you in 2016 as well as important information on how to enroll in your benefits. Read it carefully so that you can make informed decisions that are right for you and your family. To the extent the benefits are subject to the Employee Retirement Income Security Act, the Guide is also a Summary of Material Modifications that describes the changes in those benefits that are effective in 2016. Please keep this Guide for future reference.

You will find detailed instructions about how to enroll starting on page 37.

BE AN ACTIVE HEALTH CARE CONSUMER

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

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

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

For all these reasons and more, **we encourage you to be an active health care consumer and engage in your own health.** Be proactive about your health care needs, make informed lifestyle choices, seek early screening for health care issues and work with health providers to address specific concerns. National Grid's Commitment to Health and Wellbeing provides additional resources for you and your family (see page 28).

YOUR BENEFITS ENROLLMENT KIT INCLUDES:

1. This *2016 Benefits Enrollment Guide*, which describes the benefit options and how they work.

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

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

In addition, your *2016 Personalized Enrollment Worksheet* will be mailed separately to your home. The worksheet includes your current coverage and your available options and costs for 2016. If you do not receive your *2016 Personalized Enrollment Worksheet* by October 26, 2015, please contact the National Grid Benefit Services Center at 1-888-483-2123.

As in past years, after you've enrolled in your 2016 benefits, you will receive a written confirmation of your choices, and you'll have the chance to make changes before your coverage becomes effective on January 1, 2016.

Don't Wait Until the Last Minute to Enroll!

- Look at your enrollment tools and resources as soon as possible to make your decision easy and timely.
- Avoid peak hours — during Open Enrollment, 7 a.m. to 11 a.m. ET is the busiest time for the National Grid Benefit Services Center. The best way to get your questions answered quickly is to call mid-week in the afternoon.
- Don't wait until the last minute to enroll — the last day of the enrollment period is a busy time for the online enrollment Web site and the National Grid Benefit Services Center!

What's New

At National Grid, your health and wellbeing is important to us. That's why we have a tradition of providing high-quality, company-subsidized healthcare coverage to eligible employees and their families. In 2016, you will continue to have access to comprehensive benefit programs, along with some exciting new options to choose from and plan features to explore.

As a nation, we are experiencing a period of significant change in the healthcare industry due to the requirements imposed by the Affordable Care Act (ACA). National Grid continues to comply with these requirements and is planning for the future as the imposition of additional taxes on high value plans, like those we offer to our employees, will become effective in 2018. Through it all, National Grid remains committed to providing you with a comprehensive and sustainable program of health and wellness benefits that help you evaluate, maintain and improve your health and the health of your family.

To support these efforts and increase your engagement in the healthcare choices you make for yourself and your family members, our plans have been designed to incorporate elements of consumerism advocating for the awareness in the use, and cost of healthcare. We are introducing a new low cost plan option, the Consumer Driven Health Plan (CDHP) along with a Health Savings Account (HSA) which gives you a way to save for and pay for your healthcare expenses. The new CDHP has the lowest plan contribution.

You will find details on your 2016 cost for coverage in the *A Comparison of National Grid Health Benefits*. By continuing to work together, we can make a greater impact on future healthcare costs.

The following is a summary of the health and welfare benefit plan modifications that become effective January 1, 2016 as negotiated under the collective bargaining agreement or as a result of regulatory and/or administrative changes.

- **New Medical Plan Option (Low Cost Alternative Plan)**
  - CDHP with Blue Cross Blue Shield (BCBS) and HSA with HealthEquity. The CDHP offers comprehensive coverage with preventive care covered at 100% just like the PPO plans, with the same network of providers. It also provides access to an HSA, which is a tax-advantaged savings account allowing you to save money for eligible medical expenses now and in retirement. In addition to your own contributions, National Grid will provide an annual contribution to your HSA. The plan has a higher deductible and out-of-pocket expenses than the traditional plans, but employee contribution rates are lower than those for the PPO plans. More details on this plan can be found beginning on page 15 of this guide.
- **Changes to the GHI Premier PPO**
  - Employee contributions will increase from $36 individual/$81 family to $38 individual/$86 family

In-Network

  - Increase annual deductible to $150 individual/$300 family

- Decrease annual out-of-pocket maximum to $5,000 individual/$10,000 family
- Increase co-payment for Emergency Room to $250
- Implement an Inpatient Hospital co-payment of $150

Out-of-Network

- Decrease annual deductible to $300 individual/$600 family
- Increase annual out-of-pocket maximum to $10,000 individual/$20,000 family
- Increase Emergency Room copay to $250

- **Changes to the GHI Standard PPO Plan**
  - Employee contributions will increase from $18.50 individual/$44.50 family to $23 individual/$49.50 family

In-Network

- Increase annual deductible t3o $400 individual/$800 family
- Decrease annual out-of-pocket maximum to $2,400 individual/$4,800 family
- Implement 90% coinsurance after deductible for non-co-payment based services, except preventive care services which will continue to be covered at 100% per the Patient Protection and Affordable Care Act (PPACA)
- Replace Emergency Room copay with 90% coinsurance after deductible
- Replace Inpatient Hospital copay with 90% coinsurance after deductible

Out-of-Network

- Increase annual deductible to $800 individual/$1,600 family
- Increase annual out-of-pocket maximum to $4,800 individual/$9,600 family
- Replace Emergency Room copay with 90% coinsurance after deductible

- **Life Insurance**
  - MetLife will eliminate the age 70 limit on dependent spouse coverage effective January 1, 2016.
  - The requirement for an employee who signs up for optional/supplemental life insurance to be actively at work on the plan's effective date and not have been 'hospitalized'' in the prior 90-day period will be eliminated effective January 1, 2016.

- **Supreme Court Decision on Same-Sex Marriage**
  - Earlier this year, the U.S. Supreme Court ruled that the right to marry is a fundamental right inherent in the liberty of the person under the Due Process and **Equal Protection Clauses of the Fourteenth Amendment**; same-sex couples may not be deprived of that right. The Court ultimately concluded that same-sex couples may exercise the fundamental right to marry. As a result of this decision, there is no longer any legal barrier to same-sex marriage in the United States. National Grid will provide medical and dental coverage to your “legally married spouse,” regardless of sex.

Important Enrollment Information

You will enroll through the National Grid Benefit Services Center either online or via phone (see page 37 for instructions). You will need to enroll if you want to:

- Change your current medical and/or dental coverage
- Enroll in the Consumer Driven Health Plan (CDHP)
- Enroll in the Health Savings Account (HSA) for 2016 (CDHP participants only).
- Waive medical coverage
- Waive dental coverage
- Change the dependents you cover in the medical and/or dental plans
- Enroll in a Health Care Spending Account (HCSA) and the Health Savings Account (HSA) for 2016
- Enroll in the Dependent Care Reimbursement Account (DCRA) for 2016
- Enroll in the Long-Term Disability plan
- Enroll in or change your parking and/or transit benefits
- Enroll in Legal Services.

If You Waived Medical Coverage in 2015

If you elected to waive medical coverage in 2015, and you do not enroll in medical coverage for 2016, you will have no medical coverage for 2016.

Making Changes During the Year

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

Contact the carrier directly to:

- Purchase or increase optional life insurance coverage for you, your spouse, or your children. If you would like to enroll in optional life insurance, contact MetLife at 1-866-492-6983.
- Enroll in supplemental cancer coverage for the first time. Contact Aflac by calling 1-800-99AFLAC.

If you do not take any action before **November 6**, **2015**, and you are already eligible for and enrolled in subsidized medical and dental coverage, you will default into the following plan elections:

Default Benefit Plans	
Medical (If enrolled in 2015)	The coverage you had in 2015
Supplemental Cancer Coverage (If enrolled in 2015)	The coverage you had in 2015
Dental (If enrolled in 2015)	The coverage you had in 2015
Flexible Spending Accounts Health Care Dependent Care	 Waive-No Coverage Waive-No Coverage
Optional Life Insurance	The coverage you had in 2015
Long-Term Disability	The coverage you had in 2015

Default Benefit Plans	
Transit Benefits	The coverage you had in 2015
Legal Services	Waive-No Coverage

WHO IS ELIGIBLE?

You are eligible to choose coverage under one of the medical plan options and to enroll in dental coverage if you are an active employee who is represented by Local 101 and you have completed the required months of service as per the governing collective bargaining agreement. Please refer to the *When Your Coverage Begins* section on page 8.

Important Note Regarding Dependent Eligibility

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

If You Want to Opt Out of Medical Coverage

If you elected to opt out of medical coverage in 2015 and you do not enroll in a medical plan during Open Enrollment, you will not receive medical benefits for 2016. (See page 20 for more information.)

MEDICAL

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

- Your legally married spouse.
- Your child(ren) who are under the age of 26, married or unmarried regardless of full-time student or tax dependent status. A child includes:
  - Natural child(ren), legally adopted child(ren) or child(ren) placed with you pending legal adoption, child(ren) for whom you or your spouse serve as legal guardian, eligible foster child(ren), stepchild(ren), child(ren) of a 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 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 the child attains age 26. Coverage may be extended indefinitely if the child has been certified as disabled by your medical plan prior to his/her 26th birthday.

Note: Spouses of married dependents and child(ren) of dependents are NOT eligible for coverage.

DENTAL

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

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

  Note:* ***Grandchild(ren) are not eligible for coverage unless adopted by you or under your legal guardianship.*
- Dependent child(ren) are covered until December 31 of the year in which the child attains age 19.
- Coverage for your child(ren) as defined above may be extended beyond age 19, until the end of the year in which the child reaches age 25, as long as the child is a full-time student, and you enroll the child as a “Sponsored Dependent” for coverage.
- Annual certification is required to confirm a child’s continuing full-time student status.

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WHEN YOUR COVERAGE BEGINS

The elections you make during this Open Enrollment period will take effect on January 1, 2016 and will remain in effect through December 31, 2016. You can only make a change during the year if you have a qualified life event as described on page 11 of this guide.

Choose Well

Choose well means enrolling in the right benefits for you and your family. It is important for you to consider your/your family's own needs for the upcoming year when making your elections for eligible benefits. The information in this guide together with your comparison chart provides a summary overview of many benefits and highlights what's new and changing in 2016.

NEW HIRES

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

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

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

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Benefit	Eligibility	
	NGEM Direct Hires	Utility & Customer Ops Employees Hired On or Before 10/15/11
Medical Plan	**Full cost** First of the month following or coincident with your date of hire **Subsidized cost** First of the month following or coincident with the completion of 60-days of employment	
Health Savings Account (HSA)	Only for those who enroll in CDHP Voluntary employee contributions begin upon enrollment in the HSA through HealthEquity One time employer contribution will be applied to HSA upon enrollment (pro-rated for mid-year enrollments) See page 16 for details	
Dental Plan	**Full cost** First of the month following or coincident with your date of hire **Subsidized cost** After completion of six months of service	
Supplemental Cancer Coverage	Available at Open Enrollment only; not available to those who waived National Grid medical coverage	
Health Care Spending Account	After six months of service	
Dependent Care Reimbursement Account	After six months of service	
Basic Life Insurance	After six months of service: One times base salary, up to $100,000	After one year of service: $5,000 After two years of service: Two times base salary, up to $500,000 For Customer Operations Employees hired on or after October 16, 2010: One times base salary
Optional Life Insurance **Spousal Life Insurance** **Dependent Life Insurance**	After six months of service	
Basic Accidental Death and Dismemberment Coverage	After six months of service: One times annual base up to $200,000, with an additional $50,000 benefit available for an occupational loss	After six months of service: One times base salary up to $200,000, with an additional $50,000 benefit available for an occupational loss
Long-Term Disability	First of the month following or coincident with the completion of three months of service	
Transit Benefits	First of the month following three months of service	
Legal Services	Available at Open Enrollment only	

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PAYING FOR COVERAGE

Your *2016 Personalized Enrollment Worksheet* and *A Comparison of National Grid Health Benefits* chart include the cost for each of your medical and dental benefit options, as well as the coverage levels available to you. Optional life insurance coverage is provided through a separate enrollment with MetLife. During Open Enrollment, you may contact MetLife directly if you want to confirm your current coverage, enroll in optional life or change current elections. If you are a newly hired employee, you will receive your MetLife information with your other enrollment information and new hire documentation.

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

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

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

MAKING CHANGES DURING THE YEAR

The benefit elections you make during this Open Enrollment period will stay in effect throughout 2016. You can only make changes to your coverage during the year if you experience a qualified life event — a significant change in your life that has a direct impact on your coverage. Documented proof of the qualified life event(s) will be required.

Qualified life events include:

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

The benefit change you make must reflect the change in status that you experience. For example, if you get married mid-year, you may add your spouse to your current coverage, but you may not change medical plans. **If you experience a 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 a change.**

How are you spending time?

People spend an average of 6.8 hours researching buying a car, 4.9 hours holiday shopping, and 1.3 hours buying a pair of shoes, according to Guardian Life industry data. And on average, people are spending about 1.4 hours reviewing their benefits plans.

It takes time to make sure your needs are covered. Smart benefits decisions may not have that "new car smell"—but peace of mind is an accessory that doesn't wear off quickly. The choices you make—or don't make—during Open Enrollment will impact you and your family for the next year. Take the time to give your benefits a thorough check-up this year.

Your 2016 Benefit Choices

National Grid's benefits program offers a broad choice of quality, affordable coverage for you and your family. This chart highlights the 2016 choices available to employees represented by Local 101. More details about each benefit follow.

Your 2016 Benefit Choices	
Medical Plan Options All plans include prescription drug coverage	• A choice between the GHI Premier PPO and the GHI Standard PPO • Consumer Driven Health Plan (CDHP) with Health Savings Account (HSA) • Ability to waive medical coverage (if you have coverage elsewhere) These plans cover in-network preventive care at 100% and pay for a wide range of other medically necessary services and supplies, including prescriptions, office visits, specialist visits, hospitalization and behavioral health.
Health Savings Account	• Enrollment available to CDHP participants only • Contribute up to $3,350 annually for individual coverage, and $6,750 annually for family coverage. These limits can be reached through a combination of employee and employer contributions (see *A Comparison of National Grid Health Benefits* chart for Company contribution to the HSA)
Supplemental Cancer Coverage	• Enroll in a supplemental policy through Aflac You must be enrolled in medical coverage to purchase this supplemental policy. Cash benefits payable under this policy are in addition to what your Company-sponsored medical plan covers. Policies with various coverage types and premiums are available.
Dental Plan	• One plan option through GHI • Ability to waive dental coverage The plan pays the full cost of preventive care and other services, including fillings, crowns, periodontal care and orthodontia (for children up to age 19 only).
Flexible Spending Accounts	• **Health Care**: Contribute up to $2,550 pre-tax for eligible health care expenses. • **Dependent Care**: Contribute the following amounts pre-tax for eligible dependent care expenses; o Up to $5,000 a year if you're single or married and filing a joint tax return o Up to $2,500 if you're married and filing separately, or married and your spouse also works at National Grid and is contributing to his/her own Dependent Care Spending Account

Your 2016 Benefit Choices	
Life Insurance for Employees	**Company-Paid Basic Life Insurance** For NGEM direct hires: • One times base salary up to $100,000 For Corporate Utility employees: • $5,000 after one year of service • Two times base salary up to $500,000 after two years of service For Customer Operations employees hired on or after October 16, 2010: • One times base salary **Optional Life Insurance** • Purchase coverage up to five times your annual salary rounded to the next highest $10,000 or $250,000
Dependent Life Insurance Check with carrier for further details on eligibility and evidence of insurability requirements	• For your spouse: Purchase in increments of $10,000, cannot exceed the employee's coverage or $100,000 whichever is less ($10,000 minimum) • For your child(ren): $2,000 or $4,000
Accidental Death and Dismemberment	Basic: one times base salary up to $100,000; for Occupational-related loss, additional coverage of $50,000 is provided The Company pays the full cost of basic AD&D coverage; you are automatically enrolled.
Long-Term Disability	Monthly benefit equals 60% of your monthly base earnings. Maximum monthly benefit is $8,000; minimum is $100 or 10% of the gross benefit, whichever is greater
Transit Benefits	Save pre-tax dollars to pay for work-related commuting expenses, including parking and mass transit fares
Auto and Homeowners Insurance	Purchase insurance at discounted group rates
Legal Services	Purchase access to legal services through Hyatt Legal Plans, including telephone advice and office consultations for services including will preparation and real estate closings

Medical Plan Options

For 2016, National Grid will continue to offer the choice of two Preferred Provider Organization (PPO) plans administered through GHI. In addition, a Consumer Driven Health Plan (CDHP) with Blue Cross Blue Shield will also be offered. Each plan covers the same wide range of health care services, and each includes prescription drug coverage.

What to Consider When Choosing Your Plan

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

- What do you think your health care needs will be in 2016? What are your typical health care needs? Do you or a covered family member have any chronic health conditions?
- What are your total costs under each option–including the contributions, deductibles, co-insurance, co-payments and non-covered services?
- How does your National Grid coverage compare to any other coverage you might have, such as through your spouse's plan?

Here's a Tip: Play an Active Role

Patients who ask questions are more satisfied with their care and see more of an improvement in their health than patients who do not.

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

You will have a choice of two medical plan options in 2016 administered by EmblemHealth – the GHI Standard PPO and the GHI Premier PPO.

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

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

GENERALISTS AND PCPS

When you visit a participating GHI medical provider or mental health care provider, you will pay a $25 co-payment per visit in the GHI Premier Plan or a $30 co-payment in the GHI Standard Plan..

SPECIALISTS

When you visit a participating GHI specialist, you will pay a $35 co-payment per visit in the GHI Premier Plan or a $50 co-payment in the GHI Standard Plan. Specialists include dermatologists, surgeons and surgical subspecialties, including providers who practice Cardiothoracic and Thoracic Surgery, Colon and Rectal Surgery, General Surgery, Neurological Surgery, Ophthalmology, Oral Surgery, Orthopedic and Hand Surgery, Otolaryngology, Plastic Surgery, Podiatry and Podiatric Surgery, Traumatic Surgery, Urology, Vascular and Veno Surgery.

COVERAGE WHEN YOU ARE AWAY FROM HOME

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

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

CONSUMER DRIVEN HEALTH PLAN (CDHP)

The CDHP includes comprehensive coverage for medical, prescription drug and mental health / substance abuse just like traditional PPO plans. The CDHP also provides the flexibility of going to an in or out of network provider. When and how you pay for services differentiates this plan from other plans.

With a CDHP you are in charge of your health care choices and control how you spend your healthcare dollars. Payroll contributions to a CDHP are typically lower than the PPO plans. The dollars you save in employee contributions can be deposited into a Health Savings Account (or HSA) that can be drawn upon to pay for any out-of-pocket medical expenses like deductibles and co-insurance. The annual deductible (the amount you are responsible for before the plan pays a portion of the cost for health care services) is typically higher in a CDHP than traditional PPO plans.

Purchasing Power of a CDHP

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

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

How do you become a better consumer of health care?

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

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

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

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

Employee payroll contributions to the HSA are made on a pre-tax basis and roll over from year to year — unlike other tax-advantaged health care accounts, the HSA has no IRS “use it or lose it” rule. The dollars are yours until you decide to use them. Employees represented by Local 101 who participate in an HSA will also benefit from a one-time employer contribution of up to $750 for individual coverage or up to $1,500 for family coverage (pro-rated for mid-year enrollments).

You can read more about the HSA on page 16.

When you join a CDHP:

- Certain in-network annual preventive visits, related routine tests, and immunizations subject to a schedule are covered at 100% with no deductible or coinsurance.

- You can receive care from any doctor or specialist. By choosing a preferred provider (also called an in-network provider) for a covered service, your out-of-pocket costs will be lower than if you choose a non-preferred provider (also called an out-of-network provider).
- For all non-preventive care services (including the cost for most prescription drugs), you pay 100% of the cost up to the **annual deductible**.
- After you satisfy the deductible, you and National Grid share in the cost of medical services AND prescription drugs through coinsurance. Those in a family plan must meet the family deductible before the plan starts paying co-insurance.
- If your total expenses (deductible plus co-insurance) for medical services and prescription drugs reach your **out-of-pocket maximum**, National Grid will fully cover all eligible expenses at 100% – that means you pay nothing else for the rest of the plan year.
  - The individual out-of-pocket maximum does not apply to those in a family plan. The family out-of-pocket maximum must be met by one or more family members before the plan plays 100% of future claims costs through the end of the plan year.
- If you use a non-preferred provider:
  - Your cost will be based on allowed charges, including your co-insurance and any amounts that exceed allowed charges.
  - You will use a BCBS claim form to submit a claim for reimbursement.

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

HEALTH SAVINGS ACCOUNT (HSA)

The HSA, administered by HealthEquity, is a great way to pay for current and save for future eligible health care expenses. You must enroll in the CDHP and meet certain eligibility requirements to open an HSA. Your contributions to the HSA will be automatically deducted from each paycheck on a pre-tax basis or you can elect to contribute amounts outside of the payroll process entirely. You can change your contribution amount to the HSA at any time during the year.

In 2016, National Grid will make a one-time contribution to your HSA. Those enrolled in the CDHP with individual coverage will be funded $750, those enrolled in the CDHP with family coverage will be funded $1,500. Those enrolling mid-year will receive a pro-rated amount of the employer contribution (subject to enrollment in the HSA). **The employer and employee contributions will be accessible in the HSA only after your account has been set up with HealthEquity.**

BENEFITS OF THE HSA

1. **You can use your HSA for 2016 eligible health care expenses – even after you incur them.** You can put your HSA dollars toward your deductible and other eligible medical, prescription, dental and vision expenses.

   Unlike a Flexible Spending Account (FSA), you can contribute to your HSA *after you incur out-of-pocket costs* and then use those tax-free dollars to reimburse yourself. So, even if you have unexpected health care costs in 2016, you can contribute additional money to your HSA to pay for those expenses.
2. **You can roll over dollars you don't use.** Unused money rolls over from year to year, which helps you build savings for future eligible health care expenses. You can also use dollars in your HSA to pay for eligible expenses in future years even if you're not enrolled in the CDHP at the time.
3. **You can take it with you.** The money in your HSA is always yours, so you can take your unused balance when you retire or leave National Grid.
4. **Triple-tax advantages.** You never pay taxes on your HSA dollars as long as you use them to pay for eligible health care expenses. You won't be taxed when you make contributions, as your account grows with interest, or when you withdraw the money to pay for eligible expenses.
5. **It's convenient.** You can use the HSA Debit Card from HealthEquity and/or you can pay providers online (just like online banking) to use your HSA to pay for eligible healthcare expenses.
6. **Increase your healthcare savings through investments.** HealthEquity provides the opportunity to invest your health care dollars. More information is available at www.bluecrossma.com/nm/cdhp-national-grid

HSA Contribution Limits

The IRS limits your maximum annual HSA contribution. For 2016, the annual limits are $3,350 for individual coverage and $6,750 for family coverage. Once you are age 55, and each year thereafter, you are eligible to make an additional annual "catch up" contribution of up to $1,000 to your HSA for that year.

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

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

FREQUENTLY ASKED QUESTIONS

Who is eligible to open and contribute to an HSA?

"Eligible individuals" are any individuals who are:

- Covered under a Consumer Driven Health Plan (CDHP).
- Not covered by any other health plan that is not a CDHP (with certain exceptions for plans providing certain limited types of coverage). This means you cannot be covered under your spouse's medical coverage unless it too is a CDHP.
- Not enrolled in Medicare, including Part A.
- Not claimed as a dependent on another person's tax return.

- Veterans who have not received treatment through the Veteran's Administration other than preventive care, within the last 3 months.

Will the health FSA impact employees' HSA eligibility?

Individuals enrolled in a traditional FSA in 2015 who wish to participate in a CDHP with HSA in 2016 may be required to delay their enrollment in, and contributions to, the HSA.

If you are enrolled in the National Grid 2015 FSA plan and have an outstanding balance in your FSA account as of January 1, 2016, you are subject to the 2 ½ month grace period. You must wait to enroll and contribute to the HSA until the end of the FSA grace period. The earliest you can attempt to enroll in the HSA is April 1. National Grid will provide 100% of the employer seed for the 2016 plan once your HSA enrolment has been completed.

If you are enrolled in the National Grid 2015 FSA plan and do not have an outstanding balance in your FSA account as of January 1, 2016 you can enroll and contribute to the HSA effective January 1. National Grid will provide 100% of the employer seed contribution for the 2016 plan year once your HSA enrollment has been completed. If your enrollment in the HSA is effective January 1, 2016, the employer seed will be sent to Health Equity by the end of January.

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

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

How are prescription drug costs paid under the CDHP?

Prescription drug coverage for the CDHP is administered by CVS Caremark. Prescription drug expenses also count toward your annual deductible and out-of-pocket maximum. This means that you will pay the full cost of your prescriptions until you meet your plan's annual deductible. For certain preventive medications, the deductible is waived under the CDHP. Coinsurance applies after the deductible is met.

How do I enroll in the HSA?

By electing the CDHP plan you will be defaulted into the Health Savings Account (HSA). You have the choice to remain in the HSA or elect to waive this plan option. By agreeing to the default option (i.e. enrolment in the HSA plan) you will be authorizing HealthEquity to open a health savings account (HSA). For details about the terms of the account you can access their HSA Custodial Agreement at http://healthequity.com/en/Site/EducationCenter/Forms.aspx. In compliance with the USA PATRIOT Act, HealthEquity must verify the identity of all customers seeking to open an HSA. As part of this identity verification process, you may be asked to provide additional information and/or documentation before your account can be established. In addition, your enrollment and health information will be shared with HealthEquity for the purpose of administering and coordinating payments under the health savings account.

Tools and Resources

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

COVERAGE LEVEL OPTIONS

You can choose from the following coverage options:

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

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

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

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

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

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

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

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

WAIVING MEDICAL COVERAGE

If you have coverage under another medical plan (for example, through your spouse's employer), you may elect to waive coverage through the Company. If you choose to waive medical coverage, you will have no medical coverage for yourself or your family through National Grid for 2016.

To certify that you have coverage under another employer-provided medical plan and waive medical coverage through National Grid for 2016, contact the National Grid Benefit Services Center online at www.nationalgridbenefitservices.com and select "no coverage" under the medical benefit plan option. You may also call the National Grid Benefit Services Center at 1-888-483-2123.

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

Prescription Drug Benefits

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

Here's a Tip: Use Generic Drugs Whenever Possible

Generic drugs are as effective as brand-name drugs but almost always cost less. If you take a brand-name drug, talk with your health care provider to determine if a generic equivalent might be a smarter choice for you.

FILLING PRESCRIPTIONS THROUGH CVS CAREMARK

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

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

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

The mail order co-payment will be the same, regardless of which method you use: home delivery or CVS retail pick-up.

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

Compounded Drugs Prior Authorization

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

Generic Step Therapy

This prescription program encourages members to utilize more cost effective first-line generics and provides coverage for one preferred select brand in most classes. The preferred select brand is determined by clinical effectiveness based on FDA approved indications, lowest net cost and/or shortest remaining patent life. For some classes, such as the PPI class where sufficient generics are available, a generic trial is required before any single source brand is covered.

Generic Step Therapy requires that a cost-effective generic alternative is tried first before a single-source brand is covered. Here is how it works:

When a prescription for a targeted 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 will be paid. If there is no history of a generic trial, the pharmacist will receive a message for the prescriber to call a toll-free number for more information. In the event that the prescriber advises CVS Caremark that a generic alternative is not right for the member, he or she can call the Prior Authorization Department.

This program is intended to actively educate members and prescribers with regards to clinically appropriate medications, and to guide them to more cost-effective options.

Specialty Preferred Drug Program

Another prescription drug program is designed to help prescribers select the most clinically effective therapy, at the lowest cost in specific specialty therapeutic categories. The preferred medication is a well-supported treatment option and represents the most cost-effective medication. The Specialty Preferred Drug Program will apply to the following specialty medication categories: multiple sclerosis, auto-immune medications (medications used to treat Crohn's disease, psoriasis, rheumatoid arthritis).

When/if you present a prescription for preferred specialty medication, the prescription will automatically be approved. When/if you present a prescription for a non-preferred specialty medication, 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, he or she 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.

Supplemental Cancer Coverage

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

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

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

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

Employees who are on an unpaid leave of absence are responsible for remitting premiums to Aflac until they return to active duty. Unpaid premiums may cause a lapse or cancellation in coverage.

For more information about this plan visit **www.aflac.com**. To enroll in this benefit, please call 1-917-532-3011.

CONTINUING PARTICIPATION IF YOU TERMINATE EMPLOYMENT

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

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

Dental Plan

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

Medical and Dental Plan Coverage Levels

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

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

COVERAGE LEVEL OPTIONS

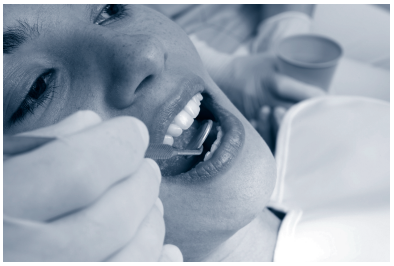
You can choose from the following coverage options:

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

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

Here's a Tip: Get a Regular Dental Check-up

Did you know that getting a preventive dental check-up can help detect early signs of dental disease? Schedule a dental appointment and help reduce future cost and stress.



Flexible Spending Accounts

National Grid offers two flexible spending accounts:

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

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

Using Your HCSA

Your total annual contribution is available for reimbursement on January 1, 2016. Your annual contribution election will be deducted in equal installments each pay period before applicable payroll taxes are deducted.

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

HEALTH CARE SPENDING ACCOUNT

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

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

Eligible Health Care Spending Account Expenses

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

For a complete list of eligible and ineligible expenses, contact WageWorks (see page 41 for contact information), contact the IRS toll-free at 1-800-829-3676 and ask that Publication 502 be sent to you free of charge, or visit **www.irs.gov.**

DEPENDENT CARE REIMBURSEMENT ACCOUNT

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

Eligible Dependent Care Reimbursement Account Expenses

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

For a complete list of eligible and ineligible expenses, contact WageWorks (see page 41 for contact information), contact the IRS toll-free at 1-800-829-3676 and ask that Publication 503 be sent to you free of charge, or visit **www.irs.gov**.

USING YOUR DCRA

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

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

Dependent Care Tax Credit

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

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

ADDITIONAL FLEXIBLE SPENDING ACCOUNT RULES

- **Contributions.** Once you enroll in either (or both) the health or dependent care account, you may not change or stop your contributions until the next Open Enrollment period (unless you experience a qualified life event as indicated on page 11).
- **Reimbursement.** To be reimbursed for eligible health or dependent care expenses incurred between January 1, 2016 and March 15, 2017, obtain the applicable reimbursement claim form by visiting **https://www.wageworks.com/employees/support-center/important-forms.aspx**. Submit your completed form along with a receipt or proof of payment (including the Explanation of Benefits (EOB) if provided by a health plan). WageWorks will then reimburse you for your eligible out-of-pocket expenses up to the total amount of your HCSA 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, 2017 to submit claims for all eligible expenses incurred between January 1, 2016 and March 15, 2017. That's why it's important to carefully consider the amount you will use over the course of the year before contributing to either account. Those who are considering enrolling in the new Consumer Driven Health Plan (CDHP) should refer to page 18 to learn about how the CDHP Health Savings Account is affected by the HCSA 2 ½ month grace period.

If You Have Questions

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

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

CONTINUING PARTICIPATION IF YOU TERMINATE YOUR EMPLOYMENT

Terminated or retired employees may choose to continue funding their HCSA on an after-tax basis by electing continued coverage through COBRA. Details will be included in the Ceridian COBRA package.

National Grid's Commitment to Health and Wellbeing

Our Integrated Health Management Department offers targeted programs and services free of charge for employees, with the intent to create healthier and happier personal and working lives.

HEALTH & WELLNESS RESOURCE CENTER

www.bluecrossma.com/nationalgrid

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

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

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

Live Well

Live well includes taking control of your/your family's physical, mental and financial health. Take the time to put wellness into your daily activities. Taking advantage of the various health/wellness programs offered by our health providers, and maintaining appropriate optional life insurance can help to positively influence your physical and mental wellbeing.

QUITNET — SMOKING CESSATION

Quitnet is an online smoking cessation program offering resources for a smoke-free life.

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

CORPORATE COUNSELING ASSOCIATES (CCA) — WORK/LIFE ASSISTANCE

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

INJURY PREVENTION FOR FIELD EMPLOYEES

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

Did You Know?

56% of all injuries reported at National Grid are soft tissue related. Soft tissue injury is the damage of muscles, ligaments and tendons throughout the body. Stretching and flexing before work can significantly reduce your risk of soft tissue injury.

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

Life Insurance and AD&D Benefits

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

Medical Evidence of Insurability (EOI)

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

BASIC COVERAGE

IF YOU ARE A NGEM DIRECT HIRE:

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

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

IF YOU ARE A CORPORATE UTILITY EMPLOYEE:

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

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

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

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

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

OPTIONAL LIFE INSURANCE COVERAGE

FOR YOURSELF

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

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

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

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

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

About Optional Life Insurance

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

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

FOR YOUR SPOUSE

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

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

FOR YOUR CHILD(REN)

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

Imputed Income

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

Naming a Beneficiary

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

By October 26, you should receive a direct home mailing from MetLife which describes how you can enroll in these optional programs. If you need assistance, please call the MetLife Call Center at 1-866-492-6983.

Long-Term Disability

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

About Your Payroll Contributions

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

WHEN BENEFITS BEGIN

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

For example, let's assume that your annual salary for purposes of the Plan is $48,000 a year or $4,000 a month (note: your annual salary is defined as your previous year's August 31 base salary). Now let's assume that you are totally disabled for more than 90 consecutive days and have used all your paid sick leave days. Your monthly payments from the LTD Plan will be $2,400 ($4,000 x 60%) less any other benefits you are receiving from other sources (e.g., Social Security, your pension, Workers' Compensation or other benefits).

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

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

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

THE COST OF LONG-TERM DISABILITY COVERAGE

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

As a new hire, your annual salary for purposes of the Plan is your base salary. In subsequent years, your annual salary will be your previous year's August 31 base salary.

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

If you decide you do not want LTD coverage after January 1, 2016, you can cancel your coverage at any time. However, you will not receive a refund for LTD deductions that have been already taken from your pay.

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.

Transit Benefits

With National Grid's transit benefits, you can set aside pre-tax dollars to pay for work-related commuting expenses (excluding tolls). You make separate elections to the commuter (mass transit) benefit component and the parking component. Each of these benefits has a monthly maximum which is set annually by the IRS. Currently, the monthly maximum is $250 for parking and $130 for transit. Limits may change for 2016 depending on the maximum set by the IRS.

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

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

Auto and Homeowners Insurance

National Grid has contracted with MetLife to allow employees to insure their cars, homes and other personal property at special discounted group rates via payroll deduction.

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

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

Legal Services

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

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

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

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

CONTINUING PARTICIPATION IF YOU TERMINATE YOUR EMPLOYMENT

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

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

Enrolling in Your Benefits

Once you've reviewed your benefit options and the information on your *2016 Personalized Enrollment Worksheet*, it's time to get online and enroll! **Remember, you have until November 6, 2015 by 6 p.m. ET via phone and 12 midnight via Web to elect your benefits for 2016**. If you don't enroll, you will automatically receive default coverage (see page 5 for more details). If you want to keep your default benefit elections and you do not plan to participate in the flexible spending accounts, you do not need to enroll. If you do not enrol in another Medical plan or waive coverage, you will be defaulted into the GHI Standard PPO with Employee Only coverage

To Enroll or Make Changes by Phone

You are encouraged to enrol online. However, if you do not have access to the Web you can enroll by contacting the National Grid Benefit Services Center at **1-888-483-2123**. Be sure to have your *2016 Personalized Enrollment Worksheet* in front of you when you call.

TO ENROLL OR MAKE CHANGES ONLINE/BY PHONE

There are two ways to enroll:

1. Through the Web at **www.nationalgridbenefitservices.com**. The secure Web site is available 24 hours a day, so you can make your benefit elections during the Open Enrollment period, at a time that is convenient for you.

Please note - you will be prompted to enter your:

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

OR

2. By calling the National Grid Benefit Services Center toll-free at **1-888-483-2123.** The National Grid Benefit Services Center is available Monday through Friday, from 7 a.m. to 6 p.m. ET. You may speak with a Benefits Specialist who will walk you through the enrollment process.

Step-By-Step Web Enrollment Instructions

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

You will be able to change your elections as many times as you like until the enrollment period ends on November 6, 2015. 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, 2016, 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, please contact the National Grid Benefit Services Center at 1-888-483-2123 during the Open Enrollment Correction Period scheduled from December 7, 2015 through December 11, 2015 (between 7 a.m. and 6 p.m. ET).

Enrollment Deadline

You can enroll between October 26, 2015 and November 6, 2015. **You must enroll by November 6, 2015 at 6 p.m. ET via phone and 12 midnight via Web.** If you have any questions about benefits or the enrollment process, call the National Grid Benefit Services Center at 1-888-483-2123.

PERSONAL AND EMERGENCY CONTACT INFORMATION

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

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

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

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

Glossary

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

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

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

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

Deductible – The annual dollar amount for covered services that you must pay before the plan pays benefits.

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

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

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

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

Out-of-pocket maximum – The maximum amount you will pay for covered medical expenses during the year under the plan (including deductibles, co-insurance and co-payments for medical, pharmacy, and mental health/substance abuse treatments). Any covered medical or pharmacy expenses above the maximum will be covered at 100% by the plan, up to the reasonable and customary limit, for the rest of the calendar year.

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

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

Contact Information

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

STEPS YOU MUST TAKE BY NOVEMBER 6, 2015 AT 6 P.M. ET VIA PHONE OR 12 MIDNIGHT VIA WEB	
If you want to... • Enroll in, change or waive your medical coverage for 2016 • Enroll in the Health Savings Account for 2016 (for CDHP participants only) • Enroll in, change or waive your dental coverage for 2016 • Enroll or re-enroll in the Health Care Spending Account and/or Dependent Care Reimbursement Account for 2016 • Enroll or re-enroll in Legal Services for 2016	You must enroll online at: www.nationalgridbenefitservices.com or call the National Grid Benefit Services Center at 1-888-483-2123.
• Purchase or change optional life insurance for 2016	You must call the MetLife Call Center at 1-866-492-6983

Don't forget: If the coverage listed on your *2016 Personalized Enrollment Worksheet* meets your needs for 2016, you do not need to enroll.

Reminder: False or Misleading Information

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

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

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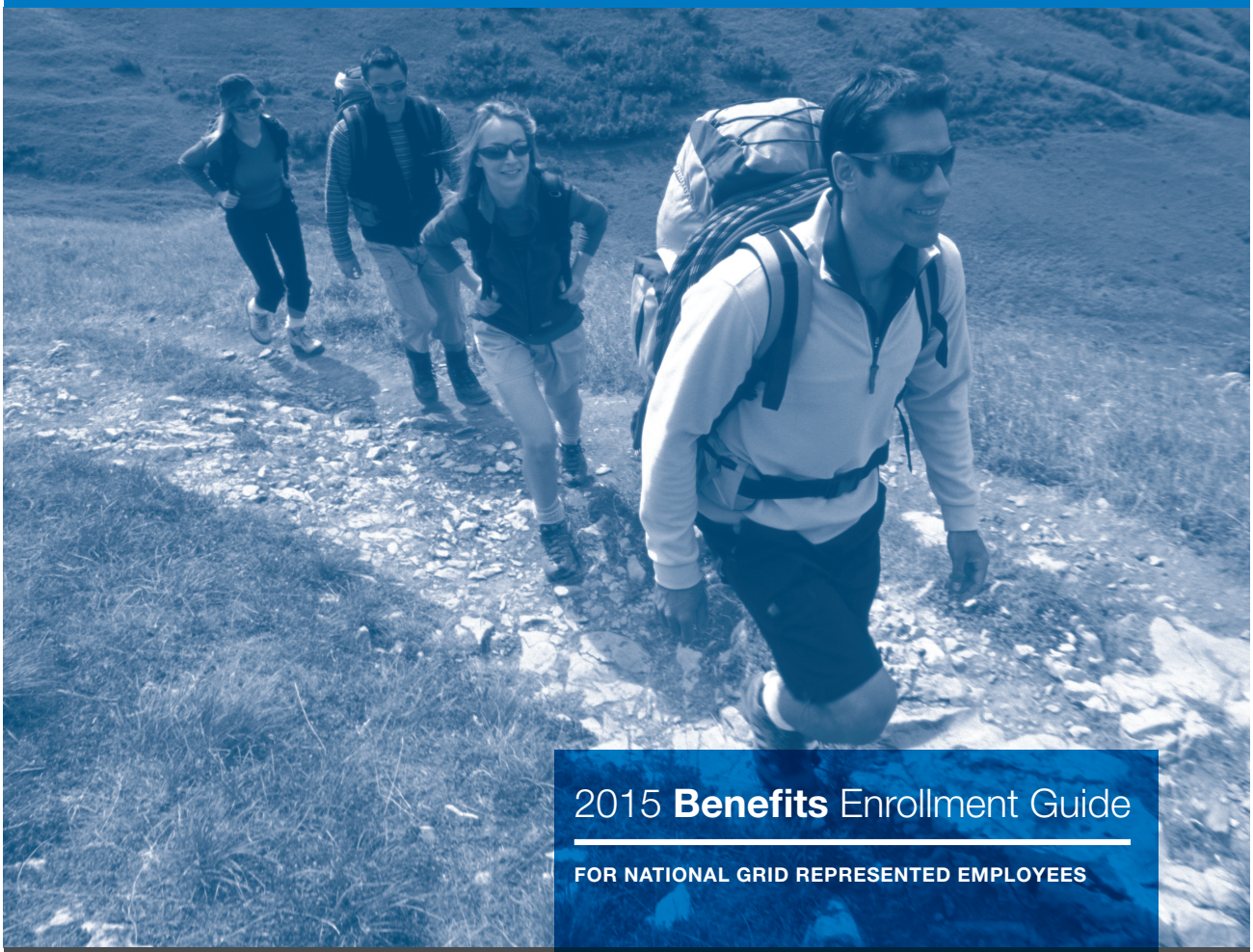
Benefits Connection:
Choose well
Be well
Live well

OPEN ENROLLMENT **2015**



2015 **Benefits** Enrollment Guide

FOR NATIONAL GRID REPRESENTED EMPLOYEES

Local 12003, Local 12012-04, Local 318, Local 350/369, Local 13507

What's Inside

Welcome to 2015 Open Enrollment!

As an employee of National Grid, you have access to a range of quality benefit options so you can get the coverage you need for yourself and your eligible family members. Open Enrollment is your annual opportunity to reassess your health care, life insurance and other benefit needs — by considering how you used your benefits in 2014 and how your needs may change in 2015.

When to Enroll

The Open Enrollment period will begin on Friday, October 17 at 8 a.m. and end on Friday, October 31 at 5 p.m. Eastern Time (ET) via phone and 12 midnight via Web.

This Benefits Enrollment Guide describes the benefits available to you in 2015 as well as important information on how to enroll in your benefits. Read it carefully so that you can make informed decisions that are right for you and your family. To the extent the benefits are subject to the Employee Retirement Income Security Act, the Guide is also a Summary of Material Modifications that describes the changes in those benefits that are effective in 2015. Please keep this Guide for future reference.

You will find detailed instructions about how to enroll starting on page 27.

WHAT'S IN YOUR BENEFITS ENROLLMENT KIT?

YOUR BENEFITS ENROLLMENT KIT INCLUDES:

1. This *2015 Benefits Enrollment Guide*, which describes your benefit options and how they work.

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

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

You will receive a Personalized Enrollment Worksheet at your home separate from this communication package. The worksheet shows the options available to you as well as your costs for 2015. If you do not receive your *2015 Personalized Enrollment Worksheet* by October 17, 2014, please contact the Mercer Benefits Service Center at 1-866-294-8052.

As in past years, after you've enrolled in your 2015 benefits, you will receive a written confirmation of your choices, and you'll have the chance to make changes before your coverage becomes effective on January 1, 2015.

Don't Wait Until the Last Minute to Enroll!

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

What's New

You will continue to have access to comprehensive benefit programs in 2015. You will find your 2015 cost for coverage in the enclosed *A Comparison of National Grid Health Benefits* chart. The following is a summary of the health and welfare benefit plan modifications that become effective January 1, 2015, as negotiated under collective bargaining agreements or as a result of regulatory and/or administrative changes.

- **Change in Flexible Spending Accounts Benefits Administrator.** Beginning January 1, 2015, administration of the Health Care Spending Account and Dependent Care Reimbursement Account will transition from Ceridian to WageWorks.
- **Due to new Health Care Reform requirements, the following changes will also become effective January 1, 2015:**
  - Comprehensive in-network out-of-pocket maximum to include Prescription cost
    - Effective January 1, 2015, prescription drug co-payments will accrue to the in-network out-of-pocket maximum. A combined maximum has been set to which both medical and prescription drug costs will accrue. The out-of-pocket maximum now includes deductible, co-payments, co-insurance, mental health/substance abuse treatments and prescription co-payments. Please refer to the *A Comparison of National Grid Health Benefits* chart to see changes to your current in-network out-of-pocket maximum levels.
  - Expanded treatments for tobacco cessation, when prescribed by a health care provider.
  - Enhanced coverage for Breast Cancer Preventive Medications for women with increased risk.
  - BRCA risk assessment and genetic testing for women.
  - Lung cancer screening for adults aged 55 to 80 years with a 30 pack per year smoking history and currently smoke or quit within the past 15 years.
- **Fallon will be issuing new ID cards due to new branding for the organization.**
- **Additional benefits will be available through the Harvard Pilgrim Health Care HMO plan**
  - Transgender reassignment surgery
  - Acupuncture benefits
  - Expanded out-of-area dependent coverage

FOR LOCAL 13507:

DENTAL

- Employee contributions for the Delta Dental PPO will increase to 15% for Employee Only and Employee Plus Family coverage.

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FOR LOCAL 12003, 12012-04, 318, 350/369:

MEDICAL

- Employee contributions for the Blue Cross Blue Shield of Massachusetts (BCBSMA) PPO will increase to 17.5% for Employee Only and Employee Plus Family coverage.

DENTAL

- Employee contributions for the Delta Dental PPO will increase to 17.5% for Employee Only and Employee Plus Family coverage.

Local 12003, Local 12012-04, Local 318, Local 350/369, Local 13507

Important Enrollment Information

You will enroll through the Mercer Benefits Service Center either online or by phone (see page 27 for instructions). You will need to enroll if you want to:

- Change your current medical and/or dental coverage.
- Waive medical coverage (if you are covered under another medical plan).
- Change the dependents you cover in the medical and/or dental plans.
- Enroll in the Health Care Spending Account (HCSA) for 2015.
- Enroll in the Dependent Care Reimbursement Account (DCRA) for 2015.
- Enroll in Legal Services.
- Purchase or increase optional/supplemental life insurance coverage for you, your spouse and/or your children. You may enroll or change your coverage by contacting MetLife.

If You Waived Medical Coverage in 2014

If you waived medical coverage in 2014, and you do not re-elect to waive coverage for 2015 or enroll in medical coverage for 2015, you will have no medical coverage for 2015.

If you do not take any action before October 31, 2014, and you were already eligible for and enrolled in subsidized medical and dental coverage, you will default into the following plan elections:

Default Benefit Plans	
Medical (If enrolled in 2014)	The coverage you had in 2014
Dental (If enrolled in 2014)	The coverage you had in 2014
Flexible Spending Accounts • **Health Care** • **Dependent Care**	 Waive-No Coverage Waive-No Coverage
Optional/Supplemental Life Insurance	The coverage you had in 2014
Legal Services	Waive-No Coverage

WHO IS ELIGIBLE?

You are eligible to choose coverage under one of the medical and dental plan options if you are an active employee and you have completed 30 days of service.

MEDICAL

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

- Your legally married spouse, including same-sex spouse (if you were married in a state that recognizes same-sex marriage, regardless of where you actually reside), or qualified same-sex domestic partner (if you live in a state that does not recognize same-sex marriage).
- Your child(ren) who are under the age of 26, married or unmarried regardless of full-time student or tax dependent status. A child includes:
  - Natural child(ren), legally adopted child(ren) or child(ren) placed with you pending legal adoption, child(ren) for whom you or your spouse serve as legal guardian, step-child(ren), foster child(ren), child(ren) of a domestic partner or same-sex spouse. **You must elect coverage for your same-sex domestic partner if you want to elect coverage for his/her dependent child(ren).** ***Note:** Grandchild(ren) are not eligible for coverage unless adopted or legal guardian*.
- 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 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 the child attains age 26. Coverage may be extended indefinitely if the child has been certified as disabled by your medical plan prior to his/her 26th birthday.

Spouses of married dependents and child(ren) of dependents are NOT eligible for coverage.

Important Note Regarding Dependent Eligibility

If you add dependents to your coverage, you will be required to provide documentation that verifies their eligibility. You will be contacted separately after Open Enrollment with instructions for submitting the appropriate documentation to verify eligibility.

If You Were Divorced in Massachusetts

Depending on your plan, if you were divorced in the Commonwealth of Massachusetts, your ex-spouse may be eligible for coverage depending on your divorce decree. Immediately after the divorce is finalized, you must provide National Grid a copy of the divorce decree to determine continued benefits eligibility for your ex-spouse.

DENTAL

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

- Your legally married spouse, including same-sex spouse (if you were married in a state that recognizes same-sex marriage, regardless of where you actually reside), or qualified same-sex domestic partner (if you live in a state that does not recognize same-sex marriage).
- Your dependent child(ren), including your unmarried natural child(ren), step-child(ren), legally adopted child(ren), child(ren) placed with you pending legal adoption, and child(ren) for whom you or your spouse serve as a legal guardian. This also includes your same-sex spouse's or same-sex domestic partner's dependent child(ren).

  **Note: Grandchild(ren) are not eligible for coverage unless adopted or legal guardian.*
- **You must elect coverage for your same-sex domestic partner if you want to elect coverage for his/her dependent child(ren).**
- Dependent child(ren) are covered through the end of the month in which the child attains age 19.
  - Full-time students are covered until the midnight prior to their 25th birthday, with the exception of dependents covered under the Local 13507 rules. For full-time students under the Local 13507 rules coverage is through the end of the month in which the child turns age 25.
  - Annual certification is required to confirm a child's continuing full-time student status.

WHEN YOUR COVERAGE BEGINS

The elections you make during this Open Enrollment period will take effect on January 1, 2015 and will remain in effect through December 31, 2015. You can only make a change during the year if you have a qualified life event as described on page 9.

NEW HIRES

All full-time regular new hires are required to call 1-888-4TDC-123 (1-888-483-2123) within 31 days of first becoming eligible for either full cost or subsidized health benefits or voluntary benefits in order to make elections and ensure adequate coverage. See the chart on the next page for more information about the eligibility for certain benefits.

Choose Well

Choose well means enrolling in the right benefits for you and your family. It is important for you to consider your/your family's own needs for the upcoming year when making your elections for eligible benefits. The information in this guide together with your comparison chart provides a summary overview of many benefits and highlights what's new and changing in 2015.

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Benefits	Eligibility
Medical Plan	**Full cost** First of the month following or coincident with your date of hire **Subsidized cost** First of the month following or coincident with the completion of 30 days of service
Dental Plan	**Full cost** First of the month following or coincident with your date of hire **Subsidized cost** First of the month following or coincident with the completion of 30 days of service
Health Care Spending Account	First of the month following or coincident with the completion of 30 days of service
Dependent Care Reimbursement Account	First of the month following or coincident with the completion of 30 days of service
Basic Life Insurance (except Local 13507)	First of the month following three months of service. The greater of two times previous year's gross earnings or two times annual salary after general wage increase
Accidental Death and Dismemberment (except Local 13507)	**Occupational loss** After three months of service then automatically enrolled at four times your base annual salary up to a maximum of $300,000 **Non-occupational loss** First of month following date of hire, one times salary up to $75,000 maximum
Basic Life Insurance (for Local 13507)	After six months of service then automatically enrolled; $65,000 flat Company-paid benefit
Accidental Death and Dismemberment (for Local 13507)	After six months of service then automatically enrolled; $65,000 flat Company-paid benefit for Non-Occupational coverage.
Legal Services	Available at Open Enrollment only

If you fail to make a medical benefit election at the point in time when you first become eligible for subsidized medical coverage, you will be defaulted into the Blue Cross Blue Shield PPO with Employee Only coverage. If you fail to make a dental benefit election when you first become eligible for subsidized dental coverage, you will be defaulted into the dental plan with Employee Only coverage.

PAYING FOR COVERAGE

Your *2015 Personalized Enrollment Worksheet* and *A Comparison of National Grid Health Benefits* chart include the cost for each of your medical and dental benefit options, as well as the coverage levels available to you. Optional life insurance coverage is provided through a separate enrollment with MetLife. During Open Enrollment, you may contact MetLife directly to review your options. If you are a newly hired employee, you will receive your MetLife information with your other enrollment information and new hire documentation.

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

Special Tax Considerations for Covering Same-Sex Domestic Partners

If you are covering a same-sex domestic partner and his/her child(ren), the cost of coverage for those individuals will be deducted from your paycheck on an after-tax basis, per IRS regulations. In addition, the Company-paid portion of medical or dental coverage for your same-sex domestic partner and his/her child(ren) will be considered taxable income to you. This information will appear on your W-2 form and the appropriate taxes will be withheld from your pay.

To learn more about these regulations, you may want to consult a legal or tax professional for advice.

Pre-Tax Contributions Apply to These Benefits:	After-Tax Contributions Apply to These Benefits:
• Medical Coverage • Dental Coverage • Health Care Spending Account (HCSA) • Dependent Care Reimbursement Account (DCRA)	• Optional Life Insurance • Dependent Life Insurance • Legal Services

Paying with Pre-Tax Dollars

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

MAKING CHANGES DURING THE YEAR

The benefit elections you make during this Open Enrollment period will stay in effect throughout 2015. You can only make changes to your coverage during the year if you experience a qualified life event — a significant change in your life that has a direct impact on your coverage. 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/same-sex domestic partner or child, or a change in the eligibility of a covered dependent.
- Your spouse/same-sex domestic partner gains or loses employment.
- You or your spouse/same-sex domestic partner change from part-time to full-time employment status or vice versa.
- You or your spouse/same-sex domestic partner take an unpaid leave of absence.
- You or your spouse/same-sex domestic partner experience a significant change in health coverage due to your spouse's/same-sex domestic partner's employment. (For example, his/her employer changes payroll withholding, or he/she chooses a different medical plan or coverage during the year.)
- You move out of your medical plan's service area.

How are you spending time?

People spend an average of 6.8 hours researching buying a car, 4.9 hours holiday shopping, and 1.3 hours buying a pair of shoes, according to Guardian Life industry data. And on average, people are spending about 1.4 hours reviewing their benefits plans.

It takes time to make sure your needs are covered. Smart benefits decisions may not have that "new car smell" — but peace of mind is an accessory that doesn't wear off quickly. The choices you make — or don't make — during Open Enrollment will impact you and your family for the next year. Take the time to give your benefits a thorough check-up this year.

Although National Grid can permit coverage changes, it cannot permit changes to the pre-tax elections made during the open enrollment period for domestic partner events.

The benefit change you make must reflect the change in status that you experience. For example, if you get married mid-year, you may add your spouse to your current coverage, but you may not change medical plans. **If you experience a qualified life event, you must contact the Mercer Benefits Service Center at 1-866-294-8052 within 31 days of the event to make a change**.

Your 2015 Benefit Choices

National Grid's benefits program offers a broad choice of quality, affordable coverage for you and your family. This chart highlights your choices for 2015. More details about each benefit follow.

Your 2015 Benefit Choices	
Medical All plans include prescription drug coverage	• A Preferred Provider Organization (PPO) Plan managed by Blue Cross Blue Shield of Massachusetts • Additional medical plan option(s) based on your union affiliation • Ability to waive medical (if you have coverage elsewhere)
Dental	• One plan option through Delta Dental • Ability to waive dental coverage The plan pays the full cost of preventive care and shares costs of other services, including fillings, crowns, periodontal care and orthodontia (for children only).
Flexible Spending Accounts	• **Health Care:** Contribute up to $2,000 pre-tax for eligible health care expenses • **Dependent Care:** Contribute the following amounts pre-tax for eligible dependent care expenses: — Up to $5,000 a year if you're single or married and filing a joint tax return — Up to $2,500 if you're married and filing separately, or married and your spouse works for National Grid and is contributing to his/her own Dependent Care Spending Account
Life Insurance for Employees	• **Basic** — *Local 12003, Local 12012-04, Local 318, Local 350/369:* two times base annual pay or two times previous year's gross earnings (whichever is greater), to a maximum of $500,000 (including optional life insurance) — *Local 13507:* $65,000 You are automatically enrolled in basic life insurance coverage. • **Optional:** Buy up to three times base annual salary, to a maximum of $500,000 (including basic life insurance)
Dependent Life Insurance	• For your spouse/same-sex domestic partner: Purchase in increments of $2,000, up to $20,000 • For your child(ren): Purchase in increments of $1,000, up to $10,000
Accidental Death and Dismemberment	• *Local 12003, Local 12012-04, Local 318, Local 350/369:* one times current base salary or the previous year's gross salary (whichever is greater) for non-occupational related incident, to a maximum of $75,000; four times current base salary or the previous year's gross salary (whichever is greater) for occupational related incident, to a maximum of $300,000 • *Local 13507:* $65,000 for non-occupational related incident; $105,000 for occupational related incident *The Company pays the full cost of AD&D insurance; you are automatically enrolled.*
Legal Services	Purchase access to legal services through Hyatt Legal Plans, including telephone advice and office consultations for services including will preparation and real estate closings

Local 12003, Local 12012-04, Local 318, Local 350/369, Local 13507

Your 2015 Benefit Choices	
Auto and Homeowners Insurance	Purchase insurance at discounted group rates

Local 12003, Local 12012-04, Local 318, Local 350/369, Local 13507

Medical Plan Options

For 2015, National Grid will continue to offer the choice between a Preferred Provider Organization (PPO) and additional plan option(s). Each plan covers the same range of health care services, and each includes prescription drug coverage. The difference is where and how you receive care, as described below.

Refer to the enclosed *A Comparison of National Grid Health Benefits* chart for more details about the plans available in your area, including information about deductibles, co-insurance, co-payments and employee contributions.

What to Consider When Choosing Your Plan

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

- What do you think your health care needs will be in 2015? What are your typical health care needs? Do you or a covered family member have any chronic health conditions?
- What are your total costs under each option–including the contributions, deductibles, co-insurance, co-payments and non-covered services?
- How does your National Grid coverage compare to any other coverage you might have, such as through your spouse's plan?

THE BLUE CROSS BLUE SHIELD (BCBS) PPO

Here's a Tip: Play an Active Role

Patients who ask questions are more satisfied with their care and see more of an improvement in their health than patients who do not.

With this plan, you can choose to receive care within the BCBS network or outside the network. You can see any provider within the network without a referral from a primary care physician (PCP). If you receive care in the network, you benefit from lower rates because the providers have negotiated special rates with BCBS. With this plan, you pay co-payments or a deductible and co-insurance depending on whether you receive care in or outside the network. If you receive care outside the network, you pay more and the plan pays less.

Because the BCBS PPO plan offers a nationwide network of health care providers, you can likely receive in-network care no matter where you are. For example, if you have a dependent away at college, you need medical attention while travelling domestically, or you want to visit a specialist or hospital in another state, as long as the provider is part of the BCBS network (and most are), you will receive in-network benefits.

Nearly all the providers National Grid employees currently use are in the BCBS network. You can confirm that your doctor participates by checking the BCBS Web site at **https://www.bluecrossma.com/wps/portal/members/using-my-plan/doctors-hospitals/findadoctor** and searching in the BlueCard network. For general information about BCBS, visit **www.bluecrossma.com**.

ADDITIONAL PLAN(S)

You will have the choice to enroll in an additional plan (or plans) based on your union affiliation. For 2015, National Grid will continue to offer these plans to give you access to additional provider networks in certain regions. To see what plans are available to you, refer to *A Comparison of National Grid Health Benefits* included with this guide.

COVERAGE LEVEL OPTIONS

You can choose from the following coverage options:

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

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

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

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

WAIVING MEDICAL COVERAGE

If you have coverage under another medical plan (for example, through your spouse's employer), you may elect to decline coverage through the Company. If you choose to waive medical coverage, you will have no medical coverage for yourself or your family through National Grid for 2015.

You can waive coverage by either logging onto the Mercer Benefits Service Center Web site (**www.NationalGridEmployeeServices.MercerHRS.com**) and selecting "no coverage" under the medical benefit plan option, or you can call the Mercer Benefits Service Center at 1-866-294-8052.

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

Local 12003, Local 12012-04, Local 318, Local 350/369, Local 13507

IMPORTANT NOTE FOR MASSACHUSETTS RESIDENTS WHO WAIVE COVERAGE

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 Commonwealth Health Connector for each month you go without coverage (after a 63-day grace period).

To avoid tax penalties, you will be required to file proof of creditable health insurance coverage annually along with your personal income tax return. The sponsor of your medical coverage will send you the form you need. You provide your proof of creditable coverage in the form of a tax form, Form MA 1099-HC. In early 2015, you will receive the Form MA 1099-HC that will indicate you have creditable coverage. Use this form when filing your 2014 taxes.

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

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

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

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

For more information, visit **www.mahealthconnector.org** or call the Mercer Benefits Service Center at 1-866-294-8052.

PATIENT PROTECTION NOTICE (REQUIRED BY HEALTH CARE REFORM)

National Grid offers several HMOs that generally require you to designate a primary care provider. You have the right to designate any primary care provider who participates in the HMO network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the health plan in which you are enrolled.

You do not need prior authorization from a primary care provider to obtain access to obstetrical or gynecological care from a health care professional in the HMO network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the health plan in which you are enrolled.

Prescription Drug Benefits

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

FILLING PRESCRIPTIONS THROUGH CVS CAREMARK

ALL EMPLOYEES (EXCEPT THOSE ENROLLED IN THE CIGNA PPO):

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

Your prescription coverage allows you to receive **up to two 30-day refills** of the same medication at a retail pharmacy. After the second refill, you will be required to fill your maintenance medications through either the CVS Caremark Mail Service Pharmacy or directly at a local CVS Pharmacy through their Maintenance Choice Program. **Failure to fill maintenance medications through either the Maintenance Choice Program or mail order will result in you being charged for 100% of the cost at 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 Pharmacy to avoid paying full cost for your prescriptions.

FOR EMPLOYEES ENROLLED IN THE CIGNA PPO:

CIGNA administers its own prescription drug benefit, so all eligible prescriptions shall be fulfilled directly by CIGNA.

Dental Plan

National Grid offers competitive dental coverage through Delta Dental. The plan covers 100% of preventive care and shares the cost of basic and major restorative care with you.

When you participate in the dental plan, you can choose to receive care from a broad range of providers within the Delta Dental network or from any provider outside the network. The Plan will pay the same level of benefits regardless of where you receive care; however, the cost of services is typically lower within the network, as providers have negotiated special in-network rates.

Medical and Dental Plan Coverage Levels

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

To find out if your dentist is in the Delta Dental network, visit **www.deltadentalma.com** and search the Delta Dental PPO Plus Premier network.

For details on how the dental plan pays benefits, refer to the enclosed *A Comparison of National Grid Health Benefits* chart.

COVERAGE LEVEL OPTIONS

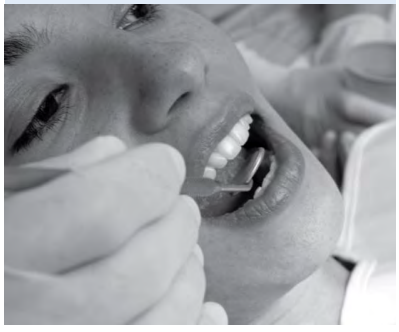
You can choose from the following coverage options:

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

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

Here's a Tip: Get a Regular Dental Check-up

Did you know that getting a preventive dental check-up can help detect early signs of dental disease? Schedule a dental appointment and help reduce future cost and stress.



Flexible Spending Accounts

National Grid offers two flexible spending accounts:

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

Using Your HCSA

Your total annual contribution is available for reimbursement on January 1, 2015. Your annual contribution election will be deducted in equal installments each pay period before applicable payroll taxes are deducted.

You may contribute to one or both flexible spending accounts. However, you must enroll each year to participate. Participation does not automatically continue from year to year. Beginning January 1, 2015, WageWorks will replace Ceridian as the administrator for both spending accounts on behalf of National Grid. See page 30 for contact information.

With a flexible spending account, you save because the money in your account is never taxed — when it goes into your account, or when you withdraw it to reimburse yourself for eligible expenses.

HEALTH CARE SPENDING ACCOUNT

With the HCSA, you can set aside up to $2,000 each year through pre-tax payroll deductions to help you save to pay for eligible health care expenses which are not otherwise covered by your health care plans.

The $2,000 cap applies on a per-employee basis. If an employee and his/her spouse are both employees of National Grid and are eligible to make contributions to the HCSA, each person may elect to contribute up to the $2,000 limit.

Eligible Health Care Spending Account Expenses

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

For a complete list of eligible and ineligible expenses, contact Ceridian (see page 30 for contact information), contact the IRS toll-free at 1-800-829-3676 and ask that Publication 502 be sent to you free of charge, or visit **www.irs.gov.**

DEPENDENT CARE REIMBURSEMENT ACCOUNT

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

Eligible Dependent Care Reimbursement Account Expenses

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

For a complete list of eligible and ineligible expenses, contact Ceridian (see page 30 for contact information), contact the IRS toll-free at 1-800-829-3676 and ask that Publication 503 be sent to you free of charge, or visit **www.irs.gov**.

USING YOUR DCRA

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

To receive reimbursement for expenses paid for dependent care, you must be an active participant in an account at the time the expense is incurred. For example, if you are required to pay a deposit in advance of your dependent attending a day camp, you must be contributing at the time the expense is incurred to receive reimbursement of that cost.

Dependent Care Tax Credit

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

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

ADDITIONAL FLEXIBLE SPENDING ACCOUNT RULES

- **Contributions.** Once you enroll in either (or both) the health or dependent care account, you may not change or stop your contributions until the next Open Enrollment period (unless you experience a qualified life event as indicated on page 9).
- **Reimbursement.** To be reimbursed for eligible health or dependent care expenses incurred between January 1, 2015 and March 15, 2016, obtain the applicable reimbursement claim form by visiting **https://www.wageworks.com/employees/support-center/important-forms.aspx**. Submit your completed form along with a receipt or proof of payment (including the Explanation of Benefits (EOB) if provided by a health plan). WageWorks will then reimburse you for your eligible out-of-pocket expenses up to the total amount of your HCSA contribution election or your DCRA balance. (Note: your 2014 account balance on December 31, 2014 will be transferred to WageWorks effective January 1, 2015 for claims incurred but not submitted for plan year 2014.) Information regarding online reimbursement will be available in November 2014 via a separate announcement.
- **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, 2016 to submit claims for all eligible expenses incurred between January 1, 2015 and March 15, 2016. That's why it's important to carefully consider the amount you will use over the course of the year before contributing to either account.

If You Have Questions

If you have any questions regarding your flexible spending accounts during Open Enrollment, please contact the Ceridian Claim Administration Department at 1-877-799-8820 between 8 a.m. and 8 p.m. ET, Monday through Friday.

Beginning January 1, 2015, please contact WageWorks at 1-855-774-7441.

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

CONTINUING PARTICIPATION IF YOU TERMINATE YOUR EMPLOYMENT

Terminated or retired employees may choose to continue funding their Health Care Spending Account on an after-tax basis by electing continued coverage through COBRA. Details will be included in the Ceridian COBRA package.

National Grid's Commitment to Health and Wellbeing

Our Integrated Health Management Department offers targeted programs and services free of charge for employees, with the intent to create healthier and happier personal and working lives.

HEALTH & WELLNESS RESOURCE CENTER

www.bluecrossma.com/nationalgrid

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

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

Did You Know?

56% of all injuries reported at National Grid are soft tissue related. Soft tissue injury is the damage of muscles, ligaments and tendons throughout the body. Stretching and flexing before work can significantly reduce your risk of soft tissue injury.

Live Well

Live well includes taking control of your/your family's physical, mental and financial health. Take the time to put wellness into your daily activities. Taking advantage of the various health/wellness programs offered by our health providers, and maintaining appropriate optional life insurance can help to positively influence your physical and mental wellbeing.

PERSONAL HEALTH ASSESSMENT

www.bluecrossma.com/nm/national-grid/healthy-weight.html

You can take the first step to better health by taking a personal health assessment. Upon completion of the confidential questionnaire, you will receive a personalized report and recommendations for appropriate health improvement goals.

QUITNET — SMOKING CESSATION

www.bluecrossma.com/nm/national-grid/quitting-smoking.html

Quitnet is an online smoking cessation program offering resources for a smoke-free life.

CORPORATE COUNSELING ASSOCIATES (CCA) — WORK/LIFE ASSISTANCE

National Grid's Employee Assistance Program, CCA, can be reached at 1-800-833-8707 or online at **www.powerflexweb.com/1073/login.html**. (Company code: National Grid)

GLOBAL FIT

https://www.globalfit.com/club/gyms.asp

Get discounts on gyms and information on exercise, weight loss and nutrition.

INJURY PREVENTION FOR FIELD EMPLOYEES

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

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

Local 12003, Local 12012-04, Local 318, Local 350/369, Local 13507

Life Insurance and AD&D Benefits

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

Medical Evidence of Insurability (EOI)

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

BASIC COVERAGE

For full-time employees who are represented by Local 12003, Local 12012-04, Local 318 and Local 350/369, the Company pays the full cost of group life insurance coverage in the amount of two times base annual pay or two times your previous year's gross earnings (whichever is greater) to a maximum of $500,000 (combined with your optional life insurance coverage).

AD&D provides two types of coverage – Occupational AD&D and Non-Occupational AD&D. For Occupational AD&D, the benefit is four times your current base salary or the previous year's gross salary (whichever is greater) to a maximum of $300,000. For Non-Occupational AD&D, the benefit is one times your current base salary or the previous year's gross salary (whichever is greater) to a maximum of $75,000.

Full-time employees who are represented by Local 12003, Local 12012-04, Local 318, Local 350/369 are eligible for these coverages on the first day of the month coincident with or next following the completion of three months of service.

For full-time employees who are represented by Local 13507, the Company pays the full cost of group life insurance coverage in the amount of $65,000.

AD&D provides two types of coverage – Occupational AD&D and Non-Occupational AD&D. For Occupational AD&D, the benefit is $105,000. For Non-Occupational AD&D, the benefit is $65,000.

Full-time employees who are represented by Local 13507 are eligible for these coverages on the first day of the month coincident with or next following the completion of six months of service.

OPTIONAL LIFE INSURANCE COVERAGE

If you want additional life insurance for yourself, you can purchase it on an after-tax basis, through the optional life insurance program administered through MetLife. The maximum optional life insurance amount you can purchase is three times your annual salary based on the greater of either current base salary or previous year gross salary. For employees who are represented by Local 13507, the maximum optional life insurance amount you can purchase is three times your annual salary, to a maximum of $500,000, based on the greater of either current base salary or previous year's gross salary.

If you are currently enrolled in optional life insurance for yourself, you can purchase an additional one times your annual salary during this Open Enrollment process without providing medical evidence of insurability, provided you have not been hospitalized within the last 90 days.

SPOUSE LIFE INSURANCE

Optional life insurance is available for your spouse/same-sex domestic partner in $2,000 increments to a maximum of $20,000 (spouse life cannot exceed the employee life amount). The cost of coverage for your spouse/same-sex domestic partner is based on his or her age and the level of coverage you elect. Rates will be included in the MetLife enrollment materials you will receive separately.

About Optional Life Insurance

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

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

If your spouse is enrolled within 31 days of the initial eligibility date, he or she will not need to provide medical evidence of insurability if he or she has not been hospitalized in the past 90 days and the appropriate enrollment form is completed. If you are applying for spouse coverage and more than 31 days have passed since the initial eligibility date or your spouse has been hospitalized in the past 90 days, you are required to submit EOI. If both you and your spouse work for National Grid, you cannot buy coverage for your spouse, but your spouse may have his or her own coverage as an employee.

CHILD LIFE INSURANCE

You may also choose to purchase life insurance for your child(ren) through the optional life insurance plan. Coverage is available in $1,000 increments, up to the maximum of $10,000. Your dependent must be at least 14 days old and less than 19 years old. If your dependent is a full-time student, he or she must be under the age 23 to be eligible for child life insurance coverage.

Imputed Income

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

Naming a Beneficiary

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

By October 17, you should receive a direct home mailing from MetLife which describes how you can enroll in these optional programs. If you need assistance, please call the MetLife Call Center at 1-866-492-6983.

Legal Services

All eligible full-time employees can elect to participate in a comprehensive legal services plan. Services include telephone advice and office consultations with a plan attorney of your choice on a range of services as shown in the chart below. The plan excludes employment and business-related issues. You may enroll only during Open Enrollment.

The plan is administered by Hyatt Legal Plans, a MetLife subsidiary. Over 13,000 attorneys nationwide participate. Fees for covered services provided by a plan attorney are fully covered and paid. Out-of-network options are also available through this plan.

National Grid subsidizes the cost of this benefit so your contribution is just $5 per month, deducted in equal installments from each weekly paycheck. The rate includes coverage for you, your spouse/same-sex domestic partner and dependent child(ren). You may not disenroll from the program until the next Open Enrollment period.

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

CONTINUING PARTICIPATION IF YOU TERMINATE YOUR EMPLOYMENT

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

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

Auto and Homeowners Insurance

You are eligible for auto and home insurance through MetLife Home & Auto. Contact MetLife to receive information regarding auto and home insurance program through payroll deductions.

National Grid has contracted with MetLife to allow employees to insure their cars, homes and other personal property at special discounted group rates via payroll deduction.

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

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

Enrolling in Your Benefits

Once you've reviewed your benefit options and the information on your *2015 Personalized Enrollment Worksheet*, it's time to get online and enroll! You have until October 31, 2014, by 5 p.m. ET via phone and 12 midnight via Web to elect your 2015 benefits. If you don't enroll, you will automatically receive default coverage (see page 4 for details). If you want to keep your default benefit elections and you do not plan to participate in the flexible spending accounts, you do not need to enroll.

To Enroll or Make Changes by Phone

You can enroll by contacting the Mercer Benefits Service Center at 1-866-294-8052. Be sure to have your *2015 Personalized Enrollment Worksheet* in front of you when you call.

TO ENROLL OR MAKE CHANGES ONLINE

Step 1: Log on to the Mercer Benefits Service Center Web site at **www.NationalGridEmployeeServices.MercerHRS.com**

Step 2: You will need your User ID and Personal Identification Number (PIN) to log on to the Mercer Benefits Service Center Web site.

- Your User ID is your Employee ID number, which can be located on your *2015 Personalized Enrollment Worksheet* as well as on your pay advice.
- If you do not remember your PIN, you have the ability to reset it by clicking ***Click here to reset your PIN*** from the log on page. If this is the first time you are using the Web site, your PIN has been set to the last four digits of your Social Security Number. Once you log on, you will be asked to reset your PIN and select a series of security questions. Please keep this information for future access.

Step 3: Click on the ***My Health*** link at the top of the page to begin. From this page, you may review your current 2014 elections, personal data and dependent data or you can enroll in your 2015 benefits.

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, please contact the Mercer Benefits Service Center at 1-866-294-8052 during the Open Enrollment Correction Period scheduled from November 18, 2014 through November 25, 2014 (Monday through Friday, between 8 a.m. and 5 p.m. ET).

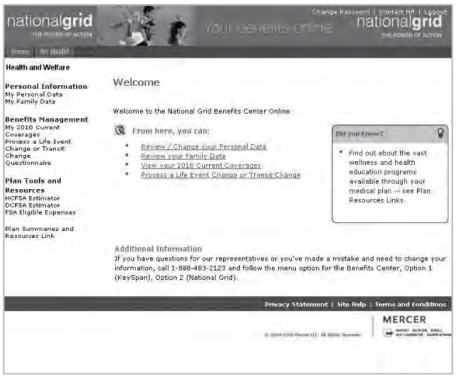
Step 4: Review your information on each of the tabs described here:

My Cost — Review your cost for your 2015 benefits.

About Me — Review your personal information. If any of the information on this page is not correct, please call the Transaction Delivery Center at 1-888-483-2123.

My Dependents — Review and update your dependent information listed on this page before electing coverage. If assistance is needed with changing dependent data (name, SSN, etc.), you can call Mercer at 1-866-294-8052.

Click ***Complete Your 2015 Open Enrollment***. You will reach the Enrollment Summary page. Choose the benefits you would like to change by clicking on the ***Change*** button. The Web site will guide you through choosing your plan, selecting which dependents to cover and/or entering a contribution amount for a flexible spending account.



If you want to waive medical coverage for 2015, you must click on the ***Change*** button to the left of the medical line and select ***No Coverage.***

Step 5: Once you have made your elections, click ***Submit My Elections***.

Step 6: Your elections are not final until you receive your confirmation number. Once you receive your confirmation number, you will have an opportunity to print a copy of your elections. Click ***Continue*** to complete a quick online survey.

You will be able to change your elections as many times as you like until the enrollment period ends on October 31, 2014. If you would like to make a change after receiving your confirmation number, you will need to restart the enrollment process from the beginning. Your changed elections, which become effective January 1, 2015, will not be saved until you receive a new confirmation number.

Glossary

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

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

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

Deductible – The annual dollar amount for covered services that you must pay before a PPO plan pays out-of-network benefits.

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

Out-of-network care – Care you receive from providers outside of a PPO network. Under a PPO, you pay more for out-of-network care.

Out-of-pocket maximum – The maximum amount you will pay for covered medical expenses during the year under the plan (including deductibles, co-insurance and co-payments for medical, pharmacy and mental health/substance abuse treatments for in-network treatment). Any covered medical or pharmacy expenses above the maximum will be covered at 100% by the plan, for the rest of the calendar year.

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

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

Contact Information

For Information On:	Call:	Or Visit The Web Site:
Medical Plans		
Blue Cross Blue Shield PPO	1-800-287-8757	www.bluecrossma.com
Harvard Pilgrim PPO	1-888-333-4742	www.harvardpilgrim.org/members
Fallon HMO	1-800-868-5200	www.fchp.org
CIGNA Open Access Plus PPO	1-800-CIGNA24 (1-800-244-6224)	www.cigna.com
Prescription Drug Benefits		
CVS Caremark	1-800-378-8826	www.caremark.com
Dental Plan		
Delta Dental	1-800-872-0500	www.deltadentalma.com
Flexible Spending Accounts		
Ceridian through December 31, 2014 WageWorks beginning January 1, 2015	1-877-799-8820 1-855-774-7441	www.ceridian-benefits.com www.wageworks.com
Life Insurance and AD&D		
MetLife	1-866-492-6983	www.metlife.com/mybenefits
Legal Services		
Hyatt Legal Plans	1-800-821-6400	www.legalplans.com If not yet a member, click “Thinking About Enrolling” and enter password 3990010
Auto and Homeowners Insurance		
MetLife	1-800-438-6388	www.metlife.com/mybenefits
Enrollment		
Mercer Benefits Service Center	1-866-294-8052	www.NationalGridEmployeeServices.MercerHRS.com
General Benefit Questions		
Transactions Delivery Center	1-888-4TDC-123 (1-888-483-2123)	www.nationalgridtdc123.com

STEPS YOU MUST TAKE BY OCTOBER 31 AT 5 P.M. ET VIA PHONE OR 12 MIDNIGHT VIA WEB	
If you want to...	You must enroll online at **www.NationalGridEmployeeServices.MercerHRS.com** or call the Mercer Benefits Service Center at 1-866-294-8052.
• Enroll in, change or waive your medical coverage for 2015 • Enroll in, change or waive your dental coverage for 2015 • Enroll or re-enroll in the Health Care Spending Account and/or Dependent Care Reimbursement Account for 2015 • Enroll or re-enroll in Legal Services for 2015	
• Purchase or change optional life insurance for 2015	• You must call the MetLife Call Center at 1-866-492-6983

Don't forget: If the coverage listed on your *2015 Personalized Enrollment Worksheet* meets your needs for 2015, you do not need to enroll.

Reminder: False or Misleading Information

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

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

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Engage in Your Benefits

OPEN ENROLLMENT **2016**

2016 **Benefits** Enrollment Guide

FOR NATIONAL GRID REPRESENTED EMPLOYEES

Local 12003, Local 12012-04, Local 318, Local 350/369, Local 13507

What's Inside

Welcome to 2016 Open Enrollment!

As an employee of National Grid, you have access to a range of quality benefit options so you can get the coverage you need for yourself and your eligible family members. Open Enrollment is your annual opportunity to reassess your health care, life insurance and other benefit needs — by considering how you used your benefits in 2015 and how your needs may change in 2016.

When to Enroll

The Open Enrollment period will begin on Monday, October 26 at 7 a.m. and end on Friday, November 6 at 6 p.m. Eastern Time (ET) via phone and 12 midnight via Web.

This Benefits Enrollment Guide describes the benefits available to you in 2016 as well as important information on how to enroll in your benefits. Read it carefully so that you can make informed decisions that are right for you and your family. To the extent the benefits are subject to the Employee Retirement Income Security Act, the Guide is also a Summary of Material Modifications that describes the changes in those benefits that are effective in 2016. Please keep this Guide for future reference.

You will find detailed instructions about how to enroll starting on page 28.

BE AN ACTIVE HEALTH CARE CONSUMER

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

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

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

For all these reasons and more, **we encourage you to be an active health care consumer and engage in your own health.** Be proactive about your health care needs, make informed lifestyle choices, seek early screening for health care issues and work with health providers to address specific concerns. National Grid's Commitment to Health and Wellbeing provides additional resources for you and your family (see page 21).

YOUR BENEFITS ENROLLMENT KIT INCLUDES:

1. This *2016 Benefits Enrollment Guide*, which describes your benefit options and how they work.

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

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

In addition, your *2016 Personalized Enrollment Worksheet* will be mailed separately to your home. The worksheet includes your current coverage and your available options and costs for 2016. If you do not receive your *2016 Personalized Enrollment Worksheet* by October 26, 2015, please contact the Benefit Services Center at 1-888-483-2123.

As in past years, after you've enrolled in your 2016 benefits, you will receive a written confirmation of your choices, and you'll have the chance to make changes before your coverage becomes effective on January 1, 2016.

Don't Wait Until the Last Minute to Enroll!

- Look at your enrollment tools and resources as soon as possible to make your decision easy and timely.
- Avoid peak hours — during Open Enrollment, 7 a.m. to 11 a.m. ET is the busiest time for the National Grid Benefit Services Center. The best way to get your questions answered quickly is to call mid-week in the afternoon.
- Don't wait until the last minute to enroll — the last day of the enrollment period is a busy time for the online enrollment Web site and the National Grid Benefit Services Center!

What's New

You will continue to have access to comprehensive benefit programs in 2016. You will find your 2016 cost for coverage in the enclosed *A Comparison of National Grid Health Benefits* chart. The following is a summary of the health and welfare benefit plan modifications that become effective January 1, 2016, as negotiated under collective bargaining agreements or as a result of regulatory and/or administrative changes. The health benefits and wellness programs offered by National Grid—combined with more employees taking an active role in managing their health—are helping to manage the pace of health care cost increases.

- **Supreme Court Decision on Same-Sex Marriage**
  - Earlier this year, the U.S. Supreme Court ruled that the right to marry is a fundamental right inherent in the liberty of the person under the Due Process and Equal Protection Clauses of the Fourteenth Amendment; same-sex couples may not be deprived of that right. The Court ultimately concluded that same-sex couples may exercise the fundamental right to marry. As a result of this decision, there is no longer any legal barrier to same-sex marriage in the United States. National Grid will provide medical and dental coverage to your "legally married spouse," regardless of sex.
- **Life Insurance**
  - MetLife will eliminate the age 70 limit on dependent spouse coverage effective January 1, 2016.
  - The requirement for an employee who signs up for optional/supplemental life insurance to be actively at work on the plan's effective date and not have been 'hospitalized" in the prior 90-day period will be eliminated effective January 1, 2016.
- **Applied Behavior Analysis (ABA) services**
  - Fallon will be removing co-payments on Applied Behavior Analysis (ABA) services effective October 1, 2015. There will also be no limit on ABA physical therapy and occupational therapy visits, effective 1/1/2016.

FOR LOCAL 13507:

DENTAL

- Employee contributions for the Delta Dental PPO will increase to 17.5% for Employee Only and Employee Plus Family coverage.

FOR LOCAL 12003, 12012-04, 318, 350/369:

MEDICAL

- Employee contributions for the Blue Cross Blue Shield of Massachusetts (BCBSMA) PPO will increase to 20% for Employee Only and Employee Plus Family coverage.

DENTAL

- Employee contributions for the Delta Dental PPO will increase to 20% for Employee Only and Employee Plus Family coverage.

Important Enrollment Information

You will enroll through the National Grid Benefit Services Center either online or by phone (see page 28 for instructions). You will need to enroll by November 6, 2015 if you want to:

- Change your current medical and/or dental coverage.
- Waive medical coverage (if you are covered under another medical plan).
- Change the dependents you cover in the medical and/or dental plans.
- Enroll in the Health Care Spending Account (HCSA) for 2016.
- Enroll in the Dependent Care Reimbursement Account (DCRA) for 2016.
- Enroll in Legal Services.
- Purchase or increase optional/supplemental life insurance coverage for you, your spouse and/or your children. You may enroll or change your coverage by contacting MetLife.

If You Waived Medical Coverage in 2015

If you waived medical coverage in 2015, and you do not enroll in medical coverage for 2016, you will have no medical coverage for 2016.

If you do not take any action before November 6, 2015, and you were already eligible for and enrolled in subsidized medical and dental coverage, you will default into the following plan elections:

Default Benefit Plans	
Medical (If enrolled in 2015)	The coverage you had in 2015
Dental (If enrolled in 2015)	The coverage you had in 2015
Flexible Spending Accounts • **Health Care** • **Dependent Care**	 Waive-No Coverage Waive-No Coverage
Optional Life Insurance	The coverage you had in 2015
Legal Services	Waive-No Coverage

WHO IS ELIGIBLE?

You are eligible to choose coverage under one of the medical and dental plan options if you are an active employee and you have completed 30 days of service. In addition to yourself, you may also enroll additional family members in some of the benefit options available to you.

MEDICAL

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

- Your legally married spouse.
- Your child(ren) who are under the age of 26, married or unmarried regardless of full-time student or tax dependent status. A child includes:
  - Natural child(ren), legally adopted child(ren) or child(ren) placed with you pending legal adoption, child(ren) for whom you or your spouse serve as legal guardian, step-child(ren), eligible foster child(ren), 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 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 the child attains age 26. Coverage may be extended indefinitely if the child has been certified as disabled by your medical plan prior to his/her 26th birthday.

Note: Spouses of married dependents and child(ren) of dependents are NOT eligible for coverage.

Important Note Regarding Dependent Eligibility

If you add dependents to your coverage, you will be required to provide documentation that verifies their eligibility. You will be contacted separately after Open Enrollment with instructions for submitting the appropriate documentation to verify eligibility.

If You Were Divorced in Massachusetts

Depending on your plan, if you were divorced in the Commonwealth of Massachusetts, your ex-spouse may be eligible for coverage depending on your divorce decree. Immediately after the divorce is finalized, you must provide National Grid a copy of the divorce decree to determine continued benefits eligibility for your ex-spouse.

DENTAL

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

- Your legally married spouse.
- Your dependent child(ren), including your unmarried natural child(ren), step-child(ren), legally adopted child(ren), eligible foster child(ren), child(ren) placed with you pending legal adoption, child(ren) of a legally married spouse, and child(ren) for whom you or your spouse serve as a legal guardian. **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 through the end of the month in which the child attains age 19. Full-time students are covered until the midnight prior to their 25th birthday, with the exception of dependents covered under the Local 13507 rules. For full-time students under the Local 13507 rules coverage is through the end of the month in which the child turns age 25.
- Annual certification is required to confirm a child's continuing full-time student status.

WHEN YOUR COVERAGE BEGINS

The elections you make during this Open Enrollment period will take effect on January 1, 2016 and will remain in effect through December 31, 2016.

NEW HIRES

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

Choose Well

Choose well means enrolling in the right benefits for you and your family. It is important for you to consider your/your family's own needs for the upcoming year when making your elections for eligible benefits. The information in this guide together with your comparison chart provides a summary overview of many benefits and highlights what's new and changing in 2016.

If you do not make a medical benefit election when you first become eligible for subsidized coverage, you will be defaulted into the BCBSMA PPO with Employee Only coverage. If you do not make a dental benefit election when you first become eligible for subsidized coverage, you will be defaulted into the dental plan with Employee Only coverage.

Benefits	Eligibility
Medical Plan	**Full cost** First of the month following or coincident with your date of hire **Subsidized cost** First of the month following or coincident with the completion of 30 days of service
Dental Plan	**Full cost** First of the month following or coincident with your date of hire **Subsidized cost** First of the month following or coincident with the completion of 30 days of service
Health Care Spending Account	First of the month following or coincident with the completion of 30 days of service
Dependent Care Reimbursement Account	First of the month following or coincident with the completion of 30 days of service
Basic Life Insurance (except Local 13507)	First of the month following three months of service. The greater of two times previous year's gross earnings or two times annual salary after general wage increase
Accidental Death and Dismemberment (except Local 13507)	**Occupational loss** After three months of service then automatically enrolled at four times your base annual salary up to a maximum of $300,000 **Non-occupational loss** First of month following date of hire, one times salary up to $75,000 maximum
Basic Life Insurance (for Local 13507)	After six months of service then automatically enrolled; $65,000 flat Company-paid benefit
Accidental Death and Dismemberment (for Local 13507)	After six months of service then automatically enrolled; $65,000 flat Company-paid benefit for Non-Occupational coverage.
Legal Services	Available at Open Enrollment only

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

PAYING FOR COVERAGE

Your *2016 Personalized Enrollment Worksheet* and *A Comparison of National Grid Health Benefits* chart include the cost for each of your medical and dental benefit options, as well as the coverage levels available to you. Optional life insurance coverage is provided through a separate enrollment with MetLife. During Open Enrollment, you may contact MetLife directly to review your options. If you are a newly hired employee, you will receive your MetLife information with your other enrollment information and new hire documentation.

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

Pre-Tax Contributions Apply to These Benefits:	After-Tax Contributions Apply to These Benefits:
• Medical Coverage • Dental Coverage • Health Care Spending Account (HCSA) • Dependent Care Reimbursement Account (DCRA)	• Optional Life Insurance • Dependent Life Insurance • Legal Services

Paying with Pre-Tax Dollars

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

MAKING CHANGES DURING THE YEAR

The benefit elections you make during this Open Enrollment period will stay in effect throughout 2016. You can only make changes to your coverage during the year if you experience a qualified life event — a significant change in your life that has a direct impact on your coverage. 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 change from part-time to full-time employment status or vice versa
- You or your spouse take an unpaid leave of absence
- You or your spouse experience a significant change in health coverage due to your spouse's employment (For example, his/her employer changes payroll withholding, or he/she chooses a different medical plan or coverage during the year)
- You move out of your medical plan's service area

How are you spending time?

People spend an average of 6.8 hours researching buying a car, 4.9 hours holiday shopping, and 1.3 hours buying a pair of shoes, according to Guardian Life industry data. And on average, people are spending about 1.4 hours reviewing their benefits plans.

It takes time to make sure your needs are covered. Smart benefits decisions may not have that "new car smell" — but peace of mind is an accessory that doesn't wear off quickly. The choices you make — or don't make — during Open Enrollment will impact you and your family for the next year. Take the time to give your benefits a thorough check-up this year.

The benefit change you make must reflect the change in status that you experience. For example, if you get married mid-year, you may add your spouse to your current coverage, but you may not change medical plans. **If you experience a 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 a change**.

Your 2016 Benefit Choices

National Grid's benefits program offers a broad choice of quality, affordable coverage for you and your family. This chart highlights your choices for 2016. More details about each benefit follow.

Your 2016 Benefit Choices	
Medical All plans include prescription drug coverage	• A Preferred Provider Organization (PPO) Plan managed by Blue Cross Blue Shield of Massachusetts • Additional medical plan option(s) based on your union affiliation • Ability to waive medical (if you have coverage elsewhere)
Dental	• One plan option through Delta Dental • Ability to waive dental coverage The plan pays the full cost of preventive care and shares costs of other services, including fillings, crowns, periodontal care and orthodontia (for children only).
Flexible Spending Accounts	• **Health Care:** Contribute up to $2,000 pre-tax for eligible health care expenses • **Dependent Care:** Contribute the following amounts pre-tax for eligible dependent care expenses: — Up to $5,000 a year if you're single or married and filing a joint tax return — Up to $2,500 if you're married and filing separately, or married and your spouse works for National Grid and is contributing to his/her own Dependent Care Spending Account
Life Insurance for Employees	• **Basic** — *Local 12003, Local 12012-04, Local 318, Local 350/369:* two times base annual pay or two times previous year's gross earnings (whichever is greater), to a maximum of $500,000 (including optional life insurance) — *Local 13507:* $65,000 You are automatically enrolled in basic life insurance coverage. • **Optional:** Buy up to three times base annual salary, to a maximum of $500,000 (including basic life insurance)
Dependent Life Insurance	• For your spouse: Purchase in increments of $2,000, up to $20,000 • For your child(ren): Purchase in increments of $1,000, up to $10,000
Accidental Death and Dismemberment	• *Local 12003, Local 12012-04, Local 318, Local 350/369:* one times current base salary or the previous year's gross salary (whichever is greater) for non-occupational related incident, to a maximum of $75,000; four times current base salary or the previous year's gross salary (whichever is greater) for occupational related incident, to a maximum of $300,000 • *Local 13507:* $65,000 for non-occupational related incident; $105,000 for occupational related incident *The Company pays the full cost of AD&D insurance; you are automatically enrolled.*

Your 2016 Benefit Choices	
Legal Services	Purchase access to legal services through Hyatt Legal Plans, including telephone advice and office consultations for services including will preparation and real estate closings
Auto and Homeowners Insurance	Purchase insurance at discounted group rates

Medical Plan Options

For 2016, National Grid will continue to offer the choice between a Preferred Provider Organization (PPO) and additional plan option(s). Each plan covers the same range of health care services, and each includes prescription drug coverage. The difference is where and how you receive care, as described below.

Refer to the enclosed *A Comparison of National Grid Health Benefits* chart for more details about the plans available in your area, including information about deductibles, co-insurance, co-payments and employee contributions.

What to Consider When Choosing Your Plan

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

- What do you think your health care needs will be in 2016? What are your typical health care needs? Do you or a covered family member have any chronic health conditions?
- What are your total costs under each option–including the contributions, deductibles, co-insurance, co-payments and non-covered services?
- How does your National Grid coverage compare to any other coverage you might have, such as through your spouse's plan?

THE BLUE CROSS BLUE SHIELD (BCBS) PPO

Here's a Tip: Play an Active Role

Patients who ask questions are more satisfied with their care and see more of an improvement in their health than patients who do not.

With this plan, you can choose to receive care within the BCBS network or outside the network. You can see any provider within the network without a referral from a primary care physician (PCP). If you receive care in the network, you benefit from lower rates because the providers have negotiated special rates with BCBS. With this plan, you pay co-payments or a deductible and co-insurance depending on whether you receive care in or outside the network. If you receive care outside the network, you pay more and the plan pays less.

Because the BCBS PPO plan offers a nationwide network of health care providers, you can likely receive in-network care no matter where you are. For example, if you have a dependent away at college, you need medical attention while travelling domestically, or you want to visit a specialist or hospital in another state, as long as the provider is part of the BCBS network (and most are), you will receive in-network benefits.

Nearly all the providers National Grid employees currently use are in the BCBS network. You can confirm that your doctor participates by checking the BCBS Web site at **https://www.bluecrossma.com/wps/portal/members/using-my-plan/doctors-hospitals/findadoctor** and searching in the BlueCard network. For general information about BCBS, visit **www.bluecrossma.com**.

ADDITIONAL PLAN(S)

You will have the choice to enroll in an additional plan (or plans) based on your union affiliation. For 2016, National Grid will continue to offer these plans to give you access to additional provider networks in certain regions. To see what plans are available to you, refer to *A Comparison of National Grid Health Benefits* included with this guide.

COVERAGE LEVEL OPTIONS

You can choose from the following coverage options:

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

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

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

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

WAIVING MEDICAL COVERAGE

If you have coverage under another medical plan (for example, through your spouse's employer), you may elect to decline coverage through the Company. If you choose to waive medical coverage, you will have no medical coverage for yourself or your family through National Grid for 2016.

To certify that you have coverage under another employer-provided medical plan and waive medical coverage through National Grid for 2016, contact the National Grid Benefit Services Center online at www.nationalgridbenefitservices.com and select "no coverage" under the medical benefit plan option. You may also call the National Grid Benefit Services Center at 1-888-483-2123.

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

IMPORTANT NOTE FOR MASSACHUSETTS RESIDENTS WHO WAIVE COVERAGE

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 Commonwealth Health Connector for each month you go without coverage (after a 63-day grace period).

To avoid tax penalties, you will be required to file proof of creditable health insurance coverage annually along with your personal income tax return. The sponsor of your medical coverage will send you the form you need. You provide your proof of creditable coverage in the form of a tax form, Form MA 1099-HC. In early 2016, you will receive the Form MA 1099-HC that will indicate you have creditable coverage. Use this form when filing your 2015 taxes.

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

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

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

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

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

PATIENT PROTECTION NOTICE (REQUIRED BY HEALTH CARE REFORM)

National Grid offers several HMOs that generally require you to designate a primary care provider. You have the right to designate any primary care provider who participates in the HMO network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the health plan in which you are enrolled.

You do not need prior authorization from a primary care provider to obtain access to obstetrical or gynecological care from a health care professional in the HMO network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the health plan in which you are enrolled.

Prescription Drug Benefits

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

Here's a Tip: Use Generic Drugs Whenever Possible

Generic drugs are as effective as brand-name drugs but almost always cost less. If you take a brand-name drug, talk with your health care provider to determine if a generic equivalent might be a smarter choice for you.

FILLING PRESCRIPTIONS THROUGH CVS CAREMARK

ALL EMPLOYEES (EXCEPT THOSE ENROLLED IN THE CIGNA PPO):

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

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

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

The mail order co-payment will be the same, regardless of which method you use: home delivery or CVS retail pick-up.

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

FOR EMPLOYEES ENROLLED IN THE CIGNA PPO:

CIGNA administers its own prescription drug benefit, so all eligible prescriptions shall be fulfilled directly by CIGNA.

Dental Plan

National Grid offers competitive dental coverage through Delta Dental. The plan covers 100% (up to the in-network amount) of preventive care and shares the cost of basic and major restorative care with you.

When you participate in the dental plan, you can choose to receive care from a broad range of providers within the Delta Dental network or from any provider outside the network. The plan will pay the same level of benefits regardless of where you receive care; however, the cost of services is typically lower within the network, as providers have negotiated special in-network rates.

Medical and Dental Plan Coverage Levels

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

To find out if your dentist is in the Delta Dental network, visit **www.deltadentalma.com** and search the Delta Dental PPO Plus Premier network.

For details on how the dental plan pays benefits, refer to the enclosed *A Comparison of National Grid Health Benefits* chart.

COVERAGE LEVEL OPTIONS

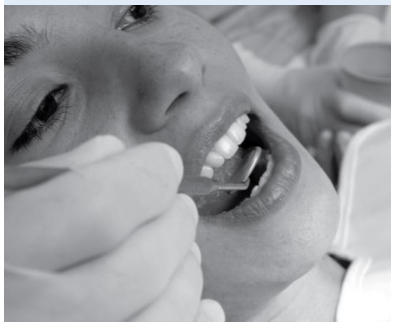
You can choose from the following coverage options:

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

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

Here's a Tip: Get a Regular Dental Check-up

Did you know that getting a preventive dental check-up can help detect early signs of dental disease? Schedule a dental appointment and help reduce future cost and stress.



Flexible Spending Accounts

National Grid offers two flexible spending accounts:

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

Using Your HCSA

Your total annual contribution is available for reimbursement on January 1, 2016. Your annual contribution election will be deducted in equal installments each pay period before applicable payroll taxes are deducted.

You may contribute to one or both flexible spending accounts. However, you must enroll each year to participate. Participation does not automatically continue from year to year.

With a flexible spending account, you save because the money in your account is never taxed — when it goes into your account, or when you withdraw it to reimburse yourself for eligible expenses.

HEALTH CARE SPENDING ACCOUNT

With the HCSA, you can set aside up to $2,000 each year through pre-tax payroll deductions to help you save to pay for eligible health care expenses which are not otherwise covered by your health care plans.

The $2,000 cap applies on a per-employee basis. If an employee and his/her spouse are both employees of National Grid and are eligible to make contributions to the HCSA, each person may elect to contribute up to the $2,000 limit.

Eligible Health Care Spending Account Expenses

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

For a complete list of eligible and ineligible expenses, contact WageWorks (see page 32 for contact information), contact the IRS toll-free at 1-800-829-3676 and ask that Publication 502 be sent to you free of charge, or visit **www.irs.gov.**

DEPENDENT CARE REIMBURSEMENT ACCOUNT

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

Eligible Dependent Care Reimbursement Account Expenses

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

For a complete list of eligible and ineligible expenses, contact WageWorks (see page 32 for contact information), contact the IRS toll-free at 1-800-829-3676 and ask that Publication 503 be sent to you free of charge, or visit **www.irs.gov**.

USING YOUR DCRA

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

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

Dependent Care Tax Credit

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

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

ADDITIONAL FLEXIBLE SPENDING ACCOUNT RULES

- **Contributions.** Once you enroll in either (or both) the health or dependent care account, you may not change or stop your contributions until the next Open Enrollment period (unless you experience a qualified life event as indicated on page 8).
- **Reimbursement.** To be reimbursed for eligible health or dependent care expenses incurred between January 1, 2016 and March 15, 2017, obtain the applicable reimbursement claim form by visiting **https://www.wageworks.com/employees/support-center/important-forms.aspx**. Submit your completed form along with a receipt or proof of payment (including the Explanation of Benefits (EOB) if provided by a health plan). WageWorks will then reimburse you for your eligible out-of-pocket expenses up to the total amount of your HCSA 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, 2017 to submit claims for all eligible expenses incurred between January 1, 2016 and March 15, 2017. That's why it's important to carefully consider the amount you will use over the course of the year before contributing to either account.

If You Have Questions

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

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

CONTINUING PARTICIPATION IF YOU TERMINATE YOUR EMPLOYMENT

Terminated or retired employees may choose to continue funding their HCSA on an after-tax basis by electing continued coverage through COBRA. Details will be included in the Ceridian COBRA package.

National Grid's Commitment to Health and Wellbeing

Our Integrated Health Management Department offers targeted programs and services free of charge for employees, with the intent to create healthier and happier personal and working lives.

HEALTH & WELLNESS RESOURCE CENTER

www.bluecrossma.com/nationalgrid

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

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

Live Well

Live well includes taking control of your/your family's physical, mental and financial health. Take the time to put wellness into your daily activities. Taking advantage of the various health/wellness programs offered by our health providers, and maintaining appropriate optional life insurance can help to positively influence your physical and mental wellbeing.

Health & Wellness information is also available from these health care providers:

- Harvard Pilgrim Health Care www.harvardpilgrim.org
- Fallon Health www.fallonhealth.org

QUITNET — SMOKING CESSATION

Quitnet is an online smoking cessation program offering resources for a smoke-free life.

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

http://smokefree.gov/

CORPORATE COUNSELING ASSOCIATES (CCA) — WORK/LIFE ASSISTANCE

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

INJURY PREVENTION FOR FIELD EMPLOYEES

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

Did You Know?

56% of all injuries reported at National Grid are soft tissue related. Soft tissue injury is the damage of muscles, ligaments and tendons throughout the body. Stretching and flexing before work can significantly reduce your risk of soft tissue injury.

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

Life Insurance and AD&D Benefits

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

Medical Evidence of Insurability (EOI)

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

BASIC COVERAGE

For full-time employees who are represented by Local 12003, Local 12012-04, Local 318 and Local 350/369, the Company pays the full cost of group life insurance coverage in the amount of two times base annual pay or two times your previous year's gross earnings (whichever is greater) to a maximum of $500,000 (combined with your optional life insurance coverage).

Defining Your Base Annual Salary for Life Insurance

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

AD&D provides two types of coverage – Occupational AD&D and Non-Occupational AD&D. For Occupational AD&D, the benefit is four times your current base salary or the previous year's gross salary (whichever is greater) to a maximum of $300,000. For Non-Occupational AD&D, the benefit is one times your current base salary or the previous year's gross salary (whichever is greater) to a maximum of $75,000.

Full-time employees who are represented by Local 12003, Local 12012-04, Local 318, Local 350/369 are eligible for these coverages on the first day of the month coincident with or next following the completion of three months of service.

For full-time employees who are represented by Local 13507, the Company pays the full cost of group life insurance coverage in the amount of $65,000.

AD&D provides two types of coverage – Occupational AD&D and Non-Occupational AD&D. For Occupational AD&D, the benefit is $105,000. For Non-Occupational AD&D, the benefit is $65,000.

Full-time employees who are represented by Local 13507 are eligible for these coverages on the first day of the month coincident with or next following the completion of six months of service.

OPTIONAL LIFE INSURANCE COVERAGE

If you want additional life insurance for yourself, you can purchase it on an after-tax basis, through the optional life insurance program administered through MetLife. The maximum optional life insurance amount you can purchase is three times your annual salary based on the greater of either current base salary or previous year gross salary, to a maximum of $500,000. For employees who are represented by Local 13507, the maximum optional life insurance amount you can purchase is three times your annual salary, to a maximum of $500,000, based on the greater of either current base salary or previous year's gross salary.

If you are currently enrolled in optional life insurance for yourself, you can purchase an additional one times your annual salary during this Open Enrollment process without providing medical evidence of insurability, provided you have not been hospitalized within the last 90 days. You will be required to show medical evidence of insurability, also called EOI, if you elect to increase to a benefit of more than two times your annual salary or $200,000.

SPOUSE LIFE INSURANCE

Optional life insurance is available for your legal spouse in $2,000 increments to a maximum of $20,000 (spouse life cannot exceed the employee life amount). The cost of coverage for your spouse is based on his or her age and the level of coverage you elect. Rates will be included in the MetLife enrollment materials you will receive separately.

About Optional Life Insurance

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

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

If your spouse is enrolled within 31 days of the initial eligibility date, he or she will not need to provide medical evidence of insurability as long as the appropriate enrollment form is completed. If you are applying for spouse coverage and more than 31 days have passed since the initial eligibility date or your spouse has been hospitalized in the past 90 days, you are required to submit EOI. If both you and your spouse work for National Grid, you cannot buy coverage for your spouse, but your spouse may have his or her own coverage as an employee.

CHILD LIFE INSURANCE

You may also choose to purchase life insurance for your child(ren) through the optional life insurance plan. Coverage is available in $1,000 increments, up to the maximum of $10,000. Your dependent must be at least 15 days old and less than 19 years old and unmarried. If your dependent is a full-time student, he or she must be under the age 23 and unmarried to be eligible for child life insurance coverage.

Imputed Income

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

Naming a Beneficiary

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

By October 26, you should receive a direct home mailing from MetLife which describes how you can enroll in these optional programs. If you need assistance, please call the MetLife Call Center at 1-866-492-6983.

Legal Services

All eligible full-time employees can elect to participate in a comprehensive legal services plan. Services include telephone advice and office consultations with a plan attorney of your choice on a range of services as shown in the chart below. The plan excludes employment and business-related issues. You may enroll only during Open Enrollment.

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

National Grid subsidizes the cost of this benefit so your contribution is just $1.16 per month, deducted in equal installments from each weekly paycheck on a post-tax basis. The rate includes coverage for you, your spouse and dependent child(ren). You may not disenroll from the program until the next Open Enrollment period.

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

CONTINUING PARTICIPATION IF YOU TERMINATE YOUR EMPLOYMENT

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

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

Auto and Homeowners Insurance

You are eligible for auto and home insurance through MetLife Home & Auto. Contact MetLife to receive information regarding auto and home insurance program through payroll deductions.

National Grid has contracted with MetLife to allow employees to insure their cars, homes and other personal property at special discounted group rates via payroll deduction.

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

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

Enrolling in Your Benefits

Once you've reviewed your benefit options and the information on your *2016 Personalized Enrollment Worksheet*, it's time to get online and enroll! Remember **you have until November 6, 2015, by 6 p.m. ET via phone and 12 midnight via Web to elect your 2016 benefits**. If you don't enroll, you will automatically receive default coverage (see page 4 for details). If you want to keep your default benefit elections and you do not plan to participate in the flexible spending accounts, you do not need to enroll.

To Enroll or Make Changes by Phone

You are encouraged to enroll online. However, if you do not have access to the Web, you can enroll by contacting the National Grid Benefit Services Center at 1-888-483-2123. Be sure to have your *2016 Personalized Enrollment Worksheet* in front of you when you call.

TO ENROLL OR MAKE CHANGES ONLINE/BY PHONE

There are two ways to enroll:

1. Through the Web at **www.nationalgridbenefitservices.com**. The secure Web site is available 24 hours a day, so you can make your benefit elections during the Open Enrollment period, at a time that is convenient for you.

Please note you will be prompted to enter your:

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

OR

2. By calling the National Grid Benefit Services Center toll-free at **1-888-483-2123.** The National Grid Benefit Services Center is available Monday through Friday, from 7 a.m. to 6 p.m. ET. You may speak with a Benefits Specialist who will walk you through the enrollment process.

Step-By-Step Web Enrollment Instructions

1. Visit the National Grid Benefit Services Web site at: **www.nationalgridbenefitservices.com**. You will be prompted to enter your User ID and Password.
2. **If this is the first time that you login:**

- You will be prompted to read and accept the user agreement.
- You will also be prompted to change your password (must be at least 8 digits with one upper case, one lower case and one number).
- You will also be prompted to complete a security question to be used in the event you forget your password.

3. **Start your enrollment:** By clicking on the 'Open Enrollment' Notification or Tile.
4. **Review your personal profile information:** If you would like to update your telephone number or email preferences, click on the 'Edit' button.
5. **Change/Add New Dependents:** The dependent screen displays dependent information currently on file or newly added dependents are added. If you need to add dependents click the 'Add New Dependent' button to begin. If you need to make changes to your dependents, click on the pencil icon to the left of the dependent's name. It is your responsibility to make sure that all enrolled dependents are eligible to participate in the National Grid benefit plans.
   - In order for new family members to be eligible for coverage, you must submit proof of their eligibility. Any elections for the dependent will be pending until documentation is received and approved.
6. **Enrollment Acknowledgement:** You will be prompted to read and confirm your understanding that any changes made to your benefit elections will be saved even if you do not submit your final elections at the end of the enrollment event.
7. **Select Your Benefits:** All of your eligible benefits are displayed on this screen. To begin making elections click on the benefit name and then click on the 'Change' button.
8. **Select Your Benefit Options:** The change screen allows you to review the options for that benefit and choose an option. When you click on next, it will bring up a screen to assign dependents to that coverage if applicable.
9. **Review Elections:** The review election screen shows a snapshot of your elections at a glance including costs. You will need to click on 'Save Elections' to finalize your selections.
10. **Save Elections Confirmation:** You will be asked to confirm that you are ready to save your elections. Click 'Yes' to submit your elections or click 'No' to go back and make changes.
11. **Enrollment Confirmation:** The Enrollment Confirmation screen shows your elections at a glance once they have been saved. There are two options, you can print the page and/or download it for your records.

You will be able to change your elections as many times as you like until the enrollment period ends on November 6, 2015. 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, 2016, 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, please contact the National Grid Benefit Services Center at 1-888-483-2123 during the Open Enrollment Correction Period scheduled from December 7, 2015 through December 11, 2015 (between 7 a.m. and 6 p.m. ET).

Enrollment Deadline

You can enroll between October 26, 2015 and November 6, 2015. **You must enroll by November 6, 2015 at 6 p.m. ET via phone and 12 midnight via Web.** If you have any questions about benefits or the enrollment process, call the National Grid Benefit Services Center at 1-888-483-2123.

PERSONAL AND EMERGENCY CONTACT INFORMATION

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

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

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

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

Glossary

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

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

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

Deductible – The annual dollar amount for covered services that you must pay before a plan pays benefits.

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

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

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

Out-of-pocket maximum – The maximum amount you will pay for covered medical expenses during the year under the plan (including deductibles, co-insurance and co-payments for medical, pharmacy and mental health/substance abuse treatments for in-network treatment). Any covered medical or pharmacy expenses above the maximum will be covered at 100% by the plan, for the rest of the calendar year.

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

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

Contact Information

For Information On:	Call:	Or Visit The Web Site:
Medical Plans		
Blue Cross Blue Shield PPO	1-800-287-8757	www.bluecrossma.com
Harvard Pilgrim PPO	1-888-333-4742	www.harvardpilgrim.org/members
Fallon HMO	1-800-868-5200	www.fchp.org
CIGNA Open Access Plus PPO	1-800-CIGNA24 (1-800-244-6224)	www.cigna.com
Prescription Drug Benefits		
CVS Caremark	1-800-378-8826	www.caremark.com
Dental Plan		
Delta Dental	1-800-872-0500	www.deltadentalma.com
Flexible Spending Accounts		
WageWorks	1-877-924-3967	www.wageworks.com
Life Insurance and AD&D		
MetLife	1-866-492-6983	www.metlife.com/mybenefits
Legal Services		
Hyatt Legal Plans	1-800-821-6400	www.legalplans.com If not yet a member, click “Thinking About Enrolling” and enter password 3990010
Auto and Homeowners Insurance		
MetLife	1-800-438-6388	www.metlife.com/mybenefits
Enrollment		
National Grid Benefit Services Center	1-888-483-2123 Follow the phone prompt for benefits/medical and dental	www.nationalgridbenefitservices.com
General Benefit Questions		
National Grid Services Delivery Center	1-888-483-2123	www.nationalgridsdc123.com

STEPS YOU MUST TAKE BY NOVEMBER 6, 2015 AT 6 P.M. ET VIA PHONE OR 12 MIDNIGHT VIA WEB	
If you want to...	
• Enroll in, change or waive your medical coverage for 2016 • Enroll in, change or waive your dental coverage for 2016 • Enroll or re-enroll in the Health Care Spending Account and/or Dependent Care Reimbursement Account for 2016 • Enroll or re-enroll in Legal Services for 2016	You must enroll online at **www.nationalgridbenefitservices.com** or call the National Grid Benefit Services Center at 1-888-483-2123.
• Purchase or change optional life insurance for 2016	You must call the MetLife Call Center at 1-866-492-6983

Don't forget: If the coverage listed on your *2016 Personalized Enrollment Worksheet* meets your needs for 2016, you do not need to enroll.

Reminder: False or Misleading Information

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

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

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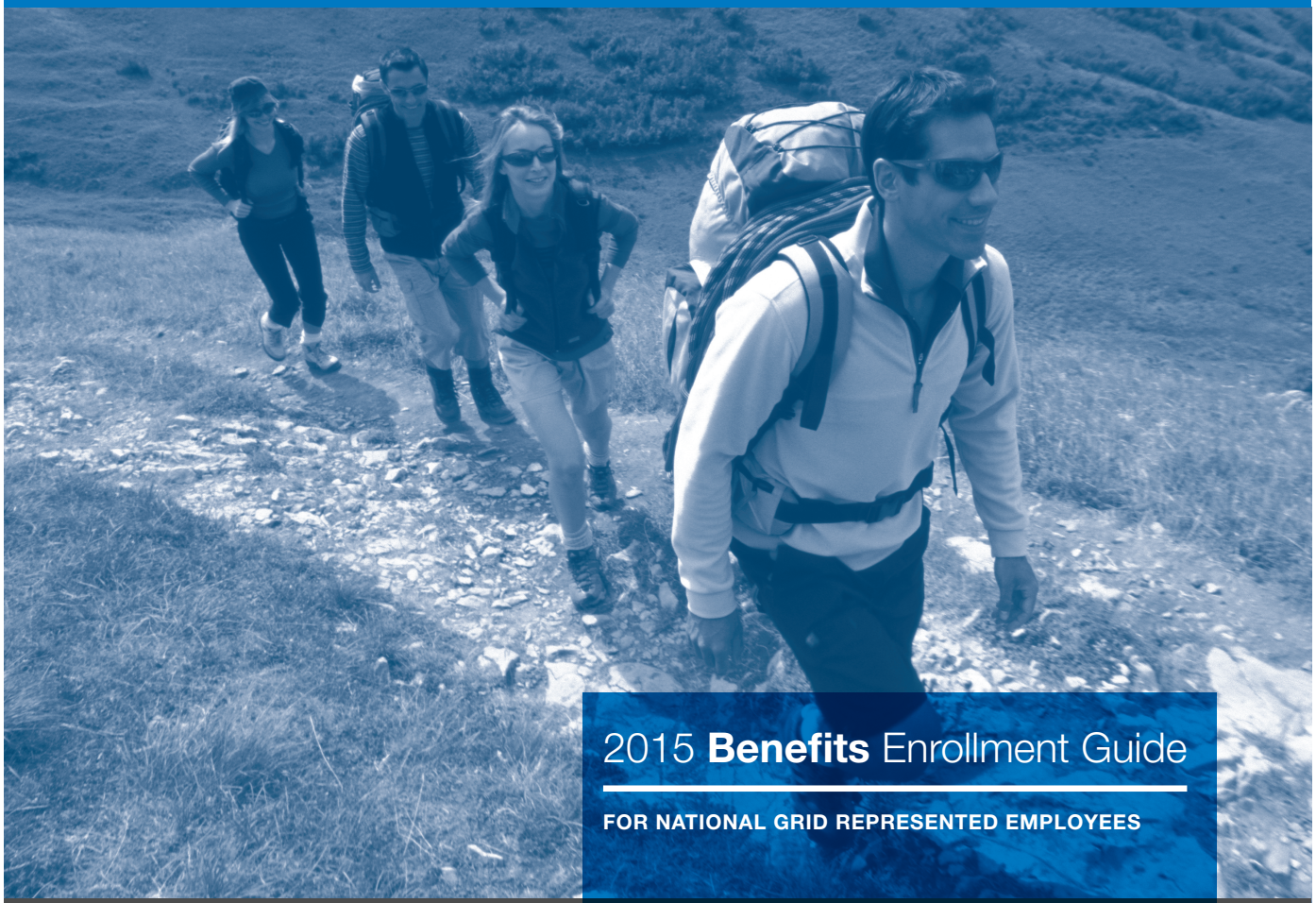
Benefits Connection:
Choose well
Be well
Live well

OPEN ENROLLMENT **2015**



2015 **Benefits** Enrollment Guide

FOR NATIONAL GRID REPRESENTED EMPLOYEES

New England Unions:
USW 12431
UWUA 369
UWUA BUW 310, 310B, 317, 322, 329, 330
IBEW 326, 486, 1465

New York Union:
IBEW 97

What's Inside

Welcome to 2015 Open Enrollment!

As an employee of National Grid, you have access to a range of quality benefit options so you can get the coverage you need for yourself and your eligible family members. Open Enrollment is your annual opportunity to reassess your health care, life insurance and other benefit needs — by considering how you used your benefits in 2014 and how your needs may change in 2015.

When to Enroll

The Open Enrollment period will begin at 8:00 a.m. on Friday, October 17 and end on Friday, October 31 at 5 p.m. Eastern Time (ET) via phone and 12 midnight via Web.

This Benefits Enrollment Guide describes the benefits available to you in 2015 as well as important information on how to enroll in your benefits. Read it carefully so that you can make informed decisions that are right for you and your family. To the extent the benefits are subject to the Employee Retirement Income Security Act, the Guide is also a Summary of Material Modifications that describes the changes in those benefits that are effective in 2015. Please keep this Guide for future reference.

YOUR BENEFITS ENROLLMENT KIT INCLUDES:

1. This *2015 Benefits Enrollment Guide*, which describes the benefit options and how the programs work.

2. *A Comparison of National Grid Plan Benefits*, a chart that summarizes the benefits under each medical plan and the dental plan, and your cost for coverage.

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

In addition, your *2015 Personalized Enrollment Worksheet* will be mailed separately to your home. This worksheet includes your current coverage and your available options and costs for 2015. If you do not receive your *2015 Personalized Enrollment Worksheet* by October 17, 2014, please contact the Mercer Benefits Service Center at 1-866-294-8052.

Don't Wait Until the Last Minute to Enroll!

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

What's New

You will continue to have access to comprehensive benefit programs in 2015. You will find your 2015 cost for coverage in the enclosed *A Comparison of National Grid Health Benefits* chart. The following is a summary of the health and welfare benefit plan modifications that will become effective on January 1, 2015 as negotiated under the collective bargaining agreement or as a result of regulatory and/or administrative changes.

- **Change in Flexible Spending Accounts Benefits Administrator**
  - Beginning January 1, 2015, administration of the Health Care Spending Account and Dependent Care Reimbursement Account will transition from Ceridian to WageWorks.
- **Due to new Health Care Reform requirements, the following changes will also become effective January 1, 2015:**
  - Comprehensive in-network out-of-pocket maximum to include Prescription drug costs **(FOR ALL UNIONS WITH THE EXCEPTION OF NEW YORK UNION):**
    - Effective January 1, 2015, prescription drug co-payments will accrue to the in-network out of pocket maximum. A combined maximum has been set to which both medical and prescription drug costs will accrue. The out of pocket maximum now includes deductible, medical co-payments and co-insurance, mental health/substance abuse treatments and prescription co-payments. Please refer to the *A Comparison of National Grid Health Benefits* chart to see changes to your current in-network out of pocket maximum levels.
    - Note: Health New England will have separate out of pocket maximums for medical ($250 individual/$250 family) and prescriptions drug costs ($250 individual/$250 family).
  - All plans except for those offered to employees represented by the New York Union will receive the following changes:
    - Expanded treatments for tobacco cessation, when prescribed by a health care provider
    - Enhanced coverage for Breast Cancer Preventive Medications for women with increased risk
    - BRCA risk assessment and genetic testing for women
    - Lung cancer screening for adults aged 55 to 80 years with a 30 pack per year smoking history and currently smoke or quit within the past 15 years.
- **Fallon ID cards.** Employees currently enrolled in the Fallon plan will receive new ID cards under a separate mailing from Fallon during fall 2014 due to new branding for the organization.
- **RMSCO ID cards**. Employees currently enrolled in the RMSCO plan will receive new ID cards under a separate mailing from RMSCO during fall 2014 due to a change in company name to "Lifetime Benefit Solutions."

- **New England Unions True-Up Analysis.** This year's true-up analysis resulted in a credit for 2015. See the enclosed special insert for more information.

FOR LOCAL 12431:

- **Introduce High Deductible Health Plan (HDHP) with Blue Cross Blue Shield (BCBS) and employee-funded Health Savings Account (HSA) with Health Equity. Employee will contribute 10% toward the cost of medical coverage for this plan.**
- **Change in medical contributions.** Employees will contribute 17.50% toward the cost of medical coverage for the BCBSMA PPO for Steelworkers.
- **Change in dental contributions**. Employees will contribute 15% toward the cost of dental coverage.

FOR NE UNION LOCALS 310, 310B, 369, 317, 322, 329, 330:

- **Introduce High Deductible Health Plan (HDHP) with Blue Cross Blue Shield (BCBS) and employee-funded Health Savings Account (HSA) with Health Equity. Employee will contribute 10% toward the cost of medical coverage for this plan.**

FOR NE UNION LOCALS 326, 486, 1465:

- **Introduce High Deductible Health Plan (HDHP) with Blue Cross Blue Shield (BCBS) and employee-funded Health Savings Account (HSA) with Health Equity. Employee will contribute 10% toward the cost of medical coverage for this plan.**
- **The medical opt out credit will be eliminated as of January 1, 2015.**
- **Increase AD&D coverage from $25,000 to one times base salary.**
- **Implementation of the following Prescription Drug Programs with CVS Caremark (refer to the Prescription Drug Benefits section for further information):**
  - **Mandatory Mail Program.** Members are required to fill a 90-day supply of a maintenance medication at either CVS Mail Order or CVS Pharmacy.
  - **Generic Step Therapy.** This is a strategy to encourage the use of generics and requires that a member has either tried or chosen a generic or preferred brand product when filling his or her prescription.
  - **Specialty Preferred Drug Therapy.** This program encourages the use of preferred specialty medications for specific therapeutic classes. The preferred drugs are well-supported treatment options and represent the most cost-effective medications for a given condition.

Due to new Health Care Reform requirements, the following changes will also become effective January 1, 2015:

- **Coverage for clinical trials.** Plans will now offer coverage for individuals participating in approved clinical trials.
- **In-network preventive care coverage covered at 100%.** Will now provide, without any cost sharing, certain preventive care, including well-child care, certain

immunizations/screenings and other items required by the Patient Protection and Affordable Care Act (the Affordable Care Act).

- **Expanded preventive care coverage for women.** The following preventive services for women are required to be covered at 100%:
  - Well-woman visits
  - Gestational diabetes screening
  - HPV DNA testing
  - Sexually transmitted infection counseling
  - HIV screening and counseling
  - FDA-approved contraception methods and contraceptive counseling
  - Breastfeeding support, supplies and counseling
  - Domestic violence screening and counseling

  To confirm coverage levels for these services, please contact your health plan.
- **Removal of dollar limits on Essential Health Benefits**. All annual and lifetime maximums will be removed on benefits that are deemed Essential Health Benefits per Health Care Reform. Several National Grid plans already meet this requirement. The ten categories deemed to be Essential Health Benefits are:
  - Ambulatory patient services
  - Emergency Services
  - Hospitalization
  - Maternity and newborn care
  - Mental health and substance abuse disorder services
  - Prescription drugs
  - Rehabilitative and habilitative services and devices
  - Laboratory services
  - Preventive wellness and chronic disease management
  - Pediatric services including oral and vision care

BCBSMA PPO:

- **Medical plan design changes**
  - Increase office visit co-payment from $20 to $25, Specialty visit from $20 to $30.
  - Add in-network out-of-pocket maximum of $6,350 individual/$12,700 family (including both medical and prescription co-payments and coinsurance for accumulation to a combined maximum)

- Increase the out-of-network deductible from $300 individual/$600 family to $500 individual/$800 family.
- Emergency Room from 100% covered to $100 co-payment (waived if admitted).
- Change MRI/CT/PET scans and nuclear imaging from 100% covered to $50 co-payment (waived if service is received at a free standing facility) Note: Non-hospital settings may not be available in all geographic areas and they also may not provide all types of imaging.

- **Change in prescription co-payment**
  - Increase retail prescription co-payment from $20 generic/$30 formulary/$30 non-formulary to $20/$30/$50.
  - Increase mail order prescription co-payment from $20 generic/$30 formulary/$30 non-formulary to $40/$60/$100.

BCBSMA and Regional POS plans:

- **Medical plan design changes**
  - Increase office visit co-payment from $10 to $20, Specialty visit from $10 to $25.
  - Add in-network out-of-pocket maximum of $500 individual/$500 family (including both medical and prescription co-payments and coinsurance for accumulation to a combined maximum, except for Health New England as stated above).
  - Increase out-of-network deductible from $200 individual/$400 family to $500 individual/$800 family.
  - Change Emergency Room from 100% covered to $75 co-payment (waived if admitted).
  - Change MRI/CT/PET scans and nuclear imaging from 100% covered to $25 co-payment (waived if service is received at a free standing facility) Note: Non-hospital settings may not be available in all geographic areas and may not provide all types of imaging.
  - Change inpatient hospital from 100% covered to $250 co-payment.
  - Change outpatient surgery from 100% covered to $150 co-payment.
- **Change in prescription co-payment**
  - Increase retail prescription drug co-payment from $10 generic/$10 formulary/$30 non-formulary to $10/$20/$50.
  - Increase mail order prescription co-payment from $10 generic/$10 formulary/ $30 non-formulary to $20/$40/$100.

Open Enrollment at National Grid

DURING OPEN ENROLLMENT, YOU MAY:

- Change your current medical and/or dental coverage.*
- Opt out of medical coverage and receive an opt-out credit (if eligible) if you are covered under another medical plan.*
- Change the dependents you cover in the medical and/or dental plans.*
- Enroll in a Health Care Spending Account (HCSA) for 2015.*
- Enroll in the Dependent Care Reimbursement Account (DCRA) for 2015.*
- Elect to purchase optional life insurance and/or voluntary AD&D insurance through MetLife. (Employees represented by Steelworkers 12431 are not eligible for these benefits.)
- Purchase additional vacation days.* (Employees represented by of New York Union and Steelworkers 12431 are not eligible for this benefit.)

You will need to call the Mercer Benefits Service Center at 1-866-294-8052 or visit the Web site at **www.NationalGridEmployeeServices.MercerHRS.com by October 31, 2014.*

Making Changes During the Year

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

IF YOU MISS THE ENROLLMENT DEADLINE

If you miss the enrollment deadline, your current medical and dental elections will continue for 2015. However, you will not be able to participate in the Health Care Spending Account or the, Dependent Care Reimbursement Account, nor will you be allowed to purchase additional vacation days. (Employees represented by New York Union and Steelworkers 12431 are not eligible to purchase additional vacation days.) You must re-enroll each year to participate in these plans.

If You Want to Opt Out of Medical Coverage

If you elected to opt out of medical coverage in 2014, and received the opt-out credit and want to opt out again in 2015, you must make an active election to opt out of medical coverage during Open Enrollment. If you do not actively elect to opt out and you do not enroll in a medical plan during Open Enrollment, you will not receive medical benefits for 2015 and you will not receive an opt-out credit (if eligible). (See page 20 for more information.)

DEFAULT COVERAGE

If you do not take any action before October 31, and you are already eligible for and enrolled in subsidized medical and dental coverage, you will default to the following plan elections:

Default Benefit Plans	
Medical (If elected in 2014)	The coverage you had in 2014
Dental (If elected in 2014)	The coverage you had in 2014
Flexible Spending Accounts • **Health Care** • **Dependent Care**	 Waive-No Coverage Waive-No Coverage
Optional Life Insurance	The coverage you had in 2014.
Vacation Purchase	No Purchase

Important Enrollment Information

WHO IS ELIGIBLE?

All regular full-time 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 Regarding 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 following the close of Open Enrollment with instructions for submitting the appropriate documentation to verify eligibility.

MEDICAL

In addition to yourself, the following family members are eligible to enroll in some of the benefit options available to you:

- Your legally married spouse, including same-sex spouse (if you were married in a state that recognizes same-sex marriage, regardless of where you actually reside), or qualified same-sex domestic partner* (if you live in a state that does not recognize same-sex marriage).
- Your child(ren) who are under the age of 26, married or unmarried regardless of full-time student or tax dependent status. A child includes:
  - Natural child(ren), legally adopted child(ren) or child(ren) placed with you pending legal adoption, child(ren) for whom you or your spouse serve as legal guardian, step-child(ren), eligible foster child(ren), child(ren) of a domestic partner* or same-sex spouse.

    **Note: Grandchild(ren) are not eligible for coverage unless adopted or legal guardian.*
- 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.

Important Note Regarding Dependent Children

You must elect coverage for your same-sex domestic partner if you want to elect coverage for his/her dependent child(ren).

**Coverage for same-sex domestic partners is only available to members of New England Union and Steelworkers 12431 who do not reside in a state that recognizes same-sex marriage.*

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.

Note: Spouses of married dependents and child(ren) of dependents are NOT eligible for coverage.

DENTAL AND LIFE INSURANCE

The following family members are eligible for dental and life insurance:

- Your legally married spouse, including same-sex spouse (if you were married in a state that recognizes same-sex marriage, regardless of where you actually reside), or qualified same-sex domestic partner* (if you live in a state that does not recognize same-sex marriage).
- Your dependent child(ren), including your unmarried natural child(ren), step-child(ren), eligible foster child(ren), legally adopted child(ren), child(ren) placed with you pending legal adoption, and child(ren) for whom you or your spouse serve as a legal guardian. This also includes your same-sex spouse's or same-sex domestic partner's* dependent child(ren).

  **Note: Grandchild(ren) are not eligible for coverage unless adopted or legal guardian.*
- Dependent child(ren) are covered until:
  - For New England Union and New York Union: Dependent child(ren) are covered until December 31 of the year in which the child attains age 19 (21 for life insurance) or until midnight prior to their 25th birthday if a full-time student.
  - Steelworkers 12431: Dependent child(ren) are covered until December 31 of the year in which the child attains age 19 or until midnight prior to their 25th birthday if a full-time student. Annual certification is required to confirm a child's continuing full-time student status. (Note: eligible for supplemental life insurance.)

Special Tax Considerations for Covering Same-Sex Domestic Partners*

If you are covering a same-sex domestic partner and his/her child(ren), the cost of coverage for those individuals will be deducted from your paycheck on an after-tax basis, per IRS regulations. In addition, the Company-paid portion of medical or dental coverage for your same-sex domestic partner and his/her child(ren) will be considered taxable income to you. This information will appear on your W-2 form and the appropriate taxes will be withheld from your pay. To learn more about these regulations, you may want to consult a legal or tax professional for advice.

* *Coverage for same-sex domestic partners is only available to members of New England Union and Steelworkers 12431 who do not reside in a state that recognizes same-sex marriage.*

WHEN YOUR COVERAGE BEGINS

The elections you make during this Open Enrollment period will take effect on January 1, 2015 and will remain in effect through December 31, 2015.

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

Beginning October 17, when you log on to **www.NationalGridEmployeeServices.MercerHRS.com** the 2015 costs will be displayed for each of your medical, dental, and vacation purchase benefit options, as well as the coverage levels available to you. Optional life insurance, and voluntary accidental death and dismemberment (AD&D), are provided through separate enrollments for these benefits and MetLife will send you information upon request.

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

Pre-Tax Contributions Apply to These Benefits:	After-Tax Contributions Apply to These Benefits:
• Medical coverage • Dental coverage • Purchased vacation days (if eligible) • Health Care Spending Account (HCSA) • Dependent Care Reimbursement Account (DCRA)	• Optional life insurance • Dependent life insurance • Voluntary AD&D coverage

BENEFITS FOR PART-TIME EMPLOYEES

If you are a part-time employee represented by a New England Union or New York Union scheduled to work at least 20 hours per week, you are eligible for the same benefits as regular, full-time employees. (Employees represented by Steelworkers 12431 are not eligible for this benefit.) Generally, your cost will be pro-rated based on your normal work schedule.

The Company contribution towards medical and/or dental coverage would be:

Weekly Work Schedule	Company Contribution*
20 – 24 hours	60%
25 – 31 hours	80%

*of employer portion

Paying With Pre-Tax Dollars: What It Means
Paying with pre-tax dollars means that you pay less in taxes because your income is lower for tax calculation purposes. It's important to note that because you don't pay Social Security taxes on pre-tax contributions, your Social Security benefits at retirement or disability may be slightly reduced. Any reduction, however, will be minimal and will probably be offset by your current tax savings. For example, for tax purposes, 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.

IMPUTING INCOME FOR FORMER SPOUSES (NOT APPLICABLE TO EMPLOYEES REPRESENTED BY THE NEW YORK UNION)

Employees will be taxed on the value of any benefit provided for a former spouse still covered by their National Grid benefits, according to IRS provisions. To determine the total taxable amount (i.e., the imputed income), multiply the per-pay-period total value of your former spouse's current National Grid benefit coverage (weekly costs) by the number of pay periods in a year (i.e., 52). To determine the amount of taxes you would owe, see the weekly pay period example below.

HOW TO DETERMINE THE TAX ON IMPUTED INCOME

Assuming a weekly imputed income of $103.85 ($450.00 a month x 12 months ÷ 52 pay weeks), a federal income tax rate of 25%, and a state income tax rate of 6%:

- **Step 1:** Determine your federal income tax rate by multiplying your weekly imputed income by the federal income tax percentage.

  $103.85 x 25% (federal tax rate) = $25.96 weekly

- **Step 2:** Determine your state income tax by multiplying the weekly imputed income amount by the state income tax percentage.

  $103.85 x 6% (state tax rate) = $6.23

- **Step 3:** Determine your FICA taxes by multiplying your weekly imputed income by 7.65%.

  $103.85 x 7.65% (FICA tax rate) = $7.94

- **Step 4:** Add your results from Steps 1-3. The total is the amount of tax you would pay weekly on the imputed income.

  $25.96 (federal taxes) + $6.23 (state income taxes) + $7.94 (FICA taxes) = $40.13

MAKING CHANGES DURING THE YEAR

The benefit elections you make during this Open Enrollment period will stay in effect throughout the 2015 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 and documented proof of the qualified life event(s) will be required:

Choose Well

Choose well means enrolling in the right benefits for you and your family. It is important for you to consider your/your family's own needs for the upcoming year when making your elections for eligible benefits. The information in this guide together with your comparison chart provides a summary overview of many benefits and highlights what's new and changing in 2015.

- Marriage, legal separation, divorce, birth, adoption or death of a spouse*/same-sex domestic partner** or child, or a change in the eligibility of a covered dependent
- Your spouse*/same-sex domestic partner** gains or loses employment
- You or your spouse*/same-sex domestic** partner changes from part-time to full-time employment status or vice versa
- You or your spouse*/same-sex domestic partner** takes an unpaid leave of absence
- You or your spouse*/same-sex domestic partner** experiences a significant change in health coverage due to your spouse's/same-sex domestic partner'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.

Although National Grid can permit coverage changes, it cannot permit changes to the pre-tax elections made during the Open Enrollment period for domestic partner events.

The benefit change you make must reflect the change in status that you experience. For example, if you get married mid-year, you may add your spouse* to your current coverage, but you may not change medical plans. **If you experience a life or work event, you must contact the Mercer Benefits Service Center at 1-866-294-8052**.

* *Your legally married spouse, including same-sex spouse (if you were married in a state that recognizes same-sex marriage, regardless of where you actually reside).*

** *Coverage for same-sex domestic partners is only available to employees represented by a New England Union and Steelworkers 12431 who do not reside in a state that recognizes same-sex marriage.*

Your 2015 Benefit Choices

The chart below summarizes the benefits in which you may be eligible to enroll. You may also change your elections for the following benefits during the Open Enrollment period.

Summary of Benefit Options for Employees Represented by a New England Union or New York Union (Except Steelworkers 12431)	
Health Care Benefits • Medical plan options (including prescription drug and mental health benefits) – High Deductible Health Plan (HDHP) with Health Savings Account (HSA)* **Note: HDHP/HSA not for New York Union* – National Preferred Provider Organization (PPO) Plan – Regional Point-of-Service (POS) Plans • Opt-out credit only for Local 97	**Flexible Spending Accounts** • Health Care Spending Account (HCSA) • Dependent Care Reimbursement Account (DCRA)
Dental Benefits • Dental Plan	**Time Off** • Purchase vacation days*
Life Insurance • Optional life insurance coverage • Voluntary accidental death and dismemberment (AD&D) coverage	**Long-Term Care Insurance Program** • Only available to currently enrolled participants. Please contact CNA directly at 1-877-777-9072 to change or cancel your current coverage • Employees represented by Local 97 may contact CNA directly at 1-877-777-9072 to enroll in coverage or can obtain enrollment information online at www.cna.com/groupltc (password: natlgrid)

Summary of Benefit Options for Steelworkers 12431	
Health Care Benefits • Medical plan options (including prescription drug and mental health benefits) – High Deductible Health Plan (HDHP) with Health Savings Account (HSA) – National Grid Custom Choice PPO Plan – National Grid PPO Plan for Steelworkers 12431	**Flexible Spending Accounts** • Health Care Spending Account (HCSA) • Dependent Care Reimbursement Account (DCRA)
Dental Benefits • Dental Plan	
Life Insurance • Company-Provided Life Insurance • Voluntary accidental death and dismemberment (AD&D) coverage	

*Only available to New England unions

Medical Plan Options

You can choose from a variety of medical plans. All represented employees are eligible for one or more Preferred Provider Organization (PPO) plans, which are administered by Blue Cross Blue Shield of Massachusetts (BCBS). If you are an employee represented by a New England Union (with the exception of Steelworkers 12431) or New York Union, you also have access to several Point-of-Service (POS) plans. The POS plans include a number of local or regional plans. A summary of both types of plans is provided below. Refer to *A Comparison of National Grid Plan Benefits* included in this Enrollment Kit for more details about the plans available to you, including information on your deductibles, co-insurance and co-payments.

Here's a Tip: Play an Active Role

Patients who ask questions are more satisfied with their care and see more of an improvement in their health than patients who do not.

HIGH DEDUCTIBLE HEALTH PLAN (HDHP)

(NOT AVAILABLE TO NEW YORK UNION)

Similar to PPO and POS plans, the HDHP is a health plan that includes comprehensive coverage for medical, prescription drug and mental health / substance abuse. However, the HDHP allows you more control over your health care dollars. Through this plan you can choose to trade lower pre-tax paycheck contributions for potentially higher costs at the point of care. Additionally, when you enroll in the HDHP you have access to a Health Savings Account (or HSA), a valuable tool to help pay for health care expenses with tax-free dollars. You can use an HSA to build savings for future health care costs (such as in retirement) as well as offset current health care costs. The tax-free dollars in an HSA roll over from year to year — unlike other tax-advantaged health care accounts, the HSA has no IRS "use it or lose it" rule. The dollars are yours until you decide to use them. You can read more about the HSA on page 16.

Similar to the PPO plan, with the HDHP you may receive care from any doctor or specialist, but if you choose a preferred provider (also called an in-network provider) for a covered service, your out-of-pocket costs will be lower than if you chose a non-preferred provider (also called an out-of-network provider).

A Different Way to Budget

The logic behind the HDHP with HSA is that you save money in paycheck contributions and instead use those funds towards any health care services you receive.

Paycheck contributions are significantly lower because you are agreeing to pay a higher deductible. You can also find added savings if you contribute tax-free dollars to an HSA and use those funds to pay for eligible health care expenses.

On the surface the deductible seems high, but the reality is that you're paying less out of your paycheck and can use tax free money from an HSA if you need care.

When you join a HDHP:

- Certain in-network annual preventive visits, related routine tests, and immunizations subject to a schedule are covered at 100% with no deductible or coinsurance.

- For all non-preventive care services (including the cost for prescription drugs), you pay 100% of the cost up to the **annual deductible**. **The entire family deductible must be satisfied before benefits are provided for any one member enrolled under a family membership.**
- After you satisfy the deductible, you and National Grid share in the cost of medical services AND prescription drugs through coinsurance.
- If your total expenses (deductible plus co-insurance) for medical services and prescription drugs reach your **out-of-pocket maximum**, National Grid will fully cover all eligible expenses at 100% – that means you pay nothing else for the rest of the plan year. **The entire family out-of-pocket maximum must be satisfied before any one member enrolled under a family membership receives full benefits.**
- If you use a non-preferred provider:
  - Your cost will be based on allowed charges, including your co-insurance and any amounts that exceed allowed charges.
  - You will use a BCBS claim form to submit a claim for reimbursement.

Nearly all the providers National Grid employees currently use are in the BCBS network. You can confirm that your doctor participates by checking the BCBS Web site at **https://www.bluecrossma.com/wps/portal/members/using-my-plan/doctors-hospitals/findadoctor** and searching in the BlueCard network.

FREQUENTLY ASKED QUESTIONS

Who is eligible to open and contribute to a Health Savings Account (HSA)?

"Eligible individuals" are any individuals who are:

- Covered under a high deductible health plan (HDHP).
- Not covered by any other health plan that is not a HDHP (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 an HDHP.
- Not enrolled in Medicare, including Part A.
- Not be claimed as a dependent on another person's tax return.
- Veterans who have not received treatment through the Veteran's Administration other than preventive care, within the last 3 months.

Will the health FSA impact employees' HSA eligibility?

Yes. Individuals enrolled in a traditional FSA – whether through their own or their spouse's employer – are not HSA eligible until the end of the health FSA plan year (including an IRS compliant two and one-half-month grace period if included in the health FSA plan). The plan year of a traditional health FSA with such a grace period ends March 15. Since HSA eligibility is determined as of the first day of the month, an enrollee cannot become HSA eligible until April 1. He cannot open or contribute to his HSA and he cannot ever reimburse any expenses that he incurs before April 1. In order to be eligible to make contributions prior to April 1 you must

spends the FSA balance by December 31. If a participant spends his entire FSA election by December 31, he can become HSA eligible January 1.

What are the costs for prescription drugs under the HDHP?

Prescription drug coverage for the HDHP is administered by CVS Caremark. Prescription drug expenses also count toward your annual deductible and out-of-pocket maximum. This means that you will pay the full cost of your prescriptions until you meet your plan's annual deductible. For certain preventive medications, the deductible is waived under the HDHP. Coinsurance applies after the deductible is met.

HEALTH SAVINGS ACCOUNT (HSA)

The HSA, administered by HealthEquity, is a great way to pay for current and save for future eligible healthcare expenses. You must enroll in the HDHP and meet certain eligibility requirements to open an HSA. Your contributions will be automatically deducted from each paycheck on a pre-tax basis or you can elect to contribute amounts outside of the payroll process entirely. You can change your contribution amount at any time during the year.

HSA Contribution Limits

The IRS limits your maximum annual HSA contribution. For 2015, the annual limits are $3,350 for individual coverage and $6,650 for family coverage. Once you are age 55, and each year thereafter, you are eligible to make an additional annual "catch up" contribution of up to $1,000 to your HSA for that year.

FIVE BENEFITS OF THE HSA

1. **You can use your HSA for 2015 eligible healthcare expenses – even after you incur them.** You can put your HSA dollars toward your deductible and other eligible medical, prescription, dental and vision expenses.

   Unlike a Flexible Spending Account (FSA), you can contribute to your HSA *after you incur out-of-pocket costs* and then use those tax-free dollars to reimburse yourself. So, even if you have unexpected healthcare costs in 2015, you can contribute additional money to your HSA to pay for those expenses.
2. **You can roll over dollars you don't use.** Unused money rolls over from year to year, which helps you build savings for future eligible healthcare expenses. You can also use dollars in your HSA to pay for eligible expenses in future years even if you're not enrolled in the HDHP at the time. Through HealthEquity, you have the option to invest HSA dollars and potentially grow your account. More information is available at www.bluecrossma.com/hdhpnationalgrid
3. **You can take it with you.** The money in your HSA is always yours, so you can take your unused balance when you retire or leave National Grid.
4. **Triple-tax advantages.** You never pay taxes on your HSA dollars as long as you use them to pay for eligible health care expenses. You won't be taxed when you make contributions, as your account grows with interest, or when you withdraw the money to pay for eligible expenses.
5. **It's convenient.** You can use the HSA Debit Card from HealthEquity and/or you can pay providers online (just like online banking) to use your HSA to pay for eligible healthcare expenses.

Tools and Resources

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

PREFERRED PROVIDER ORGANIZATION (PPO) PLAN

When you enroll in a PPO plan, you can choose your own doctors and specialists from a comprehensive list of participating preferred providers (sometimes called network providers). You can also choose to see a physician who is not part of the PPO network under this option (a "non-preferred" provider). Out-of-network care provided by a non-preferred provider is subject to benefit management procedures and you pay more for care.

When you join a PPO plan:

- You are not required to select a primary care physician (PCP).
- You can see any network specialist you choose and you do not need to be referred by a PCP.
- You are covered for certain routine care, such as physicals and eye exams, subject to a schedule.
- If you use a preferred provider:
  - Your out-of-pocket costs will be lower because BCBS has negotiated reduced rates with their preferred providers.
  - You have no claim forms to fill out and send to BCBS.
- If you use a non-preferred provider:
  - Your cost will be based on allowed charges, including your co-insurance and any amounts that exceed allowed charges.
  - You will use a BCBS claim form to submit a claim for reimbursement.
- Nearly all the providers National Grid employees currently use are in the BCBS network. You can confirm that your doctor participates by checking the BCBS Web site at **https://www.bluecrossma.com/wps/portal/members/using-my-plan/doctors-hospitals/findadoctor** and searching in the BlueCard network. For general information about BCBS, visit **www.bluecrossma.com**.

POINT-OF-SERVICE (POS) PLAN

If you join a POS plan, you can choose to receive care from participating in-network providers and pay less for your care, or you can choose to receive care from any provider outside the network and pay more. Out-of-network care is subject to each plan's policies.

When you join a POS plan:

- You choose a primary care physician (PCP), who coordinates your care in-network.
- You can choose to receive care from participating in-network doctors and the plan will pay 100% of eligible expenses after you pay the applicable co-payment, if any.
- Alternatively, you can use out-of-network providers and the plan will pay a percentage of eligible expenses after you pay your annual deductible.
- You are covered for routine care, such as physicals and eye and hearing exams, when you receive these services from in-network providers.
- You must follow the plan's procedures for filing claims when you receive care outside of the network, or you may be subject to a penalty.
- Nearly all the providers National Grid employees currently use are in the BCBS network. You can confirm that your doctor participates by checking the BCBS Web site at **https://www.bluecrossma.com/wps/portal/members/using-my-plan/doctors-hospitals/findadoctor** and searching in the BlueCard network. For general information about BCBS, visit **www.bluecrossma.com**.

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

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

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

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

SPECIAL NOTICE REQUIRED BY HEALTH CARE REFORM

GRANDFATHERED PLAN STATUS

National Grid believes the NY Union medical plans are “grandfathered health plans” under the Affordable Care Act. A grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime and annual limits on benefits.

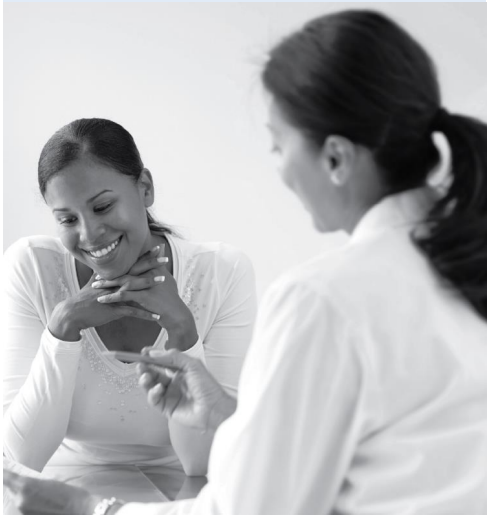
Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the TDC at 1-888-4TDC-123. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or **www.dol.gov/ebsa/healthreform**.

Important Note for Massachusetts Residents Who Opt Out of Medical Coverage

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

To avoid tax penalties, you will be required to provide 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 2015, you will receive the Form MA 1099-HC that will indicate you have creditable coverage. Use this form when filing your 2014 taxes.

For more information, visit **www.mahealthconnector.org** or call the Mercer Benefits Service Center at 1-866-294-8052.



OPTING OUT OF MEDICAL COVERAGE

If you have coverage under another medical plan (for example, through your spouse's employer), you may elect to decline coverage through the Company and receive an opt-out credit in the form of additional taxable cash compensation, payable according to your collective bargaining agreement (summarized below). To receive this benefit, you must actively enroll in the opt-out credit and re-enroll each year. If you do not enroll, you will not receive your additional cash payment for the year. To receive the opt-out credit for 2015, you must elect "no coverage" for your medical coverage by the enrollment deadline, October 31, 2014.

How are you spending time?

People spend an average of 6.8 hours researching buying a car, 4.9 hours holiday shopping, and 1.3 hours buying a pair of shoes, according to Guardian Life industry data. And on average, people are spending about 1.4 hours reviewing their benefits plans.

It takes time to make sure your needs are covered. Smart benefit decisions may not have that "new car smell"—but peace of mind is an accessory that doesn't wear off quickly. The choices you make—or don't make—during Open Enrollment will impact you and your family for the next year. Take the time to give your benefits a thorough check-up this year.

By declining medical coverage, you will have no medical benefits through the Company for yourself or your family. In addition, you will not have prescription drug coverage. If you are an employee represented by the New York Union, you (employee only) will only have managed mental health coverage.

If you lose your other coverage or experience a qualified life event during the year, you may enroll yourself and your dependents in a Company-sponsored medical plan **within 31 days** of the loss of coverage.

If you opt out and later enroll in a Company-sponsored medical plan due to a qualified life event, your opt-out benefit will end as of the effective date of the change. Your paycheck will reflect the contributions you are required to make by enrolling in a medical plan.

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

Opt-Out Credit (Only Available to Employees Represented by the New York Union)	
Availability	Available if you have coverage under another medical plan, for example, through your spouse's employer, even if your spouse is employed by National Grid.
Benefit	**Employees Represented by the New York Union:** The Company pays up to $600 per year in equal installments, payable as taxable income in your paycheck.

Prescription Drug Benefits

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

Here's a Tip: Use Generic Drugs Whenever Possible

Generic drugs are as effective as brand-name drugs but almost always cost less. If you take a brand-name drug, talk with your health care provider to determine if a generic equivalent might be a smarter choice for you.

FILLING PRESCRIPTIONS THROUGH CVS CAREMARK

NEW YORK UNION (LOCAL 97)

Your prescription drug coverage includes a retail prescription drug program and a mail order prescription drug service, both of which are administered by CVS Caremark. The amount you pay for your prescriptions will vary depending on the type of drug you use and the way you fill your prescription (at a retail pharmacy or through mail order). When you use a participating retail pharmacy or the mail order service, your co-payment applies as outlined in the enclosed *A Comparison of National Grid Plan Benefits*.

Retail Pharmacy Benefits: Prescriptions filled at a retail pharmacy are generally based on a 30-day supply. Show your prescription drug ID card and you can purchase prescription drugs at participating CVS Caremark network pharmacies (including national chains like CVS, Walgreens, Rite-Aid, and most other retail pharmacies).

Mail Order Pharmacy Benefits: If you have a recurring prescription for a "maintenance" medication (such as for high blood pressure or diabetes), you may be able to fill your prescription through a mail order drug program. Prescriptions filled through a mail order program are based on a 90-day supply. Please refer to *A Comparison of National Grid Plan Benefits* to review the specifics of your mail order benefit.

APPLICABLE TO ALL UNIONS EXCEPT NEW YORK UNION

Fill a 30-day supply of medication at a network pharmacy. Show your prescription drug ID card and you can purchase prescription drugs at participating CVS Caremark network pharmacies (including national chains like CVS, Walgreens, Rite-Aid, and most other retail pharmacies).

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

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

The mail order co-payment will be the same, regardless of which fill method you use; home delivery or CVS retail pick-up.

Failure to fill maintenance medications as outlined above will result in you being charged for 100% of the cost at 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 to avoid paying full cost for your prescriptions.

Choose what is more convenient for you

At a CVS/pharmacy You May:	With CVS Caremark Mail Service You May:
• Pick-up your long-term medication directly from the pharmacy at a time that is convenient for you	• Enjoy convenient home delivery
• Enjoy same-day prescription availability	• Receive medication in confidential, tamper-resistant and (when necessary) temperature-controlled packaging
• Talk face-to-face with a pharmacist	• Talk to a pharmacist by phone

PHARMACY PROGRAMS (APPLICABLE TO ALL UNIONS EXCEPT NEW YORK UNION)

GENERIC STEP THERAPY

This new prescription program encourages members to utilize more cost effective first-line generics and provides coverage for one preferred select brand in most classes. The preferred select brand is determined by clinical effectiveness based on FDA approved indications, lowest net cost and/or shortest remaining patent life. For some classes, such as the PPI class where sufficient generics are available, a generic trial is required before any single source brand is covered.

Generic Step Therapy requires that a cost-effective generic alternative is tried first before a single-source brand is covered. Here is how it works:

When a prescription for a targeted 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 will be paid. If there is no history of a generic trial, the pharmacist will receive a message for the prescriber to call a toll-free number for more information. In the event that the prescriber advises CVS Caremark that a generic alternative is not right for the member, he or she can call the Prior Authorization Department.

This program is intended to actively educate members and prescribers with regards to clinically appropriate medications, and to guide them to more cost-effective options.

SPECIALTY PREFERRED DRUG PROGRAM

Another new prescription drug program is designed to help prescribers select the most clinically effective therapy, at the lowest cost in specific specialty therapeutic categories. The preferred medication is a well-supported treatment option and represents the most cost-effective medication. The Specialty Preferred Drug Program will apply to the following specialty medication categories: multiple sclerosis, auto-immune medications (medications used to treat Crohn's disease, psoriasis, rheumatoid arthritis).

When/if you present a prescription for preferred specialty medication, the prescription will automatically be approved. When/if you present a prescription for a non-preferred specialty medication, 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, he or she 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.

Dental Plan

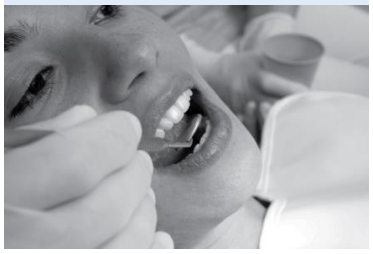
When you participate in the dental plan, you can choose to receive care from a broad network of providers or from any provider outside the network. Dental coverage is administered by Delta Dental of Massachusetts.

The dental plan covers the following types of dental services:

- Diagnostic and Preventive Services:
  - Exams
  - Cleanings
  - X-rays
- Basic Restorative Services:
  - Fillings
  - Oral surgery
  - Root canal treatment
- Major Restorative Services:
  - Inlays
  - Crowns
  - Dentures
  - Bridgework

Here's a Tip: Get a Regular Dental Check-up

Did you know that getting a preventive dental check-up can help detect early signs of dental disease? Schedule a dental appointment and help reduce future cost and stress.



ORTHODONTIA BENEFITS

The plan also covers orthodontia for eligible family members as described below:

- **Steelworkers 12431:** Dependent child(ren) are covered until December 31 of the year in which the child attains age 19 or until midnight prior to their 23rd birthday if a full-time student.
- **New England Union**: Dependent child(ren) are covered until December 31 of the year in which the child attains age 19 or until midnight prior to their 25th birthday if a full-time student.
- **New York Union:** Dependent child(ren) are covered until December 31 of the year in which the child attains age 19 or until midnight prior to their 25th birthday if a full-time student.

Please refer to *A Comparison of National Grid Plan Benefits* for coverage levels and examples of the types of services provided.

Flexible Spending Accounts

National Grid offers two flexible spending accounts:

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

Using Your HCSA

Your total annual contribution is available for reimbursement on January 1, 2015. Your annual contribution election will be deducted in equal installments each pay period before applicable payroll taxes are deducted.

You may contribute to one or both flexible spending accounts. However, you must enroll each year to participate. Participation does not automatically continue from year to year. Beginning January 1, 2015, WageWorks will replace Ceridian as the administrator for both spending accounts on behalf of National Grid. See page 38 for contact information.

With a flexible spending account, you save because the money in your account is never taxed — when it goes into your account, or when you withdraw it to reimburse yourself for eligible expenses.

HEALTH CARE SPENDING ACCOUNT

With the HCSA, you can set aside up to $2,500 each year through pre-tax payroll deductions to help you save to pay for eligible health care expenses which are not otherwise covered by your health care plans.

The $2,500 cap applies on a per-employee basis. If an employee and his/her spouse are both employees of National Grid and are eligible to make contributions to the HCSA, each person may elect to contribute up to the $2,500 limit.

**Note: the HCSA is not available if you elect the High Deductible Health Plan.*

Eligible Health Care Spending Account Expenses

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

For a complete list of eligible and ineligible expenses, contact Ceridian (see page 38 for contact information), contact the IRS toll-free at 1-800-829-3676 and ask that Publication 502 be sent to you free of charge, or visit **www.irs.gov**.

DEPENDENT CARE REIMBURSEMENT ACCOUNT

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

Dependent Care Tax Credit

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

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

Eligible Dependent Care Reimbursement Account Expenses

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

For a complete list of eligible and ineligible expenses, contact Ceridian (see page 38 for contact information), contact the IRS toll-free at 1-800-829-3676 and ask that Publication 503 be sent to you free of charge, or visit **www.irs.gov**.

USING YOUR DCRA

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

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

ADDITIONAL FLEXIBLE SPENDING ACCOUNT RULES

- **Contributions.** Once you enroll in either (or both) the health or dependent care account, you may not change or stop your contributions until the next Open Enrollment period (unless you experience a qualified life event as indicated on page 12).
- **Reimbursement.** To be reimbursed for eligible health or dependent care expenses incurred between January 1, 2015 and March 15, 2016, obtain the applicable reimbursement claim form by visiting **https://www.wageworks.com/employees/support-center/important-forms.aspx**. Submit your completed form along with a receipt or proof of payment (including the Explanation of Benefits (EOB) if provided by a health plan). WageWorks will then reimburse you for your eligible out-of-pocket expenses up to the total amount of your HCSA contribution election or your DCRA balance. (Note: your 2014 account balance on December 31, 2014 will be transferred to WageWorks for claims incurred but not submitted for plan year 2014.) Information regarding online reimbursement will be available in November 2014 via a separate announcement.
- **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, 2016 to submit claims for all eligible expenses incurred between January 1, 2015 and March 15, 2016. That's why it's important to carefully consider the amount you will use over the course of the year before contributing to either account.

If You Have Questions

If you have any questions regarding your flexible spending accounts during Open Enrollment, please contact the Ceridian Claim Administration Department at 1-877-799-8820 between 8 a.m. and 8 p.m. ET, Monday through Friday.

Beginning January 1, 2015, please contact WageWorks at 1-855-774-7441.

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.

CONTINUING PARTICIPATION IF YOU TERMINATE YOUR EMPLOYMENT

Terminated or retired employees may choose to continue funding their health care spending account on an after-tax basis by electing continued coverage through COBRA. Details will be included in the Ceridian COBRA package.

National Grid's Commitment to Health and Wellbeing

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

HEALTH & WELLNESS RESOURCE CENTER

www.bluecrossma.com/nationalgrid

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

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

Live Well

Live well includes taking control of your/your family's physical, mental and financial health. Take the time to put wellness into your daily activities. Taking advantage of the various health/wellness programs offered by our health providers, and maintaining appropriate optional life insurance can help to positively influence your physical and mental wellbeing.

PERSONAL HEALTH ASSESSMENT

www.bluecrossma.com/nm/national-grid/healthy-weight.html

You can take the first step to better health by taking a personal health assessment. Upon completion of the confidential questionnaire, you will receive a personalized report and recommendations for appropriate health improvement goals.

QUITNET — SMOKING CESSATION

www.bluecrossma.com/nm/national-grid/quitting-smoking.html

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

CORPORATE COUNSELING ASSOCIATES (CCA) — WORK/LIFE ASSISTANCE

National Grid's Employee Assistance Program, CCA, can be reached at 1-800-833-8707or online at **www.powerflexweb.com/1073/login.html**. (Company code: National Grid)

GLOBAL FIT

https://www.globalfit.com/club/gyms.asp

Get discounts on gyms and information on exercise, weight loss and nutrition.

INJURY PREVENTION FOR FIELD EMPLOYEES

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

Did You Know?

56% of all injuries reported at National Grid are soft tissue related. Soft tissue injury is the damage of muscles, ligaments and tendons throughout the body. Stretching and flexing before work can significantly reduce your risk of soft tissue injury.

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

Life Insurance

COMPANY-PROVIDED BASIC LIFE INSURANCE

The life insurance program pays a benefit to your designated beneficiary if you die.

- **New York Union:** You automatically receive Company-provided life insurance coverage equal to either one and a half times base pay (Plan A) or two and a half times base pay (Plan B).

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.

- **New England Union:** You automatically receive Company-provided life insurance coverage equal to two times your base pay.
- **Steelworkers 12431:** You automatically receive Company-provided life insurance coverage in a flat-dollar amount equal to $90,000.

OPTIONAL LIFE INSURANCE

(EMPLOYEES REPRESENTED BY THE STEELWORKERS 12431 ARE NOT ELIGIBLE FOR THIS BENEFIT)

If you want additional life insurance, you can purchase optional life insurance for yourself at discounted group rates. You can also purchase optional life insurance for your spouse, children, or both at discounted group rates.

- You can purchase up to five times your annual base pay in optional life insurance for yourself. 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.
- You can purchase either $25,000 or $50,000 in optional life insurance for your spouse.
- You can purchase $2,500, $4,000 or $10,000 in optional life insurance for your children. Eligible children are unmarried and under age 21 (up to age 25 if a full-time student), including handicapped or disabled children.
- Optional life insurance coverage is portable through MetLife. This means you are eligible to continue your coverage if you leave or retire from National Grid.
- 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 find rates for optional insurance can on the MetLife Web site in the Book of Options.
- Should you need to update information with MetLife, please contact the MetLife Call Center.

By October 17, you should receive a direct home mailing from MetLife which describes how you can enroll in these optional programs. If you need assistance, please call the MetLife Call Center at (866) 492-6983.

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) COVERAGE

AD&D coverage 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.

Defining Your Base Annual Salary for Life Insurance

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

- **Applicable to all Unions except New York Union:** The Company automatically provides non-occupational AD&D coverage equal to one times base pay. The Company also provides occupational AD&D coverage equal to six times base pay (to a maximum of $600,000).
- **Steelworkers 12431:** The Company automatically provides AD&D coverage equal to your current life insurance benefit.

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

VOLUNTARY AD&D COVERAGE

(EMPLOYEES REPRESENTED BY THE STEELWORKERS 12431 ARE NOT ELIGIBLE FOR THIS BENEFIT)

You may buy additional AD&D coverage for yourself, your spouse and/or children. You may purchase coverage for yourself at one, two or three times your base pay. In addition, you may purchase voluntary AD&D coverage for your spouse equal to 50% of your coverage amount or for your children at 15% of your coverage amount. If you elect coverage for both your spouse and children, the amounts of coverage you can purchase will be limited to 40% for your spouse and 10% for your child(ren).

Call MetLife directly if you want to confirm your current coverage, enroll in voluntary AD&D, or change your current elections.

Please note that any contributions you make for voluntary AD&D coverage will be deducted from your pay on an after-tax basis.

DEFINING YOUR BASE ANNUAL SALARY FOR LIFE INSURANCE

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

Imputed Income

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

Naming a Beneficiary

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

Vacation Purchase Program

(EMPLOYEES REPRESENTED BY THE NEW YORK UNION AND STEELWORKERS 12431 ARE NOT ELIGIBLE FOR THIS BENEFIT)

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.

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 31, 2014 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 2014 to be eligible to purchase additional vacation days.

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.

If you choose to purchase additional days, you should be aware of the following:

- Your manager and/or supervisor must approve your purchase of vacation days and has full discretion over the authorization of vacation days and the number of days you can purchase.
- 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, 2015.
- If you leave National Grid or go on disability before the end of the year, and have not used your purchased days, you will be reimbursed for the amount that you have paid for those days. You must notify the Mercer Benefits Service Center at 1-866-294-8052 before December 15, 2015 in order to receive reimbursement.

Auto and Homeowners Insurance

(Employees represented by the Steelworkers 12431 are not eligible for this benefit)

National Grid has contracted with MetLife to allow employees to insure their cars, homes and other personal property at special discounted group rates via payroll deduction.

Contact MetLife to receive information regarding auto and home insurance program through payroll deductions.

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

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

Enrolling in Your Benefits

Once you have reviewed your benefit options and the information on your *2015 Personalized Enrollment Worksheet*, it is time to get online and enroll! **Remember, you have until October 31, by 5 p.m. ET via phone and 12 midnight via web to elect your benefits for 2015**. If you don't enroll, you will automatically receive default coverage (see page 7 for more details). If you want to keep your default benefit elections and you do not plan to participate in the flexible spending accounts, you do not need to enroll.

To Enroll or Make Changes by Phone

You are encouraged to enroll online. However, if you do not have access to the Web, you can enroll by contacting the Mercer Benefits Service Center at 1-866-294-8052. Be sure to have your *2015 Personalized Enrollment Worksheet* in front of you when you call.

TO ENROLL OR MAKE CHANGES ONLINE

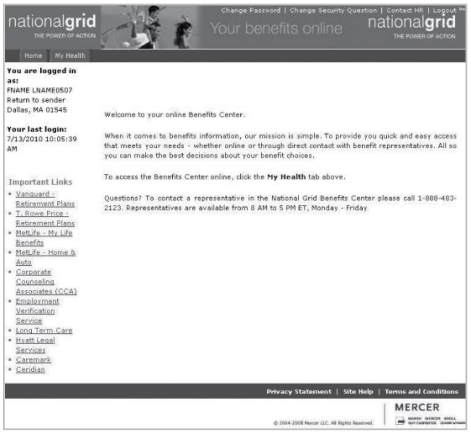
Step 1: Log on to the Mercer Benefits Service Center Web site at **www.NationalGridEmployeeServices.MercerHRS.com**

Step 2: You will need your User ID and Personal Identification Number (PIN) to log on to the Mercer Benefits Service Center Web site.

Your User ID is your Employee ID number, which can be located on your *2015 Personalized Enrollment Worksheet* as well as on your pay advice.

If you do not remember your PIN, you have the ability to reset it by clicking ***Click here to reset your PIN*** from the log on page. If this is the first time you are using the Web site, your PIN has been set to the last four digits of your Social Security Number (SSN). Once you log on, you will be asked to reset your PIN and select a series of security questions. Please keep this information for future access.

Step 3: Click the ***My Health*** link at the top of the page to begin. From this page, you may review your current 2014 elections, personal data and dependent data or you can enroll in your 2015 benefits.



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, please contact the Mercer Benefits Service Center at 1-866-294-8052 during the Open Enrollment Correction Period scheduled from November 18, 2014 through November 25, 2014 (Monday through Friday, between 8 a.m. and 5 p.m. ET).

Step 4: Review your information on each of the tabs described here:

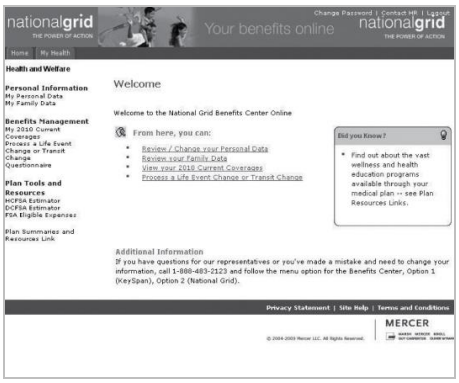
My Cost — Review your cost for your 2015 benefits as well as the amount that National Grid contributes toward your benefits.

About Me — Review your personal information. If any of the information on this page is not correct (name, SSN, d/o/b, address), please call the TDC at 1-888-483-2123.

My Dependents — Review and update your dependent information listed on this page before electing coverage. If assistance is needed with changing dependent data (name, SSN, etc.) the employee can call the Mercer Benefits Service Center at 1-866-294-8052.

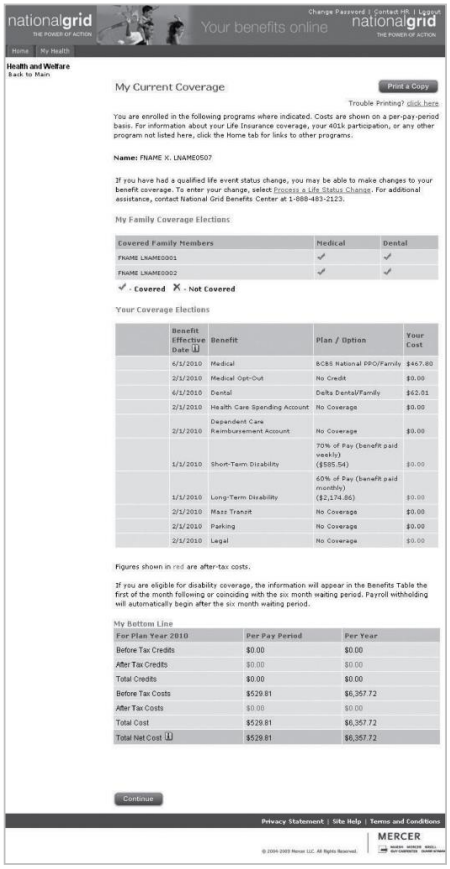
Click ***Complete Your 2015 Open Enrollment***. You will reach the Enrollment Summary page. Choose the benefits you would like to change by clicking on the ***Change*** button. The Web site will guide you through choosing your plan, selecting which dependents to cover, and/or entering a contribution amount for a flexible spending account.

If you want to opt out of medical coverage for 2015, you must click on the ***Change*** button to the left of the medical line and select ***No Coverage***.



Step 5: Once you have made your elections, click ***Submit My Elections***.

Step 6: Your elections are not final until you receive your confirmation number. Once you receive your confirmation number, you will have an opportunity to print a copy of your elections. Click ***Continue*** to complete a quick online survey.



You will be able to change your elections as many times as you like until the enrollment period ends on October 31. If you would like to make a change after receiving your confirmation number, you will need to restart the enrollment process from the beginning. Your changed elections, which become effective January 1, 2015, will not be saved until you receive a new confirmation number.

Glossary

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

Co-payment – The fee you pay (under most plans) when you use outpatient services.

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

Deductible – The annual dollar amount for covered services that you must pay before the plan pays benefits.

In-network care – Care you receive from providers inside of a health plan's network.

Out-of-network care – Care you receive from providers of your choice outside of the network.

Out-of-pocket maximum – The maximum amount you will pay for covered medical expenses during the year under the plan (including deductibles, co-insurance and co-payments for medical, pharmacy, and mental health/substance abuse treatments for in-network treatment). Any covered medical or pharmacy expenses above the maximum will be covered at 100% by the plan, up to the reasonable and customary limit, for the rest of the calendar year.

Point-of-Service (POS) Plan – A health plan that allows you to choose where to receive care: from a network of participating providers or from providers outside the network. If you receive in-network care, a primary care physician (PCP) must coordinate all services, including referrals to specialists and other providers. If you receive out-of-network care, you must pay deductibles and co-insurance, and submit claim forms for reimbursement.

Preferred Provider Organization (PPO) Plan – A PPO is an organization that arranges contracts between a select group of health care providers (hospitals, physicians) and health plans or insurance companies. If you participate in a PPO plan, you do not need to select a primary care physician to manage your care. While there are some restrictions, a PPO offers you flexibility in benefits design and freedom of choice in selecting your providers. If you receive out-of-network care, you must pay deductibles and co-insurance, and submit claim forms for reimbursement.

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

Primary care physician (PCP) – A physician who may be a general practitioner or specialist, such as a pediatrician or a doctor of internal medicine, and who supervises and coordinates all your medical care.

Contact Information

For Information On:	Call:	Or Visit The Web Site:
Medical Plans		
National Grid PPO or Custom Choice Plus	1-800-287-8757	www.bluecrossma.com
CDPHP	1-877-724-2579	www.cdphp.com
Harvard Pilgrim POS	1-888-333-4742	www.harvardpilgrim.org/members
Blue Choice 2 New England	1-800-287-8757	www.bluecrossma.com
Fallon Community Health Plan	1-800-868-5200	www.fchp.org
Health New England	1-800-791-7944	www.hne.com
Independent Health PPO	1-800-501-3439	www.independenthealth.com
MVP PPO	1-800-229-5851	www.mvphealthcare.com
Western New York POS	1-800-889-1904	www.lifetimebenefitsgroup.com/
Traditional Blue	1-888-840-6322	www.bcbswny.com
Prescription Drug Benefits		
CVS Caremark	1-800-378-8826	www.caremark.com
Dental Plan		
Delta Dental	1-800-872-0500	www.deltadentalma.com
Flexible Spending Accounts		
Ceridian through December 31, 2014 WageWorks beginning January 1, 2015	1-877-799-8820 1-855-774-7441	www.ceridian-benefits.com www.wageworks.com
Life Insurance and AD&D		
MetLife	1-866-492-6983	www.metlife.com/mybenefits
Long-Term Care		
CNA (current enrollees only)	(Suspended until further notice to new enrollees except for Local 97). • Current participants may contact CNA directly by calling the phone number listed on your policy contract. • Employees represented by Local 97 may contact CNA directly at 1-877-777-9072 to enroll in coverage or can obtain enrollment information online at www.cna.com/groupltc (password: natlgrid).	
Enrollment		
Mercer Benefits Service Center	1-866-294-8052	www.NationalGridEmployeeServices.MercerHRS.com
General Benefit Questions		
Transactions Delivery Center	1-888-4TDC-123 (1-888-483-2123)	www.nationalgridtdc123.com

STEPS YOU MUST TAKE BY OCTOBER 31 AT 5 P.M. ET VIA PHONE OR 12 MIDNIGHT VIA WEB	
If you want to... • Enroll in, change or opt out of medical coverage for 2015 • Enroll in or decline dental coverage for 2015 • Enroll or re-enroll in the Health Care Spending Account and/or Dependent Care Reimbursement Account for 2015 • Purchase vacation time*[1] • Purchase or change optional life insurance and/or voluntary AD&D for 2015	You must enroll online at **www.NationalGridEmployeeServices.MercerHRS.com** or call the Mercer Benefits Service Center at 1-866-294-8052. You must call the MetLife Call Center at 1-866-492-6983

Don't forget: If the coverage listed on your *2015 Personalized Enrollment Worksheet* meets your needs for 2015, you do not need to enroll.

Reminder: False or Misleading Information

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

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

* Only available to New England unions

nationalgrid

nationalgrid

Engage in Your Benefits

OPEN ENROLLMENT **2016**

2016 **Benefits** Enrollment Guide

FOR NATIONAL GRID REPRESENTED EMPLOYEES

New England Unions:
USW 12431
UWUA 369
UWUA BUW 310, 310B, 317, 322, 329, 330
IBEW 326, 486, 1465

New York Union:
IBEW 97

What's Inside

Welcome to 2016 Open Enrollment!

As an employee of National Grid, you have access to a range of quality benefit options so you can get the coverage you need for yourself and your eligible family members. Open Enrollment is your annual opportunity to reassess your health care, life insurance and other benefit needs — by considering how you used your benefits in 2015 and how your needs may change in 2016.

When to Enroll

The Open Enrollment period will begin at 7:00 a.m. on Monday, October 26 and end on Friday, November 6 at 6 p.m. Eastern Time (ET) via phone and 12 midnight via Web.

This Benefits Enrollment Guide describes the benefits available to you in 2016 as well as important information on how to enroll in your benefits. Read it carefully so that you can make informed decisions that are right for you and your family. To the extent the benefits are subject to the Employee Retirement Income Security Act, the Guide is also a Summary of Material Modifications that describes the changes in those benefits that are effective in 2016. Please keep this Guide for future reference.

You will find detailed instructions about how to enroll starting on page 34.

BE AN ACTIVE HEALTH CARE CONSUMER

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

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

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

For all these reasons and more, **we encourage you to be an active health care consumer and engage in your own health.** Be proactive about your health care needs, make informed lifestyle choices, seek early screening for health care issues and work with health providers to address specific concerns. National Grid's Commitment to Health and Wellbeing provides additional resources for you and your family (see page 27).

YOUR BENEFITS ENROLLMENT KIT INCLUDES:

1. This *2016 Benefits Enrollment Guide*, which describes the benefit options and how they work.

2. *A Comparison of National Grid Plan Benefits*, a chart that summarizes the benefits under each medical plan and the dental plan, and your cost for coverage.

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

In addition, your *2016 Personalized Enrollment Worksheet* will be mailed separately to your home. The worksheet includes your current coverage and your available options and costs for 2016. If you do not receive your *2016 Personalized Enrollment Worksheet* by October 26, 2015, please contact the National Grid Benefit Services Center at 1-888-483-2123.

As in past years, after you've enrolled in your 2016 benefits, you will receive a written confirmation of your choices, and you'll have the chance to make changes before your coverage becomes effective on January 1, 2016.

Don't Wait Until the Last Minute to Enroll!

- Look at your enrollment tools and resources as soon as possible to make your decision easy and timely.
- Avoid peak hours — during Open Enrollment, 7 a.m. to 11 a.m. ET is the busiest time for the National Grid Benefit Services Center. The best way to get your questions answered quickly is to call mid-week in the afternoon.
- Don't wait until the last minute to enroll — the last day of the enrollment period is a busy time for the online enrollment Web site and the National Grid Benefit Services Center!

What's New

You will continue to have access to comprehensive benefit programs in 2016. You will find your 2016 cost for coverage in the enclosed *A Comparison of National Grid Health Benefits* chart.

The following is a summary of the health and welfare benefit plan modifications that will become effective on January 1, 2016 as negotiated under the collective bargaining agreement or as a result of regulatory and/or administrative changes. The health benefits and wellness programs offered by National Grid—combined with more employees taking an active role in managing their health—are helping to manage the pace of health care cost increases.

- **Supreme Court Decision on Same-Sex Marriage**
  - Earlier this year, the U.S. Supreme Court ruled that the right to marry is a fundamental right inherent in the liberty of the person under the Due Process and **Equal Protection Clauses of the Fourteenth Amendment**; same-sex couples may not be deprived of that right. The Court ultimately concluded that same-sex couples may exercise the fundamental right to marry. As a result of this decision, there is no longer any legal barrier to same-sex marriage in the United States. National Grid will provide medical and dental coverage to your "legally married spouse," regardless of sex.
- **Life Insurance**
  - MetLife will eliminate the age 70 limit on dependent spouse coverage effective January 1, 2016.
  - The requirement for an employee who signs up for for optional/supplemental life insurance to be actively at work on the plan's effective date and not have been 'hospitalized'' in the prior 90-day period will be eliminated effective January 1, 2016.
- **New England Unions True-Up Analysis**
  - This year's true-up analysis resulted in a credit for 2016. See the enclosed special insert for more information.

FOR LOCAL 12431:

- **Change in medical contributions.** Employees will contribute 18.75% toward the cost of medical coverage for the BCBSMA PPO for Steelworkers.
- **Change in dental contributions.** Employees will contribute 17.5% toward the cost of dental coverage.

FOR NEW YORK UNION (LOCAL 97):

- **Long-Term Care Insurance Program.** As of February 1, 2016, CNA will close this benefit to new enrollees. Current participants in good standing will be unaffected by this decision and will continue to be serviced by CNA and its vendors. As long as premiums are paid, coverage will continue uninterrupted with the same features and benefits available prior to ceasing new entrants into the plan.

Open Enrollment at National Grid

DURING OPEN ENROLLMENT, YOU MAY:

- Change your current medical and/or dental coverage.*
- Opt out of medical coverage and receive an opt-out credit (if eligible) if you are covered under another medical plan.*
- Change the dependents you cover in the medical and/or dental plans.*
- Enroll in the Health Savings Account (HSA) for 2016 (CDHP participants only).
- Enroll in a Health Care Spending Account (HCSA) for 2016.*
- Enroll in the Dependent Care Reimbursement Account (DCRA) for 2016.*
- Elect to purchase optional life insurance and/or voluntary AD&D insurance through MetLife. (Employees represented by Steelworkers 12431 are not eligible for these benefits.)
- Purchase additional vacation days.* (Employees represented by New York Union (Local 97) and Steelworkers 12431 are not eligible for this benefit.)

**You will need to call the National Grid Services Delivery Center at 1-888-483-2123 or visit the Web site at* www.nationalgridbenefitservices.com *by November 6, 2015.*

Making Changes During the Year

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

If You Want to Opt Out of Medical Coverage

If you elected to opt out of medical coverage in 2015, and received the opt-out credit and want to opt out again in 2016, you must make an active election to opt out of medical coverage during Open Enrollment. If you do not actively elect to opt out and you do not enroll in a medical plan during Open Enrollment, you will not receive medical benefits for 2016 and you will not receive an opt-out credit (if eligible). (See page 19 for more information.)

IF YOU MISS THE ENROLLMENT DEADLINE

If you miss the enrollment deadline, your current medical and dental elections will continue for 2016. However, you will not be able to participate in the Health Care Spending Account or the Dependent Care Reimbursement Account, nor will you be allowed to purchase additional vacation days. (Employees represented by Steelworkers 12431 and New York Union are not eligible to purchase additional vacation days.) You must re-enroll each year to participate in these plans.

DEFAULT COVERAGE

If you do not take any action before November 6, and you are already eligible for and enrolled in subsidized medical and dental coverage, you will default to the following plan elections:

Default Benefit Plans	
Medical (If elected in 2015)	The coverage you had in 2015
Dental (If elected in 2015)	The coverage you had in 2015
Flexible Spending Accounts **Health Care** **Dependent Care**	 Waive-No Coverage Waive-No Coverage
Optional Life Insurance	The coverage you had in 2015.
Vacation Purchase Employees represented by Steelworkers 12431 and New York Union are not eligible to purchase additional vacation days.	No Purchase

Important Enrollment Information

WHO IS ELIGIBLE?

All regular full-time 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 Regarding 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 following the close of Open Enrollment with instructions for submitting the appropriate documentation to verify eligibility.

MEDICAL

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

- Your legally married spouse.
- Your child(ren) who are under the age of 26, married or unmarried regardless of full-time student or tax dependent status. A child includes:
  - Natural child(ren), legally adopted child(ren) or child(ren) placed with you pending legal adoption, child(ren) for whom you or your spouse serve as legal guardian, step-child(ren), eligible foster child(ren), child(ren) of a legally married spouse.

    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.

Important Note Regarding Dependent Children

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

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

Note: Spouses of married dependents and child(ren) of dependents are NOT eligible for coverage.

DENTAL AND LIFE INSURANCE

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), step-child(ren), eligible foster child(ren), legally adopted child(ren), child(ren) placed with you pending legal adoption, and child(ren) for whom you or your spouse serve as a legal guardian, 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.*
- Dependent child(ren) are covered until:
  - For New England Union and New York Union: Dependent child(ren) are covered until December 31 of the year in which the child attains age 19 (21 for life insurance) or until midnight prior to their 25th birthday if a full-time student.
  - Steelworkers 12431: Dependent child(ren) are covered until December 31 of the year in which the child attains age 19 or until midnight prior to their 25th birthday if a full-time student. Annual certification is required to confirm a child's continuing full-time student status.

WHEN YOUR COVERAGE BEGINS

The elections you make during this Open Enrollment period will take effect on January 1, 2016 and will remain in effect through December 31, 2016.

NEW HIRES

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

If you 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).

Benefits	Eligibility
Medical Plan	**Full cost** First of the month following or coincident with your date of hire **Subsidized cost** First of the month following or coincident with the completion of 30 days of service
Health Savings Account (HSA)	Only for those who enroll in CDHP Voluntary employee contributions begin upon enrollment in the HSA through HealthEquity See page 14 for details
Dental Plan	**Full cost** First of the month following or coincident with your date of hire **Subsidized cost** First of the month following or coincident with the completion of 30 days of service
Health Care Spending Account	First of the month following or coincident with the completion of 30 days of service
Dependent Care Reimbursement Account	First of the month following or coincident with the completion of 30 days of service
Basic Life Insurance	First of the month following three months of service.
Accidental Death and Dismemberment (Except New York Union)	**Occupational loss** After three months of service **Non-occupational loss** First of month following date of hire

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

PAYING FOR COVERAGE

Beginning October 26, when you log on to www.nationalgridbenefitservices.com the 2016 costs will be displayed for each of your medical, dental, and vacation purchase benefit options, as well as the coverage levels available to you. Optional life insurance, and voluntary accidental death and dismemberment (AD&D), are provided through separate enrollments for these benefits and MetLife will send you information upon request.

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

Pre-Tax Contributions Apply to These Benefits:	After-Tax Contributions Apply to These Benefits:
• Medical coverage • Health Savings Account (HSA), except for New York Union • Dental coverage • Purchased vacation days (if eligible) • Health Care Spending Account (HCSA) • Dependent Care Reimbursement Account (DCRA)	• Optional life insurance • Dependent life insurance • Voluntary AD&D coverage

BENEFITS FOR PART-TIME EMPLOYEES

If you are a part-time employee represented by a New England Union or New York Union scheduled to work at least 20 hours per week, you are eligible for the same benefits as regular, full-time employees. (Employees represented by Steelworkers 12431 are not eligible for this benefit.) Generally, your cost will be pro-rated based on your normal work schedule.

The Company contribution towards medical and/or dental coverage would be:

Weekly Work Schedule	Company Contribution*
20 – 24 hours	60%
25 – 31 hours	80%

*of employer portion

Paying With Pre-Tax Dollars: What It Means
Paying with pre-tax dollars means that you pay less in taxes because your income is lower for tax calculation purposes. It's important to note that because you don't pay Social Security taxes on pre-tax contributions, your Social Security benefits at retirement or disability may be slightly reduced. Any reduction, however, will be minimal and will probably be offset by your current tax savings. For example, for tax purposes, 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 CHANGES DURING THE YEAR

The benefit elections you make during this Open Enrollment period will stay in effect throughout the 2016 calendar year. You can only make changes to your coverage during the year if you experience a qualified life event — a significant change in your life that has a direct impact on your coverage. Documented proof of the qualified life event(s) will be required.

Choose Well

Choose well means enrolling in the right benefits for you and your family. It is important for you to consider your/your family's own needs for the upcoming year when making your elections for eligible benefits. The information in this guide together with your comparison chart provides a summary overview of many benefits and highlights what's new and changing in 2016.

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

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

Your 2016 Benefit Choices

The chart below summarizes the benefits in which you may be eligible to enroll. You may also change your elections for the following benefits during the Open Enrollment period.

Summary of Benefit Options for Employees Represented by a New England Union or New York Union (Except Steelworkers 12431)	

Health Care Benefits
• Medical plan options (including prescription drug and mental health benefits)
  • Consumer Driven Health Plan (CDHP) with Health Savings Account (HSA)*
  **Note: CDHP/HSA not offered for New York Union*
  • National Preferred Provider Organization (PPO) Plan
  • Regional Point-of-Service (POS) Plans
• Opt-out credit only for New York Union
	Flexible Spending Accounts
	• Health Care Spending Account (HCSA)
	• Dependent Care Reimbursement Account (DCRA)

Dental Benefits • Dental Plan	**Time Off** • Purchase vacation days*
Life Insurance • Optional life insurance coverage • Voluntary accidental death and dismemberment (AD&D) coverage	**Long-Term Care Insurance Program** • Only available to currently enrolled participants. Please contact CNA directly at 1-877-777-9072 to change or cancel your current coverage • As of February 1, 2016, CNA will close this benefit to new enrollees.

Summary of Benefit Options for Steelworkers 12431	

Health Care Benefits
• Medical plan options (including prescription drug and mental health benefits)
  • Consumer Driven Health Plan (CDHP) with Health Savings Account (HSA)
  • National Grid Custom Choice PPO Plan
  • National Grid PPO Plan for Steelworkers 12431
	Flexible Spending Accounts
	• Health Care Spending Account (HCSA)
	• Dependent Care Reimbursement Account (DCRA)

Dental Benefits • Dental Plan	
Life Insurance • Company-Provided Life Insurance • Company-Provided accidental death and dismemberment (AD&D) coverage	

*Only available to New England unions

Medical Plan Options

You can choose from a variety of medical plans. All represented employees are eligible for one or more Preferred Provider Organization (PPO) plans, which are administered by Blue Cross Blue Shield of Massachusetts (BCBS). If you are an employee represented by a New England Union (with the exception of Steelworkers 12431) or New York Union, you also have access to several Point-of-Service (POS) plans. The POS plans include a number of local or regional plans. Employees represented by New England Unions also have a choice to enroll in a Consumer Driven Health Plan (CDHP). A summary of all plans is provided below. Refer to *A Comparison of National Grid Plan Benefits* included in this Enrollment Kit for more details about the plans available to you, including information on your deductibles, co-insurance and co-payments.

What to Consider When Choosing Your Plan

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

- What do you think your health care needs will be in 2016? What are your typical health care needs? Do you or a covered family member have any chronic health conditions?
- What are your total costs under each option–including the contributions, deductibles, co-insurance, co-payments and non-covered services?
- How does your National Grid coverage compare to any other coverage you might have, such as through your spouse's plan?

CONSUMER DRIVEN HEALTH PLAN (CDHP)

(NOT AVAILABLE TO NEW YORK UNION LOCAL 97)

The CDHP includes comprehensive coverage for medical, prescription drug and mental health / substance abuse, just like traditional PPO and POS plans. The CDHP also provides the flexibility for you to go to an in or out-of-network provider. When and how you pay for services differentiates this plan from the others.

With a CDHP, you are in charge of your health care choices and control how you spend your health care dollars. Payroll contributions to a CDHP are typically lower than the PPO and POS plans. The dollars you save in employee contributions can be deposited into a Health Savings Account (or HSA) that can be drawn upon to pay for any out-of-pocket medical expenses, like deductibles and co-insurance. The deductible (the amount you are responsible for before the plan pays a portion of the cost for health care services) is typically higher in a CDHP than traditional PPO/POS plans.

Here's a Tip: Play an Active Role

Patients who ask questions are more satisfied with their care and see more of an improvement in their health than patients who do not.

The HSA is a valuable tool to help you save for and pay for healthcare expenses with tax-free dollars. Not only can you use the HSA to offset current health care costs, it can be used to build savings for future health care costs (such as in retirement). Payroll contributions to the HSA are made on a pre-tax basis and roll over from year to year — unlike other tax-advantaged health care accounts, the HSA has no IRS "use it or lose it" rule. The dollars are yours until you decide to use them. You can read more about the HSA on page 14.

When you join a CDHP:

- Certain in-network annual preventive visits, related routine tests, and immunizations subject to a schedule are covered at 100% with no deductible or coinsurance.
- You can receive care from any doctor or specialist. By choosing a preferred provider (also called an in-network provider) for a covered service, your out-of-pocket costs will be lower than if you choose a non-preferred provider (also called an out-of-network provider).
- For all non-preventive care services (including the cost for most prescription drugs), you pay 100% of the cost up to the **annual deductible**.
- After you satisfy the deductible, you and National Grid share in the cost of medical services AND prescription drugs through coinsurance. Those in a family plan must meet the family deductible before the plan starts paying co-insurance.
- If your total expenses (deductible plus co-insurance) for medical services and prescription drugs reach your **out-of-pocket maximum**, National Grid will fully cover all eligible expenses at 100% – that means you pay nothing else for the rest of the plan year.
- The individual out-of-pocket maximum does not apply to those in a family plan. The family out-of-pocket maximum must be met by one or more family members before the plan plays 100% of future claims costs through the end of the plan year.
- If you use a non-preferred provider:
  - Your cost will be based on allowed charges, including your co-insurance and any amounts that exceed allowed charges.
  - You will use a BCBS claim form to submit a claim for reimbursement.

Purchasing Power of a CDHP

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

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

How do you become a better consumer of health care?

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

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

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

HEALTH SAVINGS ACCOUNT (HSA)

The HSA, administered by HealthEquity, is a great way to pay for current and save for future eligible health care expenses. You must enroll in the CDHP and meet certain eligibility requirements to open an HSA. Your contributions to the HSA will be automatically deducted from each paycheck on a pre-tax basis or you can elect to contribute amounts outside of the payroll process entirely. You can change your contribution amount to the HSA at any time during the year.

HSA Contribution Limits

The IRS limits your maximum annual HSA contribution. For 2016, the annual limits are $3,350 for individual coverage and $6,750 for family coverage. Once you are age 55, and each year thereafter, you are eligible to make an additional annual "catch up" contribution of up to $1,000 to your HSA for that year.

BENEFITS OF THE HSA

1. **You can use your HSA for 2016 eligible health care expenses – even after you incur them.** You can put your HSA dollars toward your deductible and other eligible medical, prescription, dental and vision expenses.

   Unlike a Flexible Spending Account (FSA), you can contribute to your HSA *after you incur out-of-pocket costs* and then use those tax-free dollars to reimburse yourself. So, even if you have unexpected health care costs in 2016, you can contribute additional money to your HSA to pay for those expenses.
2. **You can roll over dollars you don't use.** Unused money rolls over from year to year, which helps you build savings for future eligible health care expenses. You can also use dollars in your HSA to pay for eligible expenses in future years even if you're not enrolled in the CDHP at the time. Through HealthEquity, you have the option to invest HSA dollars and potentially grow your account. More information is available at www.bluecrossma.com/cdhpnationalgrid
3. **You can take it with you.** The money in your HSA is always yours, so you can take your unused balance when you retire or leave National Grid.
4. **Triple-tax advantages.** You never pay taxes on your HSA dollars as long as you use them to pay for eligible health care expenses. You won't be taxed when you make contributions, as your account grows with interest, or when you withdraw the money to pay for eligible expenses.
5. **It's convenient.** You can use the HSA Debit Card from HealthEquity and/or you can pay providers online (just like online banking) to use your HSA to pay for eligible health care expenses.
6. **Increase your health care savings through investments**. HealthEquity provides the opportunity to invest your health care dollars. More information is available at www.bluecrossma.com/nm/cdhp-national-grid

FREQUENTLY ASKED QUESTIONS

Who is eligible to open and contribute to an HSA?

"Eligible individuals" are any individuals who are:

- Covered under a Consumer Driven Health Plan (CDHP).

- Not covered by any other health plan that is not a CDHP (with certain exceptions for plans providing certain limited types of coverage). This means you cannot be covered under your spouse's medical coverage unless it too is a CDHP.
- Not enrolled in Medicare, including Part A.
- Not be claimed as a dependent on another person's tax return.
- Veterans who have not received treatment through the Veteran's Administration other than preventive care, within the last 3 months.

Will the health FSA impact employees' HSA eligibility?

Individuals enrolled in a traditional FSA in 2015 who wish to participate in a CDHP with HSA in 2016 may be required to delay their enrollment in, and contributions to, the HSA.

If you are enrolled in the National Grid 2015 FSA plan and have an outstanding balance in your FSA account as of January 1, 2016, you are subject to the 2 ½ month grace period. You must wait to enroll and contribute to the HSA until the end of the FSA grace period. The earliest you can attempt to enroll is April 1.

If you are enrolled in the National Grid 2015 FSA plan and do not have an outstanding balance in your FSA account as of January 1, 2016, you can enroll and contribute to the HSA effective January 1. If you are eligible to be reimbursed by your spouse's FSA plan, the same rules apply.

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

How are prescription drug costs paid under the CDHP?

Prescription drug coverage for the CDHP is administered by CVS Caremark. Prescription drug expenses also count toward your annual deductible and out-of-pocket maximum. This means that you will pay the full cost of your prescriptions until you meet your plan's annual deductible. For certain preventive medications, the deductible is waived under the CDHP. Coinsurance applies after the deductible is met.

How do I enroll in the HSA?

By electing the CDHP plan you will be defaulted into the Health Savings Account (HSA). You have the choice to remain in the HSA or elect to waive this plan option. By agreeing to the default option (i.e. enrolment in the HSA plan) you will be authorizing HealthEquity to open a health savings account (HSA). For details about the terms of the account you can access their HSA Custodial Agreement at http://healthequity.com/en/Site/EducationCenter/Forms.aspx. In compliance with the USA PATRIOT Act, HealthEquity must verify the identity of all customers seeking to open an HSA. As part of this identity verification process, you may be asked to provide additional information and/or documentation before your account can be established. In addition, your enrollment and health information will be shared with HealthEquity for the purpose of administering and coordinating payments under the health savings account.

Tools and Resources

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

PREFERRED PROVIDER ORGANIZATION (PPO) PLAN

When you enroll in a PPO plan, you can choose your own doctors and specialists from a comprehensive list of participating preferred providers (sometimes called network providers). You can also choose to see a physician who is not part of the PPO network under this option (a "non-preferred" provider). Out-of-network care provided by a non-preferred provider is subject to benefit management procedures and you pay more for care.

When you join a PPO plan:

- You are not required to select a primary care physician (PCP).
- You can see any network specialist you choose and you do not need to be referred by a PCP.
- You are covered for certain routine care, such as physicals and eye exams, subject to a schedule.
- If you use a preferred provider:
  - Your out-of-pocket costs will be lower because BCBS has negotiated reduced rates with their preferred providers.
  - You have no claim forms to fill out and send to BCBS.
- If you use a non-preferred provider:
  - Your cost will be based on allowed charges, including your co-insurance and any amounts that exceed allowed charges.
  - You will use a BCBS claim form to submit a claim for reimbursement.

Nearly all the providers National Grid employees currently use are in the BCBS network. You can confirm that your doctor participates by checking the BCBS Web site at **https://www.bluecrossma.com/wps/portal/members/using-my-plan/doctors-hospitals/findadoctor** and searching in the BlueCard network. For general information about BCBS, visit **www.bluecrossma.com**.

POINT-OF-SERVICE (POS) PLAN

If you join a POS plan, you can choose to receive care from participating in-network providers and pay less for your care, or you can choose to receive care from any provider outside the network and pay more. Out-of-network care is subject to each plan's policies.

When you join a POS plan:

- You choose a primary care physician (PCP), who coordinates your care in-network.
- You can choose to receive care from participating in-network doctors and the plan will pay 100% of eligible expenses after you pay the applicable co-payment, if any.
- Alternatively, you can use out-of-network providers and the plan will pay a percentage of eligible expenses after you pay your annual deductible.
- You are covered for routine care, such as physicals and eye and hearing exams, when you receive these services from in-network providers.
- You must follow the plan's procedures for filing claims when you receive care outside of the network, or you may be subject to a penalty.

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

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

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

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

Nearly all the providers National Grid employees currently use are in the BCBS network. You can confirm that your doctor participates by checking the BCBS Web site at **https://www.bluecrossma.com/wps/portal/members/using-my-plan/doctors-hospitals/findadoctor** and searching in the BlueCard network. For general information about BCBS, visit **www.bluecrossma.com**.

Please refer to *A Comparison of National Grid Health Benefits* chart for the Web site addresses for other POS health care providers, including; Harvard Pilgrim, Fallon Community Health Plan, Health New England and MVP.

SPECIAL NOTICE REQUIRED BY HEALTH CARE REFORM

GRANDFATHERED PLAN STATUS (APPLICABLE TO EMPLOYEES REPRESENTED BY THE NEW YORK UNION)

National Grid believes the NY Union medical plans are "grandfathered health plans" under the Affordable Care Act. A grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime and annual limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the National Grid Services Delivery Center at 1-888-483-2123. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or **www.dol.gov/ebsa/healthreform**.

Important Note for Massachusetts Residents Who Opt Out of Medical Coverage

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

To avoid tax penalties, you will be required to provide 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 2015, you will receive the Form MA 1099-HC that will indicate you have creditable coverage. Use this form when filing your 2014 taxes.

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

OPTING OUT OF MEDICAL COVERAGE

If you have coverage under another medical plan (for example, through your spouse's employer), you may elect to decline coverage through the Company and receive an opt-out credit in the form of additional taxable cash compensation, payable according to your collective bargaining agreement. To receive this benefit, you must actively enroll in the opt-out credit and re-enroll each year. **This option is only avaible if you are represented by the New York Union (Local 97)**. If you do not enroll, you will not receive your additional cash payment for the year. To receive the opt-out credit for 2016, you must **actively s**elect **the** "no coverage" **option** for your medical coverage by the enrollment deadline, November 6, 2015.

How are you spending time?

People spend an average of 6.8 hours researching buying a car, 4.9 hours holiday shopping, and 1.3 hours buying a pair of shoes, according to Guardian Life industry data. And on average, people are spending about 1.4 hours reviewing their benefits plans.

It takes time to make sure your needs are covered. Smart benefit decisions may not have that "new car smell"—but peace of mind is an accessory that doesn't wear off quickly. The choices you make—or don't make—during Open Enrollment will impact you and your family for the next year. Take the time to give your benefits a thorough check-up this year.

By declining medical coverage, you will have no medical benefits through the Company for yourself or your family. In addition, you will not have prescription drug coverage. If you are an employee represented by the New York Union, you (employee only) will only have managed mental health coverage.

If you lose your other coverage or experience a qualified life event during the year, you may enroll yourself and your dependents in a Company-sponsored medical plan **within 31 days** of the loss of coverage.

If you opt out and later enroll in a Company-sponsored medical plan due to a qualified life event, your opt-out benefit will end as of the effective date of the change. Your paycheck will reflect the contributions you are required to make by enrolling in a medical plan.

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

Opt-Out Credit (Only Available to Employees Represented by the New York Union)	
Availability	Available if you have coverage under another medical plan (for example, through your spouse's employer, even if your spouse is employed by National Grid). To receive this benefit, you must actively select the "no coverage" medical option each year during Open Enrollment. If you do not re-enroll each year, you will not receive the additional cash compensation.
Benefit	If you elect to decline medical coverage ("opt out") through the Company, you will receive additional cash compensation (referred to as the "opt-out credit"), which pays up to $600 per year in equal installments, payable as taxable income in your paycheck.

Prescription Drug Benefits

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

Here's a Tip: Use Generic Drugs Whenever Possible

Generic drugs are as effective as brand-name drugs but almost always cost less. If you take a brand-name drug, talk with your health care provider to determine if a generic equivalent might be a smarter choice for you.

FILLING PRESCRIPTIONS THROUGH CVS CAREMARK

NEW YORK UNION (LOCAL 97)

Your prescription drug coverage includes a retail prescription drug program and a mail order prescription drug service, both of which are administered by CVS Caremark. The amount you pay for your prescriptions will vary depending on the type of drug you use and the way you fill your prescription (at a retail pharmacy or through mail order). When you use a participating retail pharmacy or the mail order service, your co-payment applies as outlined in the enclosed *A Comparison of National Grid Plan Benefits*.

Retail Pharmacy Benefits: Prescriptions filled at a retail pharmacy are generally based on a 30-day supply. Show your prescription drug ID card and you can purchase prescription drugs at participating CVS Caremark network pharmacies (including national chains like CVS, Walgreens, Rite-Aid, and most other retail pharmacies).

Mail Order Pharmacy Benefits: If you have a recurring prescription for a "maintenance" medication (such as for high blood pressure or diabetes), you may be able to fill your prescription through a mail order drug program. Prescriptions filled through a mail order program are based on a 90-day supply. Please refer to *A Comparison of National Grid Plan Benefits* to review the specifics of your mail order benefit.

APPLICABLE TO ALL UNIONS EXCEPT NEW YORK UNION

- **You can fill a 30-day supply of medication at a network pharmacy.** Show your prescription drug ID card and you can purchase prescription drugs at participating CVS Caremark network pharmacies (including national chains like CVS, Walgreens, Rite-Aid, and most other retail pharmacies).
- **Mandatory Mail Order for Maintenance (long-term) Medication: Once you receive a prescription and two refills for the same maintenance medication, you are required to use the CVS Caremark mail order plan.** You will have two options for filling your maintenance medication prescriptions. You will have the choice of:
    - Receiving your 90-day supply of maintenance medication through the CVS Caremark Mail Service Pharmacy
    - Receiving your 90-day supply of maintenance medication at the local retail CVS/pharmacy

  The mail order co-payment will be the same, regardless of which fill method you use; home delivery or CVS retail pick-up.

Failure to fill maintenance medications as outlined above will result in you being charged for 100% of the cost at retail point of sale. We strongly urge you to take advantage of the convenience of submitting a mail order request through CVS Caremark's Maintenance Choice Program or by bringing your 90-day prescription to your local CVS or participating network pharmacy to avoid paying full cost for your prescriptions.

Choose what is more convenient for you

At a CVS/pharmacy You May:	With CVS Caremark Mail Service You May:
Pick-up your long-term medication directly from the pharmacy at a time that is convenient for you	Enjoy convenient home delivery
Enjoy same-day prescription availability	Receive medication in confidential, tamper-resistant and (when necessary) temperature-controlled packaging
Talk face-to-face with a pharmacist	Talk to a pharmacist by phone

PHARMACY PROGRAMS (APPLICABLE TO ALL UNIONS EXCEPT NEW YORK UNION)

COMPOUNDED DRUGS PRIOR AUTHORIZATION (applies only to the CDHP)

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

GENERIC STEP THERAPY

This prescription program encourages members to utilize more cost effective first-line generics and provides coverage for one preferred select brand in most classes. The preferred select brand is determined by clinical effectiveness based on FDA approved indications, lowest net cost and/or shortest remaining patent life. For some classes, such as the PPI class where sufficient generics are available, a generic trial is required before any single source brand is covered.

Generic Step Therapy requires that a cost-effective generic alternative is tried first before a single-source brand is covered. Here is how it works:

When a prescription for a targeted 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 will be paid. If there is no history of a generic trial, the pharmacist will receive a message for the prescriber to call a toll-free number for more information. In the event that the prescriber advises CVS Caremark that a generic alternative is not right for the member, he or she can call the Prior Authorization Department.

This program is intended to actively educate members and prescribers with regards to clinically appropriate medications, and to guide them to more cost-effective options.

SPECIALTY PREFERRED DRUG PROGRAM

Another prescription drug program is designed to help prescribers select the most clinically effective therapy, at the lowest cost in specific specialty therapeutic categories. The preferred medication is a well-supported treatment option and represents the most cost-effective medication. The Specialty Preferred Drug Program will apply to the following specialty medication categories: multiple sclerosis, auto-immune medications (medications used to treat Crohn's disease, psoriasis, rheumatoid arthritis).

When/if you present a prescription for preferred specialty medication, the prescription will automatically be approved. When/if you present a prescription for a non-preferred specialty medication, 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, he or she 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.

Dental Plan

When you participate in the dental plan, you can choose to receive care from a broad network of providers or from any provider outside the network. Dental coverage is administered by Delta Dental of Massachusetts.

To find out if your dentist is in the Delta Dental network, visit **www.deltadentalma.com** and search the Delta Dental PPO Plus Premier network.

The dental plan covers the following types of dental services:

- Diagnostic and Preventive Services:
  - Exams
  - Cleanings
  - X-rays
- Basic Restorative Services:
  - Fillings
  - Oral surgery
  - Root canal treatment
- Major Restorative Services:
  - Inlays
  - Crowns
  - Dentures
  - Bridgework

Here's a Tip: Get a Regular Dental Check-up

Did you know that getting a preventive dental check-up can help detect early signs of dental disease? Schedule a dental appointment and help reduce future cost and stress.

ORTHODONTIA BENEFITS

The plan also covers orthodontia for eligible family members as described below:

- **Steelworkers 12431:** Dependent child(ren) are covered until December 31 of the year in which the child attains age 19 or until December 31 of their 23rd birthday if a full-time student.
- **New England Union**: Dependent child(ren) are covered until December 31 of the year in which the child attains age 19 or until December 31 of their 25th birthday if a full-time student.
- **New York Union:** Dependent child(ren) are covered until December 31 of the year in which the child attains age 19 or until December 31 of their 25th birthday if a full-time student.

Please refer to *A Comparison of National Grid Plan Benefits* for coverage levels and examples of the types of services provided.

To find out if your dentist is in the Delta Dental network, visit **www.deltadentalma.com** and search the Delta Dental PPO Plus Premier network.

Flexible Spending Accounts

National Grid offers two flexible spending accounts:

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

You may contribute to one or both flexible spending accounts. However, you must enroll each year to participate. Participation does not automatically continue from year to year.

Using Your HCSA

Your total annual contribution is available for reimbursement on January 1, 2016. Your annual contribution election will be deducted in equal installments each pay period before applicable payroll taxes are deducted.

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

With a flexible spending account, you save because the money in your account is never taxed — when it goes into your account, or when you withdraw it to reimburse yourself for eligible expenses.

HEALTH CARE SPENDING ACCOUNT

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

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

Eligible Health Care Spending Account Expenses

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

For a complete list of eligible and ineligible expenses, contact WageWorks (see page 39 for contact information), contact the IRS toll-free at 1-800-829-3676 and ask that Publication 502 be sent to you free of charge, or visit **www.irs.gov**.

DEPENDENT CARE REIMBURSEMENT ACCOUNT

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

Dependent Care Tax Credit

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

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

Eligible Dependent Care Reimbursement Account Expenses

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

For a complete list of eligible and ineligible expenses, contact WageWorks (see page 39 for contact information), contact the IRS toll-free at 1-800-829-3676 and ask that Publication 503 be sent to you free of charge, or visit **www.irs.gov**.

USING YOUR DCRA

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

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

ADDITIONAL FLEXIBLE SPENDING ACCOUNT RULES

Contributions. Once you enroll in either (or both) the health or dependent care account, you may not change or stop your contributions until the next Open Enrollment period (unless you experience a qualified life event as indicated on page 10).

If You Have Questions

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

Reimbursement. To be reimbursed for eligible health or dependent care expenses incurred between January 1, 2016 and March 15, 2017, obtain the applicable reimbursement claim form by visiting **https://www.wageworks.com/employees/support-center/important-forms.aspx**. Submit your completed form along with a receipt or proof of payment (including the Explanation of Benefits (EOB) if provided by a health plan). WageWorks will then reimburse you for your eligible out-of-pocket expenses up to the total amount of your HCSA 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, 2017 to submit claims for all eligible expenses incurred between January 1, 2016 and March 15, 2017. That's why it's important to carefully consider the amount you will use over the course of the year before contributing to either account. Those who are considering enrolling in the Consumer Driven Health Plan (CDHP) should refer to page 15 to learn about how the CDHP Health Savings Account is affected by the HCSA 2 ½ month grace period.

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

CONTINUING PARTICIPATION IF YOU TERMINATE YOUR EMPLOYMENT

Terminated or retired employees may choose to continue funding their HCSA on an after-tax basis by electing continued coverage through COBRA. Details will be included in the Ceridian COBRA package.

National Grid's Commitment to Health and Wellbeing

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

HEALTH & WELLNESS RESOURCE CENTER

www.bluecrossma.com/nationalgrid

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

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

Live Well

Live well includes taking control of your/your family's physical, mental and financial health. Take the time to put wellness into your daily activities. Taking advantage of the various health/wellness programs offered by our health providers, and maintaining appropriate optional life insurance can help to positively influence your physical and mental wellbeing.

QUITNET — SMOKING CESSATION

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

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

http://smokefree.gov/

CORPORATE COUNSELING ASSOCIATES (CCA) — WORK/LIFE ASSISTANCE

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

INJURY PREVENTION FOR FIELD EMPLOYEES

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

Did You Know?

56% of all injuries reported at National Grid are soft tissue related. Soft tissue injury is the damage of muscles, ligaments and tendons throughout the body. Stretching and flexing before work can significantly reduce your risk of soft tissue injury.

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

Life Insurance

COMPANY-PROVIDED BASIC LIFE INSURANCE

The life insurance program pays a benefit to your designated beneficiary if you die.

New York Union: You automatically receive Company-provided life insurance coverage equal to either one and a half times base pay rounded to the next higher $1,000, to a maximum of $625,000 (Plan A – those hired on or before October 1, 1984 who did not make a one-time election under Plan B) or two and a half times base pay to a maximum of $625,000 (Plan B).

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.

New England Union: You automatically receive Company-provided life insurance coverage equal to two times your base pay rounded to the next higher multiple of $2,000, to a maximum of $200,000.

Steelworkers 12431: You automatically receive Company-provided life insurance coverage in a flat-dollar amount equal to $90,000.

OPTIONAL LIFE INSURANCE

(EMPLOYEES REPRESENTED BY THE STEELWORKERS 12431 ARE NOT ELIGIBLE FOR THIS BENEFIT)

If you want additional life insurance, you can purchase optional life insurance for yourself at on an after-tax basis discounted group rates. You can also purchase optional life insurance for your legal spouse, children, or both at discounted group rates.

- You can purchase up to five times your annual base pay, to a maximum of $1,000,000, in optional life insurance for yourself. 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.
- You can purchase either $25,000 or $50,000 in optional life insurance for your spouse. You will be required to show medical evidence of insurability, also called EOI, if you elect more than $25,000 for your spouse.
- You can purchase $2,500, $4,000 or $10,000 in optional life insurance for your children. Your dependent must be at least 15 days old and less than 21 years old, unmarried (up to age 25 if a full-time student), including handicapped or disabled children.
- Optional life insurance coverage is portable through MetLife. This means you are eligible to continue your coverage if you leave or retire from National Grid.
- 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 find rates for optional insurance on the MetLife Web site in the Book of Options.

- Should you need to update information with MetLife, please contact the MetLife Call Center.

By October 26, you should receive a direct home mailing from MetLife which describes how you can enroll in these optional programs. If you need assistance, please call the MetLife Call Center at (866) 492-6983.

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) COVERAGE

AD&D coverage 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.

Applicable to all Unions except New York Union: The Company automatically provides non-occupational AD&D coverage equal to one times base pay, rounded to the next higher multiple of $2,000. The Company also provides occupational AD&D coverage equal to six times base pay, rounded to the next higher multiple of $2,000 (to a maximum of $600,000).

Defining Your Base Annual Salary for Life Insurance

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

New York Unions AD&D benefits are rounded to the nearest higher $1,000 for non-occupation and occupational related injuries.

Steelworkers 12431: The Company automatically provides AD&D coverage equal to your current life insurance benefit.

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

VOLUNTARY AD&D COVERAGE

(EMPLOYEES REPRESENTED BY THE STEELWORKERS 12431 ARE NOT ELIGIBLE FOR THIS BENEFIT)

You may buy additional AD&D coverage for yourself, your spouse and/or children. You may purchase coverage for yourself at one, two or three times your base pay, to a maximum of $625,000. In addition, you may purchase voluntary AD&D coverage for your spouse equal to 50% of your coverage amount or for your children at 15% of your coverage amount. If you elect coverage for both your spouse and children, the amounts of coverage you can purchase will be limited to 40% for your spouse and 10% for your child(ren).

Call MetLife directly if you want to confirm your current coverage, enroll in voluntary AD&D, or change your current elections.

Please note that any contributions you make for voluntary AD&D coverage will be deducted from your pay on an after-tax basis.

DEFINING YOUR BASE ANNUAL SALARY FOR LIFE INSURANCE

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

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

Naming a Beneficiary
It is important that you name a beneficiary for life insurance and AD&D coverage. Your beneficiary is the person who will receive benefits from these plans if you die. You may choose to name more than one beneficiary, and you can change your beneficiary designations as often as you want. You elect your beneficiary directly through MetLife.

Vacation Purchase Program

(EMPLOYEES REPRESENTED BY THE NEW YORK UNION AND STEELWORKERS 12431 ARE NOT ELIGIBLE FOR THIS BENEFIT)

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.

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 31, 2015 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 2015 to be eligible to purchase additional vacation days.

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.

If you choose to purchase additional days, you should be aware of the following:

- Your manager and/or supervisor must approve your purchase of vacation days and has full discretion over the authorization of vacation days and the number of days you can purchase.
- 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, 2016.
- If you leave National Grid or go on disability before the end of the year, and have not used your purchased days, you will 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, 2016 in order to receive reimbursement.

Auto and Homeowners Insurance

(EMPLOYEES REPRESENTED BY THE STEELWORKERS 12431 ARE NOT ELIGIBLE FOR THIS BENEFIT)

National Grid has contracted with MetLife to allow employees to insure their cars, homes and other personal property at special discounted group rates via payroll deduction.

Contact MetLife to receive information regarding auto and home insurance program through payroll deductions.

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

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

Enrolling in Your Benefits

Once you have reviewed your benefit options and the information on your *2016 Personalized Enrollment Worksheet*, it is time to get online and enroll! **Remember, you have until November 6, by 6 p.m. ET via phone and 12 midnight via web to elect your benefits for 2016**. If you don't enroll, you will automatically receive default coverage (see page 5 for more details). If you want to keep your default benefit elections and you do not plan to participate in the flexible spending accounts, you do not need to enroll.

To Enroll or Make Changes by Phone

You are encouraged to enroll online. However, if you do not have access to the Web, you can enroll by contacting the National Grid Benefit Services Center at 1-888-483-2123. Be sure to have your *2016 Personalized Enrollment Worksheet* in front of you when you call.

Please note: if you opted out of medical coverage in 2015 and intend to do so again for 2016, you must click on the **Change** button and select **No Coverage** for the opt-out credit to apply for 2016 (applicable to Local 97 only). In order to ensure the appropriate value for your opt out credit, you will be required to list your dependents who are eligible to be covered under the medical plan.

TO ENROLL OR MAKE CHANGES ONLINE/BY PHONE

There are two ways to enroll:

1. Through the Web at **www.nationalgridbenefitservices.com**. The secure Web site is available 24 hours a day, so you can make your benefit elections during the Open Enrollment period, at a time that is convenient for you.

Please note you will be prompted to enter your:

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

OR

2. By calling the National Grid Benefit Services Center toll-free at **1-888-483-2123.** The National Grid Benefit Services Center is available Monday through Friday, from 7 a.m. to 6 p.m. ET. You may speak with a Benefits Specialist who will walk you through the enrollment process.

Step-By-Step Web Enrollment Instructions

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

You will be able to change your elections as many times as you like until the enrollment period ends on November 6, 2015. 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, 2016, 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, please contact the National Grid Benefit Services Center at 1-888-483-2123 during the Open Enrollment Correction Period scheduled from December 7, 2015 through December 11, 2015 (7 a.m. and 6 p.m. ET).

Enrollment Deadline

You can enroll between October 26, 2015 and November 6, 2015. **You must enroll by November 6, 2015 at 6 p.m. ET via phone and 12 midnight via Web.** If you have any questions about benefits or the enrollment process, call the National Grid Benefit Services Center at 1-888-483-2123.

PERSONAL AND EMERGENCY CONTACT INFORMATION

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

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

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

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

Glossary

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

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

Co-payment – The fee you pay (under most plans) when you use outpatient services, such as office visits and prescriptions. Expressed as a dollar amount.

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

Deductible – The annual dollar amount for covered services that you must pay before the plan pays benefits.

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

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

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

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

Out-of-pocket maximum – The maximum amount you will pay for covered medical expenses during the year under the plan (including deductibles, co-insurance and co-payments for medical, pharmacy, and mental health/substance abuse treatments for in-network treatment). Any covered medical or pharmacy expenses above the maximum will be covered at 100% by the plan, up to the reasonable and customary limit, for the rest of the calendar year.

Point-of-Service (POS) Plan – A health plan that allows you to choose where to receive care: from a network of participating providers or from providers outside the network. If you receive in-network care, a primary care physician (PCP) must coordinate all services, including referrals to specialists and other providers. If you receive out-of-network care, you must pay deductibles and co-insurance, and submit claim forms for reimbursement.

Preferred Provider Organization (PPO) Plan – A PPO is an organization that arranges contracts between a select group of health care providers (hospitals, physicians) and health plans or insurance companies. If you participate in a PPO plan, you do not need to select a

primary care physician to manage your care. While there are some restrictions, a PPO offers you flexibility in benefits design and freedom of choice in selecting your providers. If you receive out-of-network care, you must pay deductibles and co-insurance, and submit claim forms for reimbursement.

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

Primary care physician (PCP) – A physician who may be a general practitioner or specialist, such as a pediatrician or a doctor of internal medicine, and who supervises and coordinates all your medical care.

Contact Information

For Information On:	Call:	Or Visit The Web Site:
Medical Plans		
National Grid PPO or Custom Choice Plus BCBSMA CDHP	1-800-287-8757 1-800-287-8757	www.bluecrossma.com www.bluecrossma.com/nm/cdhp-national-grid
CDPHP	1-877-724-2579	www.cdphp.com
Harvard Pilgrim POS	1-888-333-4742	www.harvardpilgrim.org/members
Blue Choice 2 New England	1-800-287-8757	www.bluecrossma.com
Fallon Community Health Plan	1-800-868-5200	www.fchp.org
Health New England	1-800-791-7944	www.hne.com
Independent Health PPO	1-800-501-3439	www.independenthealth.com
MVP PPO	1-800-229-5851	www.mvphealthcare.com
Western New York POS	1-800-889-1904	www.lifetimebenefitsgroup.com/
Traditional Blue	1-888-840-6322	www.bcbswny.com
Health Equity (Health Savings Account)	1-866-346-5800	www.healthequity.com
Prescription Drug Benefits		
CVS Caremark	1-800-378-8826	www.caremark.com
Dental Plan		
Delta Dental	1-800-872-0500	www.deltadentalma.com
Flexible Spending Accounts		
WageWorks	1-877-924-3967	www.wageworks.com
Life Insurance and AD&D		
MetLife	1-866-492-6983	www.metlife.com/mybenefits
Long-Term Care		
CNA (current enrollees only)	As of **February 1, 2016**, CNA will **close** this benefit to new enrollees.Current participants may contact CNA directly by calling the phone number listed on your policy contract.	
Enrollment		
National Grid Benefit Services Center	1-888-483-2123 Follow the phone prompt for benefits/medical and dental	www.nationalgridbenefitservices.com
General Benefit Questions		
National Grid Services Delivery Center	1-888-483-2123	www.nationalgridsdc123.com

STEPS YOU MUST TAKE BY NOVEMBER 6, 2015 AT 6 P.M. ET VIA PHONE OR 12 MIDNIGHT VIA WEB	
If you want to... • Enroll in, change or opt out of medical coverage for 2016 • Enroll in or decline dental coverage for 2016 • Enroll or re-enroll in the Health Care Spending Account and/or Dependent Care Reimbursement Account for 2016 • Purchase vacation time[1] • Purchase or change optional life insurance and/or voluntary AD&D for 2016	You must enroll online at www.nationalgridbenefitservices.com or call the National Grid Benefit Services Center at 1-888-483-2123. You must call the MetLife Call Center at 1-866-492-6983

Don't forget: If the coverage listed on your *2016 Personalized Enrollment Worksheet* meets your needs for 2016, you do not need to enroll.

Reminder: False or Misleading Information

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

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

[1]Only available to New England unions

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nationalgrid

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

This is a summary of the major benefits offered by each health care plan and also provides employee contributions/costs effective January 1, 2015 to December 31, 2015.

MEDICAL PLAN COMPARISON: HOW PLANS COVER SERVICES

	GHI Premier PPO Plan		GHI Standard PPO Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
GENERAL PROVISIONS				
Annual deductible	None	$500/individual $1,000/family	$300/individual $600/individual family member	$1,500/individual $4,500/family
Benefit level (what the plan pays for most eligible expenses)	Plan pays services at 100% after you pay your co-payment	Plan pays services at 70% after you satisfy the deductible, you pay 30%	Plan pays services at 100% after you pay your co-payment	Plan pays services at 70% after you satisfy the deductible, you pay 30%
Annual out-of-pocket maximum (including deductible, medical & Rx copayments and coinsurance)	$6,350/individual $12,700/family	$2,500/individual $7,000/family	$6,350/individual $12,700/family	$7,000/individual $21,000/family
Maximum lifetime benefit per individual	None	None	None	None
Dependent coverage	Until December 31 of the year in which the child attains age 26			
Inpatient covered services	100%	70% of reasonable and customary charges after deductible	100% after $500 co-payment	70% after deductible of the average in-network hospital payment
OUTPATIENT COVERED SERVICES				
Preventive care visits	100%	70% after deductible	100%	70% after deductible
Primary care office visits	100% after $25 co-payment per visit	70% after deductible	100% after $30 co-payment per visit	70% after deductible
Specialist office visits	100% after $35 co-payment per visit	70% after deductible	100% after $50 co-payment per visit	70% after deductible
Outpatient surgery and pre-admission testing	100%	70% of the average in-network hospital payment	100% after $100 co-payment	70% after deductible
Routine vision (one per calendar year)	100%	100% of in-network payment covered; responsible for any charge exceeding this payment	100%	Member reimbursed 100% of in-network payment. Member is responsible for any excess of this payment.
Routine hearing exams	100%	70% after deductible	100%	70% after deductible
Diagnostic lab and X-ray	100%	70% after deductible	100% after $30 co-payment	70% after deductible
MENTAL HEALTH AND SUBSTANCE ABUSE				
Inpatient	100%	70% of average in-network payment	100%	70% of average in-network payment
Outpatient	100%	70% after deductible	100%	70% after deductible
MATERNITY BENEFITS				
Prenatal care	100% after $25 co-payment for initial visit	70% after deductible	100% after $30 co-payment for initial visit	70% after deductible
In-hospital delivery	100%	70% after deductible	100% after $500 inpatient co-payment	70% after deductible
EMERGENCY ROOM CARE				
	$100 co-payment (waived if admitted)	$100 co-payment (waived if admitted)	$250 co-payment (waived if admitted)	$250 co-payment (waived if admitted)

Prescription Drug Coverage

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

PRESCRIPTION DRUG COVERAGE

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

	RETAIL (30-DAY SUPPLY)	MAIL ORDER (90-DAY SUPPLY)
GHI Premier PPO Plan		
Generic (Tier I)	$10	$20
Formulary Brand (Tier II)	$30	$60
Non-Formulary Brand (Tier III)	$50	$100
GHI Standard PPO Plan		
Generic (Tier I)	$10	$20
Formulary Brand (Tier II)	$30	$60
Non-Formulary Brand (Tier III)	$50	$100

Medical Plan Costs*

MEDICAL COSTS (Including Prescription Drug Coverage)	GHI PREMIER PPO PLAN		GHI STANDARD PPO PLAN	
	Individual	Family	Individual	Family
Monthly Cost Summary				
Employee pays	$156.00	$351.00	$80.17	$192.83
Weekly Cost Summary				
Employee pays	$36.00	$81.00	$18.50	$44.50

* Deducted in pre-tax dollars

Medical Plan Contact Information

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

CUSTOMER SERVICE TELEPHONE NUMBERS AND WEBSITES FOR EACH PLAN	
	GHI PPO
For a provider directory, service area map or more information call:	1-800-624-2414
Or visit their website at:	www.emblemhealth.com
For CVS Caremark, call 1-800-378-8826 or go to www.caremark.com.	

Dental Plan

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

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

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

Dental Plan Costs*

GHI DENTAL			
	Individual	Family	Sponsored Dental - Individual
Monthly Cost Summary			
Employees pay	$0	$0	$16.29
Weekly Cost Summary			
Employees pay	$0	$0	$3.76

* Deducted in pre-tax dollars

Dental Plan Contact Information

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

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

This is a summary of the major benefits offered by each health care plan and also provides employee contributions/costs effective January 1, 2016 to December 31, 2016.

MEDICAL PLAN COMPARISON: HOW PLANS COVER SERVICES

	GHI Premier PPO Plan		GHI Standard PPO Plan		BCBS Consumer Driven Health Plan*	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
GENERAL PROVISIONS						
Annual deductible	$150/individual $300/family	$300/individual $600/family	$400/individual $800/family	$800/individual $1,600/family	$1,550/individual $3,100/family	$3,100/individual $6,200/family
Benefit level (what the plan pays for most eligible expenses)	Plan pays services at 100% after you pay the deductible or your co-payment	Plan pays services at 70% after you satisfy the deductible, you pay 30%	Plan pays services at 90% after you satisfy the deductible, you pay 10%	Plan pays services at 70% after you satisfy the deductible, you pay 30%	Plan pays services at 90% after you satisfy the deductible, you pay 10%	Plan pays services at 70% after you satisfy the deductible, you pay 30%
Annual out-of-pocket maximum (including deductible, medical & Rx co-payments and coinsurance)	$5,000/individual $10,000/family	$10,000/individual $20,000/family	$2,400/individual $4,800/family	$4,800/individual $9,600/family	$2,700/individual $5,400/family	$5,400/individual $10,800/family
Maximum lifetime benefit per individual	None	None	None	None	None	None
Dependent coverage	Until December 31 of the year in which the child attains age 26					
Inpatient covered services	100% after $150 co-payment per continuous stay	70% of reasonable and customary charges after deductible	90% after deductible	70% after deductible of the average in-network hospital payment	90% after deductible	70% after deductible
Health Savings Account Contribution from National Grid	NA		NA		$750/individual $1,500/family	
OUTPATIENT COVERED SERVICES						
Preventive care visits	100%	70% after deductible	100%	70% after deductible	100%	70% after deductible
Primary care office visits	100% after $25 co-payment per visit	70% after deductible	100% after $30 co-payment per visit	70% after deductible	90% after deductible	70% after deductible
Specialist office visits	100% after $35 co-payment per visit	70% after deductible	100% after $50 co-payment per visit	70% after deductible	90% after deductible	70% after deductible
Outpatient surgery and pre-admission testing	100% after deductible	70% of the average in-network hospital payment	100% after $100 co-payment	70% after deductible	90% after deductible	70% after deductible
Routine vision (one per calendar year)	100%	100% of in-network payment covered; responsible for any charge exceeding this payment	100%	Member reimbursed 100% of in-network payment. Member is responsible for any excess of this payment	100%	70% after deductible
Routine hearing exams	100%	70% after deductible	100%	70% after deductible	100%	70% after deductible
Diagnostic lab and X-ray	100% after deductible	70% after deductible	100% after $30 co-payment	70% after deductible	90% after deductible	70% after deductible

MENTAL HEALTH AND SUBSTANCE ABUSE						
Inpatient	100% after $150 co-payment	70% of average in-network payment	90% after deductible	70% of average in-network payment	90% after deductible	70% after deductible
Outpatient	100% after deductible	70% after deductible	90% after deductible	70% after deductible	90% after deductible	70% after deductible
MATERNITY BENEFITS						
Prenatal care	100% after $25 co-payment for initial visit	70% after deductible	100% after $30 co-payment for initial visit	70% after deductible	100%	70% after deductible
In-hospital delivery	100% after $150 co-payment	70% after deductible	90% after deductible	70% after deductible	90% after deductible Well-Baby 100%	70% after deductible
EMERGENCY ROOM CARE						
	$250 co-payment (waived if admitted)	$250 co-payment (waived if admitted)	90% after deductible	90% after deductible	90% after deductible	90% after deductible

* The deductibles and out-of-pocket maximums cross accumulate across in- and out-of-network.

Prescription Drug Coverage

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

PRESCRIPTION DRUG COVERAGE

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

	RETAIL (30-DAY SUPPLY)	MAIL ORDER (90-DAY SUPPLY)
GHI PREMIER PPO PLAN		
Generic (Tier I)	$10	$20
Formulary Brand (Tier II)	$30	$60
Non-Formulary Brand (Tier III)	$50	$100
GHI STANDARD PPO PLAN		
Generic (Tier I)	$10	$20
Formulary Brand (Tier II)	$30	$60
Non-Formulary Brand (Tier III)	$50	$100
BCBS CONSUMER DRIVEN HEALTH PLAN*		
Generic (Tier I)	10% after deductible	10% after deductible
Formulary Brand (Tier II)	10% after deductible	10% after deductible
Non-Formulary Brand (Tier III)	10% after deductible	10% after deductible

Mandatory mail order (picked up at retail or via mail) for maintenance drugs, generic step therapy and specialty preferred drug therapy applies to all plans.

MEDICAL PLAN COSTS*

MEDICAL COSTS (Including Prescription Drug Coverage)	GHI PREMIER PPO PLAN		GHI STANDARD PPO PLAN		BCBS CONSUMER DRIVEN HEALTH PLAN	
	Individual	Family	Individual	Family	Individual	Family
Monthly Cost Summary						
Employee pays	$164.67	$372.67	$99.67	$214.50	$65.00	$173.33
Weekly Cost Summary						
Employee pays	$38.00	$86.00	$23.00	$49.50	$15.00	$40.00

* Deducted in pre-tax dollars

MEDICAL PLAN CONTACT INFORMATION

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

CUSTOMER SERVICE TELEPHONE NUMBERS AND WEBSITES FOR EACH PLAN

	GHI PPO	BCBS Consumer Driven Health Plan	Health Equity for HSA
For a provider directory, service area map or more information call:	1-800-624-2414	1-800-588-5507	1-866-346-5800
Or visit their Web site at:	www.emblemhealth.com	www.bluecrossma.com/wps/portal	www.healthequity.com

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

DENTAL PLAN

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

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

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

DENTAL PLAN COSTS*

GHI DENTAL			
	Individual	Family	Sponsored Dental - Individual
Monthly Cost Summary			
Employee pays	$0	$0	$16.43
Weekly Cost Summary			
Employee pays	$0	$0	$3.79

* Deducted in pre-tax dollars

DENTAL PLAN CONTACT INFORMATION

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

A COMPARISON OF NATIONAL GRID HEALTH BENEFITS FOR EMPLOYEES REPRESENTED BY LOCAL 12003

This is a summary of the major benefits offered by each health care plan and also provides employee contributions/costs effective January 1, 2015 to December 31, 2015.

MEDICAL PLAN COMPARISON: HOW PLANS COVER SERVICES

	Blue Cross Blue Shield PPO		Harvard Pilgrim HMO	Fallon HMO
	In-Network	Out-of-Network	In-Network Only	In-Network Only
GENERAL PROVISIONS				Open only to current participants
Annual deductible	None	$500/individual $1,000/family	None	None
Benefit level (what the plan pays for most eligible expenses)	Plan pays services at 100% after you pay your co-payment	Plan pays services at 80% after you satisfy the deductible, you pay 20%	Plan pays services at 100% after you pay your co-payment	Plan pays services at 100% after you pay your co-payment
Annual out-of-pocket maximum (including deductible, medical & Rx copayments and coinsurance)	$6,350/individual $12,700/family	$2,500/individual $5,000/family	$6,350/individual $12,700/family	$6,350/individual $12,700/family
Maximum lifetime benefit per individual	None	None	None	None
Dependent coverage	Until December 31 of the year in which the child attains age 26			
Inpatient covered services	100%	80% after deductible	100%	100%
OUTPATIENT COVERED SERVICES				
Preventive care visits	100%	80% after deductible	100%	100%
Primary care office visits	100% after $15 co-payment	80% after deductible	100% after $5 co-payment	100% after $10 co-payment
Specialist office visits	100% after $20 co-payment	80% after deductible	100% after $5 co-payment	100% after $10 co-payment
Outpatient surgery and pre-admission testing	100%	80% after deductible	100%	100%
Routine vision (one per calendar year)	100%	80% after deductible	100%	100%
Diagnostic lab and X-ray	100%	80% after deductible	100%	100%
MENTAL HEALTH AND SUBSTANCE ABUSE				
Inpatient	100%	80% after deductible	100%	100%
Outpatient	100% after $15 co-payment	80% after deductible	100% after $5 co-payment	100% after $10 co-payment
MATERNITY BENEFITS				
Prenatal care	100% after $20 co-payment (first visit only)	80% after deductible	100%	100% after $10 co-payment (first visit only)
In-hospital delivery	100%	80% after deductible	100%	100%
EMERGENCY ROOM CARE				
	100% after $50 co-payment (waived if admitted); separate $50 co-payment applies for observation in the Emergency Room	100% after $50 co-payment (waived if admitted); separate $50 co-payment applies for observation in the Emergency Room	100% after $50 co-payment per visit (waived if admitted)	100% after $50 co-payment

Prescription Drug Coverage

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

PRESCRIPTION DRUG COVERAGE

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

	RETAIL (30-DAY SUPPLY)	MAIL ORDER (90-DAY SUPPLY)
Blue Cross Blue Shield PPO, Harvard Pilgrim HMO, Fallon HMO		
Generic (Tier I)	$10	$20
Preferred Brand (Tier II)	$25	$50
Non-Preferred Brand (Tier III)	$40	$80

Medical Plan Costs*

MEDICAL COSTS (Including Prescription Drug Coverage)	BCBS PPO		HARVARD PILGRIM HMO		FALLON HMO	
	Individual	Family	Individual	Family	Individual	Family
Monthly Cost Summary						
Employee pays	$145.24	$388.80	$416.96	$1,138.97	$195.99	$422.67
Weekly Cost Summary						
Employee pays	$33.52	$89.72	$96.22	$262.84	$45.23	$97.54

* Deducted in pre-tax dollars

Medical Plan Contact Information

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

CUSTOMER SERVICE TELEPHONE NUMBERS AND WEBSITES FOR EACH PLAN			
	BCBS PPO	Harvard Pilgrim HMO	Fallon HMO
For a provider directory, service area map or more information call:	1-800-287-8757	1-888-333-4742	1-800-868-5200
Or visit their website at:	www.bluecrossma.com	www.harvardpilgrim.org/member	www.fchp.org

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

Dental Plan

Each time you need care, you choose to receive care from an in- or out-of-network provider. When you receive care from an in-network provider your cost will generally be lower because Delta Dental negotiates discounted rates with those providers.

DENTAL PLAN: HOW THE PLAN PAYS BENEFITS	
General Provisions	
Annual Deductible	None
Maximum Annual Benefit	$2,000 per individual
Type I: Diagnostic and Preventive Care • Exams and cleanings (once every 6 months) • X-rays (full mouth every 36 months, bitewings every 6 months, single tooth as needed) • Fluoride for children under 19 (once every 6 months) • Space maintainers (required due to premature loss of teeth for members under 14, not for replacement of primary or permanent anterior teeth)	Plan pays 100%
Type II: Basic Restorative Services • Fillings • Oral surgery • Extractions • Root canal therapy • Treatment of gum disease (periodontal treatment)	Covered at 80%
Type III: Major Restorative Services • Crowns • Dentures • Bridgework	Covered at 70%
Dependent coverage	Dependents covered to age 19; Full time students to age 25
Children's Orthodontia	
Orthodontia (coverage for dependent children up to age 19)	100% of maximum plan allowable. $2,000 lifetime maximum per individual

Dental Plan Costs*

DELTA DENTAL		
	Individual	Family
Monthly Cost Summary		
Employees pay	$7.42	$24.10
Weekly Cost Summary		
Employees pay	$1.71	$5.56

* Deducted in pre-tax dollars

Dental Plan Contact Information

For more information about dental plan benefits, contact Delta Dental directly at 1-800-872-0500, or visit www.deltadentalma.com.

A COMPARISON OF NATIONAL GRID HEALTH BENEFITS FOR EMPLOYEES REPRESENTED BY LOCAL 12003

This is a summary of the major benefits offered by each health care plan and also provides employee contributions/costs effective January 1, 2016 to December 31, 2016.

MEDICAL PLAN COMPARISON: HOW PLANS COVER SERVICES

	Blue Cross Blue Shield PPO		Harvard Pilgrim HMO	Fallon HMO
	In-Network	Out-of-Network	In-Network Only	In-Network Only
GENERAL PROVISIONS				Open only to current participants
Annual deductible	None	$500/individual $1,000/family	None	None
Benefit level (what the plan pays for most eligible expenses)	Plan pays services at 100% after you pay your co-payment	Plan pays services at 80% after you satisfy the deductible, you pay 20%	Plan pays services at 100% after you pay your co-payment	Plan pays services at 100% after you pay your co-payment
Annual out-of-pocket maximum (including deductible, medical & Rx co-payments and coinsurance)	$6,350/individual $12,700/family	$2,500/individual $5,000/family	$6,350/individual $12,700/family	$6,350/individual $12,700/family
Maximum lifetime benefit per individual	None	None	None	None
Dependent coverage	Until December 31 of the year in which the child attains age 26			
Inpatient covered services	100%	80% after deductible	100%	100%
OUTPATIENT COVERED SERVICES				
Preventive care visits	100%	80% after deductible	100%	100%
Primary care office visits	100% after $15 co-payment	80% after deductible	100% after $5 co-payment	100% after $10 co-payment
Specialist office visits	100% after $20 co-payment	80% after deductible	100% after $5 co-payment	100% after $10 co-payment
Outpatient surgery and pre-admission testing	100%	80% after deductible	100%	100%
Routine vision (one per calendar year)	100%	80% after deductible	100%	100%
Diagnostic lab and X-ray	100%	80% after deductible	100%	100%
MENTAL HEALTH AND SUBSTANCE ABUSE				
Inpatient	100%	80% after deductible	100%	100%
Outpatient	100% after $15 co-payment	80% after deductible	100% after $5 co-payment	100% after $10 co-payment
MATERNITY BENEFITS				
Prenatal care	100% after $20 co-payment (first visit only)	80% after deductible	100%	100% after $10 co-payment (first visit only)
In-hospital delivery	100%	80% after deductible	100%	100%
EMERGENCY ROOM CARE				
	100% after $50 co-payment (waived if admitted)	100% after $50 co-payment (waived if admitted)	100% after $50 co-payment per visit (waived if admitted)	100% after $50 co-payment

Prescription Drug Coverage

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

PRESCRIPTION DRUG COVERAGE

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

	RETAIL (30-DAY SUPPLY)	MAIL ORDER (90-DAY SUPPLY)
BLUE CROSS BLUE SHIELD PPO, HARVARD PILGRIM HMO, FALLON HMO		
Generic (Tier I)	$10	$20
Preferred Brand (Tier II)	$25	$50
Non-Preferred Brand (Tier III)	$40	$80

Mandatory mail order (picked up at retail or via mail) for maintenance drugs, generic step therapy and specialty preferred drug therapy applies to all plans.

MEDICAL PLAN COSTS*

MEDICAL COSTS (Including Prescription Drug Coverage)	BCBS PPO		HARVARD PILGRIM HMO		FALLON HMO	
	Individual	Family	Individual	Family	Individual	Family
Monthly Cost Summary						
Employee pays	**$173.08**	**$462.84**	**$520.54**	**$1,420.77**	**$252.26**	**$567.72**
Weekly Cost Summary						
Employee pays	**$39.94**	**$106.81**	**$120.13**	**$327.87**	**$58.21**	**$131.01**

* Deducted in pre-tax dollars

MEDICAL PLAN CONTACT INFORMATION

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

CUSTOMER SERVICE TELEPHONE NUMBERS AND WEBSITES FOR EACH PLAN			
	BCBS PPO	HARVARD PILGRIM HMO	FALLON HMO
For a provider directory, service area map or more information call:	1-800-287-8757	1-888-333-4742	1-800-868-5200
Or visit their Web site at:	www.bluecrossma.com	www.harvardpilgrim.org/member	www.fchp.org

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

DENTAL PLAN

Each time you need care, you choose to receive care from an in- or out-of-network provider. When you receive care from an in-network provider your cost will generally be lower because Delta Dental negotiates discounted rates with those providers.

DENTAL PLAN: HOW THE PLAN PAYS BENEFITS	
General Provisions	
Annual Deductible	None
Maximum Annual Benefit	$2,000 per individual
Type I: Diagnostic and Preventive Care • Exams and cleanings (once every 6 months) • X-rays (full mouth every 36 months, bitewings every 6 months, single tooth as needed) • Fluoride for children under 19 (once every 6 months) • Space maintainers (required due to premature loss of teeth for members under 14, not for replacement of primary or permanent anterior teeth)	Plan pays 100%
Type II: Basic Restorative Services • Fillings • Oral surgery • Extractions • Root canal therapy • Treatment of gum disease (periodontal treatment)	Covered at 80%
Type III: Major Restorative Services • Crowns • Dentures • Bridgework	Covered at 70%
Dependent coverage	Until December 31 of the year the dependent attains age 19; full-time students to age 25
Children's Orthodontia	
Orthodontia (coverage for dependent children up to age 19)	100% of maximum plan allowable, $2,000 lifetime maximum per individual

DENTAL PLAN COSTS*

DELTA DENTAL		
	Individual	Family
Weekly Cost Summary		
Employee pays	$7.62	$24.76
Weekly Cost Summary		
Employee pays	$1.76	$5.71

* Deducted in pre-tax dollars

Dental Plan Contact Information

For more information about dental plan benefits, contact Delta Dental directly at 1-800-872-0500, or visit www.deltadentalma.com.

A Comparison of National Grid Plan Benefits for Employees Represented by New England Union and Under Age 65 Retirees.

(Locals 326, 486, 1465 and BUW 310, 310B, 317, 322, 329, 330, UWUA 369)

This chart summarizes major benefits offered by each health care plan (Preferred Provider Plan, Point of Service Plan and High Deductible Health Plan) and also provides employee contributions/costs effective January 1, 2015 to December 31, 2015. If you need more information about each plan, you may call the plan's Customer Service Department directly, or visit their Web sites (phone numbers and Web site addresses are listed on the reverse side). Please see the last page for dental benefits.

Medical Benefits

PPO & POS Plans
(See page 3 for High Deductible Health Plan)

	Preferred Provider Organization (PPO) National Grid PPO Blue Cross Blue Shield of Massachusetts		**Point-of-Service** Harvard Pilgrim, Blue Choice 2 New England (NH & RI), Fallon Community Health Plan, Health New England**, MVP Select Care	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
General Provisions				
Annual deductible	None	$500/individual $800/family	None	$500/individual $800/family
Benefit level (what the plan covers for most eligible expenses)	100% after you pay your co-payment	80%*	100% after you pay your co-payment	70%*
Annual out-of-pocket maximum (includes deductible, medical and Rx co-payments)	$6,350/individual $12,700/family	$1,500/individual $2,100/family	$500/individual $500/family***	$1,300/individual $1,900/family
Maximum lifetime benefit per individual	No limit		No limit	
Dependent coverage	Until December 31 of the year in which the child attains age 26		Until December 31 of the year in which the child attains age 26	
Inpatient covered services	100%	80%*	100% after $250 co-payment	70%*
Outpatient Covered Services				
Outpatient surgery and pre-admission testing	100%	80%*	$150 co-payment; testing at 100%	70%*
Preventive care	100% (subject to schedule)	80%* (subject to schedule)	100%	70%*
Primary care office visits	$25 co-payment per visit	80%*	$20 co-payment per visit	70%*
Routine hearing exams	100%	80%*	100%	70%*
Routine vision exams	100% (once every 24 months)	80%* (once every 24 months)	100% (once every 12 months)	70%*
Specialty office visits	$30 co-payment per visit	80%*	$25 co-payment per visit	70%*
Diagnostic lab and X-ray	100%	80%*	100%	70%*
MRI/CT/PET scans and nuclear imaging	$50 co-payment per visit (waived if service is received at free standing/non-hospital setting)	80%*	$25 co-payment per visit (waived if service is received at free standing/non-hospital setting)	70%*
Maternity Benefits				
Prenatal care	100%	80%*	100%	70%*
In-hospital delivery and well-baby visit	100%	80%*	100% after $250 co-payment	70%*
Emergency Room Care				
	$100 co-payment (waived if admitted)	$100 co-payment per visit (waived if admitted)	$75 co-payment per visit (waived if admitted)	$75 co-payment (waived if admitted)

Mental Health and Substance Abuse

	PPO	**Point-of-Service**				
	National Grid PPO	**Harvard Pilgrim Health Care**	**Blue Choice 2 New England (NH & RI)**	**Fallon Community Health Plan**	**Health New England****	**MVP Select Care**
Inpatient—In-Network	100%	100% after $250 co-payment	100% after $250 co-payment	100% after $250 co - payment	100% after $250 co-payment	100% after $250 co-payment
Inpatient—Out-of-Network	80%*	70%*	70%*	70%*	70%*	70%*
				Prior authorization required		
Outpatient—In-Network	$15 co-payment per visit	$5 co-payment per visit	$5 co-payment per visit	$5 co-payment per visit	$5 co-payment per visit	$5 co-payment per visit
Outpatient—Out-of-Network	80%*	70%*	70%*	70%*	70%*	70%*

*After you satisfy your deductible.
** Heath New England is only available for employees represented by Local 326, 486 and 1465 and retirees formally represented by Local 326, 486 and 1465.
*** Health New England's plan design has a $250/$250 out-of-pocket maximum on medical and a separate $250/$250 out-of-pocket maximum on prescription.

Prescription Drugs (administered by CVS Caremark) for PPO and POS Plans*

	National Grid PPO	**Harvard Pilgrim Health Care**	**Blue Choice 2 New England (NH & RI)**	**Fallon Community Health Plan**	**Health New England****	**MVP Select Care**
Retail (30-day supply)						
Generic (Tier I)	$20 co-payment	$10 co-payment	$10 co-payment	$10 co-payment	$10 co-payment	$10 co-payment
Preferred Brand (Tier II)	$30 co-payment	$20 co-payment	$20 co-payment	$20 co-payment	$20 co-payment	$20 co-payment
Non-Preferred Brand (Tier III)	$50 co-payment	$50 co-payment	$50 co-payment	$50 co-payment	$50 co-payment	$50 co-payment
Mail Order Maintenance Drugs (90-day supply)						
Generic (Tier I)	$40 co-payment	$20 co-payment	$20 co-payment	$20 co-payment	$20 co-payment	$20 co-payment
Preferred Brand (Tier II)	$60 co-payment	$40 co-payment	$40 co-payment	$40 co-payment	$40 co-payment	$40 co-payment
Non-Preferred Brand (Tier III)	$100 co-payment	$100 co-payment	$100 co-payment	$100 co-payment	$100 co-payment	$100 co-payment

* Mandatory mail order (picked up at retail or via mail) for maintenance drugs, generic step therapy and specialty preferred drug therapy applies to all plans.

Note: Prior authorization may be required for certain medications.
** Heath New England is only available for employees represented by Local 326, 486 and 1465 and retirees formally represented by Local 326, 486 and 1465.

Medical Costs*+

	National Grid PPO			Point-of-Service		
	Individual	2-Person	Family	Individual	2-Person	Family
Total monthly cost	$688.46	$1,376.91	$1,965.58	$716.78	$1,433.55	$2,046.29
National Grid pays	$550.77	$1,101.53	$1,572.46	$573.42	$1,146.84	$1,637.03
New England Union employees pay	$137.69	$275.38	$393.12	$143.36	$286.71	$409.26
Credit	($6.40)	($12.81)	($18.25)	($6.19)	($12.38)	($17.64)
Full-time employees pay monthly	$131.29	$262.57	$374.87	$137.17	$274.33	$391.62
Full-time employees pay weekly	$30.30	$60.59	$86.51	$31.65	$63.31	$90.37
80% part-time employees pay weekly	$56.01	$112.02	$159.93	$58.41	$116.81	$166.74
60% part-time employees pay weekly	$81.73	$163.46	$233.34	$85.16	$170.31	$243.11

*Deducted in pre-tax dollars

+ For applicable **retirees**, rates will be provided under separate cover. Please refer to your confirmation statement.

Customer Service Telephone Numbers and Web Sites for Each Plan

	PPO	Point-of-Service				
	National Grid PPO	Harvard Pilgrim Health Care	Blue Choice 2 New England (NH & RI)	Fallon Community Health Plan	Health New England**	MVP Select Care
For a provider directory, service area map or more information, call:	1-800-287-8757	1-888-333-4742	1-800-287-8757	1-800-868-5200	1-800-791-7944	1-800-229-5851
Or visit their Web site at:	www.bluecrossma.com	www.harvardpilgrim.org/member	www.bluecrossma.com	www.fchp.org	www.hne.com	www.mvphealthcare.com

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

** Heath New England is only available for employees represented by Local 326, 486 and 1465 and retirees formally represented by Local 326, 486 and 1465.

SEE NEXT PAGE FOR HIGH DEDUCTIBLE HEALTH PLAN DETAILS

High Deductible Health Plan *

	In-Network	Out-of-Network
General Provisions		
Annual deductible (applies to medical and Rx services)	$1,500/individual $3,000/ 2-person & family	$1,500/individual $3,000/ 2-person & family
Benefit level (what the plan covers for most eligible expenses)	90%*	70%*
Annual out-of-pocket maximum (includes deductible, medical and Rx coinsurance)	$3,200 individual $6,400/ 2-person & family	$6,000 individual $12,000 2 -person & family
Maximum lifetime benefit per individual	No limit	No limit
Dependent coverage	Until December 31 of the year in which the child attains age 26	
Inpatient covered services	90%*	70%*
Outpatient Covered Services		
Outpatient surgery and pre-admission testing	90%*	70%*
Preventive care (subject to schedule)	100%	70%*
Primary care office visits	90%*	70%*
Routine hearing exams	100%	70%*
Routine vision exams	100% (once every 24 months)	70%* (once every 24 months)
Specialty office visits	90%*	70%*
Diagnostic lab and X-ray	90%*	70%*
MRI/CT/PET scans and nuclear imaging	90%*	70%*
Maternity Benefits		
Prenatal care	100%	70%*
In-hospital delivery and well-baby visit	Delivery: 90%* Well-Baby: 100%	70%*
Emergency Room Care	90%*	90%*
Mental Health and Substance Abuse		
Inpatient—In-Network	90%*	
Inpatient—Out-of-Network	70%*	
Outpatient—In-Network	90%*	
Outpatient—Out-of-Network	70%*	

*After you satisfy your deductible.

Prescription Drugs for the High Deductible Health Plan (administered by CVS Caremark) **	High Deductible Health Plan
Retail (30-day supply)	
Generic (Tier I)	10% after deductible
Preferred Brand (Tier II)	10% after deductible
Non-Preferred Brand (Tier III)	10% after deductible
Mail Order Maintenance Drugs (90-day supply)	
Generic (Tier I)	10% after deductible
Preferred Brand (Tier II)	10% after deductible
Non-Preferred Brand (Tier III)	10% after deductible

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

Medical Costs for High Deductible Health Plan*

	Individual	2-Person	Family
Total monthly cost	$617.60	$1,235.19	$1,763.63
National Grid pays	$555.84	$1,111.67	$1,587.27
New England Union employees pay	$61.76	$123.52	$176.36
Full-time employees pay weekly	$14.25	$28.50	$40.70
80% part-time employees pay weekly	$39.91	$79.81	$113.96
60% part-time employees pay weekly	$65.56	$131.12	$187.22

*Deducted in pre-tax dollars

For retirees interested in the HDHP, contact the Mercer Benefits Center or log onto their website noted in your confirmation statement to determine plan costs.

Customer Service Telephone Numbers and Web Sites for HDHP and HSA

	Blue Cross Blue Shield	Health Equity for HSA
For a provider directory, service area map or more information, call:	1-800-588-5507	1-866.346.5800
Or visit their Web site at:	www.bluecrossma.com/wps/portal	www.healthequity.com

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

Dental Benefits (Dental benefits are available only to certain retirees based on retirement date)

Delta Dental of Massachusetts: For more information, contact the plan at 1-800-872-0500 or visit www.deltadentalma.com

Dependent coverage — To age 19 or age 25 if full-time student

Dental Benefits	Annual Deductible	Plan Pays (after deductible)	Plan Maximum
Type I: Diagnostic and Preventive Services • Exams and cleanings, two times per year • X-rays • Fluoride for children under age 19 • Space maintainers	None	100%	Active Employees: $2,000 per calendar year/per person (excludes orthodontia) Retirees: $1,000 per calendar year/per person (excludes orthodontia)
Type II: Basic Restorative Services • Fillings (once every 24 months) • Oral surgery • Anesthesia • Extractions • Root canal therapy • Treatment of gum disease	Individual: $50 Family: $150	80% (after annual deductible)	
Type III: Major Restorative Services • Inlays • Crowns • Dentures • Bridgework • Repair or maintenance to any of the above		50% (after annual deductible)	
Orthodontia (for children up to age 19, or if a full-time student, age 25)	None	50%	$1,500 lifetime maximum per child

When you and your family receive care from a participating dentist, no claim forms are necessary. Your dentist files claims for you.

Dental Costs* +

Your cost for dental benefits is listed below.

	Delta Dental of Massachusetts		
	Individual	2-Person	Family
Total monthly cost	$41.16	$82.32	$117.31
National Grid pays	$32.93	$65.86	$93.85
New England Union employees pay monthly	$8.23	$16.46	$23.46
Full-time employees pay weekly	$1.90	$3.80	$5.41
80% part-time employees pay weekly	$3.42	$6.84	$9.75
60% part-time employees pay weekly	$4.94	$9.88	$14.08

*Deducted in pre-tax dollars

+For applicable **retirees**, rates will be provided under separate cover. Please refer to your confirmation statement.

A Comparison of National Grid Plan Benefits for Employees Represented by New England Union

(Locals 326, 486, 1465 and BUW 310, 310B, 317, 322, 329, 330, UWUA 369)

This chart summarizes major benefits offered by each health care plan (Preferred Provider Plan, Point of Service Plan and Consumer Driven Health Plan) and also provides employee contributions/costs effective January 1, 2016 to December 31, 2016. If you need more information about each plan, you may call the plan's Customer Service Department directly, or visit their Web sites (phone numbers and Web site addresses are listed on the reverse side). Please see the last page for dental benefits.

MEDICAL BENEFITS

	Preferred Provider Organization (PPO) (National Grid PPO, Blue Cross Blue Shield of Massachusetts)		**Point-of-Service** (Harvard Pilgrim, Blue Choice 2 New England (NH & RI), Fallon Community Health Plan, Health New England**, MVP Select)		**Consumer Driven Health Plan*** (Blue Cross Blue Shield of Massachusetts)	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
GENERAL PROVISIONS						
Annual deductible	None	$500/individual $800/family	None	$500/individual $800/family	$1,500/individual $3,000/2-person & family	
Benefit level (what the plan covers for most eligible expenses)	100% after you pay your co-payment	80%*	100% after you pay your co-payment	70%*	90%*	70%*
Annual out-of-pocket max. (includes deductible, medical & Rx co-payments and coinsurance)	$6,350/individual $12,700/family	$1,500/individual $2,100/family	$500/individual $500/family***	$1,300/individual $1,900/family	$3,200/individual $6,400/2-person & family	$6,000/individual $12,000/2-person & family
Maximum lifetime benefit per individual	No limit		No limit		No limit	
Dependent coverage	Until December 31 of the year in which the child attains age 26					
Inpatient covered services	100%	80%*	100% after $250 co-payment	70%*	90%*	70%*
OUTPATIENT COVERED SERVICES						
Primary care office visits	$25 co-payment per visit	80%*	$20 co-payment per visit	70%*	90%*	70%*
Outpatient surgery and pre-admission testing	100%	80%*	$150 co-payment; testing at 100%	70%*	90%*	70%*
Preventive care	100% (subject to schedule)	80%* (subject to schedule)	100%	70%*	100% (subject to schedule)	70%* (subject to schedule)
Routine vision	100% (once every 24 months)	80%* (once every 24 months)	100% (once every 12 months)	70%*	100% (once every 12 months)	70%* (once every 12 months)
Routine hearing exams`	100%	80%*	100%	70%*	100%	70%*
Specialty office visits	$30 co-payment per visit	80%*	$25 co-payment per visit	70%*	90%*	70%*
Diagnostic lab and X-ray	100%	80%*	100%	70%*	90%*	70%*
MRI/CT/PET scans and nuclear imaging	$50 co-payment per visit (waived if service is received at free standing/non-hospital setting)	80%*	$25 co-payment per visit (waived if service is received at free standing/non-hospital setting)	70%*	90%*	70%*
MATERNITY BENEFITS						
Prenatal care	100%	80%*	100%	70%*	100%	70%*
In-hospital and well-baby visit	100%	80%*	100% after $250 co-payment	70%*	Delivery: 90%* Well-Baby: 100%	70%*
EMERGENCY ROOM CARE						
	$100 co-payment per visit (waived if admitted)		$75 co-payment per visit (waived if admitted)		90%*	
MENTAL HEALTH AND ABUSE						

	PPO	**Point-of-Service**					**BCBS Consumer Driven Health Plan***
	National Grid PPO	**Harvard Pilgrim Health Care**	**Blue Choice 2 New England (NH & RI)**	**Fallon Community Health Plan**	**Health New England*** **	**MVP Select Care**	
Inpatient – In-network	100%	100% after $250 co-payment	100% after $250 co-payment	100% after $250 co-payment	100% after $250 co-payment	100% after $250 co-payment	90%*
Inpatient – Out-of-network	80%*	70*%	70*%	70*%	70*%	70*%	70%*
		Prior authorization required					
Outpatient – In network	$15 co-payment per visit	$5 co-payment per visit	$5 co-payment per visit	$5 co-payment per visit	$5 co-payment per visit	$5 co-payment per visit	90%*
Outpatient – Out-of-network	80%*	70%*	70%*	70%*	70%*	70%*	70%*
PRESCRIPTION DRUG COVERAGE (administered by CVS Caremark)							
	National Grid PPO	**Harvard Pilgrim Health Care**	**Blue Choice 2 New England (NH & RI)**	**Fallon Community Health Plan**	**Health New England***** **	**MVP Select Care**	**BCBS Consumer Driven Health Plan***
Retail (30-day supply)							
Generic (Tier I)	$20 co-payment	$10 co-payment					10% after deductible
Preferred Brand (Tier II)	$30 co-payment	$20 co-payment					10% after deductible
Non-Preferred Brand (Tier III)	$50 co-payment	$50 co-payment					10% after deductible
Mail Order Maintenance Drugs (90-day supply)							
Generic (Tier I)	$40 co-payment	$20 co-payment					10% after deductible
Preferred Brand (Tier II)	$60 co-payment	$40 co-payment					10% after deductible
Non-Preferred Brand (Tier III)	$100 co-payment	$100 co-payment					10% after deductible

* After you satisfy your deductible.
** Health New England is only available for employees represented by Local 326, 486 and 1465.
*** Health New England's plan design has a $250/$250 out-of-pocket maximum on medical and a separate $250/$250 out-of-pocket maximum on prescription.
**** Mandatory mail order (picked up at retail or via mail) for maintenance drugs, generic step therapy and specialty preferred drug therapy applies to all plans.
***** NOTE: Prior authorization may be required for certain medications
The deductibles and out-of-pocket maximums cross accumulate across in- and out-of-network.

MEDICAL COSTS*

	Preferred Provider Organization (PPO) (National Grid PPO, Blue Cross Blue Shield of Massachusetts)			Point-of-Service (Harvard Pilgrim, Blue Choice 2 New England (NH & RI), Fallon Community Health Plan, Health New England**, MVP Select)			BCBS Consumer Driven Health Plan*		
	Individual	2-Person	Family	Individual	2-Person	Family	Individual	2-Person	Family
Total monthly cost	$702.41	$1,404.82	$2,004.01	$733.81	$1,467.62	$2,093.50	$630.46	$1,260.92	$1,798.95
National Grid pays	$561.93	$1,123.86	$1603.21	$587.05	$1,174.10	$1,674.80	$567.41	$1,134.83	$1,619.05
New England Union employees pay	$140.48	$280.96	$400.80	$146.76	$293.52	$418.70	$63.05	$126.09	$179.90
Credit	($12.52)	($25.05)	($35.79)	($12.82)	($25.63)	($36.62)	($5.66)	($11.32)	($16.17)
Full-time employees pay monthly	$127.96	$255.91	$365.01	$133.94	$267.89	$382.08	$57.39	$114.77	$163.73
Full-time employees pay weekly	$29.53	$59.06	$84.23	$30.91	$61.82	$88.17	$13.24	$26.49	$37.78
80% part-time employees pay weekly	$56.04	$112.08	$159.88	$58.60	$117.19	$167.16	$39.69	$79.38	$113.25
60% part-time employees pay weekly	$82.56	$165.11	$235.53	$86.28	$172.57	$246.15	$66.14	$132.28	$188.73

*Deducted in pre-tax dollars
** Health New England is only available for employees represented by Local 326, 486 and 1465

CUSTOMER SERVICE TELEPHONE NUMBERS AND WEBSITES FOR EACH PLAN

	National Grid PPO	Harvard Pilgrim Health Care	Blue Choice 2 New England (NH & RI)	Fallon Community Health Plan	Health New England**	MVP Select Care	Blue Cross Blue Shield (BCBS)	Health Equity for HSA
For a provider directory, service area map or more information, call:	1-800-287-8757	1-888-333-4742	1-800-287-8757	1-800-868-5200	1-800-791-7944	1-800-229-5851	1-800-588-5507	1-866-346-5800
Or visit their Web site at:	www.bluecrossma.com	www.harvardpilgrim.org/member	www.bluecrossma.com	www.fchp.org	www.hne.com	www.mvphealthcare.com	www.bluecrossma.com/wps/portal	www.healthequity.com

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

DENTAL BENEFITS

Delta Dental of Massachusetts: For more information, contact the plan at 800-872-0500 or visit www.deltadentalma.com

Dental Benefits	Annual Deductible	Plan Years (after deductible)	Plan Maximum
Type I: Diagnostic and Preventive Services • Exams and cleanings, two times per year • X-rays • Fluoride for children under age 19 • Space maintainers	None	100%	$2,000 per calendar year/per person (excludes orthodontia)
Type II: Basic Restorative Services • Fillings (once every 24 months) • Oral surgery • Anesthesia • Extractions • Root canal therapy • Treatment of gum disease	Individual: $50 Family: $150	80% (after annual deductible)	
Type III: Major Restorative Services • Inlays • Crowns • Dentures • Bridgework • Repair or maintenance to any of the above		50% (after annual deductible)	
Orthodontia (for children up to age 19, or if a full-time student, age 25)	None	50%	$1,500 lifetime maximum per child
Dependent coverage	Until December 31 of the year the dependent attains age 19 or age 25 if full-time student		

When you and your family receive care from a participating dentist, no claim forms are necessary. Your dentist files claims for you.

DENTAL COSTS*

	Delta Dental of Massachusetts		
	Individual	2-Person	Family
Total monthly cost	$40.11	$80.22	$114.32
National Grid pays	$32.09	$64.18	$91.46
New England Union employees pay	$8.02	$16.04	$22.86
Full-time employees pay weekly	$1.85	$3.70	$5.28
80% part-time employees pay weekly	$3.33	$6.66	$9.50
60% part-time employees pay weekly	$4.81	$9.63	$13.72

*Deducted in pre-tax dollars

PUC 1-39

Request:

Please provide the average health care cost per employee incurred by the Company during the years 2015 and 2016. Please provide the working rate used for each of the respective years.

Response:

The average health care cost per employee for The Narragansett Electric Company for 2015 and 2016 is provided on Attachment PUC 1-39-1. The working rates used for 2015 and 2016 are provided on Attachment PUC 1-39-2.

Prepared by or under the supervision of: Maureen P. Heaphy

The Narragansett Electric Company and National Grid USA Service Company, Inc.
2015 and 2016 Healthcare Costs

Narragansett Electric Company
Summary of Healthcare Costs - 2015
Based on Claims Incurred in 2015

	Total Cost	No. of Employees	Per Employee Cost
Healthcare *	$10,958,060.50	766	$14,305.56

*Includes Medical and Dental

Narragansett Electric Company
Summary of Healthcare Costs - 2016
Based on Claims Incurred in 2016

	Total Cost	No. of Employees	Per Employee Cost
Healthcare *	$9,929,277.00	763	$13,013.47

*Includes Medical and Dental

National Grid USA Service Company
Summary of Healthcare Costs - 2015
Based on Claims Incurred in 2015

		Total Cost	No. of Employees		Per Employee Cost
Healthcare *	$	72,559,683.19	5,318	$	13,644.17

* Includes Medical and Dental

National Grid USA Service Company
Summary of Healthcare Costs - 2016
Based on Claims Incurred in 2016

		Total Cost	No. of Employees		Per Employee Cost
Healthcare *	$	99,481,066.20	5,958	$	16,697.06

* Includes Medical and Dental

Narragansett Electric Company Working Rates

Management	2015			2016		
	Ind	Ind+1	Family	Ind	Ind+1	Family
National Grid EPO	679.18	1,358.37	1,942.73	658.58	1,317.16	1,879.89
National Grid PPO	630.20	1,260.40	1,799.50	648.59	1,297.17	1,850.61
Regional PPO (Harvard Pilgrim, Independent Health, MVP Select Care, Oxford Health)	630.20	1,260.40	1,799.50	648.59	1,297.17	1,850.61
BCBSMA CDHP	N/A	N/A	N/A	601.02	1,202.04	1,715.05
Delta Dental	47.98	95.96	136.75	48.19	96.38	137.35

Union	2015			2016		
	Ind	Ind+1	Family	Ind	Ind+1	Family
BCBSMA PPO	795.15	N/A	1,913.50	865.42	-	2,314.22
BCBSMA CDHP	N/A	N/A	N/A	630.46	1,260.92	1,798.95
POS (Harvard Pilgrim, Fallon, Health New England, MVP)	716.78	1,433.35	2,046.29	733.81	1,467.62	2,093.50
Delta Dental	41.16	82.32	117.31	40.11	80.22	114.32

National Grid USA Service Company Working Rates

Management	2015			2016		
	Ind	Ind +1	Family	Ind	Ind +1	Family
National Grid EPO	679.18	1,358.37	1,942.73	658.58	1,317.16	1,879.89
National Grid PPO	630.20	1,260.40	1,799.50	648.59	1,297.17	1,850.61
Regional PPO (Harvard Pilgrim, Independent Health, MVP Select Care, Oxford Health)	630.20	1,260.40	1,799.50	648.59	1,297.17	1,850.61
BCBS CDHP	N/A	N/A	N/A	601.02	1,202.04	1,715.05
Delta Dental	47.98	95.96	136.75	48.19	96.38	137.35

Union	2015			2016		
	Ind	Ind +1	Family	Ind	Ind +1	Family
BCBS MA PPO	795.15	N/A	1,913.50	788.36	N/A	1,895.22
National Grid Custom Choice Plus PPO	866.24	N/A	2,084.09	858.96	N/A	2,064.66
National Grid PPO	688.46	1,376.91	1,965.58	702.41	1,404.82	2,004.01
BCBS CDHP	617.60	1,235.19	1,763.63	630.46	1,260.92	1,798.95
BCBS PPO	829.96	N/A	2,221.72	865.42	N/A	2,314.22
Harvard HMO	1,012.00	N/A	2,727.95	1,114.06	N/A	3,003.36
POS (Blue Choice 2 New England, Fallon, Harvard Pilgrim, Health New England)	716.78	1,433.55	2,046.29	733.81	1,467.62	2,093.50
Delta Dental	41.16	82.32	117.31	53.72	N/A	128.92

PUC 1-40

Request:

Please provide an itemized list of all vehicles leased or purchased by National Grid and the Company. For each vehicle, please provide the make, model, year and rental charge or original book value. In the response, please separate the distribution company vehicles out by Narragansett Electric and Narragansett Gas. For purposes of this question, vehicle includes all equipment used on or off-road for electric or gas operations (i.e., backhoes, trailers, etc.

Response:

The Company uses several methods to reduce health care costs:

A) Given the very large size of the employee population, the Company has elected to self-insure employee healthcare claims. This eliminates the cost risk and margin charges and results in a situation where the Company is paying claims only where there is actual utilization of the insurance by employees and their dependents plus the administrative expense necessary for the plan administrators to pay claims.

B) The Company's prescription drug benefits are carved out of the medical plans to a single Prescription Benefits Manager. This approach makes it possible for the Company to leverage a volume discount with one national vendor and achieve economies of scale.

C) The Company's medical plans provide low cost or free health and wellness programs designed to reduce health care risks, reduce the occurrence of costly diseases, and improve the health status of the employees. Weight control, smoking cessation, and chronic disease management are a few of the many kinds of programs available to employees through the medical plans. Specifically, Blue Cross Blue Shield of MA (BCBSMA), National Grid's medical vendor with the largest enrollment, offers a clinical decision support tool to help members make more informed treatment decisions for preference-sensitive conditions, including musculoskeletal disorders that may lead to back surgery or joint replacement. These programs, combined with coverage for preventive check-ups and screenings, provide a benefit structure that, over time, should help to mitigate costs and improve employee wellness.

D) The Company's medical plans cover in-network preventative services at 100 percent, which promotes the well-being of employees.

E) The Company's plans employ utilization review practices that review intended admissions, oversee ongoing admissions, require pre-approval for home health services, and mandate case management for large claims.

Prepared by or under the supervision of: Maureen P. Heaphy

F) The Company implemented Consumer Driven Health Plans (CDHP) coupled with an employee funded Health Savings Account (HSA) for both its non-union employees and the union employees in The Narragansett Electric Company. This is expected to help drive consumerism and promote a culture of health by improving cost control, quality, patient compliance, and healthy outcomes.

G) The Company uses plan design components to encourage the efficient use of medical services. In 2018, over 60 percent of non-union employees will be enrolled in a CDHP medical plan. The CDHP plan with the highest enrollment is the Health Savings Plan. The Health Savings Plan has an annual deductible of $1,800/$3,600 for individual/family coverage and 90 percent coinsurance for office visits, inpatient services, outpatient surgery, emergency room visits and diagnostic labs, x-rays, advanced radiology, and prescription drugs. The plan is designed to encourage awareness in the use and cost of health care.

H) The Company introduced several utilization programs in an effort to control the cost of prescription drug coverage: prior authorization is required for compounded drugs; generic step therapy and specialty preferred drug therapy was introduced as well as an exclusive specialty pharmacy program that requires all specialty medications to be processed through and delivered by CVS Caremark. In addition, for the non-union plans, bulk powders on compound drugs were excluded and an advanced control specialty formulary was introduced to help ensure clinically appropriate utilization of specialty therapies.

I) The Company's largest medical vendor, BCBSMA, has implemented solutions for enhancing cost and quality transparency, which gives members access to even greater resources to help with their healthcare planning.

J) The Company introduced Telehealth into the BCBSMA medical plans. Telehealth covers both medical and behavioral health care for conditions that can be treated through video visits at the in-network primary care office visit coverage level. Care Concierge consists of a team of dedicated nurses that help employees and their families learn more about health conditions, healthier habits and programs and resources available to get the most from the health plans.

K) Employees are required to pay a portion of the monthly cost for the plans, with the plans priced to reflect the varying benefit levels and network limitations that may apply. For management employees, the cost sharing is assessed each year to be consistent with the marketplace. For union employees, contributions are collectively bargained.

L) The Company has eliminated all payments to employees who opt-out of medical coverage.

Prepared by or under the supervision of: Maureen P. Heaphy