EVERSOURCE

2017 Benefits Open Enrollment
Represented Employees
October 2016

The deadline for enrolling in 2017 benefits is November 10, 2016.

Dear Fellow Employee:

As an Eversource employee, you have access to a wide variety of benefits. Your benefit programs are designed to help keep you and your family healthy and financially secure with coverage options that feature choice, flexibility, and tax-savings opportunities.

ENROLLING IN YOUR HEALTH CARE BENEFITS

- **Enroll in Workday**
  All employees will make their enrollment elections online through Workday. Instructions for enrolling through Workday are included within the enclosed guide on pages 17, 18 and 19; and more detailed instructions can be found in Workday job aids at www.eversource.com/EmployeeEnrollment.
- **New enrollment website at www.eversource.com/EmployeeEnrollment**
  In addition to the employee intranet and HRConnect, you also have an external webpage you can access without logging into the Eversource network. You can find the following materials on this webpage:
  - 2017 Schedule of Health Care Costs
  - Instructions for using Okta Extra Verification (if you want to enroll remotely)
  - Workday job aids with detailed instructions for enrolling and adding a new dependent
  - Electronic versions of your enrollment guide
- **Accessing Workday remotely**
  To access Workday, Workforce, Eversource's intranet, or other Eversource applications while at home or from the public internet, you will need to install Okta Extra Verification to work with your cell phone or tablet and configure a few settings. Directions for installing Okta Extra Verification are located at www.eversource.com/EmployeeEnrollment.
- **If you do not enroll**
  Most of your elections will roll over into 2017—your elections for medical (including your Health Savings Account contribution amount if you elected the Saver option for 2016), dental, vision and life and accident coverage—if you do not enroll. You must actively enroll if you want to change an election, opt out of coverage, elect Legal Assistance, or contribute to a flexible spending account.

ELECTING VACATION BUY HOURS

- **Enroll in WorkForce**
  You will purchase additional vacation hours through WorkForce, our time and attendance system. You can access WorkForce from the employee intranet home page and the HRConnect pages. You can also access WorkForce from home using Okta Extra

Verification. Detailed instructions for electing your Vacation Buy hours for 2017 are included in the enclosed ***Electing Vacation Buy Guide*****.** If you have questions about WorkForce, please call HRConnect at 1-800-841-8684 and select the "Payroll" prompt.

The benefits and programs Eversource makes available to you and your family are a significant part of your total compensation. Understanding your choices, their associated costs, and the level of benefits they provide is essential for deriving the most value from these programs. Please read the enclosed enrollment materials carefully and choose the most appropriate options for you and your family.

If you have questions regarding enrollment or your benefits, call HRConnect at 1-800-841-8684 and select the "HR Generalist" prompt.

Sincerely,

Michael P. Synan
Director, Benefits Strategy

2017
Open Enrollment

Deadline November 10

EVERSOURCE

Represented Employees in CT, NH, and Western MA

WELCOME

Eversource's benefit programs are designed to help keep you and your family healthy and financially secure with coverage options that feature choice, flexibility, and tax-savings opportunities. This guide is custom-designed for you to learn about and select the benefit choices available to you and your eligible dependents.

Getting started

This guide describes each of your 2017 benefit options and includes important details to help you make informed elections for you and your family. It leads you through the enrollment process step-by-step and in the same order as your benefits enrollment screens in Workday to make it easy for you to follow along.

What should I do first?

Read through this enrollment guide first to learn about any changes. If you have a spouse or other family members who are impacted by enrollment, review the options outlined in this book with them before logging in to make your elections.

How do I enroll?

You will enroll online through Workday. Log into Workday to view your open enrollment benefit options, the cost you will pay for each option, and the cost Eversource pays on your behalf. Please see page 17 for your specific enrollment instructions.

When is my enrollment deadline?

You have until November 10, 2016, to enroll for benefit elections effective January 1, 2017. All enrollment activities are completed online in Workday.

Can I change my elections at any other time during the year?

Once enrolled, your benefits will be effective January 1, 2017, and will remain in effect until December 31, 2017. Annual open enrollment is the only time during the year that you can make changes to your benefit elections unless you experience a qualifying life event or HIPAA special enrollment event. If you experience a qualifying life event, you must log into Workday and initiate a "Change Benefits" request through the "Benefits" worklet (from the home page of Workday), within 31 days of the event.

What if I don't enroll?

Some of your elections—your medical option election (including your Health Savings Account contribution amount if you elected the Saver option for 2016), dental option election, vision election, and amount of life, accident and long-term disability coverage—will roll over into 2017. You must actively enroll if you want to change an election, opt out of your current coverage, contribute to a flexible spending account, or participate in the Legal Assistance benefit.

Your Open Enrollment Guide

This Open Enrollment Guide serves as your summary of material modifications (SMM) to the summary plan description for the Eversource Flexible Benefits Plan and the Group Welfare Benefits Plan for Employees of Eversource. Please retain a copy of this guide for your records so you can read it together with your summary plan description (as formally amended by this SMM) in order to fully understand your benefits.

Step 1 | LEARN ABOUT ANY CHANGES

Every year, as a result of new health care reform requirements, IRS limits, or adjustments to benefit administration, your benefits will undergo change. To help you see the changes to your benefits before making new elections, we've included the changes to be aware of as you enroll for 2017 benefits below.

Health Savings Account and the Saver Medical Option

Company contributions to the Health Savings Account (HSA) are increasing for represented employees who enroll in the Saver medical option for 2017 depending upon bargaining unit.

Employees represented by the Connecticut Teal contract and represented employees in western Massachusetts who enroll as an employee plus one or more dependents in the Saver medical option for 2017 will receive an additional $250 in company contributions into their HSA, for a total of $1,250 for 2017. Or, they will receive an additional $125 in company contributions into their HSA if they enroll as an employee only in the Saver medical option for 2017, for a total of $625.

The remaining represented employees in Connecticut and New Hampshire will receive $1,000 (if enrolling as an employee plus one or more dependents) and $500 (if enrolling as an employee only) in contributions to their HSA for 2017 if they elect the Saver medical option for 2017.

The overall limit on contributions to tax-favored accounts, like the HSA, is determined each year by the IRS. The maximum contribution amounts (company and employee combined) to the HSA in 2017 as an employee only is $3,400, and as an employee plus one or more dependents is $6,750. Employees age 55 or older at any time in 2017 can contribute an additional $1,000. Please see the chart on page 12 for more information.

Optional Life and Accident Insurance

Represented employees in western Massachusetts have a new life and accident insurance program, effective January 1, 2017. Please refer to the separate Life and Accident Insurance booklet included with your enrollment materials for more detailed information about these benefits.

Vacation Buy

Any represented employee who is eligible to purchase additional vacation time during open enrollment will do so in our time and attendance system, WorkForce. Please refer to the separate Vacation Buy insert for more detailed instructions on how to enroll for this benefit.

Enrollment through Workday

All employees will make their enrollment elections online through Workday. Instructions for enrolling through Workday are included on page 17. More detailed instructions can also be found within Workday benefit enrollment job aids posted on the HRConnect web pages and at www.eversource.com/EmployeeEnrollment.

Coming Soon: New telehealth services for Eversource employees

Beginning January 1, 2017, Cigna will begin offering Eversource employees new "telehealth" services—online and on-demand health care services that offer participants 24/7/365 access to online video or telephone consultations with Board Certified internal medicine, family practice, and pediatric physicians. Look for more information about this exciting new service soon in *Today* and on HRConnect.

Step 2 | ADD OR REMOVE DEPENDENTS

Open enrollment provides you the opportunity to add or remove dependents from coverage. If you are adding a dependent, please follow the instructions below, and remember to electronically attach your required verification documents in Workday to ensure your dependent is included in coverage.

Your Dependents

Before you determine which medical option to consider, determine whom you want to cover. You should also add or remove any dependents within the Workday online enrollment process before you choose a medical option to ensure Workday calculates the most accurate rates for your coverage.

Whom Can You Add to Coverage?

- Your legal spouse (same sex or opposite sex);
- Your dependent child through the last day of the month in which he or she reaches age 26, who is a natural child or legally adopted child (or a child for whom you have entered into a formal order of adoption), stepchild, foster child, or a child for whom you are legal guardian;
- Your unmarried child (as described above) will continue to be eligible after his or her 26th birthday if deemed mentally or physically incapable of self support (subject to annual certification once the child reaches age 26) and covered under the Plan immediately prior to turning age 26.

Verification Documents

If you add a new dependent during this open enrollment period, you must submit certain required documents electronically to verify dependent eligibility when you enroll online in Workday. Required documents are as follows:

- Legal Spouse (same sex or opposite sex): marriage certificate
- Children: birth certificate, adoption certificate, guardianship papers, or foster care agreement

Workday Job Aid

If you need more detailed instructions for adding a dependent in Workday, please refer to the Workday job aid for adding a dependent during enrollment. You can find the Workday enrollment job aids from a link on the home page of the HRConnect web pages and at www.eversource.com/EmployeeEnrollment.

If you are adding a dependent

Your new dependent will not be covered unless you electronically attach all dependent eligibility verification documents in Workday by November 10, 2016.

Designate beneficiaries with Minnesota Life

Minnesota Life provides life and accident insurance beneficiary designation and record-keeping services for Eversource. If you are electing a new life or accident benefit, Minnesota Life will reach out to you with instructions for designating a beneficiary. If you want to make changes to your beneficiary designation, please go to LifeBenefits.com or call 1-866-293-6047 for assistance.

Step 3 | HEALTH CARE ELECTIONS: MEDICAL

Compare medical options and choose one that best fits your needs and those of your family. Cigna is your medical benefit carrier.

Your Medical Options

You have two Preferred Provider Organization (PPO) medical options and one high-deductible medical option (Saver) from which to choose in addition to the option to waive medical coverage if you have coverage elsewhere:

- ◯ Saver Medical Option
- ◯ PPO 100 Medical Option
- ◯ PPO 90 Medical Option
- ◯ Opt out of medical coverage (receive taxable compensation unless you are a covered dependent — spouse or child — under another Eversource option)

Coverage details are outlined on the following pages. Consult the Medical Option Comparison charts to view a side-by-side comparison and learn what the out-of-pocket maximum amounts mean for each option to help you determine which option is most appropriate for you.

Medical Opt-Out

Eversource will automatically provide you with a $500 lump sum opt-out payment in January if you waive medical coverage for 2017 and you are not a covered spouse or child dependent under another Eversource medical program.

If you have a qualifying life event during the year and later enroll in a medical option, you will owe a pro-rated amount back to Eversource through a payroll adjustment.

Coverage Levels

You also have the choice of whom, in addition to yourself, you want to cover under medical benefits. Your coverage level options (for example, you only, you and spouse, you, spouse and children, etc.) will be displayed for you within Workday.

Prescription Drugs

Prescription drug benefits are included with your medical option election. If you enroll in the PPO 100 or PPO 90 medical option, your prescription drug coverage will be administered by Express Scripts and you will have a copay and coinsurance for non-formulary retail pharmacy benefits as indicated below. It will also be mandatory for you to fill your maintenance medications through the Home Delivery Pharmacy.

If you enroll in the Saver medical option, your prescription drug coverage will be administered by Cigna and you will have to first satisfy the deductible ($1,300 as an employee only or $2,600 as an employee plus one or more dependents) and then the prescription drug copays, as indicated below, will apply.

Medical Option	**Type of Drug**	**Retail Pharmacy** (Up to a 34-day supply)	**Mail Order** (Up to a 90-day supply)	
PPO 100 and PPO 90 (Express Scripts)	Generic	$6	$12	Mail order is mandatory for maintenance medications
	Brand (Formulary)	$25	$50	
	Non-Formulary	50% coinsurance (up to an annual $1,000 maximum/person)	$97	
Medical Option	**Type of Drug**	**Retail Pharmacy** (Up to a 30-day supply)	**Mail Order** (Up to a 90-day supply)	
Saver Option (Cigna) (copays apply once the annual deductible is met; there are no copays or deductible for generic medication considered preventive)	Generic	$0	$12	Mail order is NOT mandatory for maintenance medications
	Brand (Formulary)	$25	$50	
	Non-Formulary	$50	$97	

Glossary of Health Care Terms

Coinsurance

The percentage of allowed charges for covered services that you are required to pay. For example, your benefits plan may cover 90 percent of charges for a covered hospitalization, and you will be responsible for the other 10 percent up to your maximum out-of-pocket limits. This 10 percent cost is known as the coinsurance.

Copayment (Copay)

A flat dollar amount you must pay for a covered service. For example, you may have to pay a copayment for each covered visit to a primary care or specialist doctor. Copays are not always subject to the out-of-pocket limit.

Deductible

The amount you pay each year before your benefits plan shares in the cost of certain services. The deductible may not apply to all services. For example, preventive care is always covered and no deductible will be required before your preventive services are paid.

Formulary

A list of approved prescription drug medications that your benefits plan will cover. Your formulary includes both generic and brand-name drugs and categorizes them into different coverage tiers.

Out-of-Pocket Costs

Your expenses for medical care that are incurred when you seek care and are not reimbursed by insurance. Out-of-pocket costs include deductibles, coinsurance, and copays for covered services, plus all costs for services that aren't covered—including amounts above the maximum reimbursable fees.

Out-of-Pocket Limit

The most you can pay for certain copays and any deductibles and coinsurance amounts. Once you pay this amount out of your pocket during the year, your benefits plan usually pays 100 percent of covered services, excluding payroll contributions. If you elect medical options PPO 100 or PPO 90, you will continue to pay for provider office visit copays and prescription drug copays. If you elect the Saver medical option, all in-network covered expenses—including copays—are limited to the total out-of-pocket maximum limit.

In no event will out-of-pocket costs in any medical option plan design exceed the maximum limits established under Affordable Care Act regulations. In 2017, the limits are $7,150 for individual coverage and $14,300 for family coverage. Limits under each option will be significantly lower for some services. Lower limits are imposed by Plan rules and may not apply to all services.

Compare medical rates

You can quickly access your rates without logging into Workday by going to www.eversource.com/EmployeeEnrollment and clicking on the 2017 Health Care Cost document that applies to you.

If you have coverage elsewhere

Please be advised that if you elect the Saver medical option and you have non-high-deductible coverage elsewhere, you will be in violation of IRS regulations.

In-network preventive care is covered at 100 percent

Preventive care includes periodic well visits, routine immunizations, certain prescription drugs, and routine screenings provided on an age-based schedule. Preventive care is covered at 100 percent no matter which medical option you elect. Preventive care determination is generally made by your physician based on your age, gender and family history.

Medical Option Comparison Charts

In-Network Coverage

This chart refers to benefit coverage available if you use a provider who participates in the Cigna network.

In-Network Highlights	PPO 90	PPO 100	Saver Option
Lifetime Maximum	Unlimited		
Annual Deductible	$250 per person up to a $500 family maximum	None	$1,300 employee only OR $2,600 employee plus one or more dependent(s)
Coinsurance	10%	None	10%
Annual Out-of-Pocket (OOP) Maximum* (Includes Deductible)	$1,500 per person up to a $3,000 family maximum	$750 per person up to a $1,500 family maximum	$2,500 employee only OR $5,000 employee plus one or more dependent(s)
Health Care FSA or HSA	Health Care FSA	Health Care FSA	HSA
Employer HSA Funding Non-Represented Employees, Represented Employees in Western MA, and Employees Represented by Local 12004 and the CT Teal Contract	No	No	$625 employee only OR $1,250 employee plus one or more dependent(s)
Employer HSA Funding Employees Represented by Local 369 and all other Represented Employees in CT and NH	No	No	$500 employee only OR $1,000 employee plus one or more dependent(s)
Prescription Drug (Retail Copays)	No deductible applies $6 (generic) $25 (brand) 50% of cost up to $1,000 (non-formulary) Express Scripts	$6 (generic) $25 (brand) 50% of cost up to $1,000 (non-formulary) Express Scripts	Full cost until deductible is met; then copays apply: $0 (generic) $25 (brand) $50 (non-formulary) Cigna
Prescription Drug (Mail Order Copays)	No deductible applies $12 (generic) $50 (brand) $97 (non-formulary) Express Scripts	$12 (generic) $50 (brand) $97 (non-formulary) Express Scripts	Full cost until deductible is met; then copays apply: $12 (generic) $50 (brand) $97 (non-formulary) Cigna
Office Visit (PCP)	$20 copay No deductible applies	$15 copay	10% coinsurance after meeting deductible
Office Visit (Specialist)	$35 copay No deductible applies	$30 copay	
Preventive Care[1]	100% covered, No deductible applies	100% covered	100% covered, No deductible applies
Inpatient Hospital	10% coinsurance after deductible	$150 per day (not to exceed $300 per admission)	10% coinsurance after deductible is met
Outpatient Surgery		$150 copay	
Emergency Room	$100 copay (waived if admitted)	$100 copay (waived if admitted)	
Urgent Care/Walk-In	$30 copay	$30 copay	
Lab and X-Ray	10% coinsurance after deductible	100% covered	
Advanced Radiology (MRI, CAT/PET Scan)		$150 copay	
Infertility Procedures	Plan pays $25,000 lifetime maximum per person for in- and out-of-network combined for procedures related to artificial insemination, in-vitro fertilization, GIFT and ZIFT.		
Hearing Aid Device	Up to $1,000 lifetime maximum benefit for the hearing aid device.		

[1]Preventive care is determined by your physician. Any non-preventive services provided by an In-Network provider as part of a preventive care visit will be considered standard service and any annual deductibles, copays, and coinsurance will apply.

*In no event will out-of-pocket costs in any medical option plan design exceed the maximum limits established under Affordable Care Act regulations. In 2017, the limits are $7,150 for individual coverage and $14,300 for family coverage. Limits under each option will be significantly lower for some services. Lower limits are imposed by Plan rules and may not apply to all services. See pages 8 and 9 for more information.

Out-of-Network Coverage

This chart refers to benefit coverage available if you use a provider who DOES NOT participate in the Cigna network. The cost of out-of-network services is based on the carrier's maximum reimbursable charges (MRC), a defined fee schedule developed by the medical carrier and/or what other doctors in your area charge. You will pay 100 percent of costs above MRC and these amounts do not apply to your deductible or out-of-pocket maximum.

<table>
<tr><th>Out-of-Network Highlights</th><th>PPO 90</th><th>PPO 100</th><th>Saver Option</th></tr>
<tr><td>Lifetime Maximum</td><td colspan="3">Unlimited</td></tr>
<tr><td>Annual Deductible</td><td>$1,000 per person up to a $2,000 family maximum</td><td>$400 per person up to a $1,200 family maximum</td><td>Combined amount for in- and out-of-network, see In-Network chart</td></tr>
<tr><td>Coinsurance</td><td>30%</td><td>30%</td><td>30%</td></tr>
<tr><td>Annual Out-of-Pocket (OOP) Maximum (Includes Deductible)</td><td>$3,000 per person up to a $6,000 family maximum</td><td>$3,000 per person up to a $6,000 family maximum</td><td>Combined amount for In- and Out-of-Network, see In-Network chart</td></tr>
<tr><td>Health Care FSA or HSA</td><td>Health Care FSA</td><td>Health Care FSA</td><td>HSA</td></tr>
<tr><td>Employer HSA Funding</td><td>No</td><td>No</td><td>(See In-Network Chart)</td></tr>
<tr><td>Prescription Drug (Retail Copays)</td><td rowspan="2">No Out-of-Network coverage</td><td rowspan="2">No Out-of-Network coverage</td><td rowspan="7">30% coinsurance after deductible is met (No coverage for mail order prescription drugs)</td></tr>
<tr><td>Prescription Drug (Mail Order Copays)</td></tr>
<tr><td>Office Visit (PCP)</td><td rowspan="5">30% coinsurance after deductible is met</td><td rowspan="5">30% coinsurance after deductible is met</td></tr>
<tr><td>Office Visit (Specialist)</td></tr>
<tr><td>Preventive Care</td></tr>
<tr><td>Inpatient Hospital</td></tr>
<tr><td>Outpatient Surgery</td></tr>
<tr><td>Emergency Room</td><td>$100 copay per visit (waived if admitted)</td><td>$100 copay per visit (waived if admitted)</td><td rowspan="2">10% coinsurance after deductible is met</td></tr>
<tr><td>Urgent Care/Walk-In</td><td>$30 copay</td><td>$30 copay</td></tr>
<tr><td>Lab and X-Ray (at independent lab or facility)</td><td rowspan="2">30% coinsurance after deductible is met</td><td rowspan="2">30% coinsurance after deductible is met</td><td rowspan="2">30% coinsurance after deductible is met</td></tr>
<tr><td>Advanced Radiology (MRI, CAT/PET Scan) at outpatient facility</td></tr>
<tr><td>Infertility Procedures</td><td colspan="3">Plan pays $25,000 lifetime maximum per person for in- and out-of-network combined for procedures related to artificial insemination, in-vitro fertilization, GIFT and ZIFT.</td></tr>
<tr><td>Hearing Aid Device</td><td colspan="3">Up to $1,000 lifetime maximum benefits for the hearing aid device.</td></tr>
</table>

Legal Notices

A collection of legal notices is included with this enrollment guide. Keep this collection of notices with your Summary Plan Description and other benefit materials.

Medical Option Comparison Charts

How are the three medical options the same?

No matter which medical option you elect, your medical benefits will be administered by Cigna and the Open Access Plus/Tufts/Carelink network and the same network discounts apply. All preventive care is covered at 100 percent and you will have no lifetime maximums or pre-existing limitations on essential health services to worry about.

In-Network Services	PPO 90	PPO 100	Saver
:: Cigna/Open Access Plus/Tufts/Carelink network :: Same carrier discounts for in-network services :: Out-of-network coverage :: No referrals for specialty care :: No PCP designation required :: Same coverage rules for all services	✓	✓	✓
100% Coverage for Preventive Care :: Annual physicals, routine, age-based screenings, immunizations, etc. :: Preventive care is generally determined by your doctor	✓	✓	✓
:: No lifetime maximums or pre-existing condition limits :: No annual limits on essential health services :: Protection against catastrophic cost through out-of-pocket maximums	✓	✓	✓

Saver Medical Option

The Saver option has the lowest fixed paycheck cost but also has the least predictable out-of-pocket costs.

All services other than preventive care are subject to a deductible. After the deductible is satisfied, coinsurance and copays apply. One hundred percent of costs are subject to the annual out-of-pocket limits. Limits under the Saver option are based on the level of coverage you elect. If you elect "employee only" coverage, the annual deductible is $1,300 and your out-of-pocket maximum amount is $2,500. If you elect "employee plus one or more dependent(s)," the annual deductible is $2,600 and the out-of-pocket maximum is $5,000—and limits for this coverage level can be met by one individual or by all family members combined.

Saver Medical Option			
Service (In Network Only)	**You Pay**	**Is there a Deductible?**	**Does Out-of-Pocket Limit Apply?**
Preventive Care	$0	NO	NO
Prescription Drugs	Cigna Copays (after deductible)	YES - all services $1,300 employee only OR $2,600 employee plus one or more dependent(s)	YES - all services $2,500 employee only OR $5,000 employee plus one or more dependent(s) (Includes deductible)
PCP Office Visit	10%		
Specialist Office Visit	10%		
Urgent Care/Walk-in Clinic	10%		
Lab & X-Ray	10%		
Advanced Imaging (MRI, CT, PET)	10%		
Emergency Room	10%		
Outpatient Surgery	10%		
Inpatient Hospitalization	10%		

PPO 90 Medical Option

PPO 90 has a lower fixed paycheck cost than PPO 100 and more predictable out-of-pocket costs than Saver.

Although fixed copays apply for basic services, other services are subject to a deductible and coinsurance. All copays of $100 or more plus deductibles and coinsurance are subject to annual out-of-pocket maximum limits. Copays under $100 are not limited, which means that once you reach the out-of-pocket maximum amount, you will continue to pay these copays.

PPO 90 Medical Option			
Service (In Network Only)	**You Pay**	**Is there a Deductible?**	**Does Out-of-Pocket Limit Apply?***
Preventive Care	$0	NO	NO
Prescription Drugs	Express Scripts Copays		
PCP Office Visit	$20		
Specialist Office Visit	$35		
Urgent Care/Walk-in Clinic	$30		
Emergency Room	$100 (waived if admitted)		YES $1,500/person up to $3,000/family (Includes deductible)
Lab & X-Ray	10%	YES $250/person up to a $500 family maximum	
Advanced Imaging (MRI, CT, PET)	10%		
Outpatient Surgery	10%		
Inpatient Hospitalization	10%		

PPO 100 Medical Option

PPO 100 has the highest fixed paycheck cost and the most predictable out-of-pocket costs.

All charges are subject to a fixed copay amount and no deductibles apply. Only copays of $100 or more are subject to an annual out-of-pocket limit. Other services, such as office visit and prescription drug copays, are not limited.

PPO 100 Medical Option			
Service (In Network Only)	**You Pay**	**Is there a Deductible?**	**Does Out-of-Pocket Limit Apply?***
Preventive Care	$0	NO	NO
Prescription Drugs	Express Scripts Copays		
PCP Office Visit	$15		
Specialist Office Visit	$30		
Urgent Care/Walk-in Clinic	$30		
Lab & X-Ray	$0		
Advanced Imaging (MRI, CT, PET)	$150		YES $750/person up to $1,500/family
Emergency Room	$100 (waived if admitted)		
Outpatient Surgery	$150		
Inpatient Hospitalization	$150/day up to $300/ admission		

*In no event will out-of-pocket costs in any medical option plan design exceed the maximum limits established under Affordable Care Act regulations. In 2017, the limits are $7,150 for individual coverage and $14,300 for family coverage. Limits under each option will be significantly lower for some services. Lower limits are imposed by Plan rules and may not apply to all services.

Step 4 | HEALTH CARE ELECTIONS: DENTAL

You have two dental options from which to choose and the option to waive dental coverage. Your dental carrier is Delta Dental of Massachusetts.

Your Dental Options

Before you determine which dental option to consider, determine whom you want to cover. The coverage level for dental does not need to be the same as medical—this means you can choose to cover yourself only for dental and your family for medical. The two-year dental lock, however, remains in place. If you waive dental coverage, you won't be able to re-enroll in dental coverage for two years unless you experience a qualifying life event.

You have the following dental options:

- ○ Dental 1000
- ○ Dental 1800
- ○ Waive Dental Coverage

Dental Benefit Highlights	Your Costs under Dental 1000	Your Costs under Dental 1800
Your Annual Deductible	$50 per person to a family maximum of $150	$25 per person
Preventive and Diagnostic Treatment (exams, x-rays and cleanings)	20% after deductible	No cost; no deductible
Restorative and other Basic Services (standard amalgam and composite fillings, dentures, denture repair, simple extractions and root canals)	20% after deductible	20% after deductible
Oral and Periodontal Surgery (not subject to the calendar year maximum) *Please note that Delta Dental of MA is the primary insurance carrier when submitting oral or periodontal surgery claims.*	20% after deductible	20% after deductible
Prosthodontics and other Services (bridges and crowns; implants allowed once per 60 months per implant)	50% after deductible	40% after deductible
TMJ Appliance (subject to deductible and calendar year maximum)	50% after deductible	50% after deductible
Maximums Paid by the Plan	**Plan Pays**	**Plan Pays**
Calendar Year Maximum for Covered Services	$1,000 per person* (includes orthodontia)	$1,800 per person*
Lifetime Maximum for Orthodontia (for adults and children)	100% up to $750 lifetime maximum*; included in calendar year maximum; not subject to deductible	100% up to separate $1,800 lifetime maximum* per person; not subject to deductible
*You pay 100 percent of services once calendar and lifetime maximums have been paid by the Plan.		

Step 5 | HEALTH CARE ELECTIONS: VISION

Vision is a separate election from your medical option election. Vision Service Plan (VSP) is your vision administrator.

You can elect vision benefits independent of your medical and/or dental elections, which means you can elect vision coverage for yourself and any qualified dependent regardless of whom you cover under medical. You also don't need a benefit identification card when receiving care from a vision provider who participates in VSP's network. Always identify yourself as a VSP participant when scheduling your appointment.

Benefit	Description	Copay	Frequency
Well Vision Exam	Focuses on your eyes and overall wellness	$15	Every calendar year
Prescription Glasses		$25	See frame and lenses
Frame	- $130 allowance for a wide selection of frames - 20% off amount over your allowance	Included in Prescription Glasses	Every other calendar year
Lenses	- Single vision, lined bifocal, and lined trifocal lenses - Polycarbonate lenses for dependent children	Included in Prescription Glasses	Every other calendar year
Lens Options	- Standard progressive lenses - Premium progressive lenses - Custom progressive lenses - Average 20-25% off other lens options	Plan pays $55 (Standard) $95 – $105 (Premium) $150 – $175 (Custom)	Every other calendar year
Contacts (instead of glasses)	- $335 allowance for contacts (includes fitting and evaluation)	$0	Every other calendar year
Diabetic Eye Care Plus Program	- Services related to type 1 and 2 diabetes; ask your VSP doctor for details	$5	As needed
Extra Savings and Discounts	**Glasses and Sunglasses** - 20% off additional glasses and sunglasses, including lens options, from any VSP doctor within 12 months of your last Well Vision Exam		
	Laser Vision Correction - Average 15% off the regular price or 5% off the promotional price; discounts available only from contracted facilities		
Your Coverage with Other Providers (Out-of-Network Benefits)			
Visit vsp.com if you plan to see a provider other than a VSP doctor. Plan copays still apply. Exam: up to $45 Frame: up to $47	Single Vision Lenses: up to $45 Lined Bifocal Lenses: up to $65	Lined Trifocal Lenses: up to $85 Progressive Lenses: up to $85	Contacts: up to $105

Vision Benefit Authorization

Follow these steps each time you or your eligible dependents seek vision care so your provider can obtain benefit authorization on your behalf:

1. Locate a VSP provider by visiting www.vsp.com or by calling 1-800-877-7195.
2. Choose the VSP "Choice" network of providers.
3. Call the VSP provider to schedule an appointment.
4. Always identify yourself as a VSP participant when scheduling your appointment.

Step 6 | HEALTH SAVINGS ELECTIONS (SAVER OPTION ONLY)

If you enroll in the Saver medical option, you also have access to a Health Savings Account (HSA) administered by Cigna/HSA Bank. Once you elect the Saver medical option in Workday, you must also elect the HSA—even if you decide not to contribute additional funds. Eversource contributes money to your HSA depending on your employment status and which coverage level you elect.

If you enroll in the Saver medical option, **you must also elect the Health Savings Account (HSA) in Workday.** If you elected to contribute to the HSA in 2016, your election will roll over into 2017 unless you make a change. The IRS allows you to contribute pre-tax dollars in your HSA during enrollment to help you save and pay for your eligible health care expenses. The maximum amount you can contribute to the HSA (as determined by the IRS) is shown in the chart below. (If you are age 55 or older, you can make an additional contribution of up to $1,000.) The company contribution amount counts toward the annual maximum contribution amounts.

Coverage Level		IRS Maximum Contribution	Company Contribution	Remaining Amount You Can Contribute
Employee Only	Non-Represented Employees, Represented Employees in Western MA, and Employees Represented by Local 12004 and the CT Teal Contract	$3,400	$625	$2,775
	Employees Represented by Local 369 and all other Represented Employees in CT and NH	$3,400	$500	$2,900
Employee Plus One or More Dependent	Non-Represented Employees, Represented Employees in Western MA, and Employees Represented by Local 12004 and the CT Teal Contract	$6,750	$1,250	$5,500
	Employees Represented by Local 369 and all other Represented Employees in CT and NH	$6,750	$1,000	$5,750
Employees age 55 or older who are not enrolled in Medicare may contribute up to an additional $1,000.				

Enrolling in the HSA

If you are electing the Saver medical option, you must also elect the HSA in Workday during enrollment. Eversource will contribute to your HSA according to the chart above. You can also elect to make additional pre-tax contributions from your paycheck during enrollment through Workday.

Contributing to your HSA

- Contribute by automatic payroll deductions throughout the year, which can be changed at any time in Workday;
- Contribute by personal check, electronic funds transfer, after-taxes, up-front, and taking your tax deduction at the end of the year when you file your income tax return.

If you are age 65 or over and enrolled in Medicare

If you are age 65 or older and enrolled in Medicare, you are eligible to enroll in the Saver medical option, but you are not eligible to participate in the HSA. Contact HRConnect if you are enrolled or will be enrolled in Medicare.

Accessing the funds in your HSA

HSA funds are available for reimbursement only after you have contributed them. If you are a new HSA participant for 2017, you will receive a welcome package from Cigna/HSA Bank with more information about your account and a debit card for accessing your account funds. If you are currently participating in the HSA, continue to use your debit card for 2017.

Dependents and the HSA

Qualified medical expenses are those incurred by the following:

- You and your spouse;
- All dependents you claim on your tax return; and
- Any person you could have claimed as a dependent on your return except that:
  - The person filed a joint return,
  - The person had gross income over the limit as described in IRS Publication 969, or
  - You (or your spouse if filing jointly) could be claimed as a dependent on someone else's tax return.

Step 7 | SPENDING ACCOUNT ELECTIONS

Discovery Benefits is the administrator for Eversource's Health Care and Dependent Day Care Flexible Spending Accounts (FSAs).

Health Care FSA

You may contribute up to $2,550 on a pre-tax basis into a Health Care FSA for 2017. The amount you elect will be taken in equal amounts from each paycheck during the year. You can use the Health Care FSA for expenses you and your dependents* incur that are not covered by the medical, prescription drug, dental or vision benefits including:

:: Deductibles and copays
:: Charges that exceed maximum reimbursable limits
:: Expenses not covered by the Plan that meet IRS guidelines

The Health Care FSA includes the use of a debit card for convenient access to your funds. If you are electing to contribute to the Health Care FSA for the first time, Discovery Benefits will mail you a debit card for use beginning January 1, 2017.

If you are currently enrolled in the Health Care FSA and re-enroll to contribute for 2017, keep the debit card you have and continue to use it for 2017. Discovery Benefits will not mail you a new one unless your card is expiring.

**Dependents eligible for Health Care FSA reimbursements are those covered by an Eversource medical option (according to dependent rules described on page 3) and any qualified tax dependent.*

Dependent Day Care FSA

You may contribute up to $5,000 per family (or up to $2,500 per person if you are married and file a separate tax return) on an annual pre-tax basis to pay for dependent day care expenses for qualified tax-dependent children under 13 years of age and qualified elder dependents. You can use the Dependent Day Care FSA for the following expenses:

:: Babysitting and au pair services
:: Before- and after-school programs
:: Day care and nursery school
:: Pre-school programs
:: Senior day care and elder care services

FSA Rules and Restrictions

:: You do not need to elect an Eversource medical option to participate in either FSA.
:: You must re-enroll in the FSAs each year during open enrollment. Participation is not automatic.
:: Unused money in your FSA is forfeited—you must use it or you will lose it.
:: You will have until December 31, 2017, to exhaust 2017 Dependent Care FSA funds, and until June 30, 2018, to submit claims for reimbursement.
:: You will have until March 15, 2018, (the grace period) to exhaust 2017 Health Care FSA funds, and until June 30, 2018, to submit claims for reimbursement. You can use your debit card during the grace period.
:: You cannot transfer funds during the year between Health Care and Dependent Day Care FSAs.
:: Funds for reimbursement in the Health Care FSA are available January 1, 2017. Funds for reimbursement in the Dependent Day Care FSA are available as they are contributed to your Dependent Day Care FSA account.

If you enroll in the Saver option for 2017

If you enroll in the Saver option for 2017 (which includes the use of the Health Savings Account) and were enrolled in the Health Care FSA during 2016, any balance remaining in your 2016 Health Care FSA that rolls into 2017 will be subject to "limited use" rules and can be used only for eligible dental, vision and preventive care expenses from January 1 through March 15, 2017.

The Saver option and FSAs

Enrolling in the Saver option allows you to participate in a Health Savings Account (HSA) but prevents you from participating in a Health Care FSA. You may participate in the Dependent Care FSA regardless of which medical option you elect.

Step 8 INSURANCE ELECTIONS: OPTIONAL LIFE

Optional Employee Life insurance benefits are administered by Minnesota Life Insurance.

Optional Employee Life

You can waive or elect Optional Employee Life coverage in amounts equal to one, two, three or four times your annual base salary up to a maximum amount of $1.5 million. If you make no changes to your coverage during open enrollment, the same multiple of salary election you made for 2016 will remain for the 2017 Plan year. Employee contributions for this benefit will be on a pre-tax basis and amounts above $50,000 continue to result in imputed income.

If you are purchasing Optional Life for the first time, or you are choosing to increase your Optional Life amount, Minnesota Life will require you to provide evidence of insurability (EOI) and will contact you regarding those requirements. You will have 30 days to provide EOI to Minnesota Life.

Imputed Income

Because you pay for life insurance with pre-tax dollars, the value of your life insurance coverage beyond the first $50,000 is considered taxable income to you per IRS rules. This taxable income amount is shown separately on your pay stub. Imputed income is based on your age and the amount of life insurance you purchase.

Are you a represented employee in western Massachusetts?

Your life and accident benefits differ from what is described in this guide. Please refer to your Life and Accident Insurance Special Enrollment booklet included with this guide to learn more about your new life and accident insurance enrollment options.

Step 9 INSURANCE ELECTIONS: DEPENDENT LIFE

You can elect Dependent Life coverage for your dependents if you elect Optional Employee Life coverage of at least one times your annual base salary.

Minnesota Life is the Dependent Life carrier. You have the following three Dependent Life options, including the option to waive Dependent Life:

- ○ $5,000 for Spouse, $1,000 for Child
- ○ $10,000 for Spouse, $2,000 for Child
- ○ $15,000 for Spouse, $3,000 for Child
- ○ Waive Dependent Life

If you elect Dependent Life, you must select your eligible dependents for coverage from the "Enroll Dependents" column in Workday. (See page 17 for Workday enrollment instructions.) Employee contributions for this benefit will be on an after-tax basis. If you elected Dependent Life last year, your current coverage level will roll over into 2017, unless you elect otherwise. Any amount of coverage elected above your current coverage amount will require your spouse to satisfy evidence of insurability (EOI). Minnesota Life will contact you regarding the need for EOI and, if applicable, your spouse will have 30 days to submit EOI.

Step 10 | INSURANCE ELECTIONS: LONG-TERM DISABILITY

Long-Term Disability (LTD) insurance offers financial protection in the event of a serious illness or injury. You continue to have three LTD options from which to choose. Your LTD carrier is Liberty Mutual.

Eversource currently pays the full cost of your core LTD benefit, up to 40 percent of your pre-disability earnings (to a maximum of $200,000). Your cost for increasing your LTD coverage is provided to you in Workday. Your biweekly pre-tax deductions will be based on your base salary and will automatically change if your salary changes. **Employees are allowed to elect only one LTD option.**

- ○ 40 percent coverage (company-paid)
- ○ 60 percent coverage
- ○ 70 percent coverage

Benefits begin after six months of a qualified, continuous disability. You can elect to increase your LTD coverage to 60 percent or 70 percent of your pre-disability earnings (subject to the same $200,000 maximum). You will see an automatic increase in your biweekly deduction if you turn age 30, 40, or 50 in 2017. At age 60, the biweekly deduction decreases.

If you elect to increase your LTD

You do not need to provide proof of good health or evidence of insurability if you are electing above the company-paid coverage option during enrollment. However, a pre-existing condition limitation does apply. If you apply for additional coverage for the first time during this open enrollment period and later experience a disability related to an illness or injury (within the first twelve months of being covered) for which you received medical treatment or took prescription drugs during the three months immediately before the higher coverage amount becomes effective, your disability income will automatically revert to the prior coverage level.

Step 11 | INSURANCE ELECTIONS: OPTIONAL AD&D

You can purchase Accidental Death and Dismemberment (AD&D) coverage for yourself, your spouse and/or your child dependents. Minnesota Life is your AD&D carrier.

For yourself, you may elect any increment of $10,000 up to a maximum amount of $1.5 million. The bi-weekly pay period rates for AD&D coverage are provided to you in Workday. You must elect AD&D coverage for yourself to elect coverage for your dependents. The dependents you select from the "Enroll Dependents" column in Workday will automatically receive their own coverage as a percentage of the dollar amount you elect for yourself:

:: You and your children: 20% for each eligible child

:: You, your spouse, and children:

- If you have a spouse only, 70%
- If you have a spouse and children, 60% for spouse and 15% for each eligible child

If your spouse is an Eversource employee or Eversource retiree

If you are married to an Eversource employee or retiree, you cannot elect Optional Life, Optional AD&D, Dependent Life or Retiree Optional Life coverage for each other or duplicate coverage for your dependents under these elections. This means you, as an employee, cannot be covered as an employee under your own policy and also as a dependent spouse under your spouse's policy. It also means you cannot cover your dependent children under your policy and also as dependent children under your spouse's policy. You may be contacted once enrollment closes if a change in coverage is necessary.

Step 12 | ADDITIONAL BENEFITS: LEGAL ASSISTANCE

Hyatt Legal Plans, a MetLife company, offers Eversource employees a voluntary legal assistance benefit called MetLaw. This benefit is not a part of the Eversource Flexible Benefits Plan and is not sponsored by Eversource.

The MetLife legal assistance benefit offers access to a nationwide network of more than 13,500 attorneys and representation for $15.75 a month. With the MetLaw legal benefit, you can receive legal advice and representation on a wide range of matters, including estate planning documents, financial matters, real estate matters, immigration assistance and consumer protection.

Payroll deduction is required for the full cost of this benefit, and deductions are taken on an after-tax basis. Enrollment does not carry over from year to year—you must elect this benefit each year during the open enrollment period. Once enrolled, employees will be required to remain in the benefit for the full benefit plan year.

Limitations and restrictions apply

Certain limitations and restrictions apply to the Legal Assistance benefit. For more information and to find a participating attorney in your area, go to www.metlife.com/mybenefits, type in "Eversource" and click "Submit." Scroll down to the Group Legal Services section and click on either link. On the following screen, enter access code 6091090 to learn more.

More Information

If you are interested in enrolling and want to find out more about this benefit, go to www.metlife.com/mybenefits and enter "Eversource" in the account sign-in space and click "Submit." On the following screen, click either link under the Group Legal Services section. On the next screen, enter access code 6091090 to learn more. You can also call Hyatt Legal at 800-821-6400 Monday through Friday, 8 a.m. to 7 p.m. Eastern Time.

How do I use the benefit?

Once you enroll in MetLaw, you can access more information online at www.metlife.com/mybenefits by following the online instructions above. Once you reach the "Legal Plan Resource Center," click on the "Member Login" tab.

Internet Access

To verify your eligibility, you will be asked to enter the last four digits of your Social Security number and your postal ZIP code number. Once inside the Hyatt Group Legal website, you can:

:: Click on "Covered Services" to get an indication of whether your legal matter is covered (your Network Attorney will make the final determination);

:: Click on "Attorney Locator" to find the most convenient Network Attorney office;

:: Click on "Obtain Case Number" to get the case number your Network Attorney will need to provide service.

Telephone Access

Call 1-800-821-6400 Monday through Friday, 8 a.m. to 7 p.m. Eastern Time.

Be prepared to give the last four digits of your Social Security number to verify eligibility. If you are the spouse or an eligible dependent child of a participant, you will need the Social Security number of the employee through whom you are eligible.

Scheduling an Appointment

Once you obtain your case number, you then call the Network Attorney you select to schedule an appointment at a time convenient to you. When talking to the attorney's office, you should indicate that you are a new client referred to them by Hyatt Legal Plans and need to make an appointment for a new matter. Inquire about evening and Saturday appointments if you need one.

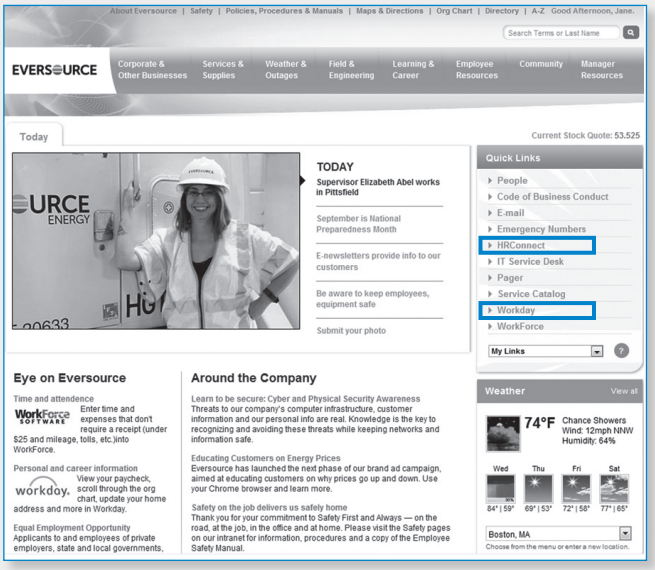
Enrollment Instructions

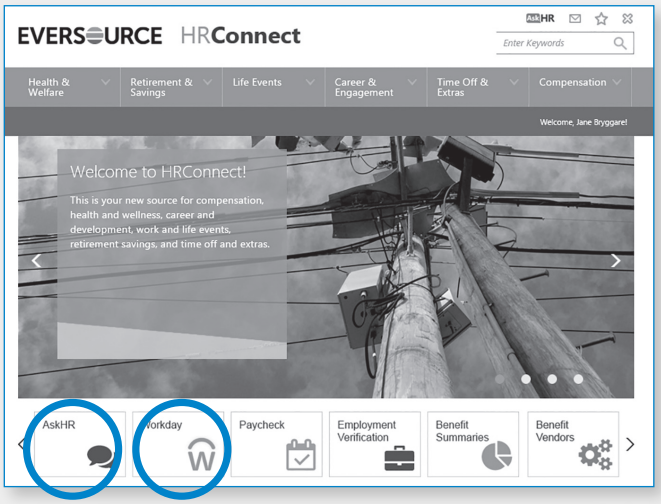
Your benefits enrollment will be done online through Workday. You can access Workday at work through the employee intranet home page and the HRConnect pages. You can also access Workday from home at Eversource.Okta.com.

Log onto the employee intranet by using your Windows user name and password that you use to log onto your computer at work. If you are not sure of your user name or password, contact the IT Support Center at 860-665-4357. You can make changes to your elections as many times as you like during the open enrollment period. Your last selections are processed once enrollment closes.

At Work

1. Click the "Workday" link in the "Quick Links" category located on the home page of the Eversource employee intranet.
2. You can also access Workday through HRConnect, your source for benefit and HR information. A link to "HRConnect" is also available in the "Quick Links" category on the employee intranet home page.
3. Once you arrive on the HRConnect home page, click on the "Workday" tab.



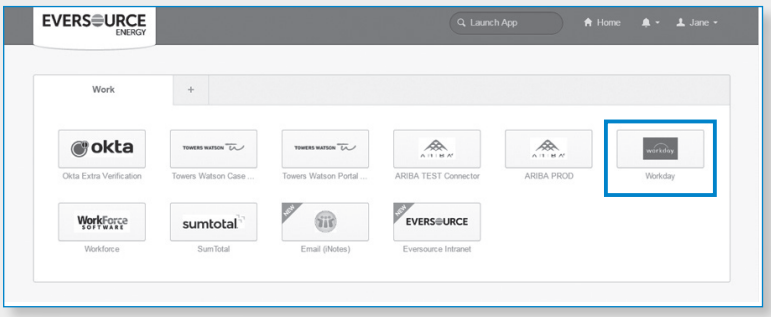


At Home

To access Workday, Workforce, Eversource's intranet, or other Eversource applications while at home or from the public internet, you will need to install **Okta Extra Verification** to work with your cell phone or tablet and configure a few settings. Directions for installing Okta Extra Verification are located at www.eversource.com/EmployeeEnrollment.

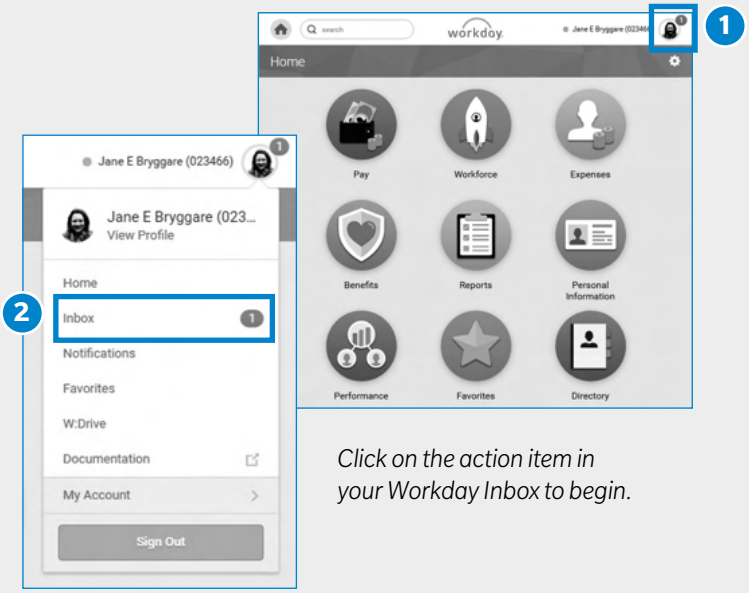
Once you register for Okta Extra Verification, you will access Workday from Eversource.Okta.com. From the Okta page, select the "Workday" application option.

If you need further assistance with setting up Okta Extra Verification, or you need assistance retrieving your Eversource username or password, please contact the IT Support Center by calling 860-665-4357.



Your Workday Inbox

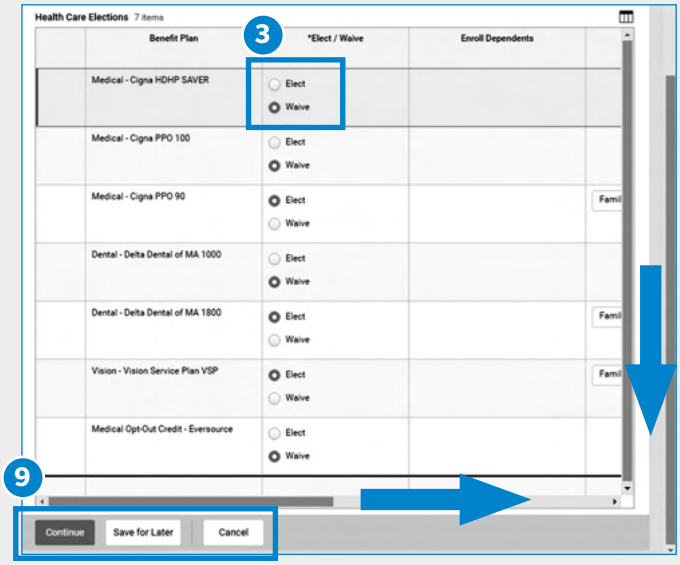
1. From the Workday home page, you'll see a red indicator alerting you to an action item in your Workday inbox.
2. Click on your name, then on the "Inbox" link.
3. You'll see you've opened your "Open Enrollment Change" action item and will see your election options on the right side of the screen.



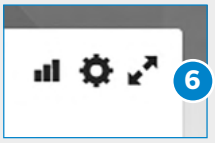
Click on the action item in your Workday Inbox to begin.

Change Benefits for Open Enrollment

4. The first elections you will see will be titled "Health Care Elections." You'll be presented with your medical, dental, and vision election options.
5. You'll notice that your election from last year will be selected. To change your election, click the "Elect" radio button for the option you prefer.
6. Please note that you will need to scroll up and down and right and left to view your coverage level options, your cost for the election, and the cost Eversource pays on your behalf. Your can also click the "maximize" icon to maximize your enrollment screens.
7. Your dependents should be listed under the "Enroll Dependents" column and the "Existing Dependents" category. If you don't see a dependent that you want to include in coverage, you can add him or her by clicking the "Add My Dependent from Enrollment" option. If you add a dependent, you must electronically upload the required verification documents (for example, birth certificate or marriage certificate) into Workday. You should also answer "no" to the beneficiary question that appears when you add a dependent.
8. Your coverage level (family, employee only, etc.) will display under the "Coverage" column.
9. At the bottom of the screen, you'll see three options: Continue, Save for Later, or Cancel. As you continue through the site, you will also see a Go Back option.



To maximize your screen views, click on the "maximize" icon.



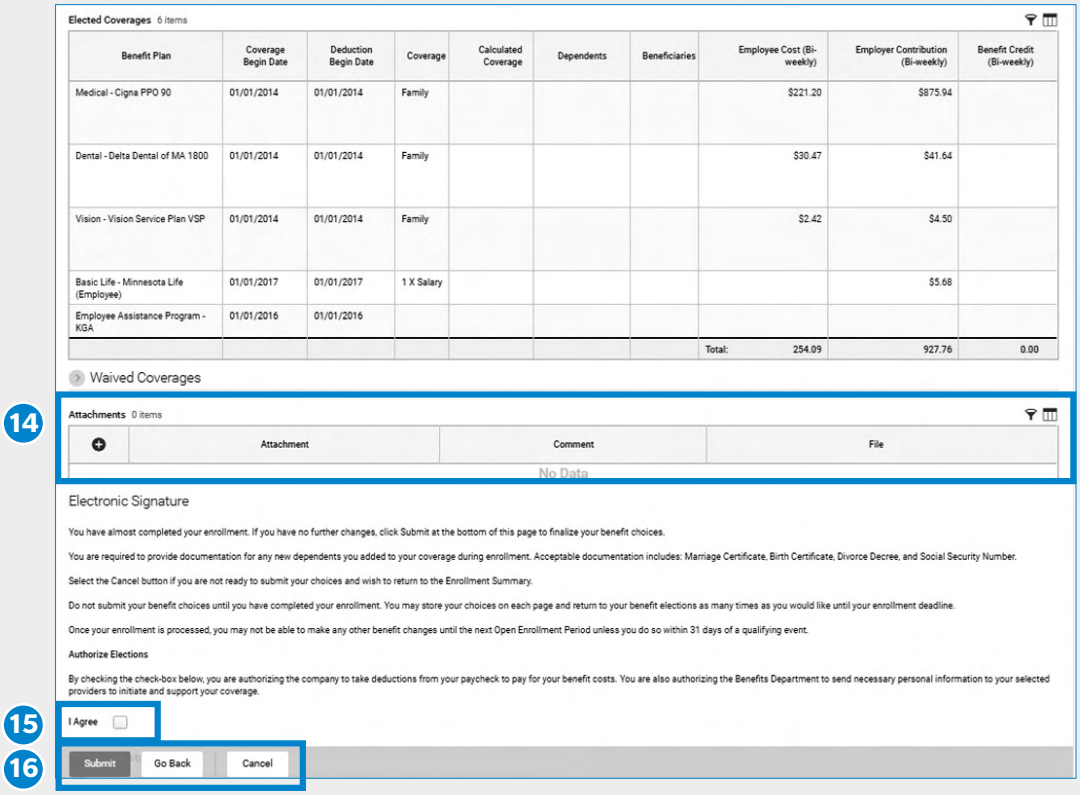
10. Clicking "Continue" will take you to the Health Savings Account Plan Dependencies page—regardless of which medical option you choose. If you choose the Saver option, this is where you will elect to contribute additional funds to your Health Savings Account (HSA). Even if you choose not to make additional contributions, you must click "elect" to avoid an error. If you elect anything other than the Saver medical option, you'll notice this election is not available to you, however, you must click "Continue" to proceed.
11. You'll then be presented with your Spending Account options, and so on through your enrollment screens.
12. Please note that some options will automatically display for you yet you won't be able to elect them (for example, the "Employee Assistance Program").

Your enrollment deadline is November 10

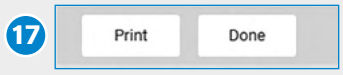
You can access Workday, make your enrollment elections, save them, and submit them as many times as you'd like, until midnight on Thursday, November 10. At that time, enrollment will close for processing. The last elections you submitted will be your benefit elections for 2017.

Finalizing Your Benefit Elections

13. The final screen will be titled "Elected Coverages" and will capture all of your election results, including your cost.
14. You'll also see a section on this final page titled "Attachments." If you've added a new dependent to enrollment, you must upload electronic verification documents to this section by November 10, 2016—the enrollment deadline. If you do not upload the required documents, your new dependent(s) will not be added to coverage.
15. As you scroll down the "Elected Coverages" screen, you'll also see the "Electronic Signature" section. Please click the "I Agree" box to authorize Eversource to take deductions from your paycheck to pay for your portion of the benefit cost.
16. Next, click the green "Submit" button.



17. Your final options are "Print" and "Done." Click the Print option to save a copy of your elections for your records. Once you click Done, your Workday inbox enrollment notice will disappear. You can still make changes to your elections and re-submit them, however, by clicking the "Benefits" worklet on the Workday home page and the "Change Open Enrollment" link. You can change your elections as many times as you'd like, until midnight, on Thursday, November 10, 2016.



If you are adding a dependent

Your new dependent will not be covered unless you electronically attach all dependent eligibility verification documents in Workday by November 10, 2016.

Need help?

If you need assistance, please click on the **"AskHR"** link from the HRConnect web pages to electronically submit your question to HR, or call **1-800-841-8684** and select the "HR Generalist" prompt.

Information Resources

HRConnect is your source for benefit, compensation, time off, health and wellness, and career development information.

Benefit Carriers

Eversource's benefit carriers can provide you with benefit coverage, eligibility, and network provider information. If you have detailed coverage questions—for example, you want to know if a particular service or treatment is covered and at what cost—please contact the appropriate benefit carrier listed below.

Dental
Delta Dental of Massachusetts
800-872-0500
www.deltadentalma.com

Flexible Spending Accounts
Discovery Benefits
866-451-3399
www.discoverybenefits.com

Legal Assistance
Hyatt Legal
800-821-6400
www.metlife.com/mybenefits
(Enter "Eversource" and access code 6091090)

Life and Accident
Minnesota Life
866-293-6047
www.LifeBenefits.com

Medical, Behavioral Health, and Health Savings Account
Cigna
800-564-7642 / 800-244-6224
www.mycigna.com

Prescription Drugs
Express Scripts (PPO 100, PPO 90)
800-351-0509
www.express-scripts.com

Cigna (Saver)
800-244-6224
www.mycigna.com

Vision
Vision Service Plan (VSP)
800-877-7195
www.vsp.com

HRConnect

Your source for information on your benefits, compensation, time off, health and wellness, and career development is HRConnect. HRConnect is where you will go to find a list of your benefit carriers, plan documents and HR news. This is also the place to go to submit an electronic ticket to HR with any requests or questions. A link to HRConnect can be found on the employee intranet home page in the "Quick Links" category.

You'll notice that the HRConnect site is hosted by Towers Watson and that you will be automatically signed in when you are logged into the Eversource system. This means HRConnect will know who you are and you won't have to log in again. If you don't have intranet access, or need further assistance, please call HRConnect at 1-800-841-8684 and select the "HR Generalist" prompt.

Workday Job Aid for Enrollment

If you need more detailed instructions for enrolling through Workday, please consult the step-by-step job aid available from a link on the home page of the HRConnect web pages and at www.eversource.com/EmployeeEnrollment.

Enrolling Remotely

If you would like to enroll in Workday remotely from a personal device, you must be registered for Okta Extra Verification. More information and instructions are available at www.eversource.com/EmployeeEnrollment.

Eversource 10/2016

EVERSOURCE

Printed on recycled paper

2017
Vacation Buy Enrollment

Deadline November 10

EVERSOURCE

Vacation Buy

As a represented employee whose bargaining unit negotiated for this benefit, you have the opportunity to purchase additional vacation time for the coming calendar year. You must re-enroll in the Vacation Buy program each year—participation does not automatically roll over year-to-year.

When can I buy my vacation?

You have the option to purchase additional vacation time during the annual benefits open enrollment period for the coming 2017 calendar year. You have until November 10, 2016, to make benefit enrollment elections and purchase additional vacation time for 2017.

How do I purchase my vacation time?

You can purchase additional vacation time through our time and attendance system, WorkForce. Please see the detailed instructions on page 3.

How many hours of vacation can I buy?

The number of vacation hours you are eligible to purchase depends on your bargaining unit agreement. Instructions for electing your Vacation Buy hours are included on page 3.

How is the cost of my vacation time calculated?

The cost of vacation time is calculated using base salary on December 1 prior to the start of the calendar year for which the election is being made. To determine the annual total contribution required, base salary (expressed as an hourly rate) is multiplied by the number of whole hours elected for purchase. The cost is payroll deducted on a pre-tax basis in equal installments during the calendar year for which the election is made.

Important Considerations

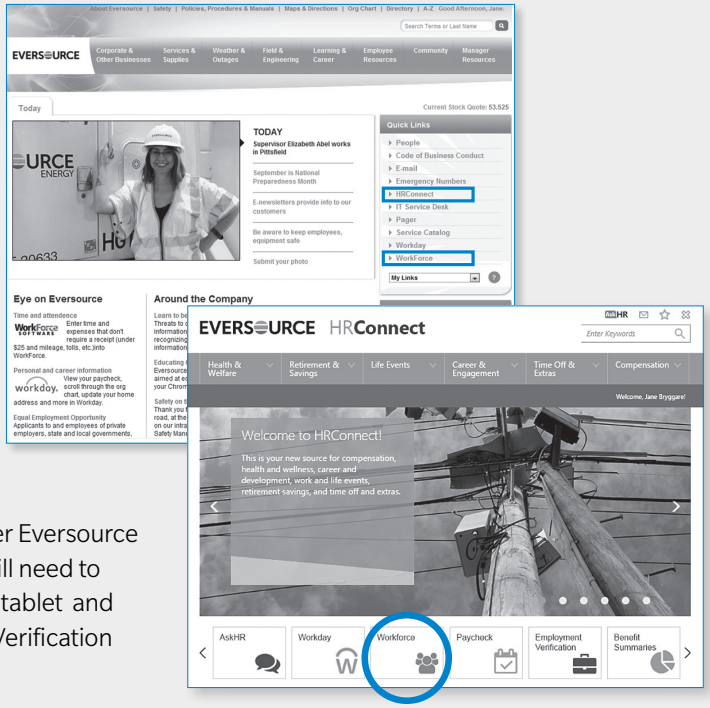
- Under IRS regulations, the election to buy additional vacation time is irrevocable (except in certain business emergency circumstances).
- You must use all other vacation time prior to using purchased vacation time.
- Purchased vacation time cannot be carried over into the subsequent calendar year—nor can it be sold back to Eversource.
- Managerial approval is not required to buy additional vacation time; however, managerial approval is required for scheduling vacation. Participants are strongly encouraged to check with their supervisor prior to electing to buy vacation to ensure there are no anticipated scheduling conflicts that could restrict you from using all of your vacation time.
- If there is a change in work schedules—such as from part-time to full-time, or a change in base salary at any time during the year—the number of hours purchased and the resulting payroll deduction for those hours will not change.

Enrollment Instructions

You will purchase additional vacation hours through WorkForce, our time and attendance system. You can access WorkForce from the employee intranet home page and the HRConnect pages. You can also access WorkForce from home using Okta Extra Verification.

At Work

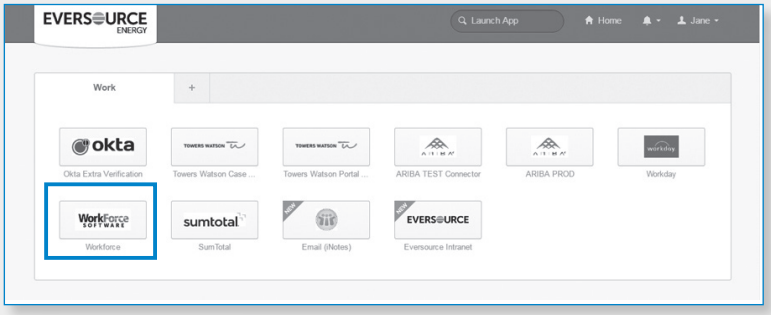
1. Click the "WorkForce" link under the "Quick Links" category located on the home page of the Eversource employee intranet.
2. You can also access WorkForce through HRConnect, your source for benefit and HR information. A link to "HRConnect" is also available under the "Quick Links" category.
3. Once you arrive on the HRConnect home page, click on the "WorkForce" tab.



At Home

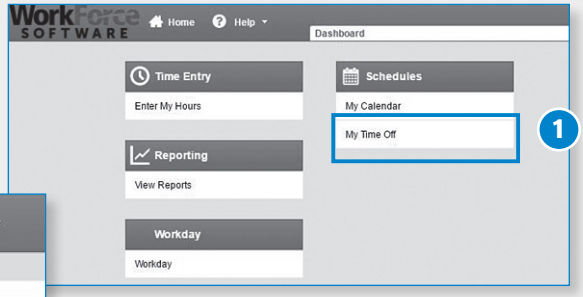
To access Workday, Workforce, Eversource's intranet, or other Eversource applications while at home or from the public internet, you will need to install Okta Extra Verification to work with your cell phone or tablet and configure a few settings. Directions for installing Okta Extra Verification are located at www.eversource.com/EmployeeEnrollment.

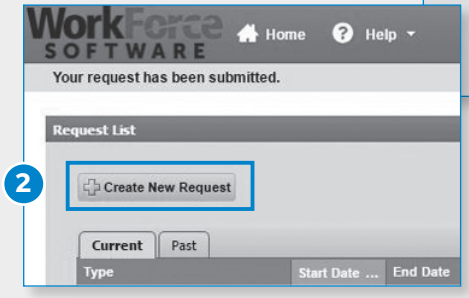
Once you register for Okta Extra Verification, you will select WorkForce from Eversource.Okta.com. If you need further assistance with setting up Okta Extra Verification, or you need assistance retrieving your Eversource username or password, please contact the IT Support Center at 860-665-4357.



WorkForce Home Page

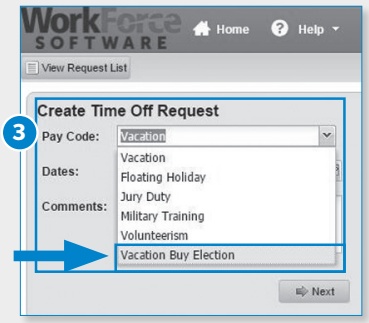
1. Once you arrive at the WorkForce home page, click the "My Time Off" link under the "Schedules" section.
2. Click the "Create New Request" option.

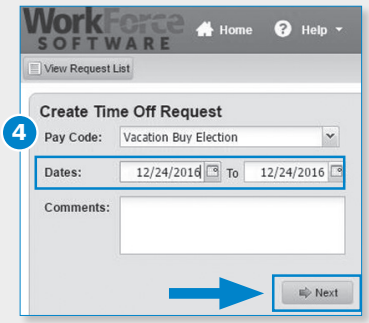




3. Next, select the "Vacation Buy Election" drop-down option from the "Pay Code" section by clicking the arrow.

4. Enter the date **12/24/2016** in both the from and the to boxes (exactly as you see on the example) and then click "Next."

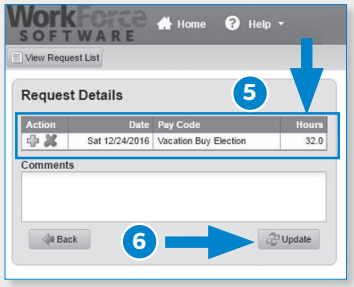


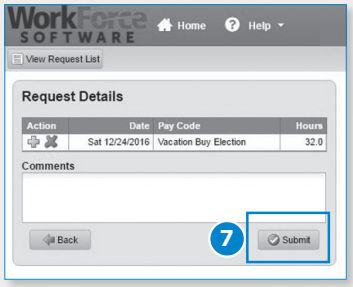


5. On the next screen, you will enter the hours you would like to purchase and click "Enter" on your keyboard.

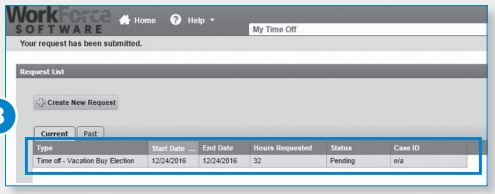
6. Then click "Update."

7. After you click "Update," you should verify the hours you are purchasing and then click "Submit."

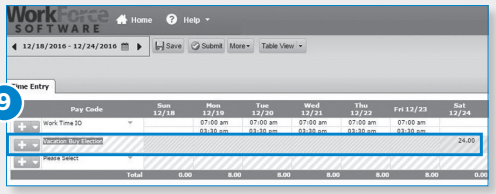




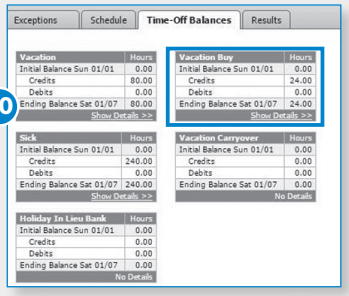
8. You will see that your request has been submitted and will show as "pending" until the request is approved at the end of the open enrollment period.



9. You will see your Vacation Buy election appear on your timesheet for the 12/18/2016 - 12/24/2016 timesheet, but your bank balance will not show your purchased vacation time until January 1, 2017.



10. On January 1, 2017, you will see your Vacation Buy time within your time-off balances.



Need help?

If you need assistance, please click the "AskHR" link from the HRConnect home page to electronically submit your question to HR, or call **1-800-841-8684** and select the "Payroll" prompt.

Eversource 10/2016

EVERSOURCE

Printed on recycled paper

EVERSOURCE

2017 Legal Notices

Group Welfare Benefits Plan for Employees of Eversource and
Eversource Flexible Benefits Plan

The following notices provide important information about your rights with respect to benefits under the Eversource Flexible Benefits Plan and the Group Welfare Benefits Plan for Employees of Eversource (the "Plan"). Other than reading them carefully and retaining them with other Plan documents, no participant action is required. If you have questions or need more information, contact Human Resources at P.O. Box 270, Hartford, Connecticut 06141-0270, or toll-free at 1-800-841-8684.

If you (or your dependents) will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see page 11 for more details.

HIPAA Privacy Notice

Enclosed is a Privacy Notice Regarding Protected Health Information (PHI). Eversource Energy Service Company ("Eversource") is required to send this to you because you are eligible to participate in one or more of the following Eversource-sponsored programs: the Eversource Flexible Benefits Plan, the Group Welfare Benefits Plan for Employees of Eversource, the Med-Vantage Plan, and/or the Group Health and Welfare Plan for Retirees of Eversource. You may have received similar Privacy Notices from your doctors, dentists, and other health care providers.

In addition to providing you with the Privacy Notice, the Privacy Regulation effective April 14, 2003, for the Health Insurance Portability and Accountability Act of 1986, as amended ("HIPAA") requires us to protect the privacy of your individually identifiable personal health information ("PHI").

Eversource HRConnect handles limited PHI regarding your elected medical coverage options and any qualifying status changes and will provide you with information regarding the following:

- Your and your dependents' eligibility for coverage under the Plans;
- Cost information about the Plans and billing information (payroll and pension deductions, COBRA bills);
- Enrollment information; and
- General descriptions of covered benefits.

The Carriers with whom Eversource contracts to provide services (such as Cigna, Discovery Benefits, Express Scripts, Vision Service Plan, and Delta Dental) will be your primary contact for the following:

- Specific coverage questions;
- Answers to your questions regarding claim status and claim denials; and
- Claim processing and all related activities including appeals.

To meet these standards:

- HRConnect and the Benefits Section of the Eversource Human Resources Department ("Benefits Group") will retain only the minimum required PHI, such as enrollment information and family status change forms.
- Unless you request differently, HRConnect and the Benefits Group will not request answers to your claim questions from the Carriers. You should contact the Carriers directly with your claim questions and issues. The Carriers are available to help guide you through the appeals process should you need assistance.

Please note that the HIPAA Privacy Regulation does not apply to medical information or records used in the course of employment, such as Workers' Compensation, HealthLink, Fitness for Duty, Short-Term Disability, Long-Term Disability and the medical records kept in the Berlin Health Unit.

We diligently ensure the privacy of your PHI and maintain compliance with the Privacy Regulation and other laws protecting the confidentiality of your medical information.

PRIVACY NOTICE REGARDING PROTECTED HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

PLEASE DIRECT ANY QUESTIONS YOU HAVE ABOUT THIS NOTICE TO EVERSOURCE HRCONNECT. YOUR QUESTIONS WILL BE COMMUNICATED TO THE DESIGNATED PRIVACY OFFICIAL.

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice. You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting HRConnect.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share**.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

You have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

We *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

We typically use or share your health information in the following ways:

Help manage the health care treatment you receive. We can use your health information and share it with professionals who are treating you. *For example, if a doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*

Run our organization

- In some cases, the plans may disclose your PHI to summarize claims experience of plan participants, as a group, but without identifying specific individuals in order to assess the plan's design, costs and rates. *For example, if we want to consider adding or changing organ transplant benefits, we may receive this summary health information to assess the costs of those services.* A plan may also disclose limited health information to us in connection with the enrollment or disenrollment of individuals into or out of the plan.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long-term care plans. *For example, we can use health information about you to develop better services for you.*

To Business Associates. The plans may hire third parties that may need your PHI to perform certain services on behalf of the Plan. These third parties are "**Business Associates**" of the plan. Business Associates must protect any PHI they receive from, or create and maintain on behalf of, the plan. For example, the plan may hire a third party administrator to process claims, an auditor to review how an insurer or third-party administrator is processing claims, or an insurance agent to assess coverage and help with claim problems.

Pay for your health services. We can use and disclose your health information as we pay for your health services. *For example, we can share information about you with your dental plan to coordinate payment for your dental work.*

Administer your plan. We may disclose your health information to your health plan sponsor for plan administration. For e*xample, we may receive certain information from a Carrier regarding certain statistics to explain the premiums.*

We are also allowed or required to share your information in other ways—usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues. We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research. We can use or share your information for health research.

Comply with the law. We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director.

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests. We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, presidential protective services, and disaster relief efforts

Respond to lawsuits and legal actions. We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice. We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our website, and we will mail a copy to you.

Privacy Official

The Plan Sponsor and the Plan have designated a Privacy Official, who has a general duty to oversee compliance with the privacy standards of HIPAA under the Plan and who can answer questions and provide information to you about your privacy rights. You may contact the Privacy Official at the following address and phone number:

HIPAA Privacy Official
c/o Eversource HRConnect

Eversource Energy Service Company
Post Office Box 270
Hartford, Connecticut 06141-0270

Telephone: 1-800-841-8684
Fax: 860-665-5418

Effective Date of Notice
This Notice was last updated effective September 23, 2016. Please note that changes in law affecting your privacy rights may take effect at different times.

HIPAA Special Enrollment

A federal law called HIPAA requires that we notify you about a "special enrollment provision" in the Plan that will allow you to add coverage for yourself or your dependents outside of open enrollment. This enrollment opportunity will apply if you acquire a new dependent, or if you decline coverage under the Plan for yourself or an eligible dependent while other employer group health plan, Medicaid, or state Child Health Insurance Program (CHIP) coverage is in effect and later lose that other coverage for certain qualifying reasons or if you become eligible for a premium assistance subsidy under Medicaid or a state CHIP plan.

- **Loss of Other Coverage (Excluding Medicaid or a State CHIP Plan)**
  If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in the Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

- **Loss of Coverage for Medicaid or a State CHIP Plan**
  If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state CHIP plan is in effect, you may be able to enroll yourself and your dependents in the Plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state CHIP plan (a separate CHIP notice will be provided separately).

- **New Dependent by Marriage, Birth, Adoption, or Placement for Adoption**
  If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

- **Eligibility for Medicaid or a State CHIP Plan Premium Assistance Subsidy**
  If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state CHIP plan with respect to coverage under the Plan, you may be able to enroll yourself and your dependents in the Plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance. If your dependent child is receiving Medicaid or HIP premium assistance toward the cost of Plan benefits, you may also be able to disenroll the child from a health insurance program and enroll the child in and receive child health assistance under the state child health plan, effective on the first day of any month for which the child is eligible for premium assistance, to the extent required by state law.

To request special enrollment, contact Eversource HRConnect toll-free at 1-800-841-8684.

Special Rights on Childbirth

Group health plans offering group insurance coverage generally may not, under the provisions of the Newborns' and Mothers' Health Protection Act (NMHPA) law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than the above periods. In any case, the plan may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of the above periods.

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

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). As required by WHCRA, the Eversource Flexible Benefits Plan and the Group Welfare Benefits Plan for Employees of Eversource provide coverage for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient. These benefits will be provided subject to the same copays, deductibles and coinsurance applicable to other medical and surgical benefits provided under the Eversource Flexible Benefits Plan and the Group Welfare Benefits Plan for Employees of Eversource.

Genetic Information Nondiscrimination Act (GINA)

Eversource does not discriminate against employees or applicants because of genetic information. Genetic information is not used in any aspect of employment including hiring, firing, pay, job assignments, promotions, layoffs, training, fringe benefits and any other term or condition of employment. Furthermore, Eversource does not request or attempt to acquire genetic information on applicants, employees or their families. Genetic information includes information about genetic tests of applicants, employees or their family members; the manifestation of diseases or disorders in family members (family medical history); and requests for or receipt of genetic services by applicants, employees or their family members.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

When key parts of the health care law took effect in 2014, the Health Insurance Marketplace ("Marketplace") became a new way to buy health insurance. To assist you in evaluating options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2016 for coverage starting as early as January 1, 2017.

Can I Save Money on my Health Insurance Premiums through the Marketplace?

You may qualify to lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5 percent of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1] Note that even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution—as well as your employee contribution to employer-offered coverage—is often excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about coverage offered by your employer, please check your summary plan description or contact Eversource HRConnect toll-free at 1-800-841-8684.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit www.HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

---

1 An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

Notice of Creditable Coverage

Important Notice from Eversource Energy Service Company (Eversource) about your prescription drug coverage and Medicare

---

If you, your spouse, or other dependent are eligible for Medicare coverage or anticipate becoming eligible within the Plan year (for example, if you are now at least age 65 or are turning age 65 this year, you are eligible for Social Security Disability Insurance, or you have End Stage Renal Disease), then please read this notice carefully and keep it where you can find it. If you are receiving this notice electronically, you are responsible for providing a copy of this notice to your spouse or other Medicare eligible dependents that are covered under the Plan.

This notice has information about your current prescription drug coverage with Eversource under the Eversource Flexible Benefits Plan and the Group Welfare Benefits Plan for Employees of Eversource, and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Eversource has determined that the prescription drug coverage offered under the Eversource Flexible Benefits Plan and the Group Welfare Benefits Plan for Employees of Eversource is, on average for all Plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 through December 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Eversource coverage may be affected. If you elect Medicare Part D, in addition to having prescription drug coverage under the Eversource Flexible Benefits Plan and the Group Welfare Benefits Plan for Employees of Eversource, Eversource's plans will become secondary to the Medicare Part D coverage in circumstances described in the Plan. If you do decide to join a Medicare drug plan and drop your current Eversource Flexible Benefits Plan and Group Welfare Benefits Plan for Employees of Eversource coverage, which includes prescription drug coverage, be aware that you and your dependents may not be able to re-enroll in the Plan until the next open enrollment period.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with the Eversource Flexible Benefits Plan or the Group Welfare Benefits Plan for Employees of Eversource, and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least one percent of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19 percent higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information about This Notice or Your Current Prescription Drug Coverage

Contact HRConnect at the phone number listed below. NOTE: you will get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Eversource Flexible Benefits Plan changes. You also may request a copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. If you are currently enrolled in Medicare coverage, you will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For More Information about Medicare Prescription Drug Coverage:

- Visit **www.medicare.gov.**
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at **www.socialsecurity.gov**, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

REMEMBER: KEEP THIS CREDITABLE COVERAGE NOTICE

If you decide to join one of the Medicare Part D drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: 10/01/16

Name of Entity/Sender: Eversource Energy Service Company
Contact: Eversource HRConnect
Address: P.O. Box 270 Hartford, CT 06141-0270
Phone Number: 1-800-841-8684

If you would like more information on any of the notices contained in this packet, contact HRConnect at the address or phone numbers above.

CHIP Notice

Premium Assistance under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid of CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, you can contact your state Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your state Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the state if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2016. You should contact your state for further information on eligibility:

ALABAMA – Medicaid	**FLORIDA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.hip.in.gov Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Medicaid	**IOWA – Medicaid**
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: http://www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562

KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/ma/ Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/hipp Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: http://www.scdhhs.gov Phone: 1-888-549-0820
TEXAS – Medicaid	**WASHINGTON – Medicaid**
Website: http://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: 1-800-562-3022 ext. 15473

UTAH – Medicaid and CHIP	WEST VIRGINIA – Medicaid
Website: http://health.utah.gov/upp Phone: 1-866-435-7414	Website: http://www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
VERMONT– Medicaid	**WISCONSIN – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
VIRGINIA – Medicaid and CHIP	**WYOMING – Medicaid**
Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647	Website: http://www.health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531

To see if any more states have added a premium assistance program since July 31, 2016, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services Employee
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565

OMB Control Number 1210-0137 (expires 10/31/2016)

EVERSOURCE