

Summary of Benefits 2021

Medicare Advantage Plan
with Prescription Drugs

UnitedHealthcare® Group Medicare Advantage (PPO)
Group Name (Plan Sponsor): CenterPoint Energy
Group Number: 13517

H2001-816-000

Look inside to take advantage of the health services and drug coverages the plan provides.
Call Customer Service or go online for more information about the plan.



Toll-free **1-877-456-4831**, TTY **711**
8 a.m. - 8 p.m. local time, 7 days a week



www.UHCRetiree.com/centerpoint



Summary of Benefits

January 1, 2021 - December 31, 2021

The benefit information provided is a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. The Evidence of Coverage (EOC) provides a complete list of services we cover. You can see it online at www.UHCRetiree.com/centerpoint or you can call Customer Service for help. When you enroll in the plan you will get information that tells you where you can go online to view your Evidence of Coverage.

About this plan.

UnitedHealthcare® Group Medicare Advantage (PPO) is a Medicare Advantage PPO plan with a Medicare contract.

To join this plan, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, live in our service area as listed below, be a United States citizen or lawfully present in the United States, and meet the eligibility requirements of your former employer, union group or trust administrator (plan sponsor).

Our service area includes the 50 United States, the District of Columbia and all US territories.

About providers and network pharmacies.

UnitedHealthcare® Group Medicare Advantage (PPO) has a network of doctors, hospitals, pharmacies, and other providers. You can see any provider (network or out-of-network) at the same cost share, as long as they accept the plan and have not opted out of or been excluded or precluded from the Medicare Program. If you use pharmacies that are not in our network, the plan may not pay for those drugs, or you may pay more than you pay at a network pharmacy.

You can go to www.UHCRetiree.com/centerpoint to search for a network provider or pharmacy using the online directories. You can also view the plan Drug List (Formulary) to see what drugs are covered, and if there are any restrictions.

UnitedHealthcare® Group Medicare Advantage (PPO)

Premiums and Benefits

| | In-Network | Out-of-Network |
|---|---|----------------|
| Monthly Plan Premium | Contact your group plan benefit administrator to determine your actual premium amount, if applicable. | |
| Annual Medical Deductible | \$500 per year for some in-network and out-of-network services. | |
| Maximum Out-of-Pocket Amount (does not include prescription drugs) | Your plan has an annual combined in-network and out-of-network out-of-pocket maximum of \$2,000 each plan year. | |
| | If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. | |
| | Please note that you will still need to pay your monthly premiums, if applicable, and cost-sharing for your Part D prescription drugs. | |

UnitedHealthcare® Group Medicare Advantage (PPO)

Benefits

| | | In-Network | Out-of-Network |
|---|---|--|---|
| Inpatient Hospital¹ | | \$200 copay per day: for days 1-5 \$0 copay per day: for days 6 and beyond | \$200 copay per day: for days 1-5 \$0 copay per day: for days 6 and beyond |
| | | Our plan covers an unlimited number of days for an inpatient hospital stay. | |
| Outpatient Hospital¹ Cost sharing for additional plan covered services will apply. | Ambulatory Surgical Center (ASC) | 20% coinsurance | 20% coinsurance |
| | Outpatient surgery | 20% coinsurance | 20% coinsurance |
| | Outpatient hospital services, including observation | 20% coinsurance | 20% coinsurance |
| Doctor Visits | Primary Care Provider | 20% coinsurance | 20% coinsurance |
| | Virtual Doctor Visits | \$0 copay | \$0 copay |
| | Specialists ¹ | 20% coinsurance | 20% coinsurance |
| Preventive Care | Medicare-covered | \$0 copay | \$0 copay |
| | | Abdominal aortic aneurysm screening Alcohol misuse counseling Annual "Wellness" visit Bone mass measurement Breast cancer screening (mammogram) Cardiovascular disease (behavioral therapy) Cardiovascular screening Cervical and vaginal cancer screening Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy) Depression screening Diabetes screenings and monitoring Diabetes - Self-Management training Dialysis training | |

Benefits

| | | In-Network | Out-of-Network |
|---------------------------------|------------------|---|---|
| | | <p>Glaucoma screening Hepatitis C screening HIV screening Kidney disease education Lung cancer with low dose computed tomography (LDCT) screening Medical nutrition therapy services Medicare Diabetes Prevention Program (MDPP) Obesity screenings and counseling Prostate cancer screenings (PSA) Sexually transmitted infections screenings and counseling Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) Vaccines, including flu shots, hepatitis B shots, pneumococcal shots “Welcome to Medicare” preventive visit (one-time)</p> | |
| | | <p>Any additional preventive services approved by Medicare during the contract year will be covered. This plan covers preventive care screenings and annual physical exams at 100%.</p> | |
| | Routine physical | \$0 copay; 1 per plan year* | \$0 copay; 1 per plan year* |
| Emergency Care | | <p>\$100 copay (worldwide)</p> <p>If you are admitted to the hospital within 24 hours, you pay the inpatient hospital copay instead of the Emergency copay. See the “Inpatient Hospital” section of this booklet for other costs.</p> | |
| Urgently Needed Services | | <p>\$35 copay (worldwide)</p> <p>If you are admitted to the hospital within 24 hours, you pay the inpatient hospital copay instead of the Urgently Needed Services copay. See the “Inpatient Hospital” section of this booklet for other costs.</p> | <p>\$35 copay (worldwide)</p> <p>If you are admitted to the hospital within 24 hours, you pay the inpatient hospital copay instead of the Urgently Needed Services copay. See the “Inpatient Hospital” section of this booklet for other costs.</p> |

Benefits

| | | In-Network | Out-of-Network |
|---|--|--|---|
| Diagnostic Tests, Lab and Radiology Services, and X-Rays | Diagnostic radiology services (e.g. MRI) ¹ | 20% coinsurance | 20% coinsurance |
| | Lab services ¹ | 20% coinsurance | 20% coinsurance |
| | Diagnostic tests and procedures ¹ | 20% coinsurance | 20% coinsurance |
| | Therapeutic Radiology ¹ | 20% coinsurance | 20% coinsurance |
| | Outpatient x-rays ¹ | 20% coinsurance | 20% coinsurance |
| Hearing Services | Exam to diagnose and treat hearing and balance issues ¹ | 20% coinsurance | 20% coinsurance |
| | Routine hearing exam | 20% coinsurance (1 exam per plan year)* | 20% coinsurance (1 exam per plan year)* |
| | Hearing Aids | Through UnitedHealthcare Hearing, the plan pays up to a \$300 allowance for hearing aid(s) every 3 years. Hearing aid coverage under this plan is only available through UnitedHealthcare Hearing. | Hearing aids ordered through providers other than UnitedHealthcare Hearing are not covered. |
| Vision Services | Exam to diagnose and treat diseases and conditions of the eye ¹ | 20% coinsurance | 20% coinsurance |
| | Eyewear after cataract surgery | \$0 copay | \$0 copay |
| Mental Health | Inpatient visit ¹ | 20% coinsurance per stay | 20% coinsurance per stay |
| | | Our plan covers an unlimited number of days for an inpatient hospital stay. | |

Benefits

| | | In-Network | Out-of-Network |
|---|--|---|-------------------------------------|
| | Outpatient group therapy visit ¹ | 20% coinsurance | 20% coinsurance |
| | Outpatient individual therapy visit ¹ | 20% coinsurance | 20% coinsurance |
| | Virtual Behavioral Visits | 20% coinsurance | 20% coinsurance |
| Skilled Nursing Facility (SNF)¹ | | 20% coinsurance per day: days 1-100 | 20% coinsurance per day: days 1-100 |
| | | Our plan covers up to 100 days in a SNF per benefit period. | |
| Physical Therapy and speech and language therapy visit¹ | | 20% coinsurance | 20% coinsurance |
| Ambulance² | | 20% coinsurance | 20% coinsurance |
| Routine Transportation | | Not covered | |
| Medicare Part B Drugs | Chemotherapy drugs ¹ | 20% coinsurance | 20% coinsurance |
| | Other Part B drugs ¹ | 20% coinsurance | 20% coinsurance |

Prescription Drugs

If the actual cost for a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.

Your plan sponsor has chosen to make supplemental drug coverage available to you. This coverage is in addition to your Part D prescription drug benefit. The drug copays in this section are for drugs that are covered by both your Part D prescription drug benefit and your supplemental drug coverage. You can view the Certificate of Coverage at www.UHCRetiree.com/centerpoint or call Customer Service to have a hard copy sent to you.

Your plan sponsor has elected to offer additional coverage on some prescription drugs that are normally excluded from coverage on your Formulary. Please see your Additional Drug Coverage list for more information.

If you reside in a long-term care facility, you will pay the same for a 31-day supply as a 30-day supply at a retail pharmacy.

| | | |
|---|--|--|
| Stage 1: Annual Prescription (Part D) Deductible | \$150 | |
| Stage 2: Initial Coverage (After you pay your deductible, if applicable) | Retail Cost-Sharing | Mail Order Cost-Sharing |
| | One-month supply | Three-month supply |
| Tier 1: Preferred Generic | \$12 copay | \$30 copay |
| Tier 2: Preferred Brand | \$40 copay | \$100 copay |
| Tier 3: Non-preferred Drug | \$80 copay | \$200 copay |
| Tier 4: Specialty Tier | \$100 copay | \$100 copay (limited to a 30-day supply) |
| Stage 3: Coverage Gap Stage | After your total drug costs reach \$4,130, the plan continues to pay its share of the cost of your drugs and you pay your share of the cost. | |
| Stage 4: Catastrophic Coverage | After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$6,550, you pay \$3.70 copay for generic (including brand drugs treated as generic), and a \$9.20 copay for all other drugs. | |

Additional Benefits

| | | In-Network | Out-of-Network |
|----------------------------|---|--|--|
| Acupuncture | Medicare-covered acupuncture | 20% coinsurance | 20% coinsurance |
| | Routine acupuncture | 20% coinsurance (Up to 20 visits per plan year)* | 20% coinsurance (Up to 20 visits per plan year)* |
| Chiropractic Care | Medicare-covered chiropractic care (manual manipulation of the spine to correct subluxation) ¹ | 20% coinsurance | 20% coinsurance |
| | Routine chiropractic care | 20% coinsurance (Up to 20 visits per plan year)* | 20% coinsurance (Up to 20 visits per plan year)* |
| Diabetes Management | Diabetes monitoring supplies ¹ | <p>\$0 copay</p> <p>We only cover Accu-Chek® and OneTouch® brands.</p> <p>Covered glucose monitors include: OneTouch Verio Flex®, OneTouch Verio Reflect®, Accu-Chek® Guide Me, and Accu-Chek® Guide.</p> <p>Test strips: OneTouch Verio®, OneTouch Ultra®, Accu-Chek® Guide, Accu-Chek® Aviva Plus, and Accu-Chek® SmartView.</p> <p>Other brands are not covered by your plan.</p> | <p>\$0 copay</p> <p>We only cover Accu-Chek® and OneTouch® brands.</p> <p>Covered glucose monitors include: OneTouch Verio Flex®, OneTouch Verio Reflect®, Accu-Chek® Guide Me, and Accu-Chek® Guide.</p> <p>Test strips: OneTouch Verio®, OneTouch Ultra®, Accu-Chek® Guide, Accu-Chek® Aviva Plus, and Accu-Chek® SmartView.</p> <p>Other brands are not covered by your plan.</p> |

Additional Benefits

| | | In-Network | Out-of-Network |
|---|---|---|--|
| | Medicare covered Therapeutic Continuous Glucose Monitors (CGMs) and supplies ¹ | \$0 copay | \$0 copay |
| | Diabetes Self-management training | \$0 copay | \$0 copay |
| | Therapeutic shoes or inserts ¹ | 20% coinsurance | 20% coinsurance |
| Durable Medical Equipment (DME) and Related Supplies | Durable Medical Equipment (e.g., wheelchairs, oxygen) ¹ | 20% coinsurance | 20% coinsurance |
| | Prosthetics (e.g., braces, artificial limbs) ¹ | 20% coinsurance | 20% coinsurance |
| Fitness program through SilverSneakers® | | <p>You have access to SilverSneakers®, a Medicare fitness program. SilverSneakers includes a \$0 membership fee for a standard, monthly membership at a participating fitness center.</p> <p>To get your SilverSneakers ID number or learn more about this benefit, visit SilverSneakers.com or call 1-888-423-4632, TTY 711, 8 a.m. – 8 p.m. ET, Monday – Friday.</p> | |
| Foot Care (podiatry services) | Foot exams and treatment ¹ | 20% coinsurance | 20% coinsurance |
| | Routine foot care | 20% coinsurance for each visit (Unlimited visits per plan year)* | 20% coinsurance for each visit (Unlimited visits per plan year)* |
| Home Health Care¹ | | 20% coinsurance | 20% coinsurance |
| Hospice | | <p>You pay nothing for hospice care from any Medicare-approved hospice. You may have to pay part of the costs for drugs and respite care. Hospice is covered by Original Medicare, outside of our plan.</p> | |

Additional Benefits

| | | In-Network | Out-of-Network |
|--|--|--|-----------------|
| NurseLine | | Receive access to nurse consultations and additional clinical resources at no additional cost. | |
| Occupational Therapy Visit¹ | | 20% coinsurance | 20% coinsurance |
| Opioid Treatment Program Services¹ | | \$0 copay | \$0 copay |
| Outpatient Substance Abuse | Outpatient group therapy visit ¹ | 20% coinsurance | 20% coinsurance |
| | Outpatient individual therapy visit ¹ | 20% coinsurance | 20% coinsurance |
| Private duty nursing | | <p>We cover medically necessary nursing services provided in the home by a private duty nurse who holds a valid, recognized nursing certificate and is licensed according to state law in the state where services are received. The services requested must be ordered by a treating practitioner or specialist after a face-to-face evaluation takes place with a written treatment plan and letter of medical necessity. Covered services include nursing services of a registered nurse (RN), licensed practical nurse (LPN) or licensed vocational nurse (LVN) delivered to a covered individual who is confined in the home due to a medical condition.</p> <p>Note: Custodial and domestic services are not covered.</p> <p>20% coinsurance</p> <p>There is no allowance limit per plan year for private duty nursing services.</p> | |
| Renal Dialysis¹ | | 20% coinsurance | 20% coinsurance |

¹ Some of the network benefits listed may require your provider to obtain prior authorization. You never need approval in advance for plan covered services from out-of-network providers. Please refer to the Evidence of Coverage for a complete list of services that may require prior authorization.

² Authorization is required for Non-emergency Medicare-covered ambulance ground and air transportation. Emergency Ambulance does not require authorization.

*Benefits are combined in and out-of-network

Required Information

Plans are insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract and a Medicare-approved Part D sponsor. Enrollment in the plan depends on the plan's contract renewal with Medicare.

Plans may offer supplemental benefits in addition to Part C and Part D benefits.

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

UnitedHealthcare Insurance Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-814-6894 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-814-6894 (TTY: 711)。

This information is available for free in other languages. Please call our Customer Service number located on the first page of this book.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments and restrictions may apply.

Benefits, premium and/or copayments/coinsurance may change each plan year.

Drugs and prices may vary between pharmacies and are subject to change during the plan year. Prices are based on quantity filled at the pharmacy. Quantities may be limited by pharmacy based on their dispensing policy or by the plan based on Quantity Limit requirements; if prescription is in excess of a limit, copay amounts may be higher.

You are not required to use OptumRx home delivery for a 90-day supply of your maintenance medication. If you have not used OptumRx home delivery, you must approve the first prescription order sent directly from your doctor to OptumRx before it can be filled. New prescriptions from OptumRx should arrive within ten business days from the date the completed order is received, and refill orders should arrive in about seven business days. Contact OptumRx anytime at 1-888-279-1828, TTY 711. OptumRx is an affiliate of UnitedHealthcare Insurance Company.

The Formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

You must continue to pay your Medicare Part B premium.

Out-of-network/non-contracted providers are under no obligation to treat UnitedHealthcare members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

The Nurseline service should not be used for emergency or urgent care needs. In an emergency, call 911 or go to the nearest emergency room. The information provided through this service is for informational purposes only. The nurses cannot diagnose problems or recommend treatment and are not a substitute for your doctor's care. Your health information is kept confidential in accordance with the law. Access to this service is subject to terms of use.

Availability of the SilverSneakers program varies by plan/market. Refer to your Evidence of Coverage for more details. Consult a health care professional before beginning any exercise program. Tivity Health and SilverSneakers are registered trademarks or trademarks of Tivity Health, Inc., and/or its subsidiaries and/or affiliates in the USA and/or other countries. © 2018. All rights reserved.