2022 Benefit Choices

AN ENROLLMENT GUIDE FOR NEW EMPLOYEES

Enroll online: CNPBenefits.com

Benefit Resources

This booklet provides a summary of your benefit options and serves as a guide to selecting and enrolling in your benefits. CenterPoint Energy also provides you with online tools to manage many of your benefits whenever it's convenient for you.

At **CNPBenefits.com**, you can review your current benefits and dependents, report a life event change, link to benefit forms and chat online with a Benefits Service Center representative. You'll also use this site to enroll in benefits, both as a new hire and during open enrollment.

To access the site, go to **CNPBenefits.com** and enter your User ID (your 8 digit employee number) and password. For your initial logon, your password will be the last four digits of your Social Security number. You will then be prompted to enter a new password.

The CNP Savings Plan is a financial security benefit the company provides to help you prepare for retirement. Visit **cnpsavings.voya.com** to check your current Savings Plan balances, make or change your Savings Plan elections, review investment information and model future estimated retirement benefits.

For policies, summary plan descriptions, legal notices and general HR information, follow the "Career and Life" link on the intranet home page or go to **CNPToday.com/HR**.

Please see page 11 for details on COVID-19 vaccination.

You will have 31 days from your employment date to select from the available medical, dental, vision, supplemental life insurance, flexible spending accounts and long-term disability (LTD) plan options outlined in this brochure.

If you (and/or your dependents) have Medicare or 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 10 for more details.

Enroll online: CNPBenefits.com

Find the Benefits that Fit You Best

Want to see which health plan saves you the most money? Have a question or two about something specific? Looking for a guide from start to finish?

It's Easy with Ask Emma

Ask Emma is the private, personalized virtual assistant that helps you get the most from your benefits. She has interviews, calculators, videos, and FAQs available for a number of benefits.

Your Initial Enrollment Period

Once you elect your benefits during the first 31 days of employment, your benefits are retroactive to the first day of employment. However, your dependent(s) will not be enrolled in any elected coverage until you complete their enrollment by providing the required dependent verification documentation. If complete and proper documentation is submitted within 31 days after your hire date, your dependent's coverage will be retroactive to your first day of employment. If such documentation is submitted after 31 days, your dependent's coverage will be prospective only, following approval of the submitted documentation. **If complete and proper documentation is not submitted within 60 days, your dependent will not be enrolled in coverage and you may not enroll the dependent until the next open enrollment period, unless you experience a corresponding "qualified life event."**

To upload your dependent verification documents, log into your account at **CNPBenefits.com**. Click "My Profile," then "Employee File," then "View and Upload Documents." To view the list of required dependent documentation at **CNPBenefits.com**, search "Library" then "Dependent Verification Required Documents."

Any premiums due for your retroactive coverage will be deducted in full from the next paycheck following enrollment. Any eligible expenses covered by your retroactive coverage that were incurred during any temporary gap in coverage should be submitted to the claims administrator for reimbursement.

If you do not make any elections during your enrollment period, no medical, dental or vision coverage is provided. Although you must make your election for LTD plan coverage within 31 days of your employment date, coverage is effective the first day after completing 90 days of continuous active service.

Even if you are not enrolling in CenterPoint Energy's health benefits, you must still designate beneficiaries for your company-paid life insurance and any supplemental life or accident insurance you choose at **CNPBenefits.com**.

Important Reminder

If you are hired in 2022, you may receive two enrollment packets – this one for coverage through the end of 2022 and an open enrollment brochure for 2023. Be sure to sign up for 2022 benefits within 31 days of hire to receive coverage effective from your date of hire through December 31, 2022. You may also need to sign up for 2023 benefits. If you wish to enroll in Dependent Care Flexible Spending, Health Care Flexible Spending, Limited Flexible Spending or Health Savings Account elections, you must make an active election for the 2023 enrollment period as these elections will not carry over from 2022. If you have any questions, contact the Benefits Service Center at **833-236-3487**.

What Are Qualified Life Events?

The benefits you select and eligible dependents you cover during new hire enrollment will remain in effect until December 31, unless you experience a qualified life event. These events include marriage, divorce, birth, adoption, death in your family or a change in job status for you or your spouse and allow you to change coverage under most benefit plans.

You generally must make any changes within 31 days of a status change or qualified life event. Proof of good health is required to increase life insurance coverage and LTD coverage.

When adding dependents to coverage, you must provide any requested information and documentation by the stated deadlines or your dependent will not be added to coverage. Also, make sure you supply their Social Security Numbers, so there aren't any issues administering their benefits or generating forms for tax reporting purposes. When enrolling a newborn child, you do not have to wait until you receive your child's SSN to enroll him/her in your coverage. However, you will still need to provide a birth facts document, birth certificate or other documents, as needed by the stated deadline in order to continue covering your child(ren).

Please note that your benefit change must be consistent with the life event. If you experience a qualified life event, you generally have 31 days to adjust your benefit coverage by calling the Benefits Service Center at **833-236-3487** or report changes online at **CNPBenefits.com**.

Important Information Regarding Nonsmoker Discount for Optional Life Insurance Coverage

Cigna, our life insurance carrier, offers lower cost employee and spouse life insurance coverage to nonsmokers due to the decreased risk of premature death. For benefit purposes, the definition of a nonsmoker is an employee who does not smoke at the time of enrollment and agrees to completely refrain from smoking.

2022 Medical Plans

You can only make changes to benefits during open enrollment or if you experience a qualifying life event.

MEDICAL PLAN OPTION	TRADITIONAL PLAN[1]		HEALTH SAVINGS PLAN[1]	
	In-Network	Out-of-Network[7]	In-Network	Out-of-Network[7]
Annual Deductible[2]	$500 per person $1,500 per family	$2,000 per person $6,000 per family	$2,000 employee-only coverage $4,000 family coverage[8]	$4,000 employee-only coverage $8,000 family coverage[8]
Physician Visits[3]	$30 PCP copay $40 Specialist copay (Copay for office visit exam fee only. Coinsurance may apply to other services.)	60% of non-network reimbursement rate after deductible	80% after deductible	60% of non-network reimbursement rate after deductible
Testing and Ancillary Services[3]	100% coverage for age appropriate testing related to preventive care 80% coinsurance applies to other charges after deductible	60% of non-network reimbursement rate after deductible	100% coverage for age appropriate testing related to preventive care 80% after deductible	60% of non-network reimbursement rate after deductible
Emergency Room (True emergency only)	80% after $300 ER visit copay	80% after $300 ER visit copay	80% after deductible	80% after deductible
Non-emergency visits to ER	Not covered	Not covered	Not covered	Not covered
Hospital Admission/ Outpatient Surgery	80% after deductible and $300 hospital admission copay 80% after deductible and $150 outpatient copay	60% of non-network reimbursement rate after deductible	80% after deductible	60% of non-network reimbursement rate after deductible
Retail Prescriptions (30-day supply)[5, 6]	**Generic:** $12 **Preferred Brand:** $40 **Non-Preferred:** $80	Not covered	80% after deductible; Certain preventive medications – Generic is $10 and Brand is $25	Not covered
Mail Order Prescriptions (90-day supply)[5, 6]	**Generic:** $30 **Preferred Brand:** $100 **Non-Preferred:** $200	Not covered	80% after deductible; Certain preventive medications – Generic is $10 and Brand is $25	Not covered
Specialty Mail Order Prescriptions (30-day supply)	**Generic:** $75 **Preferred Brand:** $150 **Non-Preferred:** $225	Not covered	80% after deductible	Not covered
Out-of-Pocket Maximum[2]	$6,000 per person $12,000 per family [4]	$25,000 per person $50,000 per family [4]	$6,000 employee-only coverage $12,000 family coverage [4]	$25,000 employee-only coverage $50,000 family coverage [4]
Cost Per Month*	**Employee Only:** $165 **Employee and Spouse:** $354 **Employee and Children:** $313 **Employee and Family:** $544		**Employee Only:** $128 **Employee and Spouse:** $275 **Employee and Children:** $243 **Employee and Family:** $423	Company contributes HSA seed money. $500 for employee only $1,000 for remaining tiers

***The monthly premiums above DO NOT include the monthly COVID-19 vaccine surcharge. See page 11 for details.**

1 *For those participants who live outside the defined network service area, an out-of-area plan with separate benefits is available with no restrictions on utilizing network providers.*

2 *In-network expenses do not apply to out-of-network out-of-pocket maximums (OOPM). Out-of-network expenses do not apply to in-network OOPMs. For the Traditional Plan, deductibles, coinsurance and copays count toward satisfying OOPMs. For the Health Savings Plan option, deductibles and coinsurance count toward satisfying OOPMs.*

3 *Preventive care is not covered out of network.*

4 *Plan benefits start paying at 100% for a covered individual once that person reaches the individual OOPM. If you have family coverage, your family does not have to meet the family OOPM before the plan will pay at 100% for a person who has met the individual OOPM.*

5 *General provisions: Reimbursement is limited to non-excluded drugs per the current formulary and to the generic drug benefit when a non-generic is utilized. Participants will pay the lesser of the copay or the actual cost of the drug. Mail order prescriptions are available in a 90-day supply, except specialty drugs, which are only available in a 30-day supply. Drugs that have not been evaluated and approved by CVS Caremark's Pharmacy and Therapeutics Committee (or other appropriate reviewing body) or drugs that have been excluded from the formulary are not eligible for coverage.*

6 *Fee (in addition to regular copay and coinsurance for maintenance prescriptions under the Maintenance Choice Program – generic: $15; preferred brand: $25; non-preferred: $40). See Maintenance Choice Program description on page 4.*

7 *In-Network vs. Out-of-Network: You pay less when you use in-network providers – doctors, hospitals and pharmacies that are in the plan. When you and your family use these providers, you save money because network providers have agreed to accept negotiated rates for their services and you pay a lower portion of coinsurance and deductibles.*

8 *For the Health Savings Plan, the family deductible must be met before any benefits are payable if you have enrolled any family members in addition to yourself. The deductible does not apply to covered preventive care services.*

Maintenance Choice Program

Through the Incentivized Maintenance Choice Program, you and your family members can receive 90-day supplies of long-term medication(s) through either the CVS Caremark Mail Service Pharmacy or at a CVS/pharmacy. Either way, your payment will be the same reduced rate. If however, after two fills of a medication, you choose to continue to receive your maintenance prescriptions in 30-day supplies, an additional fee will be added to your copay or coinsurance ($15 for generic; $25 for preferred brand; $40 for non-preferred). This fee will not apply if you choose to receive the 90-day refills of your long-term medications through mail service or at a CVS/pharmacy.

Dental Plans

The company offers a choice of two dental options, a Dental PPO and a DMO plan. The DMO option is not available in all areas.

How the Dental Plan Options Compare

DENTAL PLAN OPTION	Dental PPO Administered by Delta Dental of Texas (with orthodontia)	Dental Maintenance Organization (DMO) Administered by Aetna (not available in all areas)
Choosing a Primary Care Dentist	You may choose any dentist. However, participating dental providers provide services that are not subject to a deductible and agree to accept negotiated, discounted rates that are within the recognized charge limits.	Choose a DMO network dentist. See "DocFind" list on aetna.com.
Non-Network Benefits	Plan offers non-network benefits subject to deductibles and reasonable and customary limits.	No benefits, except for limited emergency benefit.
Filing of Claims	You or your dentist will submit claims.	No paperwork to file. Your dentist will submit any claims.
Accessing Specialty Care	You may choose any dentist. However, Delta Dental PPO providers stay within reasonable and customary limits and offer discounted care.	Referral from primary care dentist required to access network specialist.
Emergency Care	You may choose any dentist. However, Delta Dental PPO providers stay within reasonable and customary limits and offer discounted care.	Call primary care dentist, or if out of area, Aetna member services at 800-772-1416.
Deductibles	**Network:** None **Non-Network:** $50 per person for Basic & Major Restorative Services	**Network:** None **Non-Network:** No benefits
Coinsurance or Copays for Services	No copay for office visits. **Preventive:** 100% coverage **Basic Restorative:** 80% coverage **Major Restorative:** 60% coverage	No copay for office visits. **Preventive:** 100% coverage **Basic and Major:** Copays vary according to service provided.
Maximum Annual Benefit	$1,800 per person	No limit
Orthodontic Coverage	Plan pays 50% to a maximum of $1,600 per child (lifetime max). Dependent children under age 19 only.	Maximum copay is $2,000. Coverage available for adults and covered dependents.
Cost Per Month	**Employee Only:** $15 **Employee and Spouse:** $30 **Employee and Children:** $39 **Employee and Family:** $49	**Employee Only:** $9 **Employee and Spouse:** $17 **Employee and Children:** $24 **Employee and Family:** $33

Network vs. Non-Network Dental Benefits

You may choose any dentist with the PPO plan. There is no deductible if you choose network dental providers who generally charge patients about 25% less for covered services. Non-network care is subject to a $50 deductible for restorative care and benefits are subject to recognized charge limits.

There are no non-network benefits with Aetna's DMO option, and you must designate a primary care dentist. Choose this plan only if a DMO network provider is available to you.

To locate a Network Dentist:

You can locate participating DMO dentists and their provider ID number on Aetna's website at **aetna.com/docfind**. To locate PPO dentists and their provider ID, go to **deltadentalins.com**.

Vision Plan

The company offers coverage through Vision Service Plan (VSP), which includes an annual eye exam and either one pair of glasses or contact lenses once every calendar year (subject to copays and certain limits and restrictions).

BENEFIT	NETWORK COVERAGE	NON-NETWORK COVERAGE
Comprehensive Vision Exam (once every calendar year)	100% covered after $10 copay.	Reimbursement up to $45 after $10 copay is applied.
Prescription Glasses (once every calendar year)	$25 materials copay, which is a single payment that is applied to the entire purchase, not the lens and frame individually.	
	Lenses: 100% covered after materials copay. Patient options not covered by the plan, such as some progressive lenses, photochromic lenses, UV protection and anti-reflective coatings, may be purchased through the plan at a 20-25% discount. Standard progressive lenses are now covered at a $0 copay.	**Lenses:** Reimbursement after copay is applied: • Single vision up to $30 • Lined Trifocal up to $65 • Lined Bifocal up to $50
	Frames: $180 retail frame allowance, and 20% off any out-of-pocket costs.	**Frames:** Reimbursement up to $70 after copay is applied.
Contact Lenses (once every calendar year)	Contact lenses may be selected in lieu of prescription glasses.	
	Elective: When you choose contacts instead of glasses, your $180 contact lens allowance applies to the cost of your contacts and the contact lens exam (fitting and evaluation). This exam, which is discounted 15%, is in addition to your vision exam to ensure the proper fit of contacts. If you choose contact lenses, you will be eligible for prescription glasses during the next calendar year.	Reimbursement up to $105 for elective contact lenses and contact lens exam.
	Medically Necessary: Medically necessary contacts prescribed for certain conditions are 100% covered after $25 copay. VSP doctor must receive approval from VSP prior to dispensing.	Reimbursement up to $210 for medically necessary contact lenses and contact lens exam.
Laser Eye Surgery	VSP participants receive PRK, LASIK and Custom LASIK at a discounted fee. Discounts vary by location, but will average 15% off of the contracted laser center's usual and customary price. Additionally, if the participating laser center is offering a temporary price reduction, VSP members will receive 5% off the promotional price.	Not covered.
Cost Per Month	**Employee Only:** $7.19 **Employee and Spouse:** $15.22 **Employee and Children:** $16.30 **Employee and Family:** $22.54	

Create an account on **vsp.com** to view your in-network coverage and to find a VSP network doctor.

Optional Benefits

Supplemental Life Insurance

- You may purchase supplemental term-life insurance of one to seven times annual base pay up to $3 million, in addition to the basic life insurance coverage provided by the company. Evidence of Insurability (EOI) may be required. The company provides basic life insurance coverage of one times your annual base salary, up to $50,000.
- You may purchase supplemental spouse term-life insurance in multiples of $25,000 up to a maximum of $300,000. EOI may be required.
- You may purchase supplemental child term-life insurance in amounts of $5,000, $10,000 or $15,000. This benefit does not apply for dependent children age 26 or older.
- Supplemental life insurance coverages are paid through payroll deduction with after-tax dollars.

Accidental Death & Dismemberment (AD&D)

- You may purchase AD&D insurance of one to ten times your annual base pay, up to $3 million. AD&D insurance is also available for your spouse and/or children.
- AD&D pays a benefit if you or a covered family member die or are severely injured in an accident.
- AD&D is paid through payroll deduction with after-tax dollars.

Long-term Disability

- 50% of eligible monthly pay (employer paid) – subject to applicable waiting period.
- Option to increase coverage to 60% for an additional cost.

Vacation Buy/Sell

- Bargaining unit employees should refer to their applicable labor agreement for information regarding eligibility for Vacation Buy/Sell.

2022 HSA & FSA

Who is eligible for an HSA?

An eligible individual is one who:

- Is covered under a high-deductible health plan (HDHP),
- Is not covered by any other health insurance plan, unless it is another HSA-qualified HDHP,
- Is not enrolled in Medicare,
- May not be claimed as a dependent on another person's tax return, and
- Has not received Veterans Administration (VA) benefits in the past three months other than preventive services. This exclusion does not apply to veterans with a disability rating from the VA.

In 2022, you can contribute up to the Internal Revenue Service (IRS) maximum of $3,650 for employee coverage or $7,300 for family coverage. The company's seed money contribution counts toward the max, helping you reach it sooner.

Advantage: You don't pay Federal and Social Security taxes on HSA money. And if you don't spend all of the money in your account during the year, the money stays in your HSA even if you change jobs or medical plans. You may also be able to earn interest on money in your HSA. Just keep in mind there is a tax on distributions from HSAs for non-qualified medical expenses.

FSA

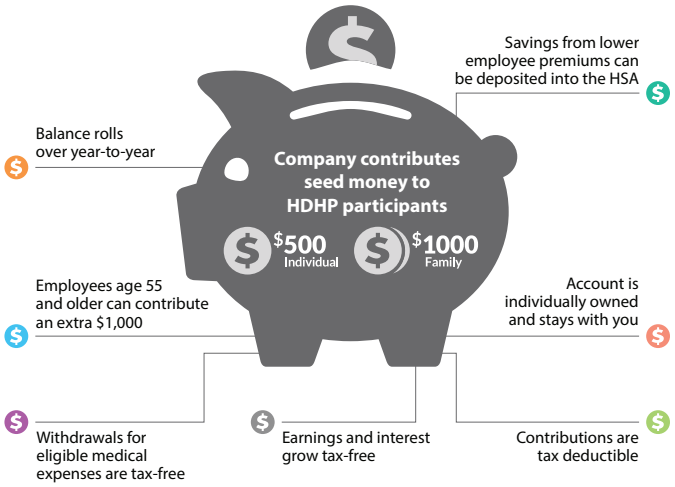
FSAs let you pay for certain expenses – e.g., childcare, deductibles, copays, qualified prescription drugs, insulin, medical devices, etc. – with pre-tax dollars. Because your contributions are deducted from your pay before Federal and Social Security taxes are withheld, you pay less in taxes and keep more money in your own pocket.*

**NOTE: Participants enrolled in the Health Savings Plan can have a Limited Purpose Flexible Spending Account (LPFSA) that can only be used for dental and vision costs. After you satisfy the deductible, you may use your Limited Purpose FSA for any health care expense that would be eligible for reimbursement under a General Purpose Health Care FSA.*

Health Care Flexible Spending Account (HCFSA)

The HCFSA lets you set aside pre-tax dollars (up to $2,750) to reimburse yourself for certain health care expenses. In general you can be reimbursed if the expenses are:

- Incurred during the plan year while you're participating in the HCFSA.
- Not reimbursable under another health insurance plan.
- Considered tax-deductible by the IRS.
- Medically necessary (cosmetic services are not eligible).



Limited Purpose Flexible Spending Account (LPFSA)

A Limited Purpose FSA is a type of Medical FSA - but with a catch: it can only be used for dental and vision costs. If you are enrolled in the Health Savings Plan, you can only have a Limited Purpose FSA instead of the traditional Medical FSA. After you satisfy the deductible, you may use your Limited Purpose FSA for any health care expense that would be eligible for reimbursement under a General Purpose Health Care FSA. For more information on eligible expenses, visit **www.irs.gov** (Publication 502 and 969) or check with a tax advisor.

Dependent Care FSA

This account helps you pay for day care for your child(ren) or disabled dependent, but there are a few special rules. You can only contribute up to $5,000 to the account per household per year. The day care services must be necessary so you can work. If you're married, your spouse must be either employed, a full-time student at least five months during the year or mentally or physically disabled and unable to provide care for himself or herself. For more information on eligible expenses, visit **www.irs.gov** (Publication 503) or check with a tax advisor.

Important FSA Rules

Because of the tax advantages available through FSAs, the IRS has established special rules for participating:

Use It or Lose (Most of) It

If you don't spend all the money in your HCFSA for the year, you may only roll over $550 to the next year. Any other balance will be forfeited and used to offset plan expenses. No rollover is available for the dependent care FSA. If you don't spend all the money in your dependent care FSA for the year, your remaining balance will be forfeited and used to offset plan expenses.

SAVE YOUR RECEIPTS: Our FSA and HSA administrator, Optum Financial, frequently requests receipts to show proof of purchase. It is ultimately your responsibility to check transactions, balances and to ensure proper use of the card.

Automatically Enrolled Benefits

Basic Life Insurance

- The company provides basic life insurance coverage of one times your annual base salary up to $50,000.
- Coverage is automatic and at no cost to employees.

Business Travel Accident (BTA)

- $200,000 life insurance covering accidental death or serious injury while traveling on company business.
- Coverage is automatic and at no cost to employees.

Employee Assistance Program (EAP)

- A confidential, 24-hour program that provides counseling, legal and financial services for employees and their families.
- Coverage is automatic and at no cost to employees.

CNP Savings Plan (401k)

- The company offers employer contributions in the CNP Savings Plan as follows:
  - Dollar for dollar matching contributions, up to 6% of your eligible pay.
  - Automatic non-matching contributions of 3% of your eligible pay.
- Employees may contribute up to 50% of regular pay and/or bonus pay as pre-tax and/or Roth contributions, and up to 16% as after-tax contributions, for a combined maximum of 66% of eligible pay up to the IRS limits.
- Immediate, 100% vesting of company matching contributions and company non-matching contributions.
- Employees are automatically enrolled at a pre-tax contribution rate of 6%, unless they elect otherwise within 30 days of employment. Employee contributions, company match and company non-match will default to the age appropriate target retirement date fund, unless the employee elects a different investment option.
- If you are making contributions to the plan, your contribution rate will be automatically increased by 1% each April after the year of your automatic enrollment (or when you would have been automatically enrolled if you had not made an affirmative election), up to a maximum rate of 10%, unless you elect to opt out. This 1% increase will apply to your pre-tax contribution rate unless that rate is zero, in which case the increase will apply to your Roth contribution rate or, if your Roth contribution rate is zero, to your after-tax contribution rate.

ALWAYSWELL

The health and well-being of our employees are top priorities for CenterPoint Energy. We want our members to be able to make healthy lifestyle choices and improve their well-being. CNP's Always Well program was designed to make employees more aware of their health and to provide the tools, resources and educational materials needed to improve habits over time.

2022 Always Well Plan Components

Eligible employees* must reach level 4 by 12/31/2022 in order to earn a day of PTO to use in 2023.

Optional program components:

- Daily cards
- Journeys
- Coaching
- Challenges
- Healthy Habits

If you are an eligible employee and think you might be unable to meet a standard for a reward under the Always Well program, you might qualify for an opportunity to earn the same reward by different means. Contact Virgin Pulse at 888-671-9395, and they will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you, considering your health status.

How to Register

Single Sign-On

- If you are logging on from CNP Today, click on the Always Well link under "Career and Life" to be taken directly to your account set up.
- If you are logging on for the first time, use your CenterPoint Energy email address and complete consent and site demonstrations to access the Always Well site.

Registering from the App or Outside Computer

- New members: visit ***join.virginpulse.com/Centerpoint***
- Enter your last name and date of birth (DOB)
- Enter your identifier: Employee key → CNP Employee ID number, 8-digit number (some ID's may contain leading zeros) Ex: 00000012, 00012345, 12345678
- Enter the registration code: alwayswell (case sensitive)
- Follow the prompts to complete registration

**Employees represented by IBEW Local 66 are not eligible for biometric screenings or incentives. Employees must be hired before Oct. 1, 2022, to be eligible for the 2022 Always Well program.*

Important Reminders

Employee Assistance Program (EAP)

The EAP, administered by Magellan, will put you in touch with professional counseling services and can provide assistance with mental health, substance abuse, counseling and coaching when needed. The EAP is free and confidential for all employees and their dependents, up to three visits per incident. For more information, call **800-424-4349** or visit **MagellanAscend.com**.

Legal Notices

Health Insurance Portability and Accountability Act (HIPAA) Notice

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 31 days after your other coverage ends (or if the employer stops making contributions for such other coverage). In addition, 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 dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. If you or your dependents lose coverage under Medicaid or a state child health plan or become eligible for premium assistance under Medicaid or a state child health plan, you may be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 60 days of such event. Contact the Benefits Service Center to request special enrollment or for further information at **833-236-3487**.

Newborns' and Mothers' Health Protection Act

Health insurance issuers and group health plans (such as the CenterPoint Energy Group Welfare Benefits Plan) generally may not, under Federal 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 vaginal delivery or less than 96 hours following a Caesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consultation with the mother, from discharging the mother or the newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay that is less than 48 hours (or 96 hours, as applicable). Longer hospital stays may still require prior authorization, however, and all other plan provisions will continue to apply.

Privacy Notice Reminder

This reminder applies to the non-insured portions of the CenterPoint Energy Medical Plan; the CenterPoint Energy Dental Plan; the CenterPoint Energy Retiree Medical Plan; the CenterPoint Energy Retiree Dental Plan; the CenterPoint Energy Health Care Flexible Spending Plan; and the CenterPoint Energy Employee Assistance Program (each, further identified as "plan").

Participants previously received a Notice of Privacy Practices relating to the plan, and at least once every three years, the plan is required by law to remind participants that a copy of the plan-related notices can be requested. To request a copy of the privacy notice, you must make your request in writing and mail it via U.S. Postal Service to the HIPAA privacy officer at the following address:

HIPAA Privacy Officer
CenterPoint Energy, Inc.
P.O. Box 4567
Houston, TX 77210-4567

For more information regarding this reminder or your privacy rights under HIPAA, call the plan's privacy officer through the Benefits Service Center at **833-236-3487**. You must identify both yourself and the CenterPoint Energy plan in which you participate to receive a response. Please note, however, that the majority of medical information resides with business vendors who provide services to the plans listed above. To access this information, you should contact the vendor directly at the address or phone number listed on your member identification card.

Women's Health and Cancer Rights Act of 1998

The CenterPoint Energy Medical Plan covers mastectomy-related services, in a manner determined in consultation with the attending physician and the patient, including all stages of reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction to achieve symmetry between the breasts, prostheses, and complications resulting from all stages of a mastectomy (including lymphedema). These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. For more information, contact the Benefits Service Center at **833-236-3487**.

Summary of Benefits and Coverage and Summary Plan Description

The Summary of Benefits and Coverage (SBC) for each medical plan option is located at **CNPBenefits.com**. You may print the SBC from the website or request a paper copy, free of charge, by contacting the Benefits Service Center at **833-236-3487**.

This guide is a Summary of Material Modifications for the CenterPoint Energy Group Welfare Benefits Plan and supplements the Summary Plan Description. The Summary Plan Description is available at **CNPBenefits.com**. You may also request a paper copy by contacting the Benefits Service Center at **833-236-3487**.

Premium Assistance under Medicaid and 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 are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs, but you may be able to buy individual 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 in the chart, 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 to participate in either of these programs, contact your state Medicaid or CHIP office or dial **1-877-KIDSNOW** 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.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow 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 fail to request special enrollment within this 60-day time period, you will not be permitted to enroll yourself and/or your dependents in the plan until the plan's next open enrollment period, unless you experience another life event that permits you to enroll mid-year. Please contact the Benefits Service Center at **833-236-3487** for more information regarding the plan's enrollment requirements. If you have questions about enrolling in your employer plan, contact the Department of Labor at **askebsa.dol.gov** or by calling toll-free **866-444-EBSA (3272)**. Of the states where CenterPoint Energy employees reside, Arizona, Illinois, Michigan, Mississippi, New Mexico and Tennessee currently do not offer premium assistance programs.

If you live in one of the following states, you may be eligible for assistance paying your employer health premiums. The following list is current as of July 31, 2020. Contact your State for more information on eligibility.

STATE	Medicaid/CHIP	WEBSITE	PHONE
ARKANSAS	Medicaid	myarhipp.com	855-692-7447
COLORADO	Medicaid and CHIP	Health First Colorado: www.healthfirstcolorado.com/ CHP+: www.colorado.gov/pacific/hcpf/child-health-plan-plus Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program	Health First Colorado: 800-221-3943/State Relay 711 CHP+: 800-359-1991/ State Relay 711 HIBI Customer Service: 1-855-692-6442
GEORGIA	Medicaid	https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp	678-564-1162 ext 2131
INDIANA	Medicaid	Healthy Indiana Plan for low-income adults 19-64 www.in.gov/fssa/hip/ All other Medicaid www.in.gov/medicaid/	Healthy Indiana Plan for low-income adults ages 19-64 877-438-4479 All other Medicaid 800-457-4584
IOWA	Medicaid	HIPP Website: http://dhs.iowa.gov./ime/members/medicaid-a-to-z/hipp Medicaid Website: https://dhs.iowa.gov/ime/members Hawki Website: dhs.iowa.gov/Hawki	HIPP Phone: 888-346-9562 Medicaid: 800-338-8366 Hawki Phone: 800-257-8563
KANSAS	Medicaid	http://www.kdheks.gov/hcf/default.htm	800-792-4884
KENTUCKY	Medicaid	Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP): https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Email: KIHIPP.PROGRAM@ky.gov KCHIP: https://kidshealth.ky.gov/Pages/index.aspx Kentucky Medicaid: https://chfs.ky.gov	Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP): 855-459-6328 KCHIP: 877-524-4718
LOUISIANA	Medicaid	www.medicaid.la.gov o www.ldh.la.gov/lahipp	888-342-6207 (Medicaid hotline) or 855-618-5488 (LaHIPP)
MINNESOTA	Medicaid	mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp	800-657-3739
MISSOURI	Medicaid	dss.mo.gov/mhd/participants/pages/hipp.htm	573-751-2005
NEBRASKA	Medicaid	ACCESSNebraska.ne.gov	855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
OKLAHOMA	Medicaid and CHIP	www.insureoklahoma.org	888-365-3742
TEXAS	Medicaid	gethipptexas.com	800-440-0493
WISCONSIN	Medicaid and CHIP	dhs.wisconsin.gov/publications/p1/p10095.pdf	800-362-3002

To see if any more states have added a premium assistance program since July 31, 2020, or for more information on special enrollment rights, you can contact either:

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
877-267-2323, Menu option 4, Ext. 61565

The Prescription Drug Coverage and Medicare Part D notice is being provided to you as required under Part D of Title XVIII of the Social Security Act. This notice provides information about your prescription drug coverage if you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months. This notice is for informational purposes, and no action is required from you.

Your Prescription Drug Coverage and Medicare Part D

This notice is intended for CenterPoint Energy Medical Plan and Retiree Medical Plan participants and covered dependents who are enrolled in Medicare and eligible for Medicare Part D.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the medical plan options offered under the CenterPoint Energy Medical Plan or the CenterPoint Energy Retiree Medical Plan (each referred to in this notice as "the CenterPoint Plan," or "the Plan") and the prescription drug coverage offered by Medicare Part D. This information can help you decide whether or not you want to join a Medicare prescription drug plan. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

All Medicare Part D plans (e.g., Medicare prescription drug plans, Medicare Advantage plans) will provide at least a standard level of coverage set by Medicare. Some plans might also offer more coverage for a higher monthly premium. Because your existing prescription drug coverage under the CenterPoint Plan is creditable coverage (i.e., on average for all individuals covered by the Plan, it is expected to pay as much as standard Medicare Part D coverage), you can keep your current coverage under the Plan and not pay higher Medicare premiums if you later decide to enroll in Medicare Part D.

You may join a Medicare Part D plan when you first become eligible for Medicare and each year from October 15 to December 7. You will also be eligible to enroll in a Medicare Part D plan during a 2-month special enrollment period if you lose your current creditable prescription drug coverage through no fault of your own.

If you are covered under the Plan as an active employee or a dependent of an active employee, your current coverage under the Plan generally will not be affected if you decide to enroll in a Medicare Part D plan. However, if you decide to enroll in a Medicare Part D plan and drop plan coverage, you will generally only be able to re-enroll at the next annual enrollment period. If you are covered under the Plan as a retiree or a dependent of a retiree, you will become ineligible for retiree coverage under the Plan if you decide to enroll in a Medicare Part D plan, and you will be dropped from your current coverage under the Plan. If you have COBRA coverage under the Plan, your coverage will terminate upon becoming entitled to Medicare benefits after electing COBRA continuation coverage. If you became entitled to Medicare benefits before electing COBRA coverage under the Plan, your Plan coverage will not terminate if you decide to enroll in a Medicare Part D plan, and the Plan will coordinate with the Part D coverage. Be aware that for retiree and COBRA coverage, if you drop Plan coverage, you will not be able to reinstate it at any time in the future. In addition, the Plan covers other health expenses in addition to prescriptions. You should compare your current coverage, including which drugs are covered and the other medical benefits offered, with the coverage and cost of Medicare Part D plans in your area.

You should also know that if you drop or lose your coverage under the CenterPoint Plan and then don't enroll for Medicare Part D, you may have to pay a higher premium to enroll later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly Medicare Part D premium may go up at least 1% of the Medicare based beneficiary premium per month for every month that you did not have creditable coverage. For example, if you go nineteen months without coverage, your Medicare Part D premium may consistently be at least 19% higher than the Medicare base beneficiary premium. In addition, you may have to wait until the next October to enroll in Medicare Part D.

Contact the Benefits Service Center for further information.

NOTE: You may receive this notice annually and at other times in the future, such as before the next period you can enroll in Medicare Part D coverage, or if this coverage changes. You also may request a copy at any time. For more information on your current prescription drug coverage, contact CenterPoint Energy's Benefits Service Center at 833-236-3487.

For more information about your options under Medicare prescription drug coverage: More detailed information about Medicare plans that offer prescription drug coverage is available in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail from Medicare annually. You may also be contacted directly by Medicare prescription drug plans. You can also get more information about Medicare prescription drug plans from these places:

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

For people with limited income and resources, extra help paying for a Medicare prescription drug plan may be available. For more information about this extra help, visit the Social Security Administration at **socialsecurity.gov**, or call **800-772-1213 (TTY 800-325-0778)**.

Remember: Keep this notice. If you enroll in a Medicare Part D plan, you may need to give a copy of this notice when you join to show that you are not required to pay a higher premium amount.

Contact the **Benefits Service Center** for further information.

CenterPoint Energy, Inc.
CenterPoint Energy Benefits Service Center
P.O. Box 617907
Chicago, IL 60661

Phone: 833-236-3487

COVID-19 Vaccination Surcharge

If you elect to enroll in the company medical plan, a $90 monthly surcharge will apply to your 2022 medical plan premiums unless you timely provide proof of being fully vaccinated against COVID-19. **You must provide proof of your COVID-19 vaccination within 60 days of your date of hire to avoid the surcharge.** If you do not submit proof of vaccination within 60 days of hire, the surcharge will apply to your medical plan premiums for 2022 and will not be removed if you later provide proof of vaccination. Go to **CNP Today** and select Vaccine Disclosure Form under the Coronavirus Resources to upload a copy of your vaccination card. If proof of vaccination is timely received, the surcharge will be removed from your premiums, and a refund of any previously paid surcharge amounts will be processed back to your date of hire.

*If you think you might be unable to receive a COVID-19 vaccination due to a medical condition, or if it is medically inadvisable for you to receive the vaccine, you might qualify for an opportunity to avoid the premium surcharge by different means, which will take into account the recommendations of your doctor. You may also request a reasonable alternative if you are unable to receive a COVID-19 vaccination because it conflicts with a sincerely held religious belief. Go to Coronavirus Resources on **CNP Today** or contact the **HR Hotline** at HR.Hotline@centerpointenergy.com to request a reasonable alternative in light of your health status or religious belief. Your completed request must be submitted to the Vaccine Disclosure Form Portal on CNP Today within 60 days of your date of hire.*

Verify Your Dependent Information

Is your Dependent Eligible?

To be eligible for coverage in the medical, dental and vision plans, a spouse must be a lawful spouse who is not divorced from the plan participant. Dependent children are your children up to the age of 26 (including legally adopted children, stepchildren or eligible foster children) even if they have other outside coverage options. Dependent children who became mentally or physically handicapped before age 26 and are incapable of self-support also may be specially approved for coverage over the age limit if they rely on you for support and have been continuously covered under the plan.

You may also cover qualifying relatives under the age of 26 if you are their court-ordered legal guardian and claim them as a dependent for income tax purposes.

To be eligible for coverage in the life insurance and the accidental death and dismemberment plans, your dependents must meet the rules shown above, and dependent children must also be unmarried, under age 26, and dependent on you for maintenance and support. Please refer to the complete eligibility rules available at **CNPBenefits.com.**

Dependent Enrollment is Subject to Verification

All benefit plan coverage provided by CenterPoint Energy is based on the truthfulness of statements made by the plan participants during the enrollment process, regardless of enrollment method.

For any misrepresentation or fraudulent statements made to plan fiduciaries or a service provider, the plan administrator may, in its sole discretion, take action to remedy the situation, including but not limited to denying coverage for a fraudulent claim, voiding or terminating future coverage for a participant and/or the participant's family members, or terminating the ability of a medical provider to file claims with the plan.

Please remember that you must also notify us within 31 days if one of your dependents loses eligibility for coverage under the plan, or your dependent may lose important rights such as the ability to elect COBRA continuation coverage.

The participant making an intentional misrepresentation or fraudulent statement may also be subject to federal prosecution for health care fraud pursuant to the Health Insurance Portability and Accountability Act, and the plan administrator may disclose all relevant personal health information to federal authorities for prosecution.

Your 2022 Benefit Providers

Aetna Dental – DMO Plan
800-772-1416
aetna.com

BCBS of Texas
877-260-9257
Bcbstx.com

CVS/Caremark
(Prescription services for BCBSTX)
800-516-2590
caremark.com

Delta Dental – PPO Plan
888-818-7931
deltadentalins.com

Magellan
(Employee Assistance Program)
800-424-4349
MagellanAscend.com
Access Code: CenterPoint

MDLIVE
(Telehealth)
888-680-8646
MDLIVE.com/BCBSTX

New York Life
(Life Insurance and LTD)
800-362-4462
NewYorkLife.com/group-benefit-soluctions

Optum Financial (FSA)
800-243-5543
optumbank.com

Optum Financial (HSA)
800-243-8913
optumbank.com

ReedGroup
(FMLA and STD Administration)
844-556-6374
centerpointenergy.leavepro.com

Savings Plan
844-273-8692
CNPSavings.voya.com

Virgin Pulse
888-671-9395

Vision Service Plan (VSP)
800-877-7195
centerpointenergy.vspforme.com/

24/7 Nurseline
BCBSTX Nurseline
800-581-0368

Visit CNPBenefits.com for continually updated information
Benefits Service Center representatives are available Monday through Friday, 7 a.m. - 7 p.m. Central Time at 833-236-3487.