

Newell Operating Company: Consumer Value Plan



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE:** Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. **This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, <https://eoc.anthem.com/eocdps/aso>. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call (800) 810-2583 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$5,000/member, \$7,500/member within a family or \$10,000/family for In- Network Providers. \$10,000/member, \$15,000/member within a family or \$20,000/family for Non-Network Providers.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible .
Are there services covered before you meet your deductible ?	Yes. Preventive Care . For more information see below.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	\$5,000/member, \$7,500/member within a family or \$10,000/family for In- Network Providers. \$10,000/member, \$15,000/member within a family or \$20,000/family for Non-Network Providers.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit ?	Premiums , certain specialty drugs managed by Prudent Rx, balance-billing charges, health care this plan doesn't cover, and cost containment penalties (for	Even though you pay these expenses, they don't count toward the out-of-pocket limit .

	failure to pre-certify).	
Will you pay less if you use a network provider?	Yes, for a list of in-network providers, see www.anthem.com or call (833) 897-1337. Yes, for prescription drugs: CVS Health. For a list of network retail and mail pharmacies, log on to www.caremark.com or call Customer Service at 1-800-213-0879.	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral .



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	0% coinsurance	0% coinsurance	Virtual visits (Telehealth) benefits available.
	Specialist visit	0% coinsurance	0% coinsurance	Virtual visits (Telehealth) benefits available.
	Preventive care / screening /immunization	No charge	0% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	0% coinsurance	-----none-----
	Imaging (CT/PET scans, MRIs)	0% coinsurance	0% coinsurance	Pre-certification is required, \$300 penalty if services are not pre-certified.
If you need drugs to treat your	Typically Generic (Tier 1)	0% coinsurance (retail and home delivery)	0% coinsurance (retail) and Not covered (home delivery)	Maintenance medications: Required to be filled through CVS90 program or Home Delivery

* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://eoc.anthem.com/eocdps/aso>.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
illness or condition More information about prescription drug coverage is available at www.caremark.com Note: If a prescription is attempted out of national pharmacy network, it will reject. Please visit www.caremark.com for more details.	Typically Preferred Brand & Non-Preferred Generic Drugs (Tier 2)	0% coinsurance (retail and home delivery)	0% coinsurance (retail) and Not covered (home delivery)	Retail: Limited to a 30-day supply CVS90: Members may only get 90-day Maintenance Medication at CVS/pharmacy, COSTCO Pharmacies, Target, Kroger, and Select independents. Please visit Caremark.com to verify your closest pharmacy for 90-day. These are subject to state laws – based off the state where the pharmacy is located, some of these requirements may be affected. Home Delivery: Limited to a 90-day supply. Specialty: Available in a 30-day supply through CVS Specialty Pharmacy Not all prescription drugs are covered. To determine if a specific drug is covered under your plan, log into your account at www.caremark.com . Prescription drug charges apply to the Medical deductible and out-of-pocket limit.
	Typically Non-Preferred Brand and Generic drugs (Tier 3)	0% coinsurance (retail and home delivery)	0% coinsurance (retail) and Not covered (home delivery)	
	Typically Preferred Specialty (brand and generic) (Tier 4)	For Specialty Drugs, enroll in PrudentRx to get your medication at \$0 after your deductible is met. If you do not enroll you are subject to a 30% cost share. If your Specialty Medication is not offered by PrudentRx you will pay the coinsurance with a \$250 Max. (retail and home delivery)	Not covered (retail and home delivery)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	0% coinsurance	Pre-certification is required for outpatient surgery, except for surgery performed in a physician's office; \$300 penalty if services are not pre-certified.
	Physician/surgeon fees	0% coinsurance	0% coinsurance	Pre-certification is required for outpatient surgery, except for surgery performed in a physician's office; \$300 penalty if services are not pre-certified.
	Emergency room care	0% coinsurance	Covered as In- Network	-----none-----

* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://eoc.anthem.com/eocdps/aso>.

If you need immediate medical attention	Emergency medical transportation	0% coinsurance	Covered as In- Network	Pre-certification is required; \$300 penalty if services are not pre-certified.
Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Urgent care	0% coinsurance	0% coinsurance	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	0% coinsurance	Pre-certification is required; \$300 penalty if services are not pre-certified.
	Physician/surgeon fees	0% coinsurance	0% coinsurance	Pre-certification is required; \$300 penalty if services are not pre-certified.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance	0% coinsurance	-----none-----
	Inpatient services	0% coinsurance	0% coinsurance	Pre-certification is required for inpatient mental health/substance abuse treatment (includes residential treatment facility services). Pre-certification is also required for partial hospitalization, and intensive outpatient treatment, and ABA therapy, for mental health and substance abuse treatment; \$300 penalty if services are not pre-certified.
If you are pregnant	Office visits	0% coinsurance	0% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	0% coinsurance	0% coinsurance	
	Childbirth/delivery facility services	0% coinsurance	0% coinsurance	
	Home health care	0% coinsurance	0% coinsurance	200 visits/benefit period for Home Health and Private Duty Nursing combined.
	Rehabilitation services	0% coinsurance	0% coinsurance	

* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://eoc.anthem.com/eocdps/aso>.

If you need help recovering or have other special health needs	Habilitation services	0% coinsurance	0% coinsurance	30 visits limit not combined with any other therapy. Limit combined institutional/professional. Limit combined in and out of network. Pre-certification is required for inpatient rehabilitation facility and for outpatient rehabilitation or habilitative services (physical,
Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
				occupational, and speech therapy) in excess of thirty (30) visits per calendar year. \$300 penalty if services are not pre-certified.
	Skilled nursing care	0% coinsurance	0% coinsurance	Pre-certification is required, \$300 penalty if services are not pre-certified.
	Durable medical equipment	0% coinsurance	0% coinsurance	Pre-certification is required for DME exceeding \$1,000; \$300 penalty if services are not pre-certified.
	Hospice services	0% coinsurance	0% coinsurance	Pre-certification is required; \$300 penalty if services are not pre-certified.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	-----none-----
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	

Excluded Services & Other Covered Services:

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- | | | |
|---|---|--|
| <ul style="list-style-type: none"> • Routine eye care • Cosmetic surgery • Glasses for a child | <ul style="list-style-type: none"> • Routine foot care unless you have been diagnosed with diabetes • Dental care • Eye exam (Child) | <ul style="list-style-type: none"> • Long-term care • Weight loss programs • Non-emergency care when traveling outside the U.S. |
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- | | | |
|---|---|---|
| <ul style="list-style-type: none"> • Abortion • Hearing aids 1 pair/36 months • Private-duty nursing 200 visits/benefit period combined with Home Health | <ul style="list-style-type: none"> • Acupuncture • Bariatric surgery • Infertility treatment \$25,000 maximum/lifetime | <ul style="list-style-type: none"> • Chiropractic care 30 visits/benefit period • Gender affirming care • Most coverage provided outside the United States. See www.bcbsglobalcore.com |
|---|---|---|

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Georgia Office of Insurance and Safety Fire Commissioner, Consumer Services Division 2, Martin Luther King, Jr. Drive, West Tower, Suite 716, Atlanta, Georgia 30334, (800) 656-2298, www.oci.ga.gov/ConsumerService/Home.aspx, Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), www.dol.gov/ebsa/healthreform, or contact Anthem at the number on the back of your ID card. Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact:

ATTN: Grievances and Appeals, P.O. Box 105568, Atlanta, GA 30348-5568

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

Georgia Office of Insurance and Safety Fire Commissioner, Consumer Services Division, 2 Martin Luther King, Jr. Drive, West Tower, Suite 716, Atlanta, Georgia 30334, (800) 656-2298, www.oci.ga.gov/ConsumerService/Home.aspx

Does this plan provide Minimum Essential Coverage? Yes

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet the Minimum Value Standards? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost-sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	\$5,000
■ Specialist coinsurance	0%
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
[Diagnostic tests](#) (*ultrasounds and blood work*)
[Specialist](#) visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$5,000
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$70
The total Peg would pay is	\$5,070

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$5,000
■ Specialist coinsurance	0%
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)
[Diagnostic tests](#) (*blood work*)
[Prescription drugs](#)
[Durable medical equipment](#) (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$1,100
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$4,300
The total Joe would pay is	\$5,400

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$5,000
■ Specialist coinsurance	0%
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)
[Diagnostic test](#) (*x-ray*)
[Durable medical equipment](#) (*crutches*)
[Rehabilitation services](#) (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$2,800
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$10
The total Mia would pay is	\$2,810

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

Language Access Services:

(TTY/TDD: 711)

Albanian (Shqip): Nëse keni pyetje në lidhje me këtë dokument, keni të drejtë të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për të kontaktuar me një përkthyes, telefononi (800) 810-2583

Amharic (አማርኛ): ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (800) 810-2583 ይደውሉ።

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (800) 810-2583.

Armenian (հայերեն). Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (800) 810-2583:

Bassa (Bàsɔ̀ wùdù): M̐ dyi dyi-diè-djé bě bédjé bá céè-djé nià kɛ dyí ní, ɔ m̀b̀ ni dyí-bédjéin-djé bɛ̀ m̀ kɛ gbo-kpá-kpá kè b̃́ kp̃́ djé m̀ bídjí-wùdùùn b́́ pídyi. Bɛ̀ m̀ kɛ wuɖu-zìin-nyò d̀ò gbo wùdù kɛ, d́́á (800) 810-2583.

Bengali (বাংলা): যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলার জন্য (800) 810-2583 -তে কল করুন।

Burmese (မြန်မာ): ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖု (800) 810-2583 သို့ ခေါ်ဆိုပါ။

Chinese (中文) : 如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電(800) 810-2583。

Dinka (Dinka): Na nɔŋ thiëc në ke de yā thorë, ke yin nɔŋ loŋ bē yi kuony ku wër alëu bē gɛɛr yic yin ne thoŋ du ke cin wëu tāāuë ke piny. Te kɔr yin ba jam wënë ran ye thok geryic, ke yin cɔl (800) 810-2583.

Dutch (Nederlands): Bij vragen over dit document hebt u recht op hulp en informatie in uw taal zonder bijkomende kosten. Als u een tolk wilt spreken, belt u (800) 810-2583.

Farsi (فارسي): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه‌ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (800) 810-2583 تماس بگیرید.

Language Access Services:

French (Français) : Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (800) 810-2583.

German (Deutsch): Wenn Sie Fragen zu diesem Dokument haben, haben Sie Anspruch auf kostenfreie Hilfe und Information in Ihrer Sprache. Um mit einem Dolmetscher zu sprechen, bitte wählen Sie (800) 810-2583.

Greek (Ελληνικά) Αν έχετε τυχόν απορίες σχετικά με το παρόν έγγραφο, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας δωρεάν. Για να μιλήσετε με κάποιον διερμηνέα, τηλεφωνήστε στο (800) 810-2583.

Gujarati (ગુજરાતી): જો આ દસ્તાવેજ અંગે આપને કોઈપણ પ્રશ્ન હોય તો, કોઈપણ ખર્ચ વગર આપની ભાષામાં મદદ અને માહિતી મેળવવાનો તમને અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે, કોલ કરો (800) 810-2583.

Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (800) 810-2583.

Hindi (हिंदी): अगर आपके पास इस दस्तावेज़ के बारे में कोई प्रश्न हैं, तो आपको निःशुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है।
दुभाषिये से बात करने के लिए, कॉल करें (800) 810-2583 ।

Hmong (White Hmong): Yog tias koj muaj lus nug dab tsi ntsig txog daim ntawv no, koj muaj cai tau txais kev pab thiab lus qhia hais ua koj hom lus yam tsim xam tus nqi. Txhawm rau tham nrog tus neeg txhais lus, hu xov tooj rau (800) 810-2583.

Igbo (Igbo): O bụrụ na ị nwere ajuju ọ bụla gbasara akwụkwọ a, ị nwere ikike ịnweta enyemaka na ozi n'asụsụ gị na akwụghị ụgwọ ọ bụla. Ka gị na ọkọwa okwu kwuo okwu, kpọọ (800) 810-2583.

Ilokano (Ilokano): Nu addaan ka iti aniaman a saludsod panggep iti daytoy a dokumento, adda karbengam a makaala ti tulong ken impormasyon babaen ti lenguahem nga awan ti bayad na. Tapno makatungtong ti maysa nga tagipatarus, awagan ti (800) 810-2583.

Indonesian (Bahasa Indonesia): Jika Anda memiliki pertanyaan mengenai dokumen ini, Anda memiliki hak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa biaya. Untuk berbicara dengan interpreter kami, hubungi (800) 810-2583.

Italian (Italiano): In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (800) 810-2583

Japanese (日本語): この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには (800) 810-2583 にお電話ください。

Language Access Services:

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