Group Insurance Plan of Benefits for BorgWarner Company (Control 468847) administered by Aetna International®
Effective Date: January 1, 2020

Eligibility Provision		
Employee	Regular full-time employees of BorgWarner Company participating in this plan working a minimum of 25 hours per week.	
Dependent	Wife or husband; same or opposite sex domestic partner; children to age 26, regardless of student status.	
PPO		
PLAN FEATURES	**Outside the U.S.**	**In the U.S.**
Individual deductible	$0 per calendar year	$0 per calendar year
Family deductible	$0 per calendar year	$0 per calendar year
Prior Plan Credit	Does not apply	
Individual Coinsurance Limit	$0 per calendar year	$0 per calendar year
(Does not include deductibles, copays, benefit penalties, 50% items and Outpatient Prescription Drugs. Includes Outpatient Prescription Drugs when outside the US)		
Family Coinsurance Limit	$0 per calendar year	$0 per calendar year
(Does not include deductibles, copays, benefit penalties, 50% items and Outpatient Prescription Drugs. Includes Outpatient Prescription Drugs when outside the US)		
Lifetime Maximum	Unlimited	
Member Payment Percentages		
Hospital Services		
Inpatient	No charge	No charge
Outpatient	No charge	No charge
Private Room Limit	The institution's semiprivate rate	
Pre-certification Penalty	No Penalty	$400
To avoid penalties and/or benefit reductions for non-preferred benefits received in the U.S., contact the service center to determine if precertification is needed for a procedure.		
Non-Emergency Use of the Emergency Room	No charge	50%
Emergency Room	No charge	No charge
Non-Urgent Use of Urgent Care Provider	No charge	No charge
Urgent Care	No charge	No charge
Physician Services		
PCP Office Visit	No charge	No charge
Specialist Office Visit	No charge	No charge
Allergy Testing and Treatment	No charge	No charge
Allergy Serum and Injection	No charge	No charge

Note: This is not evidence of coverage. You must enroll and be accepted for coverage with the Coverage Administrator before these documents will be effective. In the case of a discrepancy between the Plan Documents and this document, the Plan Documents will determine the Plan of Benefits. As used herein, the term "Plan Documents" includes, but is not limited to, the Booklet, Summary of Coverage and any Booklet Amendments/Riders including any state-specific variations, as applicable. For further details, refer to your Plan Documents.

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	PPO	
	Outside the U.S.	**In the U.S.**
Member Payment Percentages		
Mental Health Services		
Mental Health Inpatient Coverage *Unlimited days per calendar year*	No charge	No charge
Mental Health Outpatient Coverage *Unlimited visits per calendar year*	No charge	No charge
Alcohol/Drug Abuse Services		
Substance Abuse Inpatient Coverage *Unlimited days per calendar year*	No charge	No charge
Substance Abuse Outpatient Coverage *Unlimited visits per calendar year*	No charge	No charge
Prescription Drug Coverage		
Generic Drugs *(365 day maximum supply)*	No charge	$0 copay per month supply (includes Mail Order Drugs)
Formulary Brand Name Drugs *(365 day maximum supply)*	No charge	$0 copay per month supply (includes Mail Order Drugs)
Other Services		
Employee Assistance Program (EAP)	Included	Included
Includes up to 5 counseling sessions per issue per year per enrolled member. Access benefits by calling the member service number on ID card: 800-231-7729 or collect 813-775-0190. Services include: Cultural adjustment assistance, Marital/Family Stress, Child care and behavioral concerns, Social adaptation needs, Alcohol/Substance Abuse, Work/Life Balance and Depression.		

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Other Services		
Skilled Nursing Facility *(120 Days per calendar year)*	No charge	No charge
Hospice Care Facility Inpatient *(30 Days lifetime maximum)*	No charge	No charge
Hospice Care Facility Outpatient *(Unlimited lifetime maximum)*	No charge	No charge
Home Health Care *(120 visits per calendar year combined, includes Private Duty Nursing per calendar year)*	No charge	No charge
Spinal Disorder Treatment *(Unlimited visits per calendar year)*	No charge	No charge
Short Term Rehabilitation *(Includes coverage for Speech Therapy; 60 visits per calendar year; and Occupation and Physical Therapy; unlimited visits per calendar year)*	No charge	No charge
Diagnostic Outpatient X-ray	No charge	No charge
Diagnostic Outpatient Lab	No charge	No charge
Base Infertility Services *(Base plan coverage includes coverage limited to the testing and treatment of underlying condition)*	No charge	No charge
Comprehensive Infertility Services *(6 cycles per lifetime for Comprehensive plan coverage which includes coverage for Artificial Insemination and Ovulation Induction)*	No charge	No charge
ART Infertility Services *(6 cycles per lifetime for Advanced Reproductive Technology (ART) coverage with cryopreservation, storage and unlimited embryo transfers)*	No charge	No charge
Autism	Autism covered same as any other expense. *Member cost sharing is based on the type of service performed and the place of service where it is rendered*	

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	PPO	
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Member Payment Percentages		
Wellness Benefits		
Routine Children Physical Exams	No charge	No charge
7 exams in the first 12 months of life, 3 exams in the second 12 months of life, 3 exams in the third 12 months of life, 1 exam per 12 months thereafter to age 22 (includes immunizations)		
Routine Adult Physical Exams	No charge up to $1,000 calendar year maximum (includes immunizations, x-rays and labs)	No charge
Adults age 22+ & -65: 1 exam/12 months Adults age 65+: 1 exam/12 months includes immunizations		
Routine Gynecological Exams	No charge	No charge
Includes 1 exam and pap smear per calendar year		
Mammograms	No charge	No charge
(Unlimited visits per calendar year)		
Prostate Specific Antigen (PSA)	No charge	No charge
(Unlimited tests per calendar year)		
Digital Rectal Exam (DRE)	No charge	No charge
(Unlimited exams per calendar year)		
Cancer Screening	No charge	No charge
Includes 1 flex sigmoid and double barium contrast every 5 years; and at age 45+ 1 colonoscopy every 10 years		
Hearing Aids	No charge	No charge
1 hearing aid per ear to $1,000 maximum per ear every 3 years for child to age 24		
Vision Expenses		
Routine Eye Exam	No charge	No charge
(Covered under medical) Includes one routine exam every 24 months		
Services and Programs		
(24-hour nurse line) **In Touch Care (ITC)** **International Maternity Management Program** **Health Assessment** **Global Crisis Management Program, powered by WorldAware** **Teladoc®** **vHealth**		

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Medical Plan Caveats
This plan includes coverage under the extent required in accordance with the Federal Mental Health Parity and Addiction Equity Act (MHPAEA) beginning with plan years starting on or after January 1, 2018. *This plan includes coverage for women's preventive health benefits to the extent required under U.S. federal law effective beginning with plan years starting on or after August 1, 2012.* *Payment limits apply per individual on a calendar year basis. Only those out-of-pocket expenses resulting from the application of a payment percentage may be used to satisfy the payment limit. copays, benefit penalties and 50% items are excluded from the payment limit.* *There is cross-application between calendar year deductible, out of pocket maximum and lifetime maximum across overseas, in-network and out-of network level of benefits.* *Coverage maximums up to a certain number of days/visits per calendar year are reached by combining the Preferred and Non-Preferred benefits up to the limit for either one plan or the other, but not both. (Example, if the Preferred benefit is for 120 days and the Non-Preferred benefit is for 120 days, the maximum benefit is 120 days, not 240 days).* *Maternity expenses are covered as any other medical expense. Coverage is provided for an employee and spouse and all female family members Pregnancy benefits do not continue to be payable after coverage ends except in the event of total disability.* *For contracted hospitals, the non-contracted Radiologist, Anesthesiologist and Pathologist (RAPS) are paid at the preferred level, and will be subject to reasonable and customary charges. Note that this payment method may apply to other providers.* *** Payment for Non-Preferred Providers** *We cover the cost of care differently based on whether health care providers, such as doctors and hospitals, are "in network" or "out of network." We want to help you understand how much Aetna pays for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this out-of-network care.* *As an example, you may choose a doctor in our network. You may choose to visit an out-of-network doctor. If you choose a doctor who is out of network, your Aetna health plan may pay some of that doctor's bill. Most of the time, you will pay a lot more money out of your own pocket if you choose to use an out-of-network doctor or hospital.* *When you choose out-of-network care, Aetna limits the amount it will pay. This limit is called the "recognized" or "allowed" amount. When you choose out-of-network care, Aetna "recognizes" an amount based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much Aetna "recognizes" depends on the plan you or your employer picks.* *Your out-of-network doctor sets the rate to charge you. It may be higher -- sometimes much higher -- than what your Aetna plan "recognizes" or "allows." Your doctor may bill you for the dollar amount that Aetna doesn't recognize. You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the recognized charge counts toward your deductible or maximum out-of-pocket. To learn more about how we pay out-of-network benefits visit Aetna.com. Type "how Aetna pays" in the search box.* *You can avoid these extra costs by getting your care from Aetna's broad network of health care providers. Go to www.aetna.com and click on "Find a Doctor" on the left side of the page. If you are already a member, sign on to your Aetna Navigator member site.* *This way of paying out-of-network doctors and hospitals applies when you choose to get care out of network. When you have no choice (for example: room visit after a car accident), we will pay the bill as if you got care in network. You pay your plan's copayments, coinsurance and deductibles for you level of benefits. Contact Aetna if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for services beyond your copayments, coinsurance and deductibles.*

This plan of benefits is underwritten by Aetna Life Insurance Company (Delaware).

This is only a brief summary of the Passive PPO Medical benefits available. Some restrictions may apply.

*For more specific information about the coverage details, **including limitations, exclusions and other plan requirements**, please refer to the employee booklet.*

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For Plans Compliant with United States Federal Affordable Care Act (ACA) legislation
Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting: Civil Rights Coordinator, P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779), 1-800-648-7817, TTY: 711, Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates (Aetna).

TTY: 711

English	**To access language services at no cost to you, call the number on your ID card.**
Spanish	Para acceder a los servicios lingüísticos sin costo alguno, llame al número que figura en su tarjeta de identificación.
Chinese Traditional	如欲使用免費語言服務，請撥打您健康保險卡上所列的電話號碼
Arabic	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم الموجود على بطاقة اشتراكك.
French	Pour accéder gratuitement aux services linguistiques, veuillez composer le numéro indiqué sur votre carte d'assurance santé.
French Creole (Haitian)	Pou ou jwenn sèvis gratis nan lang ou, rele nimewo telefòn ki sou kat idantifikasyon asirans sante ou.
German	Um auf den für Sie kostenlosen Sprachservice auf Deutsch zuzugreifen, rufen Sie die Nummer auf Ihrer ID-Karte an.
Italian	Per accedere ai servizi linguistici senza alcun costo per lei, chiami il numero sulla tessera identificativa.
Japanese	無料の言語サービスは、IDカードにある番号にお電話ください。
Korean	무료 다국어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오.
Persian Farsi	برای دسترسی به خدمات زبان به طور رایگان، با شماره قید شده روی کارت شناسایی خود تماس بگیرید.
Polish	Aby uzyskać dostęp do bezpłatnych usług językowych, należy zadzwonić pod numer podany na karcie identyfikacyjnej.
Portuguese	Para aceder aos serviços linguísticos gratuitamente, ligue para o número indicado no seu cartão de identificação.
Russian	Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону, приведенному на вашей идентификационной карте.
Tagalog	Upang ma-access ang mga serbisyo sa wika nang walang bayad, tawagan ang numero sa iyong ID card.
Vietnamese	Để sử dụng các dịch vụ ngôn ngữ miễn phí, vui lòng gọi số điện thoại ghi trên thẻ ID của quý vị.