Schedule of Benefits

(GR-9N S-01-001-01)

Employer: **Borgwarner Company**

Group Policy Number: **GP-299617**

Issue Date: May 24, 2015
Effective Date: January 1, 2015
Schedule: 1A
Cert Base: 1

For: PPO Medical and Pharmacy
(Overseas Coverage only)

Comprehensive Medical Plan

PLAN FEATURES	
Lifetime Maximum Benefit per person	Unlimited

Coinsurance listed in the Schedule below reflects the Plan Coinsurance. This is the amount Aetna pays. You are responsible to pay any deductibles, and the remaining Coinsurance. You are responsible for full payment of any non-covered expenses you incur.

All Covered Expenses Are Subject To The Calendar Year Deductible Unless Otherwise Noted In The Schedule Below.

PLAN FEATURES	
Wellness Benefits	
Routine Physical Exams	
Adults and Children.	100% per exam
Includes coverage for immunizations.	No Calendar Year **deductible** applies.
Maximum Exams per 12 consecutive month period	
Age 18 to age 65	1 exam
Maximum Exams per 12 consecutive month period	
Age 65 and over	1 exam

PLAN FEATURES	
Wellness Benefits	
Well Child Exams Includes coverage for immunizations.	100% per exam No Calendar Year **deductible** applies.
Maximum Exams	
Under age 3	
first 12 months of life	7 exams
13th-24th months of life	3 exams
25th-36th months of life	3 exams
Maximum Exams per 12 consecutive month period	
From age 3 to age 18	1 exam
Routine Gynecological Exam	100% per exam No Calendar Year **deductible** applies.
Maximum per 12 consecutive month period	1 exam
Routine Cancer Screenings *(GR-9N-S-13-15-01)*	
Routine Mammography *(GR-9N-S-13-15-01)* One baseline ages 35-39	100% per test No Calendar Year **deductible** applies.
Maximum Test per 12 months age 40 and over	1 test
Prostate Specific Antigen Test For covered males age 40 and over.	100% per test No Calendar Year **deductible** applies.
Maximum Test per 12 consecutive month period	1 test

PLAN FEATURES	
Routine Cancer Screenings *(GR-9N-S-13-15-01)*	
Routine Digital Rectal Exam For covered males age 40 and over.	100% per test No Calendar Year **deductible** applies.
Maximum exam per 12 consecutive month period	1 exam
Routine Pap Smears	100% per test No Calendar Year **deductible** applies.
Maximum Tests per 12 consecutive month period	1 test
Fecal Occult Blood Test	Payable in accordance with the type of expense incurred and the place where service is provided.
Maximum Tests per 12 consecutive month period	1 test
Sigmoidoscopy Age 50 and over	Payable in accordance with the type of expense incurred and the place where service is provided.
Maximum Tests per 5 consecutive year period	1 test
Double Contrast Barium Enema *(DCBE)* Age 50 and over	Payable in accordance with the type of expense incurred and the place where service is provided.
Maximum Benefit per 5 consecutive year period	1 test
Colonoscopy age 50 and over	Payable in accordance with the type of expense incurred and the place where service is provided.
Benefit Maximum per 10 consecutive year period	1 test
Family Planning Services *(GR-9N-S-10-015-01)*	
Family Planning Services	100% per visit No Calendar Year **deductible** applies.

PLAN FEATURES	
Vision Care *(GR-9N-S-13-20-01)*	
Eye Examinations (including refraction)	100% per visit No Calendar Year **deductible** applies.
Maximum Benefit per 24 consecutive month period:	1 exam
Physician Services *(GR-9N-S-13-25-01)*	
Physician Office Visits *(non-surgical)*	100% per visit No Calendar Year **deductible** applies.
Specialist Office Visits	100% per visit No Calendar Year **deductible** applies.
Physician Office Visit ***(Surgery)***	100% per visit No Calendar Year **deductible** applies.
Physician Services for Inpatient Facility and Hospital Visits	100% per visit No Calendar Year **deductible** applies.
Administration of Anesthesia	100% per procedure No Calendar Year **deductible** applies.
Immunizations ***(when not part of the physical exam)***	Payable in accordance with the type of expense incurred and the place where service is provided.
Prenatal Visits	Payable in accordance with the type of expense incurred and the place where service is provided.

PLAN FEATURES	
Emergency Medical Services *(GR-9N-S-13-30-01)*	
Hospital Emergency Facility	100% per visit No Calendar Year **deductible** applies.
Non-Emergency Care in a Hospital Emergency Room	50% per visit No Calendar Year **deductible** applies.

Important Notice:
A separate **hospital** emergency room **deductible** applies for each visit to an emergency room for emergency care. If you are admitted to a **hospital** as an inpatient immediately following a visit to an emergency room, your deductible is waived.

Covered expenses that are applied to the emergency room **deductible** cannot be applied to any other **deductible** under your plan. Likewise, covered expenses that are applied to any of your plan's other **deductibles** cannot be applied to the emergency room **deductible**.

Urgent Medical Services *(GR-9N-S-13-30-01)*	
Urgent Medical Care *(at a non-hospital free standing urgent care facility)*	100% per visit No Calendar Year **deductible** applies.
Urgent Medical Care *(for other than a non-hospital free standing facility)*	Refer to *Emergency Medical Services* and *Physician Services* above.
Outpatient Diagnostic and Preoperative Testing *(GR-9N-S-13-35-01)*	
Complex Imaging Services	
Complex Imaging	100% per procedure No Calendar Year **deductible** applies
Diagnostic Laboratory Testing	
Diagnostic Laboratory Testing	100% per procedure No Calendar Year **deductible** applies

PLAN FEATURES	
Diagnostic X-Rays (except Complex Imaging Services)	
Diagnostic X-Rays	100% per procedure No Calendar Year **deductible** applies
Outpatient Surgery *(GR-9N-S-13-40-01)*	
Outpatient Surgery	100% per visit/surgical procedure No Calendar Year **deductible** applies
Inpatient Facility Expenses *(GR-9N-S-13-45-01)*	
Birthing Center	100% per admission No Calendar Year **deductible** applies
Hospital Facility Expenses Room and Board (including maternity) Other than Room and Board	100% per admission No Calendar Year **deductible** applies 100% per admission No Calendar Year **deductible** applies
Skilled Nursing Inpatient Facility	100% per admission No Calendar Year **deductible** applies
Maximum Days per Calendar Year	120 days
Specialty Benefits *(GR-9N-S-13-50 01)*	
Home Health Care (Outpatient)	100% per visit No Calendar Year **deductible** applies.
Maximum Visits per Calendar Year	120 visits

PLAN FEATURES	
Specialty Benefits *(GR-9N-S-13-50 01)*	
Private Duty Nursing (Outpatient)	100% per visit No Calendar Year **deductible** applies.
Maximum Visit Limit per Calendar Year	70 Private Duty Nursing Shifts. Up to 8 hours will be deemed to be one private duty nursing shift.
Hospice Benefits	
Hospice Care – Facility Expenses (Room & Board)	100% per admission No Calendar Year **deductible** applies
Hospice Care (Other Expenses during a stay)	100% per admission No Calendar Year **deductible** applies
Maximum Benefit per lifetime	30 days
Hospice Outpatient Visits ($5,000 lifetime maximum)	100% per visit No Calendar Year **deductible** applies
Infertility Treatment *(GR-9N-S-13-55-01)*	
Basic Infertility Expenses Coverage is for the diagnosis and treatment of the underlying medical condition causing the infertility only.	100% per visit No Calendar Year **deductible** applies
Inpatient Treatment of Mental Disorders *(GR-9N S-13-060-01)*	
Mental Disorders	100% per admission No Calendar Year **deductible** applies
Maximum Benefit per Calendar Year	Unlimited days
Outpatient Treatment of Mental Disorders *(GR-9N-S-13-65-01)*	
Mental Disorders	50% per visit No Calendar Year **deductible** applies
Maximum Visits per Calendar Year	Unlimited visits

PLAN FEATURES	
Inpatient Treatment of Alcoholism and Substance Abuse *(GR-9N-S-13-70-01)*	
Inpatient Treatment	100% per admission No Calendar Year **deductible** applies
Maximum Days per Calendar Year	Unlimited days
Outpatient Treatment of Alcoholism and Substance Abuse	
Outpatient Treatment	50% per admission No Calendar Year **deductible** applies
Maximum Visits per Calendar Year	Unlimited visits
Transplant Expenses	
Transplant Facility Expenses	100% per admission No Calendar Year **deductible** applies
Transplant Physician Services (including office visits)	100% per visit No Calendar Year **deductible** applies
Other Covered Health Expenses *(GR-9N-S-13-80-01)*	
Acupuncture in lieu of anesthesia	100% per visit No Calendar Year **deductible** applies
Ground, Air or Water Ambulance	100% per trip No Calendar Year **deductible** applies.
Diabetic Equipment, Supplies and Education	100% per item No Calendar Year **deductible** applies

Other Covered Health Expenses (cont'd) *(GR-9N-S-13-80-01)*

Durable Medical and Surgical Equipment	100% per item No Calendar Year **deductible** applies
(GR-9N-S-13-80-01) ***Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)***	100% per visit No Calendar Year **deductible** applies
Prescription Drugs	100% per prescription or refill, No Calendar Year **deductible** applies
Prosthetic Devices *(GR-9N-S-13-80-01)*	100% per item No Calendar Year **deductible** applies

Outpatient Therapies *(GR-9N-S-13-90-01)*

Chemotherapy	100% per visit No Calendar Year **deductible** applies
Infusion Therapy	100% per visit No Calendar Year **deductible** applies
Radiation Therapy	100% per visit No Calendar Year **deductible** applies

Short Term Outpatient Rehabilitation Therapies *(GR-9N-S-13-095-01)*

Outpatient Physical, Occupational and Speech Therapy	100% per visit No Calendar Year **deductible** applies

PLAN FEATURES	
Spinal Manipulation *(GR-9N-S-13-095-01)*	
Spinal Manipulation	100% per visit No Calendar Year **deductible** applies.
Global Emergency Assistance Program ($500,000 Calendar Year Maximum)	100% per visit No Calendar Year **deductible** applies.

Pharmacy Benefit *(GR-9N-S-26-005-01)*

Coinsurance

PLAN FEATURES	NETWORK (In the U.S.)	OUT-OF-NETWORK (In the U.S.)	OUTSIDE THE U.S.
Prescription Drug Plan Coinsurance	100% of the **negotiated charge**	Covered Under Medical	Covered Under Medical

The **prescription drug** plan **coinsurance** is the percentage of **prescription drug covered expenses** that the plan pays after any applicable **deductibles** and **copays** have been met.

Mail Order only mails to locations in the United States.

Expense Provisions *(GR-9N S-09-05 01)*

The following provisions apply to your health expense plan.
This section describes cost sharing features, benefit maximums and other important provisions that apply to your Plan. The specific cost sharing features and the applicable dollar amounts or benefit percentages are contained in the attached health expense sections of this *Schedule of Benefits*.

The insurance described in this *Schedule of Benefits* will be provided under Aetna Life & Casualty (Bermuda) Ltd. Insurance Company's policy form GR-29N.

Keep This Schedule of Benefits With Your Booklet.

Coinsurance Provisions *(GR-9N S-09-020 01)*

Coinsurance
This is the percentage of your **covered expenses** that the plan pays and the percentage of **covered expenses** that you pay. The percentage that the plan pays is referred to as the "**Plan Coinsurance**". Once applicable **deductibles** have been met, your plan will pay a percentage of the **covered expenses**, and you will be responsible for the rest of the costs. The **coinsurance** percentage may vary by the type of expense. Refer to your *Schedule of Benefits* for coinsurance amounts for each covered benefit.

General *(GR-9N S-28-01 01)*

This Schedule of Benefits replaces any similar Schedule of Benefits previously in effect under your plan of benefits. Requests for coverage other than that to which you are entitled in accordance with this Schedule of Benefits cannot be accepted. This Schedule is part of your Booklet and should be kept with your Booklet form GR-9N. Coverage is underwritten by Aetna Life & Casualty (Bermuda) Ltd. Insurance Company.