SUMMARY OF BENEFITS
Cigna Health and Life Insurance Co.

This is a summary of benefits for your Comprehensive Indemnity plan. Cigna Pharmacy plan deductibles, out-of-pocket maximums, copays and annual maximums do not integrate with the employer medical program.

BorgWarner Inc.
Comprehensive Indemnity Plan
IND8 - B&B Hourly Pre-65 Retirees
Effective 1/1/2018

BENEFIT HIGHLIGHTS	INDEMNITY
PPACA Status	Exempt
MH/SUD Parity Status	Exempt
Lifetime Maximum	Unlimited
Coordination of Benefit Administration	Pre-Medicare - Non-Duplication Medicare – Maintenance of Benefits
Coinsurance Levels	80% of the Maximum Reimbursable Charge (AKA Reasonable & Customary)
Maximum Reimbursable Charge Determined based on the lesser of: •The provider's normal charge for a similar service or supply or •A percentile of charges made by providers of such service or supply in the geographic area where it is received. These charges are compiled in a database selected by Cigna. Note: The provider may bill the customer the difference between the provider's normal charge and the Maximum Reimbursable Charge as determined by the benefit plan, in addition to applicable deductibles, co-payments, and coinsurance.	90th percentile
Calendar Year Deductible *Individual* *Family Maximum* *Aggregate*	 $250 per person $500 per family Yes
Annual Out-of-Pocket Maximum *Includes Deductible* *Individual* *Family Maximum* *Aggregate* *Out-of-Pocket Accumulation* Benefits for accident or sickness accumulate to the OOP and are paid at 100% once an individual's Out-of-Pocket maximum has been reached	 No $1,370 per person $2,740 per family Yes Does not include Non-compliance penalties, deductibles, or charges in excess of Reasonable and Customary.
Automated Annual Reinstatement	Not Applicable

BENEFIT HIGHLIGHTS	INDEMNITY
Physician's Services	
Primary Care Physician's Office visit	80% after deductible
Note: OB/GYN is considered a Specialist	
Specialty Care Physician's Office Visit	80% after deductible
Office Visits	
Consultant and Referral Physician's Services	
Surgery Performed In the Physician's Office	80% no deductible
Cigna Telehealth Connection services	80% after deductible
Note: Includes charges for delivery of medical and health-related consultations via secure telecommunications technologies, telephones and internet only when delivered by contracted medical telehealth providers (see details on myCigna.com).	
Allergy Treatment/Injections	80% after deductible
Preventive Care	
Routine Preventive Care for children through age 2	Not Covered
Routine Preventive Care from age 3 and above	Not Covered
Immunizations	Not Covered
One Routine PAP/yr	80% no deductible
Routine Mammograms	Not Covered
Second Opinions	80% after deductible
(Services will be provided on a voluntary basis)	
Outpatient Pre-Admission Testing	
Primary Care Physician's Office Visit	80% no deductible
Specialist Physician's Office Visit	80% no deductible
Outpatient Hospital Facility	80% no deductible
Independent X-ray and Lab Facility	80% no deductible
Inpatient Hospital - Facility Services	80% no deductible
Semi Private Room and Board	Limited to semi-private room negotiated rate
Private Room	Limited to semi-private room negotiated rate
Special Care Units (ICU/CCU)	Limited to negotiated rate
Outpatient Facility Services	
Operating Room, Recovery Room, Procedure Room, Treatment Room & Observation Room	80% after deductible; deductible waived if surgery performed
Inpatient Hospital Physician's Visits/Consultations	80% no deductible
Inpatient Hospital Professional Services	
Surgeon, Radiologist, Pathologist, Anesthesiologist	80% no deductible
Multiple Surgical Reduction	Multiple surgeries performed during one operating session result in payment reduction of 50% of charges to the surgery of lesser charge. The most expensive procedure is paid as any other surgery.
Outpatient Professional Services	80% no deductible
Surgeon, Radiologist, Pathologist, Anesthesiologist	

BENEFIT HIGHLIGHTS	INDEMNITY
Emergency and Urgent Care Services	
Physician's Office	80% after deductible, deductible waived is surgery performed
Hospital Emergency Room	80% after deductible, deductible waived if surgery performed
Urgent Care Facility or Outpatient Facility	80% after deductible, deductible waived if surgery performed
Ambulance	80% after deductible

BENEFIT HIGHLIGHTS	INDEMNITY
Inpatient Services at Other Health Care Facilities *Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities* Maximum days per calendar year: Unlimited	80% no deductible
Radiation Therapy	80% no deductible
Chemotherapy	80% no deductible
Laboratory and Radiology Services *MRIs, CAT Scans and PET Scans* *The copay applies on a per procedure basis, for any place of service* *Other Laboratory and Radiology Services* Outpatient Hospital Facility Independent X-ray and/or Lab Facility	80% no deductible 80% no deductible 80% no deductible
Outpatient Short-Term Rehabilitative Therapy Unlimited visits Includes: Cardiac Rehab Physical Therapy Speech Therapy Occupational Therapy Pulmonary Therapy Cognitive Therapy	80% after deductible
Chiropractic Therapy (includes Chiropractors) Up to $500/cal. yr	80% after deductible
Home Health Care Unlimited visits maximum per calendar year **Note:** The maximum number of hours per day is limited to 16 hours. Multiple visits can occur in one day; with a visit defined as a period of 2 hours or less (e.g. maximum of 8 visits per day).	80% no deductible
Outpatient Private Duty Nursing *Up to maximum $5,000/cal.yr. Includes visits billed by Home health care.*	80% no deductible
Hospice *Inpatient Services* *Up to $7000/lifetime maximum* *Outpatient Services*	No charge No charge
Bereavement Counseling *Inpatient Services* *Outpatient Services* *Calendar Year Max: 12 visits per occurrence* *Services provided by a Mental Health Professional*	 No charge, up to $25/visit No charge, up to $25/visit Covered under Mental Health benefit

BENEFIT HIGHLIGHTS	INDEMNITY
Maternity Care Services	
Initial Visit to Confirm Pregnancy	80% after deductible
All Subsequent Prenatal Visits, Postnatal Visits, and Delivery	80% no deductible
Delivery (Inpatient Hospital, Birthing Center)	80% no deductible
Abortion	
Includes therapeutic (non-elective) procedures only	
Office Visit	80% after deductible, deductible waived is surgery performed
Inpatient Facility	80% no deductible
Outpatient Facility	80% after deductible, deductible waived is surgery performed
Physician's Services	80% no deductible
Family Planning Services	
Office Visits (tests, counseling)	80% after deductible
Surgical Sterilization Procedure for Vasectomy/Tubal Ligation (excludes reversals)	
Office Visit	80% after deductible, deductible waived is surgery performed
Inpatient Facility	80% no deductible
Outpatient Facility	80% after deductible, deductible waived is surgery performed
Physician's Services	80% no deductible
Infertility Treatment	
Office Visit (tests, counseling)	80% after deductible
Coverage will be provided for the following services: • *Testing and treatment services performed in connection with an underlying medical condition.* • *Testing performed specifically to determine the cause of infertility.* • *Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition).* *Services to induce pregnancy are not covered, such as, In-vitro, Artificial Insemination, GIFT, ZIFT, etc.*	
Office Visit	80% after deductible, deductible waived is surgery performed
Inpatient Facility	80% no deductible
Outpatient Facility	80% after deductible, deductible waived is surgery performed
Physician's Services	80% no deductible

BENEFIT HIGHLIGHTS	INDEMNITY
Organ Transplant *Includes all medically appropriate, non-experimental transplants*	$1,000,000 Lifetime Max.
Office Visit	80% after deductible
Inpatient Facility	100% no deductible at Lifesource center, otherwise 80% after deductible
Physician's Services	100% no deductible at Lifesource center, otherwise 80% after deductible
Travel Services Maximum - Only available for Lifesource facilities	$10,000
Durable Medical Equipment	80% after deductible
Breast Feeding Equipment and Supplies *Limited to the rental of one breast pump per birth as ordered or prescribed by a physician*	80% after deductible
External Prosthetic Appliances	80% after deductible
Dental Care *Limited to charges made for a continuous course of dental treatment started within six months of an injury to sound, natural teeth.*	
Physician's Office	80% after deductible, deductible waived is surgery performed
Inpatient Facility	80% no deductible
Outpatient Surgical Facility	80% after deductible, deductible waived is surgery performed
Physician's Services	80% no deductible
Oral Surgery for removal of impacted teeth	Covered under Dental
TMJ - Limited to surgical treatment of TMJ disorders and injections made directly into the Temporomandibula Joint	
Physician's Office	80% after deductible, deductible waived is surgery performed
Inpatient Facility	80% no deductible
Outpatient Surgical Facility	80% after deductible, deductible waived is surgery performed
Physician's Services	80% no deductible

BENEFIT HIGHLIGHTS	INDEMNITY
Prescription Drugs *Cigna Pharmacy* *3-tier Coinsurance Mandatory Generic* • *Retail – up to 90-day supply (except Specialty up to 30-day supply)* • *Home Delivery – up to 90-day supply (except Specialty up to 30-day supply)* *Step Therapy for ACEI/ARBs* (Hypertension class), PPI and Statins* (Cholesterol class).*	**Retail**: (30-day supply, up to 100 tablets/capsules) Generic: $5 Preferred Brand: $5 then 30% Non-Preferred Brand: $5 then 30% **Retail & Home Delivery**: (90-day supply) Generic: $2 Preferred Brand: $2 Non-Preferred Brand: $2 **Specialty Drugs – Retail & Home Delivery** (30-day supply) Generic: $2 Preferred Brand: $2 Non-Preferred Brand: $2
• Retail drugs for a 30-day supply may be obtained In-network at a wide range of pharmacies across the nation although prescriptions for a 90-day supply (such as maintenance drugs) will be available at select network pharmacies. • Cigna 90 Now Program: You can choose to fill your medications in a 30- or 90-day supply. If you choose to fill a 30-day prescription, it can be filled at any network retail pharmacy or Cigna Home Delivery. If you choose to fill a 90-day prescription, it must be filled at a 90-day network retail pharmacy or Cigna Home Delivery to be covered by the plan. • This plan will not cover out-of-network pharmacy benefits. • Specialty medications are used to treat an underlying disease which is considered to be rare and chronic including, but not limited to, multiple sclerosis, hepatitis C or rheumatoid arthritis. Specialty Drugs may include high cost medications as well as medications that require special handling and close supervision when being administered. • Mandatory Generic: Patient pays the brand cost share plus the ocst difference between the brand and generic drugs up to the cost of the brand drug. • Exclusive specialty home delivery: Specialty medications must be filled through home delivery; otherwise you pay the entire cost of the prescription after 1 Retail fill. • If you receive a supply of 34 days or less at home delivery (including a Specialty Prescription Drug), the home delivery pharmacy cost share will be adjusted to reflect a 30-day supply.	
Pharmacy Deductible	None
Pharmacy Out of Pocket Maximum	None
Pharmacy Annual Maximum	None
Prescription Drug List: Your Cigna Standard Prescription Drug List includes a full range of drugs including all those required under applicable health care laws. To check which drugs are included in your plan, please log on to myCigna.com.	
Buy-Up Options	
Injectables	
Self-Administered	Included
Optional	Included
Oral Contraceptives/Devices	Included
Oral fertility	Included with prior authorization if medically necessary to maintain pregnancy only
Prescription Diet Drugs	Included
Prescription Smoking Cessation	Included through mail order only for a 90 day supply.
Insulin	Preferred or Non-preferred Brand copay/coinsurance, based on the formulary

BENEFIT HIGHLIGHTS	INDEMNITY
Diabetic Supplies ie: all syringes, including non-insulin syringes, needles, insulin injectable devices, swabs, blood monitors (eg: glucometers) and kits, urine test strips, lancets and lancet devices.	No charge if purchased with Insulin; otherwise, the generic copay applies.
Prescription Vitamins	Included
Lifestyle Drugs (injectable only)	Included
Additional Comments	Excludes Flumist

Pharmacy Program Information

Pharmacy Clinical Management and Prior Authorization

- Prior authorization required on specialty medications and quantity limits may apply.
- Your plan includes access to the TheraCare® program which works with customers to help them better understand their condition, medications and their side effects in addition to why it's important to take their medications exactly as prescribed by a physician.

Pharmacy Cost Management Program

Step Therapy: *Your plan is subject to rules for certain classes of drugs that may require you to try Generic and/or Preferred Brand drugs before use of a Non-Preferred Brand will be approved.*

- Please refer to the Prescription Drug Price Quote tool on myCigna.com or call Customer Service at the phone number listed on your ID card to determine whether any of your medications require Step Therapy. Medications requiring Step Therapy are identified on the prescription drug list with an "ST" suffix.

High Blood Pressure (ACEI/ARB)	• Generic First One Step – Step 1 (Generic) medication(s) must be used prior to using a Step 2 (Preferred Brand) or Step 3 (Non-Preferred Brand) medication. • Your plan will not provide an initial grace period for any drugs impacted by Step Therapy. • Only your first use of a Non-Preferred Brand drug will be covered. You will receive a notice advising you about your next refill.
Cholesterol Lowering (STATIN)	• Generic First One Step – Step 1 (Generic) medication(s) must be used prior to using a Step 2 (Preferred Brand) or Step 3 (Non-Preferred Brand) medication. • Your plan will not provide an initial grace period for any drugs impacted by Step Therapy. • Only your first use of a Non-Preferred Brand drug will be covered. You will receive a notice advising you about your next refill.
Heartburn/Ulcer (PPI)	• Generic First One Step – Step 1 (Generic) medication(s) must be used prior to using a Step 2 (Preferred Brand) or Step 3 (Non-Preferred Brand) medication. • Your plan will not provide an initial grace period for any drugs impacted by Step Therapy. • Only your first use of a Non-Preferred Brand drug will be covered. You will receive a notice advising you about your next refill.
Clinical Outcomes Programs: *Complex Psych Case Management* *Narcotic Therapy Management*	 Included Included

BENEFIT HIGHLIGHTS	INDEMNITY
Mental Health And Substance Abuse (Alcohol & Drug)	
Mental Health Mental Health Inpatient	80% no deductible
Mental Health Outpatient Includes Individual, Group and Intensive Outpatient	80% after plan deductible
Substance Abuse Substance Abuse Inpatient	80% no deductible
Substance Abuse Outpatient Includes Individual and Intensive Outpatient	80% after plan deductible
Partial Hospitalization, Residential Treatment and Intensive Outpatient Programs: The following administration will apply: • ***Partial Hospitalization and Residential Treatment***: Covered as inpatient Mental Health and/or Substance Abuse ***Intensive Outpatient Program (IOP):*** Covered as outpatient Mental Health and/or Substance Abuse. Coverage only if approved through CHS (Cigna Health Solutions) Case Management.	
Pre-existing Condition Limitation (PCL)	Not applicable
Pre-Admission Certification - Continued Stay Review (Required for all Inpatient Admissions)	Does Not Apply
Case Management	Does Not Apply

Medical Benefit Exclusions (*by way of example but not limited to*):

Your plan provides coverage for medically necessary services. Your plan does not provide coverage for the following except as required by law:

1. Care for health conditions that are required by state or local law to be treated in a public facility.
2. Care required by state or federal law to be supplied by a public school system or school district.
3. Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
4. Treatment of an illness or injury which is due to war, declared or undeclared.
5. Charges for which you are not obligated to pay or for which you are not billed or would not have been billed except that you were covered under this Agreement.
6. Assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
7. Any services and supplies for or in connection with experimental, investigational or unproven services. Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the Healthplan Medical Director to be: Not demonstrated, through existing peer-reviewed, evidence-based scientific literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed; or Not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use; or The subject of review or approval by an Institutional Review Board for the proposed use, except as provided in the "Clinical Trials" section of "Covered Services and Supplies;" or The subject of an ongoing phase I, II or III clinical trial, except as provided in the " Clinical Trials" section of "Covered Services and Supplies."
8. Treatment of non-surgical TMJ disorder.
9. Cosmetic Surgery and Therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance.
10. The following services are excluded from coverage regardless of clinical indications: Macromastia or Gynecomastia Surgeries; Abdominoplasty; Panniculectomy; Rhinoplasty; Blepharoplasty; Redundant skin surgery; Removal of skin tags; Acupressure; Craniosacral/cranial therapy; Dance therapy, movement therapy; Applied kinesiology; Rolfing; Prolotherapy; and Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
11. Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental x-rays, examinations, repairs, orthodontics, periodontics, surgery of impacted teeth, casts, splints and services for dental malocclusion, for any condition. However, charges made for services or supplies provided for or in connection with an accidental injury to sound natural teeth are covered provided a continuous course of dental treatment is started within 6 months of the accident. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch.
12. Medical and surgical services, initial and repeat, intended for the treatment or control of obesity, including clinically severe (morbid) obesity, including: medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision.
13. Unless otherwise covered as a basic benefit, reports, evaluations, physical examinations, or hospitalization not required for health reasons, including but not limited to employment, insurance or government licenses, and court ordered, forensic, or custodial evaluations.
14. Court ordered treatment or hospitalization, unless such treatment is being sought by a Participating Physician or otherwise covered under "Covered Services and Supplies."
15. Infertility services, infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs are also excluded from coverage.
16. Reversal of male and female voluntary sterilization procedures.
17. Transsexual surgery, including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
18. Any services, supplies, medications or drugs for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmia, and premature ejaculation.
19. Medical and hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under the Agreement.

20. Non-medical counseling or ancillary services, including, but not limited to Custodial Services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return-to-work services, work hardening programs, driving safety, and services, training, educational therapy or other non-medical ancillary services for learning disabilities, developmental delays, autism or mental retardation.
21. Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including, but not limited to routine, long-term or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
22. Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Inpatient Hospital Services," "Outpatient Facility Services," "Home Health Services," or "Breast Reconstruction and Breast Prostheses" sections of the "Covered Services and Supplies."
23. Private hospital rooms and/or private duty nursing except as provided in the Home Health Services section of "Covered Services and Supplies."
24. Personal or comfort items such as personal care kits provided on admission to a hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of illness or injury.
25. Artificial aids, including but not limited to corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
26. Aids or devices that assist with non-verbal communications, including, but not limited to communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
27. Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or postcataract surgery).
28. Routine refraction, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
29. Treatment by acupuncture.
30. All non-injectable prescription drugs, injectable prescription drugs that do not require physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in "Covered Services and Supplies."
31. Routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
32. Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
33. Genetic screening or pre-implantation genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
34. Dental implants for any condition.
35. Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the Healthplan Medical Director's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
36. Blood administration for the purpose of general improvement in physical condition.
37. Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
38. Cosmetics, dietary supplements and health and beauty aids.
39. All nutritional supplements and formulae are excluded, except for infant formula needed for the treatment of inborn errors of metabolism.
40. Expenses incurred for medical treatment by a person age 65 or older, who is covered under this Agreement as a retiree, or his Dependents, when payment is denied by the Medicare plan because treatment was not received from a Participating Provider of the Medicare plan.
41. Expenses incurred for medical treatment when payment is denied by the Primary Plan because treatment was not received from a Participating Provider of the Primary Plan.
42. Services for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit.
43. Telephone, e-mail & Internet consultations and telemedicine.
44. Massage Therapy

These are only the highlights

This summary outlines the highlights of your plan. For a complete list of both covered and not covered services, see your employer's summary plan description -- the official plan documents. If there are any differences between this summary and the plan documents, the information in the plan documents takes precedence.