SUMMARY OF BENEFITS

Cigna Health and Life Insurance Co.

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

BorgWarner Inc.
CORE Out-of-Area Comprehensive Indemnity Plan
OOA1X – Memphis, TN Mechanics, Ballwin/Washington, MO, Wooster, OH Hydraulics Medicare-eligible Retirees
Effective 1/1/2019

BENEFIT HIGHLIGHTS	INDEMNITY
PPACA Status	Exempt
MH/SUD Parity Status	Exempt
Lifetime Maximum	Unlimited
Coordination of Benefits Administration	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*	 $200 per person $400 per family Yes

BENEFIT HIGHLIGHTS	INDEMNITY
Annual Out-of-Pocket (OOP) Maximum	
Includes Deductible	Yes
Individual	$3,000 per person
Family Maximum	$6,000 per family
Aggregate	Yes
OOP Does not apply to:	Non-compliance penalties
Benefits for accident or accumulate to the OOP and are paid at 100% once an individual's out-of-pocket max has been reached.	
Automated Annual Reinstatement	Not Applicable
Physician's Services	
Primary Care Physician's Office visit	80%, no deductible
Specialty Care Physician's Office Visit *Office Visits* *Consultant and Referral Physician's Services* **Note**: OB/GYN is considered a Specialist	80%, no deductible
Surgery Performed In the Physician's Office	80%, no deductible
Cigna Telehealth Connection services **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).	80%, no deductible
Allergy Treatment/Injections	80%, no deductible
Allergy Serum (dispensed by the physician in the office)	No Charge
Preventive Care	
Routine Preventive Care for children through age 2 (including immunization) Unlimited max.	No charge, regardless of place of service
Preventive Care	
Routine Preventive Care from age 3 and above (including Routine Mammograms, PSA, Pap Smear and Immunizations) ***subject to a $300 Preventive Care Maximum.***	
Physician's Office Visit	No charge up to $300 maximum, then 80% after plan deductible
Lab and X-Ray in Physician's Office	No charge up to $300 maximum, then 80% after plan deductible
Lab and X-Ray at Independent Diagnostic Facilities	No charge up to $300 maximum, then 80% after plan deductible
Note***: The Preventive Care Maximum does not apply to routine Colonoscopy or Sigmoidoscopy services billed by an Outpatient Hospital.***	

BENEFIT HIGHLIGHTS	INDEMNITY
Inpatient Hospital - Facility Services	80% after deductible
Semi Private Room and Board	Limited to semi-private room negotiated rate
Private Room (Private room costs will be covered when medially necessary	Limited to semi-private room negotiated rate
Special Care Units (ICU/CCU)	Limited to negotiated rate
Outpatient Facility Services	80% after deductible
Operating Room, Recovery Room, Procedure Room Treatment Room and Observation Room	
Inpatient Hospital Physician's Visits/Consultations	80% after deductible
Inpatient Hospital Professional Services	80% after deductible
Surgeon *Radiologist* *Pathologist* *Anesthesiologist*	
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% after deductible
Surgeon, Radiologist, Pathologist, Anesthesiologist	
Emergency and Urgent Care Services	
Physician's Office	80%, no deductible
Hospital Emergency Room	80% after deductible
Outpatient Professional services (radiology, pathology and ER physician)	80% after deductible
Urgent Care Facility or Outpatient Facility	80% after deductible
Ambulance	80% after deductible
Inpatient Services at Other Health Care Facilities	
Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities	80% after deductible
Maximum days per calendar year: Unlimited	
Laboratory and Radiology Services (includes pre-admission testing)	
Physician's Office	80% no deductible
Outpatient Hospital Facility	80% after deductible
Emergency Room/Urgent Care Facility (billed by the facility as part of the ER/UC visit)	80% after deductible
Independent X-ray and/or Lab Facility	80% after deductible
Independent X-ray and/or Lab Facility in conjunction with an ER visit	80% after deductible

BENEFIT HIGHLIGHTS	INDEMNITY
Advanced Radiological Imaging	
MRIs, CAT Scans and PET Scans	
Inpatient Facility	80% after deductible
Outpatient Facility	80% after deductible
Emergency Room/Urgent Care Facility (billed by the facility as part of the ER visit)	80% after deductible
Outpatient Short-Term Rehabilitative Therapy	
Unlimited visits for Speech, Occupational, Physical, & Cognitive Therapy, Pulmonary & Cardiac Rehab	80% after deductible
Chiropractic Care Services	
Chiropractic Therapy (includes Chiropractors) $500 maximum per calendar year	80% after deductible
Home Health Care (Includes Outpatient Private Duty Nursing services) 120 Days 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% after deductible
Hospice	
Inpatient Services	80% after deductible
Outpatient Services	80% after deductible
Bereavement Counseling	
Inpatient/Outpatient Services provided as part of Hospice Care	80% after deductible
Services provided by a Mental Health Professional	Covered under the Mental Health Benefit
Maternity Care Services	
Initial Visit to Confirm Pregnancy	80%, no deductible
All Subsequent Prenatal Visits, Postnatal Visits, and Delivery	80% after deductible
Office Visits in addition to the global maternity fee when performed by an OB or Specialist	80%, no deductible
Delivery (Inpatient Hospital, Birthing Center)	80% after deductible
Abortion	
Includes therapeutic (non-elective) procedures only	
Office Visit	80%, no deductible
Inpatient Facility	80%, after deductible
Outpatient Surgical Facility	80% after deductible
Professional Services	80% after deductible

BENEFIT HIGHLIGHTS	INDEMNITY
Family Planning Services (does not accumulate to Preventive care maximum) Excludes coverage for Depo-Provera, Norplant, and IUDs	
Office Visits (tests, counseling)	80%, no deductible
Surgical Sterilization Procedure *for Vasectomy/Tubal Ligation (excludes reversals)*	
Inpatient Facility	80% after deductible
Outpatient Facility and Physician	80% after deductible
Physician's Office	80%, no deductible
Professional Services	80% after deductible
Infertility Treatment	
Office Visit (tests, counseling)	80%, no 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.*	
Inpatient Facility	80% after deductible
Outpatient Facility	80% after deductible
Physician's Services	80% after deductible
Organ Transplant *Includes all medically appropriate, non-experimental transplants*	
Office Visit	80%, no deductible
Inpatient Facility	100% at Lifesource center , otherwise 80% after deductible at Hospital Inpatient Facility
Physician's Services	100% at Lifesource center; otherwise 80% after deductible, up to transplant maximum
Travel Services Maximum- only available for Lifesource facilities	$10,000
Organ Transplant Lifetime Maximum	$1,000,000
Podiatry *(Non-routine foot disorders)* *May include bursitis, heel spur, sprain/strain of the foot, bunion, hammer toe, plantar fasciitis, neuroma, ingrown toenail, infections , warts (including plantar warts)*	80% after plan deductible
Routine Foot Disorders	Not covered, except for services associated with foot care for diabetes and peripheral vascular disease, when medically necessary.
Durable Medical Equipment Unlimited maximum per calendar year	80% after plan deductible

BENEFIT HIGHLIGHTS	INDEMNITY
External Prosthetic Appliances Unlimited maximum per calendar year	80% after plan 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* *Inpatient Facility* *Outpatient Surgical Facility* *Physician's Services*	 80%, no deductible 80% after deductible 80% after deductible 80% after deductible
TMJ ***Limited to surgical treatment of TMJ disorders and injections made directly into the Temporomandibular Joint*** *Physician's Office* *Inpatient Facility* *Outpatient Surgical Facility* *Physician's Services*	 80%, no deductible 80% after deductible 80% after deductible 80% after deductible
Oral Surgery ***Limited to removal of impacted teeth, ADA codes 07220, 07230, 07240, 07241*** *Physician's Office* *Inpatient Facility* *Outpatient Surgical Facility* *Physician's Services*	 80%, no deductible 80% after deductible 80% after deductible 80% after deductible
Vision-Prescription Safety Glasses	Does not apply to retirees

BENEFIT HIGHLIGHTS	INDEMNITY
Mental Health and Substance Abuse Rehabilitation	
Mental Health	
MH Inpatient	80% after plan deductible
MH Outpatient *Includes Individual, Group and Intensive Outpatient*	
Physician's Office	80% no deductible
Outpatient Facility	80% after plan deductible
Substance Abuse Rehabilitation (Alcohol and Drug) *SA Inpatient*	80% after plan deductible
SA Outpatient *Includes Individual and Intensive Outpatient*	
Physician's Office	80% no deductible
Outpatient Facility	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)	Not Applicable
Case Management	Coordinated by CIGNA HealthCare. This is a service designated to provide assistance to a patient who is at risk of developing medical complexities or for whom a health incident has precipitated a need for rehabilitation or additional health care support. The program strives to attain a balance between quality and cost-effective care while maximizing the patient's quality of life.
Prescription Drugs	Not Covered

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. 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.
9. 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.
10. Non-surgical treatment of TMJ disorder.
11. Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental x-rays, examinations, repairs, orthodontics, periodontics, 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. Hearing aids, including, but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.
27. 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.
28. Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or postcataract surgery).
29. Routine refraction, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
30. Treatment by acupuncture.
31. 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."
32. 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.
33. Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
34. 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.
35. Dental implants for any condition.
36. 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.
37. Blood administration for the purpose of general improvement in physical condition.
38. Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
39. Cosmetics, dietary supplements and health and beauty aids.
40. All nutritional supplements and formulae are excluded, except for infant formula needed for the treatment of inborn errors of metabolism.
41. 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.
42. 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.
43. Services for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit.

44. Telephone, e-mail & Internet consultations and telemedicine.
45. 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 document. If there are any differences between this summary and the plan document, the information in the plan documents takes precedence.