Schedule of benefits

Prepared for:

Policyholder:	BorgWarner Company
Policyholder number:	GP-299617
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Underwritten by Aetna Life & Casualty (Bermuda) Ltd.

Schedule of benefits

This schedule of benefits (schedule) lists the **deductibles**, **copayments** or **coinsurance**, if any apply to the **covered services** you receive under the plan. You should review this schedule to become aware of these and any limits that apply to these services.

How your cost share works

- The **deductibles** and **copayments**, if any, listed in the schedule below are the amounts that you pay for **covered services**.
  - For the **covered services** under your medical plan, you will be responsible for the dollar amount
  - For pharmacy benefits where a percentage cost share acts like a **copayment**, you will be responsible for the percentage amount
- **Coinsurance** amounts, if any, listed in the schedule below are what the plan will pay for **covered services**.
- You are responsible to pay any **deductibles**, **copayments** and remaining **coinsurance**, if they apply and before the plan will pay for any **covered services**.
- This plan doesn't cover every health care service. You pay the full amount of any health care service you get that is not a **covered service**.
- This plan has limits for some **covered services**. For example, these could be visit, day or dollar limits. They may be:
  - Based on a rolling, 12-month period starting with the date of your most recent visit under this plan

  See the schedule for more information about limits.
- Your cost share may vary if the **covered service** is preventive or not. Ask your **physician** or contact us if you have a question about what your cost share will be.

For examples of how cost share and **deductible** work, go to the *Using your Aetna benefits* section under Individuals & Families at https://www.aetna.com/

Important note:
Covered services are subject to the Calendar Year **deductible**, **maximum out-of-pocket**, limits, **copayment** or **coinsurance** unless otherwise stated in this schedule.

How your deductible works

The **deductible** is the amount you pay for **covered services** each year before the plan starts to pay. This is in addition to any **copayment** or **coinsurance** you pay when you get **covered services** from a **provider**. This schedule shows the **deductible** amounts that apply to your plan. Once you have met your **deductible**, we will start sharing the cost when you get **covered services**. You will continue to pay **copayments** or **coinsurance**, if any, for **covered services** after you meet your **deductible**.

Contact us

We are here to answer questions. See the *Contact us* section in your certificate.

Aetna Life & Casualty (Bermuda) Ltd.'s group policy provides the coverage described in this schedule of benefits. This schedule replaces any schedule of benefits previously in use. Keep it with your certificate.

Plan features

Deductible provisions
The **deductible** may not apply to some **covered services**. You still pay the **copayment** or **coinsurance**, if any, for these **covered services**.

Coinsurance
This is the percentage of **covered services** you pay after your **deductible**.

Maximum out-of-pocket limit
The **maximum out-of-pocket limit** is unlimited.

Your financial responsibility and decisions regarding benefits
We base your financial responsibility for the cost of **covered services** on when the service or supply is provided, not when payment is made. Benefits will be pro-rated to account for treatment or portions of **stays** that occur in more than one year. Decisions regarding when benefits are covered are subject to the terms and conditions of the group policy.

Covered services

Acupuncture

Description	Outside the U.S.
Acupuncture	100% per visit, no **deductible** applies

Visit limit per year	10

Ambulance services

Description	Outside the U.S.
Emergency services	100% per trip, no **deductible** applies
Description	**Outside the U.S.**
Non-emergency services	100% per trip, no **deductible** applies

Applied behavior analysis

Description	Outside the U.S.
Applied behavior analysis	50% per visit, no **deductible** applies

Autism spectrum disorder

Description	Outside the U.S.
Diagnosis and testing	50% per visit, no **deductible** applies
Treatment	50% per visit, no **deductible** applies
Occupational (OT), physical (PT) and speech (ST) therapy for autism spectrum disorder	Covered based on type of service and where it is received

Behavioral health

Mental health treatment

Coverage provided is the same as for any other illness

Description	Outside the U.S.
Inpatient services-**room and board** including **residential treatment facility**	100% per admission, no **deductible** applies

Description	Outside the U.S.
Outpatient office visit to a **physician** or **behavioral health provider**	50% per visit, no **deductible** applies
Physician or **behavioral health provider telemedicine** consultation	50% per visit, no **deductible** applies
Outpatient **mental health disorders telemedicine** cognitive therapy consultations by a **physician** or **behavioral health provider**	Not covered

Substance related disorders treatment

Includes **detoxification**, rehabilitation and **residential treatment facility**

Coverage provided is the same as for any other illness

Description	Outside the U.S.
Inpatient services-**room and board** during a **hospital stay**	100% per admission, no **deductible** applies

Description	Outside the U.S.
Outpatient office visit to a **physician** or **behavioral health provider**	50% per visit, no **deductible** applies
Physician or **behavioral health provider telemedicine** consultation	50% per visit, no **deductible** applies
Outpatient **telemedicine** cognitive therapy consultations by a **physician** or **behavioral health provider**	Not covered

Clinical trials

Description	Outside the U.S.
Experimental or investigational therapies	Covered based on type of service and where it is received
Routine patient costs	Covered based on type of service and where it is received

Durable medical equipment (DME)

Description	Outside the U.S.
DME	100% per item, no **deductible** applies

Emergency services

Description	Outside the U.S.
Emergency room	100% per visit, no **deductible** applies

Non-emergency care in a **hospital** emergency room	50% per visit, no **deductible** applies

Emergency services important note:
You may receive a bill for the difference between the amount billed by the **provider** and the amount paid by the plan. If the **provider** bills you for an amount above your cost share, you are not responsible for payment of that amount. You should send the bill to the address on your ID card and we will resolve any payment issue with the **provider**. Make sure the member ID is on the bill.

Habilitation therapy services

Physical (PT), occupational (OT) therapies

Description	Outside the U.S.
PT, OT therapies	Covered based on type of service and where it is received

Speech therapy (ST)

Description	Outside the U.S.
ST	Covered based on type of service and where it is received

Home health care

A visit is a period of 4 hours or less

Description	Outside the U.S.
Home health care	100% per visit, no **deductible** applies

Visit limit per year	120

Home health care important note:
Intermittent visits are periodic and recurring visits that skilled nurses make to ensure your proper care. The intermittent requirement may be waived to allow for coverage for up to 12 hours with a daily maximum of 3 visits.

Hospice care

Description	Outside the U.S.
Inpatient services - **room and board**	100% per admission, no **deductible** applies

Day limit per lifetime	30 days

Description	Outside the U.S.
Outpatient services	100% per visit, no **deductible** applies

Limit per lifetime	$5,000

Hospice important note:
This includes part-time or infrequent nursing care by an R.N. or L.P.N. to care for you up to 8 hours a day. It also includes part-time or infrequent home health aide services to care for you up to 8 hours a day.

Hospital care

Description	Outside the U.S.
Inpatient services – **room and board**	100% per admission, no **deductible** applies

Infertility services

Basic infertility

Description	Outside the U.S.
Treatment of basic **infertility**	Covered based on type of service and where it is received

Comprehensive infertility services

Description	Outside the U.S.
Treatment of basic **infertility**	100% per visit, no **deductible** applies

Limits

Description	Outside the U.S.
Number of ovulation induction cycles per lifetime while on medications to stimulate the ovaries	1
Number of artificial insemination cycles per lifetime	1

Jaw joint disorder

Includes TMJ

Description	Outside the U.S.
Jaw joint disorder treatment	Covered based on type of service and where it is received

Maternity and related newborn care

Includes complications

Description	Outside the U.S.
Inpatient services – **room and board**	100% per admission, no **deductible** applies
Services performed in **physician** or **specialist** office or a facility	100% per visit, no **deductible** applies
Other services and supplies	100%, no **deductible** applies

Maternity and related newborn care important note:
Any cost share collected applies only to the delivery and postpartum care services provided by an OB, GYN or OB/GYN. Review the *Maternity* section of the booklet. It will give you more information about coverage for maternity care under this plan.

Oral and maxillofacial treatment (mouth, jaws and teeth)

Description	Outside the U.S.
Treatment of mouth, jaws and teeth	Covered based on type of service and where it is received

Description	Cost share
	Outside the U.S.
Prescription drugs	100% per supply, no **deductible** applies

Outpatient prescription drugs in the U.S.

Generic prescription drugs

Description	In-network
Each 30 day supply up to 12 months at a **retail pharmacy**	$0, no **deductible** applies
Each 30 day supply up to 12 months at a **retail** or **mail order pharmacy**	$0, no **deductible** applies

Brand-name prescription drugs

Description	In-network
Each 30 day supply up to 12 months at a **retail pharmacy**	$0, no **deductible** applies
Each 30 day supply up to 12 months at a **mail order pharmacy**	$0, no **deductible** applies

Anti-cancer drugs taken by mouth

Description	In-network
Each 30 day supply up to 12 months at a **specialty pharmacy**	$0, no **deductible** applies

Outpatient prescription drug important note:
If a **provider** prescribes a covered **brand-name prescription drug** when a **generic prescription drug** equivalent is available and specifies "Dispense As Written" (DAW), you will pay the cost share for the brand-name drug. If a **provider** does not specify DAW and you request a covered **brand-name prescription drug**, you will be responsible for the cost difference between the brand-name drug and the generic drug, plus the cost share that applies to the brand-name drug.

Outpatient surgery

Description	Outside the U.S.
At **hospital** outpatient department	100%, no **deductible** applies
At facility that is not a **hospital**	100%, no **deductible** applies
At the **physician** office	Covered based on type of service and where it is received

Physician and specialist services

Physician services-general or family practitioner

Description	Outside the U.S.
Physician office hours (not surgical, not preventive)	100% per visit, no **deductible** applies
Physician surgical services	100% per visit, no **deductible** applies

Description	Outside the U.S.
Physician telemedicine consultation	100% per visit, no **deductible** applies

Description	Outside the U.S.
Physician visit during inpatient **stay**	100% per visit, no **deductible** applies

Specialist

Description	Outside the U.S.
Specialist office hours (not surgical, not preventive)	100% per visit, no **deductible** applies
Specialist surgical services	100% per visit, no **deductible** applies

Description	Outside the U.S.
Specialist telemedicine consultation	100% per visit, no **deductible** applies

All other services not shown above

Description	Outside the U.S.
All other services	100% per visit, no **deductible** applies

Preventive care

Description	Outside the U.S.
Counseling for alcohol or drug misuse	100% per visit, no **deductible** applies
Counseling for alcohol or drug misuse visit limit	5 visits/12 months
Counseling for obesity, healthy diet	100% per visit, no **deductible** applies
Counseling for obesity, healthy diet visit limit	Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling.
Counseling for sexually transmitted infection	100% per visit, no **deductible** applies
Counseling for sexually transmitted infection limit	2 visits/12 months
Counseling for tobacco cessation	100% per visit, no **deductible** applies
Counseling for tobacco cessation visit limit	8 visits/12 months
Family planning services (female contraception, counseling)	100% per visit, no **deductible** applies
Family planning services (female contraception, counseling) limit	Contraceptive counseling limited to 2 visits/12 months in a group or individual setting Counselings that exceed this limit are covered as a **physician** services office visit
Immunizations	100% per visit, no **deductible** applies
Immunizations limit	Subject to any age limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**
Routine physical exam	100% per visit, no **deductible** applies
Routine physical exam limits	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration for children and adolescents Limited to 7 exams from age 0-1 year; 3 exams every 12 months age 1-2; 3 exams every 12 months age 2-3; and 1 exam every 12 months after that age, up to age 22; 1 exam every 12 months after age 22 High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1 every 36 months
Well woman GYN exam	100% per visit, no **deductible** applies
Well woman GYN exam limit	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration

Preventive care and wellness maximum

Description	Outside the U.S.
For all preventive services listed above - Adult maximum per year	$1,000

Private duty nursing

Up to 8 hours equals one shift

Description	Outside the U.S.
Outpatient services	100% per visit, no **deductible** applies

Visit/shift limit per year	70

Prosthetic devices

Description	Outside the U.S.
Prosthetic devices	Covered based on type of service and where it is received t

Reconstructive surgery and supplies

Including breast surgery

Description	Outside the U.S.
Surgery and supplies	Covered based on type of service and where it is received

Routine cancer screenings

Description	Outside the U.S.
Colonoscopy	100% per test no **deductible** applies
Digital rectal examination (DRE)	100% per exam no **deductible** applies
Double contrast barium enema (DCBE)	100% per test no **deductible** applies
Fecal occult blood test (FOBT)	100% per test no **deductible** applies
Mammogram	100% per test no **deductible** applies
Prostate specific antigen (PSA) test	100% per test no **deductible** applies
Sigmoidoscopy	100% per test no **deductible** applies
Cancer screening limits	Subject to any age, family history and frequency guidelines as set forth in the most current: Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF The comprehensive guidelines supported by the Health Resources and Services Administration For more information contact your **physician** or see the *Contact us* section
Limit	1 screening every 12 months Screenings that exceed this limit are covered as outpatient diagnostic testing

Short-term rehabilitation services

A visit is equal to no more than 1 hour of therapy.

Cardiac rehabilitation

Description	Outside the U.S.
Cardiac rehabilitation	Covered based on type of service and where it is received

Pulmonary rehabilitation

Description	Outside the U.S.
Pulmonary rehabilitation	Covered based on type of service and where it is received

Cognitive rehabilitation

Description	Outside the U.S.
Cognitive rehabilitation	Covered based on type of service and where it is received

Physical and occupational therapies

Description	Outside the U.S.
	100% per visit, no **deductible** applies

Speech therapy (ST)

Description	Outside the U.S.
	100% per visit, no **deductible** applies

Spinal manipulation

Description	Outside the U.S.
	100% per visit, no **deductible** applies

Skilled nursing facility

Description	Outside the U.S.
Inpatient services - **room and board**	100% per admission, no **deductible** applies
Other inpatient services and supplies	100% per admission, no **deductible** applies

Day limit per year	120

Tests, images and labs – outpatient

Diagnostic complex imaging services

Description	Outside the U.S.
	100% per visit, no **deductible** applies

Diagnostic lab work

Description	Outside the U.S.
	100% per visit, no **deductible** applies

Diagnostic x-ray and other radiological services

Description	Outside the U.S.
	100% per visit, no **deductible** applies

Therapies

Chemotherapy

Description	Outside the U.S.
Chemotherapy services	Covered based on type of service and where it is received

Gene-based, cellular and other innovative therapies (GCIT)

Description	Outside the U.S.
Services and supplies	Not covered

Infusion therapy

Outpatient services

Description	Outside the U.S.
	100% per visit, no **deductible** applies

Radiation therapy

Description	Outside the U.S.
Radiation therapy	Covered based on type of service and where it is received

Respiratory therapy

Description	Outside the U.S.
Respiratory therapy	Covered based on type of service and where it is received

Transplant services

Description	Outside the U.S.
Inpatient services and supplies	100% per transplant, no **deductible** applies
Physician services	Covered based on type of service and where it is received

Urgent care services

At a freestanding facility or **provider** that is not a **hospital**

A separate urgent care cost share will apply for each visit to an urgent care facility or **provider**

Description	Outside the U.S.
Urgent care facility	100% per visit, no **deductible** applies

Vision care

Performed by an ophthalmologist or optometrist and includes refraction

Description	Outside the U.S.
	100% per visit, no **deductible** applies

Visit limit	1 visit every 24 months