BENEFIT SUMMARY

Administered by - Cigna Health and Life Insurance Co.
For - BorgWarner Inc.
Indemnity Plan
Cadillac Kysor Union Plan 501
Effective - 01/01/2023
Benefit Option: IND11

Plan Highlights	Benefit Amount
Lifetime Maximum	Unlimited
Plan Year Accumulation	Your Plan's Deductibles, Out-of-Pockets and benefit level limits accumulate on a calendar year basis unless otherwise stated.
Plan Coinsurance	Plan pays 90%
Maximum Reimbursable Charge	90th Percentile
Plan Deductible	Individual: None Family: None
Plan Out-of-Pocket Maximum	Individual: Unlimited Family: Unlimited

Benefit	Benefit Amount
Physician Services - Office Visits	
Primary Care Physician (PCP) Services/Office Visit	Not Covered
Specialty Care Physician Services/Office Visit	Not Covered
Surgery Performed in Physician's Office	Not Covered
Allergy Treatment/Injections and Allergy Serum Allergy serum dispensed by the physician in the office	Not Covered
Preventive Care	
Preventive Care Birth through age 2 Ages 3 and older	Not Covered Not Covered

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Benefit	Benefit Amount
Immunizations Birth through age 2 Ages 3 and older	Not Covered Not Covered
Mammogram, PAP, and PSA Tests	Plan pays 90%
• Includes routine and diagnostic services • Coverage includes the associated Preventive Outpatient Professional Services.	
Inpatient	
Inpatient Hospital Facility Services	Plan pays 100% - coordinated with Medicare
Note: Includes all Lab and Radiology services, including Advanced Radiological Imaging as well as Medical Specialty Drugs	
Inpatient Hospital Physician's Visit/Consultation	Plan pays 100%
Inpatient Professional Services	Plan pays 100%
• For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists	
Outpatient	
Outpatient Facility Services	Plan pays 100% for surgical services; non-surgical procedures/supplies and chronic conditions are Not Covered
Outpatient Professional Services	Not Covered
• For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists	
Emergency Services	
Emergency Room • Includes Professional, X-ray and/or Lab services performed at the Emergency Room and billed by the facility as part of the ER visit.	Plan pays 100% if admitted - coordinated with Medicare; otherwise Not Covered
Urgent Care Facility • Includes X-ray and/or Lab services performed at the Urgent Care Facility and billed by the facility as part of the urgent care visit. • Professional services are Excluded.	Plan pays 100% if admitted - coordinated with Medicare; otherwise Not Covered
Ambulance	Plan pays 100% if admitted - coordinated with Medicare; otherwise Not Covered
Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.	
Inpatient Services at Other Health Care Facilities	
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facilities	Not Covered
Laboratory Services	
Physician's Services/Office Visit • Includes diagnostic services only • Includes pre-admission testing	Plan pays 90%
Independent Lab • Includes diagnostic services only • Includes pre-admission testing	Plan pays 90%

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Benefit	Benefit Amount
Outpatient Facility • Includes diagnostic services only • Includes pre-admission testing	Plan pays 90%
Radiology Services	
Physician's Services/Office Visit • Includes diagnostic services only • Includes pre-admission testing	Plan pays 90%
Outpatient Facility • Includes diagnostic services only • Includes pre-admission testing	Plan pays 90%
Advanced Radiological Imaging (ARI)	Includes MRI, MRA, CAT Scan, PET Scan, etc.
Outpatient Facility • Includes pre-admission testing • Includes diagnostic services only	Plan pays 90%
Physician's Services/Office Visit • Includes pre-admission testing • Includes diagnostic services only	Plan pays 90%
Outpatient Therapy Services	
Outpatient Therapy and Chiropractic Services • Includes Chiropractic Care, Cognitive Therapy, Occupational Therapy, Physical Therapy, Cardiac Rehabilitation, Pulmonary Rehabilitation, and Speech Therapy	Not Covered
Hospice	
Inpatient Facilities	Not Covered
Outpatient Services	Not Covered
Bereavement Counseling	Not Covered
Medical Specialty Drugs	
Outpatient Facility	Plan pays 90%
Physician's Office	Plan pays 90%
Home	Plan pays 90%

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Benefit	Benefit Amount
Note: This benefit only applies to the cost of the Infusion Therapy drugs administered. This benefit does not cover the related Facility, Office Visit or Professional charges.	
Maternity	
Initial Visit to Confirm Pregnancy	Not Covered
All Subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (Global Maternity Fee)	Not Covered
Office Visits in Addition to Global Maternity Fee (Performed by OB/GYN or Specialist)	Not Covered
Delivery - Facility (Inpatient Hospital, Birthing Center)	Covered same as plan's Inpatient Hospital benefit
Abortion	
Abortion Services	Not Covered
Family Planning	
Women's Services	Not Covered
Men's Services	Not Covered
Outpatient Dialysis Services	
Physician's Services/Office Visit	Covered same as Physician Services - Office Visit
Home Dialysis	Covered same as plan's Home Health Care benefit
Outpatient Facility Services	Covered same as plan's Outpatient Facility Services benefit
Outpatient Professional Services	Covered same as plan's Outpatient Professional Services benefit
Other Health Care Facilities/Services	
Home Health Care	Not Covered
Organ Transplants • Travel services are Not Covered	Covered same as Inpatient benefit
Durable Medical Equipment	Not Covered
Diabetic Supplies • Includes blood glucose monitors, blood glucose test strips, lancet devices, lancets, glucose control solutions for checking the accuracy of testing equipment/test strips, insulin pumps and insulin used in insulin pumps.	Plan pays 100%
External Prosthetic Appliances (EPA)	Not Covered

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Benefit	Benefit Amount
Routine Foot Care	Not Covered
Note: Services associated with foot care for diabetes and peripheral vascular disease are covered when approved as medically necessary.	

Mental Health and Substance Use Disorder

Not Covered

Pharmacy

Benefits not provided by Cigna.

Additional Information

Maximum Reimbursable Charge

Payments made to health care professionals are determined based on the lesser of: the health care professional's normal charge for a similar service or supply, or a percentile (90th) of charges made by health care professionals of such service or supply in the geographic area where it is received. If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then state, regional or national charge data may be used. If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then data in the database for similar services may be used. These charges are compiled in a database selected by Cigna. The health care professional may bill the customer the difference between the health care professional's normal charge and the Maximum Reimbursable Charge as determined by the benefit plan, in addition to applicable deductibles, co-payments and coinsurance. Services are subject to a Calendar Year deductible and maximum reimbursable charge limitations.

Medicare Coordination

In accordance with the Social Security Act of 1965, this plan will pay as the Secondary plan to Medicare Part A and B as follows:
(a) a former Employee such as a retiree, a former Disabled Employee, a former Employee's Dependent, or an Employee's Domestic Partner who is also eligible for Medicare and whose insurance is continued for any reason as provided in this plan (including COBRA continuation);
(b) an Employee, a former Employee, an Employee's Dependent, or former Employee's Dependent, who is eligible for Medicare due to End Stage Renal Disease after that person has been eligible for Medicare for 30 months.

When a person is eligible for Medicare A and B as described above, this plan will pay as the Secondary Plan to Medicare Part A and B **regardless if the person is actually enrolled in Medicare Part A and/or Part B and regardless if the person seeks care at a Medicare Provider or not for Medicare covered services.**

Multiple Surgical Reduction

Multiple surgeries performed during one operating session result in payment reduction of 50% to the surgery of lesser charge. The most expensive procedure is paid as any other surgery.

Pre-Existing Condition Limitation (PCL) does not apply.

Definitions

Coinsurance - The portion of covered expenses you are responsible for is called Coinsurance.
Copay - A flat fee you pay for certain covered services such as doctor's visits or prescriptions.
Deductible - A flat dollar amount you must pay out of your own pocket before your plan begins to pay for covered services.
Out-of-Pocket Maximum - Specific limits for the total amount you will pay out of your own pocket before your plan coinsurance percentage no longer applies. Once you meet these maximums, your plan then pays 100 percent of the "Maximum Reimbursable Charges" or negotiated fees for covered services.
Place of Service - Your plan pays based on where you receive services. For example, for hospital stays, your coverage is paid at the inpatient level.
Prescription Drug List - The list of prescription brand and generic drugs covered by your pharmacy plan.
Professional Services - Services performed by Surgeons, Assistant Surgeons, Hospital Based Physicians, Radiologists, Pathologists and Anesthesiologists

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Exclusions

What's Not Covered (not all-inclusive):

Your plan provides for most medically necessary services. The complete list of exclusions is provided in your Certificate or Summary Plan Description. To the extent there may be differences, the terms of the Certificate or Summary Plan Description control. Examples of things your plan does not cover, unless required by law or covered under the pharmacy benefit, include (but aren't limited to):

- Care for health conditions that are required by state or local law to be treated in a public facility.
- Care required by state or federal law to be supplied by a public school system or school district.
- Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- Treatment of an Injury or Sickness which is due to war, declared, or undeclared.
- Charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan. For example, if Cigna determines that a provider or Pharmacy is or has waived, reduced, or forgiven any portion of its charges and/or any portion of Copayment, Deductible, and/or Coinsurance amount(s) you are required to pay for a Covered Expense (as shown on The Schedule) without Cigna's express consent, then Cigna in its sole discretion shall have the right to deny the payment of benefits in connection with the Covered Expense, or reduce the benefits in proportion to the amount of the Copayment, Deductible, and/or Coinsurance amounts waived, forgiven or reduced, regardless of whether the provider or Pharmacy represents that you remain responsible for any amounts that your plan does not cover. In the exercise of that discretion, Cigna shall have the right to require you to provide proof sufficient to Cigna that you have made your required cost share payment(s) prior to the payment of any benefits by Cigna. This exclusion includes, but is not limited to, charges of a non-Participating Provider who has agreed to charge you or charged you at an In-Network benefits level or some other benefits level not otherwise applicable to the services received.
- Charges arising out of or relating to any violation of a healthcare-related state or federal law or which themselves are a violation of a healthcare-related state or federal law.
- 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.
- For or in connection with experimental, investigational or unproven services.
- Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance use disorder or other health care technologies, supplies, treatments, procedures, drug or Biologic therapies or devices that are determined by the utilization review Physician to be:
    - not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed;
    - not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or Sickness for which its use is proposed;
    - the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" sections of this plan; or
    - the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" sections of this plan.

  In determining whether any such technologies, supplies, treatments, drug or Biologic therapies or devices are experimental, investigational and/or unproven, the utilization review Physician may rely on the clinical coverage policies maintained by Cigna or the Review Organization. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines.

- Cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem.
- The following services are excluded from coverage regardless of clinical indications: Macromastia or Gynecomastia Surgeries; Abdominoplasty;

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Exclusions

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.

- Surgical or non-surgical treatment of TMJ disorders.
- 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. Charges made for services or supplies provided for or in connection with an accidental Injury to teeth are covered provided a continuous course of dental treatment is started within six months of an accident.
- For 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 appearance 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.
- Unless otherwise covered in this plan, for 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.
- Court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
- Infertility services including 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 is also excluded from coverage.
- Reversal of male or female voluntary sterilization procedures.
- Any services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy, and premature ejaculation.
- Medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.
- Non-medical counseling and/or ancillary services including, but not limited to, Custodial Services, educational services, vocational counseling, training and rehabilitation services, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, 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 intellectual disabilities.
- 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.
- 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 "Home Health Services" or "Breast Reconstruction and Breast Prostheses" sections of this plan.
- Private Hospital rooms and/or private duty nursing except as provided under the Home Health Services provision.
- 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 an Injury or Sickness.
- Artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
- 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.
- 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.
- Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or post cataract surgery).
- Routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.

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Exclusions

- Treatment by acupuncture.
- All non-injectable prescription drugs, unless Physician administration or oversight is required, injectable prescription drugs to the extent they do not require Physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in this plan.
- 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.
- Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- Genetic screening or pre-implantations 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.
- Dental implants for any condition.
- Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- Blood administration for the purpose of general improvement in physical condition.
- Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- Cosmetics, dietary supplements and health and beauty aids.
- All nutritional supplements and formulae except for infant formula needed for the treatment of inborn errors of metabolism.
- For or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- Charges for the delivery of medical and health-related services via telecommunications technologies, including telephone and internet, unless provided as specifically described under Covered Expenses.
- Massage therapy.
- Abortions, unless a Physician certifies in writing that the pregnancy would endanger the life of the mother, or the expenses are incurred to treat medical complications due to abortion.

These are only the highlights
This summary outlines the highlights of your plan. For a complete list of both covered and not covered services, including benefits required by your state, see your employer's insurance certificate, service agreement or 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.

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Medical coverage

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Cigna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact customer service at the toll-free number shown on your ID card, and ask a Customer Service Associate for assistance.

If you believe that Cigna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by sending an email to ACAGrievance@Cigna.com or by writing to the following address:

Cigna
Nondiscrimination Complaint Coordinator
PO Box 188016
Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on the back of your ID card or send an email to ACAGrievance@Cigna.com. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1.800.368.1019, 800.537.7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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Proficiency of Language Assistance Services

English - ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711).

Spanish - ATENCION: Hay servicios de asistencia de idiomas, sin cargo, a su disposici6n. Si es un cliente actual de Cigna, llame al numero que figura en el reverso de su tarjeta de identificaci6n. Si no lo es, llame al 1.800.244.6224 (los usuarios de TTY deben llamar al 711).

Chinese - i.±(1"Ji1J1.?,1 t!Ef3'ii 1bbM.filU% ™m- Cigna '8JJI. F • g)'Hi,Q:i![1 '8 ID -t- im'8 u!/fJiJI. _p f,Q:i![1.800.244.6224 <Iffl : m 711) •

Vietnamese - XIN LLYU Y Ouy vj OLfQ'C cap djch v1,1 trq giup v ngon ngfr mi n phi Danh cho khach hang hien tai cua Cigna, vui long goi so a m t sau the Hoi vien. Cac trLPang hqp khac xin goi so 1.800.244.6224 (TTY: Quay so 711)

Korean -£1: Oj§ A -§-ofAI q., '2:!0J:J::I A1I::IIA§ '9-E.£ OI-§-of gq,XH Cigna 7f :J::f'aJJIIA1 ID ::'fC OJI 2.f .2..£ <2:! !--BH AI.2.. 71Ef g=q.on 1.800.244.6224 (TTY: qo1 711)º£ £I-5H AI.2..

Tagalog - PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna, tawagan ang numero sa likuran ng iyong ID card. 0 kaya, tumawag sa 1.800.244.6224 (TTY: I-dial ang 711).

Russian - BHVIMAHI!IE: BaM Moryr npep,ocraB1,1Tb 6ecnnaTHble ycnyr11 nepeBOAa. Ecm,1Bbl y>Ke y4acrByere B nnaHe Cigna, no3BOHI1Te no HOMepy, yKa3aHHOMy Ha o6paTHOH cropoHe BaweH 11AeHTI1(pl1Kal.\110HHOH KapT04KI1 y4aCTHI1Ka nnaHa. Ec1111Bbl He f!Bm:1erecb y4aCTHI1KOM OAHOro 113 Haw11x nnaHOB, no3BOHI1Te no HOMepy 1.800.244.6224 (TTY 711).

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French Creole - ATANSYON: Gen sevis ed nan lang ki disponib gratis pou ou. Pou kliyan Cigna yo, rele nimewo ki deye kat ID ou. Sinon, rele nimewo 1.800.244.6224 (TTY: Rele 711).

French - ATTENTION: Des services d'aide linguistique vous sont proposes gratuitement. Si vous etes un client actuel de Cigna, veuillez appeler le numero indique au verso de votre carte d'identite. Sinon, veuillez appeler le numero 1.800.244.6224 (ATS: composez le numero 711).

Portuguese - ATENCAO: Tern ao seu dispor servicos de assistencia linguistica, totalmente gratuitos. Para clientes Cigna atuais, ligue para o numero que se encontra no verso do seu cartao de identificacao. Caso contrario, ligue para 1.800.244.6224 (Dispositivos TTY: marque 711).

Polish - UWAGA: w celu skorzystania z dost pnej, bezplatnej pomocy j zykowej, obecni klienci firmy Cigna mogc1dzwonic pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1800 244 6224 (TTY: wybierz 711).

Japanese - 5i :B*qg g! :tl-9 ,ffl{ O) gg :ji-ij--t:'.'A cflJ ffll,\tctclt*9o!J!.ttO)CignaO)cB I;J:, ID1J- r'iriffiO) g!Wf-ls-*"('\ cB g!1;::z;:·i!i! <tc I,\o -fO)ft!30)J'51;J:,1.800.244.6224 (TTY: 711) *c-,s g!1;::zci!i! <tc I,\o

Italian - ATTENZIONE: Sono disponibili servizi di assistenza linguistica gratuiti. Per i clienti Cigna attuali, chiamare ii numero sul retro della tessera di identificazione. In caso contrario, chiamare ii numero 1.800.244.6224 (utenti TTY: chiamare ii numero 711).

German - ACHTUNG: Die Leistungen der SprachunterstOtzung stehen Ihnen kostenlos zur VerfOgung. Wenn Sie gegenwartiger Cigna-Kunde sind, rufen Sie bitte die Nummer auf der ROckseite Ihrer Krankenversicherungskarte an. Andernfalls rufen Sie 1.800.244.6224 an (TTY: Wahlen Sie 711).

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