# 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 with Rx*
## *IND3 - Sterling Hgts Hrly Pre-65 Retirees prior to 3/90*
## *Effective 1/1/2023*

| BENEFIT HIGHLIGHTS | INDEMNITY |
|---|---|
| ***PPACA Status*** | Exempt |
| ***MH/SUD Parity Status*** | Exempt |
| ***Lifetime Maximum*** | Unlimited |
| ***Coordination of Benefit Administration*** | Non-Duplication |
| ***Coinsurance Levels*** | 90% of the Maximum Reimbursable Charge (AKA Reasonable & Customary) |
| ***Maximum Reimbursable Charge***<br>Determined based on the lesser of:<br>•The provider's normal charge for a similar service or supply<br>or<br>•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.<br><br>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* | $100 per person |
| *Family Maximum* | $200 per family |
| *Aggregate* | Yes |

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| BENEFIT HIGHLIGHTS | INDEMNITY |
|---|---|
| ***Annual Out-of-Pocket Maximum*** | |
| *Includes Deductible* | No |
| *Individual* | $1,000 per person |
| *Family Maximum* | $2,000 per family |
| *Aggregate* | Yes |
| *Out-of-Pocket Accumulation*<br>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. | *Does not include Non-compliance penalties, deductibles, or charges in excess of Reasonable and Customary.* |
| ***Automated Annual Reinstatement*** | Not Applicable |
| ***Physician's Services*** | |
| *Primary Care Physician's Office visit*<br>**Note:** OB/GYN is considered a Specialist | 90% after deductible |
| *Specialty Care Physician's Office Visit*<br>*Office Visits*<br>*Consultant and Referral Physician's Services* | 90% after deductible |
| *Surgery Performed In the Physician's Office* | 90% after deductible |
| *Cigna Telehealth Connection services*<br>**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). | 90% after deductible |
| *Allergy Treatment/Injections* | 90% 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* | 90% after deductible |
| *Routine Mammograms* | 100% no deductible; |
| ***Second Opinions***<br>*(Services will be provided on a voluntary basis)* | 90% after deductible |
| ***Outpatient Pre-Admission Testing*** | |
| *Primary Care Physician's Office Visit*<br>*Specialist Physician's Office Visit*<br>*Outpatient Hospital Facility*<br>*Independent X-ray and Lab Facility* | 90% after deductible<br>90% after deductible<br>90% after deductible<br>90% after deductible |

| BENEFIT HIGHLIGHTS | INDEMNITY |
|---|---|
| ***Inpatient Hospital - Facility Services*** | 90% after 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 the ICU/CCU daily room rate |
| ***Outpatient Facility Services*** | 90% after deductible |
| *Operating Room, Recovery Room, Procedure Room, Treatment Room and Observation Room* | |

| BENEFIT HIGHLIGHTS | INDEMNITY |
|---|---|
| ***Inpatient Hospital Physician's Visits/Consultations*** | 90% after deductible |
| ***Inpatient Hospital Professional Services***<br>*Surgeon*<br>*Radiologist*<br>*Pathologist*<br>*Anesthesiologist* | 90% after 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***<br>*Surgeon*<br>*Radiologist*<br>*Pathologist*<br>*Anesthesiologist* | 90% after deductible |
| ***Emergency and Urgent Care Services***<br>*Physician's Office*<br><br>*Hospital Emergency Room*<br><br>*Urgent Care Facility or Outpatient Facility*<br><br>*Ambulance* | <br>90% after deductible<br><br>90% after deductible<br><br>90% after deductible<br><br>90% after deductible |
| ***Inpatient Services at Other Health Care Facilities***<br>*Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities*<br><br>Maximum days per calendar year: Unlimited | 90% after deductible |
| ***Laboratory and Radiology Services***<br>*MRIs, CAT Scans and PET Scans*<br>*The copay applies on a per procedure basis, for any place of service*<br><br>*Other Laboratory and Radiology Services*<br>Outpatient Hospital Facility<br>Independent X-ray and/or Lab Facility | <br>90% after deductible<br><br><br>90% after deductible<br>90% after deductible |
| ***Outpatient Short-Term Rehabilitative Therapy and Chiropractic Services***<br><br>Includes:<br>Cardiac Rehab<br>Physical Therapy<br>Speech Therapy<br>Occupational Therapy<br>Pulmonary Therapy<br>Cognitive Therapy<br>Chiropractic Care | <br><br>90% after deductible |

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|---|---|
| ***Home Health Care***<br>Unlimited visits maximum per calendar year<br><br>**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). | 90% after deductible |
| ***Outpatient Private Duty Nursing*** | 50% after deductible |
| ***Hospice***<br>*Inpatient Services*<br>*Outpatient Services* | <br>Not Covered<br>Not Covered |
| ***Bereavement Counseling***<br><br>*Services provided as part of Hospice Care Inpatient & Outpatient* | Not Covered |
| ***Maternity Care Services***<br><br>*Initial Visit to Confirm Pregnancy*<br><br>*All Subsequent Prenatal Visits, Postnatal Visits, and Delivery*<br><br>*Delivery (Inpatient Hospital, Birthing Center)* | <br><br>90% after deductible<br><br>90% after deductible<br><br>90% after deductible |
| ***Abortion***<br>*Includes therapeutic (non-elective) procedures only*<br>*Office Visit*<br><br>*Inpatient Facility*<br><br>*Outpatient Surgical Facility*<br><br>*Physician's Services* | <br><br>90% after deductible<br><br>90% after deductible<br><br>90% after deductible<br><br>90% after deductible |
| ***Family Planning Services***<br>*Office Visits (tests, counseling)*<br>*Surgical Sterilization* Procedure<br>*for Vasectomy/Tubal Ligation (excludes reversals)*<br><br>*Inpatient Facility*<br>*Outpatient Facility*<br>*Inpatient Physician's Services*<br>*Outpatient Physician's Services* | <br>90% after deductible<br><br><br><br>90% after deductible<br>90% after deductible<br>90% after deductible<br>90% after deductible |

| BENEFIT HIGHLIGHTS | INDEMNITY |
|---|---|
| ***Infertility Treatment*** | |
| *Office Visit (tests, counseling)* | 90% after deductible |
| *Coverage will be provided for the following services:*<br>• *Testing and treatment services performed in connection with an underlying medical condition.*<br>• *Testing performed specifically to determine the cause of infertility.*<br>• *Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition).*<br>*Services to induce pregnancy are not covered, such as, In-vitro, Artificial Insemination, GIFT, ZIFT, etc.* | |
| *Office Visit (tests, counseling)* | 90% after deductible |
| *Inpatient Facility* | 90% after deductible |
| *Outpatient Facility* | 90% after deductible |
| *Physician's Services* | 90% after deductible |
| ***Organ Transplant***<br>*Includes all medically appropriate, non-experimental transplants* | |
| *Office Visit* | 90% after deductible |
| *Inpatient Facility* | 90% after deductible |
| *Physician's Services*<br>*Lifesource not included* | 90% after deductible |
| ***Durable Medical Equipment*** | 90% after deductible |
| ***Breast Feeding Equipment and Supplies***<br>***Limited to the rental of one breast pump per birth as ordered or prescribed by a physician*** | 90% after deductible |
| ***External Prosthetic Appliances*** | 90% after deductible |
| ***Dental Care***<br>*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* | 90% after deductible |
| *Inpatient Facility* | 90% after deductible |
| *Outpatient Surgical Facility* | 90% after deductible |
| *Physician's Services* | 90% after deductible |
| ***Oral Surgery for removal of impacted teeth*** | Covered under Dental plan |
| ***TMJ - Limited to surgical treatment of TMJ disorders andinjections made directly into the Temporomandibular Joint*** | |
| *Physician's Office* | 90% after deductible |
| *Inpatient Facility* | 90% after deductible |
| *Outpatient Surgical Facility* | 90% after deductible |
| *Physician's Services* | 90% after deductible |

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|---|---|
| ***Hearing Aids & Routine Hearing Exams***<br>*Maximum 1 Exam every 36 months*<br>*Maximum of 1 Hearing Aid/ear every 36 months* | 100% for audiometric exam, hearing and evaluation tests; hearing aids included |
| ***Prescription Drugs***<br>*Cigna Pharmacy - 3-Tier Copay Mandatory Generic* | **In-Network**<br>**Retail (Up to 100 tablets/capsules per 30-day supply)**<br>Generic: $5<br>Preferred Brand: $7<br>Non-Preferred Brand: $7<br>**Retail & Home Delivery (up to 90-day supply)**<br>Generic: $3<br>Preferred Brand: $3<br>Non-Preferred Brand: $3 |
| ***Pharmacy Deductible*** | None |
| ***Pharmacy Out of Pocket Maximum*** | None |
| ***Pharmacy Annual Maximum*** | None |

- 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 may require special handling and close supervision while being administered.
- Mandatory Generic: Patient pays the brand cost share plus the cost difference between the brand and generic drugs up to the cost of the brand drug.
- 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.

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|---|---|
| ***Specialty Pharmacy*** | Prior authorization required on specialty medications and quantity limits may apply. |
| *Clinical Program* | TheraCare® Program |
| *Medication Access Option* | Retail and/or Home Delivery |
| ***Clinical Outcomes: Complex Psych Case Management*** *Psychotropic* | Included |
| ***Clinical Outcomes: Narcotic Therapy Management*** *Narcotic Analgesic* | Included |
| **Buy-Up Options** | |
| Specialty Injectables | |
| Self-Administered | Not Included |
| Optional | Not Included |
| Oral Contraceptives/Devices | Included |
| Oral fertility | Excluded, unless medically necessary to maintain pregnancy only – prior authorization required. |
| Prescription Diet Drugs | Included with prior authorization |
| Prescription Smoking Cessation | Included through mail order only for a 90 day supply per calendar year. |
| Prescription Vitamins | Included |
| Lifestyle Drugs | Included (injectable only) |
| Insulin | Preferred or Non-preferred Brand copay/coinsurance, based on the formulary |
| 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 |
| **Additional Comments** | Exclude Flumist |
| ***Mental Health and Substance Use Disorder Services*** | |
| ***Inpatient Mental Health*** | 90% after deductible |
| ***Outpatient Mental Health.*** | 90% after deductible |
| ***Inpatient Substance Use Disorder*** | 90% after deductible |
| ***Outpatient Substance Use Disorder*** | 90% after deductible |

| BENEFIT HIGHLIGHTS | INDEMNITY |
|---|---|
| Notes:<br>• Maximums per Calendar Year<br>o Inpatient Mental Health and Substance Use Disorder: Unlimited days<br>o Outpatient Mental Health and Substance Use Disorder (office/facility): Unlimited visits<br>• Services are paid at 100% after you reach your out-of-pocket maximum<br>• Inpatient includes Acute Inpatient and Residential Treatment<br>• Outpatient – Physician's Office – includes Individual, family and group therapy, psychotherapy, medication management, etc.<br>• Outpatient – All Other Services – includes Partial Hospitalization, Intensive Outpatient Services, Applied Behavioral Analysis (ABA Therapy) and Behavioral Telehealth Consultation, etc. | |
| ***Mental Health and Substance Use Disorder Services***<br>Inpatient Management Only<br>• Inpatient utilization review and case management | |
| ***Pre-existing Condition Limitation (PCL)*** | Not applicable |
| ***Pre-Certification - Continued Stay Review – Basic Care Low Management Inpatient (Required for all Inpatient Admissions)*** | Customer is responsible for contacting Cigna HealthCare. Subject to penalty/reduction for non-compliance.<br>- 50% penalty applied to hospital inpatient charges for failure to contact Cigna HealthCare to pre-certify admission.<br>- Benefits are denied for any admission reviewed by Cigna HealthCare and not certified.<br>- Benefits are denied for any additional days not certified by Cigna HealthCare. |
| ***Pre-existing Condition Limitation (PCL)*** | 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. |

## 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. Charges for the delivery of medical and health-related services via telecommunications technologies, including telephone and internet, unless provided as specifically described under the benefit section. 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.