BorgWarner Inc.
FLEXIBLE BENEFITS PLAN

SUMMARY PLAN DESCRIPTION

As Amended October 2019

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INTRODUCTION

BorgWarner Inc. sponsors the BorgWarner Flexible Benefits Plan (the "Plan") for the benefit of employees of BorgWarner Inc. and its subsidiaries (the "Company"). The Plan is made up of all the various benefit Programs (each a "Program") offered by the Company, such as medical, dental, vision, health care flexible spending accounts, dependent care flexible spending account, life insurance, AD&D, and other benefits.

With respect to certain Programs, such as those related to health and dependent care, the Plan is considered a "cafeteria plan" or "125 plan," which means that it offers you the choice of various Programs that you can pay for on a pre-tax basis through salary reduction, instead of receiving those amounts in cash. This arrangement helps you because the dollars used to purchase these benefits are not subject to income, Social Security, and Medicare taxes. Certain Programs offered under the Plan, such as life insurance, AD&D, and disability Programs, are not offered on a pre-tax basis through a Cafeteria Plan. These Programs must be paid for on an after-tax basis. Nevertheless, these Programs can be very beneficial to you and your family.

This Summary Plan Description ("SPD") describes the basic features of the Plan as of January 1, 2020. However, it only describes certain portions of the Programs offered through the Plan. Each Program is described in detail in separate documents pertaining to that Program, such as benefits booklets, certificates of coverage, benefits summaries, enrollment materials, summaries of material modifications, and other similar documents (collectively referred to as "Program documents"). This SPD together with the Program documents for a Program make up the SPD for that Program. You should carefully read this SPD and the Program documents for each Program in which you participate to determine your rights and responsibilities. This SPD is only a summary of the Plan. The complete terms of the Plan are described in the Plan document.

The laws relating to employee benefit plans change regularly. Whenever a Plan provision is inconsistent with any change in the law, the Plan and each Program will be administered according to the new law, regardless of the terms of the Plan, this SPD, or the Program documents. Whenever significant changes are made to the Plan or a Program, you will be notified through a Summary of Material Modifications ("SMM"). You should review each SMM and refer to it any time you refer to this SPD or the Program documents.

BENEFITS AND ELIGIBILITY

What kind of Programs are offered under the Plan?

Currently, the Plan includes the following Programs, which may vary by location:

Pre-tax cafeteria plan benefits

Medical Program (including prescription drugs and Employee Assistance)

Dental Program

Vision Program

Flexible Spending Account Program (Health Care FSA and Dependent Care FSA)

Vacation Purchase Program

Wellness Program

After-tax non-cafeteria plan benefits

Term Life Insurance Program (Basic Life Insurance)

Employee Optional Group Life Insurance Program

Optional Dependent Life Insurance Program

Voluntary AD&D Insurance Program

Accidental Death & Dismemberment (AD&D) Program

Short-Term Disability (STD) Program

Long-Term Disability (LTD) Program

Business Travel Accident Program

Medical Benefits Abroad Program

Voluntary Benefit Programs such as Critical Illness and Identity Protection

Transitional Income Program

The first six Programs are generally offered through the cafeteria plan on a pre-tax basis. The remaining Programs are offered on an after-tax basis outside the cafeteria plan. You should consult any Program documents and read them together with this SPD.

Not all Programs are available at each location or for all groups of employees. Please contact your local Human Resources Office to determine which benefits are available to you.

How does the pre-tax portion of the Plan work?

When you elect to participate in the Medical, Dental, Vision, Health Care FSA, Dependent Care FSA Programs, and Vacation Purchase Program your portion of premiums and your FSA contributions will be deducted from your paycheck pre-tax. This means that these amounts are deducted before Federal and State taxes are calculated so that the actual cost to you for these benefits is less than if you were paying on an after-tax basis. If you elect to participate in the Medical, Dental, Vision, Health Care FSA, and/or Dependent Care FSA Programs, you must pay your portion of premiums and FSA contributions on a pre-tax basis. These programs are not offered on an after-tax basis.

How does the after-tax portion of the Plan work?

When you elect to participate in the Term Life Insurance, Optional Group Life Insurance, Voluntary AD&D, Voluntary Critical Illness, and STD, you make a corresponding election to have your portion of premiums (if any) deducted from your paycheck. These amounts are deducted from your paycheck after Federal and State taxes are taken out, as required by law. The Company also provides AD&D, LTD, Employee Assistance, and Business Travel Accident Programs on a taxable basis.

Who pays the cost of coverage under each Program?

The Company determines how to allocate the costs of such Program. The Company may pay all costs of a Program, may require participants to pay all costs of a Program, or may share the costs with participants. When you enroll you will be provided with information about the cost of each Program. The Company may modify the allocation of costs from time to time and will notify you of any changes.

Who is eligible to become a participant in the Plan?

The Plan is open to U.S. Employees only. An Employee is an individual actively* employed by the Company on a full-time status. Full-time status is defined as an employee whose regular scheduled work week is equal to or more than 30 hours per week. Full-time status excludes part-time employees (regularly scheduled to work less than 30 hours per week), temporary, leased, volunteer, agent, intern, co-op, contractor, or sub-contractor basis. Any part-time, intern, or co-op may qualify for medical coverage if

the employee worked during the previous look-back period (11/1 – 10/31) more than 1560 hours, or an average of 30 hours or more per week.

> * An Employee will be considered active if he/she is performing duties in the usual and customary manner at the Company's business establishment or at a location to which the Company's business requires the Employee to travel. Employees on a lay-off status of less than 30 days are considered actively employed for purposes of continuing medical, dental, and flexible spending plans without break in coverage.

If you meet these requirements, you will be eligible to participate in all pre-tax and after-tax Programs available for your position and location.

You are not considered an eligible Employee if you are employed by the Company outside the U.S. unless you are:

- On U.S. payroll and on temporary assignment for the Company outside the U.S., in which case you may continue to participate in the Plan during the temporary assignment; or
- Employed by the Company outside of the U.S. but on temporary assignment to a U.S. facility of the Company, in which case you will be eligible to participate in international assignee medical, dental and vision benefits under the Plan during your assignment.

Who qualifies as an eligible dependent under the Plan?

Several Programs offered under this Plan permit participants to enroll their dependents. The term "dependents" includes your spouse and children unless specified otherwise in this SPD or in Program documents. An employee may be covered as the dependent of a spouse who is also an employee, but no one may be covered as a dependent of more than one employee or as both a dependent and as a participant.

IMPORTANT: IF YOUR ENROLLED SPOUSE OR CHILD CEASES TO QUALIFY AS A "DEPENDENT" UNDER THE TERMS OF THE PLAN, IT IS YOUR RESPONSIBILITY TO NOTIFY YOUR LOCAL HUMAN RESOURCES OFFICE WITHIN 30 DAYS FOLLOWING THE EVENT. FAILURE TO DO SO COULD RESULT IN YOUR DEPENDENT'S LOSS OF COBRA CONTINUATION COVERAGE RIGHTS (HEALTH CARE PROGRAMS ONLY), NEGATIVE TAX CONSEQUENCES TO YOU, AND LOSS OF BENEFITS UNDER THIS PLAN.

When you first enroll a dependent in a Program, you may be required to provide documentation to demonstrate that the dependent is eligible to participate in the Program. You may also be required to recertify eligibility from time to time. If you do not provide documentation acceptable to the Company within 30 days of such request, your dependent will be terminated from the program at the end of the 30-day period and not eligible for re-enrollment until the next open enrollment period.

If your eligible spouse or child is permanently and totally disabled and eligible to participate in a government-sponsored medical assistance program, your disabled dependent must enroll in the governmental plan and the Company's health care Program will be secondary, when permitted by law.

Who qualifies as a spouse?

Under this Plan and all component Programs, your spouse is an individual to whom you are legally married as evidenced by a current and valid marriage certificate. Co-habitants, domestic partners, life partners, legally separated individuals, and divorced spouses are not considered spouses under the Plan; even if recognized under the laws of your State of domicile. For a benefit option that is fully-insured through an insurance carrier, a different definition of the term "spouse" set forth in the Program documents (including the applicable insurance policy) shall control. For purposes of the pre-tax cafeteria plan benefits, the legal marriage status between you and your spouse must exist at the time the expense was incurred for which reimbursement is claimed. With respect to any Program providing medical benefits, if your spouse is eligible for coverage under a health Plan offered by his or her employer, your spouse must enroll in his or her employer's basic health coverage with that employer in order to be eligible for medical benefits coverage as a dependent under this Plan.

Who is an eligible dependent under the Medical, Dental, Vision, and Health Care Flexible Spending Account Programs?

For purposes of these Programs, dependents include:

- Your spouse; and
- Your children who are under age 26 or who are permanently and totally disabled (as defined below).

A child includes:

- a biological child
- a child legally adopted or a child who has been placed with you for adoption;
- a stepchild, and like your spouse, if the child is eligible to participate in another employer's health plan, this Plan will only cover the child on a secondary basis;
- a child for whom your spouse has court-appointed full (not limited) legal guardianship, but if your spouse and the child are eligible to participate in another employer's health plan, this Plan will only cover the child on a secondary basis; and
- a child for whom you are required to provide health care support under a Qualified Medical Child Support Order (QMCSO).

  The child normally will continue to be eligible as a dependent until the end of the month in which he or she reaches age 26, or the date he or she ceases to be permanently disabled.

If you have a child who no longer meets one of these requirements, it is your responsibility to contact your local Human Resources department to determine whether the child still qualifies as your dependent within 30 days following the event. Failure to do so may result in the loss of your dependent's rights to COBRA health care continuation coverage, negative tax consequences for you, and loss of your benefits under the Plan.

Working Spouse Provision

If an employee's spouse is eligible for coverage under an ERISA* health plan offered by his/her employer, the spouse must enroll in their employer's basic medical in order to be eligible for coverage as a dependent under the BorgWarner medical benefits. A spouse who declines his/her employer's health coverage will be denied coverage as a dependent under BorgWarner medical benefits.

*ERISA is a health plan for which an employer takes a tax deduction. It is the acronym for the federal act "Employee Retirement Income Security Act."

BorgWarner's administrative service provider will regularly conduct a Working Spouse audit as claims are received to evaluate if other coverage should be paying primary. Employees will be required to recertify the Working Spouse requirement during an active Open Enrollment period, periodically as claims are submitted, and other qualifying events as necessary.

During new hire benefits enrollment, and all subsequent annual Open Enrollments, acknowledgement of the Working Spouse Provision is mandatory for the online enrollment to be finalized. The employee may be subject to disciplinary actions up to and including termination of employment if falsified information is provided. The Company may seek reimbursement from the employee for ineligible claims.

Who should cover my dependents if we both work at BorgWarner?

If an Employee and spouse are employed by the Company or an affiliate of the Company, the employee has the option to:

- Enroll as a dependent under his/her spouse's plan; or,
- Enroll as the Employee under his/her own plan; or,
- Decline enrollment under either plan

If an Employee and spouse are employed by the Company, or an affiliate of the Company, their eligible dependent child(ren) can be covered under either one of the parents' health care plan options, but not both.

Permanently and Totally Disabled

For purposes of the definition of dependent, your child will be considered permanently and totally disabled if he or she became disabled prior to his or her 26th birthday, was covered under this Plan prior to age 26; and is incapable of self-sustaining employment by reason of any medically determinable physical or mental impairment which can be expected to result in death, or which has lasted or can be expected to last for a continuous period of at least 12 months. An Employee must provide proof of the child's condition and dependence to the medical plan carrier within 31 days following benefit election. See HRLink for paperwork. The Company may require proof of the continuation of such condition and dependence, up to and including:

- Social Security Administration Disability Determination;
- Enrollment in any government sponsored plan where medical assistance exists (Medicare/Medicaid)

- A disabled child over age 26 must also qualify as a dependent under Federal tax law in order to be eligible for coverage continuation.

If the disabled dependent of a new hire is over the age of 26, as of the employee's date of hire, the dependent may be eligible for coverage under the BorgWarner medical benefits upon proof of disability.

Who is an eligible dependent under the Dependent Care Flexible Spending Account Program?

For purposes of the Dependent Care Flexible Spending Account Program, there are two types of dependents whose care expenses can be paid through the Program:

Child Under Age 13: a child who is under age 13 that meets the following requirements:

is your child, stepchild, foster child, brother, sister, stepbrother, stepsister, or the descendant of such relative;

has the same principal residence as you do for at least half the calendar year; a

and, does not provide over ½ of his or her own support for the calendar year.

A Disabled Dependent (spouse, parent, etc.): an individual who is physically or mentally incapable of caring for himself or herself and who has the same principal residence as you do for more than one-half of the calendar year, if the individual is either:

- Your spouse; or
- Your non-spouse dependent, regardless of age, if he or she, is your brother, sister, stepbrother, stepsister, father, mother, grandparent, stepfather, stepmother, niece or nephew, aunt or uncle, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, sister-in-law, child or grandchild (or another individual who for the calendar year has the same principal residence as you do and is a member of your household); and receives over half of his or her support for the calendar year from you.

Who is an eligible dependent under the Optional Life Insurance Program?

If you qualify for dependent optional life coverage, you may be able to cover your spouse and your unmarried dependent child (natural child, adopted child, child placed for adoption, or stepchild) who is less than 19 years old and supported by you. Coverage for an unmarried child may extend until age 25 if the child is a full-time student, unmarried, not employed on a full-time basis, and primarily supported by you. You cannot cover any individual (spouse or child) who is in the military (other than a spouse who is in the reserve forces or National Guard), or who is receiving life insurance coverage from the Company as an employee. You should consult the Program documents for details.

What else should I know about adding a dependent?

The employee shall be given up to 30 days following the eligibility date to provide documentation for the dependent eligibility. Health care dependent coverage will be denied for ineligible dependent status

and/or improper substantiation. Failure to provide the necessary documentation will result in termination of the dependent effective the last date of eligibility.

Dependent category	**Required Documentation**[1]	**When required**
Spouse	Valid marriage certificate	Required at time spouse is enrolled
Biological child	Birth Certificate (new hires) Certification of birth (birth of child)	Required at time child is enrolled
Adopted child	Legal Adoption/guardian papers	Required at time child is enrolled
Step-child/Legal guardianship	Legal guardian papers or QMCSO, and Birth Certificate[2]	Required at time child is enrolled
Disabled	See Permanently & Totally Disabled definition section	Required as dependent reaches age 26. Recertify periodically

HRLink retains copies of dependent certification in the employee's benefits file.

Employees will be notified of their dependent eligibility obligations and responsibilities at new hire orientation and open enrollment events.

An employee found in violation of the BorgWarner Dependent Certification Requirements is subject to disciplinary action up to, and including, termination. The ineligible dependent will be terminated from coverage effective immediately. At the discretion of the Employee Benefits Committee, the Company may seek reimbursement directly from the employee for any and all claims paid on behalf of the ineligible dependent. If deemed necessary, legal action may be taken.

Who is eligible to participate in retiree health and life insurance benefits?

BorgWarner maintains a separate plan providing health and life benefits to eligible retirees, known as the BorgWarner Retiree Health & Life Plan. For your convenience, the eligibility rules for the BorgWarner Health & Life Plan are described in Schedule 3 of this document.

Can I assign my benefits to someone else?

Benefits under the Plan are not in any way subject to the debts or other obligations of you, your dependents, or your beneficiaries. You may not voluntarily or involuntarily sell, transfer, or assign your benefits under the Plan.

What is the coordination of benefits rule that applies to my coverage?

The Plan coordinates its benefits with the benefits of other group health plans under which you or a dependent may be covered. If the Plan provides primary health coverage, it will pay full benefits regardless of what any other plan may pay. If the Plan is not primary, you may submit the portion not paid by your primary coverage and the Plan will consider the unpaid balance. The Plan will pay the difference between what it would have paid if Primary and the amount paid by the other insurer.

For specific rules regarding coordination of benefits, please contact the applicable insurer or claims administrator listed in Schedule 1.

Under what circumstances will my participation in the Plan end?

Your participation in the BorgWarner Flexible Benefits Plan and coverage for you and your dependents may end under the following circumstances:

- Your employment with BorgWarner ends for any reason*. As a terminated employee, active health care benefits cease on the employee's last date of active service. If health care benefits are continued pursuant to a severance agreement (TIP plan), the employee is considered a terminated employee. Depending on the location, employees who are on lay-off may be considered as suspended instead of terminated. In either event, employees must be offered and enrolled into COBRA for continuation of health care benefits.
- You or your dependent are no longer eligible for benefits under the Plan;
- You fail to pay the required contribution for coverage;
- You choose to discontinue your participation;
- Your participation is terminated for cause (for example, BorgWarner learns that you have committed or attempted to commit fraud or have been dishonest with BorgWarner about some important or material matter); or
- BorgWarner terminates the Plan or amends the Plan in a manner that eliminates your or your dependents' coverage.

*If you are age 60 with 10 years or more of service, you may qualify for certain retiree benefits under the BorgWarner Retiree Health & Life Plan.

Additional rules may appear in Program documents.

Why aren't the full details of eligibility and coverage for each Program described in this SPD?

Each Program is described in the "Program documents" for that Program. The Program documents may include plan documents, certificates of coverage, or other benefit summaries that describe that Program, as supplemented or amended by any subsequent summary of material modifications, annual summary of benefits, or enrollment materials provides by the Plan to participants for the purpose of informing participants of the most current information regarding the benefits available under a particular Program. In the event of any conflict between the foregoing documents, the most recently published document provided to participants will control, unless expressly provided otherwise in that document. In the event of any conflict between the Program documents and the terms of the Plan (and the applicable Supplement to the Plan), the Program documents will control to the extent that the terms of the Program documents do not conflict with ERISA, the Internal Revenue Code, or other applicable law.

ENROLLMENT AND ELECTION OF BENEFITS

What do I have to do to enroll in the pre-tax and after-tax Programs offered under the Plan?

The Company may automatically enroll you in certain Programs that require no employee contributions. For all other pre-tax and after-tax Programs in which you are eligible to enroll, you will receive an enrollment package when you are first hired, which will explain the steps you must take to enroll in the

Plan and any automatic enrollment rules that may apply. Failure to follow the enrollment instructions may result in waiver of benefits for you and/or your spouse and other dependents.

The Company also holds an annual open enrollment period, at which time you may enroll in one or more Programs or change your previous enrollment elections. The annual open enrollment package will include instructions and describe any automatic enrollment rules that may apply. Failure to follow the open enrollment instructions may result in waiver of benefits for you and/your spouse and other dependents.

In the case of the Flexible Spending Account (FSA) Programs for Health Care and Dependent Care, and Vacation Purchase, you must make a new election each year.

When do elections become effective?

If you are a non-collective bargaining unit employee and have submitted enrollment materials within 30 days following your hire date, your coverage under the Medical, Dental, Vision, Group Term Life, Health Care FSA and Dependent Care FSA Programs will begin on the first day of employment. For all other Programs, benefits will begin under the terms of those Programs.

If you are a collective bargaining unit employee, your participation will begin under the terms of your collective bargaining agreement.

Written elections made during open enrollment become effective January 1 of the following year. Written election changes made mid-year due to a change in circumstances, as described below, will result in a change in your payment deductions as of the pay period following the date you submit your written election and in accordance with the applicable Program, or as soon as administratively feasible thereafter. Changes in coverage will go into effect thereafter under the rules that apply to the particular Program, except that group health care coverage arising from birth, adoption or placement for adoption will be retroactive to the date of the event, and coverage arising as a result of marriage will be effective no later than the first day of the first month beginning after the enrollment request is received.

What happens if I experience a layoff?

If you experience a temporary layoff for a period of 30 days or less, you will continue your same benefit elections during the temporary layoff period under the same terms as a regular employee. Please check with your local Human Resources office to determine your options for contribution payments while you are on layoff. Your other benefits will be suspended during your layoff and will be reinstated upon your return to active employment.

If you experience a layoff that is expected to last longer than 30 days, your benefits will end according to each Program's termination rules as though you were terminated from employment.

What happens if I separate from employment (terminate)?

Active employees and their dependents covered under a medical plan will end their coverage at midnight on the date of the event that results in the loss of coverage, such as the last day at work. For active employees who retire per the Retiree Health & Life Plan, active health plan coverage ends the end of the month in which retirement occurs.

Employment end dates are transmitted to the appropriate health care vendors through the normal data feed process. The COBRA Administrator will send a package outlining your rights under COBRA and will transmit COBRA elections to the health care vendors.

Benefit contribution refunds will not be provided when coverage terminates mid-month. BorgWarner does not pro-rate at the front-end or back-end of employment for benefit deductions due to the Company paying a substantially larger cost to provide the benefits during the coverage periods than what the member contributes; and, the administration required to process a refund does not warrant the resources it would take to complete this task.

What happens if I terminate employment and I am rehired by the Company?

If you are rehired, you must meet the eligibility requirements of the Plan and each Program to re-enroll. If you meet the eligibility requirements and your rehire date is within 30 days of the date of your termination, your elections in effect on the date of your termination will be reinstated on the date you are rehired. If your rehire date is more than 30 days after the date of your termination of employment, you will be required to meet any waiting periods that apply to new employees and will need to submit a new election form within the deadline that applies to new employees.

What happens if I (or my dependent) declined coverage because of having other coverage?

If you or your eligible dependent declined coverage in writing under a Medical Program because you had other coverage, then you may enroll in that Program if: (1) the other coverage is terminated because of a loss of eligibility for coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in hours); (2) the other coverage is COBRA continuation coverage and that coverage expires; or (3) the employer contribution to the other plan is terminated. **You must notify your local Human Resources Office within 30 days of the occurrence of the event or you will not be permitted to make changes to your enrollment until the next open enrollment period.**

What happens if I have a new child or get married?

If you have a new spouse or child by marriage, birth, adoption, or placement for adoption, you may enroll the spouse or child in the Medical Programs in which you are eligible. If you are not already enrolled, you may enroll in order to enroll the spouse or child, if you are already enrolled, but other eligible dependents are not, you may also enroll them along with the new spouse or child. *You must notify your local Human Resources Office within 30 days of the occurrence of the birth, adoption, placement for adoption, or marriage. Otherwise you, your spouse, and/or your dependents will not be permitted to enroll until the next open enrollment period. Failure to enroll a dependent during open enrollment does not constitute a COBRA event.*

What happens if I become eligible for subsidized health plan premiums under Medicaid or a state children's health insurance program (SCHIP) or if I lose eligibility for Medicaid or SCHIP coverage?

If you or your dependent become eligible for a premium assistance subsidy for one of this Plan's Medical Programs through Medicaid or a state children's health insurance program (SCHIP), you may elect to enroll yourself or that dependent, if eligible, in the Medical Program. If you or your eligible dependent lose Medicaid or SCHIP coverage, you may add Medical Program coverage at the end of the Medicaid or state program period. *You must notify your local Human Resources Office within 60 days of the date you or*

your dependent become eligible for premium assistance or lose Medicaid or SCHIP coverage. Otherwise, you will not be permitted to enroll until the next open enrollment period.

Can I change my elections if I have a change in circumstances?

Normally, your election of pre-tax benefits offered through the cafeteria plan cannot be changed except at open enrollment. However, Federal law permits you to make new elections if certain circumstances change. *If you have a change of circumstances described below and would like to change your elections, you must notify your local Human Resources Office of the change within 30 days following the event or you will not be permitted to enroll until the next open enrollment period.* A copy of the Mid-Year Plan Election Changes is located at Midyear Benefit Enrollment Options.

Change in Status (Medical, Dental, Vision, Health Care FSA, Dependent Care, FSA): If you experience one of the changes in status events described, you may change or revoke your Program elections (Medical, Dental, Vision, Health Care FSA and Dependent Care FSA) and make new elections for the remainder of the year. The change must be on account of the change in status event and must be consistent with the change in status, which means they must be necessary or appropriate as a result of a change in status.

The following are change in status events if they cause a gain or loss of eligibility for coverage:

1. A change in your legal marital status, including marriage, divorce, legal separation, annulment, or death of your spouse;
2. An event affecting the number of dependents you have, including birth, death, adoption, or placement for adoption;
3. A change in employment status of you or your dependent, including termination or commence of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence, a change in work site, or a change in the employment status of you or your dependent (for example, hourly to salary, union to non-union, or full-time to part-time), which affects eligibility rights under the Plan or an underlying benefit Program;
4. An event that causes your dependent to satisfy or cease to satisfy the eligibility requirements for a particular Program, such as attaining a specified age or a change in the dependent's status as a student; or
5. A change in the residence of you or your dependent that affects eligibility for benefits.

   - Cost Changes to Certain Benefits (Medical, Dental, Vision, Dependent Care FSA): If the cost to participants of a Medical, dental, Vision, or Dependent Care FSA Program increases or decreases significantly during the year, the Plan Administrator may announce that eligible employees can make corresponding election changes. If this occurs, you will be notified with the details of the permitted changes. In addition, the Plan Administrator may increase or decrease Salary Reduction Contributions of all participants if the cost to participants increases or decreases during the year. You may not change your Dependent Care FSA election based on cost changes imposed by a dependent care provider who is your relative.
   - Coverage Changes to Certain Benefits (Medical, Dental, Vision, Dependent Care FSA): Changes to the Medical, Dental, Vision, and Dependent Care FSA Programs can result in permitted election changes as described below:

- Significant Reduction Without Loss of Coverage: If coverage under a Medical, Dental, Vision, or Dependent Care FSA Program is significantly reduced during the year, but the reduction does not result in a "loss of coverage" (see next bullet), you may revoke your elections that pertain to that Program, including Salary Reduction Contributions, and elect to receive, on a prospective basis, another benefit that provides similar coverage and is available under the Plan or Program.

- Significant Reduction With Loss of Coverage: If coverage under a Medical, Dental, Vision, and Dependent Care FSA Program is significantly reduced during the year and the reduction results in a "loss of coverage" as described below, you may revoke your election pertaining to that Program, including elections of Salary Reduction Contributions, and elect to receive, on a prospective basis, another benefit that provides similar coverage and is available under the Plan. If no similar coverage is available under the Plan, you may elect to drop coverage. A "loss of coverage" means a complete loss of coverage under the Program. However, the Plan Administrator may, in its discretion, determine that the following events constitute a loss of coverage:

- (a) a substantial decrease in the medical care providers available under the Program;

- (b) a reduction in benefits for a specific type of treatment a participant or dependent is currently receiving;

- (c) a reduction in benefits for a specific medical condition for which a participant or dependent is currently receiving treatment; or

- (d) any other similar fundamental loss of coverage.

- Addition or Improvement of Benefit Options: If a new Program is added under the Plan, or an existing Program is significantly improved, and you are eligible for that Program, you may change or revoke your benefit elections and make a corresponding change in the amount of your Salary Reduction Contributions to add coverage under the new or improved Program.

- Change in Coverage Under Another Employer Plan: If your coverage (or your dependent's coverage) changes under another employer plan, you may change or revoke your benefit elections under this Plan and make a corresponding change in the amount of your Salary Reduction Contributions, but only if: (a) the other employer plan permits participants to make an election change pursuant to Code Section 125 and applicable Treasury regulations; or (b) the other employer plan has a benefit period that differs from the Plan Year under this Plan (which is the calendar year).

- Loss of Other Group Health Coverage: If you or your dependent loses coverage under any group health plan sponsored by a governmental or educational institution, including a state children's health insurance program, a medical care program of an Indian tribal government, a state health benefits risk pool or a foreign government health plan, then you may change or revoke your benefit elections and make a corresponding change in the amount of your Salary Reduction Contributions to add coverage for yourself and/or your eligible dependent.

- Judgments, Decrees or Orders (Medical, Dental, Vision, and Health Care FSA): You may change or revoke your Medical, Dental, Vision, or Health Care FSA Program elections and make a corresponding change in the amount of your Salary Reduction Contributions for the

remainder of the year if the change or revocation is on account of a judgment, decree or order (including, but not limited to, a qualified medical child support order) resulting from a divorce, legal separation, annulment or change in legal custody of a dependent that requires accident or health coverage for a dependent child. In these cases, you may change your elections to: (i) add coverage for a dependent child if the judgment, decree, or order requires the eligible employee to provide coverage for the dependent (and you may add coverage for yourself if not enrolled and if required by the Program as a condition of enrolling a dependent); or (ii) drop coverage for a dependent child if the judgment, decree, or order requires your current or former spouse (or other individual) to provide coverage for the dependent and that coverage is, in fact, provided.

- Entitlement to Medicare or Medicaid (Medical and Health Care FSA Programs): If you or your dependent become entitled to Medicare (Part A or B) or Medicaid, you may make an election to drop or reduce coverage under the Medical or Health Care FSA Programs and make a corresponding change in the amount of your Salary Reduction Contributions for the remainder of the Plan Year for the individual who became entitled to Medicare. In addition, if you or your dependent loses entitlement to Medicare, you may make a corresponding election change to add or increase coverage under the Medical or Health Care FSA Programs for the individual who lost entitlement to Medicare or Medicaid.

- Family and Medical Leave Act (Medical, Dental, Vision, Health Care FSA and Dependent Care FSA Programs): If you take leave under the Family and Medical Leave Act of 1993, at the onset of your leave you may revoke your existing election for Medical, Dental, Vision and Health Care FSA benefits and upon your return make another election for the remainder of the Plan Year to the extent required under the Family and Medical Leave Act of 1993. If your need for dependent care changes as a result of your leave, you may also make a change to your dependent care FSA election at the beginning of your leave and upon your return.

- Change on Account of a Reduction in Hours: You may revoke an election for accident or health coverage during the Plan Year if: (i) you have been employed in an employment status where you were reasonably expected to average at least 30 hours per week and your status changed so that you will reasonably be expected to work fewer than 30 hours per week (regardless of whether this change in employment status results in an ineligibility for coverage) and (ii) you intend to enroll in another plan providing minimum essential coverage (as defined under the ACA) effective no later than the first day of the second month following the month the coverage is revoked.

- Change on Account of Enrollment in a Qualified Health Plan (QHP): You may revoke an election for accident or health coverage during the Plan Year if: (i) you are eligible for special enrollment or open enrollment for QHPs available through the Healthcare Marketplace, and (ii) the revocation relates to your intended enrollment (and other covered dependents) into a QHP through the Healthcare Marketplace for new coverage that is effective no later than the last day of the Plan coverage.

What happens if I am absent due to military service?

If you will be absent due to "uniformed service," as that term is defined by the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), you should contact your local Human Resources Office to discuss how this will impact your benefits under each Program. If you qualify, you may elect to continue participation in the Plan up to 24 months (or until you fail to apply for reinstatement or return to employment with the Company within the required timeframes). You are responsible for making the required employee contributions during the period in which you are in "uniformed service." HRLink can explain how to make contributions while you are away.

How do I make contributions if I am on a leave of absence, FMLA leave or on temporary short-term layoff?

If you are on a leave of absence during which you continue to be paid through the Company's payroll, the Company will deduct your monthly contributions just as it does when you are actively at work.

If you take an unpaid leave of absence (for example, under the Family and Medical Leave Act of 1993) and elect to continue participation under the Plan, or if your benefits are continued while you are on a temporary layoff of 30 days or less or on a leave during which you receive salary continuation benefits through insurance or other third-party arrangements (for example, short term disability benefits), you are responsible for making your required contributions toward the cost of any Programs in which you participate. There are three potential ways in which you can make payments:

Catch-Up Option (Default): If you are not receiving compensation from the Company during your leave, the Company suspends your contributions, accumulates what you must pay toward your benefits, and upon return the balance is deducted from your first paycheck on a pre-tax basis (and your second check, if necessary) as a deduction in arrears.

Prepayment Option: You may prepay the contributions that will be due during the leave or temporary layoff period. Prepayments may be made from salary, vacation pay or sick pay, to the extent permitted by applicable law, and may be pre-tax.

Pay-As-You-Go Option: If you are receiving compensation during your leave, you may pay your contributions due during the leave or temporary layoff period based on the same schedule as payments would have been due if you had not been on Leave or temporary layoff – i.e., on a payroll-period basis (or on any other schedule permitted by the Plan Sponsor). Contributions may be paid pre-tax if you receive compensation during your leave.

You must check with HRLink to determine which pay options will be available to you.

HEALTH CARE FLEXIBLE SPENDING ACCOUNT (FSA) PROGRAM

What is a Health Care FSA?

A Health Care FSA is a type of flexible spending account to which you contribute amounts deducted from your pay on a pre-tax basis throughout the "contribution period." The account can then be used throughout the "coverage period" to reimburse "eligible health care expenses" *(defined below)*.

Who is an eligible dependent under my Health Care FSA?

See the section entitled BENEFITS AND ELIGIBILITY.

What is the contribution period for my Health Care FSA?

The contribution period is the calendar year. Your contributions are deducted from your pay in equal amounts each payroll period.

How much can I contribute to my Health Care FSA?

The maximum amount you may contribute for the year is $2,750 (for 2020, or such amount as communicated by the Company each year during annual open enrollment) and the minimum amount is $100. Your reimbursements for the coverage period are limited to the amount you elect. Spouses who are both employed by BorgWarner may each contribute within the minimum or maximum separately.

The Company, at its sole discretion, may adjust the maximum contribution amount for inflation when permitted under the Internal Revenue Code. Each year, the Company will notify you of the adjusted contribution limit in your open enrollment materials.

What is the coverage period for my Health Care FSA?

The coverage period is the period commencing on January 1 and ending on December 31. However, when you first join the Plan, your first coverage period starts on the date you first become a participant in the Health Care FSA and ends on December 31.

What is the latest date that I can submit a claim (claim submission period)?

Although each coverage period ends on December 31, you have until March 31 of the following year to submit claims incurred during the coverage period. Any claims incurred after that date would be applied against the next coverage period (assuming you elected to participate in the Health Care FSA for that year).

What is an eligible health care expense?

Eligible health care expenses are those medical care expenses that you incur, for yourself or your dependents, after you have commenced participation in the Health Care FSA and during the coverage period. To qualify, the expense must constitute "medical care" as defined in Section 213(d) of the Internal Revenue Code and be approved by the Plan Administrator or its designee in accordance with Internal Revenue Service regulations and rulings. An expense is "incurred" when you or your dependent is furnished the medical care or services giving rise to the claimed expense.

Not all health expenses qualify for reimbursement. For example, eligible health care expenses do not include the payment of premiums under a health insurance not sponsored by the Company or any expenses reimbursed or reimbursable under any other health care coverage. Contact HRLink for examples.

What happens if I don't use all the amounts in my account during the coverage period?

The law requires that you use all the money in your Health Care FSA by the end of the Plan Year, subject to the following exceptions:

Carryover Feature: Up to $500 of the unused balance existing in your Health Care FSA as of last day of the Plan Year (i.e. December 31st) may be carried over to reimburse you for eligible medical care expenses that are incurred during the subsequent Plan Year. Unused dollars in your account in excess of $500 may not be carried over to the next year and will be forfeited. Notwithstanding this carryover feature, any unused account balance existing as of the date your participation in the Health Care FSA ends will be terminated.

Examples:

Scenario 1: You elect to make $2,750 in pre-tax contributions for the 2020 Plan Year and you have a $800 unused balance existing in your Health Care FSA as of December 31, 2019.

> With respect to the $800 unused balance existing on 12/31/2019, the Plan Administrator will carry over $500 to your Health Care FSA for your use during the 2019 Plan Year. In other words, you will have a total of $3,250 ($2,750 election + $500 rollover) available to reimburse you for eligible health care expenses incurred during the entire 2020 Plan Year. The Plan Administrator will forfeit the remaining $300 from the unused balance existing in your 2019 Health Care FSA, the forfeiture will occur on March 31, 2020.

Scenario 2: You elected to make $2,750 in pre-tax contributions for the 2019 Plan Year of which you have a remaining balance of $600 as of December 31, 2019. You elect to make no pre-tax contributions for the 2020 Plan Year.

> With respect to the $600 unused balance existing on 12/31/2019, the Plan Administrator will carry over $500 to your Health Care FSA for your use during the 2020 Plan Year. The Plan Administrator will forfeit the remaining $100 from the unused balance existing in your 2019 Health Care FSA, the forfeiture will occur on March 31, 2020.

What is the ordering rule of reimbursement?

You cannot receive payment for the same Eligible Medical Expense under both the Health Care Flexible Spending Account Program and the Health Reimbursement Arrangement in Schedule 2. Because reimbursement under the Health Care Flexible Spending Account Program is available only after reimbursements equal to the amount of contributions your HRA Account have been paid, you will receive payment for an Eligible Medical Expense from your HRA Account first, then seek payment of any unreimbursed Eligible Medical Expense under the Health Care Flexible Spending Account Program.

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA) PROGRAM

What is a Dependent Care FSA?

A Dependent Care FSA is a type of flexible spending account to which you contribute amounts deducted from your pay on a pre-tax basis throughout the "contribution period." The account can then be used throughout the "coverage period" to reimburse "eligible dependent care expenses" *(defined below)*.

Who is an eligible dependent under my Dependent Care FSA?

See the section entitled BENEFITS AND ELIGIBILITY.

What is the contribution period for my Dependent Care FSA?

The contribution period is the calendar year. Your contributions are deducted from your pay in equal amounts each payroll period.

How much can I contribute to my Dependent Care FSA?

The maximum amount you may contribute for the year is $5,000 ($2,500 if you are married and file separate tax returns). If you are a highly compensated employee, then the maximum amount you may contribute for the year varies if the plan is in violation of annual IRC testing. The amount will be communicated to you by HRLink. In general, you are a "highly compensated employee" for a year if your compensation in the prior year exceeds the amount specified by the IRS. For 2020, that amount is $125,000. This amount is indexed periodically. The minimum amount you may contribute is $100. Your reimbursements for the coverage period are limited to the amount you elect to contribute. However, your reimbursements for the coverage period cannot exceed the lower of the following:

- Your earned income for the year; or
- Your spouse's earned income (if your spouse is a student or incapable of caring for himself or herself, then he or she is considered to have "deemed earned income" of $250 per month, or $500 per month if you have two or more dependents eligible under the Dependent Care FSA Program).

In addition, if you or your spouse receives dependent care assistance benefits from any other employer during the year, the maximum amount for which you are eligible under the Dependent Care FSA will be reduced by that amount.

What is the coverage period for my Dependent Care FSA?

The coverage period is the one-year period that begins on January 1 and ends on December 31. However, when you first join the Plan, your first coverage period starts on the date you first become a participant and ends on December 31 of that year.

What is the latest date that I can submit a claim?

Although each coverage period ends on December 31, you have until March 31 of the following year to submit claims incurred during the coverage period.

What is an eligible dependent care expense?

Eligible dependent care expenses include expenses for the care of a qualifying dependent and household services performed in connection with that care provided their primary function is to assure the well-being and protection of your qualifying dependent and they are incurred to enable you and your spouse, if you are married, to be gainfully employed or to actively seek employment. Eligible dependent care expenses include:

- Fees for nursery schools, day care (including day camps) or other dependent care centers. If the school or center serves more than six children, it must comply with applicable state and local licensing laws;
- Fees for before-and after-school care programs;

- Fees for care centers that provide day care – not overnight care – for dependent adults (if the dependent adult spends at least eight hours a day in your household);
- Expenses for services of individuals who provide care for your dependent child or dependent adult in or outside of your home (but not including care services provided by (i) your own child who is under age 19, (ii) an individual you or your spouse can claim as a tax dependent , (iii) your spouse, or (iv) a parent of your qualifying dependent);
- Expenses for household services provided in connection with the care of a qualifying dependent in your home;
- Expenses for transportation to or from a caregiver if the transportation is provided by the caregiver;
- The cost of providing room and board to a caregiver; and
- Related expenses that are not directly for the care of an eligible dependent, such as application fees, agency fees and deposits required to obtain care.

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If a portion of an expense is for household services or for the care of a qualifying dependent and a portion is for another purpose, a reasonable allocation must be made and, unless the portion of expense for the other purpose is minimal or insignificant, only the portion attributable to household services or care is considered a qualified expense.

If you are temporarily absent from work for a period not exceeding two consecutive weeks, dependent care expenses incurred during your absence will be considered eligible dependent care expenses provided your agreement with your caregiver requires payment during the absence.

If you (or your spouse) work part-time, dependent care expenses incurred on a day you (or your spouse) are not scheduled to work will be considered eligible dependent care expenses provided your agreement with your caregiver requires payment for a period that includes both working and nonworking days.

What Dependent Care Expenses Cannot Be Reimbursed?

There are some dependent care expenses that cannot be reimbursed under this Plan. These include:

- Expenses for an overnight camp;
- Household services that are not related to the care of a dependent;
- Educational expenses (e.g., private school tuition from kindergarten up, summer school, or tutoring programs);
- Forfeited application or agency fees and deposits if care is not provided;
- Food, lodging or clothing; and
- Any expense incurred before the effective date of this Dependent Care Program or while you were not participating in the Dependent Care Program.

Is there a limit to how much I can be reimbursed from my Dependent Care FSA?

The amount available for reimbursement is limited to the balance in your Dependent Care FSA at the time of the claim.

What happens if I don't use all the amounts in my account during the coverage period?

Amounts contributed to your account must be used for eligible expenses that you incur during the same calendar year in which you contributed the funds. Any unused amounts will be forfeited in accordance with Federal law.

What happens if my participation in the Department Care FSA Program ends before the end of the calendar year?

When your employment with BorgWarner ends, whether through retirement or termination, or if you otherwise are no longer eligible to participate in the Plan, your participation in the Dependent Care FSA Program will also end. However, you may use any amounts credited to your account as of the date your participation ends for reimbursement of eligible expenses you incur through the end of the calendar year and during the Grace Period, if applicable.

Claims may be submitted for your Dependent Care FSA until March 31 of the calendar year following the year in which the expense was incurred. To the extent you do not request reimbursement of such expenses, you will forfeit your remaining account balance.

How do all these concepts work together?

At open enrollment in the Fall of 2019, you elect to participate in the Dependent Care FSA Program for 2020. You elect $1,200. Assuming you are scheduled to have 24 payroll periods, $50 of each paycheck would be contributed on a pre-tax basis to your Dependent Care FSA. Throughout the year, you would submit claims for those dependent care services that your qualifying dependent has received. You would be reimbursed for the expense, up to the amount that is in your Dependent Care FSA account at the time of your claim.

You would have until March 31, 2020, to submit claims for the eligible services your dependent received through March 15, 2020 (the end of the Grace Period). If there is any balance remaining in your 2019 account after March 15, 2020, that amount would be forfeited.

If you were to leave BorgWarner mid-year in 2020, you would no longer be able to contribute to the Dependent Care FSA, but you would have until the end of the calendar year to use up any remaining balance in your account. You would have until March 31, 2021, to submit claims for the eligible services that your dependent received through March 15, 2021 (the end of the Grace Period). Any balance remaining after March 15, 2021 would be forfeited.

COBRA CONTINUATION COVERAGE FOR HEALTH CARE BENEFITS

This section describes the continuation coverage requirements that apply to the Programs offered under this Plan.

What is COBRA continuation coverage?

A Federal law, called the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), requires that group health plans allow participants and eligible dependents to continue coverage for a limited time

after the occurrence of certain events that cause a loss of coverage. Under certain circumstances, the Company may partially or fully subsidize COBRA premium payments; however, it is the individual's responsibility to elect COBRA to remain enrolled in certain BorgWarner benefit programs.

Plan administrators are required by law to provide general COBRA notification for each employee and his/her spouse once he/she enrolls in health plan coverage. BOS, the BorgWarner COBRA administrator, will mail a COBRA Initial Enrollment Rights to all new hires as required by law.

Which Programs are subject to COBRA?

COBRA applies to the Medical, Dental, Vision, and Health Care FSA Programs offered under this Plan (but see below for special rules applicable to Health Care FSA Programs). COBRA is not a separate coverage policy; it is a right to obtain the same coverage as active employees and their dependents.

Who is eligible to elect continuation coverage? (Qualified Beneficiaries/Qualifying Events)

Three groups of people are eligible for COBRA coverage: (1) employees, (2) former employees and (3) former employees' spouses and dependent children. To be eligible, such individual must have been covered under one of BorgWarner's health plans as of the day prior to the qualifying event.

To be eligible for COBRA, a qualifying event must have occurred. A qualifying event is broadly defined as an occurrence resulting in the loss of health coverage under the Company health plan. COBRA is triggered when one of the following qualifying events occurs: (1) employee's termination of job (for any reason other than gross misconduct); (2) employee's reduction in hours ; (3) employee's entitlement to Medicare; (4) divorce or legal separation from the spouse; (5) death of employee; (6) loss of dependent child status; and (7) with respect to retiree coverage, an employer's commencement of a bankruptcy proceeding under Title 11 of the US Code.

If you or your dependents are enrolled in a covered Program (i.e., Medical, Dental, Vision, or Health Care FSA) and experience a "Qualifying Event" (defined below) that will cause a loss of coverage, then you are considered a "Qualified Beneficiary" entitled to elect continuation coverage.

A "loss of coverage" means that you have ceased to be eligible to participate under the same terms and conditions as in effect immediately before the Qualifying Event. A loss of coverage need not occur immediately after the Qualifying Event, so long as the loss of coverage will occur before the end of the maximum continuation coverage period.

"Qualifying Events": The following are "Qualifying Events" under the employee health care Programs:

For an employee:

- Reduction in work hours less than 30 hours weekly; or
- Termination of employment, including retirement (but excluding termination for gross misconduct).

For a spouse:

- death of the employee;

- reduction in the employee's work hours;
- termination of the employee's employment (the filing of a petition for a divorce or legal separation is not sufficient, there must be a final court order); or
- the employee's becoming entitled to Medicare.

For a dependent child:

  - his or her ceasing to qualify as a dependent under the Plan;
  - death of the employee;
  - reduction in the employee's work hours;
  - termination of the employee's employment, including retirement (but excluding termination for gross misconduct);
  - the spouse's divorce or legal separation from the employee (the filing of a petition for a divorce or legal separation is not enough, there must be a final court order), or
  - the employee's becoming entitled to Medicare.

What happens if a Qualifying Event occurs?

If a Qualifying Event is a Participant's death, termination of employment relationship (for reasons other than the Participant's gross misconduct), reduction in hours of employment, entitlement to Medicare, or the bankruptcy of the Company, the Company will notify the Plan Administrator of that Qualifying Event within 30 days after the date of the Qualifying Event.

If the Qualifying Event is your divorce or legal separation or a dependent child ceasing to be an eligible dependent, you (or the affected Qualified Beneficiary) must notify the Plan Administrator of that Qualifying Event within 60 days after the later of the date of the Qualifying Event or the date coverage under the Program would be lost.

> Plan Administrator's Fourteen (14) Day Notification Requirement upon Notification of a Qualifying Event: Within 14 days after the Plan Administrator receives notification of a Qualifying Event, the Plan Administrator will notify each Qualified Beneficiary of the individual's right to elect Continuation Coverage. If you do not live with your spouse at the time of the notice, notification to your spouse who is a Qualified Beneficiary is treated as notification to the spouse and all Qualified Beneficiaries who reside with the spouse.

How do Qualified Beneficiaries elect continuation coverage?

Qualified Beneficiaries must make their elections no later than 60 days following the later of the date coverage ends or the date that they are sent the notice of right to elect Continuation Coverage. The elections must be submitted on an Election Form provided by the Plan's COBRA Administrator, which will include the address where the form must be submitted.

Unless the election specifies otherwise, a participant's election of Continuation Coverage is deemed to include an election of Continuation Coverage on behalf of that participant's Qualified Beneficiaries who would lose coverage under the Plan because of the Qualifying Event. In addition, unless the election specifies otherwise, an election of Continuation Coverage by a Qualified Beneficiary who is a participant's

spouse is deemed to include an election of Continuation Coverage on behalf of the spouse and the participant's other Qualified Beneficiaries who would lose coverage under the Plan because of the Qualifying Event. If a choice among types of coverage under the Plan is available, each Qualified Beneficiary is entitled to make a separate selection among the types of coverage.

An individual's election of Continuation Coverage is deemed to be made on the date the individual's election is sent to the address listed on the Election Form. If a participant or other Qualified Beneficiary waives Continuation Coverage during the election period, that waiver may be revoked at any time before the end of the election period. If any waiver is revoked before the end of the election period, however, Continuation Coverage under the Plan is effective prospectively only, from the date the waiver is revoked.

During the annual open enrollment period, Qualified Beneficiaries must be given the option to switch health plan options to any options available to other similarly situated individuals. Open Enrollment materials will be mailed to you from the COBRA Administrator. COBRA participants also have the right to add or remove dependents as other coverage is obtained or a qualifying event occurs including a birth, adoption, or marriage. COBRA participants have 31 days to report a birth, adoption or marriage.

If you are retiring from BorgWarner and eligible for the Retiree Health & Life Plan, you will be given a choice between COBRA coverage under the employee health care program and health benefits under the Retiree Health & Life Plan. You may elect COBRA continuation coverage or Retiree Health & Life Plan health benefits, but not both. If you elect health benefits under the Retiree Health & Life Plan, you will be declining COBRA continuation of medical coverage under the employee health care Program. Any Qualified Beneficiary who elects COBRA continuation coverage under the employee health plan will not be eligible for health benefits under the Retiree Health & Life Plan when COBRA continuation coverage ends.

How long does COBRA continuation coverage last?

Qualifying Event	Impacts	Coverage Period
• Employee's termination (e.g.) quit, fired, retired, or failed to return from leave) • Employee's reduction in hours	• Employee • Spouse • Dependent Child	• 18 months • May be extended to 29 months if disabled *(see below)*
• Divorce or Legal Separation • Death of Employee • Employee entitled to Medicare benefits	• Spouse • Dependent Child	• 36 months
• Loss of Dependent Child Status	• Dependent Child	• 36 months

The periods described above commence on the day following the Qualifying Event for non-collectively bargained locations. For collectively bargained locations, the periods described above commence on the first day of the month following the Qualifying Event.

The extension to 29 months described in the chart is available if a Qualified Beneficiary is determined before the 61st day of Continuation Coverage to be eligible for Social Security disability benefits under Title II or XVI of the Social Security Act. You must notify the Plan Administrator of the disability determination within 60 days of the determination (or, if later, within 60 days from the date of the qualifying event or the date coverage would be lost on account of the qualifying event) but before the end of the initial 18-month period.

If a Qualified Beneficiary is entitled to and elects Continuation Coverage that has a maximum period of 18 months or 29 months, and during that period experiences one or more Qualifying Events (not including the bankruptcy of the Company) which would entitle him or her to a maximum period of Continuation Coverage of 36 months, then the Continuation Coverage period is extended to 36 months from the date coverage was lost.

When the qualifying event is a termination of employment or reduction of hours, and this event occurs within 18 months after the date the employee becomes eligible for Medicare, coverage for Qualified Beneficiaries (other than the Medicare-eligible covered employee) will extend to the date 36 months from the date the employee became eligible for Medicare. Note, the Medicare-eligible employee's COBRA ends as of this date.

Can continuation coverage terminate sooner than the maximum period?

Certain events may cause the period of Continuation Coverage to terminate earlier than the end of the applicable 18-month, 29-month, or 36-month period. Except as otherwise specified, a Qualified Beneficiary's Continuation Coverage will terminate immediately upon the occurrence of any of the following events:

- The individual becomes covered under any other group health plan (as an employee or otherwise).
- The individual becomes entitled to Medicare under Title XVI of the Social Security Act.
- *Attention Medicare-age members:* If you are enrolled in or are eligible for Medicare but not enrolled and are no longer employed, your claims will be processed first through Medicare as the primary payor, then Cigna, even if you aren't enrolled in Medicare. That means you may be responsible for higher balances not covered by Cigna as the secondary insurer.
- COBRA coverage will pay as the secondary plan to Medicare A and B regardless of whether you are enrolled in Medicare A and B and regardless of whether you seek care at a Medicare provider for Medicare covered services.
- The individual fails to pay the required premium in a timely manner. If the premium payment is the first payment and if the election of Continuation Coverage occurs after the Qualifying Event, the premium payment may be made within 45 days after the election. A payment of any premium, other than the first premium, is timely if made within 30 days after the premium due date specified by the Plan Administrator. If payment is not received within this 30-day grace period, coverage will be terminated retroactive to the premium due date.
- For COBRA payments that are short by an "insignificant amount" (i.e., the lesser of 10% or $50) BorgWarner must accept the short payment as payment in full or notify the COBRA

participant of the deficiency and allow the COBRA participant another 30)days from the date that the COBRA participant received notification to correct the deficiency.

- The Company no longer sponsors or maintains any group health Plan (including successor Plans) for any of its employees.
- A final determination is made that the individual is no longer entitled to Social Security disability benefits (i.e., is no longer disabled under Title II or XVI of the Social Security Act), in the case of an individual who was previously determined to have been disabled at the time of the Qualifying Event and who has been receiving Continuation Coverage for 18 months or more. Such an individual's Continuation Coverage will end as of the first day of the month that begins more than 30 days after the date the final determination is made. The individual must notify the Plan Administrator within 30 days following the determination that he or she is longer disabled.

What is the required premium for continuation coverage and how it is paid?

The monthly premium for Continuation Coverage can be no more than the full cost to the Company for active participants plus a 2% administrative fee. However, if you are disabled (see above) and have extended the Continuation Coverage period beyond the initial 18 months based on disability, the monthly premium for Continuation Coverage can be no more than the full cost to the Company for active participants plus a 50% administrative fee. The election form will indicate the amount you are required to pay.

Are the rules different for Health Care FSAs?

Generally, COBRA continuation coverage must be offered with respect to a Health Care FSA. However, continuation coverage is not available under the Health Care FSA if the total amount you could be required to pay for continuation coverage for the remainder of the year in which the Qualifying Evert occurs exceeds the total amount of reimbursement that you are eligible to receive under the Health Care FSA for the remainder of the corresponding coverage period.

Unlike other Programs, the maximum period of continuation coverage for the Health Care FSA is until the last day of the calendar year in which the Qualifying Event occurs. This maximum period is not subject to extension for disability or for multiple Qualifying Events.

The monthly premium for Continuation Coverage under a Health Care FSA cannot exceed 102% of the monthly amount that you elected to contribute to your Health Care FSA.

What is my duty to notify of any changes in address?

In order to ensure that we can communicate with you and your family about your COBRA rights, you and your participating family members must notify your local Human Resources Office in writing of any changes in address. If you are already on COBRA coverage, then you and your participating family members must notify the Plan Administrator in writing of any changes.

What is my duty to notify of any qualifying events?

When the initial qualifying event is the end of employment or reduction of hours of employment, or death of the employee, the Company will provide the Plan Administrator with notice of the right to continued coverage. However, if the initial qualifying event is legal separation, divorce, or your child's loss of dependent status, then it is your and your covered dependents' responsibility to notify the local Human

Resources Office. To be eligible for Plan coverage, you and your covered dependents must notify the local Human Resources Office within 60 days after legal separation, divorce or your child's loss of dependent status or, if later, within 60 days after coverage is lost because of such an event. If you fail to notify the local Human Resources Office within this 60-day period, COBRA coverage will not be available. You must contact the local Human Resources Office and complete whatever forms the local Human Resources Office may require on a timely basis.

If your dependents are already receiving COBRA coverage because of an 18-month qualifying event, a second qualifying event may entitle your dependents to extend COBRA coverage, but only if the event would have caused your spouse and/or dependents to lose coverage under the group health plan had the first qualifying event not occurred. If a second qualifying event takes place within the 18-month COBRA continuation period, it will be your and your dependents' responsibility to notify the Plan Administrator of the second event within 60 days. If you or your dependents fail to notify the Plan Administrator within this 60-day period, the extended coverage will not be available.

If you or a COBRA-eligible dependent are disabled before the 61st day of COBRA coverage, to trigger the 11-month disability extension you must notify the Plan Administrator of a disability determination in writing, together with a copy of the Social Security determination, before the end of the first 18 months of COBRA coverage. Also, if the Social Security Administration determines that the disability has ended before the end of COBRA extension coverage, you must notify the Plan Administrator in writing of that fact within 30 days.

Who may give notice?

For purposes of meeting these notice requirements, you, your COBRA-eligible dependents, or a representative acting on behalf of you or your COBRA-eligible dependents may provide the notice and notice by one individual will satisfy the notice requirements for all individuals with respect to a particular qualifying event.

Do I need to keep copies of any notices?

You should keep a copy for your records of any notices you send to this local Human Resources Office or to the Plan Administrator, along with evidence of when you mailed the notice. If there is a dispute as to whether you provided timely notice, you will be required to produce documentation of your notice and when you provided it.

What if I purchase Marketplace coverage?

Qualified Beneficiaries may be eligible to purchase an individual health insurance policy through the Health Insurance Marketplace, which coverage may cost less than COBRA coverage under this Plan. Qualified Beneficiaries can learn more about the Marketplace coverage as an alternative to COBRA coverage under this Plan by reviewing the Plan's COBRA Notice and visiting www.healthcare.gov.

CLAIMS AND REVIEW PROCEDURES – MEDICAL, DENTAL, VISION, AND HEALTH CARE FSA PROGRAMS

This section describes how claims are generally handled under the health care Programs – which currently include the Medical, Dental, Vision, and Health Care FSA Programs.

How do I File a Claim for Medical, Dental or Vision Benefits?

When you enroll for coverage, you will receive an Identification card from the claims administrator. In most cases, when you Incur a covered expense, you will show this card to the provider. Because physicians and hospitals often provide information directly to the claims administrator, claim forms usually are not necessary.

However, if you pay a bill for a covered expense yourself, you must send the original bill and a paid receipt and/or copy of your cancelled check to the claims administrator, along with such other information as the claims administrator may require. If the bill is for your covered dependent that has other primary medical coverage, send a copy of the coverage's Explanation of Benefits (proof of payment or denial). Please refer to the Program documents for your medical, dental and vision Programs for the address of the claims administrator, the procedures to follow, and the applicable deadlines. Be sure to keep a copy of your original bill and paid receipt for your records.

If you have paid the bill yourself and you do not forward a receipt or a copy of a cancelled check to the claims administrator, the Plan will assume that you did not pay the bill and will pay the claim, on your behalf, directly to the provider. Therefore, if you wish to be reimbursed by the Plan for expenses which you have already paid, make sure you forward a paid receipt or a copy of a cancelled check.

How Do I File a Claim for Health Care FSA Reimbursements?

If you or your eligible spouse or dependents have incurred an eligible medical expense that is not paid by the medical, dental, or vision Programs (for example because you have not met your deductible for the year), you may submit the original bill and a paid receipt and/or a copy of your cancelled check to the claims administrator, along with the necessary reimbursement request form. Please refer to the Program documents for the Health Care FSA Program for the address of the claims administrator, the procedures to follow, and the applicable deadlines. Be sure to keep a copy of your original bill and paid receipt for your records.

How Quickly Will Claims Be Processed?

Generally, your claim will be paid or denied within 30 days of receipt unless the claims administrator is unable to decide within that time for reasons beyond its control. The claims administrator must notify you before 30 days have expired that an extension (not to exceed 15 days) is required.

If you are required to obtain pre-certification for medical care, your request will be decided within 15 days unless the claims administrator notifies you prior to that time than an extension (not to exceed 15 days) is required. If your request involves an urgent care situation, such that a delay could either seriously jeopardize your life or health, the ability to regain maximum function, or subject you to severe pain that could not be adequately managed without the requested care or treatment, the decision will be made as soon as possible, but in all cases within 24 hours. In an urgent care situation, your doctor or another health care professional with knowledge of your condition may act as your representative.

If paperwork you have submitted in incomplete, the claims administrator will inform you that it needs additional information within 30 days (within 5 days in the case of a pre-certification request, and within 25 hours if the pre-certification request involves an urgent care situation). IMPORTANT: If you do not submit the additional information, the claims administrator will decide the claim based on the incomplete information you have submitted.

What If I need to Extend a Pre-Certified Course of Treatment?

If you are undergoing a course of treatment that required pre-certification, and you are requesting an extension of that course of treatment, you must submit the extension request at least 24 hours before the approved course is scheduled to end. If your extension request is timely, the claims administrator will make a decision within 24 hours. Otherwise, the decisions will be made within 15 days (subject to a possible 15-day extension) or within 24 hours if it is an urgent care situation.

What if My Claim is Denied?

If your claim is denied in whole or in part, you will be notified in writing. The notice of denial will provide information to help you identify the claim, explain the reason for the denial, make specific references to the provisions of the Plan on which the decision is based, list any rules standards or guidelines used in making the decision, and describe any additional information needed to approve your claim. If the denial is based on medical necessary, experimental treatment, or similar exclusion or limit, the notification will either explain the scientific or clinical judgement underlying the denial or advise you that an explanation will be provided free of charge. The notice will also explain your right to appeal the decision, including a statement of your right to bring a civil action under ERISA Section 502(a).

If you were undergoing a course of treatment that required pre-certification, and the Plan reduces or terminates that course treatment (other than because the Plan has been amended or terminated), you will also receive an explanation of the change and of your right to appeal the decision. If your claim involves an urgent care situation, the notification will also explain the expedited review process available for such claims.

How Can I Appeal a Denied Claim?

First Level Review

Within 180 calendar days after you receive a notice of denial, you or your authorized representative may appeal the decision. You may review and receive at no cost a copy of the Plan document and any other documents relevant to your claim. If, after reviewing these documents, you think your claim is valid, you may request a review to the claims administrator for your health care Program. You should call the claims administrator (see Schedule 1) for information on where and how to submit the appeal. Your appeal must include the reasons why you disagree with the denial and any other information you feel is pertinent to the claim.

Upon receiving your appeal, the claims administrator will review your claim, notify you of any additional evident or rationale for denying the claim and provide you with an opportunity to submit evidence in support of your appeal. The claims administrator will notify you of its decision within 30 days either in writing or electronically (15 days in the case of a pre-certification request; or a request to extend a pre-certified course of treatment; 72 hours if the claim involves an urgent care situation).

The appeal will be assigned to a reviewer who did not make the initial determination and does not work for the person who did. The reviewer will not give any deference to the prior decision denying your claim, but will consider all comments, documents testimony, and other information, and evidence you have submitted, regardless of whether this information was considered when your claim was denied. If the denial is based in whole or in part on a medical judgement, the reviewer may consult with another health care professional who is trained and experienced in the field of medicine involved in the medical judgment and who was neither consulted in connection with the denial nor a subordinate of such an individual. If

the reviewer consults with another health care professional and your appeal is denied, the reviewer will provide you with information about the other health care professional whether the reviewer relied on the other health care professional's advice.

Right to a Second Review

If your claim denial is upheld at the first level of review, you may request a second level of review within 60 calendar days of the first decision. Again, you may review and receive at no cost documents relevant to your claim and may submit to the claims administrator testimony and evidence you would like considered.

The second level review will be conducted by one or more reviewers who were not involved in the prior decision denying your claim, nor will any reviewer be the subordinate of someone who previously denied your claim. A reviewer will not give any deference to the prior decisions denying your claim, but will take into account all comments, documents, affidavits, and other information you have submitted, regardless of whether the information was submitted or considered in the prior determinations.

As with first-level review, a health care professional will be consulted if necessary, and you will be given information about the health care professional if your claim is denied.

The claims administrator will notify you of its determination within 30 days of receiving your request for a second-level review.

Second-Level review for Pre-certification Requests

If you request a second-level review of a decision denying a pre-certification request (other than an urgent care situation), the appeal will follow the same procedures noted above, except that the reviewers will notify you of the results within 15 days of receiving your written request.

External Review

If your second-level review is denied, the notice will explain the reasons for the denial and the procedures to follow to seek an external appeal of the decision with an independent review organization. Generally, you will have the right to seek an external appeal unless your claim was denied, because you are not eligible to participate in the health coverage. You will have up to 4 months to file an external appeal. The independent review organization will evaluate your claim using procedures consistent with federal requirements, and its decision will be final.

Expedited Review of Urgent Care Pre-Certification Requests

Pre-certification requests of urgent care situations are handled on an expedited basis and have only one level of review. When you submit a pre-certification request in an urgent care situation, you will be notified of the decision within 24 hours of receipt (unless your submission was incomplete, in which case you will be notified within 24 hours and given 28 hours to submit the additional information needed to escalate your claim). The notice of denial (as described above) may be provided to you, in which case you will be sent a written electronic confirmation within 3 days of the oral notification.

If you decide to appeal the decision, you may make your request for an appeal to the claims administrator orally or in writing. The appeal will be handled by a reviewer using the same procedures noted above,

but on an expedited basis. You may submit information that you wish the reviewer to consider by telephone, facsimile, or other methods acceptable to the reviewer. The reviewer will notify you of the decision as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receiving your request for review.

You may also seek an expedited external review of your claim in an urgent care situation, in which case the independent review organization will notify you of its decision within 72 hours of receiving your appeal. If there is insufficient time for both an internal and external appeal, you may take your appeal directly to the independent review organization.

You Must Follow the Appeals Process

With limited exceptions, you will not be able to file a lawsuit for benefits under the Plan, unless you have exhausted the appeals process described above. You must file your lawsuit within one year from the date of the final notice denying your appeal.

CLAIMS AND REVIEW PROCEDURE – DISABILITY BENEFITS

This section describes how claims for disability benefits are generally handled (e.g., STD and LTD Programs). All disability claims will be processed in a manner designed to ensure independence and impartiality of the persons involved in making the decisions such as the claim adjudicators and medical/vocational experts (i.e., not based on the likelihood that the individual will support the denial of benefits). Please contact the claims administrator (see Schedule 1) or your local Human Resources office for more information).

How Do I file a Claim for Disability Benefits?

In order to receive Disability Benefits, you must file a claim. Please contact the claims administrator (see Schedule 1) for the applicable forms, mailing address and deadlines. Be sure to keep a record of your request.

How Quickly will Disability Claims be Processed?

You will receive written notice of whether your claim is approved within 45 days from the date the claims administrator receives your completed claim for disability benefits. If necessary, for reasons beyond the control of the claims administrator, the claims administrator may with prior notice extend the period for two additional 30 days periods. If the reason for an extension is that your paperwork is incomplete, you will have 45 days to respond, and the claims administrator will notify you of its decision within 30 days of receiving your response.

What if My Disability Claim is Denied?

If your request for benefits is denied, either in whole or in part, you will receive written notification, in a culturally and linguistically appropriate manner, of the specific reasons for the denial. The written denial will include: (1) the reasons for the denial, including references to the Plan provisions upon which the denial is based; (2) standards that govern the decision for denial; (3) a description of additional information needed and why such material/information that would permit payment of your claim; (4) a description of the review procedures and time limits (including a statement of your right to bring a civil action under Section 502(a) of the Act and a description of any contractual limitation period that applies to bringing an action including the date the period expires; (5) a discussion of the decision with an explanation for disagreeing with the (a) views of your health care, professional treating, or vocational

professionals evaluating you (b) the views of the medical or vocational experts or the determination of the medical or vocational professional whose advice was obtained (whether or not relied upon), and (c) any Social Security Administration disability determination; (6) an explanation that you can have access to or copies of relevant documents upon request and without charge; (7) a statement that you are entitled to receive, upon request, all documents relevant to the claim; and (8) a summary of any new or additional evidence considered, relied upon, or generated and/or any rationale applied by the Plan in making the decision.

The notice will also explain your right to appeal the decision, including a statement of your right to bring civil action under ERISA Section 502(a) if your claim is denied on appeal. If you choose a 502(a) remedy, the claim and appeal is deemed denied on review without exercise of discretion by an appropriate fiduciary.

How Can I Appeal a Denied of a Short- or Long-Term Disability Claim?

Within 180 calendar days after you receive a notice of denial, you or your authorized representative may appeal the decision. You may review and receive at no cost a copy of the Plan document and any other documents relevant to your claim. If, after reviewing these documents, you think your claim is valid, you may request a review to the claims administrator for your disability claim. You should call the claims administrator (see Schedule 1) for information on where and how to submit the appeal. Your appeal must be made in writing, must state that you are appealing a claim denial, and must include the reason you disagree with the denial and any other information you feel in pertinent to the claim.

> Upon receiving your appeal, the claims administrator will review your claim and notify you of its decision within 45 days. If the additional time is necessary to respond to your appeal because of matters beyond the claims administrator control, the claims administrator may extend the period for up to forty-five days, so long as it notifies you of the extension before the initial 45-day period expires. If the reason for the extension is that your paperwork is incomplete, you will have 45 days to respond, and the claims administrator will notify you of its decision within 45 days of receiving your response. You are guaranteed right to present evidence and testimony to support your claim during the appeal process. You will be given a fair opportunity to respond to new or additional evidence or rationales before they become a basis for denials and filing an appeal.

The appeal will be assigned to a reviewer who did not make the initial determination and does not work for the person who did. The reviewer will not give any deference to the prior decision denying your claim, but will consider all comments, documents, records and other information you have submitted, regardless of whether this information was considered when your claim was denied. If the denial is based in whole or in part on a medical judgement, the reviewer may consult with another health care professional who is trained and experienced in the field of medicine involved in the medical judgement and who was neither consulted in connection with the denial nor a subordinate of such an individual. If the reviewer consults with another health care professional and your appeal is denied, the reviewer will provide you with information about the health care professional whether the reviewer relied on the other health care professional's advice.

In the case of a denial on appeal, if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the decision, the claims administrator will notify you that such a rule, guideline,

protocol or other similar criterion was relied on, and that either (i) a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon written request or (ii) that such rules, guidelines, protocols, standards, or other similar criteria do not exist. In addition, if a denial is based on medical necessity or experimental treatment or a similar exclusion or limit, the claims administrator will provide either an explanation of the scientific or clinical judgment for the decision, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request. You may request free of charge, copies of all documents, records and other information relevant to your claim.

You Must Follow the Appeals Process

You will not be able to file a lawsuit for benefits under this Plan, unless you have exhausted the appeals process described above. If you disagree with the final decision on appeal and wish to file a lawsuit, you must do so within one year from the date of the final notice denying your appeal.

Are there special rules for disability determinations made under non-STD and non-LTD Programs?

In the case of any Program other than an STD or LTD Program that conditions eligibility for a benefit upon a finding that the Claimant is "disabled," under the Company's long-term disability Plan or by the Social Security Administration. The claim will be governed by the general claims procedures in the next section instead of these disability claims procedures.

GENERAL CLAIMS AND REVIEW PROCEDURES (DEPENDENT CARE FSA, LIFE/AD&D, CRITICAL ILLNESS, BUSINESS TRAVEL)

This section describes how the claims are generally handled that are not governed by the health and disability procedures described in the previous two sections. These procedures also apply to requests relating to eligibility to participate in a Program when eligibility is not associated with a specific request for benefits under the Program. Please contact the claims for your coverage (see Schedule 1) for more information.

How Do I File a Claim for Benefits?

In order to receive Benefits, you must file a claim with the claims administrator. Please contact the claims administrator (see Schedule 1) for the applicable forms, mailing address and deadlines. Be sure to keep a record of your request.

How Quickly Will Claims be Processed?

You will receive written notice of whether your claim is approved within 90 days from the date the claims administrator received your completed claim for benefits. If necessary because of special circumstances, the claims administrator may with prior notice extend the period for an additional 90 day period.

What If My Claim is Denied?

If your request for benefits is denied, either in whole or in part, you will reserve written notification of the specific reasons for the denial. The written denial will include: (1) the reasons for the denial, including references to the Plan provisions upon which the denial is based; (2) a description of additional information that would permit payment of your claim; and (3) an explanation of any claims review

procedures. The notice will also explain your right to appeal the decision, including a statement of your right to bring a civil action under ERISA Section 502(a) if your claim is denied on appeal.

How can I Appeal a Denied Claim?

Within 60 calendar days after you receive a notice of denial, you or your authorized representative may appeal the decision. You may review and receive at no cost a copy of the Plan document and any other documents relevant to your claim. If, after reviewing these documents, you think your claim is valid, you may request a review to the claims administrator for your Program. You should call the claims administrator (see Schedule 1) for information on where and how to submit the appeal. Your appeal must be made in writing, must state that you are appealing a claim denial, and must include the reasons you disagree with the denial and any other information you feel is pertinent to the claim.

Upon receiving your appeal, the claims administrator will review your claim and notify you of its decision within 90 days. If additional time is necessary to respond to your appeal, because of special circumstances, the claims administrator may extend the period for up to 90 days, so long as it notifies you of the extension before the initial 90-day period expires.

The appeal will be assigned to a reviewer who did not make the initial determination and does not work for the person who did. The reviewer will not give any deference to the prior decision denying your claim, but will take into account all comments, documents, records and other information you have submitted, regardless of whether this information was considered when your claim was denied. If the denial is based in whole or in part on a medical judgment, the reviewer may consult with another health care professional who is trained and experienced in the field of medicine involved in the medical judgement and who was neither consulted in connection with the denial nor a subordinate of such an individual. If the reviewer consults with another health care professional and your appeal is denied, the reviewer will provide you with information about the other health care professional whether or not the reviewer relied on the other health care professional's advice.

You will not be able to file a lawsuit or benefits under the Plan unless you have exhausted the appeals process described above. If you disagree with the final decision on appeal and wish to file a lawsuit, you must do so within one year from the date of the final notice denying your appeal.

GENERAL CLAIMS AND REVIEW PROCEDURES (TRANSITIONAL INCOME PLAN)

If you believe that you did not receive the correct benefits under the Plan or were eligible for Plan benefits not provided, you must file a written claim with the Plan Administrator setting forth the nature of the claim and the relief or correction sought. The Plan Administrator will respond to the claim within 90 days of its receipt (unless special circumstances require an extension).

If your claim is denied in whole or in part, you will receive a written notice from the Plan Administrator setting forth the specific reasons for the denial, specific reference to the provisions of the Plan on which the denial is based, a description of any additional material or information for the claim to be approved, and a description of the claims review procedure under the Plan.

You may have the denial reviewed again by the Plan Administrator and, in that review, you or your representative may examine all Plan documents and submit issues and comments in writing. If you want the Plan Administrator to review the denial, you must inform the Plan Administrator in writing within 60

days after you receive the Plan Administrator's notice of denial. The Plan Administrator will inform you in writing of the final decision and the specific reasons for that decision within 60 days of your request for review (unless special circumstances justify a delay).

You must exhaust these claims procedures in resolving every claim or dispute arising under the Plan, and you have one year only after the Plan Administrator's final decision to sue in court. After the one year expires, you will be time barred from bringing any claim or dispute in court.

Any claim or dispute relating to the Plan may only be brought in the United States District Court for the Eastern District of Michigan after you exhaust the claims procedures but before you are time barred. This court will have personal jurisdiction over you.

Claims – Additional Rules

Who is the claims administrator for each Program?

The term "claims administrator" generally refers to any insurer or other company that the Plan Administrator appoints to administrator a Program and may be different for each Program, in certain cases the Plan Administrator may act as claims administrator for purposes of claims or appeals.

Are there other general rules that apply to claims?

The following general rules apply to all claims:

1. All claims for benefits under any Program are subject to any review procedures established for the Program by the Plan Administrator or applicable claims administrator.

2. Unless claims are submitted by the provider, you must submit written proof of your claim to the Plan Administrator (or the claims administrator for that Program) within 12 months following the end of the Plan Year during which the expense is incurred (unless it is not reasonably possible to do so and you provide proof as soon as reasonably possible).

3. A claimant is entitled to designate in writing an authorized representative to act on his or her behalf in pursuing a claim under the Plan. The Plan Administrator or claims administrator may require that the designation be made on a specific form.

4. Before approving any claim under the Plan, the Plan Administrator or the claims administrator may request, and will be entitled to receive (to the extent lawful) from any health care providers, such information and records relating to attendance to, examination of, or treatment provided to a Claimant as may be required in the administration of such claims. The Plan Administrator or the claims administrator may also require that a Claimant be examined by a dentist or physician or other appropriate provider or consultant retained by the Plan Administrator or the claims administrator in or near the Claimant's community of residence. This may be done as often as the Plan Administrator or claims administrator may reasonably require. Payment of benefits is conditioned upon the Plan Administrator's right to require the examination of any participant or dependent whose loss is the basis for a claim and to perform an autopsy where not forbidden by law.

5. You may not file suit against the Plan with respect to any benefit claim or claim as to eligibility to participate in a Program until you have exhausted all administrative procedures outlined above and those established under any Program. In addition, you may not file suit at all after one year has passed from the time your final appeal is denied.

The Plan Administrator and claims administrator may act through one or more delegates.

What happens if a claim is overpaid?

The Plan Administrator has the power and authority to collect from you (or any other Claimant or service provider, including any claims administrator) the amount of any overpayment relating to a claim for benefits made under this Plan. An overpayment may be collected regardless of whether the overpayment results from a mistake on the part of a Claimant, an administrative error made by a service provider, or from a fraudulent act on the part of a Claimant or service provider.

The Plan Administrator may take any of the following steps (without limitation) in response to a verified overpayment of any claim for benefits under this Plan:

- Request repayment from you (or your dependent if applicable), service provider or other payee.
- Offset the amount of the overpayment against further approved claims to you and your enrolled dependents (or to your service provider or other payee);
- Pursue collection of the overpayment through legal procedures.

If you or your dependent fail to respond or comply with a request from the Plan Administrator for repayment, the Plan Administrator may, in its sole discretion, and upon proper notification and in compliance with applicable law, terminate eligibility to participate in the Plan.

What happens if I receive payment for an injury or illness from another source and from the Plan?

If you or your dependent suffer an illness or injury for which you obtain health care of other goods or services covered by the Plan and that illness or injury occurred through the negligence or willful act or omission of another person, benefits provided under this Plan with respect to that illness or injury will be considered advancements to the extent of any amounts paid to, or the benefit of, you or your dependent as a result of any settlement or judgement you or your dependent receive from that other person.

The Plan Administrator in its discretion may deny payment of benefits otherwise provided under this Plan with respect to that illness or injury, unless you or your dependent signs a repayment confirming the right of the Plan to receive repayment in full for any such benefit payments. If you or your dependent acquire any rights of recovery against another for negligence or a willful act or an omission resulting in an illness or injury for which benefits are provided under this Plan, the Plan will be “subrogated” to those rights, and will be entitled to reimbursement for payments under the Plan to the extent of any settlement or judgement. Basically, this means that since you are paid for your loss from a third party because of the third party, the Plan can recover that amount to cover the Plan’s portion of the benefits already paid. This also applies to payments received by the parents or legal guardians in the event the dependent is a minor or the heirs, administrators, or executors of the estate; when applicable.

By accepting benefits (either directly or indirectly) under this Plan, you and your dependents are considered to have assigned any rights of recovery to secure recovery, including to:

- Cooperate fully with the Plan Administrator in obtaining information about the loss and its cause;
- Notify the Plan Administrator of any claim for damages made, or lawsuit filed, on behalf of the Participant or dependent in connection with the loss;
- Include the amount of benefits paid by the Plan on behalf of you or your dependent in claims (or damages against other parties);
- Provide the Plan Administrator with first priority lien on the extent of the cash value of the services and supplies provided (which such lien may be filed with the person whose act caused the Injuries, such person's agent, or a court having jurisdiction in the matter);
- Hold in trust for the benefit of the Plan any proceeds of settlement or judgement that you, your agent, or any third party at your direction received when the Plan has a right of subrogation or recovery;
- Reimburse the Plan Administrator for any damages collected to the extent of the cash value of the services and supplies immediately upon collection of damages, whether by settlement, judgement or otherwise (whereby the Plan Administrator shall be reimbursed first from any settlement or judgment, and if any balance then remains it shall be given to your or your dependent, as applicable);
- Pay to the Plan Administrators all costs and expenses, including attorney's fees, which shall be incurred or expended by the Plan Administrator in obtaining, or attempting to obtain, payment from you or your dependent if you or your dependent fails or refuses to reimburse the Plan Administrator as required under the Plan.
- Permit the Plan Administrator to file a lawsuit in the name of you or your dependent against the person whose act caused illness or injury;
- Notify the Plan Administrator to file a lawsuit in the name of you or your dependent against the person whose act cause the illness or injury;
- Notify the Plan Administrator of a proposal settlement at least 30 days before any claim or lawsuit is settled regarding the loss;
- Sign any documents necessary to accomplish the purposes described above; and
- Cooperate with the Plan Administrator to accomplish purposes described above.

At its option the Plan will be reimbursed for your total recovery before any amounts, including expenses or attorneys' fees, are deducted, whether the recovery is specifically for medical payments, and regardless of how the proceeds are characterized or the source of the recovery. That is a right of the first reimbursement and the "make whole" rule or "common fund" rule will not apply. The Plan will not pay,

offset any recovery, or in any way be responsible for any fee or costs associated with pursuing a claim unless the Plan agrees to do so in writing.

What is the Role of the Employee Benefits Committee?

The BorgWarner Employee Benefits Committee is responsible for the design of the Plan, including the benefits that are covered and not covered by the Plan. If after going through the applicable appeals procedures described in the prior sections you believe that the outcome is inconsistent with the Plan or if at any time you would like the Committee to consider a possible change to the Plan, you may ask the BorgWarner Employee Benefits Committee to consider your request.

You may submit your request to:

BorgWarner Employee Benefits Committee

c/o BorgWarner Inc.

3850 Hamlin Road

Auburn Hills, MI 48326

(248) 754-9200

You may submit whatever materials you would like to support your request, and the Committee will consider your request at its next quarterly meeting. This is an informal process and is not part of the required, formal appeal process; after you have exhausted the formal appeal process described in the prior sections, you may pursue your ERISA rights, even if you have not submitted a request to the Employee Benefits Committee.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

What is a Qualified Medical Child Support Order (QMCSO)?

A QCSMO is a court order that creates or recognizes the existence of an alternate recipients right to, or assigns to an alternate recipient the right to, receive benefits for which a participant or dependent is eligible under this Plan. For example, if you and your spouse divorced, you could be ordered by a court to provide health coverage for your child, even though he or she is in your spouse's custody.

What information must the order include to be considered a QMCSO?

The order must:

- Clearly specify the name and the last known mailing address (if any) of the participant (you) and the name and mailing address of each alternate recipient covered by the order;
- Provide a reasonable description of the type of coverage to be provided by the applicable Program to each alternate recipient, or the way the type of coverage is to be determined;
- Clearly specify the period to which the order applies; and
- Not require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of a law relating to medical child support described in Section 1908 of the Social Security Act.
- The order must be submitted to your local Human Resources office.

What happens after an order is submitted?

You will be notified, along with each alternate recipient (and his or her custodial parent or guardian) of the receipt of the order and the Plan's procedures for determining whether medical child support orders are QMCSOs. You will also receive notification once your local Human Resources office has determined whether the order is a QMCSO. You or your dependents may obtain a copy of the Plan's QMCSO procedures from your local Human Resources office, free of charge.

AMENDMENT AND TERMINATION OF THE PLAN AND PROGRAMS

The Company intends to continue the Plan and each Program indefinitely. However, the Company reserves the right to modify, amend, or terminate the Plan, or any Program under the Plan, at any time for any reason. You will be notified of any material changes to the Plan or any Program in which you are enrolled.

HEALTH LAW PROTECTIONS

What does the Newborns and Mothers Health Protection Act provide?

Under the Federal Newborns and Mothers Health Protection Act, group health plans and health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from the discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

What does the Women's Health Cancer Rights Act provide?

Group health plans and health insurance issuers that provide medical and surgical benefits with respect to a mastectomy, must provide, in a case of a participant, spouse or dependent, who is receiving benefits in connection with a mastectomy, coverage for:

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of mastectomy, including lymph edemas;
- in a manner determined in consultation with the attending physician and the patient. This coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and are consistent with those established for other benefits under the Plan or coverage.

PLAN ADMINISTRATION

The administration of the Plan and each Program is under the supervision of the Plan Administrator who has the discretion to interpret the Plan, administer the Plan under its terms and to interpret Plan policies and procedures, resolve and clarify inconsistencies, ambiguities and omissions in the Plan and among and between the Plan document and other related documents, take all actions and make all decisions regarding questions of coverage, eligibility and entitlement to benefits, and benefit amounts, and process and approve or deny all claims for benefits.

The decisions of the Plan Administrator (or its delegate), including, but not limited to, questions of construction, interpretation and administration shall be final, conclusive and binding on all persons having an interest in or under the Plan. And such decisions will be afforded full deference under the law. The Plan Administrator also has record-keeping and similar responsibilities such as distributing information to participants.

Benefits offered under this Plan may be insured or self-funded as indicated in Schedule 1. When a benefit is insured, the insurer is solely responsible for payment of the benefits. When benefits are self-insured, the benefits are not insured but are paid from the general assets of the Company, as supplemented by any applicable participant contributions. The Company will determine from time to time the amount, if any, to be contributed by participants in order to be covered by a Program.

LIMITATION OF RIGHTS

The Plan, this SPD, and the Program documents describe the benefits for which you may be eligible as an Employee of the Company. However, neither the establishment of the Plan, nor any amendment thereof, nor the payment of any benefits, will be construed as giving you or any other person any rights against the Company or the Plan Administrator, except with respect to the benefits provided under the Plan.

Neither the Plan nor any Program is a contract of employment between you and the Company or is to be consideration or an inducement for your employment. Nothing in the Plan or any Program gives you the right to be retained in the service of the Company or any other right with respect to the Company's right to discharge its employees.

Your rights (and the rights of your dependents and beneficiaries) to benefits under the Plan are conditioned upon each of your provision to the Company and the Plan Administrator of such information, evidence, and signed documents as may reasonably be requested by the Company, the Plan Administrator, any claims administrator (or any delegate thereof) from time to time for the purpose of administration of the Plan.

STATEMENT OF ERISA RIGHTS

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). ERISA provides that all plan participants shall be entitled to:

Examine, without charge, at the Plan Sponsor's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual reports (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable change for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage:

Continue health care coverage for your dependents if there is a loss of coverage under a Program that constitutes a group health plan as a result of a qualifying event. You and your dependents must pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries:

In addition, ERISA imposes duties upon fiduciaries — the people responsible for the operation of the Plan. Fiduciaries must act prudently and in the interest of Plan participants. No one may discriminate against you to prevent you from obtaining a benefit or exercising your rights under ERISA. If your claim for a benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You may have the Plan reviewed and your claim reconsidered.

Enforce Your Rights:

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce your rights. For instance, if you request materials from the Company and do not receive them within 30 days, you may sue in the United States District

Court for the Eastern District of Michigan. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits denied or ignored, in whole or in part, you may sue after you exhaust the claim procedures, but before you are time barred, in the United States District Court for the Eastern District of Michigan. If the Plan fiduciaries discriminated against you for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may sue in the United States District Court for the Eastern District of Michigan. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court.

The court will decide who should pay court costs and legal fees. If you succeed, the court may order the person you have sued to pay court costs and fees. If you lose, the court may order you to pay these costs and fees.

Assistance with Your Questions:

If you have questions about the Plan, contact the Plan Administrator. If you have questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

IMPORTANT INFORMATION ABOUT THE PLAN

Name of Plan:	BorgWarner Inc. Flexible Benefits Plan
Plan Sponsor:	BorgWarner Inc. 3850 Hamlin Road Auburn Hills, MI 48326
Plan Administrator:	BorgWarner Employee Benefits Committee c/o BorgWarner Inc. 3850 Hamlin Road Auburn Hills, MI 48326 Telephone No.: 248-754-9200
Claims Administrator:	Claims under each component Program are administered by the Insurer or Third-Party Administrators listed in Schedule 1
COBRA Administrator:	BOS-BorgWarner COBRA Service Center 3149 Haggerty Highway Commerce Township, MI 48390 Telephone No.: 1-877-206-0283
Employer Identification Number:	13-3404508
Plan Number:	501
Type of Plan:	Health and welfare, severance benefit plan
Type of Administration:	Self-administered with certain elements of contract administration
Plan Effective Date:	The Plan is amended and restated effective as of October 1, 2019.
Plan Year:	January 1 – December 31
Agent for Service of Legal Process:	Service of legal process may be made on the Plan Administrator at the above address

SCHEDULE 1

BENEFIT PROGRAMS

The benefit Programs listed in the ***Qualified Benefit for Active Employees*** constitute Programs that are eligible for payments through the cafeteria plan's Pre-Tax Premium Program for eligible active employees. The specific benefits available may vary by location and employee classification, as set forth in the documents for each location.

Qualified Benefits for Active Employees

Benefit Program	Funding	Insurer or Administrator
Medical Program – including prescription drug & EAP	1. Self-Insured High Deductible Health Care Plan with HRA 2. Fully-Insured Global Benefits Plan 3. Self-Insured On-Site Medical Clinics Subject to ERISA	1. CIGNA 2. AETNA 3. CIGNA, HealthStat
Dental Program	Self-Insured Dental PPO	CIGNA
Vision Program	Self-Insured Vision PPO	CIGNA
Health Flexible Spending Account	Self-funded with employee contributions	CIGNA
Dependent Care Flexible Spending Account	Self-funded with employee contributions	CIGNA
Vacation Purchase	Self-funded with employee contributions	Plan Sponsor

The benefit Programs listed in the ***Non-Qualified Benefit for Active Employees*** constitute Programs that are offered outside of the cafeteria plan to eligible active employees. The specific benefits available may vary by location and employee classification, as set forth in the documents for each location.

Non-Qualified Benefits for Active Employees

Benefit Program	Funding	Insurer or Administrator
Term Life Insurance Program*	Insured	MetLife
Optional Term Life Insurance Program	Insured	MetLife
Voluntary AD&D Program	Insured	MetLife
AD&D Program*	Insured	MetLife
Business Travel Accident Program*	Insured	CIGNA
Medical Benefits Abroad Program*	Insured	CIGNA
Short-Term Disability Program**	Insured	Reed Group - CIGNA
Long-Term Disability Program*	Insured	CIGNA
Voluntary Programs	Insured	AllState, Info Armor, MetLaw, MDLIVE
Transitional Income Program	Self-Insured	Plan Sponsor

* Not subject to election; all eligible employees participate.

** In addition to the insured Program, some locations operate a non-ERISA payroll practice Program.

Insurer and Administrator Information

Insurance and plan administration services are provided through contracts with the following companies:

Programs:	Voluntary Benefits:
Aetna 151 Farmington Avenue Hartford, CT 06156-0002 800-231-7729	Allstate P.O. Box 660598 Dallas, TX 75266-0598 800-521-3535
CIGNA 900 Cottage Grove Road Bloomfield, CT 06002 800-237-2904	Info Armor 7001 N. Scottsdale Road Suite 2020 Scottsdale AZ 85253 (800)789-2720
HealthStat, Inc. 4651 Charlotte Park Drive, Suite 300 Charlotte, NC 28217 704-529-6161	MDLIVE 13630 NW 8th Street, Suite 205 Sunrise, FL 33325 888-726-3171
MetLife 200 Park Avenue New York, NY 10166 Life: 888-622-6616	Met Law 1111 Superior Avenue Cleveland, OH 44114 800-821-6400
ReedGroup P.O. Box 6248 Broomfield, CO. 80021 800-441-9628	

If you have questions about claims, you may contact your insurer or administrator.

SCHEDULE 2
HEALTH REIMBURSEMENT ARRANGEMENT PROGRAM

Establishment of Plan. The Company maintains the BorgWarner Inc. Health Reimbursement Arrangement Plan ("HRA Plan") for the purpose of allowing employees of the Company to obtain reimbursement of certain Health Care Expenses on a nontaxable basis from his or her HRA Account.

Definitions. The following terms shall have the meanings set forth below:

"Benefit Credit" means the amount credited to an employee's HRA Account for the provision of benefits under the Plan.

"Health Care Expense" means an expense incurred by an employee for unreimbursed medical expenses (as defined in Code Section 213(d)), other than expenses that are for prescription drugs. Health Care Expenses will also not include expenses reimbursed or reimbursable under any other arrangement (including the Health Care Flexible Spending Account Program) or any amount claimed as a deduction on the federal income tax return of the employee.

"HRA Accounts" means the hypothetical accounts established for an employee to hold his or her Benefit Credits.

Participation.

An employee will commence participation in this HRA Plan on the date he or she becomes covered as an active employee by either the self-insured basic medical Plan or the self-insured buy-up medical plan.

An employee will cease participation in this HRA Plan when he or she is no longer covered by either the self-insured basic medical plan or the self-insured buy-up medical plan.

Funding.

The benefits will be provided by the Company out of its general assets. As such, each HRA Account is a hypothetical account that merely reflects a bookkeeping concept and does not represent assets that are set aside for the exclusive purpose of providing benefits to the employee under the terms of the HRA Plan or that are protected from the reach of the Company's creditors. In no event may any benefits under the HRA Plan be funded with employee contributions.

On an annual basis, the Company will credit the HRA Accounts with Benefit Credits as established by the Company in its annual open enrollment materials. The amount of Benefit Credits credited to the HRA Account of any employee may vary based on which medical plan the employee chooses and the tier of coverage in which the employee enrolls. The amount of Benefit Credits for employees who are hired or become eligible to participate in the HRA Plan after the first day of the Plan Year will be prorated on a monthly basis. Unused Benefit Credits for the year may rollover into the subsequent year, subject to a cap on rollovers, as described in the Company's annual open enrollment materials. The amount of the rollover cap may vary based on which medical plan the employee chooses and the tier of coverage in which the employee enrolls. No earnings will be credited at any time with respect to any HRA Account.

Benefits.

The HRA Plan will reimburse employees for Health Care Expenses, up to the unused amount of Benefit Credits in the employee's HRA Account. An employee will be entitled to reimbursement only for Health Care Expenses incurred after he or she begins participating in the HRA Plan and before his or her participation has ceased. In no event will any benefits be provided in the form of cash or other taxable benefits other than reimbursement for Health Care Expenses.

At all times during the Plan Year, an employee will be entitled to benefits under this Plan for payment of Health Care Expenses in an amount that does not exceed the balance of the Benefit Credits credited to his or her HRA Account. Each reimbursement will be a charge to such HRA Account available to pay Health Care Expenses under the HRA Plan.

Upon an employee's loss of eligibility under the HRA Plan, coverage under the HRA Plan will cease, the employee will receive no further Benefit Credits under the Plan, and his or her Health Care Expenses incurred after such date will not be reimbursed even if Benefit Credits remain in the HRA Account. The employee may submit claims for reimbursement for Health Care Expenses incurred prior to his or her loss of eligibility, provided the employee files such claims within 180 days of such loss of eligibility.

The Company requires enrollment in its medical and prescription drug coverage for the employee's claim to be reimbursed through the HRA. The Plan Administrator automatically adjudicates medical and prescription drug claims toward the employee's HRA balance, applying a proportional amount of the balance toward the employee's share of the out of pocket expense under the medical and prescription drug coverage.

Employees must furnish a claim form to the Plan Administrator along with a bill, receipt, cancelled check, or other written evidence or certification of payment in order to be reimbursed for eligible Health Care Expenses not submitted directly to the Plan Administrator by a healthcare professional. In this circumstance, rather than paying the service provider directly, the Company will reimburse the employee for out of pocket expenses from the general assets of the Employer, if the expenses are eligible and not in excess of the employee's HRA balance. The Company reserves the right to verify to its satisfaction all claimed Health Care Expenses prior to reimbursement. Claims will be paid in the order in which they are filed and will be charged to the HRA of the employee who generates the claim.

The Company may limit, reallocate, or deny any benefit to any employee who was a highly compensated individual to the extent necessary to avoid discrimination under Code Section 105(h).

Amendment and Termination.

The Company reserves the right to amend, modify, or terminate this HRA Plan at any time, including but not limited to the right to modify the individuals eligible for participation, benefits paid by the HRA Plan, the amount of Benefit Credits to be credited, and the right to reduce or eliminate existing HRA Accounts.

SCHEDULE 3
BORGWARNER RETIREE HEALTH & LIFE PLAN

The following eligibility rules apply to the BorgWarner Retiree Health & Life Plan, which is a separate plan maintained by BorgWarner for the benefit of eligible retirees.

Who is eligible to participate in the BorgWarner Retiree Health & Life Plan?

Eligibility in the BorgWarner Retiree Health & Life Plan is restricted to "Retirees." Whether you are considered a Retiree depends on several factors including location, date of hire, years of service, if you were disabled while employed, and participation in the employee Medical Program of the BorgWarner Flexible Benefits Plan. The benefits offered under the BorgWarner Retiree Health & Life Plan may vary by location, by job classification and by age, so you should contact the retiree service center at 13975 BorgWarner Drive, Noblesville, IN 46060, phone (877) 259-5373 if you need further information.

Active Employees Who Retire

Non-Union employees at active locations

If you are a non-union employee hired at one of the active locations listed in Table 1 below, you are eligible to participate in the BorgWarner Retiree Health & Life Plan if you were hired prior to the date listed for your location, meet the age and service requirement for the location, and participate in the employee Medical Program immediately prior to your retirement. Please contact your local Human Resources Office for more information.

Table 1: Active Locations (Non-Union) Hire Dates

Location	Began Employment Before
Asheville, North Carolina	September 1, 1999
Auburn Hills, Michigan (PTC)	Dates are specific to hiring division
Auburn Hills, Michigan (World Headquarters)	January 1, 1995
Bellwood, Illinois	January 1, 1994
Cadillac, Michigan	September 1, 1999
Dixon, Illinois	January 1, 1995
Fletcher, North Carolina	October 1, 1999
Frankfort, Illinois	January 1, 1994
Ithaca, New York (salaried) (Warren Rd. and Luker Rd. sites)	January 1, 1996
Livonia, Michigan	July 1, 1995
Lombardi/Addison, Illinois	January 1, 1994
Marshall, Michigan	October 1, 1999
Muncie, Indiana (salaried) (through May 1, 2009)	January 1, 1994

If you are a non-union employee who had a break in service and were re-hired between January 1, 2004 and December 31, 2008, you will receive continuous years of service credit for purposes of the BorgWarner Retiree Health & Life Plan for the time you were employed immediately before and after your break in servicer if:

- You were originally hired by the Company prior to January 1, 1995;
- You initially terminated employment with the Company after at least 10 years of continuous service ("initial termination of employment");
- You were participating in the Medical Program of the BorgWarner Flexible Benefits Plan at the time of your initial termination of employment;
- You were rehired by the Company less than 5 years after your initial termination of employment;
- You are a participant in the Medical Program of the BorgWarner Flexible Benefits Plan immediately prior to retirement; and
- You were still an active employee as of January 1, 2009.

You must still meet the eligibility rules for the Active Locations in Table 1 above.

Union employees at active locations

If you are a union employee, you will be eligible to participate in the BorgWarner Retiree Health & Life Plan if you were originally hired at one of the locations listed in Table 2 below, began your employment prior to the date listed for that location, meet the age and service requirements that apply to that location, and participate in the Medical Program of the BorgWarner Flexible Benefits Plan immediately prior to your retirement. For more information, please contact your local Human Resources Office.

Table 2: Union Location Hire Dates

Location	Began Employment Before
Cadillac Michigan (Kysor union hourly)	January 1, 1992
Ithaca, New York (union hourly) (Warren Rd. and Luker Rd. sites)	October 4, 1998
Muncie, Indiana (union hourly) (through February 1, 2009)	January 1, 1993
Muncie, Indiana (guards) (through May 1, 2009)	January 1, 1994
Sterling Heights, Michigan (union hourly)	March 1, 1993

Divested Locations

If you were employed by BorgWarner at a divested location, your eligibility will be determined by rules that apply to your specific location. You should contact the retiree service center at 3850 Hamlin Road, Auburn Hills MI 48326, phone (877) 259-5373 for further information.

Disabled employees

You may also be considered a Retiree if you became totally and permanently disabled, you were originally hired at and meet the service requirements for the locations in Table 1 or 2 above, and participate in the Medical Program of the BorgWarner Flexible Benefits Plan immediately prior to your termination with the Company. For more information, please contact HRLink.

Dependent child

The employee's unmarried children who are under age 19, or who are under age 25 if a full-time student at an accredited institution, or who are permanently and totally disabled (as defined below).

A child includes:

- a legally adopted child or a child who has been placed with you for adoption;
- a stepchild who lives with retiree, but if the spouse and the child are eligible to participate in another employer's health plan, the Plan will only cover the child on a secondary basis;
- a child for whom retiree has court-appointed full (not limited) legal guardianship;
- a child for whom the spouse has court-appointed full (not limited) legal guardianship, but if spouse and the child are eligible to participate in another employer's health plan, this Plan will only cover the child on a secondary basis; and
- a child for whom employee is required to provide health care support under a Qualified Medical Child Support Order (QMCSO).

The child normally will continue to be eligible as a dependent until the last day prior to the date he or she reaches age 19 or, if a full-time student, age 25, or the date he or she ceases to be permanently disabled.

Student Status: If a child is required to show student status, member must provide confirmation from an accredited educational institution that the dependent is or will be attending. This confirmation must include the following key information:

- school insignia;
- child's name;
- period of enrollment; and
- language enough to indicate that the child meets the definition of a full-time student.

In order to be eligible to participate as a student, your child must also continue to reside with you (ignoring temporary absences due to illness, vacation, being at school, etc.).

If the retiree has a child who no longer meets one of these requirements, it is the retiree's responsibility to contact local Human Resources department to determine whether the child still qualifies as a dependent. Failure to do so may result in the loss of dependent's rights to COBRA health care continuation coverage, negative tax consequences, and loss of benefits under the Plan.

SCHEDULE 4
BORGWARNER INC. TRANSITIONAL INCOME PLAN

This summary describes, in non-technical language, the main provisions of the BorgWarner Inc. Transitional Income Plan (the "Plan"). The Plan is effective for terminations of employment on and after May 1, 2019.

The Plan provides transitional income and benefits to an eligible employee because of an employee's termination of employment with BorgWarner Inc. and its affiliates (the "Company") under the circumstances described below.

This document is only a summary of the benefits under the Plan. Your eligibility to participate in the Plan and the benefits you will receive are determined solely by the official Plan document which describes the Plan and is available in the Human Resources Department for your review. To the extent a conflict exists between this summary document and the official Plan document, the Plan official document will control.

Eligibility

The Plan provides a Transitional Benefit for regular full-time salaried employees of the Company in the United States whose employment with the Company is terminated because of:

- a reduction in workforce or a restructuring; or

- a permanent elimination of a job position.

Notwithstanding the above sentence, you will not be eligible for a Transitional Benefit if:

- You voluntarily terminate employment with the Company;

- Your employment is terminated for cause, including, for breach of a Company policy or agreement to which you are bound, dishonesty, nonperformance or dereliction of duty, insubordinate conduct, or poor performance or failure to improve in accordance with a written performance improvement plan, or

- Your employment is terminated because of circumstances beyond the control of the Company, including, a disaster (natural or otherwise), a Labor dispute, act of war, or sabotage or riot;

- You are on an unapproved leave of absence on your termination date (except for short leave of absences, such as, for vacation, jury duty, bereavement, or similar leaves); or

- You refuse to accept re-employment with the Company or an employment offer from another employer to whom operations or assets have been sold or transferred.

Transitional Benefit and Determination of Eligible Weeks

If you qualify under the Plan and you timely sign and return, and do not revoke, if applicable, a release of claims agreement, you will receive a Transitional Benefit consisting of a Lump Sum Benefit and a Group Insurance Benefit based on the number of your Eligible Weeks.

- The Lump Sum Benefit is equal to your regular weekly salary you were receiving from the Company immediately prior to your termination date multiplied by your Eligible Weeks.

- The Group Insurance Benefit is a premium subsidy for medical and prescription insurance coverage and the group dental and vision coverage under the Company's group health plan equal to the Company-paid portion of your premiums for such coverages you're enrolled in as of your termination date. The subsidy will allow you to pay the similar premiums active employees pay. The subsidy is contingent on timely electing continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). Within 45 days after your termination, you will be notified of your right to elect COBRA continuation coverage. You must elect COBRA continuation coverage within 60 days after you receive this notice. The subsidy will be provided until the earlier of the expiration of your number of Eligible Weeks or the date your COBRA continuation period terminates as described in your initial COBRA notice. You may continue your COBRA continuation coverage after the expiration of your Eligible Weeks by paying the full COBRA premium for the remainder of your COBRA continuation period.

The calculation of Eligible Weeks for both the Lump Sum Benefit and the Group Insurance Benefit depends on your salary grade level at the time of your termination of employment. For eligible employees with a salary grade level of 15 or less at the time of termination, Eligible Weeks is equal to 1 Eligible Week for each full year of your employment with the Company, subject to a minimum of 4 and a maximum of 26. For eligible employees with a salary grade level of 16 or higher at the time of their termination of employment, Eligible Weeks is equal to 26.

Release of Claims

The Company will pay you the Transitional Benefit only if you sign and return the release of claims agreement by the due date and, if applicable, you do not revoke your release of claims agreement. The release of claims agreement will be presented to you on your employment termination date.

You will have 14 days from your employment termination date to sign and return your release of claims agreement. But, if you are over age 40, your time to sign and return your release of claims agreement will be increased to 21 days or, if your termination of employment is in connection with an employment exit program, to 45 days, and you will be provided 7 days following the date you sign to revoke your release of claims agreement.

The release of claims agreement will be a written agreement in a form provided by the Administrator, as determined in its sole discretion, whereby you agree to release the Company and other releasees from all legal claims you may have against the Company or the other releasees.

Lump Sum Benefit Payment Date and Tax Withholdings

The payment of the Lump Sum Benefit will be paid in a cash lump sum at the next regular pay date following the date the Company receives your signed and irrevocable release of claims agreement, but the Lump Sum Benefit shall not be paid later than sixty (60) days after your employment termination date. All required deductions for Federal, state and municipal taxes will be taken from the Lump Sum Benefit.

Revision and Continuance of Plan

The Company expects to maintain the Plan indefinitely but reserves the right to amend or terminate the Plan at any time and in any manner, with or without notice, if the Company believes the situation so requires. You will be notified in writing if there is any significant amendment or if the Plan is terminated.

SCHEDULE 5

VACATION PURCHASE PROGRAM

Objective

The Vacation Purchase Plan allows you to purchase additional vacation time on a pre-tax basis and spread the cost of doing so over the calendar year. Enrollment in the Plan is optional during the annual Open Enrollment Period. Vacation purchase is not available at any other time and, like all other vacation time, its use is subject to the approval of your manager.

Because you will forfeit any unused time purchased under this Plan at the end of the year please act as follows:

- Seek manager approval, preferably via email or memo so there is confirmation of understanding by both parties
- Reference the BorgWarner Salaried Vacation policy at the time you elect to purchase vacation under this Plan. You cannot exceed more than 5 weeks of vacation time between the BorgWarner Vacation time and this program.

Eligibility

Active Employees - All Regular, salaried employees of BorgWarner Inc. (the "Employer") and its participating employers who work at least 30 hours per week are eligible for the Vacation Purchase Plan each annual Open Enrollment Period.

Enrollment

Eligible employees may enroll in the Vacation Purchase Plan during the annual Open Enrollment Period. Days purchased during the annual Open Enrollment Period are available the first day of the following calendar year.

Once you enroll, you must continue participation in the plan until the end of the Vacation Purchase calendar year, or your termination date of employment, if earlier.

Benefit Provided

The maximum vacation time available between this plan and BorgWarner paid vacation time cannot exceed 5 weeks during a calendar year. You may purchase a minimum of 1 day or a maximum of 5 days of vacation, in work-day increments if your BorgWarner paid vacation does not exceed 5 weeks.

Time purchased under this plan is taken after you have used all other vacation time earned under any other BorgWarner vacation policy.

Benefit Cost

The cost of each vacation day is factored using your base salary at the open enrollment election window divided by 260 (52 weeks x 5 workdays in a week). The cost to you will change during the year if your base salary changes.

Example: $50,000 / 260 work days in year = $192.30 per day purchased

Deductions are taken pre-tax in equal installments from your paycheck. When vacation days are taken, they are paid to you like all BorgWarner vacation days, as regular earnings.

Note: The IRS requires BorgWarner to perform annual non-discrimination testing to ensure the benefits we provide employees do not favor highly compensated employees over non-highly compensated employees. If the test is failed, the value of the benefit above the testing threshold is taxable to highly-compensated employees during Q4.

Deduction Reimbursement

If you do not use up all the time that you have purchased, it will not be carried over to the next calendar year or reimbursed to you unless your employment with the company is terminated. If your employment with the Company terminates and you purchased days that you did not use, you will receive a refund for the unused days purchased. If your employment with the Company terminates and you have used days that were not fully paid for, the Company will withhold the amount of the payment for the "used but unpaid days" from your final pay-check. When you purchase days during Open Enrollment, you are authorizing us to do so.

Employees are highly encouraged to discuss the ability to schedule added vacation time off with their manager prior to purchase to avoid purchasing time that, for business reasons, cannot be taken.

Definitions

Base Salary – For purposes of the Vacation Purchase Plan, Base Salary is your annual salary excluding overtime pay, bonuses, commissions and any other types of incentives.
Calendar Year — The Calendar Year begins on January 1 and ends December 31.
Company — BorgWarner Inc. or an affiliated employer that participates in the Plan
Highly-Compensated Employee – as defined by the Internal Revenue Code ($125,000 in 2019)
Open Enrollment Period – The Open Enrollment Period is held once a year, generally during the month of November. During the Open Enrollment Period, you may elect your Vacation Purchase option for the following calendar year. Vacation days purchased do not carry forward from year to year. You must re-elect this benefit each year. Elections can be changed only during the Open Enrollment Period, even if your hours or Base Salary change. You cannot purchase vacation if you experience a mid-year benefit qualified status change.
Pre-Tax — Deductions from your annual salary are taken each pay period before federal income taxes—and in most cases, before state and local income taxes—are calculated. These contributions reduce your current taxable income, and therefore, reduce the current income taxes you pay.
Regular Employee – A Regular Employee is an employee classified and treated for federal income tax purposes by the Employer as a regular full-time or regular part-time employee of the Employer (as opposed to a temporary, seasonal or casual employee, intern, independent contractor or consultant, agency worker or leased employee) even if the Employer's classification is later determined to be incorrect.