# Take the Wheel Benefits for the Road Ahead

**Ithaca Hourly Employee Benefit Guide 2019**

BorgWarner

BorgWarner

2019 Ithaca Hourly Employee
Benefit Guide

# Have Questions? We Have Answers!

| Benefit Vendor: | | Contact by Phone: | Contact Online: |
|---|---|---|---|
| CIGNA<br>Choice Health Fund HRA | Medical &<br>Prescription Drugs | Provider, claim and health information including health coaching:<br>1-800-237-2904 | www.mycigna.com |
| | Cigna Mail Order<br>(Tel-Drug) | 1-800-TEL-DRUG<br>(1-800-835-3784) | www.mycigna.com |
| Teamsters<br>HRA Health Plan | Excellus Medical &<br>Prescription Drugs | Teamsters Upstate Union Health & Welfare Fund<br>1-315-471-4164 x11<br><br>Excellus Provider and Claim Information:<br>1-800-499-1275 | www.excellusbcbs.com |
| Teamsters HRA | HealthNow<br>HRA Debit Card | HealthNow<br>1-800-518-8332<br><br>Teamsters Local #294 Health & Welfare Office:<br>1-518-437-9837 | www.mywealthcareonline.com/myhnas |
| CIGNA<br>Dental & Vision | | 1-800-237-2904<br>(Dental only)<br>1-877-478-7557<br>(Vision only) | www.mycigna.com |
| Flexible Spending Accounts (FSAs) | Administered by Cigna regardless of medical plan enrollment | 1-800-237-2904 | www.mycigna.com |
| MetLife | Life Insurance &<br>Accident Insurance | 1-888-622-6616<br>TTY:1-888-688-2860 | www.metlife.com/mybenefits |
| Vanguard | Retirement Savings Program | 1-800-523-1188 | https://www.retirementplans/vanguard.com |
| Allstate | Critical Illness | 1-800-521-3535 | https://www.allstateatwork.com/mybenefits |
| CIGNA | Disability / FMLA | 1-800-362-4462 | |
| BorgWarner<br>HR Link | General Benefit Questions & Family Status Changes | 1-844-4HR-LINK<br>(1-844-429-5465) | For additional general plan information www.borgwarner.com/benefits/ithaca or email hrlink@borgwarner.com |

If you have questions about Workday, see any local HR Representative

For more information on benefit plans and options visit

www.borgwarner.com/benefits/ithaca

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At BorgWarner, we believe that a healthy workforce is a more productive workforce, and healthy employees are happier employees. Because health care can be expensive, BorgWarner's benefits offer you and your family:

- ✓ Access to programs and services that promote healthy lifestyles and provide preventive care such as screenings, physicals, immunizations and well-child care
- ✓ Assistance in paying health care expenses
- ✓ Protection against catastrophic health care costs
- ✓ On-site wellness program and access to tools and coaching

BorgWarner uses an on-line data base system called Workday to maintain employee data including benefit elections. As a new employee, an HR Representative will help you log in to the Workday system and will review the benefits and enrollment process with you during your new hire orientation. You must complete the election of your benefits online through Workday within 30 days of the date you become eligible to enroll. Workday can be accessed from any computer with internet access using an approved browser. See your HR Representative for more information.

Once you are enrolled, you have the opportunity to review and change your benefits each year during BorgWarner's Open Enrollment held annually in the fall. Information on the available plans and enrollment information will be sent to all employees each year, even if you are not currently enrolled in benefits.

You can choose to enroll in one, some or all of the benefits offered. In addition, you can choose different coverage levels for each. For example, you can choose employee only coverage for Medical and family coverage for Dental/Vision. However, it's important to remember that you must log in to Workday each year and make your elections, even if you want to waive all coverage or to keep your coverage the same.

*This guide provides a brief description of the benefits offered to BorgWarner employees. For more details about your benefits, see your HR Link Representative or visit* www.borgwarner.com/benefits/ithaca *for a copy of our Summary Plan Descriptions*

# Start Your Engines!

This guide is designed to help make the trip easier. Whether you're taking your first trip or you've been down this road before, it's important that you carefully **consider your needs, choose well, and enroll on time**.

## How to Enroll:

1. Read this guide to learn about your benefit options. Discuss options with your family.
2. Log in to the Workday system and make your elections or changes to coverage. If you have problems logging in to Workday or making elections, contact the HR Office for help.
3. If you are enrolling eligible dependents who have not been covered previously, you must provide required documentation (marriage license for a spouse, birth certificate for children under age 26) in order to complete enrollment. Your dependents will not be enrolled until you provide this information. Bring the appropriate document(s) to your HR Benefits Representative located in Plant 2 before the deadline. If you aren't sure if this information is needed, contact your HR Benefits Representative.
4. If you enroll in a CIGNA health plan, you will need to take action to avoid paying two (2) $50 monthly medical premium surcharges. First, complete the CIGNA HRQ online. Next, if you have not used tobacco in the last twelve (12) months, complete the Tobacco Free Pledge (or as an alternative if you use tobacco, complete an approved Tobacco Cessation program). These actions must be taken annually before the deadline each year to maintain your eligibility to receive the discount.

## Enrollment Deadlines:

All new employees must log into Workday within thirty (30) days of employment to make elections or waive coverage, and provide dependent documentation, if applicable. New employees are eligible to enroll in the CIGNA Choice Health Fund medical plan, including prescription, and/or CIGNA dental/vision coverage after completion of ninety (90) days of employment.

For current employees, we post information each year regarding annual open enrollment meetings, plan changes, and deadlines. This is your once-per-year opportunity to change plans or coverage.

**Be sure to pay attention to the deadlines and enter your elections each year on time!**

Once you enroll, you can only change your elections if you have a family status change or during the annual open enrollment period each fall.

**If You Don't Make Your Elections in Workday on Time:**

You must make your elections before the New Hire/Open Enrollment deadline, If you don't make elections, your enrollment will be based on the coverage listed in the chart to the right.

| Benefit | Current Employees | New Employees (after 90 days of employment) |
|---|---|---|
| **Medical** | CIGNA Choice Health Fund – Employee only (Single) coverage | CIGNA Choice Health Fund – Employee only (Single) coverage |
| **Dental/Vision** | No coverage | No coverage |
| **Flexible Spending Accounts (FSAs)** | No participation | No participation |
| **Disability** | Current coverage continues | Basic coverage |

# Rules of the Road

**Eligibility**

Your BorgWarner benefits are designed to provide coverage for:

- **You** – as an actively employed, full-time employee of BorgWarner regularly scheduled to work at least 30 hours a week once you have completed ninety (90) days of employment.
- **Your spouse** – defined as your lawful spouse as evidenced by a marriage license. Co-habitants, common-law marriages, legally separated individuals, life partners or divorced spouses are not eligible.
- **Your dependent children** – including children to age 26*, regardless of whether the child is a student. Coverage is also available to children 26 and older if legally deemed permanently and totally disabled**. A child is defined as:
    - Biological child;
    - Legally adopted child or a child who has been placed with you for adoption;
    - Stepchild who lives with you. (Restrictions may apply. If you have a stepchild that lives with you, but your stepchild is eligible to participate in another employer's health plan, the BorgWarner Plan will only cover the stepchild on a secondary basis.
    - Court-appointed child for whom you have full (not limited) legal guardianship; or
    - A child for whom you are required to provide health care support under a Qualified Medical Child Support Order (QMCSO).

** If your child is married, his or her spouse and children are not eligible for coverage under the BorgWarner plans. Dependent eligibility is different for life insurance. Details can be obtained from your Summary Plan Description found at www.borgwarner.com/benefits/Ithaca, or contact MetLife directly.*

*** A Physicians Statement of Disability will be required for all disabled dependent children.*

**If you and your spouse work at BorgWarner,** your dependent children can be covered under either one of the parents' Medical and Dental/Vision plans, but not both. In addition, you and your spouse cannot enroll under two plans (both as a dependent and an employee, for example).

**Proof of dependency (such as a marriage or birth certificate, legal guardian or adoption papers, court order, tax documents) is required by BorgWarner.** Documents must be submitted when enrollment is completed in Workday. In all cases, BorgWarner will adhere to all court orders in determining dependent status, such as in a divorce settlement.

**If you have a child or spouse who may no longer qualify as a dependent,** it is your responsibility to contact your HR Benefits Representative within 30 days of the status change event. Failure to do so may result in the loss of your dependent's rights to COBRA health care continuation coverage and may have negative tax consequences for you.

### Working Spouse Rule

If your spouse works more than 35 hours per week and is eligible for coverage under a group health, prescription drug, organ or tissue transplant benefit offered by his or her employer, and the employer pays 65% or more of the plan's cost, then your spouse must enroll in their employer's basic health coverage as primary in order to be eligible for coverage as a dependent under the BorgWarner medical plan.

### Family Status Changes

Generally, according to government rules, you can only change your benefit elections during the annual open enrollment period, unless you have a **qualifying family status change**, including:

- Marriage or divorce
- Birth or adoption
- Job change for you, your spouse or dependent child
- Eligibility for Medicare for you, your spouse or dependent child
- Death of a spouse or dependent child

You have 30 days after the change to notify your HR Benefits Representative if you want to make new elections. In addition, the change must be consistent with the qualifying event. See your Summary Plan Description or your HR Benefits Representative for more information.

***Important Reminder about Mid-Year Insurance Changes:***

**If you are making changes to your insurance coverage mid-year due to a qualifying event such as those listed above, you must complete a benefit update in Workday and bring supporting documentation of the status change to your HR Benefits Representative. This information must be submitted within 30 days after the change occurs.**

**Some examples of acceptable documents include birth certificate, marriage license, divorce decree, COBRA notice, or Certificate of Insurance from an employer or insurance company.**

**For more information, talk to your HR Link Representative located in the Human Resources Department in Plant 2.**

# Medical and Prescription Drugs

You have two (2) medical plans to choose from*, each with different coverage level options. Both offer coverage for in-network care, preventive care and prescription drugs.

The main differences between the plans are the amount you pay in payroll contributions, premium surcharges/discounts offered, deductible amount, and the level of coinsurance you pay after you meet the deductible. Each plan comes with a Health Reimbursement Account (HRA) and both have an out-of-pocket maximum, providing you and your family with a "safety net" by capping the amount you would pay in coinsurance in a given year in the event of a costly illness or injury. Once you reach this limit, you stop paying coinsurance and the Plan begins paying 100% of any additional eligible expenses for the remainder of the year.

Below is a quick comparison of the plans that you will choose from, highlighting some of the similarities and differences. (More detailed plan information found at www.borgwarner.com/benefits/ithaca)

| In-Network Benefits | CIGNA/MVP Choice Health Fund (Single or Family) | Teamsters HRA Health Plan (Single or EE+1/Family) |
|---|---|---|
| Deductible | $1,500 or $3,000 | $2,600 or $5,200 |
| BW Funded HRA | $750 or $1,500 | $1,300 or $2,600 |
| Co-Pays | N/A | N/A |
| Co-insurance (The amount employee pays for services after deductible is met) | 20% | 10% |
| Annual Out-of-Pocket Max (Employee Portion of Deductible + Co-Insurance) | $2,250 - $4,500 | $2,300 - $4,600 |
| Annual HRA Rollover Max (Unused HRA money will roll over from year to year as long as you remain enrolled in the same plan) | Yes – No Limit/Max | Yes – No Limit/Max |
| Preventive Services | 100% paid by plan | 100% paid by plan |

***** *Newly hired employees are eligible to enroll only in the CIGNA Choice Health Fund (CHF) medical plan, including prescription, and/or CIGNA dental/vision coverage after completion of ninety (90) days of employment. Teamsters HRA Health Plan will be available for election during the first open enrollment period following the ninety (90) day eligibility period.*

Below and on the pages that follow, you will find information to understand how an HRA Plan works as well as highlights on each of the medical plans we offer. Use this information to help you make a decision on which plan to elect. Alternately, you may also choose to waive our plans if you have coverage from another source, such as a spouse's health plan.

## Understanding How An HRA Plan Works

Your HRA money is used to help you pay for a portion of your deductible when you have medical expenses.

**1** **Doctor Visit**: Visit an in-network provider or medical center and present your ID card. The doctor's office will submit a claim to the insurance company for the cost of your visit.

**2** If the visit was for **preventive care**, the insurance company will pay the claim 100%.

OR

**HRA Pays First**: If the visit was **not for preventive care,** the insurance company will pay the claim from the HRA as long as money is available. This expense will go towards the plan deductible.

- CIGNA = Provider paid directly by Cigna

- Teamsters = Employee pays Provider using HealthNow Debit Card (form/receipts must be submitted after debit card use)

**3** **You Pay After HRA**: Not enough HRA dollars to cover the entire cost of the claim? The insurance company will notify both you and the doctor of the remaining amount you owe.

**4** **Annual Maximum**: Once you have paid the plan out-of-pocket maximum (not including HRA), the plan pays 100% for the rest of the year.

* *Debit card purchases must be substantiated by submitting the proper form and copies of receipts after each use.*

## Important Terms to Know:

- Deductible
  Fixed amount of money that is paid before the health plan begins to pay for covered medical expenses
- Health Reimbursement Account (HRA)
  Money that is put into an account by BorgWarner to help pay for a portion of the plan deductible
- Coinsurance
  Portion of medical claim that is paid by the plan/employee
- Out of Pocket Maximum
  Once you reach this maximum, the plan will pay 100% of your medical expense for the rest of the plan year
- HRA Rollover
  Unspent HRA dollars available to be used in the following plan years

# BorgWarner Health Plan

## CIGNA/MVP Choice Health Fund Plan

The CIGNA Choice Health Fund Plan offers comprehensive medical coverage and supports healthy living. It provides free preventive care to prevent healthcare problems before they arrive, access to free health coaching programs, and a BorgWarner funded Health Reimbursement Account (HRA) to help you cover a portion of the costs when you are ill.

**Your monthly contribution for either single or family coverage is $0 if you elect to participate in the voluntary Wellness Incentive Programs outlined on page 17.**

As a new employee, this is the plan you will be enrolled in once you have completed 90 days of service. You may switch to one of the other plans if you wish during the next annual open enrollment period – see your HR Link Benefits Administrator for more information.

Each year, BorgWarner contributes a portion of your deductible to your HRA. You use the HRA to pay for your deductible and/or your prescription drug expenses (see "Auto-Forwarding of Claims" below).

If you don't use all the money in your account this year, it automatically **rolls over** to help pay for your expenses next year as long as you remain enrolled in the plan for consecutive years. If you spend all the money in the account, you will be required to pay the remaining deductible before plan benefits begin.

### Free myCigna App with Cigna One Guide Service

Download the free myCigna App to your supported device, and use it to find network doctors, get cost estimates for care, manage and track claims, access your ID card and more.

### Auto Forwarding of Claims

With this feature, claims for eligible medical and prescription expenses are automatically submitted to your HRA (and your HealthCare FSA if you are enrolled). The provider is paid directly by CIGNA as long as there are funds available.

### Which pays first? HRA or FSA?

If you have a Health Care Flexible Spending Account (FSA), that money is used before your HRA, so that your HRA can continue to grow.

### CIGNA/MVP Choice Health Fund Plan Prescription Coverage

CIGNA administers the prescription drug program for the Choice Health Fund Plan. There are two ways to get your prescriptions filled: at a network pharmacy or through mail order. The table on the next page shows how much you pay for each prescription, depending on the type of prescription drug you buy.

The prescription drug program does not have a deductible and your HRA funds are used for prescription costs if available, however, the coinsurance and co-pays under the Prescription Drug Program do not count toward your medical deductible. You also have a separate out-of-pocket maximum just for prescriptions.

## CIGNA/MVP Prescription Coverage:

| CIGNA Choice Health Fund - Prescriptions | Retail Pharmacy 30-day supply | Mail Order 90-day supply |
|---|---|---|
| **Generic**<br>Chemically equivalent, lower-cost version of a brand-name drug.<br>**Diabetes Generic Preventive Medications** | $8<br>$0 | $16<br>$0 |
| **Formulary**<br>Lower-cost, yet highly effective brand-name prescription drugs that generally have no generic equivalent. | $8 + 30% | 30% up to $150 per Rx |
| **Non-formulary**<br>Generally has equally effective and less costly generic equivalents and/or one or more formulary options | $8 + 50% | 50% |
| **Specialty Rx Formulary**<br>Injectable drugs typically used to treat arthritis and other conditions (does not include insulin) | 30% up to $50 per Rx for initial supply only | 30% up to $150 per Rx |
| **Specialty Rx Non-Formulary**<br>Injectable drugs typically used to treat arthritis and other conditions (does not include insulin) | 50% up to $100 per Rx for initial supply only | 50% up to $300 per Rx |

### CIGNA Step Therapy and Prior Authorization

Often, there are several medication choices available to treat a given medical condition. Though the safety and clinical effectiveness of these choices can be equivalent, the cost can vary widely. Through Step Therapy, your pharmacist works with your doctor to find the most cost-effective and safest drug for treatment of your condition.

### How Step Therapy Works

- There is a sequence of two “steps” in the choice of medication used to treat the following some common medical conditions:
  - » High Blood Pressure
  - » High Cholesterol (such as Lipitor)
  - » Stomach Acid conditions
  - » ACE (Angiotensin Converting Enzyme) Inhibitors / ARB (Angiotensin II Receptor Blockers) drugs
  - » Proton Pump Inhibitors (such as Nexium or Prevacid)
- If you are filling a prescription for one of these conditions for yourself or a dependent member, your physician will prescribe a “first step” medication, generally a generic, before “stepping” up to a higher cost-medication (brand-name drug), if medically necessary.
- If you try to fill a “step two” brand-name drug, the pharmacy’s system automatically checks to see if you’ve used this before. If you have, the system pays the claim, however, if it is a new prescription the pharmacist will be directed to call your doctor and suggest trying a more cost-effective “step one” drug, such as a generic equivalent or brand formulary drug. In the meantime, you can still get a temporary supply of the “step two” drug while you await your doctor’s approval.

*Note: If you are currently taking a Step Therapy drug, you are considered “grandfathered”—meaning as long as you continue on the drug, you will not be impacted if you exhaust your refills and need a new prescription.*

# Teamsters HRA Health Plan*

## Excellus BCBS with HealthNow HRA

The medical and prescription portion of the Teamsters HRA Health Plan is administered by the Upstate Union Health and Welfare Fund through Excellus BCBS. Under the Teamsters HRA Health Plan, you can visit any provider you wish, but you always pay less if you choose an in-network provider. Plan coverage information is found on page 13 of this guidebook.

Each year, BorgWarner contributes a portion of your deductible to your HRA. You use the HRA to pay for your deductible and/or other qualifying expenses using a HealthNow debit card (see "HRA HealthNow" below and on page 12 of this guidebook).

The Teamsters HRA Health Plan requires a contribution to participate which is deducted from your paycheck. The monthly employee contribution amount can be found on page 13 of this guidebook.

This plan is available to employees during the first open enrollment period following completion of your 90-day probationary period.

Questions about the medical and prescription portion of the Teamsters HRA Health Plan
should be directed to the plan's administrators at the
Teamsters Upstate Union Health and Welfare Fund at (315)471-4164 ext.11.

## Teamsters HRA HealthNow Account

The Teamsters HRA Health Plan also makes use of a company paid health reimbursement account (HRA).

Each year, BorgWarner contributes a portion of the deductible to your account ($1,300 for employee only or $2,600 for employee+1/family) that you use to pay for your deductible, prescription drug expenses, and other eligible expenses allowed under the IRS. Your HRA is accessed through a HealthNow Debit Card process which is explained on page 12 of this guidebook

The HRA portion of the plan is funded throughout the year as outlined on page 80 of the current CBA. Funds are available for you to use on the same schedule as the plan is funded.

If you spend all the money in the account before the deductible is met, you will be required to pay the remaining deductible before plan benefits begin.

If you don't use all the money in your account, your remaining HRA automatically **rolls over** to the following year to help pay for your expenses next year as long as you remain enrolled in the plan for consecutive years.

Questions about the HealthNow Account or the debit card process for the Teamsters HRA Health Plan
should be directed to the plan's administrators at the
Teamsters Local #294 Health and Welfare Office at (518)437-9837.

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**NOTE: This plan is not available to newly hired employees. New employees are eligible to enroll only in the CIGNA Choice Health Fund (CHF) medical plan, including prescription, and/or CIGNA dental/vision coverage after completion of ninety (90) days of employment. The Teamsters HRA Health plan will be available during the first open enrollment period following completion of the ninety (90) day eligibility period.*

## Teamsters HRA Excellus Prescription Coverage:

If you are enrolled in the Teamsters HRA Health Plan, you will automatically be enrolled with Excellus for your prescription needs.

### Excellus Retail Network Pharmacy

Use a retail pharmacy any time you need a prescription filled right away. Simply show your Excellus ID card at a network pharmacy, and pay your portion of the cost. The pharmacist will file your claim for you. Most national pharmacies are in the prescription network, but you should always confirm the pharmacy is considered in-network to receive network pricing.

### Pharmacy Mail-order Service

If you use a maintenance drug – for high blood pressure, for example – you are required to use the convenient mail-order service. Order up to a 90-day supply for one co-pay, and your drugs are delivered directly to your home for free. You can order refills over the phone or online.

*Mandatory Mail Order Service*
*The Teamsters HRA Health Plan through Excellus requires mandatory mail order service for all maintenance prescriptions*

If you have questions about the prescription plan, you may contact the Excellus Health Member Services Call Center toll free by calling the number on your Excellus ID Card.

| Teamsters: Excellus - Prescriptions | Retail Pharmacy 30 Day Supply* | Mail Order 90 Day Supply* |
|---|---|---|
| **Generic** Chemically equivalent, lower-cost version of a brand-name drug. | $10 | $20* |
| **Preferred Brand Formulary** Lower-cost, yet highly effective brand-name prescription drugs that generally have no generic equivalent. | $20 | $40* |
| **Preferred Brand Non-Formulary** Generally has equally effective and less cost generic equivalents and/or one or more formulary options. | $40 | $80* |
| **Specialty Rx Formulary** Injectable drugs | N/A | 20% |

*** For all Teamsters HRA Health Plan Participants, mail order is mandatory for all long-term, on-going medications**

# Teamsters HRA Debit Card: HealthNow

The Teamsters HRA Health Plan makes use of a HealthNow debit card to access your HRA funds. Each time you use the Debit Card over a certain amount, you must submit a form to substantiate the usage. For more information on this process, please call the Teamsters Local #294 Health and Welfare Office at (518)437-9837.

You can access your HealthNow debit card account online to check your account balance (instructions below):

## Accessing your account online is as easy as 1-2-3

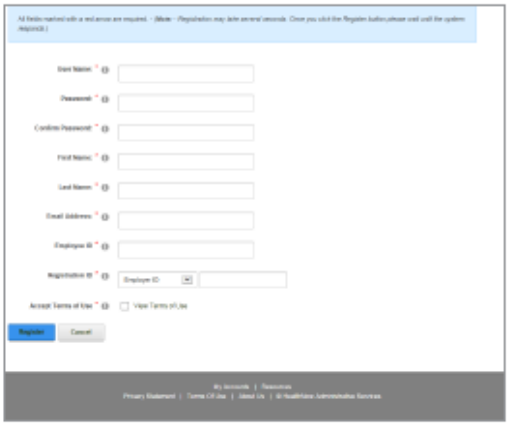
### Account Access

Online access makes it easy!

1. Home page
   - Go to mywealthcareonline.com/myhnas
   - Enter your login information

2. Create account
   - First-time users must click the *click here* button to create an account

3. Set-up account
   - At the Register screen, enter your information in all the required fields:
     - Username
     - Password
     - First and Last Name
     - Email address
     - Employee ID
     - Registration ID/Employer ID: BCI K34 or Debit Card #



4. Click Register and you're done!

## Comparison of 2019 Employee Medical Plan Options

| Healthcare Plan Monthly Employee Premium Cost Comparison | BorgWarner | | Teamsters' | |
|---|---|---|---|---|
| | CIGNA/MVP Choice Health Fund with HRA | | Excellus BCBS with Health Now HRA | |
| **Contribution/Coverage Levels - No Premium Discounts** | **$100 Single**<br>**$100 Family** | | **$258 Employee**<br>**$440 Employee+1**<br>**$553 Family** | |
| **Contribution/Coverage Levels - Both Premium Discounts: $50/month HRQ* + $50/month Tobacco*** | **$0 Single**<br>**$0 Family** | | **$258 Employee****<br>**$440 Employee+1****<br>**$553 Family**** | |
| | *action must be completed between Oct 1-Sept 30 each year (or within 60 days of new enrollment in plan) | | **premium discounts apply to CIGNA plans only (not available for the Teamster HRA) | |
| | **In-network** | **Out-of-network** | **In-network** | **Out-of-network** |
| **Deductible**<br>Per person/family | $1,500/$3,000 | $3,000/$6,000 | $2,600/$5,200 | |
| **Company-paid HRA**<br>Per person/family | $750/$1,500<br>(HRA administered through Cigna) | | $1,300/$2,600<br>(HRA adminsitered through HealthNow Debit Card*) | |
| **Coinsurance***<br>*the amount you pay for services after deductible is met, up to the Out-of-Pocket Maximum | 20% | 40% | 10% | 20% |
| **Out-of-Pocket Maximum***<br>Per person/family<br>*Employee portion of deductible and co-insurance | $2,250/$4,500 | $5,250/$10,500 | $2,300/$4,600 | |
| **Preventive Care**<br>Physicals, shots, pap test, mammogram, prostate exam | 100% covered | 40% after deductible | 100% covered | 80% after deductible<br>(well child covered at 100%) |
| **Office Visit** | 20% after deductible | 40% after deductible | 10% after deductible | 20% after deductible |
| **X-rays, lab tests, MRIs, CAT Scan, Hospice** | 20% after deductible | 40% after deductible | 10% after deductible | 20% after deductible |
| **Hospitalization**<br>Inpatient, X-ray, lab tests, skilled nursing | 20% after deductible | 40% after deductible | 10% after deductible | 20% after deductible |
| **Emergency Room** | 20% after deductible | 20% after deductible | 10% after deductible | 20% after deductible |
| **Ambulance** | 20% after deductible | 20% after deductible | 10% after deductible | 20% after deductible |
| **Urgent Care** | 20% after deductible | 20% after deductible | 10% after deductible | 20% after deductible |
| **Chiropractic** | 20% after deductible<br>(Max 12 visits/year) | 40% after deductible<br>(Max 12 visits/year) | 10% after deductible | 20% after deductible |
| **Mental Health/Substance Abuse**<br>*Inpatient:*<br>*Outpatient:* | <br>20% after deductible<br>20% after deductible | <br>40% after deductible<br>40% after deductible | <br>10% after deductible<br>10% after deductible | <br>20% after deductible<br>20% after deductible |

*HealthNow Debit Card must be substantiated after use

| PRESCRIPTION COVERAGE | Retail (30-day supply) | Mail Order or Retail 90-Now (90-day supply) | Retail* (30-day supply) | Mail Order* (90-day supply) |
|---|---|---|---|---|
| **Generic** | $8 | $16 | $10 | $20 |
| **Diabetes Generic Preventive Medications** | $0 | $0 | $10 | $20 |
| **Brand Formulary** | $8 + 30% | 30% up to $150 per Rx | $20 | $40 |
| **Brand Non-Formulary** | $8 + 50% | 50% up to $300 per Rx | $40 | $80 |
| **Specialty RX Formulary** | 30% up to $50 per Rx<br>Initial supply only | 30% up to $150 per Rx | 20% | 20% |
| **Specialty Rx Non-Formulary** | 50% up to $100 per Rx<br>Initial supply only | 50% up to $300 per Rx | 20% | 20% |
| **Rx Annual Out-of-Pocket Maximum (in-network only)** | $4,900 Individual<br>$9,800 Family | | $3,000 Individual<br>$6,000 Family | |

*Mail order is mandatory for all long-term, ongoing medications thorugh Excellus BCBS

# Rewarding Healthy Behaviors – CIGNA Wellness Incentive Programs

**(CIGNA Medical Plan Only – does not apply to Teamsters HRA Health Plan)**

## Discount Options Available to Avoid Monthly Surcharges:

To reward employees for taking positive steps toward a healthier lifestyle, BorgWarner will offer wellness initiatives that offset monthly premium surcharges for employees enrolled in the CIGNA healthcare medical plans. Participation is voluntary – the employee decides whether to complete both, one or neither.

Participation in each wellness initiative earns you $50 monthly, for a combined discount of $100, off your monthly medical premium surcharges when you are enrolled in CIGNA Choice Health Plan. If the employee does not complete the wellness initiative before the deadline to qualify, the $50 monthly surcharge will apply.

### Wellness Initiative #1: CIGNA Health Risk Questionnaire (HRQ):

- Employees who elect to take the HRQ must complete the CIGNA HRQ online at www.mycigna.com within 60 days of their benefit eligibility date to avoid paying the $50 surcharge. HRQ must then be completed once annually before the September 30 deadline.
- If the CIGNA HRQ is not completed online by the deadline, you will be charged a $50 monthly surcharge beginning with your first paycheck following the deadline.
- CIGNA will send a notification report to BorgWarner indicating employees who have completed the HRQ so that HRQ surcharges can be properly administered. Individual HRQ results are NOT shared with BorgWarner.

### Wellness Initiative #2: Tobacco Cessation:

- If you have not used tobacco within the last twelve consecutive months, complete the Tobacco Free Pledge online at www.mycigna.com within 60 days of their benefit eligibility date, and then once annually before the September 30 deadline.
- Tobacco users who elect the Tobacco Cessation Pledge must complete a BorgWarner approved tobacco cessation program (CIGNA Quit Today) within 90 days of their benefit eligibility date, and then once annually before the September 30 deadline..
- Cessation Program must be completed by phone using CIGNA Quit Today. Call 1-800-237-2904 to talk to a CIGNA health coach and set up a program with goals customized to your needs.
- You will not be charged the Tobacco Cessation Premium as long as you complete the program before the deadline. If you do not meet the deadline, you will be charged the $50 surcharge beginning with the first payroll following the deadline.

Wellness Program

## Contact the on-site Wellness Clinic today at 266-5018

We offer an on-site support and services to help employees participating in the CIGNA tobacco cessation program, as well as information on other area programs available for employees.

We can also provide a biometric screening to give you current cholesterol and blood pressure data you can use to complete the HRQ, and we offer help completing the online HRQ if you need it.

## Additional Wellness Incentives:

For taking certain healthy actions, BorgWarner will reward you and/or your spouse with Wellness Incentive Rewards.

Incentives are paid on a quarterly basis through payroll after completion of program (subject to payroll taxes). Participants must be enrolled in one of our Cigna health plans to be eligible for the incentive.

Earned dollars will be credit to you six to eight weeks after they are earned. All of BorgWarner's incentives are voluntary – you decide whether to participate.

| **Annual Plan Incentives:** Employee or Spouse can earn up to taxable cash for participating (paid quarterly - subject to payroll taxes) | |
|---|---|
| Participate in Disease Management | $200 |
| Stress Management Program | $50 |
| Weight Management Program | $50 |

# Tools and Support - The CIGNA Integrated Personal Health Team:

CIGNA's Integrated Personal Health Team model uses a "total health" approach to consolidate all CIGNA benefit plans and wellness programs under one "total health umbrella". Employees participating in one of the CIGNA health plans need make only one call to one phone number to connect with a personal health advocate who will guide them to whatever type of help they need, from advice on nutrition or help with managing stress, to resources for coping with all of the aspects of a major illness.

### One Phone Number: 1-800-237-2904

Whether you have a question about your health benefits, are checking the status of a medical claim, or have a basic health question, you simply call one phone number that is a dedicated line for use only by BorgWarner employees and family members.

### Access to an Integrated Personal Health Team

You have access to a dedicated health team who work together behind the scenes to provide you with seamless support. Your Personal Health Team consists of a wide variety of health specialists – nurses, dieticians, clinicians and counselors – who stand ready to support you.

### Your Own Personal Health Advocate

Your Personal Health Team is led by a health advocate. They are your first and primary point of contact whenever you require health and wellness support from CIGNA. Your Health Advocate personally makes sure your health and wellness needs are fully understood and that you are quickly and easily connected to the proper support, programs, and resources. This means you no longer need to figure out on your own which CIGNA wellness programs would be the best for you.

# Dental/Vision

BorgWarner also offers a combined dental and vision plan for employees who have completed 90 days of employment. Here are your options:

| YOUR OPTIONS | | |
|---|---|---|
| **Dental/Vision** | | **No Coverage** |
| Coverage Level | Monthly Contribution | |
| Employee | $18 | |
| Employee + 1 | $31 | |
| Family | $31 | |

# Dental

Your dental benefits cover routine exams, fluoride treatments, X-rays, fillings, extractions, crowns, bridges and braces. You can visit any dentist you choose. Preventive care is covered at 100% with no deductible. Coverage for other services begins after you meet your annual deductible. Then you pay a percentage of the cost, depending on the service. The plan pays benefits up to the annual maximum. After that, you are responsible for all remaining charges for the rest of the year.

| **Dental Plan Overview:** | |
|---|---|
| **Annual Deductible** | $50 per person<br>$200 per family |
| **Annual Maximum** | $2,000 per person<br>$8,000 per family |
| **Preventive and Diagnostic:**<br>Two routine exams, cleanings and bitewing X-rays per year. One set of full-mouth X-rays every three years. | 100% no deductible |
| **Basic Restorative:**<br>Fillings, root canals, denture adjustments and repairs, surgery | 80% after deductible |
| **Major Restorative:**<br>Replacement of existing dentures or bridgework once every five years | 50% after deductible |
| **Orthodontia** | 50% after deductible<br>$1,500 lifetime maximum |
| **TMJ:**<br>Non-surgical treatment only | 80% after deductible<br>up to $1,000 lifetime maximum |

### Before Expensive Dental Work Begins

If your dentist recommends a procedure that is expected to cost more than $200, you can find out how much the plan will pay before the work is done. Just ask your dentist to complete a pre-treatment estimate which describes the findings of the examination, recommended treatment and an estimate of costs. After the Dentist completes the estimate, submit it to the Insurance Company. The Insurance Company will tell you how much will be paid, if you decide to have the work done.

For more information, make sure you review the chart on the enrollment insert, or see your HR Benefits Representative.

## Vision

Your vision benefits provide coverage for one exam per calendar year, and either one pair of eyeglasses (frames and lenses) or contacts once every 24 months. More information can be found on the enrollment insert.

Like your medical benefits, coverage is higher when you visit an in-network provider. If you visit an in-network provider, you pay a co-pay, and your claims are filed for you. If you visit an out-of-network provider, your co-pays are higher, and you must file your own claims.

To locate a CIGNA Vision Network provider, visit www.mycigna.com. Log into the site, select the medical or dental tab, and click on the Vision Benefits link. Or, call CIGNA Vision Member Services at 1-877-478-7557.

| Vision Plan Overview: | Vision Care Network | Out-of-Network |
|---|---|---|
| **Exam**<br>Once per calendar year | $10 copay | $40 maximum |
| **Single Lenses*** | $10 copay | $40 copay |
| **Bifocal Lenses*** | $10 copay | $45 copay |
| **Trifocal Lenses*** | $10 copay | $50 copay |
| **Lenticular Lenses*** | $10 copay | Not covered |
| **Frames*** | $60 allowance | $30 allowance |
| **Contacts*** | $60 allowance | $60 allowance |

*Covers one pair of eyeglasses (lenses and frames) OR contact lenses once every 24 months

### Should you see an eye doctor or medical doctor?

Your vision benefits cover services performed by an ophthalmologist or optometrist to perform regular checkups and correct your vision if needed. In some cases, an eye or vision problem – such as cataracts – requires medical attention. In that case, your diagnosis and treatment would be covered under your medical plan.

# Flexible Spending Accounts

Flexible Spending Accounts (FSAs) are a great way to save on income taxes while you budget for health care and dependent care expenses. Here are your FSA options. Keep in mind, the two FSAs are separate, so you may enroll in one, both or none of them.

| YOUR OPTIONS | | | |
|---|---|---|---|
| **Health Care FSA** | **Dependent Care FSA** | **Both FSAs** | **No FSAs** |

## How FSAs Work

1. You decide how much to contribute to an FSA each year. Your election does NOT carry over into the next year.
2. Your contributions are deducted from your paychecks throughout the year before taxes are withheld. This makes savings convenient. Plus it reduces your taxable income, saving you 25% or more on income taxes, depending on your personal situation.
3. When you have an eligible expense, file a claim to get reimbursed from your FSA.

### Choice Health Fund Participants:

If you participate in the Choice Health Fund and participate in the Flexible Spending Account, your FSA funds will be used before your HRA funds. You will be able to use the Auto-Claims Forwarding process that allows you to not pay up front for Medical or Prescription expenses as long as you have money in your FSA.

### Auto-Claims Forwarding Process (CIGNA Medical and Dental Plans):

Health Care FSA claims are handled directly by CIGNA on your behalf. No claim forms to fill out or receipts to keep track of! With this “auto-forward claims” feature, it’s all handled for you automatically.

Auto-claims forwarding is not currently available for vision claims. You will need to direct submit receipts for vision expenses to CIGNA for reimbursement.

### Teamsters HRA Health Plan Participants:

If you are enrolled in the Teamsters HRA Health Plan and are going to participate in the Health Care FSA, you should note that the way you submit a claim for reimbursement from the FSA will be different. Auto-Claims forwarding is only available if you enroll in the CIGNA medical plan. Non-CIGNA members will be required to pay up front for eligible expenses, and then direct submit receipts to CIGNA for reimbursement from the plan.

The table below explains what each account is designed to cover, how much you can contribute and how to file a claim.

| | Health Care FSA | Dependent Care FSA |
|---|---|---|
| **Purpose** | For **HEALTH CARE** expenses that are not covered by your medical, dental and vision benefits for you and your dependents | For **DAY CARE** expenses for your child dependents (under age 13) while you and your spouse work |
| **How Much You Can Contribute** | **$100 - $2,550 per year** | $100 - $5,000 per year ($2,500 if you are married and file separate tax returns) |
| **Examples of Eligible Expenses** | • Deductibles, coinsurance<br>• Contacts, glasses, frames, laser eye surgery<br>• Hearing exams<br>• Chiropractic care<br>• Orthodontia<br>• Prescription drugs<br><br>For details, see www.irs.gov/publications/p502 | • Care in a home or day care center for your children (up to age 13) or a disabled adult you claim as a dependent on your taxes<br>• After-school care program<br>• Nursery school<br>• Summer day camp<br><br>For details, see www.irs.gov/publications/p503 |
| **Expenses that CANNOT be Paid with an FSA** | • Health club memberships<br>• Weight loss programs<br>• Cosmetic surgery, teeth whitening<br>• Many over-the-counter products unless accompanied by a prescription | • School tuition<br>• Nursing home expenses<br>• Babysitting while you are not working<br>• Overnight camp |
| **Reimbursement Information** | • Eligible expenses must be incurred before December 31 of the plan year. Applicable receipts must be submitted before March 30th of the year following.<br>• If you enroll in the Choice Health Fund, medical expenses are paid through your Health Care FSA first, before the Health Reimbursement Account (HRA).<br>• A maximum of $500 of unused funds may be rolled over for use the following year. | • Submit a claim form with your provider's Social Security number (or taxpayer ID) and receipt.<br>• You'll be reimbursed up to the amount currently in your account.<br>• Eligible expenses incurred before December 31st of the plan year. |

## Budget Carefully

Because FSAs give you a tax break, the IRS has set certain rules for these accounts.

- **Use it or lose it – rollover maximum of $500 of unspent funds.** Any money left in your account after the dates in the chart above may be forfeited. You cannot rollover your balance into the next year. Use the worksheets below to estimate your expenses.
- **No transfers between accounts.** You cannot transfer funds from a Health Care FSA to a Dependent Care FSA or vice versa.
- **Keep income tax deductions separate.** Any expenses paid through an FSA cannot be taken as a deduction on your personal income taxes such as the federal dependent care tax credit.
- **Once-a-year decision.** You cannot change your election unless you have a qualified family status change or life event (see the "Rules of the Road" section of this guide for more information).

# Life Insurance and Disability Benefits

## Basic Life Insurance

Your Basic Life Insurance benefit offers financial protection for your survivors if you die while you're an active employee of the company. **BorgWarner pays the full cost** of this valuable benefit.

| YOUR OPTIONS |
|---|
| **Basic Life of 1x your annual base pay as of January 1 each year** |

## Additional and Dependent Life Insurance

You can purchase additional life insurance for you, your spouse and your dependent children through MetLife. Here are your options:

| YOUR OPTIONS | | | |
|---|---|---|---|
| **You** | **Your Spouse** | **Your Dependent Children** | **No coverage** |
| 1 x annual base pay*<br>2 x annual base pay*<br>3 x annual base pay*<br>4 x annual base pay*<br>5 x annual base pay*<br>6 x annual base pay*<br>7 x annual base pay*<br>8 x annual base pay* | $ 5,000<br>$ 10,000<br>$ 25,000<br>$ 50,000<br>$150,000<br>$250,000 | $ 5,000 each<br>$10,000 each<br>$15,000 each<br>$20,000 each | |

* Up to $2,500,000

Your cost varies depending on your age, your spouse's age and the amount of coverage selected.

Your optional life insurance policy is individually owned through MetLife. Therefore, no annual enrollment is required; however, evidence of insurability may be required. If you are interested in participating in the plan, or if you are a current participant and wish to make changes, contact MetLife directly at 1-888-622-6616

## Voluntary Accident Insurance

Optional Voluntary Accident Insurance through MetLife covers accidental death, dismemberment and permanent and total disability due to accidents at home or elsewhere, whether you are engaged in business or pleasure. You can choose coverage for you and for your family as shown below.

| YOUR OPTIONS | |
|---|---|
| **Union Hourly**<br>$10,000 to $100,000 in $5,000 increments | **No Coverage** |

Because your policy is individually owned through MetLife, **no annual enrollment is required**. You pay the cost through payroll deductions. Your cost varies depending on the coverage you select. Contact your Benefits Representative for details.

## Short-term and Long-term Disability

Disability benefits provide your family with a source of income if you are unable to work due to a non-work-related illness or injury. Coverage for short-term disability begins on the first day of employment. Long-term disability coverage begins after one year of employment.

| YOUR OPTIONS |
|---|
| **STD – basic coverage** |
| **LTD60 – basic coverage** |
| **LTD70 – optional coverage** |

- **Short-term Disability (STD)** begins after you've been absent from work for seven days. It pays a portion of your current earnings while you are disabled. Weekly amounts paid during approved short-term disability leave of absences vary based on your service date with BorgWarner. See the current union agreement for details. Short-term disability ends when you recover or after six months of disability, whichever is sooner.

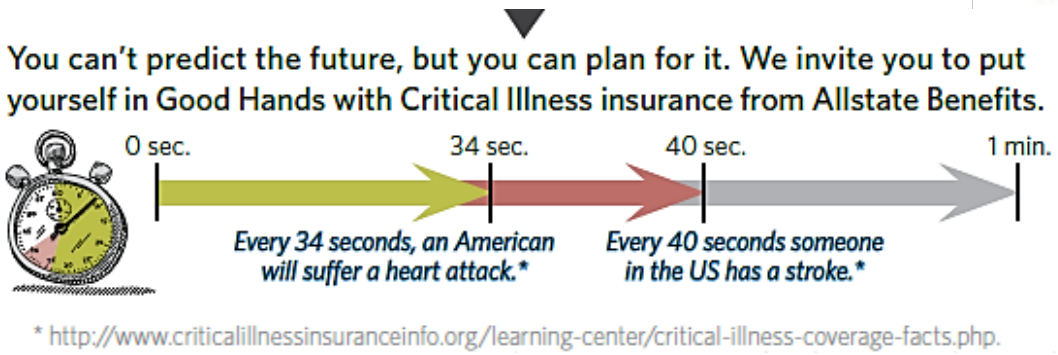
- **Long-term Disability (LTD60)** is basic coverage available to employees which begins after you've been disabled for more than six months and meet the insurer's definition of disabled. It pays 60% of your current salary up to $5,000 per month until you reach normal retirement age. Long-term disability benefits will be reduced by the amount of other income you may receive such as Social Security or workers' compensation.

- **Long-term Disability (LTD70)** is optional coverage available to employees. If elected, coverage begins after you've been disabled for more than six months and meet the insurer's definition of disabled. It pays 70% of your current salary (including a combination of bae wages and an average of 3 years of employee incentive plan payouts as calculated on Jan 1 of each year for the previous year) up to $5,000 per month until you reach normal retirement age. Long-term disability benefits will be reduced by the amount of other income you may receive such as Social Security or workers' compensation.

If you become disabled, you must file a disability form and be under the care of a physician. All disability claims and family medical leave claims are administered by CIGNA. To begin the claims process, you contact CIGNA at 1-888-842-4462.

**If you take a leave of absence,** including family and medical leave or military leave, contact your local HR Link representative about whether or not you can continue your medical coverage during your leave. Your HR Link representative can also explain how your leave may impact your other benefits.

# Critical Illness Insurance



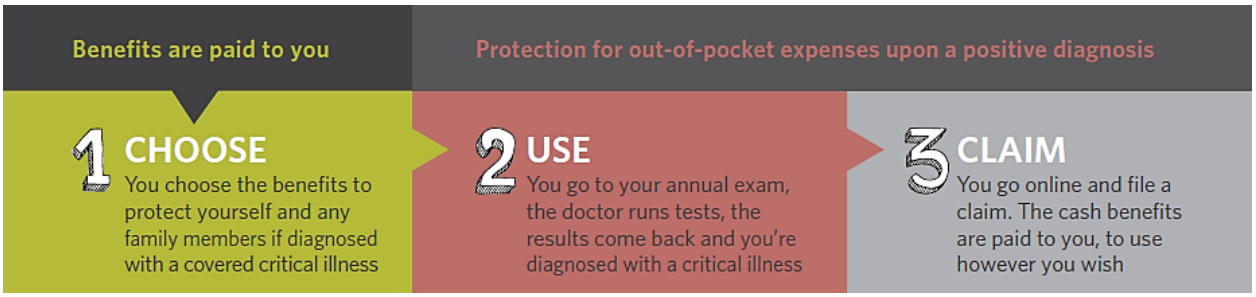

Would your financial well-being be impacted by a Critical Illness?
We can't always see the signs and know what to do to prevent an illness, but we can help protect ourselves in the even we are diagnosed with a critical illness. As a BorgWarner employee, you have the option of enrolling in Critical Illness Benefits through Allstate. Premiums are employee paid and collected on an after-tax basis through payroll.

- Provides a lump-sum benefit when you are diagnosed with a critical illness such as Heart Attack, Stroke, Cancer and other illness (see list on next page)
- Various coverage level options available. Coverage is also available for your spouse and/or children.
- You choose your desired coverage level and dependents to cover (if applicable)
- Benefits are paid regardless of other coverage
- Enroll online through Workday

***Guaranteed Issue Coverage***

*Critical Illness Insurance is Guaranteed Issue coverage, meaning no medical questions to answer, at initial enrollment which must occur during BorgWarner's Annual Open Enrollment period or as a newly hired employee (must be elected by employee within 30 days of hire date; coverage is effective after 90 days of employment)*

*Enrollment outside of the enrollment periods outlined above will not be Guaranteed Issue and Evidence of Insurability (EOI) will apply.*



## BENEFIT AMOUNTS+

+Your Spouse is covered at 100% and Your Child(ren) up to age 26 are covered at 50% of your Benefit Amount when you enroll in coverage for family. Premium costs vary based on several factors including age, tobacco use, and coverage level.

| | COVERAGE LEVEL OPTIONS | | |
|---|---|---|---|
| **INITIAL CRITICAL ILLNESS BENEFITS*** | **$10,000** | **$20,000** | **$30,000** |
| **Heart Attack** (100%) | $10,000 | $20,000 | $30,000 |
| **Stroke** (100%) | $10,000 | $20,000 | $30,000 |
| **Coronary Artery Bypass Surgery** (25%) | $2,500 | $5,000 | $7,500 |
| **Major Organ Transplant** (100%) | $10,000 | $20,000 | $30,000 |
| **End State Renal Failure** (100%) | $10,000 | $20,000 | $30,000 |
| **Waiver of Premium** (employee only) | Yes | Yes | Yes |
| **CANCER CRITICAL ILLNESS BENEFITS*** | **$10,000** | **$20,000** | **$30,000** |
| **Invasive Cancer** (100%) | $10,000 | $20,000 | $30,000 |
| **Carcinoma in Situ** (25%) | $2,500 | $5,000 | $7,500 |
| **SECOND EVENT BENEFITS*** | **$10,000** | **$20,000** | **$30,000** |
| **Second Event Initial Critical Illness Benefit** (same amount as Initial Critical Illness) | Yes | Yes | Yes |
| **Second Event Cancer Critical Illness Benefit** (same amount as Initial Critical Illness) | Yes | Yes | Yes |
| **Supplemental Critical Illness Benefits*** | **$10,000** | **$20,000** | **$30,000** |
| **Advanced Alzheimer's Disease** (25%) | $2,500 | $5,000 | $7,500 |
| **Advanced Parkinson's Disease** (25%) | $2,500 | $5,000 | $7,500 |
| **Benign Brain Tumor (**100%) | $10,000 | $20,000 | $30,000 |
| **Coma (**100%) | $10,000 | $20,000 | $30,000 |
| **Complete Blindness (**100%) | $10,000 | $20,000 | $30,000 |
| **Complete Loss of Hearing (**100%) | $10,000 | $20,000 | $30,000 |
| **Paralysis (**100%) | $10,000 | $20,000 | $30,000 |

* **Conditions, Limitations and Exclusions Affecting Your Benefits**

**Conditions and Limits**

Benefits are not payable for any critical illness diagnosed prior to the effective date. Benefits are also subject to all limitations and exclusions. All critical illnesses must meet the definitions and dates of diagnoses stated in the policy and be diagnosed by a physician while coverage is in effect. The date of diagnosis for each illness must be separated by 90 days. Emergency situations while you are outside the U.S. will be considered when you return to the U.S.

Allstate.

** For a full list of limitations and exclusions go to borgwarner.com/benefits/Ithaca or contact your HR Link Benefits Representative*

# *Enroll!*

**Now that you've read your guide and reviewed your opions, you're almost ready to complete your enrollment online using Workday.**

**Before you do, review it to make sure you:**

- ✓ Log in to Workday. Contact HR if you have trouble logging in.
- ✓ Make elections or waive coverage under each section.
- ✓ Have your dependent information available, including date of birth and social security number.
- ✓ Check the box marked "I Agree" on the last page to electronically sign and complete your enrollment.
- ✓ Print a copy for your records if you wish. Remember, you can access your information at any time throughout the year by logging into Workday. It is not necessary to give HR a copy of your form. We receive the information electronically through Workday.
- ✓ Provide all necessary documents to complete dependent(s) enrollment (marriage license, birth certificate, custody agreement, etc).
- ✓ For Cigna medical plan, log in to mycigna.com and complete the HRQ and Tobacco Pledge annually before the deadline if you want to receive surcharge credits each year.

**Information on the following pages on additional benefits made available to BorgWarner employees is provided for your use.**

**No annual enrollment is necessary for these benefits.**

**As always, please call HR Link at (844)4BW-LINK or see your HR Link Benefit Representative in Plant 2 if you have specific questions or need more information regarding any employee benefits.**

# EAP BENEFIT

## BorgWarner Employee Assistance Program
## 800-237-2904

As a full-time employee, you are automatically eligible for and enrolled in the CIGNA Employee Assistance Program (EAP), regardless of health plan enrollment.

Your Employee Assistance Program (EAP) is available to help 24 hours a day, seven days a week.

EAP benefits are available to you and members of your household:

- 3 free sessions available with an Employee Assistance Professional.
- Unlimited telephone consultations.
- 24-hour crisis line available seven days a week.
- Information and referrals related to childcare, eldercare, legal, financial, education issues, and support for pets.
- Online access to a network of EAP Professionals and other resources via www.cignabehavioral.com.

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## *WHO ARE WE?*

The Wellness Program at BorgWarner is designed to support our employee's current health care needs, help prevent future disease, and promote health and wellness. It is available to all active full-time BorgWarner Employees.

In order to offer these services and still protect the privacy of our employees, BorgWarner has contracted with the Guthrie Clinic in Ithaca to offer an on-site clinic located in Plant 2. On-site care includes the services of an RN/Health Coach, a General Practice Physician, an Occupational Medicine Physician, an Occupational Therapist, and a Dietitian.

**Our on-site Wellness Clinic and Wellness Program offer a variety of on-site services and support for all BorgWarner active full-time employees!**

**Services Include:**

**Illness, Disease Prevention, Pain Management,**
**Wellness Physicals, Health Screening, Health Coaching**
**Nutrition and Weight Evaluation & Guidance,**
**Smoking Cessation,**
**Lunch & Learns, Annual Health Fair,**
**Employee Wellness Committee,**
**Employee Support Groups**
**and much more…**

**Call the Wellness Clinic today!**
**(607)266-5016/5018**

GUTHRIE

## *WE HOPE YOU WILL CONSIDER VISITING US SOON …*

The Wellness Clinic is open daily. Hours vary by building and by provider/service.

Appointments can be scheduled by calling the clinic at (607)266-5018. You can also schedule an appointment at any of the BorgWarner Employee Kiosk locations or from the HR Intranet Site (ICE).

BorgWarner

# $250 GYM MEMBERSHIP REIMBURSEMENT

As an added wellness benefit, you are eligible to receive a reimbursement of a health club membership or exercise program fee, up to a maximum of $250 per calendar year, just for completing your annual preventive care exam either on-site with our Wellness Clinic or with your primary care provider.

This benefit applies to any fitness center of your choice. However, certain area fitness centers will offer you additional discounts if you tell them that you are a member of the BorgWarner Employee Wellness Program. For the most up to date information on discounts that may be available, you should contact the individual health clubs directly.

The process is simple:

You join a fitness center of your choice and pay their fee. Make sure you get a paid receipt from the center. Bring a copy of the paid receipt to your HR Benefits Representative that is clearly marked with your name and employee number, along with proof that you have completed your annual preventive care exam. We will then request reimbursement be paid to you as part of the normal payroll process. You should see your reimbursement in your paycheck in about two (2) weeks. Please note that this is considered a taxable benefit.

## *REIMBURSEMENT GUIDELINES TO REMEMBER:*

- To be eligible for this reimbursement, you must have had a wellness visit with one of our on-site clinic providers OR had a routine preventive exam with your own primary care physician within the last twelve (12) months. The Wellness Clinic can give you a voucher to submit with your gym membership receipt as proof of eligibility. An EOB from your insurance company will be required as proof of primary care physician services.
- Employee is responsible to pay the gym membership in advance. BorgWarner will not pre-pay any portion of the membership fee.
- Reimbursements will only be made to the employee, not the fitness center.
- Only one (1) reimbursement will be allowed per employee per calendar year. (This means for example if you turn in three months of receipts, you will be reimbursed for three months in that calendar year.)
- Reimbursements will be made for receipts within the last twelve (12) months.

*BorgWarner is committed to helping you achieve your best health status. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact your local HR and we will work with you (and, if you wish, with your doctor) to find a reasonable alternative in light of your health status.*

# Safety Shoes

Employees can purchase safety footwear from catalogs, department stores or the onsite shoe mobile. BorgWarner will reimburse based on the annual amount in the current CBA.

### When purchased at the shoe mobile:

The shoe mobile vendor comes twice a month with postings several weeks ahead. Check bulletin boards for exact dates and times. Employees may pay for the employee portion of the shoes, if owed, at the truck with cash or credit card. Employee identification badge is required at time of purchase.

### When purchased at somewhere other than the mobile vendor:

The employee must bring their original receipt for ANSI approved safety shoes to the shoe mobile operator along with the actual shoes purchased in order to request reimbursement. An employee can receive up to the maximum reimbursement level for each calendar year (January 1 to December 31). If the purchase price was lower than the maximum allowable reimbursement level, the employee will only receive a reimbursement for the actual purchase price.

# Safety Glasses

## Non-prescription Safety Glasses

Each new employee will be issued a pair of safety glasses. It will be the responsibility of each employee for the safekeeping of their safety glasses. A new pair will be given only to those who return a damaged pair. Distribution of safety glasses will be done through General Stores.

## Prescription Safety Glasses

If you need prescription safety glasses, BorgWarner offers a voucher program to help employees with the additional costs of purchasing them. Stop by the HR Office in Plant 2 to obtain a voucher and for more information on the program.

In order to purchase safety glasses, you must have a current prescription. Please note that this program helps cover the cost of the safety glasses, but does not cover the cost of an eye exam. BorgWarner will be billed up to the maximum amount for your safety glasses. Anything above and beyond the maximum amount will be the responsibility of the employee to pay at the time of service.

## Replacement Prescription Safety Glasses

### BorgWarner will only replace glasses if:

1. A 24 month period had elapsed since the last purchase of safety glasses. OR
2. A significant change in the lens prescription has occurred or if the safety glasses have been damaged or destroyed as a result of a work related incident. OR
3. Your glasses have been damaged due to a work related incident. The company will not cover the replacement cost if damaged or destroyed though employee carelessness.

# Retirement Savings Plan (RSP)

BorgWarner understands the importance of planning ahead and encourages all team members to save for the future. To that end, the Company offers a comprehensive Retirement Savings Plan (RSP) that combines personal contributions with company-matching contributions, depending on your length of service, to help you build a nest egg for your future.

Employees are eligible to begin making contributions to the RSP and begin accumulating retirement savings. upon completion of sixty (60) days of service. The Company will get involved and supplement employee contributions after completion of six (6) months of service

Your RSP Account may consist of any, or all, of the following accounts:

- Company Retirement Account (CRA)
- Savings Account (SA)
- Retiree Health Account (RHA)

## Company Retirement Account (CRA)

After six (6) months of employment, BorgWarner will automatically contribute an amount of the CRA based on a percentage of your compensation and years of service, whether or not you elect to contribute to the other accounts. The CRA is reserved for retirement savings and is not available for loan or withdrawal. The contribution schedule is based on years of service. See the current union agreement for details.

## Savings Account (SA)

After sixty (60) days of employment, you may begin contributing from 1% to 70% of your annual compensation to the SA on a before-tax, Roth, or after-tax basis. After six (6) months of employment, BorgWarner will match the first 3% of the before-tax or Roth contributions you make to this account. Contact Vanguard (by phone or on-line) to enroll in or opt out of the SA. If you do not contact them, you will automatically be enrolled to contribute 3% to the SA on a before-tax basis after one hundred twenty (120) days of employment. You may obtain a loan and make withdrawals of your own funds (matching funds are not eligible) from your SA according to the provisions of the plan. Contact Vanguard for more details.

## Retiree Health Account (RHA)

The RHA portion of the RSP is a valuable way to help you save today for medical costs you may incur after you leave BorgWarner. After 60 days of employment, you may contribute from 1% to 3% of your pay on a before-tax basis. After six (6) months of employment, BorgWarner will match RHA contributions dollar for dollar up to $500 annually. The RHA match is in addition to the company match you receive for your Savings Account Before-Tax or Roth contributions. Contact Vanguard (by phone or on-line) to enroll in the RHA or to make changes after you are enrolled.

## Vesting

You are always vested in, and have a non-forfeitable right to, the value of your contributions to your RSP Account. You become vested in the contributions made by the Company after three (3) years of continuous service with BorgWarner.

# Required Information

BorgWarner has prepared the BorgWarner Flexible Benefits Plan to comply with various disclosure requirements mandated by law, and to clarify administrative procedures and eligibility conditions for BorgWarner health and welfare benefit plans. Other plan and summary plan description documents prepared by our insurers and vendors (referred to as "Incorporated Documents") provide specific descriptions of covered and excluded benefits as well as a description of the terms and conditions to receive such benefits. Although we highlight below a number of rights and benefits, you should carefully review the summary plan description (SPD) to the Flexible Benefits Plan and Incorporated Documents to fully understand your legal rights and benefits. These documents are also posted on the BorgWarner website at www.borgwarner.com/benefits.

You also may contact the BorgWarner Employee Benefits Committee at 1-248-754-9200 for more information about any of the rights explained below or in the summary plan description to the Flexible Benefits Plan and Incorporated Documents.

BorgWarner reserves the right to modify and/or discontinue the benefits it provides, the premium amounts it pays, eligibility rules and other provisions for any of its employee benefit programs, for any reason at any time. In the event of a conflict in language or interpretation between these open enrollment materials, and the official plan documents (SPD and Benefits Guide), the terms of such official plan documents will control. Because these employee benefit programs may change or be amended from time to time, you should always check with Human Resources for current information.

## Continuation of Coverage (COBRA)

Consolidated Omnibus Budget Reconciliation Act (COBRA) is a Federal law requiring most group health benefit plans to offer employees and their families the opportunity to temporarily extend their health care coverage beyond the date on which their health care coverage would normally terminate.

Contact Human Resources if you or your spouse or dependent children lose group health coverage due to the occurrence of a COBRA Qualifying Event, which may include your termination or reduction in hours of employment, death, divorce, no longer satisfying dependent eligibility conditions, etc. Under the law, the employee or the family member is responsible for informing the Human Resource department of any family status change (e.g. divorce or attaining the limiting age) within 60 days of the event. Otherwise, COBRA rights will be lost.

For more information about COBRA, including information on alternative health insurance options available to you through the Health Insurance Marketplace, please refer to the Initial COBRA Notice attached to this booklet or at www.borgwarner.com/benefits.

## Notice of Privacy Practice

BorgWarner is committed to protecting your health information. To learn how your medical information may be used and disclosed and how you can get access to this information, please refer to the "Notice of Privacy Practices" attached to this booklet or at www.borgwarner.com/benefits.

## Summary of Benefits and Coverage

You will receive a Summary of Benefits and Coverage ("SBC") explaining the Medical Plan option available to you as part of your Enrollment Materials. A copy of the SBC also will be avail-able at www.borgwarner.com/benefits.

## Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act of 1998 requires that health plans cover post-mastectomy reconstructive breast surgery if they provide medical and surgical coverage for mastectomies. Specifically, health plans must cover:

- 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 physical complications of all stages of mastectomy, including Lymphedemas.

Benefits required under the Women's Health and Cancer Rights Act will be provided in consultation between the patient and attending physician. These benefits are subject to the health plan's regular copays and deductibles. In addition, the Plan will not (1) deny your eligibility or continued eligibility to enroll or to renew coverage under the terms of the Plan solely for purposes of avoiding this coverage, or (2) penalize or otherwise reduce or limit the reimbursement of an attending provider or provide incentives (monetary or otherwise) to an attending provider to induce the provider to provide care to you in a manner that is inconsistent with this required coverage.

## Newborns and Mothers Health Protection Notice

Group health plans generally may not, under federal law, restrict benefits for any hospital length of stay for the mother or newborn child in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending health care provider, after consulting with the mother, from discharging the mother or newborn earlier than 48 hours (or 96 hours, if applicable). In any case, the health plan will not require a provider to obtain authorization from the health plan for prescribing a length of stay of 48 hours (or 96 hours, if applicable) or less.

## Special Enrollment Events

You may have the right to enroll in the medical and other benefit plans during Special Enrollment periods, including when you lose coverage under another group health plan, Medicaid or State Children Health Insurance Programs, or when you acquire a new dependent. For more information, please refer to the SPD to the Flexible Benefits Plan and Incorporated Documents.

## Children's Health Insurance Program Reauthorization Act (CHIPRA)

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage. For more information, please refer to the full CHIPRA Notice later in this document.

## Patient Protection Notice

If the Plan provides for or requires the designation of a primary care provider, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Plan Administrator. For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Plan Administrator.

## Recovery of Plan Expenses (Subrogation)

If a Plan participant suffers an illness or injury for which the participant obtains health care services covered by the plan, and that injury or illness occurred through the negligence or willful act or omission by another person, benefits provided under the health plan under which the participant is covered from the illness or injury may be considered an advancement of payment and subrogated from any settlement or judgment the participant receives from the other person. Typically, these amounts are recovered through either party's insurer, however, your enrollment in the health plan is considered to have assigned the health plan the right to pursue reimbursement for the health plan's costs from recovery proceeds. The guide refers everyone to the health plan for further information.

## Health Insurance Marketplace Coverage Options

Your state has a website, called the Health Insurance Marketplace, where you can buy individual medical insurance directly from insurance companies. The Marketplace offers "one-stop shopping" to find and compare medical insurance options for you and your family. This year's open enrollment for the Marketplace begins November 1, 2018 and ends December 15, 2018. You may buy health insurance for yourself and your family members from your state's Marketplace.

If you and your dependents are offered medical coverage through BorgWarner Flexible Benefit Plan, BorgWarner will pay a portion of the cost of that coverage. As a result, you may not find less expensive coverage through your state's Marketplace. Also keep in mind that the contributions you and BorgWarner make to the cost of medical coverage under BorgWarner's Flexible Benefits Plan are made with pre-tax dollars that are not subject to income tax. If you buy health insurance through your state's Marketplace, you will pay for it with after-tax dollars. You also, except for unusual circumstances, will not be eligible for federal premium assistance (explained below) to help pay the cost of a Marketplace policy whenever BorgWarner's Flexible Benefits Plan meets the "minimum value" and "affordability" standards.

A federal tax credit that lowers the monthly premium of an individual health insurance policy purchased from the Marketplace is available to families with incomes between 100% and 400% of the federal poverty level. If you are employed and your income is at this level, you and your family members are eligible for premium assistance if one of the following applies:

- Your employer does not offer health coverage to you at all, Your employer offers you coverage but it does not meet the federal government's minimum value standard, or
- Your employer's health plan is not "affordable" for you, meaning that the cost of single coverage (that is, coverage for just you, not you plus your family members) is more than 9.56% of your household income for the year.

For more information about available benefits and your premium costs under BorgWarner's Flexible Benefits Plan, please contact the BorgWarner Employee Benefits Committee at 248-754-9200.

For more information about the Marketplace, go to www.healthcare.gov and select your state's Marketplace website. You may be asked for information about BorgWarner's Flexible Benefits Plan which can be found in the SPD or by contacting the BorgWarner Employee Benefits Committee at 248-754-9200.

## Continuation Coverage Rights Under COBRA

This notice applies to anyone covered under one of the group health benefit programs offered through the BorgWarner Inc. Flexible Benefits Plan (the Plan), including the Medical, Dental, Vision, Health Flexible Spending Account, and Employee Assistance Programs. This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of group health coverage under the Plan under certain circumstances when coverage would otherwise end. This notice generally explains COBRA coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA coverage can become available to you when you would otherwise lose your group health coverage under the Plan. It can also become available to your spouse and dependent children, if they are covered under the Plan, when they would otherwise lose their group health coverage under the Plan. This notice does not fully describe COBRA coverage or other rights under the Plan. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's summary plan description or contact BorgWarner Inc., which is the Plan administrator. The Plan provides no greater COBRA rights than what COBRA requires—nothing in this notice is intended to expand your rights beyond COBRA's requirements.

## What Is COBRA Coverage?

COBRA coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event occurs and any required notice of that event is properly provided to BorgWarner Inc., COBRA coverage must be offered to each person losing Plan coverage who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries and would be entitled to elect COBRA if coverage under the Plan is lost because of the qualifying event. (Certain newborns, newly adopted children, and alternate recipients under QMCSOs may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below.) Under the Plan, qualified beneficiaries who elect COBRA must pay for COBRA coverage.

## Who Is Entitled to Elect COBRA?

If you are an employee, you will be entitled to elect COBRA if you lose your group health coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct

If you are the spouse of an employee, you will be entitled to elect COBRA if you lose your group health coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

A person enrolled as the employee's dependent child will be entitled to elect COBRA if he or she loses group health coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- Your parent-employee becomes enrolled in Medicare (Part A, Part B, or both; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

## When Is COBRA Coverage Available?

When the qualifying event is the end of employment or reduction of hours of employment or death of the employee, the Plan will offer COBRA coverage to qualified beneficiaries. You need not notify BorgWarner Inc. of any of these qualifying events. You Must Give Notice of Some Qualifying Events. For the other qualifying events (divorce or legal separation of the employee and spouse, or a dependent child's losing eligibility for coverage as a dependent child), a COBRA election will be available to you only if you (or a family member) notify your Human Resources Office in writing within 60 days after the later of: (1) the date of the qualifying event; and (2) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event. If these procedures are not followed, or if the notice is not provided to your local Human Resources Office during the 60-day notice period, THEN ALL QUALIFIED BENEFICIARIES WILL LOSE THEIR RIGHT TO ELECT COBRA.

## Electing COBRA

Each qualified beneficiary will have an independent right to elect COBRA. Covered employees and spouses (if the spouse is a qualified beneficiary) may elect COBRA on behalf of all of the qualified beneficiaries, and parents may elect COBRA on behalf of their children. Any qualified beneficiary for whom COBRA is not elected within the 60-day election period specified in the Plan's COBRA election notice WILL LOSE HIS OR HER RIGHT TO ELECT COBRA.

## How much does COBRA Continuation Coverage Cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay will not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage.

## How long does COBRA Continuation Coverage Last?

COBRA coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the covered employee's divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA coverage under the Plan's Medical, Dental, Vision, and/or EAP components can last for up to a total of 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage under the Plan's Medical and Dental components for qualified beneficiaries (other than the employee) who lose coverage as a result of the qualifying event can last until up to 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA coverage for his spouse and children who lost coverage as a result of his termination can last up to 36 months after the date of Medicare

entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). This COBRA coverage period is available only if the covered employee becomes entitled to Medicare within 18 months before the termination or reduction of hours. Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA coverage under the Plan's Medical, Dental, Vision and/or EAP components generally can last for only up to a total of 18 months, unless you have a second qualifying event. COBRA coverage under the Health FSA component can last only until the end of the year in which the qualifying event occurred – see the paragraph below entitled "Health FSA Component".

The COBRA coverage periods described above are maximum coverage periods. COBRA coverage can end before the end of the maximum coverage periods described in this notice for several reasons, which are listed below.

- any required premium is not paid in full on time,
- a qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan,
- a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage, or
- the employer ceases to provide any group health plan for its employees

There are two ways (described in the following paragraphs) in which the period of COBRA coverage resulting from a termination of employment or reduction of hours can be extended. (The period of COBRA coverage under the Health FSA cannot be extended under any circumstances.)

Disability extension of COBRA coverage: If a qualified beneficiary is determined by the Social Security Administration to be disabled and you notify your local Human Resources Office in a timely fashion, all of the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the covered employee's termination of employment or reduction of hours. The disability must have started at some time before the 61st day after the covered employee's termination of employment or reduction of hours and must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months, as described above).

The disability extension is available only if you notify your Plan Administrator in writing of the Social Security Administration's determination of disability within 60 days after the latest of:

- the date of the Social Security Administration's disability determination;
- the date of the covered employee's termination of employment or reduction of hours; and
- the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination of employment or reduction of hours.

You must also provide this notice within 18 months after the covered employee's termination of employment or reduction of hours in order to be entitled to a disability extension. If these procedures are not followed, or if the notice is not provided to your Plan Administrator during the 60-day notice period, and within 18 months after the covered employee's termination of employment or reduction of hours, THEN THERE WILL BE NO DISABILITY EXTENSION OF COBRA COVERAGE.

Second qualifying event extension of COBRA coverage: If your family experiences another qualifying event while receiving COBRA coverage because of the covered employee's termination of employment or reduction of hours (including COBRA coverage during a disability extension period as described above), the spouse and dependent children receiving COBRA coverage can get up to 18 additional months of COBRA coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan Administrator. This extension may be available to the spouse and any dependent children receiving COBRA coverage if the employee or former employee dies or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. (This extension is not available under the Plan when a covered employee becomes entitled to Medicare after his or her termination of employment or reduction of hours.)

This extension due to a second qualifying event is available only if you notify the BOS/BorgWarner COBRA Service Center in writing of the second qualifying event within 60 days after the date of the second qualifying event. If these procedures are not followed, or if the notice is not provided to the BOS/BorgWarner COBRA Service Center during the 60-day notice period, THEN THERE WILL BE NO EXTENSION OF COBRA COVERAGE DUE TO A SECOND QUALIFYING EVENT.

## Health FSA Component

COBRA coverage under the Health FSA will be offered only to qualified beneficiaries losing coverage who have under spent accounts. A qualified beneficiary has an under spent account if the annual limit elected by the covered employee, reduced by the reimbursable claims submitted up to the time of the qualifying event, is equal to or more than the amount of the premiums for Health FSA COBRA coverage that will be charged for the remainder of the plan year. COBRA coverage will consist of the Health FSA coverage in force at the time of the qualifying event (i.e. the elected annual limit reduced by reimbursable claims submitted up to the time of the qualifying event). The use-it-or-lose-it rule will continue to apply, so any unused amounts will be forfeited at the end of the plan year. Unless otherwise elected, all qualified beneficiaries who were covered under the Health FSA will be covered together for Health FSA COBRA coverage.

## More Information About Individuals Who May Be Qualified Beneficiaries

A child born to, adopted by, or placed for adoption with a covered employee during a period of COBRA coverage is considered to be a qualified beneficiary provided that, if the covered employee is a qualified beneficiary, the covered employee has elected COBRA coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the Plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements (for example, regarding age). A child of the covered employee who is receiving benefits under the Plan pursuant to a qualified medical child support order (QMCSO) received by BorgWarner Inc. during the covered employee's period of employment with BorgWarner Inc. is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

## Are There Other Coverage Options Besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.HealthCare.gov.

## If You Have Questions or Address Changes

Questions concerning the Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.). In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

## Plan Contact Information

You may obtain information about the Plan from your Human Resources Office and COBRA coverage from the BOS/BorgWarner COBRA Service Center at 877-206-0283. This contact information for the Plan may change from time to time. The most recent information will be included in the Plan's most recent summary plan description (if you do not have a copy, you may request one from your Human Resources Office.).

## Plan Sponsor

**BorgWarner Employee Benefits Committee**
c/o BorgWarner Inc.
3850 Hamlin Road
Auburn Hills, MI 48236

248-754-9200

**COBRA Administrator**
**BOS/BorgWarner COBRA Service Center**
3149 Haggerty Road
Commerce Twp, MI 48390

877-206-0283

## Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these pro-grams, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2018. Contact your State for more information on eligibility –

**ALABAMA – Medicaid**
Website: http://myalhipp.com/
Phone: 1-855-692-5447

**ALASKA – Medicaid**
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

**ARKANSAS – Medicaid**
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
Health First Colorado Website:
https://www.healthfirstcolorado.com/Health First Colorado
Member Contact Center:
1-800-221-3943/ State Relay 711
CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus
CHP+ Customer Service: 1-800-359-1991/
State Relay 711

**FLORIDA – Medicaid**
Website: http://flmedicaidtplrecovery.com/hipp/
Phone: 1-877-357-3268

**GEORGIA – Medicaid**
Website: http://dch.georgia.gov/medicaid
Click on Health Insurance Premium Payment (HIPP)
Phone: 404-656-4507

**INDIANA – Medicaid**
Healthy Indiana Plan for low-income adults 19-64 Website:
http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: http://www.indianamedicaid.com
Phone 1-800-403-0864

**IOWA – Medicaid**
Website:
http://dhs.iowa.gov//hawk
Phone: 1-800-257-8563

**KANSAS – Medicaid**
Website: http://www.kdheks.gov/hcf/
Phone: 1-785-296-3512

**KENTUCKY – Medicaid**
Website: http://chfs.ky.gov
Phone: 1-800-635-2570

**LOUISIANA – Medicaid**
Website:
http://dhh.louisiana.gov/index.cfm/subhome/1/n/331
Phone: 1-888-695-2447

**MAINE – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/ index.html
Phone: 1-800-442-6003
TTY: Maine relay 711

**MASSACHUSETTS – Medicaid and CHIP**
Website:
http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 1-800-657-3739

**MINNESOTA – Medicaid**
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/ medical-assistance.jsp
Phone: 1-800-657-3739

**MISSOURI – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

**MONTANA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

**NEBRASKA – Medicaid**
Website: http://www.AccessNebraska.ne.gov Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

**NEVADA – Medicaid**
Medicaid Website: https://dhcfp.nv.gov
Phone: 1-800-992-0900

**NEW HAMPSHIRE – Medicaid**
Website: http://www.dhhs.nh.gov/ombp/nhhpp
Phone: 603-271-5218
Hotline: NH Medicaid Service Center 1-888-901-4999

**NEW JERSEY – Medicaid and CHIP**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

**NEW YORK – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

**NORTH CAROLINA – Medicaid**
Website: https://dma.ncdhhs.gov/
Phone: 919-855-4100

**NORTH DAKOTA – Medicaid**
Website:
http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

**OKLAHOMA – Medicaid and CHIP**
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

**OREGON – Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

**PENNSYLVANIA – Medicaid**
Website:
http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm
Phone: 1-800-692-7462

**RHODE ISLAND – Medicaid**
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347

**SOUTH CAROLINA – Medicaid**
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

**SOUTH DAKOTA – Medicaid**
Website: http://dss.sd.gov
Phone: 1-888-828-0059

**TEXAS – Medicaid**
Website: http://gethipptexas.com/
Phone: 1-800-440-0493

**UTAH – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

**VERMONT– Medicaid**
Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

**VIRGINIA – Medicaid and CHIP**
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm
Medicaid Phone: 1-800-432-5924
CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm
CHIP Phone: 1-855-242-8282

**WASHINGTON – Medicaid**
Website: http://www.hca.wa.gov/free-or-low-cost-health-care/ program-administration/premium-payment-program
Phone: 1-800-562-3022 ext. 15473

**WEST VIRGINIA – Medicaid**
Website: http://www.dhhr.wv.gov
Phone: 1-855-MyMVHIPP (1-855-699-8447)

**WISCONSIN – Medicaid and CHIP**
Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf
Phone: 1-800-362-3002

**WYOMING – Medicaid**
Website: https://wyequalitycare.acs-inc.com/
Phone: 307-777-7531

To see if any other states have added a premium assistance program since July 31, 2018, or for more information on special enrollment rights, contact either:

U.S. Department of Labor Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

# GROUP HEALTH PLANS OF BORGWARNER INC.
# NOTICE OF PRIVACY PRACTICES

## Introduction

BorgWarner Inc. and certain of its related entities (the "Employer") sponsor and maintain group health plans, including a Medical Plan, a Dental Program, a Vision Program, an Employee Assistance Program, and a Health Care Flexible Spending Account Program (collectively referred to as the "Plan"). The Privacy Rules under the Health Insurance Portability and Accountability Act ("HIPAA") generally restrict the ability to use and disclose certain health or medical information about you that is created or received by the Plan with respect to these health care benefit programs or by the Employer in connection with such health care benefit programs.

The Plan is required to provide this Notice of Privacy Practice (the "Notice") to you pursuant to HIPAA. This Notice describes how medical information about you may be used or disclosed by the Plan or by others that assist in the administration of Plan claims. This Notice also describes your legal rights regarding your medical information held by the Plan. References to the Plan throughout this Notice taking certain actions also shall mean the Employer, as plan sponsor of the Plan.

## Contact Person

If you have any questions about this Notice, please contact the Vice President of Human Resources, BorgWarner Inc., 3850 Hamlin Road, Auburn Hills, MI 48326, (248-754-9200).

## Protected Health Information

The HIPAA Privacy Rules protect only certain medical information known as "protected health information ("PHI"). Generally, PHI is individually identifiable health information, including demographic information, collected from you or received by a health care provider, a health care clearinghouse, a health plan or your employer on behalf of a group health plan, that relates to:

- your past, present or future physical or mental health or condition;
- the provision of health care to you; or
- the past, present or future payment for the provision of health care to you.

## Effective Date

This Notice is was originally effective on and after April 14, 2003, and has been amended and restated on several occasions, most recently effective September 23, 2013.

## Our Pledge and Responsibilities Regarding PHI

We understand that PHI about you and your health is personal and the Plan is committed to protecting PHI. The Plan is required by law to satisfy the following responsibilities with respect to any PHI created or received by the Plan:

- Maintain the privacy of your PHI;
- Provide you with certain rights with respect to your PHI;
- Give you this Notice of the Plan's legal duties and privacy practices with respect to your PHI; and
- Follow the terms of the Notice that is currently in effect.

## How the Plan May Use and Disclose Medical Information About You

Under law, the Plan may use or disclose your PHI under certain circumstances without your permission. The following categories describe different ways that the Plan may use and disclose PHI. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category is listed. However, all of the ways the Plan is permitted to use and disclose PHI will fall within one of the categories.

**For Treatment:** The Plan may use or disclose your PHI to facilitate medical treatment or services by providers. The Plan may disclose PHI about you to providers, including doctors, nurses, technicians, medical students or other hospital personnel, who are involved in taking care of you. For example, the Plan might disclose information about your prior prescriptions to a pharmacist to determine if prior prescriptions contra indicate a pending prescription.

**For Payment:** The Plan may use and disclose PHI about you to determine eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, the Plan may tell your health care provider about your medical history to determine

whether a particular treatment is experimental, investigational or medically necessary or to determine whether the Plan will cover the treatment. The Plan also may share PHI with a utilization review or precertification service provider. Likewise, the Plan may share PHI with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

The Plan may release PHI about you that is directly relevant to the involvement of a family member, close personal friend or other person in your medical care or payment for your medical care, unless you tell us not to release such information to such person.

**For Health Care Operations**: The Plan may use and disclose PHI about you for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, the Plan may use PHI in connection with: conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities.

However, the Plan may not use or disclose any PHI that is genetic information for underwriting purposes.

**To Business Associates:** The Plan may contract with individuals or entities known as Business Associates to perform various functions or to provide certain types of services on the Plan's behalf. In order to perform these functions or provide these services, Business Associates will receive, create, maintain, use and/or disclose your PHI, but only if they agree in writing with the Plan to implement appropriate safeguards regarding your PHI. For example, the Plan may disclose your PHI to a Business Associate to administer claims or provide support services, such as utilization, management, pharmacy benefit management or subrogation, but only after the Business Associate enters into a Business Associate Agreement with the Plan.

**As Required by Law:** The Plan will disclose PHI about you when required to do so by federal, state or local law. For example, the Plan may disclose PHI when required by a court order in a litigation proceeding, such as a malpractice action.

**To Avert a Serious Threat to Health or Safety:** The Plan may use and disclose PHI about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, the Plan may disclose PHI about you in a proceeding regarding the licensure of a physician.

**To Plan Sponsor (i.e. the Employer):** For the purpose of administering the Plan, PHI may be disclosed to certain employees of the Employer. However, those employees will use or disclose that PHI only as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized further uses or disclosures. Your PHI cannot be used for employment related purposes without your specific, written authorization. Information also may be disclosed to another health plan maintained by the Employer for purposes of facilitating claim payments under that health plan.

## Special Situations

In addition to the above, the following categories describe other possible ways that the Plan may use and disclose your PHI. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

**Organ and Tissue Donation:** If you are an organ donor, the Plan may release PHI to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

**Military and Veterans:** If you are a member of the armed forces, the Plan may release PHI about you as required by military command authorities. The Plan also may release PHI about foreign military personnel to the appropriate foreign military authority.

**Workers' Compensation.** The Plan may release PHI about you for worker's compensation or similar programs. These programs provide benefits for work-related injuries or illness.

**Public Health Risks:** The Plan may disclose PHI about you for public health activities. The activities generally include the following:

- To prevent or control disease, injury or disability;
- To report births and deaths;
- To report child abuse or neglect;
- To report reactions to medications or problems with products;
- To notify people of recalls of products they may be using;
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. The Plan will only make this disclosure if you agree or when required or authorized by law.

**Health Oversight Activities:** The Plan may disclose PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

**Lawsuits and Disputes:** If you are involved in a lawsuit or a dispute, the Plan may disclose PHI about you in response to a court or administrative order. The Plan also may disclose PHI about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

**Law Enforcement:** The Plan may release PHI if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct; and
- About criminal conduct.

**Coroners, Medical Examiners and Funeral Directors:** The Plan may release PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. The Plan may also release medical information about patients to funeral directors, as necessary to carry out their duties.

**National Security and Intelligence Activities:** The Plan may release PHI about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

**Inmates:** If you are an inmate of a correctional institution or under the custody of a law enforcement official, the Plan may release PHI about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

## Required Disclosures

The following is a description of disclosures of your PHI the Plan is required to make:

**Government Audits:** The Plan is required to disclose your PHI to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy rule.

**Disclosures to You:** When you request, the Plan is required to disclose to you the portion of your PHI that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. The Plan also is required, when requested, to provide you with an accounting of most disclosures of your PHI where the disclosure was for reasons other than for payment, treatment or health care operations, and where the PHI was not disclosed pursuant to your individual authorization.

## Other Disclosures

**Personal Representatives:** The Plan will disclose your PHI to individuals authorized by you, or to an individual designated as your personal representative, attorney in fact, etc., as long as you provide the Plan with a written notice/authorization and any supporting documents (e.g. durable power of health care attorney). Note that under HIPAA privacy rule, the Plan does not have to disclose PHI to a personal representative if we have a reasonable belief that:

- you have been, or may be, subjected to domestic violence, abuse or neglect by such person;
- treating such person as your personal representative could endanger you; or
- in the exercise or professional judgment, it is not in your best interest to treat the person as your personal representative.

**Spouses and Other Family Members:** With only limited exceptions, the Plan will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below "Your Rights"), and the Plan has agreed to the request, the Plan will send mail as provided by the request for Restrictions or Confidential Communications.

**Authorizations:** Other uses or disclosures of your PHI not described above will only be made with your written authorization. Additionally, most uses and disclosures of psychotherapy notes (where appropriate), uses and disclosures of PHI for marketing purposes and disclosures that constitute a sale of PHI require your authorization. You may revoke written authorization at any time, as long as the revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

## Your Rights

You have the following rights regarding PHI that the Plan maintains about you:

**Right to Inspect and Copy:** You have the right to inspect and copy PHI that may be used to make decisions about your Plan benefits. To inspect and copy PHI that may be used to make decisions about you, you must submit your request in writing to the Contact Person listed above. If you request a copy of the information, you may be charged a reasonable fee for the costs of copying, mailing or other supplies associated with your request.

You generally shall have the right, upon written request, to obtain from the Plan an electronic copy of PHI that is maintained electronically in one or more Designated Record Sets, and, if you choose, to direct the Plan to transmit such copy to an entity or person designated by you, provided that any such choice is clear, conspicuous and specific. The Plan will provide the requested PHI in the format requested by you, if it is readily producible in such form or format; or, if not, in a readable hard copy form or such other form or format as agreed to by the Plan and you. You also may direct the Plan, in a written statement signed by you, to transmit a paper or electronic copy of your PHI to an entity or person designated by you, provided that any such choice is clear, conspicuous and specific (e.g. clearly identifies the designated person and where to send a copy of your PHI).

The Plan may deny your request to inspect and copy PHI under very limited circumstances. If you are denied access to PHI, you may request that the denial be reviewed by submitting a written request to the Contact Person listed above.

**Right to Amend:** If you believe that PHI the Plan has about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan.

To request an amendment, your request must be made in writing and submitted to the Contact Person listed above. In addition, you must provide the reason that supports your request.

The Plan may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, the Plan may deny your request if you ask us to amend information that:

- Is not part of the PHI kept by or for the Plan;
- Was not created by the Plan, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is already accurate and complete.

If the Plan denies your request, you have the right to file a statement of disagreement with the Plan and any future disclosure of the disputed information will include your statement. File this statement with the Contact Person listed above.

**Right to an Accounting of Disclosures:** You have the right to request an "accounting" of certain disclosures of your PHI. The accounting generally will not include (1) disclosures made for purposes of treatment, payment or health care operations, (2) disclosures made to you, (3) disclosures made pursuant to your authorization, (4) disclosures made to friends or family in your presence or because of an emergency, (5) disclosures for national security purposes, and (6) disclosures incidental to otherwise permissible disclosures. However, to the extent required under HITECH, certain disclosures to carry out treatment, payment or health care operations which are maintained in electronic health records may need to be included in the accounting of disclosures beginning on the effective date set forth in HITECH (please call the Contact Person if you would like additional information regarding such accounting rights under the applicable guidance).

To request this list of accounting of disclosures, you must submit your request, in writing, to the Contact Person listed above. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2004. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be free. For additional lists, the Plan may charge you for the costs of providing the list. The Plan will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

**Right to Request Restrictions:** You have the right to request a restriction or limitation on the PHI the Plan uses or discloses about you for treatment, payment or health care operations. You also have the right to request a limit on the PHI the Plan discloses about you to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

The Plan generally is not required to agree to your request. Note that you have the right to request that your health care provider not disclose certain PHI to this Plan in the event that the PHI pertains solely to health care items or services that you pay for out of pocket and in full.

To request restrictions, you must make your request in writing to the Contact Person listed above. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

The Plan may terminate a restriction that it previously agreed to with respect to your PHI provided that the Plan informs you that it is terminating its agreement to the restriction and such termination is not effective for PHI that is described in the first two paragraphs of this section and only effective with respect to PHI created or received after you have been informed of such termination.

**Right to Request Confidential Communications:** You have the right to request that the Plan communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to the Contact Person listed above. The Plan will not ask you the reason for your request. The Plan will accommodate all reasonable requests if you clearly provide information that the disclosure of all or part of your PHI could endanger you. Your request must specify how or where you wish to be contacted.

**Right to be Notified of a Breach:** You have the right to be notified in the event that we discover, or a Business Associate discovers, a breach of unsecured PHI.

**Right to a Paper Copy of This Notice:** You have the right to a paper copy of this Notice. You may ask the Plan to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

To obtain a paper copy of this Notice, contact the Contact Person listed above.

## Changes to This Notice

The Plan reserves the right to change the terms of this Notice and to make new provisions regarding your protected health information that the Plan maintains, as allowed or required by law. The Plan reserves the right to make the revised or changed Notice effective for PHI the Plan already has about you as well as any information the Plan receives in the future. If the Plan makes any material change to this Notice, you will be provided with a copy of a revised Notice of Privacy Practices either by mail or electronically.

## Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Plan or with the Office of Civil Rights. Complaints to the Plan must be submitted in writing to the Contact Person listed above.

A complaint to the Office of Civil Rights should be sent to Office for Civil Rights, U.S. Department of Health & Human Services, 233 N. Michigan Ave. - Suite 240, Chicago, IL 60601, (312) 886-2359; (312) 353-5693 (TDD), (312) 886-1807 (fax). You also may visit OCR's website at: http://www.hhs.gov/ocr/privacy/hipaa/complaints/ for more information.

You will not be penalized, or in any other way retaliated against, for filing a complaint with the Plan or the Office of Civil Rights.

## Notice Regarding the BorgWarner Wellness Program

BorgWarner's Wellness Incentive Program and Cigna MotivateMe is a voluntary wellness program available to all full-time union BorgWarner employees who enroll in the Cigna Health Plan. The program is administered by Cigna according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (for example, cancer, diabetes, or heart disease). You will also have the option to complete a biometric screening, which will include a blood test for total cholesterol, LDL cholesterol, and blood sugar, and you will be asked to pledge to live a tobacco free lifestyle. You are not required to complete the HRA, to participate in the blood test or other medical examinations, or to participate in the tobacco free lifestyle program.

However, employees who choose to participate in the wellness program will receive an incentive in the form of a premium discount. Although you are not required to complete the HRA or participate in the biometric screening and tobacco program, only employees who do so will receive a premium discount. Additional incentives of up to $550 in taxable cash may be available for employees who participate in certain health-related activities, such as telephonic coaching.

**For all participants -** If you think you are unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact the Cigna Personal Health Team at 1-800-237-2904 and they will work with you and, if you wish, your doctor.

**For all participants who may have impairment –** If you are unable to participate in any of the program events, activities or goals, because of a disability, you may be entitled to a reasonable accommodation for participation or an alternative standard for rewards. Contact the Cigna Personal Health Team at 1-800-237-2904 for accommodations.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as telephonic coaching. You also are encouraged to share your results or concerns with your own doctor.

## Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and BorgWarner, Inc may use aggregate information it collects to design a program based on identified health risks in the workplace, Shift Into Better Health and Cigna MotivateMe will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is Cigna MotivateMe in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Although no one can prevent all cyber-attacks, Cigna has an information security program consisting of people, process, and technology – including encryption and monitoring tools designed to protect electronic information. We maintain safeguards intended to protect the security of your information. In the event a data breach, as defined by law, occurs involving information you provide in connection with the wellness program, we will notify you as required by law.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Benefits Department at 3850 Hamlin Road, Auburn Hills, MI 48326.

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