BORGWARNER

2024

ITHACA UNION

BENEFITS REFERENCE GUIDE

Benefits for the Road Ahead

Have questions? We have answers.

CONCERN	CALL	CONTACT INFORMATION
Medical and Dental Election Guidance	BorgWarner One Guide Team | 1-800-237-2904	Cigna Easy Choice Tool borgwarner.com/global-benefits/usa/ithaca-hourly
General Benefit and Enrollment	HR Link | 1-844-429-5465	HrLink@borgwarner.com
Health Coaching and Care Management	Cigna Customer Service Line (Personal Health Team/Health Advocate) 1-800-237-2904	n/a
Cigna Claims **(Medical, Prescription Drug, Dental)**	Cigna Customer Service Line | 1-800-237-2904	myCigna.com
Flexible Spending Accounts (FSAs)	HealthEquity | 1-866-346-5800	healthequity.com
Telehealth	MDLIVE | 1-888-726-3171	MDLIVEforCigna.com or myCigna.com (or the MyCigna mobile app)
24-hour Nurse Line	Cigna Nurse Line | 1-800-237-2904	
Mail-Order Prescriptions	Cigna | 1-800-TEL-DRUG (835-3784)	myCigna.com
Vision	Cigna | 1-877-478-7557	myCigna.com
Short-Term Disability/Family Medical Leave/ Paid Parental Leave	Alight | 1-800-441-9628 Monday – Friday, 8:00 a.m. – 8:00 p.m. EST	borgwarner.myleaveproservice.com
Long-Term Disability	New York Life | 1-800-238-2125, option 2	mynylgbs.com
Life Insurance and AD&D	MetLife | 1-888-622-6616	metlife.com/mybenefits
Critical Illness	MetLife | 1-800-438-6388	mybenefits.metlife.com
Retirement Savings Plan (RSP)	Vanguard | 1-800-523-1188	vanguard.com
Employee Assistance Program	Cigna EAP | 1-800-237-2904	myCigna.com
Mental Health Support	Headspace Care	organizations.headspace.com/connect
Diabetes Management and **High Blood Pressure Management**	Livongo 1-800- 945-4355 with code: BW-CIGNA	register.livongo.com/BW-CIGNA
Diabetes Prevention Program	Omada	go.omadahealth.com/borgwarner
Musculoskeletal Joint **Treatment Program**	Airrosti Physical Therapy 1-800-404-6050	airrosti.com

Your Benefits Information Is Just a Click Away
borgwarner.com/global-benefits/usa/ithaca-hourly

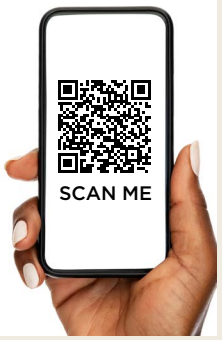
This Benefits Reference Guide provides brief descriptions of the benefits offered to full-time, Ithaca Union employees for 2024. For more information, visit the BorgWarner benefits website to:

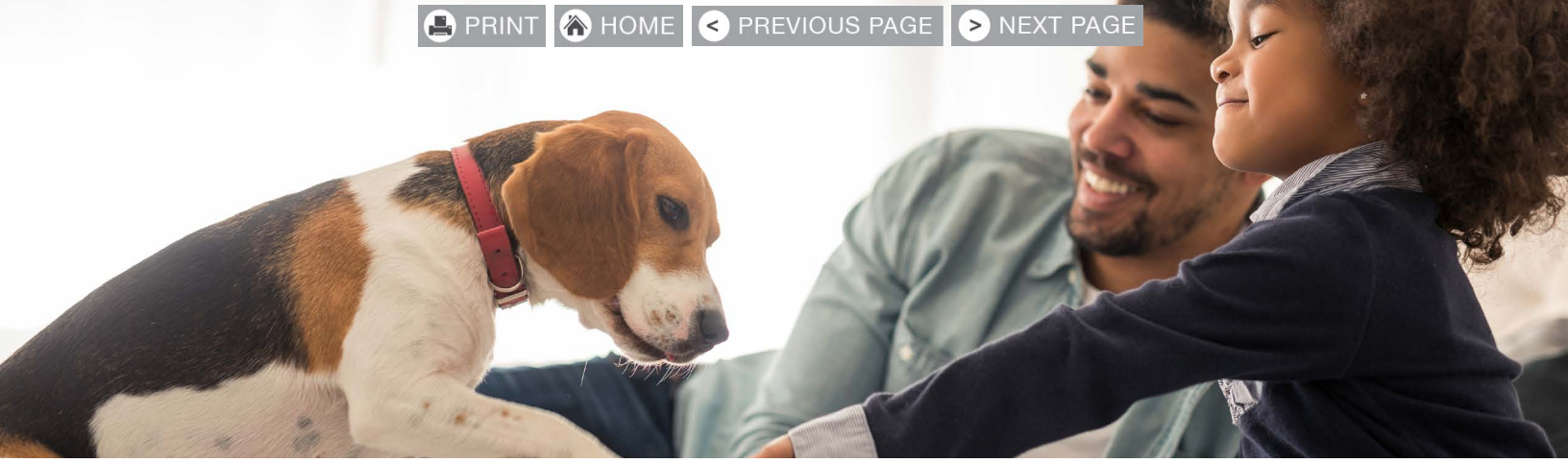
- Access enrollment materials, wellbeing forms and various notices.
- Learn about your benefits and how they work.
- Find out how the Cigna Personal Health Team can support you and your family.
- View the Summary of Benefits and Coverage (SBC).
- Access Workday® to enroll and manage your benefits.
- And more...

Have questions or need printed copies of materials?
Please contact HR Link at 1-844-429-5465.

WATCH THIS!
Watch helpful videos about BorgWarner benefits and wellbeing programs by scanning the QR code below with your smartphone:

Or, view the videos online:
borgwarner.com/global-benefits/usa/ithaca-hourly





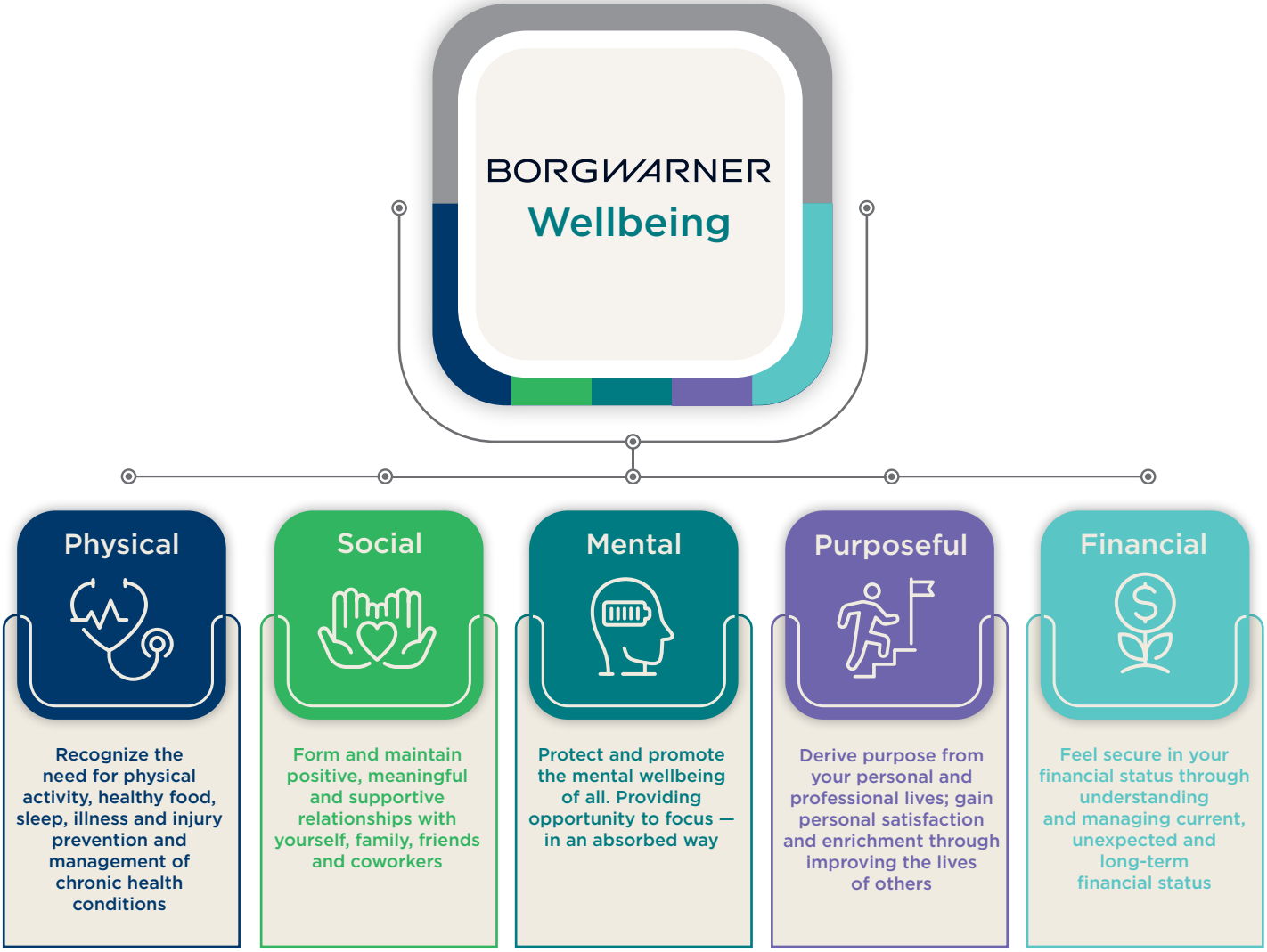
What's Inside

Wellbeing @ BorgWarner

BorgWarner defines wellbeing as the combination of:

- feeling good
- functioning well
- having control over one's life
- having a sense of purpose
- experiencing positive relationships

We offer benefits, programs, resources and education that address all aspects of total wellbeing through five main dimensions or pillars:



Your Checklist for a Successful Enrollment

LEARN

- ☐ Read your enrollment materials and learn more about your benefit options by attending a virtual BorgWarner benefits orientation meeting with an HR Link representative.
- ☐ Watch the BorgWarner benefits videos at **borgwarner.com/global-benefits/usa/ithaca-hourly**.

PREPARE

- ☐ Compare your BorgWarner plan options and any available spouse coverage to decide which will best fit your needs and budget.
- ☐ If adding dependents to your coverage, have their birthdates and Social Security numbers and required eligibility verification documents (such as a marriage or birth certificate) available so you can submit them to HR Link.
- ☐ Complete the Medical Premium Incentive requirements to lower your contribution amount.

ENROLL

NEED HELP?
Refer to the Workday® Online Enrollment Instructions Found at
borgwarner.com/benefits/usa

workday.

- ☐ As a new employee, make 2024 enrollment elections within **30** days of your date of hire: Go to **borgwarner.com/global-benefits/usa/ithaca-hourly**. Scroll down and click on the Workday logo. Once in Workday, click on "Inbox" at the top right or middle of page. Select "Benefits Event" to begin elections.
- ☐ Submit any required dependent eligibility verification documentation to HR Link.
- ☐ Double-check your elected or waived coverages before submitting your enrollment. (Think of this as important as reviewing your tax return before you send it to the IRS. Is medical elected? Dental? Are dependents attached to the plans you want them enrolled in?)

If You Don't Enroll Online On Time

If you don't enroll or elect to waive coverage within 30 days of your hire date, BorgWarner is required by law to automatically enroll you in default coverage, shown to the right. This means your spouse and dependents will NOT have coverage.

Your next opportunity to elect coverage will be during the next annual enrollment in November 2024, unless you experience a qualifying family status change (see page 5).

Plan	Your Default Coverage
Medical	Cigna Choice Health Fund *(Employee-Only Coverage)*
Dental	No Coverage
Vision	No Coverage
Flexible Spending Accounts (FSAs)	No Coverage
Short-Term Disability/Salary Continuation	BorgWarner-Provided Options
Long-Term Disability	Basic Plan
Life Insurance	BorgWarner-Provided Option
Critical Illness Insurance	No Coverage

Rules of the Road: Benefit Basics

Eligibility

Your BorgWarner benefits are designed to offer coverage to:

You

Active, full-time* BorgWarner employee regularly scheduled to work at least 30 hours a week. You become immediately eligible for benefits coverage on your first day of hire.

Your spouse

Your lawful spouse. Legally separated individuals, life partners or divorced spouses are not eligible.

Your dependent children**

A child to age 26, regardless of whether the child is living at home, is listed as a dependent on your tax return, is a student or is married.***

Coverage is also available to children, age 26 and older, if legally considered permanently and totally disabled.

Coverage runs through the end of the month in which your dependent child turns age 26.

* *If a full-time employee is on a temporary layoff of 30 days or less, healthcare plans may continue without break in coverage. Temporary staff, leased staff, volunteers, agents, contractors or sub-contractors are not eligible. Part-time employees are eligible for the BorgWarner Retirement Savings Plan only.*

** *Dependent eligibility is different for life insurance. Details can be obtained from your Summary Plan Description found at* ***borgwarner.com/benefits/usa*** *or contact MetLife directly.*

*** *If your child is married, his or her spouse and children are not eligible for coverage under the BorgWarner plans. In addition, you can't be covered as a dependent child and also be covered under your own BW policy if your parent works for BW.*

If You and Your Spouse Both Work at BorgWarner

In this situation, your dependent children can be covered under either your or your spouse's medical, dental and vision plans, but not both. In addition, you and your spouse cannot enroll under two plans (as both a dependent and an employee, for example).

Who Qualifies as a Dependent Child?

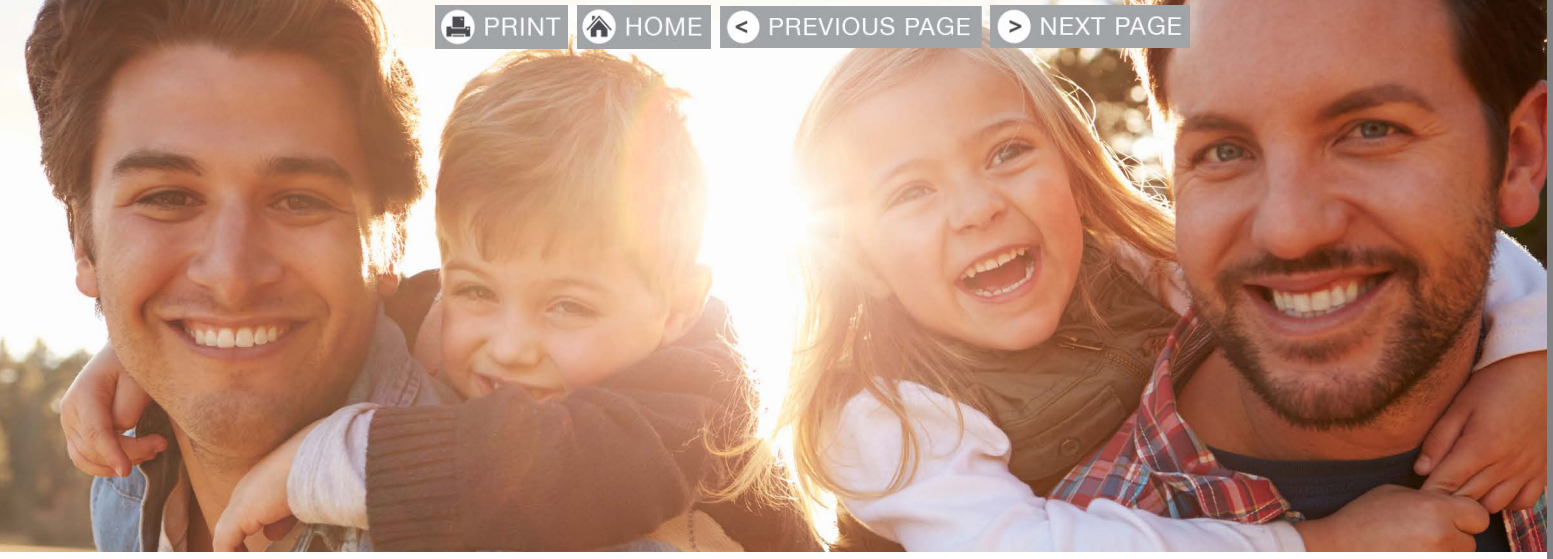
- **Biological child**
- **Legally adopted child or a child who has been placed with you for adoption**
- **Stepchild (Note: If you have a stepchild who lives with you, but is eligible to participate in another employer's health plan, the BorgWarner Plan will cover the stepchild only on a secondary basis.)**
- **Court-appointed child for whom you have full (not limited) legal guardianship**
- **A child for whom you are required to provide healthcare support under a Qualified Medical Child Support Order (QMCSO)**

Adding a Dependent

To add a dependent, you must provide acceptable documentation verifying their eligibility:

Child: Live birth verification, birth certificate (when available), adoption paperwork or tax return

Spouse: Marriage certificate or tax return



Coordination of Benefits

When you're covered under multiple health insurance plans, the plans will have to coordinate your and your children's benefits to avoid paying for the same service twice. The BorgWarner medical plan is considered the "primary" plan (meaning it will pay benefits first) for BorgWarner employees, and the spouse's plan would be considered "secondary" (meaning it pays the difference between the primary plan's payment and what the secondary plan would have paid if it were the primary coverage).

If you are covering your children under BOTH your and your spouse's plan, the order in which the plans pay benefits for them is determined by the birthday that falls first during the calendar year—yours or your spouse's. The one whose birthday falls first will be designated as the primary plan, and the other person's plan is considered secondary. Medicare is secondary for employees and spouses on BW plans.

NOTE: BorgWarner is considered the secondary payer when coordinating benefits with no fault automobile insurance.

Family Status Changes

Typically, you can change your benefit elections only during the annual enrollment period, unless you have a qualifying family status change, including:

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

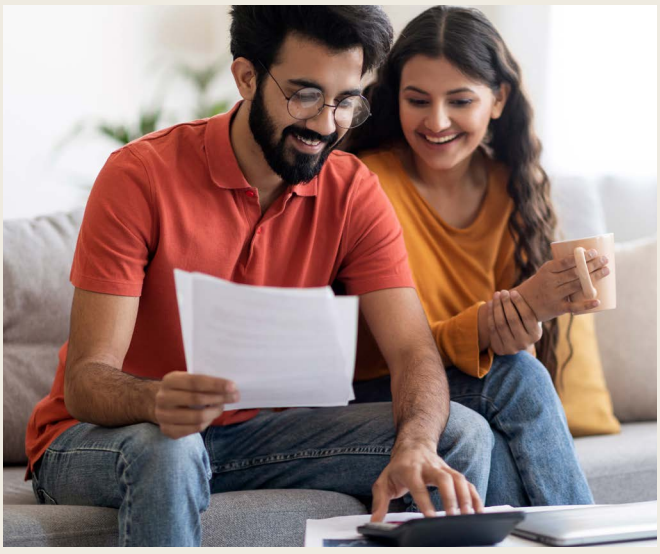
You have 30 days after the family status change to notify HR Link and provide verification of the family status change event—such as a marriage certificate or divorce decree. Depending on the type of status change, you may be eligible to change some of your benefit elections. The change must be consistent with the qualifying event. If you don't notify Human Resources within 30 days after the event, you must wait until the next annual enrollment period to make changes.

IMPORTANT: If you do not notify HR Link of spouse and/or dependent coverage changes (such as your spouse becoming employed and eligible for medical coverage), it may prevent dependent access to COBRA healthcare continuation coverage.

Working Spouse Rule

If you have a working spouse who is enrolled for healthcare coverage through their own employer and you want to add them as a dependent to your BorgWarner healthcare coverage, the BorgWarner plan will pay secondary coverage ONLY. Your spouse's primary plan would be the plan offered through their employer. If your spouse is eligible for, but chooses not to enroll in, his/her own employer's group plan, he/she WILL NOT be eligible for dependent medical benefits provided as secondary coverage under the BorgWarner plan.

If you enroll in both plans, please realize you may be required to pay two premiums and potentially a $100 monthly spouse surcharge. To ensure timely processing of claims, be sure to provide Cigna with your spouse's insurance information. **To learn more about the Working Spouse Rule and/or the surcharge, contact HR Link.**



Dedicated to Your Wellbeing:
Cigna Personal Health Team

BorgWarner believes that a health plan should do more than take care of you when you are sick. It should also support you to lead a healthier, more active and productive life. Through Cigna, BorgWarner offers eligible employees and spouses access to a dedicated health team—connecting you to a comprehensive collection of health-related programs, services, resources and tools.

The Health Team Advantage:

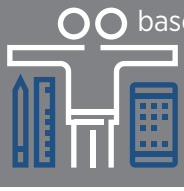
Takes the hassle, confusion and guesswork out of getting the right support, the right way and at the right time.

Gives you access to a dedicated Health Advocate who is your primary point of contact for all your health and wellbeing needs across your whole spectrum of care.

Reliable, unbiased and compassionate care by professionally trained health specialists, including nurses, dieticians, clinicians and counselors.

Your confidentiality is ensured. BorgWarner is not made aware of your participation, specific results or specifics about any interactions.

Dedicated to BorgWarner and its employees with special training on BorgWarner and our culture, giving them added insight as they assist you.



Coordinated outreach with an initial welcome, and then you may receive a second introductory call if you have been referred to a program based on claims or Cigna HRQ results.

How It Works

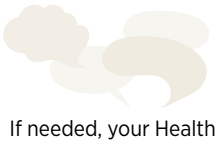
If You Initiate Contact

You have a health need

You call Cigna at **1-800-237-2904**

When prompted, say "Personal Health Team"

You are connected to your Personal Health Advocate



If needed, your Health Advocate will call on other experts within the Personal Health Team dedicated to BorgWarner members

Your health need is addressed

Rewarding Healthy Behaviors and Wise Choices

There are three different programs aimed at rewarding BorgWarner employees for taking steps toward healthy living and making wise health care choices.

1 Earning Lower Medical Premiums: The Shift Into Better Health Premium Incentive Program

IT'S A FACT: The healthier people are, the less healthcare they tend to use. That's why BorgWarner believes in rewarding those who take steps to lead healthy lifestyles. Through the Shift into Better Health Premium Incentive, you can earn a discounted medical premium rate by achieving certain health goals.

There are seven goals. For each goal met, you will be awarded one point:

Earn one point per goal

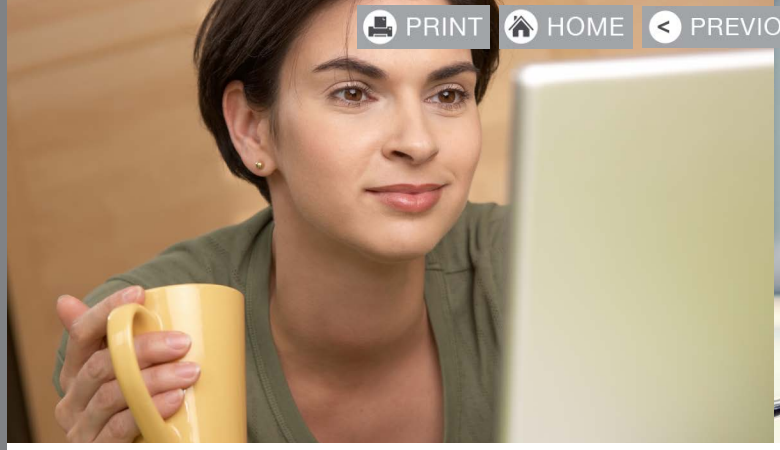
1	2	3	4	5	6	7
Complete the online Cigna Health Assessment	Complete one preventive dental cleaning/exam	Achieve a Body Mass Index (BMI) of less than 30 OR: A weight loss of 5% as compared to the last weight recorded with Cigna	Achieve total cholesterol ratio as follows: Women: less than 4.4 Men: Less than 5	Achieve a fasting blood sugar of less than 100 mg/dl OR: Achieve a non-fasting blood sugar of less than 140 mg/dl*	Complete an onsite clinic visit OR register with MDLIVE for teleheath services.***	Complete one or more of the following: **Preventive annual physical** (with your Primary Care Physician or OB/GYN) **Preventive colon cancer screening** (age 50+) **Preventive mammogram** (age 40+) *Note: Onsite visits do not qualify for earning a point in this category.*

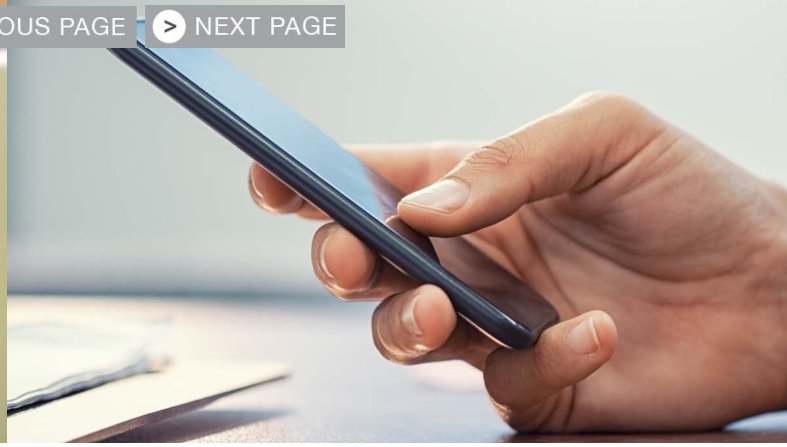
**Alternative to earn points: Enroll and participate in a Cigna telephonic coaching program that is most appropriate for you. There are multiple options available, including Weight Management, Stress Management, Disease Management or Healthy Eating. Call your Cigna Health Advocate at 1-800-237-2904 for the coaching program that's right for you.*

***Total Cholesterol divided by HDL = Cholesterol Ratio.*

**** You may only register/earn this point one time. The following types of clinic visits are not eligible for earning a point: simple injections/vaccines, blood pressure checks, blood draws and biometric screenings.*

The total number of points earned by September 30 of the given year will determine the portion of the total medical plan premium you will pay for all of the following year. (For example, points earned by **September 30, 2024**, will determine what portion of the premium you pay for 2025.) The more points earned, the more you save on your medical plan contribution.





How It Works

STEP 1: Establish Your Health Baseline

To get started and earn points, you must:

- **Complete the Cigna HRQ** online at myCigna.com.
- **Complete a biometric screening** in one of three ways: a) during the annual on-site biometric screening event, or b) through an on-site clinic, or c) with your personal physician.

Note: If you receive the biometric screening from a non-Evernorth (CIGNA) on-site clinic or a personal physician, you must have the provider complete the Wellbeing Screening Form found at borgwarner.com/global-benefits/usa/ithaca-hourly and send to Cigna by September 30.

STEP 2: Keep Earning Points

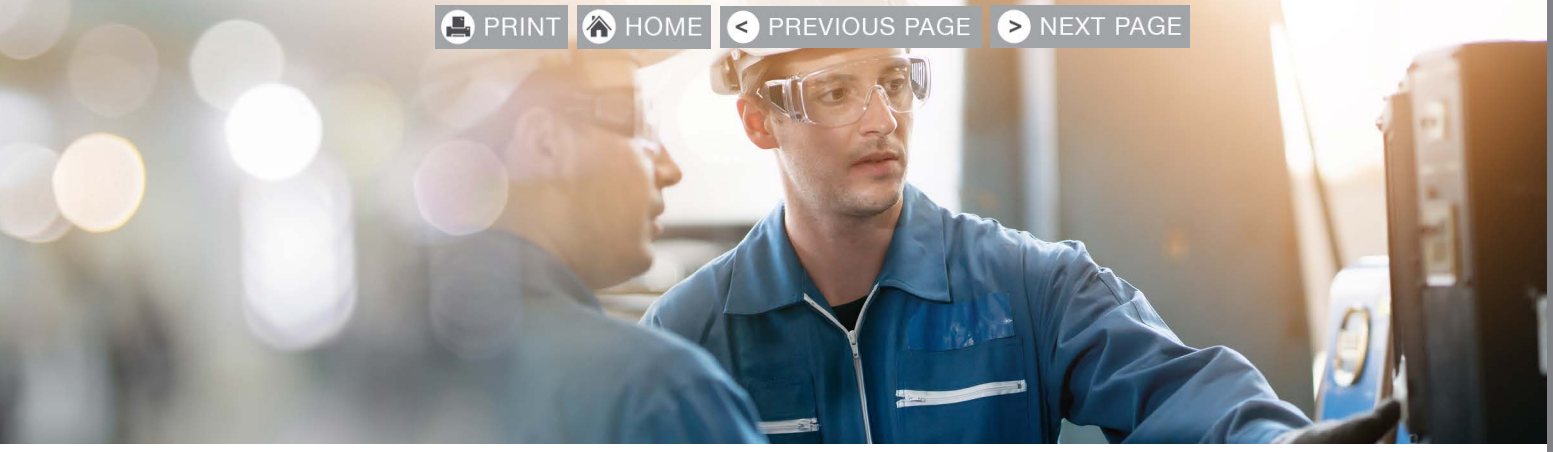
- Achieve specific health goals.
- Earn alternative points with telephonic coaching.
- Complete a preventive annual physical.

STEP 3: Track

Track your progress and see how many points you have earned by visiting **myCigna.com** and selecting the *Wellbeing* tab and then selecting the *Wellbeing & Incentives* option). The total number of points earned as of September 30 of the given year will be used to determine your medical premiums for the next plan year.

STEP 4: Participate in Open Enrollment

When you enroll for your medical plan in November, you will see the premiums for both plans based on the number of points you have earned. This amount is set and cannot be changed.



Key Deadlines for Employees New to the Medical Plan

New employees

(hired BEFORE April 1, 2024)
OR

Current employees new to the medical plan in 2024

(effective January 1, 2024 - March 31, 2024):

- You must complete the HRQ within 60 days of the date your benefits became effective to receive the best premium pricing for 2024.
- If you do not complete the HRQ within 60 days, you will pay the highest premium (20% premium rate) for the remainder of 2024.
- In addition, you are encouraged to participate in the Premium Incentive Program before the September 30, 2024 deadline to earn the best premium pricing for 2025.

New employees

(hired AFTER April 1, 2024) OR

Current employees new to the medical plan in 2024

(effective April 1, 2024 - December 31, 2024):

- You must complete the HRQ within 60 days of the date your benefits became effective to receive the best premium pricing for 2024 and 2025.
- If you do not complete the HRQ within 60 days, you will pay the highest premium (20% premium rate) for the remainder of 2024 and 2025.
- In addition, you are encouraged to participate in the Premium Incentive Program before the September 30, 2024 deadline to earn the best premium pricing for 2025.

Physical Wellbeing

Medical Coverage

Eligible after 90 days of service

Comprehensive medical coverage is an important part of supporting healthy living. BorgWarner offers two medical plan options both of which provide **free preventive care** to prevent healthcare problems before they arise, an **employer-paid Health Reimbursement Account (HRA)** to help you cover the costs when you are ill and **comprehensive medical coverage** to protect you from any catastrophic financial effects of a serious illness or injury. Both plan options include **prescription drug coverage**.

YOUR OPTIONS	☐ Cigna Choice Fund	☐ Cigna Choice Fund Plus
Coverage Level Options	☐ Employee Only ☐ Family	☐ Employee Only ☐ Family

Your Options and Cost of Coverage

Both medical plan options, cover the same types of services and provide you with solid coverage. However, they vary in the cost of coverage, the deductible requirements and out-of-pocket maximums.

The Choice Health Fund

This plan tends to appeal to someone who doesn't want to pay upfront for healthcare they are not sure they'll use.

It offers:

- Lower payroll deductions, but a higher member deductible gap.
- Higher coinsurance.

The Choice Health Fund Plus

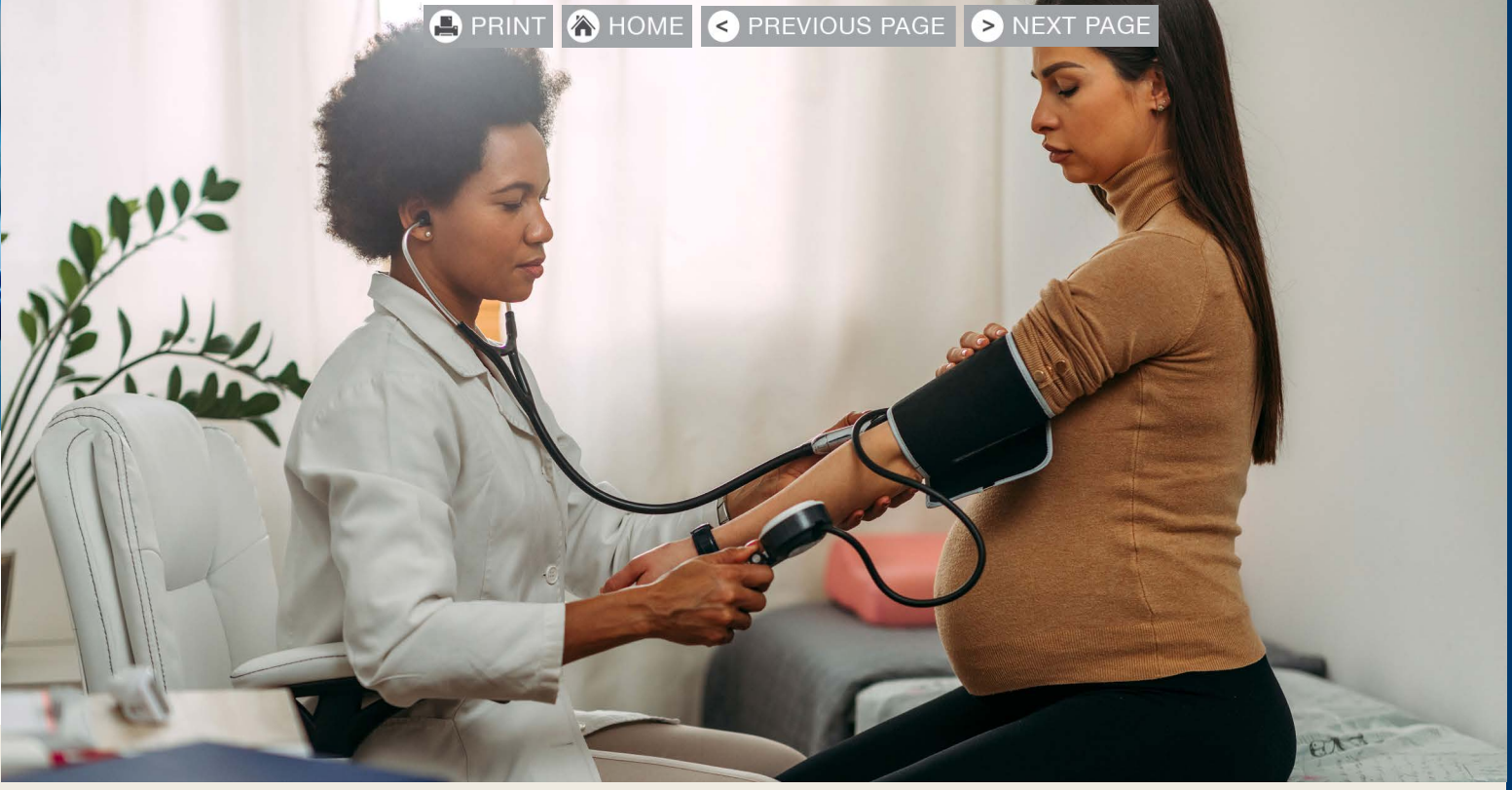
This plan tends to appeal to someone who is willing to pay more upfront so they have the security of more coverage at the time of service.

It offers:

- Higher payroll deductions, but a lower member deductible gap (due to higher HRA credits).
- Lower coinsurance.

CIGNA CHOICE HEALTH FUND	Your Monthly Contribution	
Points earned by Sept. 30, 2024	**Employee**	**Family**
0	$91.92	$303.30
1-2	$68.94	$227.47
3-4	$45.96	$151.65
5+	$0.00	$0.00

CIGNA CHOICE HEALTH FUND PLUS	Your Monthly Contribution	
Points earned by Sept. 30, 2024	**Employee**	**Family**
0	$164.27	$399.77
1-2	$141.29	$323.95
3-4	$118.31	$248.13
5+	$72.35	$96.48



LEARN MORE

myCigna App Upgrade with Cigna One Guide® Service

In addition to the regular services offered through the myCigna.com app (such as finding network doctors, getting cost estimates for care, comparing prescription prices, managing and tracking claims and accessing your ID card), you can gain a new level of support through the One Guide® service. It allows you to build your custom health team by creating a personal list of in-network doctors, dentists and facilities you use. And you can sign up for messages that can guide you to savings, incentives, coaching and more.

Understanding the Out-of-Pocket Maximum (OOPM)

For Employee + Spouse, Employee + Child(ren) and Family coverage, there are two levels of OOPMs:

A Lower "Individual" OOPM

Once a person meets the "Individual OOPM," the plan will cover that specific individual's expenses at 100% for the remainder of the year—even if the total OOPM has not yet been reached.

A "Family" OOPM

Once the total OOPM limit is reached, the plan will pay 100% of all covered expenses for every person covered, regardless of how much each individual person has accumulated in OOPM expenses.

Comparing Your Medical Plan Options

Plan Features At-a-Glance

To see plan features and coverage for other benefits, refer to the Benefits Reference Guide on borgwarner.com/global-benefits/usa/ithaca-hourly.

	Cigna Choice Health Fund		Cigna Choice Health Fund Plus	
Feature	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Plan Deductible Employee Only / Family	$1,500/$3,000	$3,000/$6,000	$1,500/$3,000	$3,000/$6,000
BorgWarner-paid HRA Fund* Employee Only / Family	$750/$1,500		$1,500/$2,500	
Member Deductible Gap Employee Only / Family (Deductible minus HRA)	$750/$1,500	$2,250/$4,500	$0/$500	$1500/$3,500
Coinsurance	Company pays 80% You pay 20%	Company pays 60% You pay 40%	Company pays 80% You pay 20%	Company pays 60% You pay 40%
HRA Medical Out-of-Pocket Maximum Employee Only / Family (HRA money applies to OOPM when used for covered medical claims)	$3,000/$6,000	$6,000/$12,000	$3,000/$6,000	$6,000/$12,000
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited	Unlimited
HRA Rollover Cap Employee Only / Family	No Limit/Max	No Limit/Max	No Limit/Max	No Limit/Max
Preventive Care	100% after deductible	60% after deductible	100% after deductible	60% after deductible
Office Visit	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Inpatient X-rays, lab tests, home healthcare, hospice	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Independent X-rays and labs	80% after deductible	60% after deductible	80% after deductible	60% after deductible
MRI/PET/CAT scans	80% after deductible	60% after deductible	80% after deductible	60% after deductible

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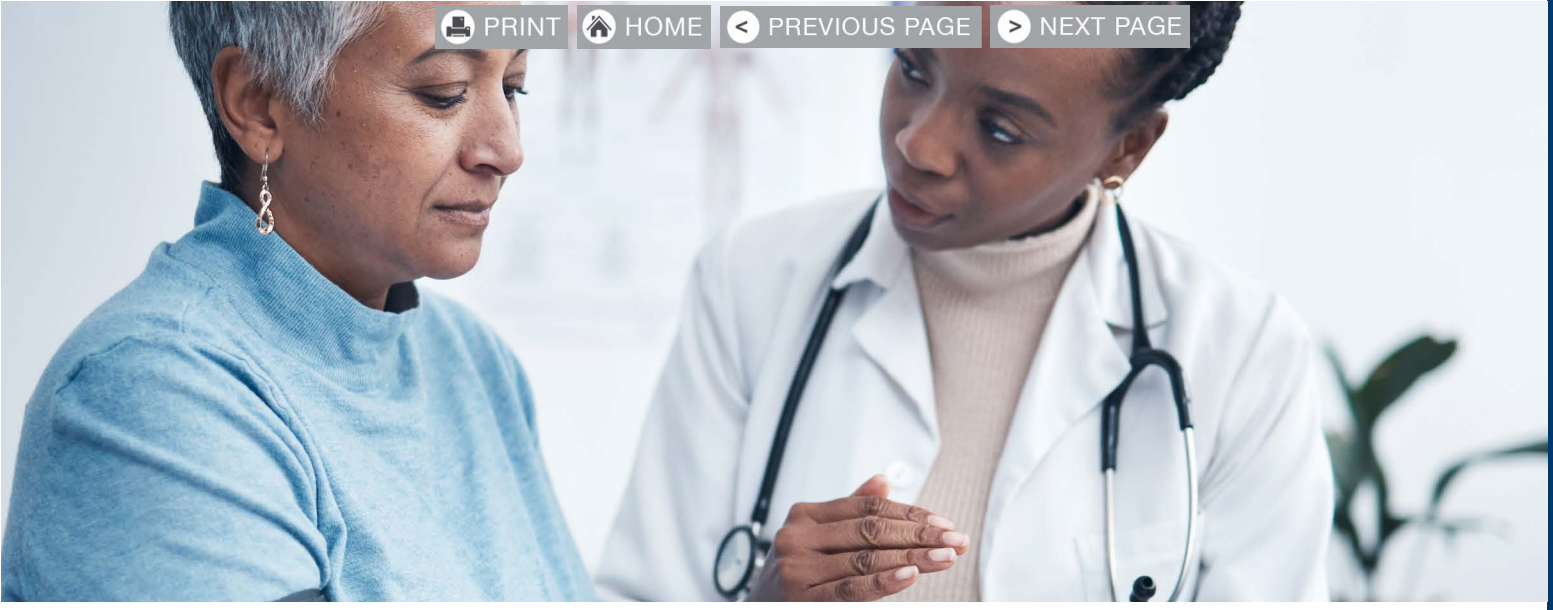


Plan Features At-a-Glance continued...

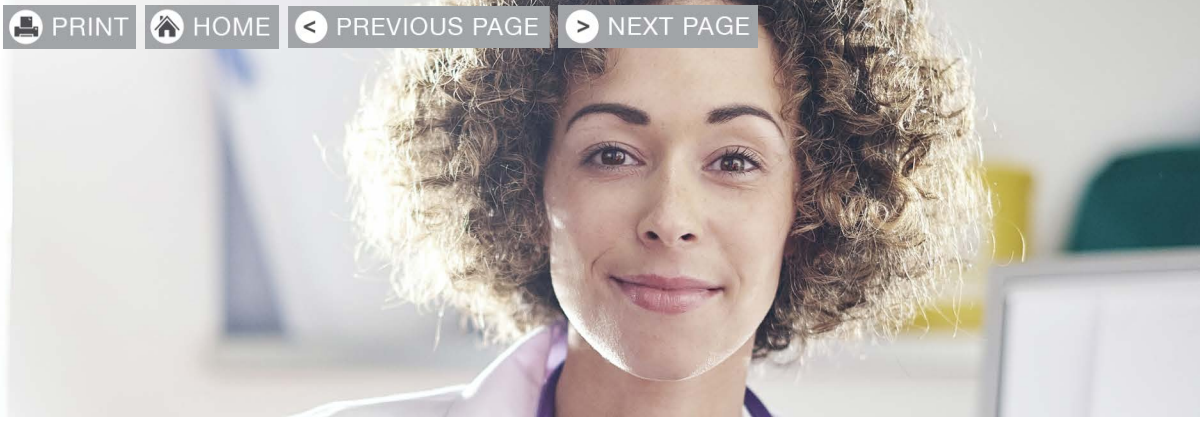
	Cigna Choice Health Fund		Cigna Choice Health Fund Plus	
Feature	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Hospitalization ** (Inpatient, outpatient, X-rays, lab tests, skilled nursing)	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Outpatient Hospice	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Chiropractic	80% after deductible (max. of 12 visits/year)	60% after deductible (max. of 12 visits/year)	80% after deductible (max. of 12 visits/year)	60% after deductible (max. of 12 visits/year)
Emergency Room	80% after deductible	80% after deductible	80% after deductible	80% after deductible
Ambulance	80% after deductible	80% after deductible	80% after deductible	80% after deductible
Urgent Care	80% after deductible	80% after deductible	80% after deductible	80% after deductible
Mental Health/Substance Abuse	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Telehealth Services	80% after deductible	60% after deductible	80% after deductible	60% after deductible

** The out-of-pocket maximum amounts shown reflect "NET" amounts—after the HRA has been applied. If one member of the Family tier exceeds $3,000 in medical costs, the Plan pays 100% of all eligible medical expenses for the remainder of the plan year for that member.*

*** Utilization review required.*

Having Trouble Choosing a Medical Plan?

Try the Cigna Easy Choice Tool at borgwarner.com/global-benefits/usa/ithaca-hourly. If logging in for the first time, use the following login credentials: User ID: bwarner2024 Password: Cigna2024



100% Preventive Care Coverage

Many potentially serious health problems are silent—such as heart disease, diabetes and breast cancer—but commonly preventable. The key is making sure you receive your recommended preventive care. The following are just some of the preventive services covered at 100% by the medical plan. For a complete list, please visit myCigna.com.

Feature	Coverage
Well-baby care exams	Up to age 3
Well-child care exams	Ages 3 to 21
Routine immunizations	Per recommended immunization schedule
Adult annual physicals*	Once per year
Colon cancer screening*	Age 45+ • Flexible sigmoidoscopy every five years • Colonoscopy every 10 years
Screenings for Women	
• OB/GYN exam (pap test)*	Once per year
• Breast cancer screening (mammogram)*	Ages 40 and older, once per year
• Cervical cancer screening*	Within three years of sexual activity, or ages 21-64, at least every three years
Screening for Men	
• Prostate cancer screening (PSA)	Once a year for men ages 50 and older or at any age with risk factors

Additional Preventive Services for Women (Covered at 100% for in-network only)

- Annual well-woman visits
- Screening for gestational diabetes
- HPV DNA testing for women 30 years and older
- Sexually transmitted infection counseling
- HIV screening and counseling
- Screening and counseling for interpersonal and domestic violence
- FDA-approved contraception methods and contraceptive counseling
- Breast-feeding support, supplies and counseling

Please visit myCigna.com for more details.

** Eligible for a point under the Shift Into Better Health Premium Incentive. Annual physicals can be completed by a Primary Care Physician or OB/GYN.*

Don't Be Wrongly Billed for In-Network Preventive Care

For your medical plan to cover 100% of the cost of your in-network preventive care service, your physician must be sure to "code" the service as "preventive." If submitted as a "diagnostic procedure" or "treatment" visit, the service won't be considered preventive—meaning your standard deductibles and coinsurance will apply. Be sure to remind your provider to code the service as "preventive."

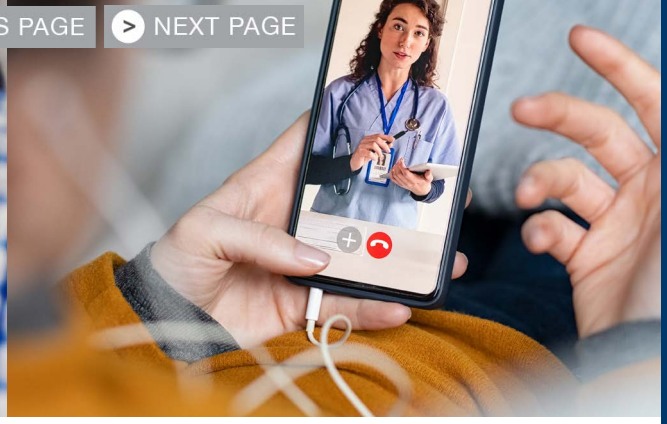
Cost of Care Estimator Tool

Cigna is taking steps to help you better understand the amount you will pay for care before it is provided so you can make informed health care decisions. The Cigna Cost of Care Estimator® makes it easier to understand your costs. You can:

- Search over 800 healthcare services by keyword or billing code.
- Compare out-of-pocket costs between providers.
- View cost information for yourself and your dependents.
- See new detailed cost information, such as in-network negotiated rate, your cost share, treatment/plan limits and more.
- Find cost estimates for a particular provider.

TAKE ACTION

To access the Cost of Care Estimator tool, visit mycigna.com.



Care Management

Cigna Care Management is designed to make sure you receive the services that are most appropriate for you. By using nurse case managers to coordinate your care and checking in advance if a service is covered (called precertification), Cigna can help you lower costs, avoid unnecessary procedures and get support during your recovery after a procedure. To learn more about Cigna Care Management and how it can help you and your family members, please contact your Health Advocate at **1-800-237-2904**.

Airrosti 1-on-1 Virtual Physical Therapy Care

BorgWarner is proud to offer Airrosti to all Cigna health plan members as an in-network musculoskeletal and joint condition treatment program.

- This virtual provider/resource can help fix chronic neck pain, back pain, joint or muscle pain, as well as provide relief from strains and sprains.
- You receive thorough assessments and orthopedic testing for accurate diagnosis, customized treatment plans and personalized rehab and at-home exercises designed to help speed recovery and prevent future injuries.

TAKE ACTION
Call **1-800-404-6050**
or visit **airrosti.com.**

Cigna Telehealth Connection:
When You Can't Get to Your Doctor

If you have a minor, non-life-threatening medical condition and need care, you can connect with a board-certified doctor on your computer through a video stream (e.g., Facetime or Skype) or over the phone, without leaving your home or office. Offered through a leading national telehealth provider — MDLIVE — you can receive confidential personal care at a lower cost than visiting your primary care physician's office.

Register Today!
Online: MDLIVEforCigna.com **OR** mycigna.com
OR via the MyCigna mobile app
Phone: 1-888-726-3171

omada

Diabetes Prevention Program

BorgWarner is pleased to partner with Omada to offer a breakthrough online program that inspires healthy habits. This comprehensive 16-week program is available to employees and their covered spouses and dependents over the age of 18. It is designed to help individuals lose weight, which can help reduce the risk factors for type 2 diabetes and other chronic diseases. Participants enrolled in a BorgWarner medical plan that are at risk for developing diabetes are eligible to enroll at no cost—that's a $600 savings! Sign up at **https://go.omadahealth.com/borgwarner** and take a one-minute health test. If you meet Omada's risk criteria for the program, you are immediately notified and can enroll on the spot.

"If you want to lose weight and keep it off, you need a lifstyle change not a diet. Omada helps you make that lifestyle change. And it works. Everything makes sense. The coaches are there to help, not judge you. The weekly lessons are very good at helping you understand your relationship with food and how to make better choices. You can do this and it isn't that hard with the right help! The coaches and the scale I think are what makes Omada different."

- Randy, Age 63, Burton MI
**Shared with permission.*

How It Works for Qualified Participants

Receive a **FREE** scale in the mail that links to your phone and to your coach

Participate in educational sessions to gain skills to replace current habits with healthy ones

Track food for first four months and weigh yourself daily

Work with coach to focus on challenges most crucial for your success

Join in the group discussions for added support and accountability

Livongo®

Diabetes Management and High Blood Pressure Management Programs

If you or a covered family member has been diagnosed with type 1 or type 2 diabetes or high blood pressure, you should consider the advantages of programs offered in partnership with Livongo. These programs combine the latest technology with personal coaching to support you in managing your condition. And best of all, these programs are covered under the BorgWarner medical plans at no cost to you!

Diabetes Management Program

- **Coaching, anytime and anywhere:** Certified Diabetes Educators answer any questions you have, from nutrition to lifestyle changes. Contact them directly by phone, email, text or mobile app.
- **FREE advanced glucose meter** ($200 value): Automatically uploads blood glucose readings from an inserted test strip to your private account. You also can get real-time tips, set alerts and notifications and sharereadings quickly and easily.
- **Unlimited test strips**: Get as many test strips and lancets as you need at no cost or copay. When you need more strips, simply tap the meter and reorder. In a few days, a new box of strips appears at your doorstep. It's that simple!

TAKE ACTION

Registering for either of the Livongo programs is quick and easy—taking less than 10 minutes.

- register.livongo.com/BW-CIGNA
- **(800) 945-4355 with code: BW-CIGNA**

High Blood Pressure Program

- **Coaching, anytime and anywhere:** Certified Chronic care professionals provide live one-on-one sessions with you and are there to answer your questions. Contact them directly by phone, email, text of mobile app.
- **FREE blood pressure monitor:** Automatically uploads your blood pressure readings to your private account, making it easy to access your readings interpret results.
- **FREE tools to better understand your condition:** You can gain insights and feedback based on your readings. Plus, have access to educational content about blood pressure basics. Tracking tools also make it easy to see progress and help you reach your goals.
- **Medication support.** Receive helpful reminders to ensure you stay on track with medications.

"I test more regularly. I don't have to find pen and notebook to jot down the readings. And I take my Livongo with me to the doctor and show her my log. LOVE this tool!!"
- Livongo participant | Shared with permission

"Using Livongo helps me stay on track of my glucose levels as well as my diet. When both of those plus exercise are in line then I am feeling much healthier."
- Livongo participant | Shared with permission

Prescription Drug Coverage

If you enroll in a medical plan, you're automatically enrolled in the Prescription Drug Program and your medical ID card issued is for prescriptions, too. Under the HRA Plan, you do not have a prescription deductible to meet, so your coverage begins with your first prescription.

There are two ways to get your prescriptions filled:

1) at a network retail pharmacy **OR** **2) through mail order**

The table below shows how much you pay for each prescription, depending on the type of prescription drug you buy and how you fill it. Keep in mind, you can refill prescriptions over the phone or through the mail.

	Retail Pharmacy 30-day Supply*	Mail Order 90-day Supply	Specialty 30-day Supply**
Generic Chemically equivalent, lower-cost version of a brand-name drug	$8 copay	$16 copay	$8 copay
Brand Formulary Lower-cost, yet highly effective brand-name prescription drugs that generally have no generic equivalent	$8 copay then you pay 30%	You pay 30% ($150 maximum)	You pay 30% ($50 maximum)
Brand Non-formulary Generally has equally effective and less costly generic equivalents and/or one or more formulary options	$8 copay then you pay 50%	You pay 50% ($300 maximum)	You pay 50% ($100 maximum)
Annual Out-of-Pocket Maximum	Individual: $5,550 / Family: $11,100		

* You can fill a 90-day supply of maintenance drugs at in-network pharmacies through the Cigna 90 Now Program. See next page for more information.

** Specialty drugs are injectable drugs typically used to treat arthritis and other conditions (does not include insulin).

USE WISELY

The Generic Advantage

Generic medications contain the same active ingredients and have the same quality, strength and purity as the brand-name medications they copy. Choosing generic medications can save you money, so check with your doctor to see if a generic alternative is appropriate for your condition.

Retail Network Pharmacy:

30-day fills

- Use when you need a prescription filled right away.
- Show your medical ID card and pay your portion of the cost.
- Pharmacist will file the claim for you.

Find a network pharmacy near you: myCigna.com.

Cigna 90 Now Program:

90-day fills

- More choice and greater savings opportunities for medicines you take on an ongoing basis for a chronic condition, such as diabetes, asthma or high blood pressure.
- Lower cost than buying three 30-day prescriptions.
- Access Cigna's network of 29,000 "long-term fill" pharmacies.

Find participating 90-day retail pharmacies near you: Cigna.com/Rx90network.

Cigna Home Delivery (Mail Order)

- An alternative to refilling your prescriptions at a retail pharmacy location.
- Offers added convenience with prescriptions delivered right to your home.

To access:

Online: myCigna.com.

Mail: Complete the order form (available at myCigna.com) and mail along with your original prescription(s) and your payment to:

Express Scripts Pharmacy
PO Box 66301
St Louis, MO 63166-6301

Phone: 1-800-Tel-Drug (835-3784).

Manage Your Prescriptions Online

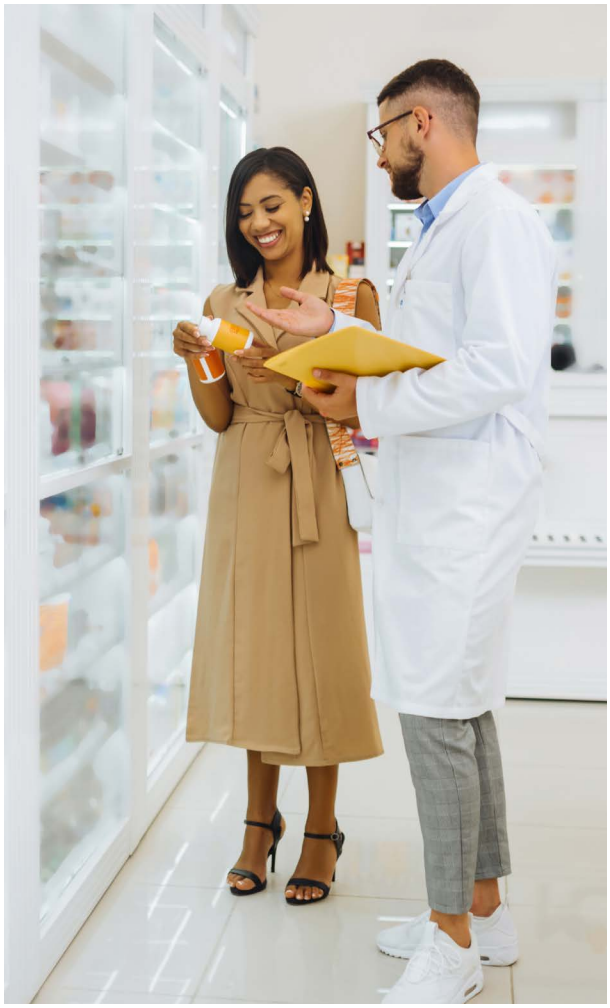
myCigna.com

(click "Prescriptions" tab)

- **Order status**
- **Number of refills remaining**
- **Rx number**
- **Prescription expiration date**
- **Prescription order history**

Specialty Drugs

Injectable drugs (excluding insulin) used to treat conditions like rheumatoid arthritis, cancer, multiple sclerosis or anemia are covered under the Prescription Drug Program. Your first 30-day supply can be purchased at a retail pharmacy. Subsequent refills must be ordered through the specialty pharmacy mail order service and will be dispensed in **30-day intervals** only (90-day supply is not available). In addition, you can take advantage of the specialty pharmacy patient advocate service for guidance and support, as well as self-care information about your condition.



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. This is most apparent with generic medications that are FDA approved to be just as effective as brand-name counterparts. Through Step Therapy, your pharmacist works with your doctor to find the most cost-effective and safest "step one" drug first for treatment of your (or dependent member age 18 or above) condition and then progresses to more costly "step two" brand-name drugs, only if medically necessary.

How Step Therapy Works

There is a sequence of two "steps" in the choice of medication used for the following:

- High blood pressure
- High cholesterol (such as Lipitor)
- Stomach acid conditions
- ACE (Angiotensin Converting Enzyme) Inhibitors / ARB (Angiotensin II Receptor Blockers) drugs used for controlling high blood pressure, treating heart failure and preventing kidney failure in people with diabetes or high blood pressure
- Proton pump inhibitors (such as Nexium or Prevacid)

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 still can get a temporary supply of the "step two" drug while you await your doctor's approval.

Prior Authorization

Our Prior Authorization system works with the Specialty Prescriptions and Step Therapy to ensure your drug therapy is appropriate. Prior Authorization is needed for use of non-preferred brand products without prior use of generic and preferred brand products. Also, if you take medications for acne, weight management, hypertension or emphysema, your pharmacist will automatically call your doctor for a diagnosis before filling your prescription.

Dental and Vision Coverage

Your dental and vision coverage is a single combined election.

YOUR OPTIONS	☐ Dental & Vision	
Your Monthly Cost of Coverage	Employee Only	= $19
	Employee + 1	= $32
	Family	= $32

Dental Plan

Eligible after 90 days of service

The mouth is a window to your health—providing warning signs for complications of heart disease, stroke, diabetes and other serious conditions. That's why your dental benefits cover a wide range of preventive and treatment services.

Coverage is available to you and your covered dependents up to age 26. You can visit any dentist you choose, however, you will spend less when visiting a dentist or specialist within the Total Cigna DDPO Network. Coverage is available for other services and 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 Coverage

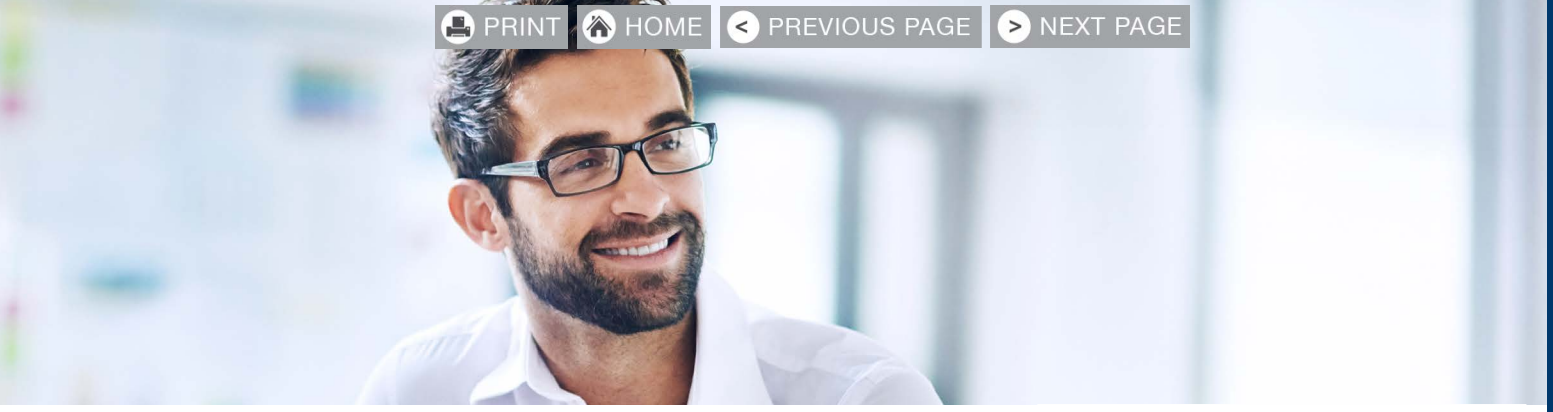
Deductible	$50 per person / $200 per family
Annual Maximum (including Preventive, Basic and Major only)	Individual: $2,000 / Family: $8,000
Preventive and Diagnostic Two routine exams, cleanings and bitewing X-rays per year; one set of full-mouth X-rays every three years	100%; no deductible ***EARN A WELLBEING POINT for preventive dental cleanings/exams***
Basic Restorative Fillings, root canals, denture adjustments and repairs and surgery	80% after deductible
Major Restorative Replacement of existing dentures or bridgework once every five years	50% after deductible
Surgical Extractions of Impacted Teeth	80% after deductible/no maximum
Orthodontia	80% after deductible $1,500 lifetime maximum*
TMJ Non-surgical treatment only	80% after deductible $1,000 lifetime maximum*

* Lifetime maximum is per person.

TAKE ACTION

Find a DDPO Network Dentist:

Visit the online provider directory at myCigna.com and click "Find Care and Costs" at the top of the web page.



Vision Plan

Eligible after 90 days of service

Vision benefits are provided through Cigna, a leading vision plan administrator.

Vision benefits cover exams, frames, lenses and contacts as shown in the table below. *Note: Safety glasses are covered under Cigna Medical only—up to $100. If you don't have Cigna Medical, be sure to see Human Resources for reimbursement.*

Like your other benefits, coverage is for you and your covered dependents up to age 26. Your benefits are higher when you visit an in-network provider. If you visit an in-network provider, you pay a flat copay and your claims are filed for you. If you visit an out-of-network provider, your copays are higher and you must file your own claims.

Vision Plan Coverage

	In-Network	Out-of-Network
Exam (Once per calendar 12 months)	$10 copay	Up to $45 allowance
Standard Eyeglass Lenses		
Single	$10 copay for any type	Up to $45 allowance
Bifocal		Up to $50 allowance
Trifocal		Up to $55 allowance
Lenticular		No allowance
Certain Lens Enhancements (Oversized, Rose 1 & 2 Solid Tints, Polycarbonate for under age 19)	Plan pays 100%	Not covered
Eyeglass Frames (One per calendar 24 months)	Up to $65 allowance	Up to $35 allowance
Contact Lenses One pair or single purchase per calendar 24 months) Elective or Therapeutic	Up to $65 allowance	Up to $65 allowance

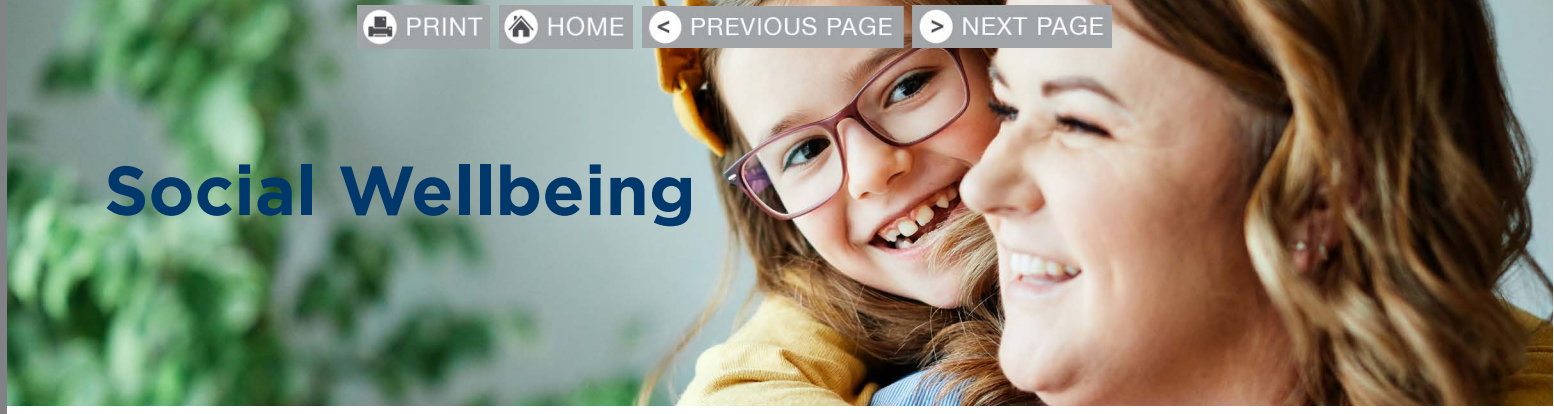
TAKE ACTION

Find a Cigna Vision Provider: Visit mycigna.com or call 1-877-478-7557.

USE WISELY

Should you see an eye doctor or medical doctor?

Your vision benefits cover services performed by an ophthalmologist or optometrist to perform regular check-ups and correct your vision if needed. If you have a vision problem—such as cataracts—diagnosis and treatment would be covered under your medical plan. If you need help deciding what type of provider to see, call your Health Advocate at 1-800-237-2904, or call Cigna at 1-877-478-7557.



Social Wellbeing

Voluntary Benefit Options

Active&Fit Direct™ Program

The Active&Fit Direct™ program is offered through American Specialty Health Fitness, Inc., one of the nation's leading fitness networks, serving millions of members.

It allows you to choose from 10,000+ fitness centers and YMCAs nationwide for $25 a month (plus a $25 enrollment fee and applicable taxes). The program offers:

- Online directory maps and locator for fitness centers (available on any device)
- A free guest pass to try out a fitness center before enrolling (where available)
- The option to switch fitness centers to make sure you find the right fit
- Online fitness tracking from a wide variety of popular wearable fitness devices, apps and exercise equipment

Note: To participate, you must be 18 years of age and have a valid email address. You may pay by credit card and would be charged in advance on a monthly basis using a recurring payment subscription. You must commit to a three-month membership. If you choose to cancel, you must provide a 30-day notice of cancellation. All payments are subject to tax, if applicable, based on your location.

TAKE ACTION

Participants may enroll in the Active&Fit Direct™ program by accessing the link through the Workday dashboard. Once enrolled, you can print an ID card to present at contracted fitness centers/YMCAs.

Mental Wellbeing

Employee Assistance Program (EAP)

Total wellbeing involves more than your physical health. It also includes your mental and emotional well-being. Available to you and your household members (regardless of whether or not you are a Cigna member), the Cigna EAP is a free, confidential resource that helps find answers to various kinds of personal concerns, offers consultation, support, information and planning, as well as referrals to professional resources in your community.

Available 24/7, your Cigna EAP services include, but are not limited to:

Counseling for stress, depression, marital issues and other issues: Allows for up to three face-to-face sessions available to you and/or a household member with a counselor in your area. Call 1-800-237-2904 for more information.

Telephonic consultation & support: Consultations may be related to questions about behavioral health-related topics, assistance with problem identification, problem-solving skills, approaches and/or resources to address behavioral concerns.

Senior care: Learn about challenges and solutions associated with caring for an aging loved one. Also includes resources and referrals for home health agencies, assisted living facilities, social and recreational programs and long-distance caregiving.

Legal assistance: Provides free 30-minute telephonic or face-to-face consultation with an attorney and up to a 25% discount on select fees.

Financial: Receive free 30-minute telephonic consultation with a qualified specialist on issues such as debt counseling or planning for retirement.

Parenting: Receive guidance on child development, sibling rivalry, separation anxiety and much more.

Childcare: Resources and referrals for childcare providers, before and after-school programs, camps and adoption organizations are available, as well as information on parenting questions and pre-natal care.

Pet care: From grooming to boarding to veterinary services, find what you need to care for your pet. Resources and referrals are available for pet sitting, obedience training, veterinarians and pet stores.

Identity theft: A free 60-minute consultation with a fraud resolution specialist is available.

LEARN MORE

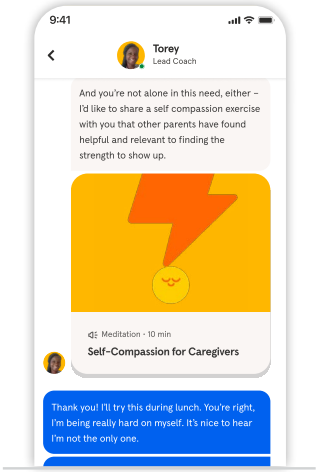
To learn more about this valuable service, call anytime day or night at 1-800-237-2904 or log on to myCigna.com and click on the "Coverage" tab, then select "Employee Assistance Program (EAP)" from the drop-down menu.

Support for All of Life's Challenges

Everyone deserves access to incredible mental healthcare. That's why Headspace Care created the world's first integrated mental health platform where coaches, therapists, and psychiatrists work as a team to coordinate the best, personalized care right from your smartphone, whenever you need it. It's like a virtual clinic without the waiting room. Headspace Care's mental health services are in-network and accessible through your behavioral health benefits.

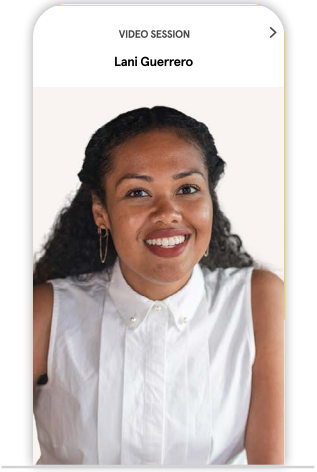
All your **care.** All in **one place.**

Available on the App Store | GET IT ON Google Play



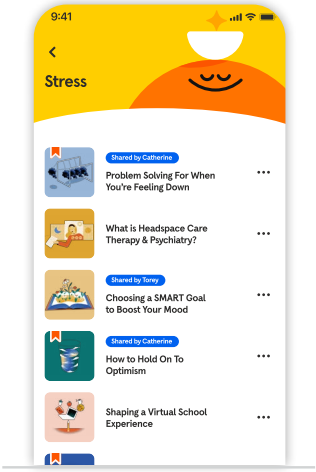
Coaching

Connect with a coach via text-based chat to receive personalized support for whatever you are going through.



Therapy and psychiatry

A licensed therapist or psychiatrist can be added to your care team if you need extra support and based on your health plan benefits. These sessions are video-based and available during evenings and weekends to fit your scheduled.



Skill-based resources

Our library of tips, tool and insights includes articles, classes and podcasts offering expert guidance on a range of topics. This in-app content is available for you to use in your own time to help you move toward your goals.

GET STARTED: Visit organizations.headspace.com/connect or download the Headspace Care app.

Resource for Opioid Addiction

Bicycle Health is putting recovery within reach as part of the Behavioral Health Services provider network.

- This confidential and virtual health platform offers comprehensive support, including online therapy, medication for addiction treatment, support groups, care management and more to help patients successfully recover from opioid use.
- The Clinical Support Specialists offer guidance and encouragement every weekday from 9 a.m. to 7 p.m. via phone, text or chat on the secure app.

Note: Bicycle Health is not currently operating in Indiana, South Carolina or New York. Employees in these three states will not have access to Bicycle Health nor see this provider listed in the provider directory.

TAKE ACTION

You can access the virtual health platform and the list of providers through your myCigna account.

Financial Wellbeing

Flexible Spending Accounts

Flexible Spending Accounts (FSAs) are a great way to save on income taxes while you budget for healthcare and dependent care expenses. Your contributions to the FSAs are made with pre-tax dollars, meaning you pay no federal or Social Security taxes on that money and, depending on your state, you may not have to pay state taxes either.

This leaves a smaller amount of your income subject to taxes. And when you pay less in income taxes, your take-home pay increases!

YOUR OPTIONS	☐ Health Care FSA	☐ Dependent Care FSA

How FSAs Work

Step 1:

Estimate Your Needs

- Estimate your out-of-pocket healthcare and/or dependent care expenses for the year.
- Decide how much you are able to contribute to the FSAs to cover these expenses.

Step 2:

Elect Your Contribution Amount

You may elect to contribute:

- Health Care FSA: up to $3,200 per year.
- Dependent Care FSA: up to $5,000 per year.
  (See page 27 for details about dependent care limits and rules.)

Step 3:

Use/Manage Your FSA

- These types of claims are automatically submitted for FSA reimbursement using the auto-forwarding feature:
  - » Cigna medical and prescription claims
  - » Network dental care (except Ortho)
- Or, pay out-of-pocket and submit the reimbursement form online or via fax or mail. The form must be used for Dependent Care FSA claims.

FSA Key Deadlines:

Enroll and elect 2024 contribution amount
Within 30 days of hire date

2024 eligible expenses must be incurred
December 31, 2024

For Health Care FSA: Remaining balance, up to $610, carried forward for use in 2025
For Dependent Care FSA: Remaining balance forfeited December 31, 2024

All 2024 claims must be filed
March 31, 2025

Flexible Spending Account Features At-a-Glance

	Health Care FSA	Dependent Care FSA
Purpose	• Allows you to use pre-tax dollars to help pay for out-of-pocket costs for healthcare expenses that are not covered by regular insurance.	• Allows you to use pre-tax dollars to reimburse yourself for daycare expenses for eligible children under age 13 (or tax-eligible dependents who can't care for themselves) and adults so you can go to work and/or school.
How Much You Can Contribute	• You may elect to contribute a whole-dollar amount between **$100 and $3,200** per participant total for the full plan year through payroll deductions. • **YOU CANNOT CHANGE YOUR ELECTION UNLESS YOU HAVE A QUALIFIED FAMILY STATUS CHANGE.**	• You may elect to contribute a whole-dollar amount between **$100 and $5,000** per year, per household ($2,500 if you are married and file separate tax returns) through payroll deductions. *Note: IRS annual testing limits this benefit for any employee who made more than $135,000 in 2023. You will be advised of any limits that apply to you.* • **YOU CANNOT CHANGE YOUR ELECTION UNLESS YOU HAVE A QUALIFIED FAMILY STATUS CHANGE.**
When Are the Funds Available	• Your entire annual contribution election is available for reimbursement on Jan. 1, even if you have not contributed the full amount to your account.	• Your funds become available as your contributions are made through payroll deductions. • If you file a dependent care reimbursement claim that is for more than the amount you currently have accumulated in your FSA, you will be reimbursed only up to the amount you've contributed to date. • You will be reimbursed for the rest of the claim as the money gets added into your account each pay period.
Examples of Eligible Expenses	• Deductibles/coinsurance/copays • Contact lenses/eyeglasses/LASIK • Dental treatments/orthodontia • Hearing exams/aids • Chiropractic care • Durable medical equipment • Prescription drugs • Other qualified medical expenses For a more extensive list of qualified healthcare expenses, visit the IRS website at irs.gov/pub/irs-pdf/p502.pdf.	• Adult and child daycare expenses • Preschool • Before- and after-school care • Summer day camps For a more extensive list of qualified medical and dependent care expenses, visit the IRS website at irs.gov/pub/irs-pdf/p503.pdf.
Expenses that Cannot Be Paid with this FSA	• Some expenses are ineligible for reimbursement, such as cosmetic expenses, hair transplants and insurance premiums.	• **THIS IS NOT USED TO REIMBURSE FOR DEPENDENT HEALTHCARE EXPENSES.**
Reimbursement Process	• You can use your FSA debit card to pay eligible expenses at the time of purchase or service. • Alternatively, you can pay out-of-pocket and the submit a claim for reimbursement through your HealthEquity mobile app or online account. • You'll be reimbursed up to the full amount you elected to contribute for the year, minus any paid claims. • You cannot transfer funds between FSA accounts.	• After incurring an expense, you are responsible for paying the cost. Be sure to keep your receipts. • Complete a Reimbursement Form, found on HealthEquity.com. • You'll be reimbursed up to the amount currently in your account.
"Use It or Lose It" Rule	**Up to $610** of any remaining balance as of **Dec. 31, 2024**, can be rolled over for use in 2025.	• Any unused balances in the Dependent Care FSA at the end of the year will be forfeited. Balances cannot be rolled over.
Important Deadlines for the 2024 Plan Year	• **Dec. 31, 2024:** Deadline to incur eligible expenses. • **Mar. 31, 2025:** Deadline to submit 2024 plan year claims.	• **Dec. 31, 2024:** Deadline to incur eligible expenses. • **Mar. 31, 2025:** Deadline to submit 2024 plan year claims.

Disability Coverage

A disability can have significant financial impact on a family. Not only does the income from the disabled person stop, but expenses usually increase for care. BorgWarner's disability coverage provides you with a source of income if you are unable to work because of a non-work-related short- or long-term illness or injury.

Vendor Partners

Alight is the vendor for:

- **Short-Term Disability**
- **Family Medical Leave Act (FMLA)**
- **Paid Parental Leaves**

New York Life is the vendor for Long-Term Disability (LTD). Please refer to the inside front cover for the contact information.

Short-Term Disability

As a BorgWarner employee, you are automatically provided with Short-Term Disability coverage through Alight at no cost to you. Coverage begins after you have been absent from work for a specified amount of time due to a non-work-related illness or injury. It pays a portion of your annual base pay while you are disabled. Benefits end when you recover, or after six months of disability, whichever comes sooner. Short-Term Disability benefits vary by location. Please contact Human Resources for details or Alight (refer to inside cover for contact information).

Long-Term Disability

Eligible after one year of service

Long-Term Disability coverage generally picks up where Short-Term Disability left off. Offered through New York Life, benefits begin if you have been disabled for more than six months and meet the insurer's definition of disabled. Depending on which coverage option you elect, benefits pay up to 50% or 70% of your annual base pay (including the average of your past three years of bonus pay) until you recover or reach normal retirement age, whichever is sooner.

YOUR OPTIONS	☐ Long-Term Disability BorgWarner-Provided	☐ Long-Term Disability Optional LTD70 (70% Annual Base Plus Bonus Earnings)

Comparing Long-Term Disability Coverage

	Coverage under the BorgWarner-Provided LTD Plan (50% benefit)	Upgrade coverage through the Optional LTD70 Plan (70% benefit)
Cost of Coverage	**Company-paid** • No cost to you.	**You and the company share the cost:** • An employee after-tax contribution is required and automatically deducted from your pay each month. • Your required contribution amount can be found on your online enrollment form in Workday®.
Benefit Amount	**Less of a Benefit** • 50% of your current BASE PAY only, up to $12,000 per month.	**Greater Benefit** • 70% of your current BASE PAY plus the average of your past three years of BONUS PAY—meaning your benefit will be greater for two reasons: + It pays an additional 20% benefit for a total of 70%. + It is calculated off a larger amount (base pay + bonus). • Maximum benefit is $16,800 per month.
Tax Consideration for Benefits Received	**Higher Taxes** • You are taxed on the entire benefit received because the company paid the full cost of coverage.	**Lower Taxes** • You are taxed only on the 20% portion of the benefit received because you paid a part of the cost of coverage.

Pre-existing condition limitation

Benefits are not payable for medical conditions for which you incurred expenses; took prescription drugs or medicine; received medical treatment, care or services (including diagnostic measures); or for which a reasonable person would have consulted a physician during the three months just prior to the most recent effective date of insurance. The pre-existing condition limitation will apply to any added benefits or increase in benefits. Benefits are not payable for any disability resulting from a pre-existing condition unless the disability occurs after you have been under this plan for 12 consecutive months.

TAKE ACTION

If you become disabled, you must file a disability claim and be under the care of a physician. To file a Short-Term Disability/Family Medical Leave/Paid Parental Leaves claim, contact Alight at 1-800-441-9628.

To file a Long-Term Disability claim, contact New York Life at 1-800-362-4462. A second opinion may be required at the company's expense.

Life Insurance & Other Financial Protection Benefits

Basic Life Insurance

Eligible after four months of service

Basic Life Insurance is offered through MetLife and provides 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.

Coverage Amount

Coverage in one times your annual base pay—from a minimum of $50,000 to a maximum benefit of $1 million. *Note: Your benefit will be reduced at age 65 and again at age 70.*

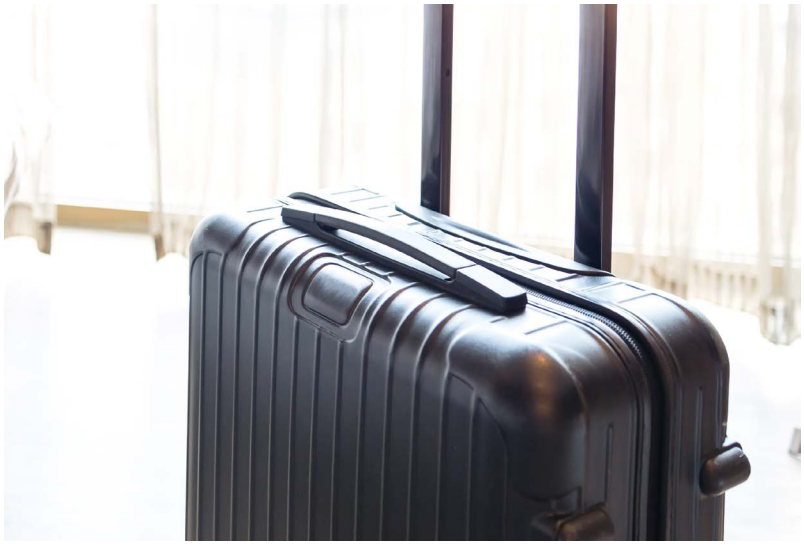
Note: According to government rules, imputed income will be assessed on your paycheck, and appropriate taxes will be deducted. You may choose to cap the benefit at $50,000 of coverage. If you are interested in capping your benefit, please complete the required information on your online enrollment form.

TAKE ACTION

Contact MetLife directly to designate or change your beneficiary for Life Insurance at metlife.com/mybenefits

SOS: Business Travel Accident and Medical Insurance

Paid for by BorgWarner, this International SOS Service provides you with peace of mind when you travel on approved business for the company. It combines global accident coverage with international medical protection. Whether you become sick or are injured while traveling abroad on company business, you have the financial protection against costly bills and convenient access to quality healthcare.



TAKE ACTION

To download and print SOS ID cards, go to borgwarner.com/benefits/usa and click on Global Business Travel. Keep these cards handy when you travel. To learn more, please contact HR Link.

Optional Life Insurance

Eligible after four months of service

For those who feel they need added protection beyond what is provided under the Basic Life benefit, BorgWarner offers a number of optional life insurance plans through MetLife. Employees can choose to purchase the following:

- **Employee Optional Life:** Ranging from 1 times annual base pay to 8 times annual base pay
- **Spouse Optional Life:** $5,000 • 10,000 • $25,000 • $50,000 • $150,000 • $250,000
- **Dependent Optional Life:** $5,000 • $10,000 • $15,000 • $20,000

To enroll or for details about your Optional Life Insurance options, please visit borgwarner.com/benefits/usa. Or, contact MetLife at metlife.com/mybenefits or call **1-888-622-6616**. *Please note: beneficiaries won't automatically carry over from Workday, which means you must designate/update beneficiary information directly with Metlife.*

Accelerated Benefit Option for Basic and Optional Life Insurance

In the unfortunate event that you or your covered spouse is diagnosed with a terminal illness with less than 24 months to live, the Accelerated Benefit Option (ABO) gives you access to the death benefits of your/your spouse's policy before you die. You/your spouse may receive up to 80% of the face value of the insurance coverage (not to exceed $500,000) in a lump-sum payment. *Note: Not available for Dependent Life Insurance, the $5,000 level for Spouse Life Insurance or AD&D and Business Travel Insurance.*

Cost of Coverage

Your costs for Employee and Spouse Optional Life Insurance is based on your age as shown below. Dependent Optional Life Insurance costs are based on the coverage amount you elect.

Employee Optional Life

Age	2024 Rate per $1,000 Benefit Coverage
Under age 25	$0.033
25-29	$0.026
30-34	$0.050
35-39	$0.064
40-44	$0.080
45-49	$0.123
50-54	$0.183
55-59	$0.288
60-64	$0.466
65	$0.741
66	$0.795
67	$0.914
68	$0.912
69	$1.245
70+	$1.476

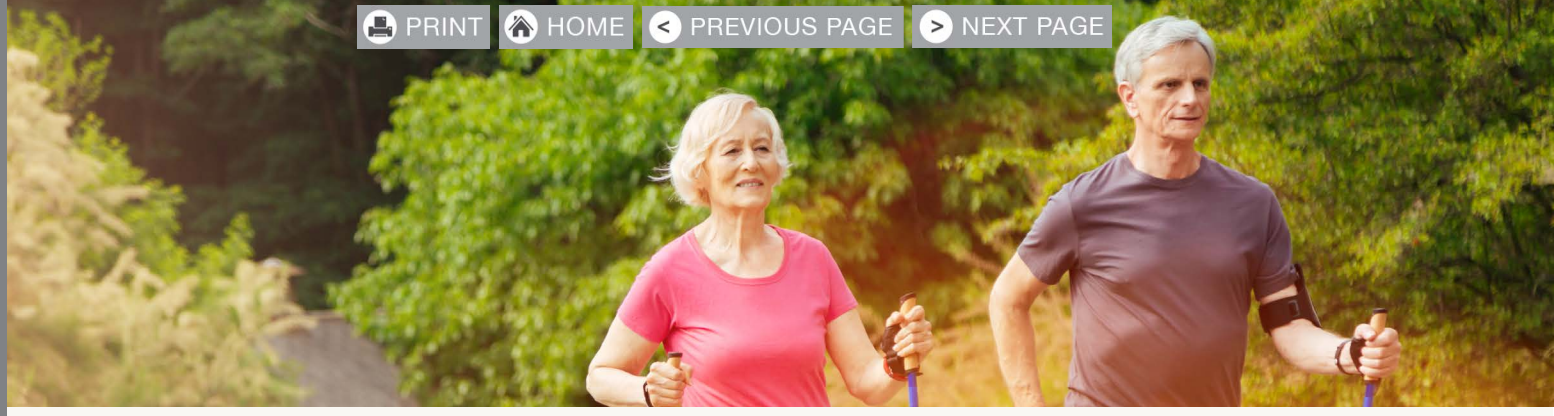
Spouse Optional Life

Age	2024 Rate per $1,000
Under age 30	$0.056
30-34	$0.067
35-39	$0.075
40-44	$0.090
45-49	$0.145
50-54	$0.216
55-59	$0.349
60-64	$0.556
65	$0.750
66	$0.876
67	$1.028
68	$1.178
69	$1.355
70+	$1.572

Dependent Optional Life

Coverage Option	2024 Rate PEPM
$5k	$0.58
$10k	$1.16
$15k	$1.74
$20k	$2.32

IMPORTANT: You must enroll for Optional Life Insurance within 30 days of a qualifying benefit event to qualify for guaranteed coverage. Guaranteed coverage is four times annual base pay for employees and $25,000 for spouses. Contact MetLife for details.



Additional Benefits Available through Optional Life Insurance

By purchasing optional life insurance, you gain financial security and peace of mind, but you also gain access to other valuable services:

- **Will Preparation Services:** Having an up-to-date will is one of the most important things you can do for your family. With a will, you can define your most important decisions, such as who will care for your children or inherit your property. The Will Preparation Service also includes the preparation of living wills and power of attorney. By enrolling for Employee Optional Life coverage, you will have access to Hyatt Legal Plans' network of more than 13,000 participating attorneys for preparing or updating these documents at no additional cost to you if you use a Hyatt Legal Plan's participating attorney.
- **Estate Resolution Services:** In the event of loss, this service (offered through Hyatt Legal Plans) provides compassionate and personal service that reduces the financial and administrative burden associated with properly distributing one's assets—giving your loved ones a sense of security in their time of need. This service fully covers participating plan attorney fees for probating your estate. The service also provides advice and face-to-face and telephone consultations for beneficiaries.

TAKE ACTION

Be sure to let MetLife know of changes to your dependents and beneficiaries, since this information does not flow over from Workday.

Optional AD&D Insurance

Eligible after four months of service

You may purchase Voluntary AD&D Insurance or coverage for you, your spouse and/or your children. You pay the full cost of coverage, but have access to more favorable group rates than if you purchased outside of BorgWarner.

Voluntary AD&D pays benefits if you or a covered dependent suffers a covered accident that results in paralysis or the loss of a limb, speech, hearing, sight, brain damage or coma. If you suffer a fatal accident, benefits would be paid to your beneficiary.

Your Options

You can choose from among the following coverage options:

Coverage Level	In-Network
Employee Only	1 to 8 times your base annual earnings, up to a maximum of $1 million
Dependent Spouse and Child(ren)	Spouse: 50% of your coverage amount Child(ren): 20% of your coverage amount
Dependent Spouse Only	60% of your coverage amount
Dependent Child(ren) Only	25% of your coverage amount

Cost of Coverage

Coverage Level	Monthly cost per $1,000 of coverage*
Employee Only	$0.03
Employee and Family	$0.04

Additional AD&D Benefits

There are some standard benefits included in this coverage—such as air bag and seatbelt use—that may increase the amounts payable to you or help offset additional expenses that result from accidental injury or loss of life. See the Summary Plan Description for details. You may apply for Voluntary Life Insurance during new hire enrollment and/or within 30 days of life event and during annual enrollment. Enrollment is quick and secure through Workday. Visit metlife.com/mybenefits. Be sure to designate a beneficiary when you enroll.

Voluntary Critical Illness Insurance

Eligible after 90 days of service

You can't predict the future, but you can plan for it. BorgWarner offers Voluntary Critical Illness insurance through MetLife that provides financial support in the form of a cash lump sum if you are diagnosed with a qualifying critical illness such as:

 Heart Attack

 Stroke

 Cancer

 Organ Transplant

 Kidney Failure

Coverage also is available for your spouse and children. Child(ren) are covered at no additional cost, but will end when the child reaches age 26, unless he or she continues to meet the requirements of an eligible dependent. By providing financial protection, this coverage allows you to focus on recuperating rather than coping with the stress of how to cover bills related to treatment or living expenses.

How It Works

1 CHOOSE

You choose the benefit options you feel are the best fit based on your needs and budget.

Options include:

- $10,000
- $20,000
- $30,000

2 USE

If you are diagnosed with a critical illness, you may be eligible for a benefit.

3 CLAIM

Go online and submit your claim at **Metlife** mybenefits.metlife.com or call 1-800-438-6388.

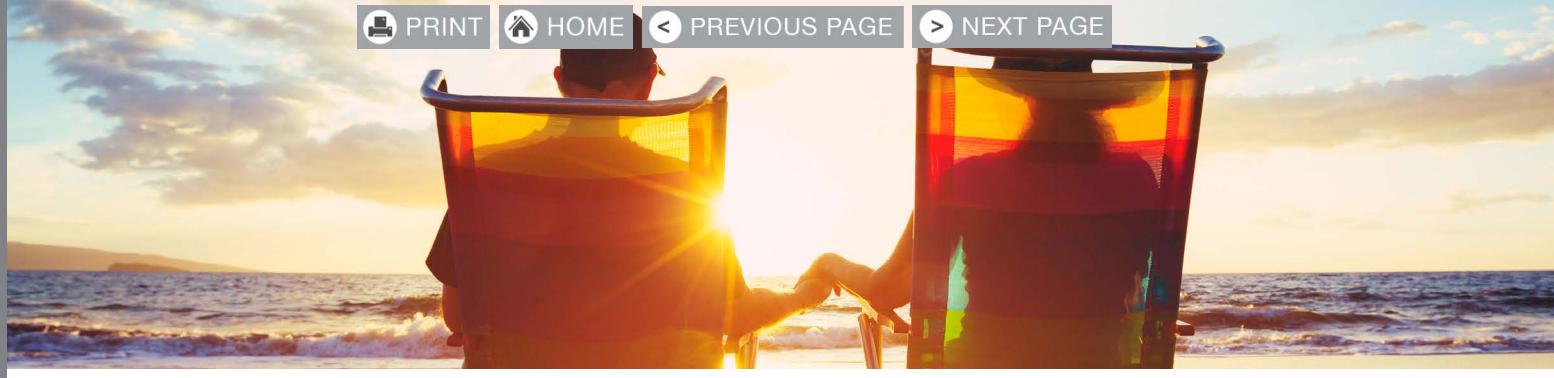
Benefits will be paid as a lump-sum cash payment.

Voluntary Critical Illness Insurance Benefit Amounts

*Note: Covered spouse receives 100% and covered child(ren) receive 50% of your basic benefit amount

	Coverage Level Options		
Initial Critical Illness Benefits†	**Plan 1**	**Plan 2**	**Plan 3**
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 Stage Renal Failure (100%)	$10,000	$20,000	$30,000
Waiver of Premium (employee only)	Yes	Yes	Yes
Cancer Critical Illness Benefits†	**Plan 1**	**Plan 2**	**Plan 3**
Invasive Cancer (100%)	$10,000	$20,000	$30,000
Carcinoma in Situ (25%)	$2,500	$5,000	$7,500
Reoccurence of Critical Illness Benefits†	**Plan 1**	**Plan 2**	**Plan 3**
Second Event Initial Critical Illness Benefit (same amount as Initial Critical Illness)	Yes	Yes	Yes
Second Event Cancer Critical Illness Benefit (same amount as Cancer Critical Illness)	Yes	Yes	Yes
Rider Benefits†	**Plan 1**	**Plan 2**	**Plan 3**
Supplemental Critical Illness Rider			
Advanced Alzheimer's Disease (100%)	$10,000	$20,000	$30,000
Advanced Parkinson's Disease (100%)	$10,000	$20,000	$30,000
Benign Brain Tumor (100%)	$10,000	$20,000	$30,000
Coma (100%)	$10,000	$20,000	$30,000
Complete Loss of Sight (100%)	$10,000	$20,000	$30,000
Complete Loss of Hearing (100%)	$10,000	$20,000	$30,000
Complete Loss of Speech (100%)	$10,000	$20,000	$30,000
Paralysis (100%)	$10,000	$20,000	$30,000
Cancer Critical Illness Option	$10,000	$20,000	$30,000
Critical Illness Reoccurrence Option	$10,000	$20,000	$30,000
Cancer Critical Illness Reoccurrence Option	$10,000	$20,000	$30,000
Supplemental Critical Illness Rider	$10,000	$20,000	$30,000
Skin Cancer Rider	$10,000	$20,000	$30,000

† You can elect coverage at any time.



Retirement Savings Plan (RSP) 401(k)

Eligible after 60 days of service

Your Retirement Savings Plan 401(k) is one of the best ways to save for retirement. The plan offers several advantages:

- **Free** money through employer contributions.
- Reduce your annual taxable income with your before-tax contribution.
- Save and plan for your future retirement with access to educational workshops, savings tools and calculators.

If you have not enrolled within 60 days of employment, you will automatically be enrolled in the plan at a before-tax rate of 3% of your pay.

You can make before-tax and/or Roth after-tax contributions of up to 70% of your eligible pay through convenient payroll deductions up to the IRS limit (2024 IRS Contribution Limit: $23,000. IRS Catch-Up Contribution Limit: $7,500 for those age 50 or older by December 31).

There are several ways to build your account balance. Here's how:

Savings Account

The Savings Account holds before- and after-tax contributions that you make through payroll deductions, plus BorgWarner matching contributions. BorgWarner offers this account for general retirement purposes.

There are three types of personal contributions you can make to your Savings Account:

1. **Before-tax**
2. **Roth after-tax**
3. **Traditional after-tax**

You can contribute up to 70% in each of these accounts, however, the combined sum of the three personal contributions cannot exceed 70% of your pay.

After six months of service, BorgWarner matches your before-tax and/or Roth after-tax contributions, as well as catch-up contributions, dollar for dollar, up to 3% of your pay. BorgWarner matching contributions become 100% vested after you have completed three years of service.

Retiree Health Account

The Retiree Health Account holds before-tax contributions that you make through payroll deductions, plus BorgWarner matching contributions. BorgWarner offers this account to help you save for your medical expenses in retirement.

You can contribute up to 3% of your pay to the Retiree Health Account.

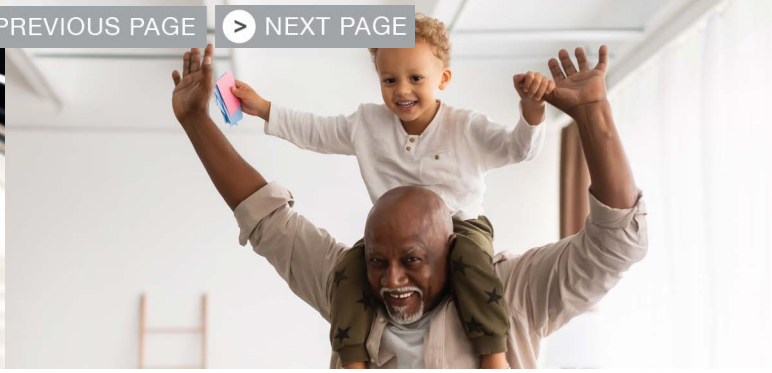
BorgWarner will match your contributions dollar for dollar up to $500 annually. BorgWarner matching contributions become 100% vested after you have completed three years of service.

Company Retirement Account

The Company Retirement Account holds before-tax contributions that BorgWarner makes to your account **after you complete six months of employment**. Even if you decide to opt out of making your own personal contributions, BorgWarner contributes to this account on your behalf.

After six months of service, BorgWarner will contribute to your Company Retirement Account each pay period. This amount will be based on your straight-time hours worked as a participant during a payroll period and your years of service with the company, based on the Collective Bargaining Agreement.

Please refer to the employee benefits website at: borgwarner.com/global-benefits/usa/ithaca-hourly or contact HR Link for more information.



Employer Matching Contributions—Savings Account

BorgWarner will match employee contributions with each paycheck for both before-tax and Roth after-tax accounts, as well as catch-up contributions, up to a maximum of 3%. See the previous page for details.

Automatic Contribution Increase

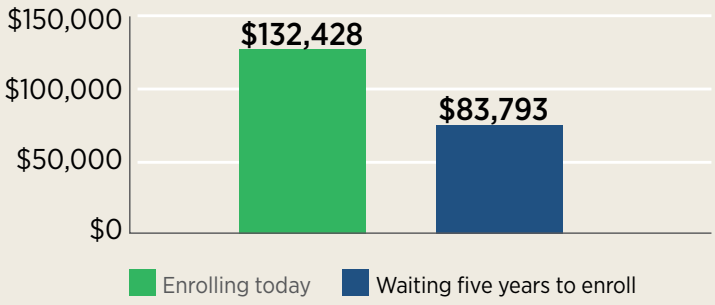
To help you save more, this service automatically increases your before-tax contribution amount each September 1st at 1% up to a maximum contribution of 10%. You have the flexibility to change the month of the annual increase or the amount of the increase, or turn off the service at any time.

BorgWarner encourages you to take advantage of your 401(k) plan so you can look forward to a more secure financial future. However, you may choose to opt-out of the auto increase program at **vanguard.com** or by speaking with a Vanguard Participant Services associate at **800-523-1188**.

Why Now Is the Best Time to Enroll

If you're tempted to put off enrolling in the plan, don't. The sooner you start saving, the more opportunity your money will have to grow.

To illustrate, consider the following hypothetical example. An employee earning $30,000 a year joins the plan right away and invests 12% annually. The employee retires in 20 years with a balance of $132,428. In contrast, if the same employee postpones joining this plan for five years, the ending balance is only $83,793.



Example assumes a salary of $30,000 with annual contributions of 12% and average earning of 6%. This hypothetical illustration does not represent the return on any particular investment. The assumed 6% rate of return is not guaranteed. It is an illustrative example of a long-term average return on a balanced investment of stocks and bonds. Market returns are not constant and will fluctuate annually.

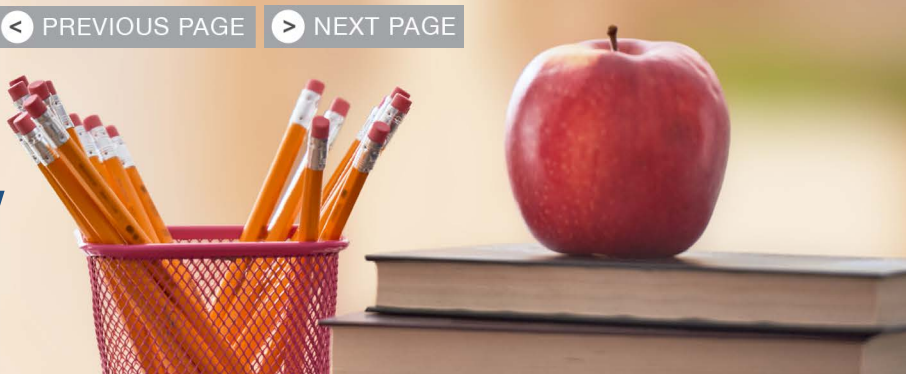
The final account balances do not reflect any taxes or penalties that may be due upon distribution. The $132, 428 figure was calculated based on 20 years of investing in the plan; the $83,793 figure was calculated based on 15 years of plan participation. Withdrawals from a tax-deferred investment before age 59-1/2 are subject to a 10% federal penalty tax unless an exception applies.

Find out how much money you may need to retire at vanguard.com.

TAKE ACTION

Be sure to name beneficiaries for your account so that your hard-earned savings are distributed according to your wishes.

Note: You can name a beneficiary or update your beneficiary information by logging into your account at vanguard.com.



Terms to Know

Affordable Care Act (ACA) – A law passed in 2010, also referred to as 'Health Care Reform" or "Obamacare," focused on extending affordable health insurance to more people, offering more protections to those covered by health insurance and helping to control healthcare costs.

Benefits – The rights of the participants or beneficiary to either cash or services after meeting the eligibility requirements of the other benefit plans.

Claim – An itemized statement of healthcare services and costs provided by a hospital, physician's office or other provider facility. Claims are submitted to the insurer or managed care plan by either the plan member or the provider for payment of the costs incurred.

COBRA – Consolidated Omnibus Budget Reconciliation Act—A federal act that requires each group health plan to allow employees and certain dependents to continue their group coverage for a stated period of time following a qualifying event that causes the loss of group health coverage. Qualifying events include reduced work hours, death or divorce of a covered employee, and termination of employment.

Deductible – A flat amount an employee must pay before the insurer will make any benefit payments.

Dependent – Generally, the lawful spouse or child of a covered individual, as defined by the plan. Can be any person who relies on, or obtains coverage through, a covered individual.

Disease Management – A voluntary program that helps to identify members at risk for certain chronic conditions, such as diabetes. Once a potential at-risk member is identified, Cigna will identify the appropriate interventions.

Employee Assistance Program (EAP) – A support program provided to BorgWarner employees through Cigna that offers information, direction, support, training, encouragement and insight to help handle life's problems.

Essential Health Benefits – Specific health benefits, such as prescription drugs, hospital care, emergency center care, maternity and baby care and preventive care that all of the plans found on the Health Insurance Marketplace must cover. In addition, as part of ACA, large employers are no longer allowed to place annual or lifetime limits on these specific benefits.

Flexible Spending Account (FSA) – FSAs are provided through employee benefit programs allowing employees to pay for certain medical expenses with before-tax dollars. These contributions are subtracted from an employee's gross salary before federal, state, FICA or local taxes are calculated and placed in a "flexible spending" account.

Generic Drugs – A generic drug contains the same active ingredients in the same strengths and dosage as brand-name drugs, but since it does not have a protected brand name and is not advertised, it is much less expensive.

Group Business Travel Insurance – An additional life and disability insurance policy for anything that could happen during travel while on company business.

Health Advocate – A member's first and primary contact for access to all Cigna health plans and wellbeing programs.

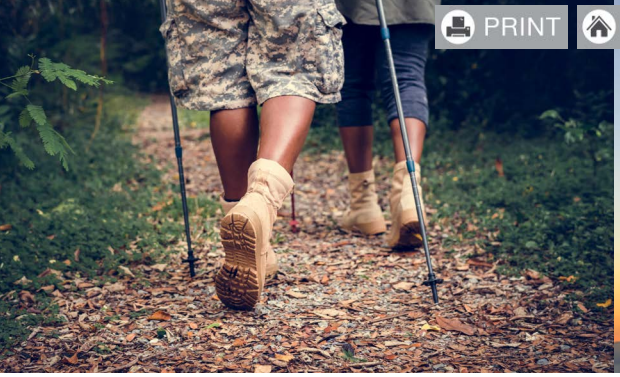
Health Insurance – Protection that provides payment of benefits for covered sickness or injury. Included under this heading are various types of insurance, such as accident insurance, disability income insurance, medical insurance, and accidental death and dismemberment insurance.

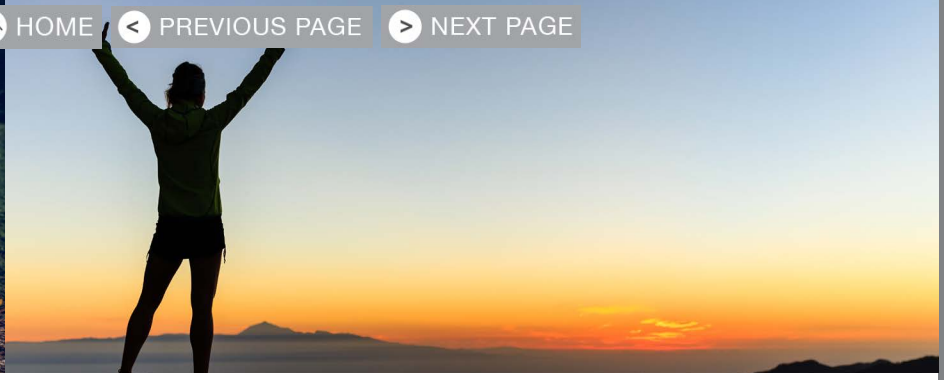
Health Insurance Marketplace – An online public shopping site where people and small businesses can compare and buy health insurance that meets the new ACA requirements of "affordable" care. All states offer a Public Health Insurance Marketplace.

HRA – HRA stands for Health Reimbursement Account. It combines traditional medical coverage with an annual fund established by BorgWarner. This fund is available to pay for covered medical expenses.

HRQ – HRQ stands for the Health Risk Questionnaire. Online versions of this health assessment are available through Cigna.

Individual Mandate – The recent ACA requirement that most people must have medical coverage by January 1, 2014, or pay a penalty. Enrolling in a BorgWarner health plan meets this requirement.





Long-Term Disability (LTD) – A significant period of disability generally ranging from six months to life.

Long-Term Disability Income Insurance – Insurance issued to an employer (group) or individual to provide a reasonable replacement of a portion of an employee's earned income lost through serious and prolonged illness or injury during the normal work career.

Member Deductible Gap – Your portion of the annual plan deductible. After your HRA is exhausted, you must pay out of pocket until reaching your member deductible gap. Once it is met, the plan begins paying benefits.

Network – The group of physicians, hospitals and other medical care professionals that a managed care plan has contracted with to deliver medical services to its members, generally at a lower cost.

Non-Occupational Disability – Insurance a person receives for an off-the-job accident or sickness. It does not cover disability resulting from injury or sickness covered by workers' compensation. Group accident and sickness policies are frequently non-occupational.

Personal Health Team – Cigna's service model for delivering health and wellbeing services to eligible members. Personal Health Team members include nurses, dieticians, clinicians and counselors—who all work together to support your needs.

Pre-Authorization – A cost-control procedure that requires the service or medication to be approved in advance by the doctor and/or the insurer. Without prior authorization, the health plan or insurer will not pay for the test, drug or services.

Premium Subsidy – The dollar amount (in the form of a tax credit that can be applied immediately) that helps offset the cost of health insurance coverage through the Marketplace. Eligibility generally depends on household income and whether you have access to employer health insurance. For example, no BorgWarner employees are currently eligible for this subsidy.

Preventive Care – Medical and dental services aimed at early detection and intervention where the member is having a wellbeing check-up or screening and is not complaining of a specific ailment. Eligible care is limited to specific age and gender—appropriate requirements. These services were selected based on a combination of factors, including risk factor prevalence, morbidity related to the resulting diseases, prevalence of complications and healthcare costs.

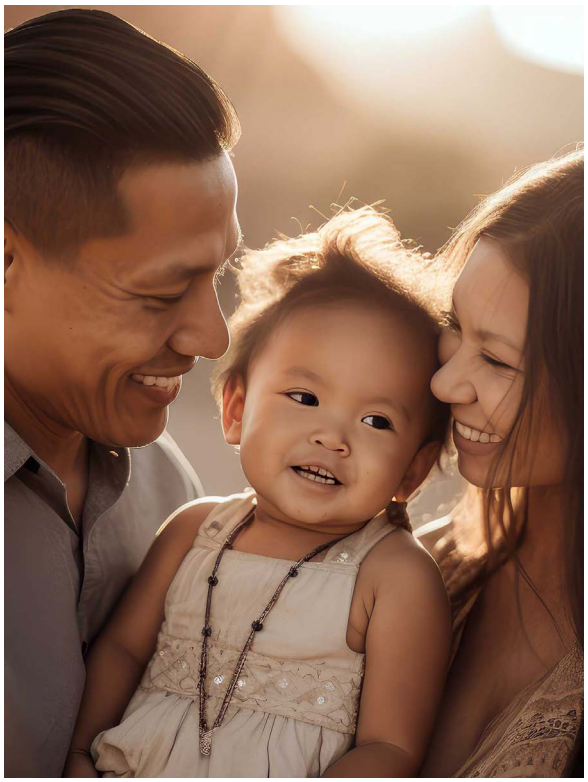
Provider – A provider is a hospital, healthcare facility, physician, pharmacist, dentist or other medical professional that provides healthcare services.

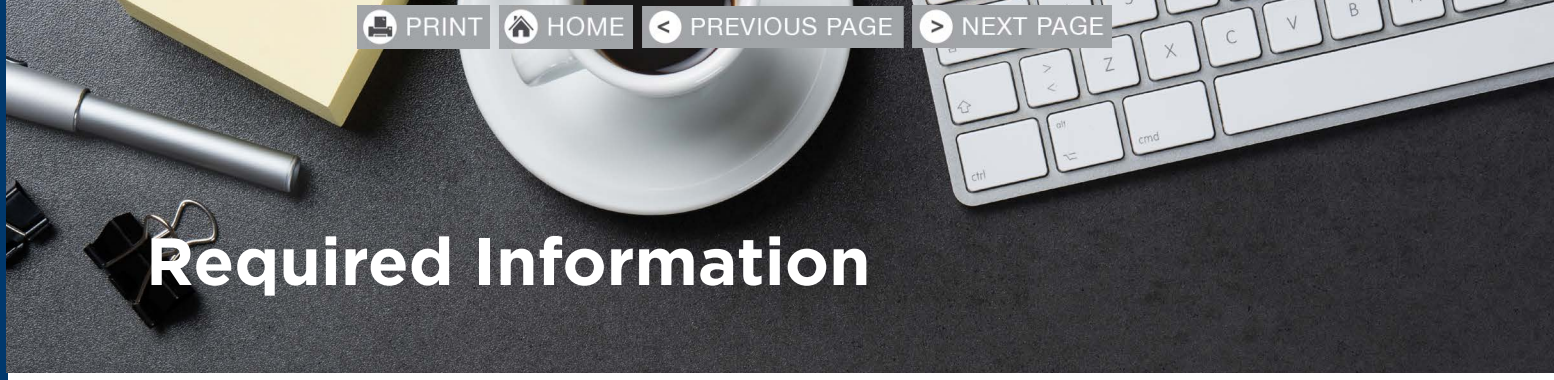
Retirement Savings Plan (RSP) – The BorgWarner 401 (k) plan, that allows eligible employees to make pre-tax contributions toward retirement savings.

Subrogation – An insurer's right to legally pursue a third party that caused an insurance loss to the insured. This is done by a means of recovering the amount of the claim paid by the insurance carrier to the insured for the loss.

Utilization Review – Utilization review is a process that helps determine if the services you receive are a covered benefit. Cigna performs utilization review, including hospital pre-admission certification, continued stay review and case management. Requests for non-emergency hospital stays other than maternity stays must be approved in advance.

Wellbeing Program – A program offered by BorgWarner that provides health and wellbeing programs and services to employees and family members (for certain services) through Cigna.





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 **borgwarner.com/benefits/usa**.

You also may contact the BorgWarner Employee Benefits Committee at 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.

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 **borgwarner.com/benefits/usa**.

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 available at **borgwarner.com/benefits/usa**.

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 Notices

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, 2023 and ends December 15, 2024. 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 **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 HR Link 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 HR Link during the 60-day notice period, THEN ALL QUALIFIED BENEFICIARIES WILL LOSE THEIR RIGHT TO ELECT COBRA. *Note that this deadline may be extended due to coronavirus-related events. Qualified beneficiaries will be notified if any extension of time is available to them.*

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.

Note that this deadline may be extended due to coronavirus-related events. Qualified beneficiaries will be notified if any extension of time is available to them.

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 HR Link 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 **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 **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 HR Link 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 HR Link).

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
1-877-206-0283

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 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 programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or 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 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, 2023. 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://health.alaska.gov/dpa/Pages/default.aspx

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

CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program
http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

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+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidt-plrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – Medicaid
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162 ext 2131
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162 Press 1GA CHIPRA
Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: (678) 564-1162, Press 2

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: https://www.in.gov/medicaid/
Phone 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563
HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid
Website: https://www.kancare.ks.gov
Phone: 1-800-792-4884

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov

LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or
1-855-618-5488 (LaHIPP)

MAINE – Medicaid
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740.
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: 1-617-886-8102

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.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
Email: HHSHIPPProgram@mt.gov

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: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 5218

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://medicaid.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: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

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: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
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
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programsp
Medicaid Phone: 1-800-432-5924
CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid
Website: https://dhhr.wv.gov/bms
http://mywvhipp.com/
Medicaid Phone: 304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badger-careplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

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

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

GROUP HEALTH PLANS OF BORGWARNER INC.
NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

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 Chief Human Resources Officer, 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 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: **https://www.hhs.gov/hipaa/filing-a-complaint/** 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 WELLBEING PROGRAM

Shift Into Better Health and Cigna MotivateMe is a voluntary wellbeing program available to all full-time non-union BorgWarner employees. The program is administered by Cigna according to federal rules permitting employer-sponsored wellbeing 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 wellbeing 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 be asked to complete a biometric screening, which will include a blood test for total cholesterol, LDL cholesterol, and blood sugar. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellbeing 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, only employees who do so will receive a premium discount. Additional incentives of up to $350 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 wellbeing 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 wellbeing 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 wellbeing 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 wellbeing program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellbeing 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 wellbeing program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellbeing program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellbeing 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 wellbeing program.

In addition, all medical information obtained through the wellbeingprogram will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellbeing 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 wellbeing 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 wellbeing 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.

2024 REQUIRED NOTICE FOR ACTIVE NON-UNION EMPLOYEES
INFORMATION ONLY—NO ACTION REQUIRED

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: GENERAL INFORMATION

When key parts of the health care law took effect in 2014, there was an additional way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the Marketplace and health coverage offered by BorgWarner.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health (medical and prescription drug) insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins November 1, 2023 and ends December 15, 2023, for coverage starting as early as January 1, 2024.

Can I Save Money on My Health Insurance Premiums in the Marketplace?

Some individuals may qualify for a tax credit that lowers their monthly premium for or reduces certain cost-sharing under a qualified health plan purchased through the Marketplace, but only if their employer does not offer coverage, or offers coverage that doesn't meet certain standards.

However, as a BorgWarner full-time eligible employee, you will not qualify for such premium or other reduction in cost-sharing because:

1. BorgWarner offers group health coverage to all full-time eligible employees;
2. BorgWarner's group health plan options meet the "minimum value" standard set by the Affordable Care Act because they pay for at least 60% of covered health care expenses; and
3. Your premium cost under the BorgWarner group health plan options that would cover you (and not any other members of your family) is less than 9.61% of your household income. In other words, BorgWarner pays a majority of the premium cost for your coverage under the BorgWarner group health plans. For that reason, you would have to make less than $13,590 in a year to qualify for a tax credit which lowers your premiums or other cost-sharing for a qualified health plan purchased through the Marketplace.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. As a full-time eligible employee, BorgWarner offers you coverage under its group health plans which meet the standards set forth above. Consequently, you will not be eligible for tax credits that lower your monthly premium or reduce certain other cost-sharing for a qualified health plan that you choose to purchase through the Marketplace. Accordingly, you may wish to enroll during the annual enrollment or other special enrollment periods in one of BorgWarner's group health plan options.

Note: If you purchase a health plan through the Marketplace instead of accepting BorgWarner health coverage, then you may lose the employer contribution to the employer-offered coverage. Also, this employer contribution, as well as your employee contribution to employer-offered coverage, is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please refer to the Summary Plan Description located on the BorgWarner Benefits website, borgwarner.com/benefits/usa.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit healthcare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: INFORMATION ABOUT HEALTH COVERAGE OFFERED BY BORGWARNER

This section contains information about any health coverage offered by BorgWarner. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name **BorgWarner Inc.**	4. Employer Identification Number (EIN) **13-3404508**	
5. Employer address **3850 Hamlin Rd**	6. Employer phone number **248-754-9200**	
7. City **Auburn Hills**	8. State **Michigan**	9. Zip code **48326**
10. Who can we contact about employee health coverage at this job? **Corporate Benefits Department**		
11. Phone number (if different from above) **248-754-0866**	12. Email address **Marketplace@borgwarner.com**	

Here is some basic information about health coverage offered by BorgWarner:

After 90 days of service, all full-time eligible employees are offered coverage under the BorgWarner group health plan. BorgWarner classifies you as a full-time eligible employee if you are regularly scheduled to work at least 30 hours a week. You also may enroll your Eligible Dependents, who include your Spouse and Children (as those terms are defined under the plan documents).

BorgWarner offers two medical plan options: The Choice Health Fund and the Choice Health Fund Plus. Both plans work generally the same way, cover the same types of services and provide you with comprehensive coverage. However, they differ in the way you pay your portion of the costs – the balance between the amount you pay up front (through premiums) versus the amount you pay at the time of care (through deductibles and coinsurance).

The Choice Health Fund is BorgWarner's lowest cost plan. By enrolling in this Plan, you pay less up front through lower payroll deductions, but more at the time of care through higher member deductible gap requirements and 20% coinsurance responsibility.

The Choice Health Fund Plus requires you to pay more up front through payroll deductions, but in return, you pay less out-of-pocket if and when you need care. It has a lower member deductible gap and 10% coinsurance.

The coverage for both BorgWarner plans meet the required minimum value standard, which means the company's share of the total allowed benefit costs covered by the plan is no less than 60% of the costs. In fact, the company share for both the BorgWarner plans is much great than 60%. As you can see in the chart below, the Choice Health Fund is 84.1%, while the Choice Health Fund Plus is 89.3%. BorgWarner plan coverage percentages are comparable to the Platinum plan offered under the Health Care Marketplace.

Plan	**% of costs covered**
Bronze	60%
Silver	70%
Gold	80%
Platinum	90%
BW Choice Health Fund	**84.1%***
BW Choice Health Fund Plus	**89.3%**

*HHS Minimum Value Calculator

If you decide to shop for coverage in the Marketplace, **healthcare.gov** will guide you through the process. The above employer information is the information you'll need to enter when you visit **healthcare.gov** to find out if you qualify for a tax credit to lower your monthly premiums or otherwise reduce cost-sharing for a qualified health plan purchased through the Marketplace.

NOTE: BorgWarner reserves the right to modify and/or discontinue the benefits it provides, the premium amounts it pays, eligibility rules and other provisions for its group health plans, within federal guidelines. In the event of a conflict in language or interpretation between this Notice, and the official plan documents, the terms of such official plan documents will control. Because these group health offerings may change or be amended from time to time, you should always check with Human Resources for current information.

BORGWARNER