BorgWarner
Flexible Benefits Plan

Amended and Restated
as of January 1, 2017

BorgWarner Inc.

FLEXIBLE BENEFITS PLAN

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ARTICLE I

INTRODUCTION

Section 1.1 Restatement of Plan. The BorgWarner Flexible Benefits Plan is amended and restated by BorgWarner, Inc. for the exclusive benefit of its Employees and their dependents, effective as of January 1, 2017. The provisions of the Plan will be applied uniformly to all Participants.

Section 1.2 Purpose of Plan. The purpose of the Plan is to provide eligible Employees and their dependents and other beneficiaries with certain Employer-sponsored health and welfare benefits and to provide eligible Employees with a choice between cash and certain "qualified benefits" as defined in Code Section 125(f).

Section 1.3 Incorporation of Provisions. The Qualified Benefit Programs and Non-Qualified Benefit Programs provided under this Plan, and the general terms and conditions governing the same, are set forth in this document, contained in one or more Summary Plan Descriptions (collectively, the "SPDs"), copies of which are provided to Participants, or in Incorporated Documents. The SPDs and Incorporated Documents, as the same may be amended from time to time, are hereby incorporated herein by reference and made a part of this Plan. Participants in this Plan are those persons so defined in Section 2.15 hereof, or in the applicable Incorporated Document(s).

Section 1.4 Employee Health and Welfare Plan. This Plan is intended to constitute a group health plan under Sections 105 and 106 of the Code, a group term life insurance plan under Section 79 of the Code, a group disability plan under Sections 105 and 106 of the Code, a cafeteria plan under Section 125 of the Code, and a dependent care plan under Section 129 of the Code.

Section 1.5 Cafeteria Plan. This Plan includes a cafeteria plan under Code Section 125, and such portion of the Plan is to be interpreted in a manner consistent with the requirements of Code Section 125, where the Plan provides eligible Employees with a choice between cash and certain qualified fringe benefits under the Pre-Tax Employee Contributions Program. Only the Dependent Care Flexible Spending Account, the Health Care Flexible Spending Account, Pre-Tax Employee Contribution and the Qualified Benefit Programs are part of the §125 arrangement. Non-Qualified Benefit Programs may be offered or available through the Plan, but not as part of the cafeteria plan.

Section 1.6 ERISA Plan Status. The Plan, together with each Component Program, is intended to constitute an "employee welfare benefit plan" as defined in ERISA. For purposes of ERISA, the terms of this Plan shall include the terms of any Incorporated Documents. To the extent that a conflict arises between an Incorporated Document and the Plan, the provisions of the Incorporated Document will control.

ARTICLE II

GENERAL DEFINITION

The following terms, when used in this Plan, have the meaning set forth in this Article II unless another meaning is clearly indicated from the context.

Section 2.1 BorgWarner – BorgWarner Inc., a Delaware corporation, or any successor thereto.

Section 2.2 Code – the Internal Revenue Code of 1986, as amended from time to time.

Section 2.3 Compensation – the total wages and salary paid during the Plan Year by the Employer to an Employee for personal services, consistent with the definition of Code Section 414(q)(4).

Section 2.4 Component Program – any of the Qualified Benefit Programs and Non-Qualified Benefit Programs provided by the Employer to Participants under the Plan, as listed in Appendix A.

Section 2.5 Contributions – for each Plan Year, the amount (if any) of Compensation otherwise payable to a Participant that a Participant elects to have allocated toward the purchase of Component Programs pursuant to an Election Agreement ("Employee Contributions"), plus the amount (if any) that the Employer at its discretion chooses to make available for a Plan Year as a "Flex Credit" (as defined in the Regulations of Section 1.125-5(b)) that the Employee elects to allocate to the cost of a Qualified Benefit Program. A Participant's Compensation for a Plan Year (or portion thereof) shall be reduced pursuant to the election of Qualified Benefit Programs through an Election Agreement only by way of payroll withholding, and such reduction shall generally be made on a ratable basis throughout the applicable Plan Year (or portion thereof), or in accordance with the applicable costs allocable to the period in question. If the Employer permits an election of Flex Credits as cash, such cash elections shall be distributed to the electing Employee ratably over the Plan Year for which it was available to be contributed to the Plan. The extent to which, if at all, the Compensation deductions described in this paragraph will be available for a Plan Year shall be determined by the Employer, in its sole discretion, prior to the first day of each Plan Year.

Section 2.6 Effective Date – the effective date of this Amended and Restated Plan is January 1, 2017.

Section 2.7 Election Agreement – the form(s) created by the Administrator by which an eligible Employee makes an election between cash Compensation and the allocation of Compensation for the purchase of benefits under one or more of the Qualified Benefit Programs, or by which an Employee enrolls in a Non-Qualified Benefit Program, as applicable.

Section 2.8 Election Period – the time period established by the Administrator during which any eligible Employee and Participant may make or change his Election Agreement regarding Qualified Benefit Programs. For new Employees, the Election Period shall generally

occur at the time of employment (subject to any applicable waiting period). For existing Employees and Participants, it shall generally occur prior to the beginning of each Plan Year.

Section 2.9 Employee – any individual who is employed by the Employer. The term "Employee" does not include: (a) any individual performing services for the Employer as an independent contractor; (b) "leased employees" within the meaning of Code Section 414(n), except to the extent required by Code Section 125 and 414(n); (c) nonresident aliens; (d) "self-employed individuals" under Code Section 401(c); (e) union employees who are members of a collective bargaining unit that has bargained in good faith over benefits substantially similar to those available under the Plan and whose participation is not provided for under such agreement; and (f) any individual who is classified by the Employer as other than an employee, even if it is later determined that the classification is incorrect. When permitted under this Plan or one of its Component Programs and to the extent permitted or required by law, the term "Employee" includes former employees.

Section 2.10 Employer – BorgWarner and any subsidiary of BorgWarner that participates in the Plan, for the locations identified in Appendix B.

Section 2.11 ERISA – the Employee Retirement Income Security Act of 1974, as amended from time to time.

Section 2.12 FMLA – the Family and Medical Leave Act of 1993.

Section 2.13 Incorporated Documents – each contract (including an insurance contract purchased on behalf of the Plan to fund certain of the Non-Qualified Benefit Program), agreement, policy, arrangement, for services or otherwise, and each Summary Plan Description ("SPD"), collective bargaining agreement, and summary or other similar document that relates to any Component Program provided under the Plan.

Section 2.14 Non-Qualified Benefit Programs – those benefits and programs made available from time to time and listed in Appendix A that an eligible Employee may elect to purchase with after-tax Contributions, including Qualified Benefit Programs listed in Appendix A that are purchased by Employees on an after-tax basis or completely paid for by the Employer.

Section 2.15 Participant – any eligible Employee who participates in a Component Program offered under the Plan.

Section 2.16 Plan – the BorgWarner Flexible Benefits Plan as described herein, including all Component Programs, as amended from time to time.

Section 2.17 Plan Sponsor – BorgWarner Inc.

Section 2.18 Plan Year – the calendar year.

Section 2.19 Qualified Benefit Programs – the benefits and programs made available by the Employer from time to time that an eligible Employee may elect to purchase with Employee Contributions in lieu of Compensation under the Pre-Tax Premium Payment Program, as set

forth in the Qualified Benefit Table for Active Employees in Appendix A and as permitted under Code Section 125(f).

Section 2.20 Regulations – the Treasury Regulations promulgated under the Code, including any proposed regulations that taxpayers are permitted to rely upon.

Section 2.21 Spouse – unless otherwise provided in a fully insured Component Program, an individual to whom you are legally married under state law. Co-habitants, domestic partners, life partners, legally separated individuals, and divorced spouses are not considered "Spouses" under the Plan.

Section 2.22 Uniformed Service – qualified military service, as defined in Code Section 414(u)(5).

Section 2.23 USERRA – the Uniformed Services Employment and Reemployment Rights Act of 1994.

ARTICLE III

ELIGIBILITY AND PARTICIPATION

Section 3.1 Eligible Employees. An Employee who is in an eligible group of Employees under the eligibility requirements of one or more Component Programs, as specified in the applicable Incorporated Documents, shall be eligible to participate in the Plan.

Section 3.2 Conditions for Participation. Employees who are eligible to participate in the Plan under Section 3.1 may elect to participate by enrolling in one or more of the Component Programs under Article IV in accordance with procedures established by the Administrator from time to time and after satisfaction of any waiting periods or other eligibility requirements, if any, specified in Section 3.3, the applicable Incorporated Documents or consistent with applicable law. Employees who are eligible to participate in any non-elective Component Programs offered by the Employer will be automatically enrolled by the Employer in such Programs and will become Participants in the Plan.

Section 3.3 Effective Date of Participation. An Employee who satisfies the conditions for participation contained in Sections 3.1 and 3.2 and who elects to participate in one or more optional Component Programs offered under the Plan in accordance with Article IV shall become a Participant in such Component Program effective as of the entry date specified in the applicable Incorporated Documents. The Administrator may establish uniform rules or policies that require elections to be made within certain time periods. An Employee will become a Participant in the Plan on the day he first becomes a participant in any voluntary or non-elective Component Program offered under the Plan.

Section 3.4 Participation During Leave of Absence. An Employee who is not at work due to an unpaid FMLA leave, an unpaid period of Uniformed Service lasting more than 31 days, or any other reason that creates a legal obligation for the Employer to extend certain benefit coverages, may, at the Employee's option, and subject to any specific limitation for any specific Component Program, continue during the period of absence any or all benefits under the Plan

that the Employee was receiving at the date the absence commenced, provided the Employee continues to make any required contributions. During the absence, the Employee may choose to make contributions by:

A. remitting payment to the Employer on or before each pay period for which Employee Contributions would have been deducted from the Employee's paycheck if an unpaid leave had not been taken, provided that any delinquent payment must be made within 30 days of its due date; or

B. if the Employer permits, prepaying the amounts that will become due during the unpaid leave out of one or more of the Employee's paychecks preceding the leave; or

C. agreeing to an arrangement prior to the leave whereby the Employer will fund the coverage during the leave and the Employee will make catch-up payments upon returning from leave (and on a pre-tax basis if the Employee participates in the Pre-Tax Payment Program).

An Employee who is absent from work for any paid leave of absence must continue any and all benefits elected under this Plan, and Employee Contributions (if any) for those benefits will continue to be deducted from the Employee's paychecks during the absence.

Section 3.5 Coverage During FMLA Leave. Notwithstanding any provision to the contrary in the Plan, if a Participant is granted a qualifying unpaid leave under the FMLA, to the extent required by the FMLA, the Employer will continue to maintain the Participant's benefits under any "group health plan" as defined in Code Section 5000(b)(1) on the same terms and conditions as though he or she were still an active Employee (i.e., the Employer will continue to pay its share of the premium) to the extent the Employee elects to continue his or her coverage. If the Employee elects to continue his or her coverage, the Employee may be given the option to:

A. prepay all or a portion of the Employee's share of the premium for the anticipated duration of the leave on a pre-tax salary reduction out of the Employee's pre-leave Compensation (and on a pre-tax basis if the Employee participates in the Pre-Tax Premium Payment Program) by making a special election to that affect prior to the date such Compensation normally would be made available to him (provided, however, that pre-tax dollars may not be utilized to fund coverage during the next year);

B. pay for the benefits while on leave (and on a pre-tax basis if the Employee participates in the Pre-Tax Premium Payment Program, but only to the extent the Employee receives compensation during the leave); or

C. agree to an arrangement prior to the leave whereby the Employer will fund the coverage during the leave and the Employee will make catch-up payments upon returning from leave (and on a pre-tax basis if the Employee participates in the Pre-Tax Premium Payment Program).

If the Employee has elected not to continue his or her coverage, upon return from such leave, the Employee will be permitted to reenter the Plan on the same basis the Employee was participating prior to taking leave, or as otherwise required by the FMLA, and shall have whatever rights as shall be applicable under Section 4.5.

Section 3.6 Layoffs. The Employer may permit an Employee to continue participation in one or more Component Programs during a temporary layoff under terms and conditions set forth in the Incorporated Documents. The Employer will permit an Employee to make Contributions for the layoff period in arrears through the Pre-Tax Premium Payment Program upon the Employee's return to regular employment status. An Employee may elect to make Employee Contributions during the period of lay-off on an after-tax basis, except pre-tax contributions may be permitted to the extent that an Employer who participates in the Pre-Tax Premium Payment Program receives compensation during the layoff.

Section 3.7 Rehired Employees. If an Employee terminates employment and is subsequently reemployed by the Employer, the Employee shall become a Participant as provided in the Incorporated Documents. If an Incorporated Document does not contain any rules for participation on reemployment, the following rules shall apply:

A. If an Employee terminates employment prior to becoming a Participant and is subsequently reemployed by the Employer, the Employee must satisfy the requirements of Sections 3.1 and 3.2 in order to participate in the Plan without regard to any prior period of employment with the Employer.

B. If an Employee terminates employment after becoming a Participant and is subsequently reemployed by the Employer within 30 or fewer days from the date the Participant terminated employment, the former Participant shall automatically participate immediately in the Plan upon reemployment, in the same Component Programs and at the same level of coverage as in effect before the Participant's termination of employment, unless a change is otherwise permitted due to a Qualified Change in Status (as defined in Section 4.5) or because a new Plan Year has begun.

C. If an Employee terminates employment after becoming a Participant and subsequently becomes reemployed with the Employer more than 30 days from the date the Participant terminated employment, the former Participant may participate in the Plan again upon reemployment when the Employee again meets the requirements of Section 3.1 and 3.2 without regard to any prior period of employment with the Employer.

Section 3.8 Termination of Participation. A Participant shall cease to be a Participant in each Component Program as of the earlier of:

A. the later of the date the Participant is no longer an Employee eligible to participate in the Plan (or the applicable Component Program) under Section 3.1 (including termination of employment), or the date participation ends under a participating location's policies or collective bargaining agreement;

B. the date of termination of the Plan;

C. the date of termination of the Component Program;

D. the date the Participant elects to terminate participation in one or more Component Programs pursuant to the rules of Article IV;

E. the date of the Participant's death; or

F. the date the Employer terminates the Participant from the Plan because of fraud or intentional misrepresentation.

Termination of participation in the Plan shall not prevent a former Participant from continued benefits or coverage under a Qualified Benefit Program if and to the extent required by such program, as described in any Incorporated Document under Non-Qualified Benefit Program or under applicable state or federal law.

Section 3.9 COBRA Continuation Coverage. The provisions of this Section 3.9 shall become applicable for Plan Years, if any, in which the Employer is subject to the requirements of Code Section 4980B, ERISA Sections 601, et seq., or 42 U.S.C. Section 300bb. During the Plan Year that this Section 3.9 is applicable, each person who is a Qualified Beneficiary shall have the right to elect to continue coverage under any applicable Component Program that is considered to be a "health plan" and subject to COBRA upon the occurrence of a Qualifying Event. Each Qualified Beneficiary must be offered coverage under a group health Component Program that is considered to be a "health plan" and subject to COBRA upon the occurrence of a Qualifying Event. Each Qualified Beneficiary must be offered coverage under a group health Component Program that is the same as the coverage offered to "similarly situated non-COBRA beneficiaries" (*i.e.*, Covered Employees, their Spouses and dependents). This coverage is known as Continuation Coverage. For purposes of this Section 3.9, "Employee" is defined as any individual who is eligible to be covered under a group health Component Program by virtue of the performance of services for an Employer maintaining the Plan:

A. Qualified Beneficiary – A Qualified Beneficiary is any person who, as of the day before a Qualifying Event, is:

1. an individual covered under the applicable Component Program by virtue of being on that day either a Covered Employee, the covered Spouse of a Covered Employee, or a covered child of the Covered Employee. A "Covered Employee" is generally any individual who is (or was) provided coverage under a group health Component Program by virtue of being or having been an Employee. A Covered Employee can be a Qualified Beneficiary only if the Qualifying Event consists of termination of employment (for any reason other than gross misconduct) or reduction of hours of the Covered Employee's employment or the bankruptcy of the Employer; or

2. any child who is born to or placed for adoption with a Covered Employee during a period of Continuation Coverage.

A Qualified Beneficiary shall have the same rights as a Covered Employee to enroll individuals (i.e., newborn children, adopted children, or new Spouses) at times other than open enrollment periods.

B. Qualifying Events – Any of the following shall be considered a Qualifying Event, provided a Qualified Beneficiary will lose coverage under the applicable group health Component Program. To "lose coverage" generally means to cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event. Qualifying Events include:

1. the Covered Employee's termination of employment (other than by reason of gross misconduct) or reduction of hours of employment below any minimum level of hours required for participation in the applicable Component Program;

2. the Covered Employee's death;

3. the Covered Employee's divorce or legal separation from the Covered Employee's Spouse;

4. the Covered Employee's becoming entitled to receive Medicare benefits under Title XVIII of the Social Security Act;

5. a child of a Covered Employee ceasing to be eligible; or

6. certain bankruptcy proceedings under Title 11 of the United States Code.

C. Notification Requirements – Within 30 days of the occurrence of a Qualifying Event under paragraph B(1), (2), (4) or (6), the Employer shall notify the Administrator of such Qualifying Event. Within 14 days of such notification, the Administrator shall furnish each Qualified Beneficiary written notification of the termination of coverage under the applicable Benefit Program, as well as the right to elect Continuation Coverage.

For Qualifying Events described in paragraph B(3) and (5), a Covered Employee or other Qualified Beneficiary must notify the Administrator in writing within 60 days of the occurrence of such Qualifying Event. Within 14 days of its receipt of such notice, the Administrator shall furnish each Qualified Beneficiary written notification of the right to elect Continuation Coverage. If a Covered Employee or Qualified Beneficiary fails to notify the Administrator within this 60-day period of such Qualifying Event, he or she shall be deemed to have waived the right to elect Continuation Coverage.

Notwithstanding any of the foregoing, notification to a Qualified Beneficiary who is a Spouse of a Covered Employee is treated as notification to all other Qualified Beneficiaries residing with that Qualified Beneficiary at the time notification is made. In addition, the Administrator may delegate the notice responsibilities to

others, such as a third party administrator, provided affected Qualified Beneficiaries are informed to whom notice must be given.

D. Election Period – A Qualified Beneficiary entitled to elect Continuation Coverage must return a signed election of Continuation Coverage to the Employer within 60 days of the later of the following dates:

1. the date upon which the Qualified Beneficiary is sent notice of his or her right to elect Continuation Coverage; or

2. the date upon which the Qualified Beneficiary's coverage under the applicable Benefit program terminates.

A Qualified Beneficiary who does not elect Continuation Coverage in connection with a Qualifying Event within 60 days of such event ceases to be a Qualified Beneficiary at the end of the Election Period.

E. Multiple Qualifying Events – Subject to paragraph G, for Qualifying Events under paragraph B(1), Continuation Coverage may extend for a maximum period of up to 18 months after the date of the Qualifying Event, unless, during such 18-month period, a subsequent Qualifying Event occurs. If a second Qualifying Event occurs during the 18-month period, then another election to extend coverage for up to 18 additional months may be available to the Qualified Beneficiary. In no event, however, shall Continuation Coverage extend more than 36 months beyond the date of the first Qualifying Event. For all other Qualifying Events under Paragraph B, Continuation Coverage may extend for a maximum period of up to 36 months after the date of the Qualifying Event.

F. Disability – If any Qualifying Event is the Employee's termination or reduction in hours of employment and a Qualified Beneficiary is disabled within the meaning of Title II or XVI of the Social Security Act at any time during the first 60 days after the Continuation Coverage begins, then the 18-month coverage period will be extended for up to a total of 29 months, provided that (1) the disabled individual notifies the Administrator of the Social Security Administration's determination of disability within 60 days after the determination is made or, if later, within 60 days from the date of the Qualifying Event or the date coverage would be lost on account of the Qualifying Event; and (2) that the Administrator receives such notice before the end of the original 18-month coverage period.

G. Termination of Continuation Coverage – For each Qualified Beneficiary electing Continuation Coverage, such coverage shall automatically cease upon the occurrence of any of the following events:

1. the Employer no longer offers the applicable Benefit to any of its Employees;

2. the required premium for Continuation Coverage is not timely paid;

3. such Qualified Beneficiary becomes covered under another group health plan ;

4. such Qualified Beneficiary becomes covered and is entitled to receive benefits under Medicare; or

5. in the event a Qualified Beneficiary is receiving extended Continuation Coverage as a result of being disabled under the Social Security Act, such individual must notify the Administrator within 30 days of the date of any final determination under the Social Security Act that he or she is no longer disabled. The extended Continuation Coverage may then be terminated after more than 30 days has passed from the date of this final determination, provided that the end of the maximum coverage period that exists without respect to the disability has not expired.

   In addition, in the event of the bankruptcy of the Employer, certain other time periods apply, as described in Code Section 4980B and the underlying Treasury Regulations.

H. Payment of Continuation Coverage Premiums – The premium cost for Continuation Coverage shall be no more than the full cost to the Plan for such period of coverage for similarly situated Covered Employees, Spouses or other dependents, for whom a Qualifying Event has not occurred. Except as provided below, a Qualified Beneficiary may also be required to pay an administration fee of up to two percent (2%) of the premium cost of Continuation Coverage, for expenses incurred in administering Continuation Coverage. In the event a Qualified Beneficiary has elected to extend his Continuation Coverage pursuant to paragraph F as a result of such disability, then the administrative fee shall be no more than fifty percent (50%) of the cost of Continuation Coverage for the 11 month extension that occurs after the original 18 month period.

   A Qualified Beneficiary's initial premium payment following the election of Continuation Coverage is considered timely if received within 45 days of the timely Continuation Coverage election. Premium payments for Continuation Coverage shall be due and payable at the same time Employee Contributions are withheld from the Compensation of Participants not receiving Continuation Coverage. Notwithstanding the foregoing, premium payments will be considered timely if they are made within 30 days of the premium payment due date. In addition, if a timely payment is made to the Plan, but such payment is short by no more than the lesser of $50 or 10% of the premium payment amount, the Plan must treat such payment as a full payment unless the Plan notifies the Qualified Beneficiary of the amount that is deficient and grants a minimum of 30 days for the Qualified Beneficiary to make up such deficiency.

I. FMLA Leave and Continuation Coverage – Continuation Coverage is not triggered when an Employee takes FMLA leave. A Qualifying Event will occur, however, if an Employee (or Spouse or dependent of the Employee) is covered by

a group health Component Program on the day before the first day of FMLA leave, the Employee does not return to work at the end of the FMLA leave and, in the absence of the election of Continuation Coverage, the Employee (or Spouse or dependent) would lose coverage under a group health Component Program before the time that would be the maximum coverage period. The Qualifying Event will be deemed to occur on the last day of FMLA leave. If a lapse in group health Component Program coverage occurs during the period of FMLA leave because the Employee fails to pay the required premium amount or declines coverage, this fact does not affect whether a Qualifying Event occurs or when such event occurs.

J. Other Requirements – The provisions of this Section 3.9 are to be interpreted in conformity with Code Section 4980B, ERISA Sections 601 et seq., and/or the Public Health Service Act (42 U.S.C. Section 300bb), as applicable, and the Regulations promulgated thereunder.

K. Health Insurance Marketplace – Starting in 2014, Qualified Beneficiaries may be eligible to purchase an individual health insurance policy through the Health Insurance Marketplace, which coverage may cost less than COBRA coverage under this Plan. Qualified Beneficiaries can learn more about the Marketplace coverage as an alternative to COBRA coverage under this Plan by reviewing the Plan's COBRA Notice and visiting www.healthcare.gov.

Section 3.10 Continuation Coverage under Health Care Flexible Spending Account Benefit Program. Notwithstanding any Plan provisions herein to the contrary, with regard to the Health Care Flexible Spending Account Benefit Program, as described in Section 5.3 of the Plan, a Qualified Beneficiary will be eligible to elect Continuation Coverage for the Health Care Flexible Spending Account Benefit Program under Section 3.9 only if the Participant's Health Care Expense Account balance at the time of the Qualifying Event exceeds the amount of COBRA premiums required to maintain coverage under the Health Care Flexible Spending Account Benefit Program for the balance of the Plan Year in which the Qualifying Event occurs. If a Qualified Beneficiary is eligible to elect Continuation Coverage under the Health Care Flexible Spending Account Benefit Program, such Continuation Coverage shall be available only until the end of the Plan Year in which the Qualifying Event occurs.

Section 3.11 USERRA Continuation of Coverage. Notwithstanding any Plan provisions herein to the contrary, with regard to each benefit made available under the Plan that is considered to be a "health plan" (as defined in Section 38 U.S.C. Section 4303(7)), a Participant who performs service in the Uniformed Services may elect continuation of coverage under the Plan as required by USERRA.

ARTICLE IV

ELECTION PROCEDURE

Section 4.1 New Participants. Under the procedures established by the Plan Administrator, each newly eligible Employee shall be provided with an Election Agreement and be permitted to elect to participate in optional Component Programs offered through the Plan for

the remainder of the Plan Year. Each such Employee who desires to have Contributions allocated toward the purchase of coverage under an optional Component Program for the remainder of the Plan Year shall so specify on the Election Agreement and shall agree to a reduction in Compensation, if applicable. For those Component Programs that are Qualified Benefit Programs, contributions shall be made on a pre-tax basis under Section 5.2 unless otherwise permitted and elected by the Employee. The Election Agreement must be received by the Administrator on or before such date as the Administrator shall specify. The Administrator may implement rules or otherwise notify the newly-eligible Employees who fail to return a properly completed Election Agreement to the Administrator on or before the specified date whether such failure shall be deemed to be an election not to participate in any optional Component Program offered through the Plan or whether any default elections will be entered on the individual's behalf. If an Employee waives or is deemed to have waived participation in the optional Component Programs, then such Employee's participation in the Plan will be limited to such non-elective Component Programs for which the Employee may qualify, if any.

Section 4.2 Annual Election Procedure. In connection with the annual Election Period, the Administrator shall provide an Election Agreement to each Participant and each other Employee who has satisfied the requirements of Article III with respect to eligibility to participate in optional Component Programs. The Election Agreement shall allow each such Employee and Participant to elect or change the optional Component Programs for which Contributions are to be allocated for the following Plan Year. Such election, which shall be effective for the Plan Year next following the Election Period, may provide for different or additional options or elections than were in effect for the prior Plan Year, or a Participant may elect to terminate participation in some or all Benefit programs under the Plan for the next Plan Year.

Section 4.3 Election Form And Timing. Elections must be made in accordance with procedures established by the Administrator. Except as provided for new Participants in Section 4.1, a Participant's election under the Plan pursuant to the Election Agreement shall be effective with the first regularly scheduled pay period of the Plan Year for which the Participant's election under the Plan is made. The election form must be received by the Administrator on or before the end of the Election Period or such other date as the Administrator shall specify, which date shall be no later than the day prior to the first day of the Plan Year for annual Elections. Election forms received on and after the first day of the Plan Year shall be void.

Section 4.4 Participant Failure to Return Election Agreement During Open Enrollment. The Administrator may implement rules or otherwise notify eligible Employees who fail to return a properly completed Election Agreement to the Administrator on or before the specified due date whether such failure shall be deemed to be an election not to participate in any optional Component Program offered through the Plan or whether any default elections will be entered on the Employee's behalf. With respect to the Component Programs described in Sections 5.3 and 5.4, eligible Employees must return a properly completed Election Agreement electing participation in such Programs in order to participate in the next following Plan Year.

Section 4.5 Qualified Change in Status. Election of a Non-Qualified Benefit Program may be changed only if and under the conditions set forth in the Incorporated Documents for the specific Non-Qualified Benefit Program. Elections of Qualified Benefit Programs made under

the Cafeteria Plan Program shall be irrevocable throughout a Plan Year unless the Participant has a "Qualified Change in Status." A Participant in the Cafeteria Plan Program may revoke an election for the balance of a Plan Year and make a new election only if both the revocation and the new election are due to and consistent with a Qualified Change in Status. A Qualified Change in Status for this purpose includes:

A. Marital Status – An event that changes the Employee's legal marital status, such as:

1. marriage;
2. divorce;
3. legal separation;
4. annulment; or the
5. death of the Employee's Spouse.

B. Number of Dependents – An event that changes the number of the Employee's dependents, such as:

1. birth;
2. death;
3. adoption;
4. placement for adoption; or
5. a change in the number of qualifying individuals as defined in Code Section 21(b)(1) for purposes of the Dependent Care Flexible Spending Account Benefit Program only.

C. Employment Status – An event that changes the employment status of the Employee, the Employee's Spouse or dependent such that the event causes the Employee, the Employee's Spouse or dependent to either gain or lose eligibility for an employer's benefit program, such as:

1. the commencement or termination of employment;
2. the commencement or termination of an unpaid leave of absence;
3. a change in work site location that removes the affected individual from a benefit plan's service provider area; or
4. any employment status change that affects the eligibility of the individual to participate in a benefit program or plan of an employer, including a change from full-time to part-time, hourly to salaried, union to non-union status, or the reverse of any such change.

D. Dependent Eligibility – A change that causes a Participant's dependent to satisfy or cease to satisfy the eligibility requirements to participate in an employer's benefit plan, including:

1. attaining the age at which eligibility ends; or
2. a change in plan eligibility requirements.

E. Cost or Coverage – A significant change in the cost or coverage of a Qualified Benefit Plan offered to the Employee, the Employee's Spouse or dependent, such as:

1. a new benefit option being added;
2. a benefit option being eliminated or significantly curtailed;
3. a coverage change made under a plan offered by the employer of the Employee's Spouse, former Spouse or dependent, if the other employer's plan allows participants to make all mid-period election changes allowed under Treas. Reg. Sections 1.125-4(b) through (g), except (f)(4);
4. a significant increase in the cost of a benefit, (such Qualified Change in Status permits the Employee to make a new benefit selection, but does not allow the Employee to revoke coverage entirely, unless no other similar coverage is available); further, in the case of the Dependent Care Flexible Spending Account Benefit Program, where the provider is a relative of the Employee, no election change is permitted for this change in status reason; or a change in dependent care provider (for purposes of elections made under the Dependent Care Flexible Spending Account Benefit Program).

F. Medicare/Medicaid – The Employee, Employee's Spouse or dependent becoming eligible for or losing benefit coverage under Part A or Part B of Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than for pediatric vaccines (for the purpose of elections made under any available accident or health plan as defined by Code Sections 105 and 106, the Health Care Flexible Spending Account Benefit Program and the Dependent Care Flexible Spending Account Benefit Program only).

G. COBRA – The eligibility for COBRA Continuation Coverage by the Employee, the Employee's Spouse or dependent (only for the purpose of allowing an election to increase any pre-tax Contributions to pay for the COBRA premium).

H. FMLA – The Employee commencing or returning from an unpaid leave of absence as permitted and regulated by the FMLA (as applied only to elections made under any available accident or health plan defined by Code Sections 105 and 106).

I. Open Enrollment – An election of coverage by an Employee's Spouse, former Spouse or an Employee's dependent during an open enrollment period that differs in time from the open enrollment period offered by the Employee's Employer.

J. Court Order – A duly executed judgment, decree or order (including a qualified medical child support order as defined in ERISA Section 609), resulting from a divorce, legal separation, annulment or change in legal custody that requires health coverage for the Employee's child or foster child (for the purpose of any elections made under any available accident or health plan as defined in Code Sections 105 and 106, the Health Care Flexible Spending Account Benefit Program and the Dependent Care Flexible Spending Account Benefit Program

only – coverage previously elected by the Employee may be dropped only if the other individual actually provides coverage for the child).

K. HIPAA – A special enrollment right that the Employee may be entitled to under the provisions of the Health Insurance Portability and Accountability Act ("HIPAA"), as defined in Code Section 9801(f) (for the purpose of any elections made under any available accident or health plan as defined by Code Sections 105 and 106 only, or the Health Care Flexible Spending Account Benefit Program if the Health Care Flexible Spending Account Benefit Program is subject to the provisions of HIPAA).

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

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

N. Other – Any such other events as may be permitted under the Regulations or required by law.

A change in election of a Qualified Benefit Program due to a Qualified Change in Status must be requested within thirty (30) days of the date of the Qualified Change in Status and shall be effective as soon as it is administratively feasible, but in no event earlier than the first pay period beginning after a new Election Agreement (or such other form as may be promulgated by the Administrator for such purpose) is completed and returned to the Administrator. If the Qualified Change of Status under paragraph N is becoming eligible for a premium assistance subsidy through Medicaid or a state children's health insurance program (SCHIP), or loss of eligibility to participate in Medicaid or SCHIP coverage, the change in election must be requested within sixty (60) days of the date the individual became eligible for premium assistance or loses Medicaid or SCHIP coverage. Changes in elections due to a Qualified Change in Status shall only be effective as to Contributions and benefits under any Qualified Benefit Program on and after the effective date of such change. However, election changes made pursuant to a special enrollment right as provided by HIPAA may result in coverage being made available retroactively to the date of the Qualified Change in Status.

Section 4.6 Forfeiture. Within a reasonable period of time established by the Administrator after the last date by which claims may be submitted for each Plan Year, any portion of a Participant's Contributions that are attributable to such immediately previous Plan Year and which cannot be distributed by the Employer for the provision of benefits under the Qualified Benefit Program for which the Contributions were made based on the Participant's election to participate during such Plan Year, shall be forfeited by the Participant and returned to the Employer. This forfeiture requirement shall be applied individually for each Qualified Benefit Program.

Section 4.7 Automatic Termination Of Election. Except as otherwise provided in the Plan, elections made or deemed to be made under this Plan shall automatically terminate on the earlier of the last day of the applicable Plan Year or the date on which the Participant ceases to be a Participant in the Plan, although coverage under a Component Program may continue if and to the extent provided by such Component Program or applicable state or federal law.

Section 4.8 Cessation of Required Contributions. Nothing in this Plan shall prevent the cessation of coverage or benefits under a Component Program, in accordance with the terms of such program, on account of a Participant's failure to pay the Participant's share of the costs of such coverage or benefits through Compensation reduction or otherwise.

ARTICLE V

CAFETERIA PLAN BENEFIT PROGRAMS

Section 5.1 Participant Elections. An Employee may elect to participate in optional Component Programs, which consist of Qualified Benefit Programs and Non-Qualified Benefit Programs. Non-Qualified Benefit Programs are not offered through the Cafeteria Plan Program and an election of a Non-Qualified Benefit Program is governed by Article VI.

The Cafeteria Plan Program consists of the following benefits:

A. Qualified Benefit Programs listed in the Qualified Benefit Table for Active Employees in Appendix A;

B. the Pre-Tax Premium Payment Program, used only for Contributions to Qualified Benefit Programs;

C. the Health Care Flexible Spending Account Benefit Program; and

D. the Dependent Care Flexible Spending Account Benefit Program.

Subject to the limitations set forth in each Qualified Benefit Program for each Plan Year, an Employee may elect, in accordance with the election procedures described in Article IV, to receive his full Compensation in cash, or to have a portion of his Compensation applied as Contributions toward the purchase of Qualified Benefit Programs under the Pre-Tax Premium Payment Program, as set forth in Section 5.2. An Employee may also elect to make Contributions through the Pre-Tax Premium Payment Program to participate in the Health Care

Flexible Spending Benefit Program described in Section 5.3 and the Dependent Care Flexible Spending Account Benefit Program described in Section 5.4.

Only Employees may participate in the pre-tax benefits offered through the Cafeteria Plan Program. When a former employee is permitted to participate in a Qualified Benefit Program, such participation will be treated as participation in a Non-Qualified Benefit Program and governed by Article VI, except to the extent permitted to be offered on a pre-tax basis under Code Section 125 (for example, to purchase Qualified Benefit Programs using severance pay).

In addition to the Qualified Benefit Programs, the Employer may provide unilateral benefits on a non-elective basis that under the Plan will be provided to all eligible Employees without any cost to or election required by such Employees. In general, such unilateral benefits shall not be considered offered under or through the Cafeteria Plan Program. When permitted under the Code, such benefits will not be included in an Employee's income.

Section 5.2 Pre-Tax Premium Payment Program.

A. Program. The Pre-Tax Premium Payment Benefit Program established under this Section 5.2 permits an Employee (excluding former employees) to reduce Compensation by completing an Election Agreement to use Employee Contributions to purchase Qualified Benefit Programs listed in the Qualified Benefit Table for Active Employees in Appendix A and as specified by the Plan Sponsor from time to time. An Employee may not reduce his Compensation under this Program by more than the required Contributions for his elected Qualified Benefit Programs.

B. Enrollment. In accordance with the eligibility requirements of Article III of the Plan and the election procedure in Article IV of the Plan, an eligible Employee or Participant may elect to participate in one or more Qualified Benefit Programs by agreeing to make the required Contributions for such Programs. For each Plan Year, the Employer shall establish the amount of Contributions (if any) required to participate in any such Benefit or any component thereof under the Pre-Tax Premium Payment Program. In the event the Employer changes the amount of Contributions required to participate in any such Qualified Benefit Program during the Plan Year, a Participant who has elected to participate in the Pre-Tax Premium Payment Program shall have his Contributions automatically adjusted to reflect such change. If there are no Contributions required by the Employer to participate in any such Qualified Benefit Program or any component thereof under the Plan, the Employer may automatically enroll eligible Employees as Participants in such program(s).

C. Period of Coverage. An Employee's election of pre-tax premium benefits in connection with Qualified Benefit Programs will be effective for the duration of the Plan Year to which the election applies. The election may only be changed if permitted under Section 4.5.

D. Benefit(s). While an election to receive Qualified Benefit Programs under the Pre-Tax Premium Payment Program may be made under the Plan, the types and amounts of Qualified Benefit Programs available under the Plan, the requirements for participating in any such program, and the other terms and conditions of coverage and benefits under any such program are set forth, from time to time, in the Incorporated Documents which govern such Qualified Benefit Programs. The Plan Sponsor retains the right to enter into a contract with one or more insurance companies, providers, or administrators for the purpose of providing Qualified Benefit Programs and to change or eliminate coverages or insurance companies, providers, or administrators at any time.

E. Qualified Benefit Programs Claims Procedure. If any person believes he is being denied any rights or benefits under any Qualified Benefit Program, such person may file a claim in writing in accordance with the claims procedures of such program, which shall in all cases control.

F. After-Tax Contributions. Any Component Programs that are not eligible to be provided under a Section 125 arrangement shall be considered to be provided outside of the Cafeteria Plan Program under Article VI.

To the extent that a portion of a Contribution for a Qualified Benefit Program is required by law to be an after-tax Contribution (for example, to provide coverage to an eligible individual who fails to qualify as a child or as a tax dependent under applicable Code sections), such portion of a Contribution shall be treated as an after-tax Contribution made under Article VI of this Plan.

G. Discrimination Prohibited. A Qualified Benefit Program that is also a self-insured medical expense reimbursement plan under Code Section 105 or an insured group health plan subject to Section 2716 of Title XXVII of the Public Health Service Act (as amended by the Patient Protection and Affordable Care Act) shall not discriminate in favor of Highly Compensated Individuals who are Participants, in accordance with applicable nondiscrimination rules. For purposes of this section, Highly Compensated Individual means an individual who is, with respect to the Employer:

1. one of the five highest paid officers;

2. a shareholder who owns (with the application of Code Section 318) more than ten percent (10%) in value of the stock of the Employer; or

3. among the highest paid twenty-five percent (25%) of all employees of the Employer (other than non-Participants who are part-time or seasonal employees, or excludable collective bargaining or nonresident alien employees as provided in Code Section 105(h)).

If the Administrator determines that any of the nondiscrimination requirements of this paragraph will not be satisfied, the Administrator may, in its discretion, reject any pre-tax Employee Contributions or take other appropriate action in order to

ensure compliance with Code requirements. Any such action shall be carried out in a uniform and nondiscriminatory fashion, and may include rejection of pre-tax Employee Contributions from one or more Highly Compensated Individuals.

H. No Deferral of Compensation. Contributions under the Pre-Tax Premium Program must be used in the Plan Year in which the Contribution is made and may not be deferred into the following Plan Year, except as allowed under Code Section 125 and permitted by the Employer.

Section 5.3 Health Care Flexible Spending Account Benefit Program.

A. Program. The Health Care Flexible Spending Account Benefit Program is established under this Section 5.3 to permit reimbursement of eligible health care expenses. The Employer may, in its discretion, determine the periods of time during which it will and will not offer the Health Care Flexible Spending Account Benefit Program to otherwise eligible Employees.

B. Definitions. For purposes of the Health Care Flexible Spending Account Benefit Program, the following special definitions shall apply:

1. Dependent – a child or other dependent as defined in Code Section 105(b) for purposes of determining who is eligible to incur expenses that may be reimbursable under the Plan.

2. Eligible Medical Expenses – those expenses incurred during a Plan Year and any applicable Grace Period (if elected by the Employer) by the Participant or the Participant's Spouse or Dependents after the date the Participant begins participating in the Health Care Flexible Spending Account Benefit Program, that are allowable as deductions under Code Section 213(d) (and permitted by Code Section 125) and that have not been, and will not be, reimbursed under any health insurance policy, other health care plan, or other source.

3. Ineligible Medical Expenses. Eligible Medical Expenses shall not include expenses incurred for:

a. Unnecessary Cosmetic Surgery. Expenses Incurred, or amounts paid for cosmetic surgery or similar procedures unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease. "Cosmetic surgery" means any procedure which is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.

b. Other Health Plan Premiums. Premiums paid for health plan coverage, including premiums paid for any other health plan

maintained by the Employer or by any employer of the Participant's Dependent.

c. Long-Term Care Services or Insurance Premiums. Long-term care services or premiums paid for any product that is advertised, marketed or offered as long-term care insurance.

d. Over-the-Counter Medication. Medicine or other drugs purchased without a prescription, except for insulin.

For purposes of the Health Care Flexible Spending Account Benefit Program, an expense is incurred when the Participant, Spouse or Dependent is furnished the medical care or services giving rise to the claimed expense. In all cases, a Participant must submit evidence acceptable to the Administrator that the Eligible Medical Expenses were paid in order to receive reimbursement.

4. Health Care Expense Account – the bookkeeping account maintained by the Administrator for each Participant that reflects the amount of Contributions allocated for the purchase of benefits consisting of the pre-tax payment of Eligible Medical Expenses under the Health Care Flexible Spending Account Benefit Program, as well as the amount of Eligible Medical Expenses reimbursed from the Health Care Flexible Spending Account Benefit Program on behalf of the Participant.

5. Highly Compensated Individual – for purposes of the nondiscrimination rules set forth in paragraph G. below, Highly Compensated Individual means an individual who is, with respect to the Employer:

a. one of the five highest paid officers;

b. a shareholder who owns (with the application of Code Section 318) more than ten percent (10%) in value of the stock of the Employer; or

c. among the highest paid twenty-five percent (25%) of all employees of the Employer (other than non-Participants who are part-time or seasonal employees, or excludable collective bargaining or nonresident alien employees as provided in Code Section 105(h)).

C. Enrollment. In accordance with the eligibility requirements of Article III of the Plan and the election procedure in Article IV of the Plan, an eligible Employee (excluding former employees) may elect to participate in the Health Care Flexible Spending Account Benefit Program. Such Employee shall designate the amount of Contributions that is to be allocated for benefits under the Health Care Flexible Spending Account Benefit Program for the Plan Year (or, in the case of the initial election, the remainder of the Plan Year).

D. Period of Coverage. An Employee's election of the Health Care Flexible Spending Account Benefit Program will be effective for the duration of the Plan Year to which the election applies and during any applicable Grace Period. The election may only be changed if permitted under Section 4.5.

E. Claims and Contribution Limits. For any Plan Year and for any corresponding Grace Period, Participants covered under the Health Care Flexible Spending Account Benefit Program may submit claims for the reimbursement of Eligible Medical Expenses up to the maximum level of reimbursement elected by the Participant (properly reduced as of any particular time for prior reimbursements for the same Plan Year and corresponding Grace Period, if applicable). The maximum annual amount of Contributions which a Participant may allocate for benefits under the Health Care Flexible Spending Account Benefit Program for any Plan Year is $2,500 ($2,600 for 2017) (which BorgWarner may adjust annually as permitted under Code section 125(i)(2)). To the extent that BorgWarner elects to grant employees Flex Credits that are not redeemable for cash or other taxable benefits, such Flex Credits will not be treated as Contributions for purposes of this section. The Administrator shall pay all permitted claims directly to the Participant upon presentation of satisfactory documentation regarding the Eligible Medical Expenses within a reasonable time after the expense was incurred, but in no event later than the limitation set forth in applicable ERISA regulations governing claims for group health plan benefits. The Administrator may require such documentation and other information regarding the claim as it deems necessary to confirm that the expenses claimed are Eligible Medical Expenses, including written evidence from an independent third party showing the nature and amount of the expense and certification by the Participant that the expense qualifies for reimbursement. Proper claims will be paid as soon as administratively practicable.

F. Termination of Participation. During any Plan Year, if a Participant terminates employment with the Employer, then such Participant shall automatically cease to participate in the Health Care Flexible Spending Account Benefit Program for the remainder of such Plan Year, unless otherwise provided under Sections 3.10 or, if applicable, Section 5.6.E.

G. Discrimination Prohibited. This Health Care Flexible Spending Account Benefit Program is intended to qualify as a medical expense reimbursement plan under Code Section 105 and shall be interpreted and administered in accordance with that Code Section and the Regulations thereunder. The Health Care Flexible Spending Account Benefit Program shall not discriminate in favor of Highly Compensated Individuals as to eligibility to participate and the benefits provided shall not discriminate in favor of Highly Compensated Individuals who are Participants, in accordance with Code Section 105.

H. Correcting Discrimination. If the Administrator determines that any of the nondiscrimination requirements of paragraph G will not be satisfied, the Administrator may, in its discretion, reject any Employee elections or reduce any

Contributions in order to ensure compliance with these requirements. Any such action shall be carried out in a uniform and nondiscriminatory fashion and may include a reduction in the Contributions of one or more Highly Compensated Individual(s).

I. Recovery of Excess Reimbursements. The Employer (or the Administrator acting on the Employer's behalf) may not seek to recover any amounts paid to or on behalf of a Participant who has terminated participation in the Health Care Flexible Spending Account Benefit Program that exceed the total amount of Contributions actually applied toward the purchase of benefits under the Health Care Flexible Spending Account Benefit Program, except to the extent the amount reimbursed exceeds the amount the Participant has elected to contribute for the Plan Year or the reimbursed amount was for a non-qualifying expense. The Employer may pursue remedies available under applicable state and federal law, but only to the extent permitted under the Code.

J. Date By Which Claims Must Be Submitted. Unless otherwise provided under relevant Incorporated Documents, in order to receive reimbursement for Eligible Medical Expenses incurred during any Plan Year in which the Participant has elected to participate in the Health Care Flexible Spending Account Benefit Program or during any corresponding Grace Period, claims for reimbursement of such Eligible Medical Expenses must be properly submitted to the Administrator on or before the March 31st following the last day of such Plan Year or corresponding Grace Period.

K. Qualified Change of Status. Notwithstanding Section 4.5 of the Plan, a Participant who has elected to participate in the Health Care Flexible Spending Account Benefit Program for a Plan Year shall be permitted to change an election under the Health Care Flexible Spending Account Benefit Program due to a Qualified Change of Status (as defined in Section 4.5 of the Plan) only for those reasons as listed in Sections 4.5.A, B, C, F, H and J, for the reason listed in Section 4.5.D if the reason for the Qualified Change of Status impacts the Dependent's eligibility under the Health Care Flexible Spending Account Benefit Program, and for the reason listed in Section 4.5.K if the Health Care Flexible Spending Account Benefit Program is subject to HIPAA.

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

M. No Deferral of Compensation. Employee Contributions to the Health Care Flexible Spending Account Benefit Program may only be used to pay for health

care services and products received during the Plan Year for which the funds were contributed and any corresponding Grace Period, except that the Employer may elect to allow such funds to be used to reimburse orthodontia expenses that an Employee has paid in advance of receiving such services. Except as provided for in this paragraph, unused amounts in a Health Care Expense Account may not be carried forward for use in a subsequent time period or to pay for services that will be received in a subsequent time period.

N. Correcting Errors in Contribution Amounts. If the Plan erroneously allows a Participant to elect a salary reduction above the Contribution Limit described in Section 5.3.E that is the result of a reasonable mistake by the Employer (or the Employer's agent) and that is not due to willful neglect by the Employer (or the Employer's agent), the Plan may correct the mistake by paying the excess contribution amounts to the Participant and reporting the excess contribution amounts as wages for income tax withholding and employment tax purposes on the Participant's Form W-2, Wage and Tax Statement (or Form W-2c, Corrected Wages and Tax Statement). The excess contribution amount will be reported as wages for the calendar year in which the correction is made.

O. Ordering of Reimbursements. An Employee cannot receive payment for the same Eligible Medical Expense under both the Health Care Flexible Spending Account Benefit Program of this Section 5.3 and the Health Reimbursement Arrangement in Appendix C. Because reimbursement under the Health Care Flexible Spending Account Benefit Program is available only after reimbursements equal to the amount of contributions the Employee's HRA Account have been paid, an Employee shall receive payment for an Eligible Medical Expense from his HRA Account first, then seek payment of any unreimbursed Eligible Medical Expense under the Health Care Flexible Spending Account Benefit Program.

Section 5.4 Dependent Care Flexible Spending Account.

A. Program. The Dependent Care Flexible Spending Account Benefit Program established under this Section 5.4 is for the reimbursement of Eligible Dependent Care Expenses. The Employer may, in its discretion, determine during which periods of time it will and will not offer the Dependent Care Flexible Spending Account Benefit Program to otherwise eligible Employees.

B. Definitions. For purposes of the Dependent Care Flexible Spending Account Benefit Program, the following special definitions shall apply:

1. Dependent –

a. Under Age 13 or Disabled. A dependent (as defined in Code Section 21(b)) of an Employee who (i) is under the age of 13, or (ii) is physically or mentally incapable of caring for himself and has the same principal place of abode as the Employee for more than one-half of the taxable year;

b. Special Dependency Rule for Divorced or Separated Parents or Parents Living Apart. A child who is (i) under age 13 or is physically or mentally incapable of self-care and (ii) receives over half of his or her support during the calendar year from parents who are divorced or legally separated under a decree of divorce or separate maintenance or who are separated under a written separation agreement or who live apart at all times during the last six months of the calendar year and (iii) in the custody of one or both parents for more than one-half of the calendar year is treated for purposes of this Dependent Care Flexible Spending Account Benefit Program as the Dependent of that parent who has custody of the child for the greater portion of the calendar year even if the parent is not entitled to a dependency exemption for the child under the Code. The child cannot be treated as a Dependent (for purposes of this Dependent Care Flexible Spending Account Benefit Program) with respect to more than one parent; or

c. Spouse. The Spouse of an Employee, if such Spouse is physically or mentally incapable of caring for himself and has the same principal place of abode as the Employee for more than one-half of the taxable year.

2. Dependent Care Account – the bookkeeping account maintained by the Administrator for each Participant which reflects the amount of Contributions that have been allocated for the purchase of benefits under the Dependent Care Flexible Spending Account Benefit Program and the amount of Eligible Dependent Care Expenses reimbursed from the Dependent Care Flexible Spending Account Benefit Program on behalf of the Participant.

3. Eligible Dependent Care Expenses – those expenses paid or incurred, after the date the Participant begins participating in the Dependent Care Flexible Spending Account Benefit Program, for household and dependent care services necessary for gainful employment that would be considered employment-related expenses under Code Section 21, excluding certain expenses noted below, and that have not been, and will not be, reimbursed under any other employee benefit plan or other source or claimed as a tax credit under Code Section 21. Under Code Sections 21 and 129, Eligible Dependent Care Expenses include:

a. Services Provided in the Home. Services inside the Participant's home for:

(i) Care of Qualified Dependent. The care of a Dependent provided the primary function of the care is to assure the well-being and protection of the Dependent; and

(ii) Household Services. Household services performed in connection with the care of a Dependent.

b. Services Provided Outside the Home. Care provided outside the home for a Dependent described in (c)(ii) below is considered an Eligible Dependent Care Expense only if the Dependent spends at least eight hours each day in the Participant's home.

Care provided by a dependent care center is an Eligible Dependent Care Expense only if the dependent care center complies with all applicable state and local laws and regulations, provides care for more than six individuals not residing at the facility, and receives payment or a grant for providing such services

Care provided by a sick child center is an Eligible Dependent Care Expense only to the extent that it does not constitute medical care.

c. Transportation. The cost of transportation by a caregiver of a Dependent to or from the place where care is provided.

d. Employment Taxes. Taxes under Code sections 3111 (relating to the Federal Insurance Contributions Act) and 3301 (relating to the Federal Unemployment Tax Act) and similar state payroll taxes if paid with respect to Eligible Dependent Care Expenses.

e. Room and Board. The additional cost of providing room and board for a caregiver over usual household expenses.

f. Indirect Expenses. Expenses that relate to but are not directly for the care of a Dependent (such as application fees, agency fees, and deposits) if the Participant is required to pay these expenses to obtain care.

g. Excluded Services. Eligible Dependent Care Expenses do not include expenses incurred for services provided by:

(i) an individual for whom the Participant or the Participant's Spouse is entitled to a personal income tax exemption under Code section 151(c);

(ii) a child of the Participant who is under age 19;

(iii) the Participant's Spouse; or

(iv) the parent of a child who is a Dependent.

In addition, Eligible Dependent Care Expenses do not include any amount paid for:

(v) services at a camp where the Dependent stays overnight;

(vi) summer school or tutoring programs;

(vii) transportation to a caregiver unless the transportation is provided by the caregiver;

(viii) food, lodging, clothing or education.

4. Earned Income – earned income, as defined in Code Section 32(c)(2), excluding any amounts paid or incurred by the Employer for Eligible Dependent Care Assistance Expenses to a Participant.

5. Highly Compensated Individual – For purposes of the nondiscrimination rules set forth in paragraph J. below, Highly Compensated Individual means a "Highly Compensated Employee" as defined in the Employer's qualified retirement plan. It includes any Employee (or a dependent of an employee) who during the current Plan Year or preceding Plan Year was a more-than-5% owner of the Employer (applying the attribution rules of Code section 318); or for the preceding Plan Year had compensation (as defined under Code section 415) from the Employer in excess of the compensation threshold in Code section 414(q) and, if consistent with the definition in the Employer's qualified retirement plan, was in the top 20% of Employees ranked on the basis of compensation (as defined under Code section 415).

C. Enrollment. In accordance with the eligibility requirements of Article III of the Plan and the election procedure in Article IV of the Plan, an eligible Employee or Participant may elect to participate in the Dependent Care Flexible Spending Account Benefit Program. Such Employee or Participant shall designate the amount of Contributions that are to be allocated for benefits under the Dependent Care Flexible Spending Account for the Plan Year (or, in the case of the initial election, the remainder of the Plan Year).

D. Period of Coverage. An Employee's election of the Dependent Care Flexible Spending Account Benefit Program will be effective for the duration of the Plan Year to which the election applies and during any applicable Grace Period. The election may only be changed if permitted under Section 4.5.

E. Daily Allocation of Expenses. Expenses incurred during a period only part of which the Participant is gainfully employed or in active search of gainful employment must be allocated on a daily basis with the following exceptions:

1. Short-Term, Temporary Absence. Provided it is otherwise a Dependent Care Expense, an expense incurred during a short-term, temporary absence from work (not to exceed two consecutive weeks) will be considered a Dependent Care Expense to the extent that the caregiver requires payment during the absence.

2. Part-Time Employment. Provided it is otherwise a Dependent Care Expense, an expense incurred on a day not worked by a Participant or Spouse because of the part-time status of his or her employment will be considered a Dependent Care Expense if the caregiver requires payment on a periodic basis (such as weekly or monthly) that includes both days worked and days not worked.

F. Claims and Contribution Limits. For any Plan Year and for any corresponding Grace Period, Participants covered by the Dependent Care Flexible Spending Account Benefit Program may submit claims for the reimbursement of Eligible Dependent Care Expenses from Contributions previously allocated to the Participant's Dependent Care Account. The maximum annual amount of Contributions which may be allocated by the Participant for benefits under the Dependent Care Flexible Spending Account Benefit Program is $5,000, or $2,500 if the Participant is married (as defined in Code Section 21(e)(3) and (4)) but files a separate income tax return, in accordance with Code Section 129. If these Code Section 129 limitations are changed in the future, the limitations applicable to the Dependent Care Flexible Spending Account Benefit Program hereunder shall automatically be changed to correspond thereto.

G. Covered Expenses. Each Participant shall be entitled to reimbursement from his Dependent Care Account for documented Eligible Dependent Care Expenses incurred during the Plan Year for which the Participant participates in the Dependent Care Flexible Spending Account Benefit Program and, if elected by the Employer, during any corresponding Grace Period. Such reimbursements shall only be made from Contributions previously allocated to the Participant's Dependent Care Account during the Plan Year (properly reduced as of any particular time for prior reimbursements for the same Plan Year or corresponding Grace Period, if applicable). Eligible Dependent Care Expenses shall be considered incurred when the service is provided and not when the Participant is formally billed, charged or pays for the Eligible Expenses. Unless otherwise provided under relevant Incorporated Documents, in order to receive reimbursement for Eligible Dependent Care Expenses incurred during any Plan Year in which the Participant has elected to participate in the Dependent Care Flexible Spending Account Benefit Program or during any corresponding Grace Period elected by the Employer, the Participant must submit claims for Eligible Dependent Care Expenses by the March 31st following the last day of the Plan Year or corresponding Grace Period. The Administrator shall pay all permitted claims directly to the Participant upon presentation of satisfactory documentation regarding the Eligible Dependent Care Expenses within a reasonable time after the expense was incurred, but in no event later than the limitation set forth in applicable ERISA regulations governing claims for benefits. The Administrator may require such documentation and other information regarding the claim as it deems necessary to confirm that the expenses claimed are Eligible Dependent Care Expenses, including written evidence from an independent third party showing the nature and amount of the expense and certification by the Participant

that the expense qualifies for reimbursement. Proper claims will be paid as soon as administratively practicable.

H. Reimbursement Limitations. No payment otherwise due under the Dependent Care Flexible Spending Account Benefit Program shall exceed the lesser of:

1. the Earned Income of such Participant for such year;

2. the Earned Income of the Spouse (if any) of such Participant for such year; or

3. the credit balance in the Participant's Dependent Care Account as of the date such payment is to be made.

For purposes of paragraphs 1 and 2, if the Participant's Spouse is a full-time student at an educational institution or physically or mentally incapable of caring for himself and shares the Participant's principal place of abode for more than half the year, such Spouse shall be deemed to be gainfully employed and to have Earned Income of $250 per month if the Participant has only one Dependent, and $500 per month if the Participant has two or more Dependents. In the case of any husband and wife, the preceding sentence shall apply with respect to only one Spouse for any one month. A Spouse is considered a full-time student if he or she is enrolled during each of five (5) calendar months for the number of course hours considered full-time at an educational institution that offers traditional classroom instruction on a regular basis.

I. Termination of Participation. During any Plan Year, if a Participant terminates employment with the Employer, then such Participant shall automatically cease to contribute to the Dependent Care Flexible Spending Account Benefit Program for the remainder of such Plan Year. A Participant in the Dependent Care Flexible Spending Account Benefit Program may continue to submit Eligible Dependent Care Expenses for reimbursement during the remainder of the Plan Year even though the Participant has terminated employment with the Employer and during the Grace Period to the extent required under Section 5.6.E.

J. Discrimination Prohibited. This Dependent Care Flexible Spending Account Benefit Program is intended to qualify as an assistance program under Code Section 129 and shall be interpreted and administered in accordance with that Code Section and the Regulations thereunder.

1. Eligibility. The Dependent Care Flexible Spending Account Benefit Program shall not discriminate in favor of Employees who are Highly Compensated Individuals or their Dependents with respect to eligibility to participate, in accordance with Code Section 129.

2. Contributions/Qualified Benefit Programs. The Dependent Care Flexible Spending Account Benefit Program shall not discriminate in favor of

Employees who are Highly Compensated Individuals as to benefits or Contributions, in accordance with Code Section 129.

3. Principal Shareholder Limitation. Not more than twenty-five percent (25%) of the amounts paid or incurred by the Employer for dependent care assistance (as defined by Code Section 129(e)(1)) may be provided for the class of persons (or their Spouses or dependents), each of whom (on any day of such Plan Year) owns more than five percent (5%) of the stock or the capital or profits interest in the Employer, as determined under Code Section 129.

4. Average Benefit Limitation. The average benefits provided to all Employees who are not Highly Compensated Individuals under the Dependent Care Flexible Spending Account Benefit Program (and all other assistance programs of the Employer) must be at least fifty-five percent (55%) of the average benefits provided to all Highly Compensated Individuals under the Dependent Care Flexible Spending Account Benefit Program (and all other assistance programs of the Employer). For purposes of this paragraph 4, in the case of Employees whose benefits are provided by salary reduction agreements, such as an Election Agreement, any Employees whose Compensation is less than $25,000 may be disregarded.

5. Excluded Employees. For purposes of paragraphs 1 and 4, the following Employees may be excluded:

   a. Employees who have not completed one year of service with the Employer and have not attained age 21 (but only if such Employees are excluded from participation in the Dependent Care Flexible Spending Account Benefit Program); and

   b. Employees not included in an assistance program of the Employer (including the Dependent Care Flexible Spending Account Benefit Program) who are covered by a collective bargaining agreement, if there is evidence that benefits were the subject of good faith bargaining between the Employer and the representative of such Employees.

6. Correcting Discrimination. If the Administrator determines that any of the nondiscrimination requirements of this paragraph J. will not be satisfied, the Administrator may, in its discretion, reject any Employee elections or reduce any Contributions in order to ensure compliance with these requirements. Any such action shall be carried out in a uniform and nondiscriminatory fashion and may include a reduction in the Contributions of one or more Highly Compensated Individual(s).

K. Annual Report of Participants. The Administrator shall furnish to each Participant on whose behalf benefits are paid, a written statement in a manner permitted by federal law, showing the amounts reimbursed or expenses incurred during the previous calendar year.

L. Forfeiture of Unused Amounts. Any amount remaining in a Participant's Dependent Care Account at the end of any Plan Year and after the date by which claims must be submitted shall be forfeited and returned to the Employer.

M. No Deferral of Compensation. Employee Contributions to the Dependent Care Flexible Spending Account Benefit Program may only be used to pay for Eligible Dependent Care Expenses incurred during the Plan Year for which the funds were contributed and any corresponding Grace Period. Unused amounts in a Dependent Care Account may not be carried forward for use in a subsequent time period or to pay for services that will be received in a subsequent time period.

Section 5.5 Cafeteria Plan Nondiscrimination.

The Cafeteria Plan Program under this Article VI will operate in compliance with the nondiscrimination requirements in Code Section 125.

A. Definition of Highly Compensated Individual – For purposes of this Section 5.5, a Highly Compensated Individual is an eligible Employee who is a highly compensated individual as defined in Code Section 125, including: officers; shareholders owning more than five percent (5%) of the voting power or value of all classes of stock of the Employer, if any; individuals who are otherwise considered highly compensated by the Internal Revenue Service for the purposes of this Plan only; and Spouses or dependents of any individuals previously described.

B. Definition of Key Employee. For purposes of this Section 5.5, a "Key Employee" is an Employee who is at any time during the Plan Year a Key Employee within the meaning of Code Section 125, including a corporate officer with annual compensation of more than the threshold amount listed in Code section 416(i)(1); a more than 5% owner of an Employer (or an Employee who is the Spouse, parent, child or grand parent of such an owner); or a more than 1% owner of a Participating Employer with annual compensation of more than $150,000.

C. Nondiscrimination as to Eligibility. The Plan will be available to a group of Employees that does not discriminate in favor of Highly Compensated Individuals.

1. Reasonable Classification. The Plan will benefit a group of Employees who qualify under a reasonable classification established by the Employer (as defined in IRS regulations § 1.410(b)-4(b)).

2. Percentage Test. The group of Employees included in the classification will satisfy the safe harbor percentage test or the unsafe harbor percentage

component of the facts and circumstances test in IRS regulations § 1.410(b)-4(c).

D. Nondiscriminatory Contributions and Benefits. Contributions and Benefits under this Plan will not discriminate in favor of Highly Compensated Individuals who participate in the Plan.

1. Uniform Opportunity to Elect Benefits. The Plan will give each similarly situated Participant a uniform opportunity to elect Benefits and Employer contributions (as defined in IRS regulations § 1.125-1(r)(1)).

2. No Disproportionate Election. Participants who are Highly Compensated Individuals must not elect or utilize a disproportionate amount of Benefits or Employer contributions. Benefits are disproportionately elected or utilized by Highly Compensated Individuals if the aggregate Benefits and Employer contributions elected or utilized by Participants who are Highly Compensated Individuals (as a percentage of aggregate Compensation of Participants who are Highly Compensated Individuals) exceed the aggregate Benefits and Employer contributions elected or utilized by Participants who are not Highly Compensated Individuals (as a percentage of aggregate Compensation of Participants who are not Highly Compensated Individuals).

3. Safe Harbor for Plans Providing Health Plan Benefits. If the Plan provides health benefits (defined as major medical coverage and excluding dental coverage and health flexible spending account benefits), then the Plan will not be treated as discriminatory as to benefits and contributions if the contributions under the Plan on behalf of each Participant include (1) an amount that equals 100% of the cost of health benefit coverage under the Plan to a majority of the Participants who are Highly Compensated Individuals, or (2) equal or exceed 75% of the cost of the health benefit coverage of the Participant (similarly situated) having the highest cost health benefit coverage under the Plan.

E. Concentration Test. The Benefits provided to Key Employees must not exceed 25% of the aggregate Benefits provided to all Participants, in accordance with Code Section 125. In computing the amount of Benefits, any amount of group-term life insurance in excess of $50,000 (and any other Benefit excluded by regulations) may be excluded.

F. Correcting Discrimination. If the Administrator determines that any of the nondiscrimination requirements of this Section 5.5 will not be satisfied, the Administrator may, in its discretion, reject any Employee election or reduce any Contributions in order to secure compliance with these requirements. Any such action shall be carried out in a uniform and nondiscriminatory fashion and may include a reduction in the Contributions of one or more Highly Compensated Individual(s).

Section 5.6 Grace Period.

With the exception of the Health Care Flexible Account Benefit Program, the Employer may elect to implement a Grace Period to extend the deadline for incurring eligible expenses for which Contributions may be used. If elected by the Employer, the Grace Period will be described in the Incorporated Documents and will be operated to conform to the following requirements:

A. The Grace Period will run no longer than the fifteenth (15^{th}) day of the third month following the end of the Plan Year for which the funds were contributed.

B. An Employee's Contributions remaining at the end of the Plan Year will be used first during the Grace Period to pay for or reimburse eligible benefits as if the expenses had been incurred in the immediately preceding plan year.

C. With the exception of the Health Care Flexible Spending Account Benefit Program, the Grace Period may be adopted for any Qualified Benefit Program, except it may not apply to a paid time off program or to elective contributions under a Section 401(k) plan (if such benefits are adopted by the Employer under this Plan). The Employer will identify which benefits are subject to the Grace Period in Incorporated Documents distributed to Participants and eligible Employees.

D. The Employer may limit the amount of unused benefits or Contributions available during the Grace Period, but the limit must be uniform and apply to all Participants and may not be based on a percentage of the unused benefits or Contributions remaining at the end of the Plan Year.

E. The Grace Period requirements must apply uniformly to all Participants in the Qualified Benefit Programs that have a Grace Period determined as of the last day of the Plan Year. Individuals who continue coverage through COBRA and individuals who were Participants as of the last day of the Plan Year but terminate during the Grace Period are Participants for the duration of the Grace Period.

F. Unused benefits or Contributions relating to a particular Qualified Benefit Program may only be used to pay or reimburse expenses incurred with respect to the same Qualified Benefit Program during the Grace Period.

G. To the extent any unused benefits or Contributions from the immediately preceding Plan Year exceed the expenses for the qualified benefit incurred during the Grace Period, those remaining unused benefits or Contributions may not be carried forward to any subsequent period (including any subsequent Plan Year), may not be cashed out, and must be forfeited.

ARTICLE VI

NON-CAFETERIA PLAN BENEFIT PROGRAMS

Section 6.1 Participant Elections. Subject to the limitations set forth in each Optional Benefit Program for each Plan Year, an Employee may elect, in accordance with the election procedures described in Article IV, to receive his full Compensation in cash, or to have a portion of his Compensation applied as Contributions toward the purchase of Component Programs that are Non-Qualified Benefit Programs.

An eligible former employee who elects to participate in a Component Program shall do so under this Article and the election shall be treated as an election of a Non-Qualified Benefit Program, unless otherwise permitted under the Cafeteria Plan Program. With respect to Component Programs offered to former employees, such election may include an option to have the required contribution (if any) deducted from severance payments, if the Employer so permits. Alternatively, former employees may pay such contributions to the Plan in accordance with payment procedures and rules established by the Administrator.

The Employer may provide unilateral benefits on a non-elective basis that under the Plan will be provided to eligible Employees without any cost to or election required by such Employees. In general, such benefits shall not be considered offered under or through the Cafeteria Plan Program. When permitted under the Code, such benefits will not be includable in an Employee's income.

Section 6.2 Enrollment. In accordance with the eligibility requirements of Article III of the Plan and the election procedure in Article IV of the Plan, an eligible Employee or Participant may elect to participate in one or more Non-Qualified Benefit Programs by agreeing to make the required Contributions for such Program(s). For each Plan Year, the Employer shall establish the amount of Contributions (if any) required to participate in any such Non-Qualified Benefit Program. In the event the Employer changes the amount of Contributions required to participate in any such Program during the Plan Year, a Participant who has elected to participate in the Program shall have his Contributions automatically adjusted to reflect such change. If there are no Contributions required by the Employee to participate in any such Program or any component thereof under the Plan, the Employer may automatically enroll eligible Employees as Participants in such Program(s).

Section 6.3 Benefit(s). While an election to participate in Non-Qualified Benefit Programs may be made under the Plan, the types and amounts of benefits available under the Program, the requirements for participating in any such Program, and the other terms and conditions of coverage and benefits under any such Program are as set forth, from time to time, in the Incorporated Documents that govern such Non-Qualified Benefit Programs. The Plan Sponsor retains the right to enter into a contract with one or more insurance companies, providers, or administrators for the purpose of providing Non-Qualified Benefit Programs and to change or eliminate coverages of insurance companies, providers, or administrators at any time.

Section 6.4 Non-Qualified Benefit Programs Claims Procedure. If any person believes he is being denied any rights or benefits under any Non-Qualified Benefit Program, such person

may file a claim in writing in accordance with the claims procedures of such Program, which shall in all cases control.

Section 6.5 After-Tax Contributions. Employee Contributions for Non-Qualified Benefit Programs shall be made on an after-tax basis. Former employee contributions for Component Programs shall be made on an after-tax basis, unless permitted to be pre-tax contributions under Article V of this Plan.

Section 6.6 Nondiscrimination Requirements. Life insurance benefits offered under the Plan that are subject to Code Section 79 nondiscrimination requirements will be operated so as not to discriminate in favor of Key Employees as to eligibility to participate or with respect to the type and amount of benefits available. For purposes of this section, a Key Employee has the same meaning as in Section 5.5.B above, but also includes any former employee who was a Key Employee when he or she separated from service. If the Administrator determines that any of the Code Section 79 nondiscrimination requirements will not be satisfied, the Administrator may in its discretion reduce benefits, provide benefits on an after-tax basis, or take other appropriate action to ensure compliances with Code Section 79 requirements. Any such action shall be carried out in a uniform and nondiscriminating fashion and may impact the benefits of one or more Key Employees.

ARTICLE VII

CLAIMS

Section 7.1 Claims Procedure. In addition to the claims procedures described in Sections 5.3 and 5.4, claims procedures and the basis on which payments are made from each Component Program are set forth in applicable Incorporated Documents. Claims and benefit payment procedures vary among the Component Programs.

Section 7.2 Appeal of Claim Denial. Procedures for the review of denied claims for each Component Program are set forth in the applicable Incorporated Documents. Appeal procedures vary among the Component Programs.

Section 7.3 Legal Proceedings. No legal action may be brought against the Plan before the claimant has exhausted all administrative remedies available under the Plan and the applicable Component Program. In addition, any legal action involving this Plan or a Component Benefit Program must be brought within one year from the date of any final decision on appeal.

Section 7.4 Questions Relating to Coverage. All questions relating to whether an individual is a Participant or is eligible to become a Participant under this Plan shall be submitted to the Administrator. The Administrator shall determine such questions in its discretion based on its review and interpretation of the terms of this Plan.

Section 7.5 Coordination of Qualified Benefit Programs. To minimize claims paid by the Plan, benefits for medical and health care related expenses payable under this Plan may be coordinated with amounts payable under other plans. Benefits will be coordinated under rules set forth in the Incorporated Documents governing a particular Component Program. Any person

claiming benefits under the Plan shall furnish information and execute documents as requested by the claims administrator for purposes of coordinating benefits.

Whenever payments which should have been made under the Plan have, in fact, been paid by some other plan or program under applicable coordination of benefit rules, the claims administrator will have the right to pay over to the paying plan or program any amounts it deems necessary to satisfy the Plan's obligations to coordinate benefits. Any amounts so paid will be in full satisfaction of the Plan's obligations to pay benefits.

Whenever payments made under this Plan exceed the maximum amount that should have been paid under applicable coordination of benefit rules, the Plan shall have the right to recover the excess payment from: (a) any person to, or for, or with respect to whom, the payments were made, (b) any insurance company, or (c) any other organization.

ARTICLE VIII

ADMINISTRATION

Section 8.1 Responsibility of BorgWarner. BorgWarner will have the following administrative responsibilities:

A. Administrator. Appointment and removal of the Plan Administrator;

B. Co-Fiduciaries. Appointment and removal of any other plan fiduciary;

C. Expenses. Payment of the expenses of administering the Plan;

D. Amendment. Amendment of the Plan; and

E. Termination. Termination of the Plan.

Section 8.2 Plan Administrator. Unless otherwise specified, the Employee Benefits Committee of BorgWarner is the plan administrator ("Plan Administrator" or "Administrator") and named fiduciary of the Plan.

Section 8.3 Responsibilities of Plan Administrator. The Plan Administrator will have responsibility for the general administration of the Plan and will have full discretion in the exercise of the following duties and powers:

A. Appointment of Fiduciaries. The responsibility for appointing and removing the trustee, if any, and any other Plan fiduciaries;

B. Establishment of Funding Vehicle. The responsibility for establishing the appropriate funding vehicle, if any, for the Plan;

C. Payment of Administrative Expenses. The responsibility to pay all reasonable and necessary expenses, fees, and charges, including fees for attorneys, actuaries, accountants, agents, or other persons, incurred in connection with the

administration or operation of the Plan (and the trust, if any) unless it directs that the expenses are to be withdrawn from the general assets of the Employer or the trust, if any;

D. Determination of Contributions. The responsibility for determining that any contributions comply with the requirements of the Plan as to amount and time of payment;

E. Claims Administrator. To appoint, suitably compensate, and remove the claims administrator for the Plan and/or one or more of the Component Programs, (and in the event no claims administrator is appointed, the Plan Administrator will be the claims administrator);

F. Administrative Records. To establish procedures for and supervise the establishment and maintenance of records necessary and appropriate for the proper administration of the Plan;

G. Administrative Rules. To determine any rules and regulations necessary for the proper conduct and administration of the Plan or the Component Programs and to change, alter, or amend such rules and regulations;

H. Information. To obtain, to the extent reasonably possible, all information necessary for the proper administration of the Plan;

I. Procedures. To establish or approve the manner of making an election, designation, application, or claim permitted hereunder;

J. Elections. To solicit and collect election forms, and to communicate Participant elections to the Employer so that Compensation may be reduced in accordance with the elections, and the reduction amount credited for coverage under the designated Component Program(s);

K. Plan Interpretation. To interpret all provisions of this instrument for the purpose of resolving any inconsistency or ambiguity, correcting any error, or supplying information to correct any omission that may appear herein;

L. Determinations. To determine all questions arising in the administration of the Plan and/or Component Program, including those relating to coverage and participation under the Plan, the rights of Participants, and the eligibility of Participants for benefits to the extent that determination of such questions is not the responsibility of the claims administrator for the Plan and/or Component Program, and its decisions on such matters are final and binding upon all persons hereunder;

M. Advisors. To employ on behalf of the Plan or the Committee, to the extent reasonably necessary for operation, administration, and management of the Plan, attorneys, actuaries, accountants, clerical employees, agents, or other persons;

N. Benefits. To compute and certify the amount and kind of Benefits payable to Participants to the extent such duty is not the responsibility of a claims administrator, and is not otherwise provided by the Component Programs, and to authorize all disbursements in accordance with the provisions of the Plan and/or Component Programs;

O. Claims. To hear, review, and determine claims for Benefits to the extent such duty is not the responsibility of a claims administrator;

P. Communications. To communicate the Plan and/or Component Programs and their eligibility requirements to the Employees and notify Employees when they become eligible to participate;

Q. Participant Records. To make available to any Participant upon request, for examination during business hours, such records as pertain exclusively to the examining Participant;

R. Report. To report to other plan fiduciaries or the claims administrator as necessary or appropriate with respect to the administration, operation and management of the Plan;

S. Bonding. To take the necessary steps to assure compliance with applicable ERISA bonding requirements;

T. ERISA Responsibilities. All other responsibilities conferred by ERISA upon the "administrator" as defined in ERISA section 3(16); and

U. Operation of Plan. All other powers and duties with respect to the operation and management of the Plan conferred upon the Administrator by this Plan or necessary and appropriate thereto, except those powers and duties allocated to another named fiduciary in this Plan.

Section 8.4 Allocation and Delegation of Fiduciary Responsibilities. The Plan Administrator may delegate responsibility for the administration, operation, or management of the Plan to a person or may allocate such responsibility among two or more persons. The allocation or delegation will be in writing. The written document will specify the date of the action and the effective date of the allocation or delegation; will identify the responsibility allocated or delegated, and will identify by name, office, or other reference, the person to whom the responsibility is allocated or delegated. Such responsibility will become the responsibility of the person identified as of the effective date, and will remain the responsibility of the person until a superseding action is taken or until the effective date of a resignation or rejection of the responsibility by the person. The allocation or delegation will be communicated to the person to whom the responsibility is assigned and written acknowledgment of the communication and acceptance of the responsibility will be made by the person. If there is a conflict, the powers of and actions by the Plan Administrator will be controlling.

Section 8.5 Indemnification. The Plan Administrator will indemnify and hold harmless each of its employees to whom responsibilities for the operation and administration of this Plan

have been delegated, against any and all claims, loss, damages, expenses, and liability arising from any action or failure to act, except when the same is judicially determined to be due to gross negligence or willful misconduct of such person. The Administrator may choose, at its own expense and discretion, to purchase and keep in effect liability insurance for each such person to cover a part or all of any such claims, loss, damage, expenses, and liability.

Section 8.6 Claims Administrator's Powers and Duties. The Plan Administrator may delegate certain administrative duties under the Plan to a claims administrator in accordance with Section 8.4. The claims administrator will have such powers as may be necessary to discharge its duties under the Plan, subject to the provisions of the Component Programs, and subject to such restrictions as the Plan Administrator may from time to time specify, including, but not limited to the following:

A. Records. The claims administrator will receive from the Employer and/or have prepared by the Employer such records and information as will be necessary for the proper performance of its duties under the Plan;

B. Reports. The claims administrator will provide the Plan Administrator with any and all reports, documents, and information that may be needed by the Plan Administrator to prepare and file or have prepared and filed with the United States Department of Labor, the United States Department of the Treasury and/or any other governmental agency all reports or other information required under federal, state, or other law, and to provide the Plan Administrator or its delegate with any other documents or records that the Plan Administrator or its delegate may request from time to time to evaluate claims and losses under the Plan; and

C. Claims. The claims administrator will establish and maintain procedures for handling and paying claims and for reviewing denials of claims consistent with the Claims Procedure Article.

Section 8.7 Information to be Furnished to Administrators. Participants will furnish to the Plan Administrator and/or the claims administrator such evidence, data, or information as may be requested.

Section 8.8 Records. The regularly kept records of the Plan Administrator and the Employer will be conclusive evidence of the status of a Participant and all other matters contained therein applicable to this Plan.

Section 8.9 Fiduciary Capacity. Each fiduciary under the Plan will carry out its duties with the care, prudence, and diligence that a prudent person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of like character with like aims under circumstances then prevailing. Moreover, any Plan fiduciary will have full discretionary authority in the exercise of its powers and duties.

Section 8.10 Fiduciary Interrelationship. Each Plan fiduciary warrants that its actions are in accordance with the Plan and trust, if any. Each Plan fiduciary may rely upon the action of another Plan fiduciary and is not required to inquire into the propriety of any actions. Each Plan fiduciary will be responsible for the proper exercise of its responsibilities. Each Plan fiduciary

may rely upon tables, valuations, certificates, opinions and reports furnished by another Plan fiduciary or by accountants, counsel, or other consultants engaged by the Plan Administrator.

Section 8.11 Fiduciary Standards. Each fiduciary under this Plan will discharge his duties with respect to the Plan solely in the interest of Participants and beneficiaries:

A. Prudence. With the care, skill, and diligence under circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use;

B. Exclusive Purpose. For the exclusive purpose of providing benefits and paying reasonable expenses of administration;

C. Plan Documents. In accordance with the documents and instruments governing the Plan, to the extent they are consistent with ERISA; and

D. Prohibited Transaction. To avoid engaging in a prohibited transaction under the Code or ERISA, unless an exemption for the transaction is available or obtained.

Section 8.12 Administrative Decisions Final. The decision of the Plan Administrator in matters within its jurisdiction will be final, binding, and conclusive upon the Employer and upon each Employee, Dependent, Participant, former Participant, and every other person or party interested or concerned.

ARTICLE IX

AMENDMENT AND TERMINATION

Section 9.1 Amendment. BorgWarner may amend, modify, change, or revise all or any part of the Plan, including any Component Program, at any time. However, no amendment may retroactively deprive a Participant of any benefit for an eligible claim incurred prior to the date of the amendment, modification, change, or revision.

Section 9.2 Termination. The following provisions will apply to termination of the Plan:

A. By BorgWarner. Even though BorgWarner presently intends this Plan to be a continuing benefit program, it may discontinue or terminate the Plan at any time.

B. Mandatory. The Plan will terminate upon liquidation or discontinuance of the business of BorgWarner, adjudication of BorgWarner as bankrupt, or a general assignment by BorgWarner for the benefits of its creditors.

C. Change of Form. The Plan also will terminate upon the merger or consolidation of BorgWarner into another entity which is the survivor, the consolidation or other reorganization of BorgWarner, or the sale of substantially all of BorgWarner's assets unless the successor or purchasing corporation adopts this Plan within 90 days.

Section 9.3 No Vested Rights. No Participant or beneficiary has any vested right to current or future benefits under this Plan. A Participant's right to benefits is limited to claims incurred before the earliest of the following occurrences: amendment of the Plan, termination of the Plan or the applicable Benefit Program, or termination of eligibility to participate.

Section 9.4 Termination Distribution. Upon termination or partial termination of the Plan, remaining assets will be applied or distributed under one of the following methods after a reasonable period of final claims administration and after all expenses of administration have been paid or accrued. Assets, upon termination, may:

A. Benefits. Be transferred to another cafeteria plan or arrangement or be used to purchase, by insurance or otherwise, benefits permitted under a cafeteria plan for Participants (and former Participants) at the date of termination.

B. Forfeitures. Be distributed in any manner permitted by applicable law for the allocation of forfeitures.

In no event will assets revert to or be applied for the benefit of the Participating Employers other than as provided in (a) or (b) above. The application or distribution of assets under (a) or (b) above will not discriminate in favor of officers, shareholders, or highly compensated employees.

Section 9.5 Merger or Consolidation of Plan. A merger, consolidation or transfer of Plan assets or liabilities will not occur unless:

A. Qualification. The other plan is a cafeteria plan under Code Section 125 (and, if the Plan and trust (if any) are so qualified, a Voluntary Employees Beneficiary Association under Code section 501(c)(9)).

B. Equal Benefit. Each Participant's reimbursement account will be at least equal to the participant's reimbursement account if the Plan was terminated immediately before the merger, consolidation, or transfer.

Section 9.6 Successor Sponsor. If the Plan Sponsor is dissolved, merged, consolidated, restructured, or reorganized, or if the assets of the Plan Sponsor are transferred, this plan and the trust, if any, may be continued by the successor, and in that event, the successor will be substituted for the Plan Sponsor.

ARTICLE X

HIPAA PROVISIONS

Section 10.1 Definitions. All definitions in the Health Insurance Portability and Accountability Act ("HIPAA") privacy regulations ("Privacy Rules") and security regulations ("Security Rules") are incorporated by reference into the Plan. If a term is not defined in the Privacy Rules or Security Rules, the term will have its generally accepted meaning.

Section 10.2 Group Health Plan. Component Programs that are group health plan benefits are subject to this Article X.

Section 10.3 Protected Health Information. The Employer will have access to the Plan's protected health information ("PHI") only as permitted under this Plan or as otherwise required or permitted by the Privacy Rules. PHI means information that is created or received by the Plan and relates to:

A. past, present, and future physical or mental health or condition of an individual;

B. provision of health care to an individual; or

C. past, present, or future payment for the provision of health care to an individual; and

that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual.

Section 10.4 Uses and Disclosures of PHI by the Plan.

A. Certification by Employer. The Plan may disclose PHI to the Employer only if the Privacy Rules specifically permit the use or disclosure, or if the individual authorizes the Plan to use or disclose PHI to the Employer. In no event will the Plan disclose PHI to the Employer before it receives certification from the Employer that the Plan has been amended to incorporate the privacy obligations of the Employer listed in Section 10.5 below.

B. Plan Administration Functions. Once the Employer receives PHI from the Plan, it may use or disclose PHI only for Plan Administration Functions. "Plan Administration Functions" are administrative tasks performed by the Employer on behalf of the Plan and exclude employment-related functions and functions performed by the Employer in connection with any other benefit or benefit plan of the Employer. Plan Administration Functions include, but are not limited to:

(i) Enrollment and disenrollment activities;

(ii) Verification of participation in the Plan;

(iii) Obtaining premium contributions;

(iv) Determining eligibility for benefits;

(v) Activities to coordinate benefits with other plans and coverages;

(vi) Final adjudication of appeals of claim denials;

(vii) Exercise of the Plan's rights of reimbursement and subrogation;

(viii) Assisting Participants in eligibility, benefit claims matters, inquiries and appeals;

(ix) Obtaining premium bids;

(x) Evaluation of health plan design;

(xi) Activities relating to placement, renewal, or replacement of a contract of health insurance or health benefits (including stop-loss and excess loss insurance);

(xii) Legal services and auditing functions (including fraud and abuse detection);

(xiii) Business planning, management and general administration;

(xiv) Making claims under stop-loss or excess loss insurance;

(xv) Activities in connection with the transfer, merger or consolidation of the Plan, including due diligence.

Section 10.5 Privacy Obligations of Employer. With respect to PHI created by or received from the Plan, the Employer will:

A. Not use or further disclose the PHI other than as permitted or required by the Plan or as required by law;

B. Ensure that any agents, including subcontractors, to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Employer with respect to such PHI;

C. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer unless authorized by the individual;

D. Report to the Plan any use or disclosure of PHI that is inconsistent with the Privacy Rules of which the Employer becomes aware;

E. Make PHI available to an individual in accordance with the access requirements of the Privacy Rules;

F. Make PHI available for amendment and incorporate any amendments to PHI in accordance with the Privacy Rules;

G. Make available the information required to provide an accounting of disclosures;

H. Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Department of Health and Human

Services Secretary for purposes of determining compliance with the Privacy Rules;

I. If feasible, return or destroy all PHI received from the Plan and retain no copies of that PHI when no longer needed by the Employer for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible); and

J. Ensure that adequate separation between the Plan and the Employer is maintained as required by the Privacy Rules. For purposes of maintaining adequate separation between the Plan and the Employer, only the employees or classes of employees identified in the Employer's policies and procedures relating to the Administration of the Plan ("Authorized Employees") will be given access to PHI. Employer's policies and procedures identifying these employees is incorporated by reference into this Plan. The access to and use of PHI by Authorized Employees is restricted to the Plan Administration Functions that the Employer performs for the Plan. If an Authorized Employee uses or discloses PHI in ways other than those permitted by the Plan or the Privacy Rules, the Authorized Employee will be subject to the disciplinary procedures described in the Employer's employee handbook. The Employer may impose, at its discretion, reasonable sanctions as necessary to ensure that no further non-compliance with the Plan or the Privacy Rules occurs.

Section 10.6 Electronic Data Security Obligations of Employer. To the extent the Employer maintains electronic PHI, the Employer will:

A. Reasonably and appropriately safeguard electronic PHI created, received, maintained, or transmitted to or by the Employer on behalf of the Plan as required by the HIPAA Security Rules;

B. Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that the Employer creates, receives, maintains, or transmits on behalf of the Plan;

C. Ensure that the separation required by Section 10.5(j) is supported by reasonable and appropriate security measures;

D. Ensure that any agents, including subcontractors, to whom the Employer provides electronic PHI agree to implement reasonable and appropriate security measures to protect the electronic PHI; and

E. Report to the Plan any security incident involving PHI of which it becomes aware.

ARTICLE XI

MISCELLANEOUS

Section 11.1 Nonassignability. Except as provided in a Qualified Medical Child Support Order under ERISA Section 609 (see Section 11.14 below), benefits under this Plan or any Component Program are not subject to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution, or levy before actual receipt, except as otherwise required by law. Any assignment that violates this Section 11.1 is void. The right to receive a benefit under the Plan will not be considered an asset in divorce, insolvency, or bankruptcy. This Section 11.1 will not prevent direct billing by and payment to a provider of a service giving rise to a claim.

Section 11.2 Required Reporting. The Plan Administrator will prepare and file annual and periodic reports required under ERISA or the Code and regulations.

Section 11.3 Effect Upon Other Salary-Related Plans. Participation in this Plan is not intended to affect any other salary-related employee benefit plans that are maintained or sponsored by the Employer. Any contributions or benefits under such other plans with respect to a Participant will, to the extent permitted by law and not otherwise provided for in such other plan, include any amounts by which the Participant's salary or wages may be reduced pursuant to the provisions of this Plan.

Section 11.4 Effect Upon Employment Relationship. No Participant has a right or claim under the Plan except in accordance with its provisions. The Plan does not create a contract of employment between the Employer and a Participant or otherwise confer upon a Participant or other legal right to continuation of employment, nor does it limit or qualify the right of the Employer to discharge a Participant.

Section 11.5 Limitation on Liability. The Employer does not guarantee benefits under any insurance policy, health maintenance organization, or other similar contract described or referred to herein, and any benefits hereunder are the exclusive responsibility of the insurer or other entity that is required to provide such benefits under such policy or contract.

Section 11.6 Benefits Provided Through Third Parties. In the case of any benefit provided through a third party, such as an insurance company, health maintenance organization or other benefit provider, pursuant to a contract or policy with such third party, if there is any conflict or inconsistency between the description of benefits contained in this Plan or the Component Program and such contract or policy, the terms of such contract or policy will control.

Section 11.7 No Interest in Employer Assets. Nothing in the Plan will be construed to give an Employee, Participant, or beneficiary an interest in the assets or business affairs of the Employer or the right to examine the books and records of the Employer.

Section 11.8 No Guarantee of Tax Consequences. Neither the Plan Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under the Plan will be excludable from the Participant's gross income for federal or

state income tax purposes, or that any other federal or state tax treatment will apply to or be available to any Participant. It is the obligation of each Participant to determine whether each payment under the Plan is excludable from the Participant's gross income for federal and state income tax purposes, and to notify the Employer if the Participant has reason to believe that any such payment is not so excludable. Notwithstanding the foregoing, the rights of Participants under this Plan are legally enforceable.

Section 11.9 Entire Agreement. The Plan and the trust, if any, constitute the entire agreement. All previous negotiations, representations, or agreements are merged and are void unless expressly incorporated into these documents (or documents expressly incorporated by reference).

Section 11.10 Severability. If any provision of this Plan is deemed invalid, unenforceable, or contrary to applicable law or regulation, the Plan will remain in effect. The affected provision will be severed from the Plan and will be of no effect to the extent and for the duration of the violation.

Section 11.11 Construction. All provisions of the Plan will be interpreted to maintain the tax qualification and benefit of the Plan and to be consistent with the express purpose and intentions of the Plan. Masculine terms will be deemed to include the feminine and the neutral and the use of the singular includes the plural and the plural includes the singular, unless the context clearly indicates otherwise. Capitalized terms have the meaning specified in the Plan. Any period of time specified in the Plan will consist of consecutive days, months, or years, as appropriate. The headings of articles and sections are included solely for convenience of reference, and if there is any conflict between the headings and the rest of the Plan, the text will control.

Section 11.12 Governing Law. The Plan will be governed and construed according to ERISA and the Code and, to the extent not preempted by ERISA or the Code, according to the laws of the State of Michigan.

Section 11.13 Dividends and Refunds. To the extent permitted by law, any dividends, retroactive rates, adjustments, or other refunds that may become payable under any insurance or other benefit contract due to actuarial error or adjustment in rate calculation will be the property of and be retained by BorgWarner.

Section 11.14 Qualified Medical Child Support Order (QMCSO). The Plan will provide benefits in accordance with the terms of a Qualified Medical Child Support Order (QMCSO). A QMCSO is a court order under state domestic relations law, generally issued as part of a settlement agreement or judgment of divorce, that provides group health coverage for the child of a Participant. The Plan will honor a QMCSO if it meets the requirements below. The order must:

A. Create, or recognize the existence of the child's right to receive group health benefits for which the Participant is eligible under the Plan;

B. Clearly specify the name and last known mailing address of the Participant and each child covered by the order;

C. Specify a reasonable description of the coverage to be provided by the Plan to each child or the manner in which the coverage is to be determined; and

D. Specify each group health plan to which the court order applies and the period to which it applies.

The order may not require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan.

The term "Alternate Recipient" means any child of a Participant who is recognized under a medical child support order as having the right to enroll under a group health plan.

When the Plan Administrator receives a medical child support order, it will:

A. Notify both the Participant and each Alternate Recipient of the receipt of the order, together with an explanation of the procedures for determining whether the order qualifies as a QMCSO;

B. Determine if the order is a QMCSO; and

C. Notify the Participant and each Alternate Recipient of the determination.

The Plan Administrator is responsible for deciding if the order satisfies the conditions of a QMCSO. If it does, the child is an Alternate Recipient and is considered a beneficiary under the Plan for purposes of ERISA and is considered a Participant under the Plan for ERISA reporting and disclosure purposes.

Section 11.15 Funding. Unless otherwise required by law, contributions to the Plan need not be placed in trust or dedicated to a specific Benefit, but may instead be considered general assets of the Employer. Furthermore, and unless otherwise required by law, nothing herein will be construed to require the Employer or the Plan Administrator to maintain any fund or segregate any amount of the benefit of any Participant, and no Participant or other person will have any claim against, right to, or security or other interest in, any fund, account or asset of the Employer from which any payment under the Plan may be made.

Section 11.16 Binding Effect. This Plan and the trust, if any, are binding upon the Employer, Participants, dependents, and beneficiaries and their respective successors and assigns.

IN WITNESS WHEREOF, BorgWarner has caused this Plan to be executed by its duly authorized officer on the_____day of_____, 2017_.

BORGWARNER INC.

By: _____

Name: _____

Title: _____

APPENDIX A
CAFETERIA PLAN BENEFIT PROGRAMS
OFFERED TO ACTIVE EMPLOYEES AS OF JANUARY 1, 2017

The benefit programs listed in the Qualified Benefit Table for Active Employees constitute Component Programs that are Qualified Benefit Programs (in addition to the Pre-Tax Premium, the Health Care Flexible Spending Account and the Dependent Care Flexible Spending Account Programs) eligible for payments through the cafeteria plan's Pre-Tax Premium Program for eligible active employees at the locations listed in the Participating Locations Table for Active Employees. The specific benefits available may vary by location and employee classification, as set forth in the Program Documents for each location.

Funding of Qualified Benefits for Active Employees

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

The benefit programs listed in the Non-Qualified Benefit Table for Active Employees constitute Component Programs that are Non-Qualified Benefit Programs offered outside of the cafeteria plan to eligible active employees at the locations listed in the Participating Locations Table for Active Employees. The specific benefits available may vary by location and employee classification, as set forth in the Program Documents for each location.

Funding of Non-Qualified Benefit Table for Active Employees

Benefit Program	Funding	Insurer or Administrator
Term Life Insurance Program*	Insured	MetLife
Optional Term Life Insurance Program	Insured	MetLife
Voluntary AD&D Program	Insured	MetLife
AD&D Program*	Insured	MetLife
Business Travel Accident Program*	Insured	CIGNA
Medical Benefits Abroad Program*	Insured	CIGNA
Short-Term Disability Program	Self-funded	CIGNA

Long-Term Disability Program*	Insured	CIGNA
Voluntary Critical Illness Program	Insured	AllState
Employee Assistance Program	Insured	CIGNA

* Not subject to election; all eligible employees participate.

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

APPENDIX B
PARTICIPATING LOCATIONS TABLE
FOR ACTIVE EMPLOYEES AS OF JANUARY 1, 2019

Location	Medical Program ***	Dental Program	Vision Program	FSA Program	Term Life Insurance Program	Voluntary Group Life Program	Voluntary Dependent Life	AD&D Program	Business Travel Accident Program	Medical Benefits Abroad Program	STD Program(Hourly) *	LTD Program	Voluntary AD&D	Voluntary Critical Illness
Anderson, IN	HRA	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Asheville, NC	HRA***	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Auburn Hills, MI – PTC	HRA	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Auburn Hills, MI – World Headquarters	HRA	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Bellwood, IL/Melrose Park, IL	HRA	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Cadillac, MI (Salary and Non – Union Hourly)	HRA	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Dixon, IL	HRA	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Fletcher, NC	HRA	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Frankfort, IL	HRA	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Hood River, OR	HRA	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Ithaca, NY (Salary)	HRA	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Laredo, TX	HRA	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Livonia, MI	HRA	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Marshall, MI	HRA	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Pendleton, IN	HRA	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
San Jose, CA	HRA	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Seneca, SC	HRA	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Southborough, MA	HRA	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Taylorsville, MS	HRA	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Water Valley, MS	HRA	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Wilsonville, OR	HRA	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

*Non-ERISA salaried short –term disability benefits provided through payroll practice
**U.S. Employees on assignment in foreign countries participate in the Global Benefits Plan
***On-site medical clinic care that qualifies as an ERISA health plan is also available to employees and certain eligible dependents at these locations.

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APPENDIX C
HEALTH REIMBURSEMENT ARRANGEMENT

Section 1.1 Establishment of Plan. BorgWarner hereby establishes the BorgWarner Inc. Health Reimbursement Arrangement Plan ("HRA Plan") for the purpose of allowing Employees of the Employer to obtain reimbursement of certain eligible medical expenses. Capitalized terms used in this Appendix that are not otherwise defined shall have the meanings set forth in the Plan. This Plan is intended to permit Employees to obtain reimbursement of Health Care Expenses on a nontaxable basis from his or her HRA Account.

This Plan is an integrated health reimbursement arrangement and is intended to qualify as an employer-provided medical reimbursement plan under Code Sections 105 and 106 and regulations issued thereunder, and as a health reimbursement arrangement as defined under IRS Notice 2002-45, and shall be interpreted to accomplish that objective. The Health Care Expenses reimbursed under the Plan are intended to be eligible for exclusion from Employees' gross income under Code Section 105(b).

Section 1.2 Definitions. The following terms shall have the meanings set forth below:

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

B. "Health Care Expense" means an expense incurred by an Employee for unreimbursed medical expenses (as defined in Code Section 213(d)). Health Care Expenses shall not include expenses reimbursed or reimbursable under any other arrangement (including the Health Care Flexible Spending Account Benefit Program) or any amount claimed as a deduction on the federal income tax return of the Employee.

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

Section 1.3 Participation.

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

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

Section 1.4 Funding.

A. The benefits provided herein shall be provided by the Employer out of its general assets, and no assets shall be segregated or earmarked for the purpose of providing benefits hereunder, nor shall any person have any right, title, or claim to

such assets prior to their payment hereunder. As such, each HRA Account established pursuant to the HRA Plan shall be a hypothetical account that merely reflects a bookkeeping concept and does not represent assets that are actually set aside for the exclusive purpose of providing benefits to the Employee under the terms of the HRA Plan or that are protected from the reach of the Employer's creditors. In no event may any benefits under the HRA Plan be funded with Employee contributions.

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

Section 1.5 Benefits.

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

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

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

D. The Employer may require the Employee to furnish a bill, receipt, cancelled check, or other written evidence or certification of payment of or obligation to pay Health Care Expenses. The Employer will reimburse the Employee from the general assets of the Employer for expenses that it determines are Health Care Expenses, up to the balance in the Employee's HRA Account. The Employer reserves the right to verify to its satisfaction all claimed Health Care Expenses prior to reimbursement. Claims will be paid in the order in which they are filed and will be charged to the HRAAccount of the Employee who submits the claim.

E. The Employer may limit, reallocate, or deny any benefit to any Employee who was a highly compensated individual (as defined in Code Section 105(h)) to the extent necessary to avoid discrimination under Code Section 105(h). Any action of the Employer under this Section shall be carried out in a uniform and non-discriminatory manner.

Section 1.6 Amendment and Termination. The Employer reserves the right to amend, modify, or terminate this HRA Plan at any time, including but not limited to the right to modify the individuals eligible for participation, benefits paid by the HRA Plan, the amount of Benefit Credits to be credited, and the right to reduce or eliminate existing HRA Accounts.

APPENDIX D
EMPLOYER SHARED RESPONSIBILITY RULES UNDER CODE SECTION 4980H

Section 1.1 Definitions. Throughout this Appendix, various terms are used repeatedly. These terms have specific and definite meanings when capitalized in the text. For convenience, capitalized terms are collected and defined below and shall be used for the sole purposes of administering the Employer Shared Responsibility Rules. Any specialized term not defined below shall have the meaning ascribed to it under the Employer Shared Responsibility Rules.

A. ACA. The Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010, and its related regulations, rules and guidance promulgated by governmental agencies.

B. Administrative Period. An optional period, selected in the sole discretion of an Applicable Large Employer Member as set forth below, of no longer than 90 days beginning immediately following the end of the Initial or Standard Measurement Period and ending immediately before the start of the associated Stability Period (and also includes the period before a new employee's start date and the beginning of the initial measurement period), as further defined under and subject to Treasury Regulations §54,4980-1(a)(1).

C. Applicable Large Employer and Applicable Large Employer Member. Applicable Large Employer and Applicable. Large Employer Member have the meanings ascribed to them under Code Section 4980H and Treasury Regulations §54.4980-1(a)(4) & (5), and generally includes an employer, for that calendar year, that employed on average at least 50 Full-Time Employees (including full-time equivalent employees) during the preceding calendar year. For purposes of this Appendix, Applicable Large Employer Member shall mean BorgWarner and each other related entity within the meaning of Code Section 414(b), (c), (m) or (o) who is participating under the Plan.

D. Employer Shared Responsibility Rules. The ACA rules that potentially impose excise taxes on Applicable Large Employer Members as codified under Code Section §4980H, Treasury Regulations §54.4980H-I, et. seq., and any other related regulations, rules and guidance promulgated by federal governmental agencies.

E. Full-Time Employee. A common-law employee of an Applicable Large Employer Member who is employed an average of at least 30 Hours of Service a week (using a 130 Hours of Service in a calendar month as the monthly equivalent of 30 Hours of Service a week) for that Applicable Large Employer Member, as further defined under and subject to Treasury Regulations §54.4980H-1(a)(21).

F. Health Insurance Marketplace or Marketplace. A government resource where individuals, families, and small businesses can: learn about their health coverage options; compare Qualified Health Plans based on costs, benefits, and other

important features; choose a Qualified Health Plan; and enroll in coverage. The Marketplace encourages competition among private Qualified Health Plans, and is accessible through websites, call centers, and in-person assistance. In some states, the Marketplace is run by the state. In others it is run by the federal government (for more information, visit https://www.healthcare.gov/marketplace-in-your-state/).

G. Hours of Service. Each hour for which an Employee is paid, or entitled to payment, for the performance of duties for the Applicable Large Employer and each hour for which an employee is paid, or entitled to payment by the employer for a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence (as defined in 29 CFR 2530.200b-2(a)). Notwithstanding anything to the contrary, Hours of Service shall not include excluded hours (e.g. for hours by bona-fide volunteers, for work-study program or outside the U.S.) in accordance with the Employer Shared Responsibility Rules.

H. Initial Measurement Period. A period of at least three (3) but not more than twelve (12) consecutive months that is used by an Applicable Large Employer Member, at its sole election as reflected below or other ACA policies, as part of the look-back measurement method, as further defined under and subject to Treasury Regulations §54.4980H-1(a)(25).

I. Look-back Measurement Method. One of the two available methods of determining an Employee's status as a Full-Time Employee or Non-Full-Time Employee for the sole purpose of the Employer Shared Responsibility Rules explained in this Appendix. The Look-Back Measurement Method involves identifying an Employee's Hours of Service over an Initial or Standard Measurement Period that is at least three consecutive months but not more than 12 consecutive months in order to determine his or her Full-Time or Non-Full-Time Employee status during a following Stability Period.

J. MEC. For purposes of the Employer Shared Responsibility Rules, Minimum Essential Coverage within the meaning ascribed under Code Section 5000A(f) and related Treasury Regulations. Under the terms of this Plan document, MEC only shall include the Medical Program sponsored by the Employer (whether fully-insured or self-funded), but shall not include excepted benefits described in Section 2791(c)(1), (c)(2), (c)(3) or (c)(4) of the Public Health Service Act (e.g. excepted dental, vision, or health care spending account coverage).

K. Monthly Measurement Method. One of the two available methods of determining an Employee's status as a Full-Time Employee or Non-Full-Time Employee for the sole purpose of the Employer Shared Responsibility Rules explained in this Appendix. The Monthly Measurement Method involves a month-to-month analysis of Hours of Service credited during a particular calendar month to determine Full-Time or Non-Full-Time Employee status.

L. New Employee. An employee who has been employed by the Applicable Large Employer for less than one complete Standard Measurement Period.

M. Non-Full-Time Employee. A common-law employee of an Applicable Large Employer Member who is employed an average of fewer than 30 Hours of Service a week (using a 130 Hours of Service in a calendar month as the monthly equivalent of 30 Hours of Service a week) for that Applicable Large Employer Member.

N. Ongoing Employee. A common-law employee of an Applicable Large Employer Member who has been employed by the employer for at least one complete Standard Measurement. Period, as further defined under and subject to Treasury Regulations §54.4980H-1(a)(31).

O. Part-Time Employee. A new common-law employee of an Applicable Large Employer Member who is employed less than one complete Standard Measurement Period for whom that employer reasonably expects to work on average less than 30 Hours of Service a week with that Applicable Large Employer Member, as further defined under and subject to Treasury Regulations §54.4980H-1(a)(32).

P. Permissible Employee Categories. The categories of employees recognized under the Employer Shared Responsibility Rules for which an Applicable Large Employer Member may elect to use different methods for determining full-time status and/or may use different periods within the Look-Back Measurement Method. The Permissible Employee Categories include only:

1. Collectively bargained employees and non-collectively bargained employees;

2. Each group of collectively bargained employees covered by separate collectively bargained employees;

3. Salaried employees and hourly employees: and

4. Employees whose primary places of employment are in different States.

Q. Qualified Health Plan. An insurance plan created under the ACA that is certified by the Marketplace, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements.

R. Seasonal Employee. A common law employee of an Applicable Large Employer Member who is hired into a position for which the customary annual employment period is six months or less with the period beginning each calendar year in approximately the same part of the year, as further defined under and subject to Treasury Regulations §54.4980H-1(a)(38).

S. Stability Period. A period that immediately follows the Initial or Standard Measurement Period (and any Administrative Period) as selected by an Applicable Large Employer Member, at its sole discretion as reflected below or other ACA policies, as part of the look-back measurement method, as further defined under and subject to Treasury Regulations §54.4980H-1(a)(45).

T. Standard Measurement Period. A period of at least three (3) but not more than twelve (12) consecutive months that is used by an Applicable Large Employer Member, at its sole election as reflected below, as part of the look-back measurement method, as further defined under and subject to Treasury Regulations §54.4980H-1(a)(46).

U. Start Date. The first day on which an employee is required to be credited with an Hour of Service with the Applicable Large Employer Member.

V. Variable Hour Employee. A common law employee of the Applicable Large Employer Member for whom the employer cannot reasonably expect to be employed an average of at least 30 hours or service a week during the Initial Measurement Period because such employee's hours are variable or otherwise uncertain, as further defined under and subject to Treasury Regulations §54.4980H-1(a)(49).

Section 1.2 Assessment of the Excise Tax. Beginning on January 1, 2015, the Applicable Large Employer Members may be subject to an excise tax under the Employer Shared Responsibility Rules under the circumstances described in subparagraphs (a) or (b) below

A. Section 4980H(a) Penalty. An Applicable Employer Member fails to offer substantially all Full-Time Employees (and their dependent-children) the opportunity to enroll in MEC and any Full-Time Employee is certified to such Applicable Large Employer Member as having received an applicable premium tax credit or cost-sharing reduction for purchasing a Qualified Health Plan through the Marketplace.

B. Section 498011(b) Penalty. An Applicable Employer Member offers substantially all of its Full-Time Employees (and their dependent-children) the opportunity to enroll in MEC and one or more Full-Time Employees is certified to such Applicable Large Employer Member as having received an applicable premium tax credit or cost-sharing reduction for purchasing a Qualified Health Plan through the Marketplace.

C. Premium Tax Credit or Cost-Sharing Reduction for a Qualified Health Plan. A Full-Time Employee generally would be eligible to receive an applicable premium tax credit or cost-sharing reduction for the purchase of a Qualified Health Plan through the Marketplace only if he or she (i) is not offered MEC or is offered MEC but it is deemed unaffordable or does not provide minimum value, (ii) has household income of less than 100% or more than 400% of federal poverty level and (iii) is not eligible for Medicare or Medicaid or similar

governmental program. If an Applicable Large Employer Member does not have any Full-Time Employee who receives a premium tax credit or cost-sharing reduction for a Qualified Health Plan, then there would be no excise tax assessment under the Employer Shared Responsibility Rules for that Applicable Large Employer Member.

Section 1.3 Amount of the Excise Tax. Both the Code Section 4980H(a) or (b) penalty are assessed on a calendar monthly basis and an Applicable Large Employer Member can only be liable for either the Code Section 4980H (a) or (b) penalty for any one calendar month, not both. For an Applicable Large Employer that has two or more members/entities under common control (within the meaning of Code Section 414(b), (c), or (m)), the Code Section 4980H penalty is determined and assessed separately against each Applicable Large Employer Member (i.e. when the penalty is assessed, it will be based on the common-law employees employed directly by that Applicable Large Employer Member and will not include the employees of other Applicable Large Employer Members under common control).

A. 4980H(a) Penalty Amount. The Code Section 4980H(a) penalty equals $166.67 (as adjusted by the IRS for inflation) multiplied by the number of Full-Time Employees of the Applicable Large Employer Member for the calendar month of assessment. In counting Full-Time Employees for a calendar month, the Applicable Large Employer Member can exclude up to its allocable share of 30 Full-Time Employees. An Applicable Large Employer Member's allocable share is equal to 30 allocated ratably among all members of the Applicable Large Employer on the basis of the number of Full-Time Employees employed by each member during that calendar month rounded to the next highest whole number.

B. 4980H(b) Penalty Amount. The Code Section 4980H(b) penalty equals $250 (as adjusted by the IRS for inflation) multiplied by the number of Full-Time Employees who actually receive premium tax credits or cost-sharing reductions for the Qualified Health Plan he or she purchases from the Marketplace; provided, however, that the aggregate amount of the Code Section 4980H penalty shall not exceed the amount of the Code Section 4980H(a) penalty multiplied by the Full-Time Employees for that calendar month (reduced by the allocable share of the 30 threshold).

Section 1.4 Determination of Full-Time Employee. Each of the Applicable Large Employer Members participating in the Plan have elected to use the Look-Back Measurement Method and apply the rules set forth below uniformly to all Permissible Employee Categories.

A. Standard Measurement Period. The following rules apply to the Standard Measurement Period:

1. The Standard Measurement Period for Ongoing Employees shall be November 1 through the following October 31. At the discretion of the Employer, the Standard Measurement Period may be adjusted for the special payroll period rule set forth. in Treasury Regulations §54.4980H-3(d)(1)(ii).

2. The Standard Measurement Period shall be followed by an Administrative Period of 61 days (November 1 —December 31) following the end of the Standard Measurement Period and ending immediately before the start of the associated Stability Period described in subparagraph (3) below.

3. The Stability Period for an Ongoing Employee who is determined to be a Full-Time Employee during the preceding Standard Measurement Period shall be January 1 — December 31.

4. An Ongoing Employee who is determined to be a Full-Time Employee during a Standard Measurement Period shall be treated as a Full-Time Employee during the associated Stability Period, subject to the rules set forth under Treasury Regulations §54.4980H-3. The Applicable Large Employer Member shall notify the affected Ongoing Employee during the associated Administrative Period of his or her status as a Full-Time Employee during the Stability Period and his or her eligibility for Medical Program coverage during the associated Stability Period, provided he or she is still employed as of the first day of the Stability Period.

5. An Ongoing Employee who is determined to be a Non-Full-Time Employee during the Standard Measurement Period shall be treated as a Non-Full-Time Employee and shall not be offered coverage during the associated Stability Period that follows the associated Standard Measurement Period, subject to the rules set forth under Treasury Regulations §54.4980H-3 or as otherwise provided in the Plan.

6. An Ongoing Employee's status as a Full-Time. or a Non-Full-Time Employee during the Standard Measurement Period results in the same status during the subsequent Stability Period, regardless of the number of Hours of Service completed or a change in employment position during such associated Stability Period.

B. Initial Measurement Period. The following rules apply to the Initial Measurement Period:

1. The Initial Measurement Period for new Variable Hour, Seasonal or Part-Time Employees shall be 12 months. At the discretion of the Employer, the Initial Measurement Period may be adjusted for the special payroll period rule set forth in Treasury Regulations §54,4980H-3(d)(3)(ii).

2. The Initial Measurement Period shall begin on the first day of the month following the date of hire.

3. If a new Variable Hour, Seasonal or Part-Time Employee is determined to be a Full-Time Employee during the Initial Measurement Period, such Employee shall be the Initial Measurement Period shall be followed by an Administrative Period that begins on the first calendar day following the close of the Initial Measurement Period and ends on the last day of the

first calendar month beginning on or after the New Employee's anniversary of his or her start date. In no event will the Administrative Period for the Initial Measurement Period exceed a total of 90 days, that includes all periods between a New Variable Hour, Part-Time or Seasonal Employee's Start Date and when such employee is first offered coverage, but excluding the Initial Measurement Period itself. Additionally, the combined length of the Initial Measurement Period and the associated Administrative Period shall not extend beyond the last day of the first calendar month beginning on or after the first anniversary of the employee's start date.

4. The Stability Period for a new Variable Flour, Seasonal or Part-Time Employee who is determined to be a Full-Time Employee during the preceding Initial Measurement Period shall be 12 months.

5. If a new Variable Hour, Seasonal or Part-Time employee is determined to be Full-Time Employee during the Initial Measurement Period, such Employee shall be treated as Full-Time Employee and will be offered Medical Program coverage during the initial stability period, provided he or she is still employed as of the first day of the Stability Period.

6. The Stability Period for a new Variable Hour, Seasonal or Part-Time Employee who is determined to be a Non-Full-Time Employee during the preceding Initial Measurement Period shall be 12 months; provided, however, that such Stability Period (i) shall begin immediately following the associated Initial Measurement Period (and the associated Administrative Period), (ii) shall not be more than one month longer than the Initial Measurement Period identified above, and (iii) shall not exceed the remainder of the first entire Standard Measurement Period (plus any Administrative Period) identified herein for which such employee has been employed.

7. A new Variable Hour, Seasonal or Part-Time Employee who is determined to be a Non-Full-Time Employee during the Initial Measurement Period shall be treated as a Non-Full-Time Employee and shall not be offered Medical Program coverage during the initial Stability Period.

8. If, as of Employee's Start Date, the Employee cannot be reasonably classified as a Variable Hour, Seasonal or Part-Time Employee (e.g., he or she is reasonably expected to work on average 30 or more Hours of Service per week and is not a Seasonal Employee), the Monthly Measurement Method (as set forth under Treasury Regulations Section 54.4980H-3(c)) must be used for this Employee until he or she becomes an Ongoing Employee. In other words, an Initial Measurement Period cannot apply to such a Now Employee, but the Standard Measurement Period can apply to him or her once they become an Ongoing Employee by being employed for a complete Standard Measurement Period.

9. If a New Employee changes employment status during the Initial Measurement Period into a position where he or she is reasonably expected to work on average 30 or more hours/week, such Employee will be treated as a Full-Time Employee as of the first day of the fourth calendar month following change in status (or if earlier, the end of the Initial Measurement Period and its associated Administrative Period).

10. During each Annual or Special Enrollment Period, the Employer shall notify Ongoing Employees and New Variable Hour, Seasonal and Part-Time Employees of their status as Full-Time or Non-Full-Time Employees for the Stability Period following the Initial and Standard Measurement Periods and of such Employees eligible or non-eligible status for an offer of coverage under the Medical Program.

Section 1.5 Rules Regarding Employees Rehired or Resuming Service After a Period of no Credited Hours of Service. Notwithstanding the main text of the Plan Document, the following additional rules apply under this Appendix:

A. Monthly Measurement Method. If the Monthly Measurement Method applies to an Employee, the following rules apply:

1. If an Employee resumes providing services for the Employer after of period during which the Employee was not credited with any Hours of Service ("break in service") of at least thirteen (13) consecutive weeks, such Employee will be treated as a newly hired Employee, If the Employee's break in service is for a period of at least four (4) consecutive weeks yet less than thirteen (13) consecutive weeks, and the break in service period is longer than the preceding employment period, the Employee also will be treated as a newly hired Employee. As a newly hired Employee, the non-assessment period shall apply as set forth under Treasury Regulations 54.4980H-3(c)(2).

2. If the Employee's break in service is either (i) less than four (4) consecutive weeks, or (ii) is greater than four (4) consecutive weeks yet less than thirteen. (13) consecutive weeks, and the break in service period was not longer than the preceding employment period, the Employee shall be treated as a continuing Employee and the non-assessment period shall not apply to him or her (i.e, if rehired as a Full-Time Employee, Medical Program coverage should be made available no later than the first day of the calendar month following resumption of services to avoid a potential assessment of the excise tax for that calendar month).

B. Look-Back Measurement Period. If the Look-Back Measurement Method applies to an Employee, the following rules shall apply:

1. An Employee who resumes providing services for the Employer after a period during which the Employee was not credited with any Hours of

Service ("break in service") of at least thirteen (13) consecutive weeks, the Employee will be treated as a newly hired Employee. An Employee whose break-in service is for a period of at least four (4) consecutive weeks yet less than thirteen (13) consecutive weeks, and the break in service period was longer than the preceding employment period, also shall be treated as a newly hired Employee. In this event, a new Initial Measurement Period will apply if rehired as a Variable Hour, Part-Time or Seasonal Employee.

2. An Employee whose break in service is either (i) less than four consecutive weeks or (ii) greater than four (4) consecutive weeks yet less than thirteen (13) consecutive weeks, and the break in service period was not longer than the preceding employment period, shall, upon resumption of services, be treated as a continuing Employee. Such a continuing Employee shall retain, upon resumption of services, the status that Employee had with respect to the application of any Stability Period. If the continuing Employee was considered a Full-Time Employee for the Stability Period and eligible for Medical Program coverage, then he or she, upon resumption of services, will be eligible for Medical Program coverage as of his or her reemployment commencement date or, if later, as soon as administratively practicable (i.e. the first day of the calendar month following resumption of services); unless such continuing Full-Time Employee previously declined the Employer's offer of coverage for that Stability Period. If the continuing Employee is not considered a Full-Time Employee for the Stability Period or previously declined coverage, then no offer of coverage under the Medical Program will be made for the remainder of that Stability Period.

3. For a continuing Employee with an special unpaid leave (i.e. FMLA, USERRA or jury duty leaves), such Employee's average Hours of Service during the measurement period generally shall be determined by computing the average hours, after excluding the special unpaid leave period during that measurement period and by using the average as the average for the entire measurement period (or adopt any other alternative permitted under Treasury Regulation 54.4980H-3(d)(6)(i)(B).

Section 1.6 Incorporation by Reference of the Employer Shared Responsibility Rules. This Appendix, along with any other policies and procedures established by each Applicable Large Employer Member participating under the Employer's Medical Program, shall indicate, if necessary, the measurement methods adopted and any other essential information for each eligible classifications of Employees implemented by the Applicable Large Employer Member for purposes of the Employer Shared Responsibilities Rules. Notwithstanding anything to the contrary, the Employer Shared Responsibility Rules are incorporated herein by reference and shall control and dictate how the measurement methods and determination rules for Full-Time Employee status shall apply to the Applicable Large Employer Member.