# BORGWARNER

# RETIREE HEALTH & LIFE PLAN

## Summary Plan Description (SPD)

## 2014

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# INTRODUCTION

BorgWarner Inc. sponsors the BorgWarner Retiree Health & Life Plan (the "Plan") for the benefit of the retirees of BorgWarner Inc. and its subsidiaries (the "Company"). The Plan is made up of various benefit programs (each a "Program") offered by the Company, such as medical and life insurance plans.

This Summary Plan Description ("SPD") along with related benefits booklets, certificates of coverage, benefits summaries, enrollment materials, summaries of material modifications, and other similar documents (collectively referred to as "program documents") describes the Retiree Health & Life Plan as of January 1, 2014. You should carefully read this SPD and the program documents to determine your rights and responsibilities. This SPD is only a summary of the Plan. The complete terms of the Plan are described in the Plan document.

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

# BENEFITS AND ELIGIBILITY GENERALLY

## What kinds of Programs are offered under the Retiree Health & Life Plan?

Currently, the BorgWarner Retiree Health & Life Plan includes the following Programs, which may vary depending upon the location from which you retired:

- The Medical Program (pre-Medicare, Medicare supplemental, and prescription drug)
- The Dental/Vision Program
- The Term Life Insurance Program (basic and voluntary life insurance)

Please see Schedule 1 and Schedule 2 at the end of this SPD for a list of the Programs offered to eligible Retirees at active and divested locations.

For a detailed description of the benefits that are available to you, please see the relevant benefits booklets, certificates of coverage, benefits summaries and enrollment materials available through your local Human Resources office. These documents will also describe circumstances that may result in loss or denial of benefits, rights (if any) to obtain conversion policies, special claims procedures that may apply to each coverage, information about contract administrators, and the specific amounts you will be required to pay for coverage.

**Who is eligible to participate in the Programs?**

Eligibility in the Retiree Health & Life Plan is restricted to "Retirees." Whether you are considered a Retiree depends on a number of factors including location, date of hire, years of service, if you were disabled while employed, and participation in the employee Medical Program. The benefits offered under the Retiree Health & Life Program may vary by location, by job classification and by age, so you should contact the retiree service center at 3850 Hamlin Road, Auburn Hills MI 48326, phone (877) 259-5373 if you need further information.

*Active Employees Who Retire*

(i) Non-Union employees at active locations.

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

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

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

| Location | Began Employment Before |
|---|---|
| Marshall, Michigan | October 1, 1999 |
| Muncie, Indiana (salaried) (through May 1, 2009) | January 1, 1994 |

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

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

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

(ii) Union employees at active locations

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

**Table 2: Union Location Hire Dates**

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

(iii) Disabled employees

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

(iv) Divested Locations

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

**Who qualifies as an eligible dependent under the Plan?**

A number of the Programs offered under this Plan permit participants to enroll their dependents. The term “dependents” includes your spouse and children unless specified otherwise in this SPD or the program documents for a particular Program.

Your “dependents” do not include any individual who does not qualify as your spouse or as your dependent under Federal tax law. It is your responsibility to ensure that you do not enroll any dependent who does not qualify as your spouse or your dependent under Federal tax law.

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

You may be required to provide documentation to demonstrate that the dependent is eligible to participate in the Program. You may also be required to recertify eligibility from time to time. If you do not provide documentation acceptable to the Company within thirty (30) days of such request, your dependent will be terminated from the Program at the end of the 30-day period.

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

**Who is an eligible dependent under the Medical, Dental and Vision Programs?**

For purposes of these Programs, dependents include:

- Your spouse; and
- Your children who are under age 19, or who are under age 25 if a full-time student at an accredited institution, or who are permanently and totally disabled (*as defined below*).

*Spouse*

Your spouse is an individual of the opposite sex or, effective for retirements occurring on or after January 1, 2014, an individual of the same sex, to whom you are legally married, as evidenced by a current and valid marriage certificate. Common-law marriages, Co-habitants, domestic partners, life partners, legally separated individuals and divorced spouses are not considered spouses under the BorgWarner Retiree Health & Life Plan, even if recognized under the laws of your State of domicile. When deciding whether an individual qualifies as a spouse, the determination will be based upon the laws of the State or jurisdiction in which the marriage was validly performed; provided, however, that for a benefit option that is fully-insured through an insurance carrier, a more restrictive definition of the term "spouse" set forth in the program documents (including the applicable insurance policy) shall control (e.g. a fully-insured policy must specifically allow and be underwritten to include same-sex spousal coverage were legally married.

In order for your spouse to qualify as your dependent under the retiree medical, dental and vision Programs, your spouse must not only meet the general requirements that apply to a spouse under this Plan, but you and your spouse must also have been married immediately prior to your retirement from the Company and your Spouse must also have been covered under the Medical Program of the BorgWarner Flexible Benefits Plan at the time of your Retirement.

*Child*

A child includes:

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

In order for your child to qualify as your dependent under the retiree medical, dental and vision Programs, your child must not only meet the general requirements listed above, but your child must also have been covered under the Medical Program of the BorgWarner Flexible Benefits Plan at the time of your Retirement.

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

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

*Student Status*

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

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

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

*Permanently and Totally Disabled*

For purposes of the definition of dependent, your child will be considered permanently and totally disabled if he or she:

- is incapable of self-sustaining employment by reason of mental or physical disability;
- became disabled prior to his or her 19th birthday; and
- was covered under the Medical Program of the BorgWarner Flexible Benefits Plan or the BorgWarner Retiree Health & Life Plan on his or her 19th birthday.

You must provide medical proof of the child's condition and proof of dependent status within thirty (30) days after the date the child otherwise ceases to qualify as a dependent because of his or her age, and may be required from time to time to provide proof of the continuation of such condition and dependence.

Coverage for a disabled child will end upon the termination/death of the eligible participant/surviving parent.

**What else should I know about adding a dependent?**

(This section only applies to Sterling Heights Hourly and Indianapolis Hourly Retirees) You are required to provide applicable legal documentation or approved correspondence for all dependents to verify eligibility prior to a dependent being enrolled.

**Who pays the cost of coverage under each Program?**

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

**Can I assign my benefits to someone else?**

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

**What are the coordination of benefits rules that apply to my coverage?**

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

For specific rules regarding coordination of benefits, please contact the applicable insurer or claims administrator listed in Schedules 1 and 2.

**Under What Circumstances Will My Participation in the Plan End?**

Your participation in the BorgWarner Retiree Health & Life Plan and coverage for you and your dependents may end under the following circumstances:

- You or your dependents are no longer eligible for benefits under the Plan;
- You fail to pay the required contribution for coverage;
- You choose to discontinue your participation;
- You are an eligible dependent of a retiree or surviving spouse who die. Coverage ends with the date of death of the last survivor.
- You or your dependents' participation is terminated for cause (for example, BorgWarner learns that you have committed or attempted to commit fraud or have been dishonest with BorgWarner about some important or material matter); or
- BorgWarner terminates the plan or amends the plan in a manner that eliminates your or your dependents' coverage.

Additional rules may appear in program documents for a Component Program.

## ENROLLMENT AND ELECTION OF BENEFITS

### What do I have to do to enroll in the Programs offered under the Plan?

For all Programs in which you were eligible to enroll, you received an enrollment package when you first retired. Once you are enrolled in a Program you will remain enrolled in that Program for subsequent years until you elect otherwise, or no longer qualify as a dependent.

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

If you or your eligible dependent declined coverage under one of the available component Programs offered through the BorgWarner Retiree Health & Life Plan because you had other coverage, you may not enroll in that Program in the future.

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

(This section only applies to Sterling Heights Hourly and Indianapolis Hourly Retirees) If you have a new spouse or child by marriage, birth, adoption, or placement for adoption, you may enroll that child in the Medical Programs in which you are eligible. If you are already enrolled, but your spouse or other eligible dependents are not, you may also enroll them along with the new child. **You must notify the retiree service center within thirty (30) days of the occurrence of the birth, adoption, placement for adoption, or marriage. You will not have another opportunity to enroll your new dependents.**

### What happens if I receive a Qualified Medical Child Support Order?

If you are ordered to provide health coverage for your child under a qualifying judgment, decree or order resulting from a divorce, legal separation, or change in legal custody, you may add coverage for that child if you also have medical coverage. If someone else is ordered to provide coverage that you have been providing for the child, you may drop the child from your coverage.

## COBRA CONTINUATION COVERAGE FOR HEALTH CARE BENEFITS

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

### What is COBRA continuation coverage?

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

**Which Programs are subject to COBRA?**

COBRA applies to the Medical, Dental, and Vision Programs offered under this plan.

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

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

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

*"Qualifying Events"*:

The following are "Qualifying Events" under the Retiree Health & Life Program:

- For a Retiree:
  - commencement of a Federal bankruptcy proceeding by or against the company.
- For a spouse of the Retiree:
  - death of the Retiree;
  - divorce or legal separation from Retiree;
  - Retiree's eligibility for Medicare; or
  - commencement of a Federal bankruptcy proceeding by or against the company.
- For a dependent child of the Retiree:
  - death of the Retiree;
  - spouse's divorce or legal separation from Retiree;
  - Retiree's eligibility for Medicare;

- his or her ceasing to qualify as a dependent under the Plan; or
- commencement of a Federal bankruptcy proceeding by or against the company.

**What happens if a Qualifying Event occurs?**

If a Qualifying Event is a Participant's death, the Retiree's entitlement to Medicare, or the bankruptcy of the Company, the Company will notify the Plan Administrator of that Qualifying Event within thirty (30) days after the date of the Qualifying Event.

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

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

**How do Qualified Beneficiaries elect continuation coverage?**

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

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

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

election period. If any waiver is revoked before the end of the election period, however, Continuation Coverage under the Plan is effective prospectively only, from the date the waiver is revoked.

**How long does COBRA continuation coverage last?**

Under the Retiree Health & Life Program, if the qualifying event is the bankruptcy of the Company, then a Retiree's maximum period of continuation coverage ends upon the Retiree's death; and for the surviving spouse and dependent child of such a deceased Retiree, the maximum period of Continuation Coverage ends on the earlier of (1) the spouse or dependent child's death, or (2) thirty-six (36) months from the date of the Retiree's death.

For other Qualifying Events, the maximum period of COBRA coverage is as follows:

| *Qualifying Event* | *Beneficiary Eligible for COBRA* | *Maximum Coverage Time* |
|---|---|---|
| • Divorce or Legal Separation<br>• Death of Retiree<br>• Retiree entitled to Medicare | • Spouse<br>• Dependent Child | • 36 months |
| • Loss of Dependent Child Status | • Dependent Child | • 36 months |

The periods described above commence on the first day of the month following the Qualifying Event.

**Can continuation coverage terminate sooner than the maximum period?**

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

- The individual fails to pay a required premium in a timely manner. If the premium payment is the first payment and if the election of Continuation Coverage occurs after the Qualifying Event, the premium payment may be made within forty five (45) days after the election. A payment of any premium, other than the first premium, is considered to be timely if made within thirty (30) days after the premium due date specified by the Plan Administrator. If payment is not received within this 30-day grace period, coverage will be terminated retroactive to the premium due date.

- The Company no longer sponsors or maintains any group health plan (including successor plans) for any of its employees.

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

The monthly premium for Continuation Coverage can be no more than the full cost to the Company for active participants plus a 2% administrative fee. The election form will indicate the amount you are required to pay.

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

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

**What is my duty to notify of any qualifying events?**

When the initial qualifying event is the retiree's entitlement to Medicare or death of the retiree, the Company will provide the COBRA Administrator with notice of the right to continued coverage. However, if the initial qualifying event is legal separation, divorce, or your child's loss of dependent status, then it is your and your covered dependents' responsibility to notify the retiree service center. To be eligible for COBRA coverage, you and your covered dependents must provide notice within sixty (60) days after legal separation, divorce or your child's loss of dependent status or, if later, within sixty (60) days after coverage is lost because of such an event. If you fail to comply within this 60-day period, COBRA coverage will not be available. You must contact the retiree service center and complete whatever forms may be required on a timely basis.

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

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

**Who may give notice?**

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

**Do I need to keep copies of any notices?**

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

## CLAIMS AND REVIEW PROCEDURES – MEDICAL, DENTAL AND VISION PROGRAMS

This section describes how claims are generally handled under the health care Programs – which currently include the Medical, Dental, and Vision Programs. Please contact the claims administrator for your coverage (see Schedules 1 and 2) for more information.

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

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

However, if you pay a bill for a covered expense yourself, you must send the original bill and a paid receipt and/or a copy of your cancelled check to the claims administrator, along with such other information as the administrator may require. If the bill is for your covered dependent that has other primary medical coverage, send a copy of the other coverage's Explanation of Benefits (proof of payment or denial). Please contact the claims administrator for your medical, dental and vision Programs (see Schedules 1 and 2) for the address and applicable deadlines. Be sure to keep a copy of your original bill and paid receipt for your records.

If you have paid the bill yourself and you do not forward a receipt or a copy of a cancelled check to the claims administrator, the plan will assume that you did not pay the bill and will pay the claim, on your behalf, directly to the provider. Therefore, if you

wish to be reimbursed by the plan for expenses which you have already paid, make sure you forward a paid receipt or a copy of a cancelled check.

**How Quickly Will Claims Be Processed?**

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

If you are required to obtain pre-certification for medical care, your request will be decided within fifteen (15) days unless the claims administrator notifies you prior to that time that an extension (not to exceed 15 days) is required. If your request involves an emergency care situation, such that a delay could either seriously jeopardize your life or health, the ability to regain maximum function, or subject you to severe pain that could not be adequately managed without the requested care or treatment, the decision will be made as soon as possible but in all cases within 72 hours. In an emergency care situation, your doctor or another health care professional with knowledge of your condition may act as your representative.

If the paperwork you have submitted is incomplete, the claims administrator will inform you that it needs additional information within thirty (30) days (within 5 days in the case of a pre-certification request, and within 24 hours if the pre-certification request involves an emergency care situation). You will then have forty-five (45) calendar days in which to submit the additional information (48 hours if the request involves an emergency care situation). IMPORTANT: If you do not submit the additional information, the claims administrator will decide the claim based on the incomplete information you have submitted.

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

If you are undergoing a course of treatment that required pre-certification, and you are requesting an extension of that course of treatment, you must submit the extension request at least 24 hours before the approved course is scheduled to end. If your extension request is timely, the claims administrator will make a decision within 24 hours. Otherwise, the decision will be made within fifteen (15) days (subject to a possible 15 day extension) or within 72 hours if it is an emergency care situation.

**What If My Claim is Denied?**

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

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

**How Can I Appeal a Denied Claim?**

*First Level Review*

Within one hundred eighty (180) calendar days after you receive a notice of denial, you or your authorized representative may appeal the decision. You may review and receive at no cost a copy of the plan document and any other documents relevant to your claim. If, after reviewing these documents, you think your claim is valid, you may request a review to the claims administrator for your health care Program. You should call the claims administrator (see Schedules 1 and 2) for information on where and how to submit the appeal. Your appeal must be made in writing, must state that you are appealing a claim denial, and must include the reasons why you disagree with the denial and any other information you feel is pertinent to the claim.

Upon receiving your appeal, the claims administrator will review your claim and notify you of its decision within thirty (30) days either in writing or electronically (15 days in the case of a pre-certification request; 72 hours if the claim involves an emergency care situation).

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

*Right to a Second Review*

If your claim denial is upheld at the first level of review, you may request a second level of review within sixty (60) calendar days of the first decision. Again, you may review and receive at no cost documents relevant to your claim, and may submit to the claims administrator any documents, records, comments or other information you would like considered.

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

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

The reviewers will notify you of their determination within thirty (30) days of receiving your request for a second-level review. The second-level review decision is final.

*Second-Level Review for Pre-certification Requests*

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

*Expedited Review of Emergency Care Pre-Certification Requests*

Pre-certification requests of emergency care situations are handled on an expedited basis, and have only one level of review. When you submit a pre-certification request in an emergency care situation, you will be notified of the decision within 72 hours of receipt (unless your submission was incomplete, in which case you will be notified within 24 hours, and the decision to approve or deny the request will be made within 48 hours from receipt of the additional information or by the end of the time in which you are required to submit the additional information). The notice of denial (as described above) may be provided to you orally, in which case you will be sent a written or electronic confirmation within three (3) days of the oral notification.

If you decide to appeal the decision, you may make your request for an appeal to the claims administrator orally or in writing. The appeal will be handled by a reviewer using the same procedures noted above, but on an expedited basis. You may submit information that you wish the reviewer to consider by telephone, facsimile, or other expeditious method acceptable to the reviewer. The reviewer will notify you of the decision as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receiving your request for a review.

*You Must Follow the Appeals Process*

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

## CLAIMS AND REVIEW PROCEDURES – GROUP TERM LIFE AND ELIGIBILITY DETERMINATIONS

This section describes how the claims are generally handled under the Life Insurance Program. Please contact the applicable claims administrator (see Schedules 1 and 2) for more information. The appeals procedures in this section also apply to appeals relating to eligibility to participate in a Program when eligibility is not associated with a specific request for benefits under the Program.

### How Do I File a Claim for Benefits?

In order to receive Benefits, you must file a claim with the claims administrator. Please call the claims administrator (see Schedules 1 and 2) for the address and applicable deadlines. Be sure to keep a record of your request.

### How Quickly Will Claims Be Processed?

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

### What If My Claim is Denied?

If your request for benefits is denied, either in whole or in part, you will receive written notification of the specific reasons for the denial. This written denial will include: (1) the reasons for the denial, including references to the plan provisions upon which the denial is based; (2) a description of additional information that would permit payment of your claim; and (3) an explanation of any claims review procedures. The notice will also explain your right to appeal the decision, including a statement of your right to bring a civil action under ERISA Section 502(a) if your claim is denied on appeal.

### How Can I Appeal a Denied Claim?

Within sixty (60) calendar days after you receive a notice of denial, you or your authorized representative may appeal the decision. You may review and receive at no cost a copy of the plan document and any other documents relevant to your claim. If, after reviewing these documents, you think your claim is valid, you may request a review to the claims administrator for your Program. You should call the claims administrator (see Schedules 1 and 2) for information on where and how to submit the appeal. Your appeal must be made in writing, must state that you are appealing a claim denial, and must include the reasons you disagree with the denial and any other information you feel is pertinent to the claim.

Upon receiving your appeal, the claims administrator will review your claim and notify you of its decision within ninety (90) days. If additional time is necessary to respond to your appeal because of special circumstances, the claims administrator may

extend the period for up to ninety (90) days, so long as it notifies you of the extension before the initial 90-day period expires.

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

*You Must Follow the Appeals Process*

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

## CLAIMS — ADDITIONAL RULES

### Who is the claims administrator for each Program?

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

### Are there other general rules that apply to claims?

The following general rules apply to all claims:

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

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

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

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

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

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

**What happens if a claim is overpaid?**

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

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

- Request repayment from you (or your dependent if applicable), service provider or other payee;

- Offset the amount of the overpayment against further approved claims to you and your enrolled dependents (or to your service provider or other payee);

- Pursue collection of the overpayment through legal procedures.

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

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

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

The Plan Administrator in its discretion may deny payment of benefits otherwise provided under this Plan with respect to that illness or injury, unless you or your dependent signs a repayment agreement confirming the right of the Plan to receive repayment in full for any such benefit payments. If you or your dependent acquires any rights of recovery against another for negligence or a willful act or an omission resulting in an illness or injury for which benefits are provided under this Plan, the Plan will be subrogated to those rights, and will be entitled to reimbursement for payments under the Plan to the extent of any settlement or judgment. This also applies to payments received by the parents or legal guardians in the event the dependent is a minor or the heirs, administrators, or executors of the estate, when applicable.

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

- Cooperate fully with the Plan Administrator in obtaining information about the loss and its cause;

- Notify the Plan Administrator of any claim for damages made, or lawsuit filed, on behalf of the Participant or dependent in connection with the loss;

- Include the amount of benefits paid by the Plan on behalf of you or your dependent in claims for damages against other parties;

- Provide the Plan Administrator with a first priority lien to the extent of the cash value of the services and supplies provided (which such lien may be filed with the person whose act caused the Injuries, such person's agent, or a court having jurisdiction in the matter);

- Hold in trust for the benefit of the Plan any proceeds of settlement or judgment that you, your agent, or any third party at your direction receives when the Plan has a right of subrogation or recovery;

- Reimburse the Plan Administrator for any damages collected to the extent of the cash value of the services and supplies immediately upon collection of damages, whether by settlement, judgment, or otherwise (whereby the Plan Administrator shall be reimbursed first from any settlement or judgment, and if any balance then remains, it shall be given to you or your dependent, as applicable);

- Pay to the Plan Administrator all costs and expenses, including attorney's fees, which shall be incurred or expended by the Plan Administrator in obtaining, or attempting to obtain, payment from you or your dependent if you or your dependent fails or refuses to reimburse the Plan Administrator as required under the Plan;

- Permit the Plan Administrator to file a lawsuit in the name of you or your dependent against the person whose act caused the illness or injury;

- Notify the Plan Administrator of a proposal settlement at least thirty (30) days before any claim or lawsuit is settled in regard to the loss;

- Sign any documents necessary to accomplish the purposes described above; and

- Cooperate with the Plan Administrator to accomplish purposes described above.

The plan will be reimbursed for your total recovery before any amounts, including expenses or attorneys' fees, are deducted, whether or not the recovery is specifically for medical payments, and regardless of how the proceeds are characterized or the source of the recovery. This is a right of first reimbursement, and the "make whole" rule or "common fund" rule will not apply. The plan will not pay, offset any recovery, or in any way be responsible for any fee or costs associated with pursuing a claim unless the plan agrees to do so in writing.

## QUALIFIED MEDICAL CHILD SUPPORT ORDERS

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

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

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

The order must:

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

The order must be submitted to your local Human Resources office.

### What happens after an order is submitted?

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

## AMENDMENT AND TERMINATION OF THE PLAN AND PROGRAMS

The Company intends to continue the Plan and each Program indefinitely. However, the Company reserves the right to modify, amend, or terminate the Plan, or any

Program under the Plan, at any time and for any reason. You will be notified of any material changes to the Plan or any Program in which you are enrolled.

## HEALTH PRIVACY

The group health care Programs under the Plan, including the retiree Medical and Dental/Vision Programs, are subject to State and Federal privacy laws, including the "HIPAA Privacy Rules." These laws ensure that the Plan, the Company, and those who provide services to the Plan do not misuse your confidential health information. You will receive a Notice of Privacy Practices separately, which outlines how the Plan may use your confidential health information and provides contact information for the Company's Privacy Officer.

## FEDERAL LAWS PROTECTING WOMEN AND NEWBORNS

### What does the Newborns and Mothers Health Protection Act provide?

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

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

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

- all stages of reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications of mastectomy, including lymph edemas;

in a manner determined in consultation with the attending physician and the patient. This coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan or coverage.

## PLAN ADMINISTRATION

The administration of the Plan and each Program is under the supervision of the Plan Administrator, who has the sole discretion and authority to interpret and administer the Plan and each Program in all of their details; including the responsibility and discretionary authority to review and make final decisions on plan eligibility and claims for benefits to determine issues of fact, and to interpret the plan for purposes of resolving any inconsistency or ambiguity, correcting any error, or supplying information to correct any omission in the plan. The determination of the Plan Administrator (or its delegate) as to any question involving the administration and interpretation of the Plan is final, conclusive, and binding.

## PLAN FUNDING

Benefits offered under this plan may be insured or self-funded as indicated in the Funding Tables at Schedule 1 and Schedule 2. When a benefit is insured, the insurer is solely responsible for payment of the benefits. When benefits are self-insured, the benefits are not insured but are paid from the general assets of the Company, as supplemented by any applicable participant contributions. The Company will determine from time to time the amount, if any, to be contributed by participants in order to be covered by a Component Program.

## LIMITATION OF RIGHTS

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

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

Your rights (and the rights of your dependents and Beneficiaries) to benefits under the Plan are conditioned upon each of your provision to the Company and Plan Administrator of such information, evidence, and signed documents as may

reasonably be requested by the Company, the Plan Administrator, any claims administrator (or any delegate thereof) from time to time for the purpose of administration of the Plan.

## STATEMENT OF ERISA RIGHTS

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

*Receive Information About Your Plan and Benefits:*

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

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

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

*Continue Group Health Plan Coverage:*

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

*Reduction or Elimination of Exclusionary Periods of Coverage for Preexisting Conditions Under Your Group Health Plan:*

You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your

COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

*Prudent Actions by Plan Fiduciaries:*

In addition to creating rights for Participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants, dependents, and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

*Enforce Your Rights:*

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within thirty (30) days, you may file suit in a federal court. In such a case, the court may require the Plan Sponsor to provide the materials and pay you to up $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Sponsor. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds that your claim is frivolous.

*Assistance with Your Questions:*

If you have any questions about your Plan, you should contact your local Human Resources Office. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Sponsor, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security

Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

## IMPORTANT INFORMATION ABOUT THE PLAN

| | |
|---|---|
| Name of Plan: | BorgWarner Inc. Retiree Health & Life Plan |
| Plan Sponsor: | BorgWarner Inc.<br>3850 Hamlin Road<br>Auburn Hills, MI 48326 |
| Plan Administrator: | BorgWarner Employee Benefits Committee<br>c/o BorgWarner Inc.<br>3850 Hamlin Road<br>Auburn Hills, MI 48326<br>Telephone No.: 248-754-9200 |
| COBRA Administrator: | BOS-BorgWarner COBRA Service Center<br>3149 Haggerty Hwy<br>Commerce Twp. MI 48390<br>COBRA Participant toll-free number:<br>1-877-206-0283 |
| Employer Identification Number: | 13-3404508 |
| Plan Number: | 600 |
| Type of Plan: | Health and welfare benefit plan. |
| Type of Administration: | Self-insured benefits are administered pursuant to contracts with the claims administrators listed in Schedules 1 and 2. Insured benefits are provided pursuant to contracts with the insurers listed in Schedules 1 and 2. |
| Plan Effective Date: | Through December 31, 2010, the Plan was a component program of the BorgWarner Flexible Benefits Plan. Effective January 1, 2011, BorgWarner has spun off the Retiree Health & Life Program as a new, separate Plan entitled The BorgWarner Retiree Health & Life Plan. |
| Plan Year: | January 1 - December 31 |
| Agent for Service of Legal Process: | Service of legal process may be made on the Plan Administrator at the above address. |

# SCHEDULE 1

## Benefit Programs Available for Eligible Retired Employees from Active Locations

| **Location You Retired From** | **Available Medical Program** | | | **Other Available Benefit Programs** | | |
|---|---|---|---|---|---|---|
| *Not all Programs are available for all groups of retirees.* | Pre-Medicare** | Medicare Supplement* | Rx Program | Dental Program | Vision Program | Life Insurance Program |
| Asheville, N.C. | CIGNA Choice Health Fund | Retiree Reimbursement Account (retired by 12/31/2008) | Included in Pre-Medicare Health Plan Only | N | N | Y |
| Auburn Hills, MI – PTC | CIGNA Choice Health Fund | Retiree Reimbursement Account (retired by 12/31/2008 | Included in Pre-Medicare Health Plan Only | N | N | Y |
| Auburn Hills, MI – World Headquarters | CIGNA Choice Health Fund | Retiree Reimbursement Account (retired by 12/31/2008 | Included in Pre-Medicare Health Plan Only | N | N | Y |
| Bellwood, IL | CIGNA Choice Health Fund | Retiree Reimbursement Account (retired by 12/31/2008 | Included in Pre-Medicare Health Plan Only | N | N | Y |
| Cadillac, MI (Salary & Non-Union Hourly) | CIGNA Choice Health Fund | Retiree Reimbursement Account (retired by 12/31/2008 | Included in Pre-Medicare Health Plan Only | N | N | Y |
| Cadillac, MI (Union) | N/A | CIGNA Indemnity | Y | N | N | Y |
| Dixon, IL | CIGNA Choice Health Fund | Retiree Reimbursement Account (retired by 12/31/2008 | Included in Pre-Medicare Health Plan Only | N | N | Y |
| Fletcher, NC | CIGNA, Choice Health Fund | Retiree Reimbursement Account (retired by 12/31/2008 | Included in Pre-Medicare Health Plan Only | N | N | Y |
| Frankfort, IL | CIGNA Choice Health Fund | Retiree Reimbursement Account (retired by 12/31/2008 | Included in Pre-Medicare Health Plan Only | N | N | Y |
| Ithaca, NY (Union Hourly retired by August 2008) | CIGNA Indemnity | CIGNA Indemnity, CIGNA Major Medical | Y | N | N | Y |

| Location You Retired From | Available Medical Program | | | Other Available Benefit Programs | | |
|---|---|---|---|---|---|---|
| *Not all Programs are available for all groups of retirees.* | Pre-Medicare | Medicare Supplement* | Rx Program | Dental Program | Vision Program | Life Insurance Program |
| Ithaca, NY (Union Hourly retired after August 2008 and before January 1, 2011) | CIGNA Indemnity/ Choice Health Fund | Retiree Reimbursement Account | Included in Pre-Medicare Health Plan Only | N | N | Y |
| Ithaca, NY (Union Hourly retired after December 31, 2010) | CIGNA Indemnity/ Choice Health Fund | N | Y | N | N | Y |
| Ithaca, NY (Salary) | CIGNA Choice Health Fund | Retiree Reimbursement Account (retired by 12/31/2008 | Included in Pre-Medicare Health Plan Only | N | N | Y |
| Livonia, MI | CIGNA Choice Health Fund | Retiree Reimbursement Account (retired by 12/31/2008 | Included in Pre-Medicare Health Plan Only | N | N | Y |
| Marshall, MI | CIGNA Choice Health Fund | Retiree Reimbursement Account (retired by 12/31/2008 | Included in Pre-Medicare Health Plan Only | N | N | Y |

***You are required to enroll in Medicare A & B to participate in the Medicare Supplemental Health Plan & RRA coverage offered by BorgWarner.**

**** N = no plan available;**

## Funding of Benefits for Retired Employees at Active Locations

| Benefit Program | Funding | Insurer, HMO, Administrator |
|---|---|---|
| Medical Program, including prescription drug | 1. Self-Insured High Deductible Health Plan with HRA<br>2. Self-Insured Indemnity Plan<br>3. Self-Insured Major Medical Plan | 1. CIGNA<br>2. CIGNA<br>3. CIGNA<br>4. United Healthcare |
| Dental/Vision Program | Self-Insured Dental/Vision PPO Plan | CIGNA (COBRA only) |
| Life Insurance Program | Insured Group Term Life Plan | MetLife |

**Insurer and Administrator Information**

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

CIGNA
900 Cottage Grove Road
Bloomfield, CT 06002

MetLife
200 Park Avenue
New York, NY 10166
United Health Care
5901 Lincoln Drive
Minneapolis, MN 55436

If you have questions about claims, you may contact your insurer, HMO or administrator at the following numbers:

CIGNA – 800-237-2904
MetLife – 888-622-6616
United Health Care – 866-931-0070

## SCHEDULE 2

## Benefit Programs Available for Eligible Retired Employees at Closed/Divested Locations

| **Location You Retired From** | **Available Medical Program** | | | **Other Available Benefit Programs** | | |
|---|---|---|---|---|---|---|
| *Not all Programs are available for all groups of retirees.* | Pre-Medicare** | Medicare Supplement* | Rx Program | Dental Program | Vision Program | Life Insurance Program |
| Ballwin/Washington MO | N/A | CIGNA Indemnity | N | N | N | Y |
| Blytheville, AR | CIGNA Indemnity | Retiree Reimbursement Account | Included in Pre-Medicare Health Plan Only | N | N | Y |
| Buffalo, NY/Springfield, OH/Chester, SC - Kuhlman/Snyder Fuel Tanks | N/A | Retiree Reimbursement Account | N | N | N | Y |
| Byron, IL - Westran | N/A | Retiree Reimbursement | N | N | N | Y |
| Cary, NC | N/A | Retiree Reimbursement | N | N | N | Y |
| Chicago, IL HQ | CIGNA Choice Health Fund | Retiree Reimbursement Account | Included in Pre-Medicare Health Plan Only | N | N | Y |
| Chicago, IL - Borg & Beck Clutch (Hourly) | Cigna Indemnity | CIGNA Indemnity | Y | Y | Y | Y |
| Chicago, IL - Borg & Beck (Salary) | N/A | Retiree Reimbursement Account | N | N | N | Y |
| Chicago, IL - Ingersoll (Hourly) | N/A | Retiree Reimbursement | N | N | N | Y |
| Chicago, IL - Ingersoll (Salary) | N/A | Retiree Reimbursement | N | N | N | Y |
| Cleveland, OH - Pesco (Hrly & Slry) | N/A | CIGNA Major Med | N | N | N | Y |
| Coldwater, MI - Kuhlman Electric | N/A | Retiree Reimbursement | N | N | N | Y |

| Location You Retired From | Available Medical Program | | | Other Available Benefit Programs | | |
|---|---|---|---|---|---|---|
| *Not all Programs are available for all groups of retirees.* | Pre-Medicare** | Medicare Supplement* | Rx Program | Dental Program | Vision Program | Life Insurance Program |
| Decatur, IL - Climate Control | CIGNA Choice Health Fund | Retiree Reimbursement Account | Included in Pre-Medicare Health Plan Only | N | N | Y |
| Decatur, IL - Fuel Systems | N/A | Retiree Reimbursement | N | N | N | Y |
| Grand Rapids, MI/Charlotte, NC - Kysor Carolina Metals Fuel Tanks | N/A | Retiree Reimbursement Account | N | N | N | Y |
| Indianapolis, IN - Schwitzer (Hourly) | N/A | CIGNA Indemnity | Y | Y | N | Y |
| Indianapolis, IN - Schwitzer (Salary) | CIGNA Choice Health Fund | Retiree Reimbursement Account | Included in Pre-Medicare Health Plan Only | N | N | Y |
| Memphis, TN - Mechanics | N/A | CIGNA Indemnity | N | N | N | Y |
| Muncie, IN (Hourly retired prior to 1980) | N/A | Anthem (Individual policies held by retirees) | N | N | N | N |
| Muncie, IN (Hourly retired pre 11/1/1989) | N/A | Anthem Indemnity | Y | N | Y | Y |
| Muncie, IN (Hourly retired post 11/1/1989) | Anthem PPO/ Anthem | Retiree Reimbursement Account (retired by 2/1/2009) | Included in Pre-Medicare Health Plan Only | N | Y | Y |
| Muncie, IN Guards | N/A | Retiree Reimbursement | N | N | N | Y |
| Muncie, IN Salary | Anthem HRA | Retiree Reimbursement Account | Included in Pre-Medicare Health Plan Only | N | N | Y |
| New Bedford, MA - BWA New Bedford Plant | N | N | N | N | N | Y |

| Location You Retired From | Available Medical Program | | | Other Available Benefit Programs | | |
|---|---|---|---|---|---|---|
| *Not all Programs are available for all groups of retirees.* | Pre-Medicare** | Medicare Supplement* | Rx Program | Dental Program | Vision Program | Life Insurance Program |
| Rockford, IL - Rockford | CIGNA Choice Health Fund | Retiree Reimbursement Account | Included in Pre-Medicare Health Plan Only | N | N | Y |
| Rolla, MO - Schwitzer (US) Inc Rolla Plant (Hourly) | N/A | CIGNA Major Med | Y | N | N | Y |
| Savannah, GA - Kuhlman Execs | CIGNA Indemnity/ MERP | CIGNA Indemnity/ MERP | Y | Y | N | Y |
| Scottsburg, IN/White Pigeon, MI - Scott Fuel Tanks | N/A | Retiree Reimbursement Account | N | N | N | Y |
| Spring Lake/Rothbury MI - (Medallion) | CIGNA Choice Health Fund | Retiree Reimbursement Account | Included in Pre-Medicare Health Plan Only | N | N | Y |
| Sterling Heights, MI (Hourly) | CIGNA Indemnity/ HAP | CIGNA Indemnity/ HAP | Y | Midwest Dental/ CIGNA | CO-OP Optical | Y |
| Sterling Heights, MI (Salary) | CIGNA Choice Health Fund | Retiree Reimbursement Account | Included in Pre-Medicare Health Plan Only | N | N | Y |
| Toledo, OH - Marvel, Schebler, Tillotson Division, Toledo Facility | N | N | Y | N | N | Y |
| Wooster, OH - Hydraulics | N | CIGNA Indemnity | N | N | N | Y |

***You are required to enroll in Medicare A & B to participate in the Medicare Supplemental Health Plan & RRA coverage offered by BorgWarner.**

**** N = no plan available; N/A = no longer has pre-Medicare participants.**

**Funding of Benefits for Retired Employees at Closed/Divested Locations**

| Benefit Program | Funding | Insurer, HMO, Administrator |
|---|---|---|
| Medical Program, including prescription drug | 1. Self-Insured PPO Plan<br>2. Self- Insured High Deductible Health Plan with HRA<br>3. Self- Insured Indemnity Plan<br>4. Self- Insured Base Major Medical<br>5. Fully-Insured Medical Kuhlman Executive Retirement Plan<br>6. Fully-Insured HMO<br>7. Fully-Insured Indemnity Plan<br>8. Self- Insured Retiree Reimbursement Account (RRA) | 1. Anthem,<br>2. Anthem, CIGNA<br>3. CIGNA, Anthem<br>4. CIGNA<br>5. CIGNA<br>6. Health Alliance Plan<br>7. Anthem<br>8. United Healthcare |
| Dental Program | 1. Self- Insured Dental PPO<br>2. Insured Dental HMO | 1. CIGNA<br>2. Midwest Dental |
| Vision Program | 1. Self- Insured Vision Program<br>2. Insured Vision HMO | 1. CIGNA<br>2. CO-OP Optical |
| Life Insurance Program | Insured Group Term Life Plan | MetLife |

**Insurer, HMO, and Administrator Information**

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

Anthem Blue Cross Blue Shield
N17 W24340 Riverwood Drive
Waukesha, WI 53188

CIGNA
900 Cottage Grove Road
Bloomfield, CT 06002

Co-op Optical
2424 E. 8 Mile
Detroit, MI 48234

Health Alliance Plan
2850 W. Grand Boulevard
Detroit, MI 48202

MetLife
200 Park Avenue
New York, NY 10166
Midwest Dental
680 Hehli Way
P.O. Box 69
Mondovi, WI 54755

United Health Care
5901 Lincoln Drive
Minneapolis, MN 55436

If you have questions about claims, you may contact your insurer, HMO or administrator at the following numbers:

Anthem – 800-530-8481
CIGNA – 800-244-6224
Co-Op Optical – 313-369-3038
Health Alliance Plan – 313-872-8100
MetLife – 888-622-6616
Midwest Dental – 313-581-6824
United Health Care – 866-931-0070

## SCHEDULE 3

### Anthem Blue Cross Blue Shield Appeals Procedures

For purposes of these Appeal provisions, "claim for benefits" means a request for benefits under the plan. The term includes both pre-service and post-service claims.

- A pre-service claim is a claim for benefits under the plan for which you have not received the benefit or for which you may need to obtain approval in advance.

- A post-service claim is any other claim for benefits under the plan for which you have received the service.

If your claim is denied or if your coverage is rescinded:

- you will be provided with a written notice of the denial or rescission; and

- you are entitled to a full and fair review of the denial or rescission.

The procedure the Claims Administrator will satisfy following the minimum requirements for a full and fair review under applicable federal regulations.

### Notice of Adverse Benefit Determination

If your claim is denied, the Claims Administrator's notice of the adverse benefit determination (denial) will include:

- information sufficient to identify the claim involved
- the specific reason(s) for the denial;
- a reference to the specific plan provision(s) on which the Claims Administrator's determination is based;
- a description of any additional material or information needed to perfect your claim;
- an explanation of why the additional material or information is needed;
- a description of the plan's review procedures and the time limits that apply to them, including a statement of your right to bring a civil action under ERISA if you appeal and the claim denial is upheld;
- information about any internal rule, guideline, protocol, or other similar criterion relied upon in making the claim determination and about your

right to request a copy of it free of charge, along with a discussion of the claims denial decision; and

- information about the scientific or clinical judgment for any determination based on medical necessity or experimental treatment, or about your right to request this explanation free of charge, along with a discussion of the claims denial decision.

- the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman who may assist you

For claims involving urgent/concurrent care:

- the Claims Administrator's notice will also include a description of the applicable urgent/concurrent review process; and

- the Claims Administrator may notify you or your authorized representative within 24 hours orally and then furnish a written notification.

**Appeals**

You have the right to appeal an adverse benefit determination (claim denial or rescission of coverage). You or your authorized representative must file your appeal within 180 calendar days after you are notified of the denial or rescission. You will have the opportunity to submit written comments, documents, records, and other information supporting your claim. The Claims Administrator's review of your claim will take into account all information you submit, regardless of whether it was submitted or considered in the initial benefit determination.

- The Claims Administrator shall offer a single mandatory level of appeal and an additional voluntary second level of appeal which may be a panel review, independent review, or other process consistent with the entity reviewing the appeal. The time frame allowed for the Claims Administrator to complete its review is dependent upon the type of review involved (e.g. pre-service, concurrent, post-service, urgent, etc.).

**For pre-service claims involving urgent/concurrent care**, you may obtain an expedited appeal. You or your authorized representative may request it orally or in writing. All necessary information, including the Claims Administrator's decision, can be sent between the Claims Administrator and you by telephone, facsimile or other similar method. To file an appeal for a claim involving urgent/concurrent care, you or your authorized representative must contact the Claims Administrator at [the number shown on your identification card] and provide at least the following information:

- the identity of the claimant;

- The date (s) of the medical service;

- the specific medical condition or symptom;
- the provider's name
- the service or supply for which approval of benefits was sought; and
- any reasons why the appeal should be processed on a more expedited basis.

**All other requests for appeals** should be submitted in writing by the Member or the Member's authorized representative, except where the acceptance of oral appeals is otherwise required by the nature of the appeal (e.g. urgent care). You or your authorized representative must submit a request for review to:

Anthem Blue Cross and Blue Shield
ATTN: Appeals
P.O. Box 33200
Louisville, Kentucky 40232-3200

Upon request, the Claims Administrator will provide, without charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim. "Relevant" means that the document, record, or other information:

- was relied on in making the benefit determination; or
- was submitted, considered, or produced in the course of making the benefit determination; or
- demonstrates compliance with processes and safeguards to ensure that claim determinations are made in accordance with the terms of the plan, applied consistently for similarly-situated claimants; or
- is a statement of the plan's policy or guidance about the treatment or benefit relative to your diagnosis.

The Claims Administrator will also provide you, free of charge, with any new or additional evidence considered, relied upon, or generated in connection with your claim. In addition, before you receive an adverse benefit determination on review based on a new or additional rationale, the Claims Administrator will provide you, free of charge, with the rationale.

**How Your Appeal will be Decided**

When the Claims Administrator considers your appeal, the Claims Administrator will not rely upon the initial benefit determination or, for voluntary second-level appeals, to the earlier appeal determination. The review will be conducted by an appropriate reviewer who did not make the initial determination and who does not work for the person who made the initial determination. A voluntary second-level review will be

conducted by an appropriate reviewer who did not make the initial determination or the first-level appeal determination and who does not work for the person who made the initial determination or first-level appeal determination.

If the denial was based in whole or in part on a medical judgment, including whether the treatment is experimental, investigational, or not medically necessary, the reviewer will consult with a health care professional who has the appropriate training and experience in the medical field involved in making the judgment. This health care professional will not be one who was consulted in making an earlier determination or who works for one who was consulted in making an earlier determination.

**Notification of the Outcome of the Appeal**

**If you appeal a claim involving urgent/concurrent care**, the Claims Administrator will notify you of the outcome of the appeal as soon as possible, but not later than 72 hours after receipt of your request for appeal.

**If you appeal any other pre-service claim**, the Claims Administrator will notify you of the outcome of the appeal within 30 days after receipt of your request for appeal

**If you appeal a post-service claim**, the Claims Administrator will notify you of the outcome of the appeal within 60 days after receipt of your request for appeal.

**Appeal Denial**

- If your appeal is denied, that denial will be considered an adverse benefit determination. The notification from the Claims Administrator will include all of the information set forth in the above section entitled “Notice of Adverse Benefit Determination.”

**Voluntary Second Level Appeals**

If you are dissatisfied with the Plan’s mandatory first level appeal decision, a voluntary second level appeal may be available. If you would like to initiate a second level appeal, please write to the address listed above. Voluntary appeals must be submitted within 60 calendar days of the denial of the first level appeal. You are not required to complete a voluntary second level appeal prior to submitting a request for an independent External Review.

**External Review**

If the outcome of the mandatory first level appeal is adverse to you, you may be eligible for an independent External Review pursuant to federal law.

You must submit your request for External Review to the Claims Administrator within four (4) months of the notice of your final internal adverse determination.

A request for a External Review must be in writing unless the Claims Administrator determines that it is not reasonable to require a written statement. You do not have to

re-send the information that you submitted for internal appeal. However, you are encouraged to submit any additional information that you think is important for review.

For pre-service claims involving urgent/concurrent care, you may proceed with an Expedited External Review without filing an internal appeal or while simultaneously pursuing an expedited appeal through our internal appeal process. You or your authorized representative may request it orally or in writing. All necessary information, including the Claims Administrator's decision, can be sent between the Claims Administrator and you by telephone, facsimile or other similar method. To proceed with an Expedited External Review, you or your authorized representative must contact the Claims Administrator at [the number shown on your identification card] and provide at least the following information:

- the identity of the claimant;
- The date (s) of the medical service;
- the specific medical condition or symptom;
- the provider's name
- the service or supply for which approval of benefits was sought; and
- any reasons why the appeal should be processed on a more expedited basis.

All other requests for External Review should be submitted in writing unless the Claims Administrator determines that it is not reasonable to require a written statement. Such requests should be submitted by you or your authorized representative to:

Anthem Blue Cross and Blue Shield
ATTN: Appeals
P.O. Box 33200
Louisville, Kentucky 40232-3200

This is not an additional step that you must take in order to fulfill your appeal procedure obligations described above. Your decision to seek External Review will not affect your rights to any other benefits under this health care plan. There is no charge for you to initiate an independent External Review. The External Review decision is final and binding on all parties except for any relief available through applicable state laws or ERISA.

**Requirement to file an Appeal before filing a lawsuit**

No lawsuit or legal action of any kind related to a benefit decision may be filed by you in a court of law or in any other forum, unless it is commenced within three years of the Plan's final decision on the claim or other request for benefits. If the Plan decides an appeal is untimely, the Plan's latest decision on the merits of the underlying claim or

benefit request is the final decision date. You must exhaust the Plan's internal Appeals Procedure but not including any voluntary level of appeal, before filing a lawsuit or taking other legal action of any kind against the Plan. If your health benefit plan is sponsored by your employer and subject to the Employee Retirement Income Security Act of 1974 (ERISA) and your appeal as described above results in an adverse benefit determination, you have a right to bring a civil action under Section 502(a) of ERISA.

**We reserve the right to modify the policies, procedures and timeframes in this section upon further clarification from Department of Health and Human Services and Department of Labor.**

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