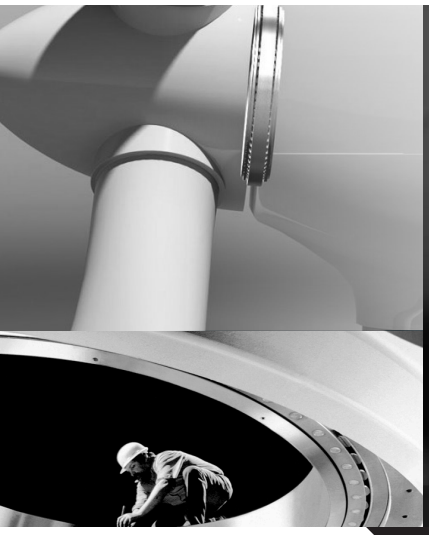
SCHAEFFLER



SUMMARY OF MATERIAL MODIFICATIONS TO THE SCHAEFFLER GROUP HEALTH AND WELFARE PLAN

EFFECTIVE AS OF JANUARY 1, 2016

This document — called a Summary of Material Modifications (SMM) — updates the Summary Plan Description ("SPD") for the Schaeffler Group Health and Welfare Plan (the "Plan"). It describes the recently announced changes to your health care benefits.

The changes described in this SMM affect the information provided in the Plan's SPD dated January 1, 2013, as updated by the SMM dated January 1, 2014 (the "2014 SMM"). This SMM summarizes the changes by topic. The changes are effective as of January 1, 2016.

Dear Schaeffler Employee:

Enclosed is a Summary of Material Modifications, Premium Assistance Under Medicaid and The Children's Health Insurance Program (CHIP) Notice, Women's Health & Cancer Rights Act Notice, Summary of Benefits and Coverage Notice and 401k Safe Harbor Notice. Although this material duplicates information we have provided online we are required by law to provide you with this information in written form.

Private employers are facing increased challenges in offering medical coverage including the Affordable Care Act, which has introduced complex reporting requirements. In 2016, large employers will be required to issue an IRS Form 1095C entitled "Employer-Provided Health Insurance Offer and Coverage" to all associates as well as file reports with the IRS detailing individual coverage. Additional reporting requirements have not assisted us in our goal to maintain high quality medical coverage which is affordable over the long term. Schaeffler's actions such as introduction of the Consumer Driven Health Plan and ADP Portal are designed to support meeting our goal.

Additional information is available on the ADP Portal (https://portal.adp.com) or by speaking with a member of your Human Resources team.

Sincerely,

David McMaster
Director – Human Resources – Shared Services

LuK INA FAG

CHANGES TO ADMINISTRATIVE SECTIONS

ENROLLMENT UPON REHIRE

If you terminate employment and are later rehired, when and how you may re-enroll for benefits under the Plan varies depending on how long you were gone. The Enrollment provisions for rehires at page 5 of the SPD (as updated by the 2014 SMM) are revised to read as follows:

Rehires: If you terminate employment with Schaeffler and are later rehired, what happens to your benefit elections varies depending on whether you had completed the one-month waiting period and how long you were gone.

Employees who had completed the one-month waiting period prior to employment termination:

- If you are rehired within 30 days of your termination, your most recent benefit elections (including an election to waive participation) will be reinstated as of your rehire date. You may not make any changes to your elections.
- If you are rehired more than 30 days after your termination, you will be treated as a new hire subject to a new one-month waiting period. Once you satisfy the one-month waiting period, you will be able to make new elections for any benefits for which you are eligible.

Employees who did not complete the one-month waiting period prior to employment termination:

- If you are rehired, you will be treated as a new hire subject to a new one-month waiting period. Once you satisfy the one-month waiting period, you will be able to make elections for any benefits for which you are eligible.

CHANGES TO MEDICAL PLAN

CONSUMER DRIVEN HEALTH PLAN (CDHP) – NEW OPTION UNDER THE MEDICAL PLAN

Effective as of January 1, 2016, the Medical Plan will offer an additional option—a Consumer Driven Health Plan (CDHP). To reflect this additional option, pages 11-21 of the Medical Plan section of SPD are deleted in their entirety and replaced with the following:

MEDICAL PLAN

Employees at locations other than Joplin, Missouri are eligible for the BCBS Plan, and employees at Joplin, Missouri are eligible for the FMH Plan. BlueCross BlueShield of South Carolina ("BCBS") is the third party administrator for the BCBS Plan, and FMH CoreSource ("FMH") is the third party administrator for the FMH Plan.

The BCBS Plan offers Plan I and Plan II, which are traditional preferred provider organization plans (PPOs) using the BCBS provider network. The FMH Plan also offers Plan I and Plan II, which mirror the BCBS plan, but using the FMH CoreSource provider network.

Effective as of January 1, 2016, all employees also will have a third plan option -- a consumer driven health plan ("CDHP"), which is a high deductible PPO administered by BCBS.

COMPARING TRADITIONAL PPOS (PLAN I AND PLAN II) AND CDHP

When you enroll in traditional preferred provider organization plans (PPOs) such as Plan I and Plan II, you pay monthly premiums in exchange for lower deductibles and copays for covered services. Preventive services are covered at 100% by law. In essence, then, in a PPO you are buying "insurance" to ensure that you will have the negotiated coverage in place should you need medical services —even though you may end up not needing services at all beyond preventive services.

By contrast, when you enroll in the CDHP, your monthly premiums will be lower in exchange for a higher annual deductible. Preventive care is covered at 100%, just like the traditional PPO plans. But, under the CDHP, you are responsible for the full cost of non-preventive medical services until you meet the deductible for the year. However—and this is key—that's only if you need non-preventive services. If you don't, you will not have spent higher premiums to ensure that you have coverage that you did not use. And, the CDHP pays covered services at 100% after you meet the deductible for a year. Please see the *Schedule of Benefits* for a listing of deductibles, out-of-pocket maximums and covered services under the CDHP. (The 2016 *Schedule of Benefits* is at Appendix A of this SMM).

To help you meet out-of-pocket expenses, the CDHP comes with a health savings account—or HSA, which is your personal health care savings plan. It enables you to set aside pre-tax dollars through payroll deductions to help cover "qualified health care expenses," as defined by IRS Code, Section 213(d). In addition, Schaeffler may contribute funds to your HSA each year.

HOW HSAs WORKS

An HSA puts health care spending in your hands. With lower premiums to pay for coverage, you choose how to spend your health care dollars. You can either pay for health care expenses by using funds in your HSA, or you can pay for them out of pocket. You can only use HSA funds as they are deposited in your account. You can always reimburse yourself later once you have accumulated sufficient funds in your HSA.

HOW HSAS ARE FUNDED

There are a couple of ways you can contribute funds to your HSA:

- Pre-tax through salary reduction contributions you elect under the Schaeffler cafeteria plan. You can elect to start or stop these contributions at any time.
- After-tax contributions that you make and that are deductible when you file your taxes

Schaeffler also may contribute to your HSA. In 2016, Schaeffler will contribute the following amount to employees who enroll in the CDHP and have established an HSA at January 5, 2016 for January contributions and April 5, 2016 for April contributions:

- $400 for single coverage
- $800 for employee + spouse and employee + child(ren) coverage
- $1,200 for family coverage

Schaeffler will make its contribution in two installments: 25% in January and the remaining 75% in April. You must have actually established your HSA at date outlined in prior paragraph and be

enrolled in the CDHP on those dates to be eligible to receive the corresponding installment. For new hires, Schaeffler's contribution will be prorated based on the date they enroll in the CDHP.

For 2016, the IRS contribution limit for HSAs is $3,350 for self-only coverage and $6,750 for family coverage. If you are (or will be) age 55 or over during 2016, you are eligible to make additional catch-up contributions of up to $1,000 for the year. The combined total of Schaeffler's contribution plus your own salary reduction or other contributions cannot exceed the applicable IRS limit.

YOU ARE THE HSA OWNER

You are the owner of your HSA. Under IRS rules, you are eligible to establish an HSA only if you are:

- Enrolled in a qualified high deductible health plan
- Not covered by any other health plan that is not a high deductible health plan,[1]
- Not enrolled in Medicare, and
- Not a dependent on another person's tax return.

1"Other health plan that is not a high deductible plan" includes a health care FSA. As a result, if you have an FSA with a balance at the end of 2015, you will be ineligible to establish and contribute to an HSA until at least April 1, 2016 (the first of the month after the FSA's grace period expires), even if you are enrolled in the CDHP.

As to owner of the HSA, you are responsible for ensuring that contributions to your account do not exceed the applicable limit. Schaeffler is only responsible for determining whether you are covered under the CDHP and your age for catch-up eligibility.

As the HSA owner, you also are solely responsible for ensuring that distributions from your HSA are for qualified health care expenses, so they can be tax-free. Funds not used for qualified expenses are taxable and subject to penalties.

IMPORTANT: Schaeffler is not the sponsor of the HSAs and is not responsible for ensuring that distributions meet IRS guidelines. You should consult your own personal financial advisor with any questions about the tax implications of establishing an HSA, taking withdrawals and filing your tax returns.

USING NETWORK AND NON-NETWORK PROVIDERS

The BCBS Plan has a network of health care providers who have contracted with BCBS to provide discounted fees to Members. As a Member, you have the freedom to choose either a Network Provider or a Non-Network provider each time you require medical care. When you use a Network Provider, you generally have lower out-of-pocket expenses – because your benefit will be based on the negotiated fee. When you use a non-network provider, you generally pay a greater portion of the total cost – because you do not receive the advantage of negotiated fees, and you will be responsible for any charges above the Plan's Allowable Charge.

Specific coverage percentages for In-Network and Non-Network Providers are listed in the Schedule of Benefits below. You will receive the maximum benefits that can be paid if you use Network Provider and if you get Pre-Authorization, when required, before getting medical care. The amount you have to pay for services and supplies will increase when you do not use Network Providers and may further increase if you do not get Pre-Authorization.

You can access a BCBS **Provider Directory** that is updated nightly on the BCBS Web site at www.SouthCarolinaBlues.com. If you cannot find the information you want on the Web site, you can use the feature **"Ask Customer Service"** to get a response from a BCBS representative. You also can call BCBS Customer Service at the number listed on your ID Card.

COPAYS FOR PHYSICIAN OFFICE VISITS – PPO PLAN I

The Copays for Physician's office visits under Plan I have changed. Accordingly, the "Physician Services in the office" section of the Schedule of Benefits (as revised by the 2014 SMM) is changed to indicate that the Copay for office visits is $25 and $50 for Specialist office visits. For the complete *Schedule of Benefits*, see Appendix A at the end of this SMM.

CHANGES TO PRESCRIPTION DRUG COVERAGE

NEW COPAYS/NEW PRESCRIPTION DRUG CATEGORY

Copays for covered prescription drugs under the Specialty/Biotech category have changed. In addition, "Preventive Drugs" are added as a new category. If you incur expenses for a prescription drug on the Generics Only Preventive Therapy Drugs List, the Plan will pay benefits as listed below. The current Generics Only Preventive Therapy Drugs List is available at https://portal.adp.com. Please note that the list is subject to changes from time to time, so make sure to check it periodically. The Generics Only Preventive Therapy Drugs List constitutes a part of the Plan and its terms and conditions are incorporated in the SPD by this reference.

To reflect the above changes, the Schedule of Benefits for Prescription Drugs (as updated by the 2014 SMM) is revised as follows effective as of January 1, 2016:

Retail Pharmacy Program (In-Network only; Non-Network not covered)			
When to use it	For immediate prescription needs or short-term medicines		
Quantity Limit	Up to a 30 day supply		
	Plan I	**Plan II**	**CDHP**
Generic Preventive	$10 Copay	$10 Copay	Deductible waived; Plan pays 80%
Generic Non-Preventive	$10 Copay	$10 Copay	Subject to deductible; then Plan pays 100%
Preferred Brand	$30 Copay	$30 Copay	Subject to deductible; then Plan pays 100%
Non-preferred brand	$50 Copay	$50 Copay	Subject to deductible; then Plan pays 100%
Specialty/Biotech	$100 Copay	$100 Copay	Subject to deductible; then Plan pays 100%

Mail Service Program (In-Network only; Non-Network not covered)			
When to use it	For long-term maintenance medicines		
Quantity Limit	Up to a 90 day supply (except Specialty/Biotech)		
	Plan I	**Plan II**	**CDHP**
Generic Preventive	$20 Copay	$20 Copay	Deductible waived; Plan pays 80%
Generic Non-Preventive	$20 Copay	$20 Copay	Subject to deductible; then Plan pays 100%
Preferred Brand	$60 Copay	$60 Copay	Subject to deductible; then Plan pays 100%
Non-preferred brand	$100 Copay	$100 Copay	Subject to deductible; then Plan pays 100%

This SMM should be read in conjunction with the SPD dated January 1, 2013 (the "2013 SPD"). With respect to the items it addresses, this SMM supersedes and replaces any prior communications, policies, rules, practices, standards and/or guidelines to the contrary, whether written or oral.

Schaeffler Group USA, Inc. reserves the right to modify, suspend or terminate the component plans under the Plan at any time, without prior notice, except as required by law. Schaeffler also retains the discretion to interpret any terms or language used in the Plan documents, the 2013 SPD or this SMM. If there is any discrepancy between the information in the 2013 SPD, as updated by this SMM, and the terms of the official plan documents, the official Plan documents govern.

Please keep this document with your copy of the 2013 SPD until a new SPD is issued and with your other Schaeffler benefit plan materials so that you have up-to-date materials on your benefit plans. If you have any questions, please call the Benefits Department at 803-548-8500.

GENERAL PROVISIONS

Benefits listed in the Schedule of Benefits that have a dollar or percentage amount will be provided subject to all terms and conditions of the BCBS Plan (see, in particular, the "Benefits," "Exclusions and Limitations" and "Definitions" sections below). When a Benefit has a "Non-Covered" notation associated with it, the Benefit is not available to Members. All Benefits are subject to the dollar or percentage amount limitation specified in this Schedule of Benefits.

Annual Deductibles and any Copayments must be met before any Covered Expenses can be paid.

Pre-Authorization is required for:

- All Admissions
- The following inpatient services/procedures: Benefits in a hospital during an Admission, room and board during an Admission; inpatient physical rehabilitation services, skilled nursing facility Admissions, long term acute care hospital, cancer therapy, respiration therapy, inpatient mental health and substance abuse services, and oxygen.
- The following outpatient procedures: Chemotherapy or radiation therapy (one time notification), hysterectomy, septoplasty, sclerotherapy, all cosmetic surgery procedures, Investigational procedures, hospice care, home health care, human organ transplant, durable medical equipment over $500 and physical rehabilitation.

Penalty for failure to obtain Pre-Authorization. If advance approval is not obtained for In-Network or Non-Network Benefits that require Pre-Authorization, the Benefit payable will be reduced by 50% up to $1,000.

SCHEDULE OF BENEFITS

	Plan I		**Plan II**		**CDHP**	
	In-Network	**Non-Network**	**In-Network**	**Non-Network**	**In-Network**	**Non-Network**
Annual Deductible[1] • per person • per family	 $500 $1,000	 $1,000 $2,000	 $1,000 $2,000	 $1,500 $3,000	 $2,500[3] $5,000	 $5,000[3] $10,000
Annual Out-of-Pocket Maximum[2] • per person • per family	 $2,500 $5,000	 $5,000 $10,000	 $2,500 $5,000	 $5,000 $10,000	 $2,500[3] $5,000	 $5,000[3] $10,000
Annual Dollar Limit on Benefits	Unlimited		Unlimited		Unlimited	

[1]Amounts paid toward the In-Network Deductible also count toward the Non-Network Deductible and vice versa.

[2]Amounts paid toward the In-Network Out-of-Pocket Maximum also apply toward the Non-Network Out-of-Pocket Maximum and vice versa. All Covered Expenses incurred will contribute to the Out-of-Pocket Maximum. Allowable Charges are paid at 100% after the Out-of-Pocket Maximum is met.

[3]The CDHP does not have an embedded individual limit. Any one member (or combination of members) covered under Employee + Spouse, Employee + Child or Family must reach the full in-network deductible of $5,000 or out-of-network deductible of $10,000 before the plan pays.

INPATIENT BENEFITS/ADMISSIONS OTHER THAN MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES						
	Plan I		**Plan II**		**CDHP**	
	In-Network	**Non-Network**	**In-Network**	**Non-Network**	**In-Network**	**Non-Network**
Hospital room and board (Pre-Authorization is required)	Plan pays 80%* after Deductible	Plan pays 60%** after Deductible	Plan pays 80%* after Deductible	Plan pays 60%** after Deductible	Plan pays 100%* after Deductible	Plan pays 100%** after Deductible
All other Hospital Benefits during an Admission (such as, facility charges related to the administration of anesthesia, obstetrical services including labor and delivery rooms, drugs, medicine, lab and x-ray services) (Pre-Authorization is required)	Plan pays 80%* after Deductible	Plan pays 60%** after Deductible	Plan pays 80%* after Deductible	Plan pays 60%** after Deductible	Plan pays 100%* after Deductible	Plan pays 100%** after Deductible
Inpatient Physical Rehabilitation services covered only if pre-authorized and performed by BCBS-designated Provider (Pre-Authorization is required)	Plan pays 80%* after Deductible	Plan pays 60%** after Deductible	Plan pays 80%* after Deductible	Plan pays 60%** after Deductible	Plan pays 100%* after Deductible	Plan pays 100%** after Deductible
Skilled Nursing Facility Admissions Limited to 60 days per calendar year (Pre-Authorization is required)	Plan pays 80%* after Deductible	Plan pays 60%** after Deductible	Plan pays 80%* after Deductible	Plan pays 60%** after Deductible	Plan pays 100%* after Deductible	Plan pays 100%** after Deductible

OUTPATIENT BENEFITS OTHER THAN MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES						
	Plan I		**Plan II**		**CDHP**	
	In-Network	**Non-Network**	**In-Network**	**Non-Network**	**In-Network**	**Non-Network**
Hospital and Ambulatory Surgical Center for covered Benefits provided on an outpatient basis, including: lab, x-ray and other diagnostic services	Plan pays 80%* after $50 Copayment	Plan pays 60%** after $100 Copayment	Plan pays 80%* after Deductible	Plan pays 60%** after Deductible	Plan pays 100%* after Deductible	Plan pays 100%** after Deductible
True Emergency Room Visits	Plan pays 80%* after $100 Copayment (Waived if admitted)	Plan pays 80%** after $100 Copayment (Waived if admitted)	Plan pays 80%* after Deductible	Plan pays 80%** after Deductible	Plan pays 100%* after Deductible	Plan pays 100%** after Deductible
Non-true Emergency Room Visits	Plan pays 80%* after $100 Copayment (Waived if admitted)	Plan pays 80%** after $100 Copayment (Waived if admitted)	Plan pays 80%* after Deductible	Plan pays 60%** after Deductible	Plan pays 100%* after Deductible	Plan pays 100%** after Deductible
Elective Sterilization Procedures (including tubal ligations and vasectomies)	Plan pays 80%* after $50 Copayment	Plan pays 60%** after $100 Copayment	Plan pays 80%* after Deductible	Plan pays 60%** after Deductible	Plan pays 100%* after Deductible	Plan pays 100%** after Deductible
Other covered outpatient Benefits	Plan pays 80%* after $50 Copayment	Plan pays 60%** after $100 Copayment	Plan pays 80%* after Deductible	Plan pays 60%** after Deductible	Plan pays 100%* after Deductible	Plan pays 100%** after Deductible

**Plan percentage is based on negotiated rate with In-Network Provider. Member pays remaining percentage.*
***Plan percentage is based on the Allowable Charge (for Non-Network Providers, the amount determined by BCBS as provided under definition of "Allowable Charge"). Member pays balance of the Provider's charge.*

PHYSICIAN SERVICES OTHER THAN MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES						
	Plan I		**Plan II**		**CDHP**	
	In-Network	**Non-Network**	**In-Network**	**Non-Network**	**In-Network**	**Non-Network**
Physician Services in a Hospital	Plan pays 80%* after Deductible	Plan pays 60%** after Deductible	Plan pays 80%* after Deductible	Plan pays 60%** after Deductible	Plan pays 100%* after Deductible	Plan pays 100%** after Deductible
Physician charges for Emergency Room Services	Plan pays 80%*	Plan pays 80%**	Plan pays 80%*	Plan pays 80%**	Plan pays 100%* after Deductible	Plan pays 100%** after Deductible
Physician charges for Anesthesiology, Radiology and Pathology	Plan pays 80%* after Deductible	Plan pays 60%** after Deductible	Plan pays 80%* after Deductible	Plan pays 60%** after Deductible (80%** if provided by Non-Network Provider in Network Facility)	Plan pays 100%* after Deductible	Plan pays 100%** after Deductible
Physician Surgical Services when rendered in a Hospital	Plan pays 80%* after Deductible	Plan pays 60%** after Deductible	Plan pays 80%* after Deductible	Plan pays 60%** after Deductible	Plan pays 100%* after Deductible	Plan pays 100%** after Deductible
Physician Services for outpatient treatment in Hospital outpatient department or Ambulatory Surgical Center	Plan pays 80%*	Plan pays 60%**	Plan pays 80%* after Deductible	Plan pays 60%** after Deductible	Plan pays 100%* after Deductible	Plan pays 100%** after Deductible
Physician Services in office (includes contraceptives and birth control (but excluding Surgical Services, Mental Health Services, maternity care, Substance Abuse Services, physical therapy, dialysis treatment and second surgical opinion). Contraceptives and birth control devices covered per PPACA guidelines are paid at 100% at In-Network Providers. **NO** benefits are payable at Non-Network providers.	Plan pays 100%* after $25 Copayment; $50 Copayment for Specialist	Plan pays 60%** after Deductible (80%** if provided by Non-Network Provider at In-Network facility)	Plan pays 80%* after Deductible	Plan pays 60%** after Deductible (80%** if provided by Non-Network Provider at In-Network facility)	Plan pays 100%* after Deductible	Plan pays 100%** after Deductible
Physician charges for Maternity Care (Initial Visit)	Plan pays 100%* after $25 Copayment	Plan pays 60%** after Deductible	Plan pays 80%* after Deductible	Plan pays 60%** after Deductible	Plan pays 100%* after Deductible	Plan pays 100%** after Deductible
Physician Services in Member's home	Plan pays 80%*	Plan pays 60%**	Plan pays 80%* after Deductible	Plan pays 60%** after Deductible	Plan pays 100%* after Deductible	Plan pays 100%** after Deductible
Second surgical opinion	Plan pays 100%* after $50 Copayment	Plan pays 60%** after Deductible	Plan pays 80%* after Deductible	Plan pays 60%** after Deductible	Plan pays 100%* after Deductible	Plan pays 100%** after Deductible
Physicians charges for oral surgery	Plan pays 100%* after $50 Copayment	Plan pays 100%** after $50 Copayment	Plan pays 80%* after Deductible	Plan pays 80%** after Deductible	Plan pays 100%* after Deductible	Plan pays 100%** after Deductible
All other Physician Services	Plan pays 80%* after Deductible	Plan pays 60%** after Deductible	Plan pays 80%* after Deductible	Plan pays 60%** after Deductible	Plan pays 100%* after Deductible	Plan pays 100%** after Deductible

**Plan percentage is based on negotiated rate with In-Network Provider. Member pays remaining percentage.*
***Plan percentage is based on the Allowable Charge (for Non-Network Providers, the amount determined by BCBS as provided under definition of "Allowable Charge"). Member pays balance of the Provider's charge.*

MENTAL HEALTH SERVICES AND SUBSTANCE ABUSE SERVICES Pre-Authorization is required for inpatient Mental Health Services and Substance Abuse Services. Penalty for Failure to obtain Pre-Authorization. If advance approval is not obtained for In-Network and/or Non-Network services that require Pre-Authorization, the amount payable will be reduced by 50% up to $1,000.						
	Plan I		Plan II		CDHP	
	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network
Inpatient Hospital charges for Mental Health Services and Substance Abuse Services (Pre-Authorization is required)	Plan pays 80%* after Deductible	Plan pays 60%** after Deductible	Plan pays 80%* after Deductible	Plan pays 60%** after Deductible	Plan pays 100%* after Deductible	Plan pays 100%** after Deductible
Outpatient Hospital or clinic charges for Mental Health Services and Substance Abuse Services	Plan pays 80%* after Deductible	Plan pays 60%** after Deductible	Plan pays 80%* after Deductible	Plan pays 60%** after Deductible	Plan pays 100%* after Deductible	Plan pays 100%** after Deductible
Inpatient Physician charges for Mental Health Services and Substance Abuse Services	Plan pays 80%* after Deductible	Plan pays 60%** after Deductible	Plan pays 80%* after Deductible	Plan pays 60%** after Deductible	Plan pays 100%* after Deductible	Plan pays 100%** after Deductible
Outpatient or Office Physician charges for Mental Health Services and Substance Abuse Services	Plan pays 80%* after Deductible	Plan pays 60%** after Deductible	Plan pays 80%* after Deductible	Plan pays 60%** after Deductible	Plan pays 100%* after Deductible	Plan pays 100%** after Deductible
Emergency Room Services (Outpatient Hospital & Physician Charges) for Mental Health Services and Substance Abuse Services	Plan pays 80%* after Deductible	Plan pays 60%** after Deductible	Plan pays 80%* after Deductible	Plan pays 60%** after Deductible	Plan pays 100%* after Deductible	Plan pays 100%** after Deductible

ORGAN AND TISSUE TRANSPLANTS						
	Plan I		Plan II		CDHP	
	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network
Human organ and tissue transplant services (excluding drugs) Covered only if provided at a transplant center approved by BCBS in writing. Physician Charges are subject to Deductible. (Pre-Authorization is required)	Plan pays 80%* after Deductible	Plan pays 60%** after Deductible	Plan pays 80%* after Deductible	Plan pays 60%** after Deductible	Plan pays 100%* after Deductible	Plan pays 100%** after Deductible

ORGAN AND TISSUE TRANSPLANTS AT BLUE QUALITY CENTER OF EXCELLENCE			
	Plan I	Plan II	CDHP
Human organ and tissue transplant services at a Blue Quality Center of Excellence. Covered only if provided at a Blue Quality Center of Excellence approved by BCBS in writing. Physician Charges are subject to Deductible. (Pre-Authorization is required)	Plan pays 100%* after Deductible Covers transportation to and from transplant site, lodging and necessary living expenses up to $100/day while at transplant site for patient and one companion (spouse, family member, guarding or dependent). Necessary expenses do not include childcare, house sitting charges, kennel boarding or reimbursement of lost wages.		

**Plan percentage is based on negotiated rate with In-Network Provider. Member pays remaining percentage.*
***Plan percentage is based on the Allowable Charge (for Non-Network Providers, the amount determined by BCBS as provided under definition of "Allowable Charge"). Member pays balance of the Provider's charge.*

PREVENTIVE CARE SERVICES						
	Plan I		Plan II		CDHP	
	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network
Preventive Care Services as defined under Health Care Reform legislation (Refer to www.healthcare.gov for guidelines). **FOR ADULTS, includes:** - Abdominal aortic aneurysm one-time screening for men age 65-75 who have smoked - Blood pressure screening - Cholesterol screening at certain ages or if at higher risk - Colorectal cancer screening (age 50) - Depression screening - Type 2 diabetes screening if have high blood pressure - Diet counseling if at higher risk for chronic disease - HIV screening if at higher risk - Immunizations as recommended by Advisory Committee on Immunization Practices of CDC - Obesity screening - Tobacco use screening and interventions - Syphilis screening if at higher risk	Plan pays 100% Deductible does not apply	Non-Covered	Plan pays 100% Deductible does not apply	Non-covered	Plan pays 100% Deductible does not apply	Non-covered

**Plan percentage is based on negotiated rate with In-Network Provider. Member pays remaining percentage.*
***Plan percentage is based on the Allowable Charge (for Non-Network Providers, the amount determined by BCBS as provided under definition of "Allowable Charge"). Member pays balance of the Provider's charge.*

PREVENTIVE CARE SERVICES						
	Plan I		Plan II		CDHP	
	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network
FOR WOMEN, includes: - Mammogram every 1 to 2 yrs. (over age 40) - FDA-approved contraceptive methods, sterilization procedures and education/counseling, but not abortifacient drugs - If sexually active: cervical cancer and HIV screening, STI counseling - If pregnant: anemia screening, bacteriuria urinary tract and other infection screening, folic acid supplements, gestational diabetes screening, hepatitis B screening, Rh incompatibility screening and follow up - Breastfeeding support and counseling for pregnant and nursing women - Breast cancer chemoprevention counseling for women at higher risk - BRCA counseling about genetic testing for women at higher risk - Chlamydia infection screening for younger women and other women at higher risk - Domestic and interpersonal violence screening - Gonorrhea screening for women at higher risk - HPV DNA test, every 3 yrs., for women with normal cytology results who are 30 or older - Osteoporosis screening (over age 60) depending on risk factors - Tobacco use screening and interventions - Well-woman visits to obtain preventive services	Plan pays 100% Deductible does not apply	Non-Covered	Plan pays 100% Deductible does not apply	Non-covered	Plan pays 100% Deductible does not apply	Non-covered

**Plan percentage is based on negotiated rate with In-Network Provider. Member pays remaining percentage.*
***Plan percentage is based on the Allowable Charge (for Non-Network Providers, the amount determined by BCBS as provided under definition of "Allowable Charge"). Member pays balance of the Provider's charge.*

PREVENTIVE CARE SERVICES						
	Plan I		Plan II		CDHP	
	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network
FOR CHILDREN, includes: - Alcohol and drug use assessments for adolescents - Autism screening, children 18-24 mos. - Behavioral assessments - Blood pressure screening - Cervical Dysplasia screening (for sexually active females - Congenital Hypothyroidism screening for newborns - Depression screening for adolescents - Dyslipidemia screening for children at higher risk - Fluoride chemoprevention supplements - Hearing screening for all newborns - Height, Weight and BMI measurements - Hematocrit or Hemoglobin screening - HIV screening for adolescents at higher risk - Immunization vaccines (to age 18) as recommended by Advisory Committee on Immunization Practices of CDC - Iron supplements for children 6-12 mos. at risk - Lead screening for children at risk of exposure - Obesity screening and counseling - PKU screening - Tuberculin testing if at higher risk - STI prevention counseling and screening for adolescents at higher risk - Vision screening	Plan pays 100% Deductible does not apply	Non-Covered	Plan pays 100% Deductible does not apply	Non-Covered	Plan pays 100% Deductible does not apply	Non-covered

**Plan percentage is based on negotiated rate with In-Network Provider. Member pays remaining percentage.*
***Plan percentage is based on the Allowable Charge (for Non-Network Providers, the amount determined by BCBS as provided under definition of "Allowable Charge"). Member pays balance of the Provider's charge.*

OTHER SERVICES						
	Plan I		Plan II		CDHP	
	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network
Ambulance service (including air ambulance)	Plan pays 80%* after Deductible	Plan pays 80%** after In-Network Deductible	Plan pays 80%* after Deductible	Plan pays 80%** after In-Network Deductible	Plan pays 100%* after Deductible	Plan pays 100%** after Deductible
Durable Medical Equipment, Prosthetics and Orthopedic Devices (Pre-Authorization is required if purchase or rental is $500 or more)	Plan pays 80%* after Deductible	Plan pays 60%** after Deductible	Plan pays 80%* after Deductible	Plan pays 60%** after Deductible	Plan pays 100%* after Deductible	Plan pays 100%** after Deductible
Medical Supplies	Plan pays 80%* after Deductible	Plan pays 60%** after Deductible	Plan pays 80%* after Deductible	Plan pays 60%** after Deductible	Plan pays 100%* after Deductible	Plan pays 100%** after Deductible
Home Health Care, Including private duty nursing 120 days/Calendar year Maximum (Pre-Authorization is required)	Plan pays 80%* after Deductible	Plan pays 60%** after Deductible	Plan pays 80%* after Deductible	Plan pays 60%** after Deductible	Plan pays 100%* after Deductible	Plan pays 100%** after Deductible
Habilitation and Rehabilitation Related to Physical Therapy and Occupational Therapy and Speech Therapy (See "Outpatient Rehabilitation" in Covered Benefits section of SPD for further applicable limitations (Pre-Authorization is required)	Plan pays 80%* after Deductible	Plan pays 60%** after Deductible	Plan pays 80%* after Deductible	Plan pays 60%** after Deductible	Plan pays 100%* after Deductible	Plan pays 100%** after Deductible
Hospice Care, 90 days/Lifetime Maximum. Pre-Authorization is required For Bereavement Counseling	Plan pays 100%*	Plan pays 100%**	Plan pays 100%*	Plan pays 100%**	Plan pays 100%* after Deductible	Plan pays 100%** after Deductible
Outpatient Rehabilitation Services (Includes Physical Therapy, Occupational Therapy and Speech Therapy) (Pre-Authorization is required)	Plan pays 80%* after Deductible	Plan pays 60%** after Deductible	Plan pays 80%* after Deductible	Plan pays 60%** after Deductible	Plan pays 100%* after Deductible	Plan pays 100%** after Deductible
Radiation therapy Cancer chemotherapy Respiratory therapy (Pre-Authorization is required)	Plan pays 80%* after Deductible	Plan pays 60%** after Deductible	Plan pays 80%* after Deductible	Plan pays 60%** after Deductible	Plan pays 100%* after Deductible	Plan pays 100%** after Deductible
Allergy Injections	Plan pays 100%* after $25 Copayment $50 Copay for Specialist	Plan pays 60%** after Deductible	Plan pays 80%* after Deductible	Plan pays 60%** after Deductible	Plan pays 100%* after Deductible	Plan pays 100%** after Deductible
Chiropractic Services Including the initial office visit	Plan pays 80%* after Deductible	Plan pays 60%** after Deductible	Plan pays 80%* after Deductible	Plan pays 60%** after Deductible	Plan pays 100%* after Deductible	Plan pays 100%** after Deductible
Diabetic Supplies	Plan pays 80%* after Deductible	Plan pays 80%** after Deductible	Plan pays 80%* after Deductible	Plan pays 80%** after Deductible	Plan pays 100%* after Deductible	Plan pays 100%** after Deductible
Oxygen (Pre-authorization is required)	Covered	Covered	Covered	Covered	Covered	Covered

**Plan percentage is based on negotiated rate with In-Network Provider. Member pays remaining percentage.*

***Plan percentage is based on the Allowable Charge (for Non-Network Providers, the amount determined by BCBS as provided under definition of "Allowable Charge"). Member pays balance of the Provider's charge.*

OTHER SERVICES						
	Plan I		Plan II		CDHP	
	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network
Temporomandibular Joint Disorder (TMJ) Surgical and Non-Surgical treatment	Plan pays 80%* after Deductible	Plan pays 60%** after Deductible	Plan pays 80%* after Deductible	Plan pays 60%** after Deductible	Plan pays 100%* after Deductible	Plan pays 100%** after Deductible
Retail Health Clinics	Plan pays 100%* after $25 Copayment	Plan pays 60%** after Deductible	Plan pays 80%* after Deductible	Plan pays 60%** after Deductible	Plan pays 100%* after Deductible	Plan pays 100%** after Deductible
Cosmetic Services	Non-Covered	Non-Covered	Non-Covered	Non-Covered	Non-Covered	Non-Covered
Disease Management Program	Covered	Non-Covered	Covered	Non-Covered	Covered	Non-Covered
Eyeglasses/Vision care	Non-Covered	Non-Covered	Non-Covered	Non-Covered	Non-Covered	Non-Covered
Health Questions Hotline	Covered	Non-Covered	Covered	Non-Covered	Covered	Non-Covered
Hearing Aids	Non-Covered	Non-Covered	Non-Covered	Non-Covered	Non-Covered	Non-Covered
Infertility treatment	Non-Covered	Non-Covered	Non-Covered	Non-Covered	Non-Covered	Non-Covered
Impotence treatment	Non-Covered	Non-Covered	Non-Covered	Non-Covered	Non-Covered	Non-Covered
Impacted tooth removal	Non-Covered	Non-Covered	Non-Covered	Non-Covered	Non-Covered	Non-Covered
Online Health Assessment Program	Covered	Non-Covered	Covered	Non-Covered	Covered	Non-Covered
Maternity Management Program	Covered	Non-Covered	Covered	Non-Covered	Covered	Non-Covered
Quit for Life Program (Covered for employee and spouse through the Company Wellness Program)	Non-Covered	Non-Covered	Non-Covered	Non-Covered	Non-Covered	Non-Covered
Orthognathic surgery	Non-Covered	Non-Covered	Non-Covered	Non-Covered	Non-Covered	Non-Covered
Weight Control Program	Non-Covered	Non-Covered	Non-Covered	Non-Covered	Non-Covered	Non-Covered
Acupuncture	Non-Covered	Non-Covered	Non-Covered	Non-Covered	Non-Covered	Non-Covered
Relationship Counseling	Non-Covered	Non-Covered	Non-Covered	Non-Covered	Non-Covered	Non-Covered
Obesity Services	Non-Covered	Non-Covered	Non-Covered	Non-Covered	Non-Covered	Non-Covered
Morbid Obesity Services	Non-Covered	Non-Covered	Non-Covered	Non-Covered	Non-Covered	Non-Covered
Massage Therapy	Non-Covered	Non-Covered	Non-Covered	Non-Covered	Non-Covered	Non-Covered

**Plan percentage is based on negotiated rate with In-Network Provider. Member pays remaining percentage.*
***Plan percentage is based on the Allowable Charge (for Non-Network Providers, the amount determined by BCBS as provided under definition of "Allowable Charge"). Member pays balance of the Provider's charge.*

Women's Health & Cancer Rights Act

MASTECTOMY NOTICE

The Schaeffler Group Health Plan provides medical and surgical benefits with respect to mastectomy.

In the case of a plan participant or beneficiary who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, the Plan will provide coverage for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedema.

This coverage will be provided in consultation with the patient and the attending physician and may be subject to the same annual deductible, coinsurance and/or copayment provisions otherwise applicable under the Plan. If you have any questions about coverage for mastectomies and post-operative reconstructive surgery, please contact the Human Resource Department or refer to your summary plan description.

Premium Assistance Under Medicaid and the

CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2015. Contact your State for more information on eligibility –

ALABAMA – Medicaid	KENTUCKY – Medicaid
Website: www.myalhipp.com Phone: 1-855-692-5447	Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570
ALASKA – Medicaid	LOUISIANA – Medicaid
Website:http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447
COLORADO – Medicaid	MAINE – Medicaid
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741
FLORIDA – Medicaid	MASSACHUSETTS – Medicaid and CHIP
Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268	Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120
GEORGIA – Medicaid	MINNESOTA – Medicaid
Website: http://dch.georgia.gov/ - Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 404-656-4507	Website: http://www.dhs.state.mn.us/id_006254 Click on Health Care, then Medical Assistance Phone: 1-800-657-3739
INDIANA – Medicaid	MISSOURI – Medicaid
Website: http://www.in.gov/fssa Phone: 1-800-889-9949	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
IOWA – Medicaid	MONTANA – Medicaid
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	Website: http://medicaid.mt.gov/member Phone: 1-800-694-3084
KANSAS – Medicaid	NEBRASKA – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884	Website: www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633

NEVADA – Medicaid	SOUTH CAROLINA – Medicaid
Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: http://www.scdhhs.gov Phone: 1-888-549-0820
NEW HAMPSHIRE – Medicaid	SOUTH DAKOTA - Medicaid
Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW JERSEY – Medicaid and CHIP	TEXAS – Medicaid
MedicaidWebsite:http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NEW YORK – Medicaid	UTAH – Medicaid and CHIP
Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-866-435-7414
NORTH CAROLINA – Medicaid	VERMONT– Medicaid
Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
NORTH DAKOTA – Medicaid	VIRGINIA – Medicaid and CHIP
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
OKLAHOMA – Medicaid and CHIP	WASHINGTON – Medicaid
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473
OREGON – Medicaid	WEST VIRGINIA – Medicaid
Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
PENNSYLVANIA – Medicaid	WISCONSIN – Medicaid and CHIP
Website:http://www.dhs.state.pa.us/hipp Phone: 1-800-692-7462	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
RHODE ISLAND – Medicaid	WYOMING – Medicaid
Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

To see if any other states have added a premium assistance program since July 31, 2015, or for more information on special enrollment rights, contact either:

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

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

OMB Control Number 1210-0137 (expires 10/31/2016)

401(k) Savings Investment Plan Safe Harbor Matching Contribution Notice

Schaeffler Group USA Inc. has elected to make "safe harbor" matching contributions to eligible participants in accordance with statutory requirements. This notice describes all contributions under the Plan, including the safe harbor matching contribution and how you become eligible to receive this contribution.

SAFE HARBOR MATCHING CONTRIBUTION

Schaeffler Group USA Inc. will make a safe harbor matching contribution to all eligible participants. To be eligible, you must also meet the Plan's age, Eligibility Service, and Entry Date requirements for making pretax contributions and be part of a class of employees eligible to participate in the Plan. You will be entitled to receive the safe harbor matching contribution if you make pretax contributions to the Plan during the Plan Year. You are not required to meet any other requirements such as working a specified number of hours of service during the Plan Year or be employed on the last day of the Plan Year.

AMOUNT OF SAFE HARBOR MATCHING CONTRIBUTION

Schaeffler Group USA Inc. will make a matching contribution to your account based on your pretax contributions in an amount equal to 100% of the first 6% of your compensation that you contribute to the Plan.

Example: Your compensation for the Plan Year is $30,000, and you contribute 6% ($1,800) to the Plan as pretax contributions. You will receive safe harbor matching contributions of $1,800 calculated as shown in the sample below.

Eligible compensation for computing your contributions and the safe harbor matching contribution is your taxable compensation for the Plan Year reportable by Schaeffler Group USA Inc. on your IRS Form W-2, including base pay, overtime, bonus, and shift differential and salary reduction contributions you made to an employer-sponsored cafeteria or 401(k) plan, but excluding reimbursements or other expense allowances, fringe benefits, moving expenses, deferred compensation, and welfare benefits. The percentage of compensation you defer is limited to the lesser of 60% or the annual IRS limit ($18,000 for 2016).

Compensation for your first year of eligible Plan participation will be measured for the portion of your initial Plan Year that you are eligible. Compensation under the Plan is limited to the applicable dollar limit in effect for the Plan Year.

ADDITIONAL CONTRIBUTIONS AVAILABLE UNDER THE PLAN

In addition to your matching contributions and the safe harbor contributions described before, the following types of contributions are available under the Plan: profit sharing contributions that are made at the time and in the amount determined by Schaeffler Group USA Inc.

VESTING AND WITHDRAWAL OF ACCOUNTS

All contributions made to the Plan, including safe harbor matching contributions, will be 100% vested and nonforfeitable. They may only be withdrawn from your account in the event of death, disability, retirement, and termination of employment or, if allowed by the Plan, on attainment of age 59 ½.

OTHER INFORMATION

Schaeffler Group USA Inc. must make the safe harbor matching contributions to your account within the time limits prescribed by Federal Law. The safe harbor matching contribution was first made for the Plan Year beginning January 1, 2007 and will continue in effect each Plan Year thereafter unless the Plan is amended to eliminate them or the Plan is terminated. Before the beginning of each Plan Year for which a safe harbor matching contribution is to be made, the Plan Administrator will provide you with a notice describing the safe harbor matching contribution and the eligibility requirements for receiving the safe harbor matching contribution for the Plan Year.

You can elect to defer a percentage of your compensation on a pretax basis to the Plan by contacting the Fidelity Retirement Benefits line at 1-800-835-5097 or access the NetBenefits web site at www.401k.com. You may increase, decrease, suspend or resume your contributions as of the first payroll period following notification to Fidelity. If you want to take one of these actions, you must call the Fidelity Retirement Benefits line or access the web site www.401k.com to make these changes.

For more information regarding the Plan and safe harbor matching contributions, please refer to the Summary Plan Description. In addition, you can obtain more information by calling the Fidelity Retirement Benefits line at 1-800-835-5097 or by contacting them at the following website: www.401k.com. You may also contact David McMaster at the Shared Services Department in Fort Mill (see below).

David McMaster
Director - Human Resources - Shared Services
Schaeffler Group North America
1-803-548-8500

Schaeffler Medical Plan Summary of Benefits and Coverage - Availability Notice

As an employee of the Schaeffler Group, the health benefits available to you represent a significant component of your compensation package. Health benefits provide important protection for you and your family in the case of illness or injury.

Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options.

The SBCs for the Schaeffler Medical Plan are available on the annual enrollment website at https://portal.adp.com.

A paper copy is also available, free of charge, by requesting this from a member of your Human Resources Team or by calling 803-548-8500.

SCHAEFFLER

LuK INA FAG

Schaeffler Group USA Inc.
308 Springhill Farm Road
Fort Mill, South Carolina 29715

IMPORTANT LEGAL NOTICES FOR 2016 BENEFITS COVERAGE ENCLOSED!