SMP®
BENEFITS

2020
Benefits Overview

WE'RE IN THIS THING TOGETHER.
TAKE CARE OF YOURSELF, AND WE'LL HELP TAKE CARE OF YOU TOO.
DRIVE YOUR HEALTH FORWARD!

Introduction

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Standard Motor Products offers you an array of benefits that are competitive and cost effective to you and the company. Your health and well-being is important to us, and we want to make sure that we are doing all we can to encourage healthy behaviors in the workplace and at home. When it comes to medical coverage, our goal has always been to protect SMP employees and their dependents from the financial impact of a catastrophic medical emergency. In these changing times, we must also consider factors such as your ability to pay and your use of the plan. With rising healthcare costs across the country, we strive to offer the best coverage we can, while keeping costs as affordable as possible.

It's important for you to fully understand how the plans work before you begin to utilize your benefits. Read through this benefits summary in its entirety, and ask questions if you are unclear about how the plans work. We have created a benefits specific web site to help you better understand the details of the plans, and we hope that you take advantage of the information provided.

For More Information & Questions

You can always access detailed benefit information at **www.SMPbenefits.com**. If you have any questions with regards to benefits and/or your personal situation, you are always encouraged to contact your local Human Resources Manager or Health Advocate at **1-866-799-2731**.

Benefits-at-a-Glance

If you meet the eligibility rules outlined on the next page, you may participate in SMP's Benefit Program, which includes the following benefits:

Benefit	Coverage
Medical/Prescription Anthem Blue Cross Blue Shield	Two plan options (PPO & HDHP) offering in-network and out-of-network benefits. Both plans include preventive, routine and emergency care.
Telemedicine Teladoc	If enrolled in an SMP medical plan, access telemedicine services through Teladoc. Telemedicine allows you and your covered dependents to access healthcare and behavioral health services remotely by web, mobile app or phone.
Dental Delta Dental	One dental plan available, which offers comprehensive coverage with both in-network and out-of-network providers.
Vision Anthem Blue View Vision	One vision plan available, which offers comprehensive coverage through one of the largest vision care networks in the country; out-of-network coverage is also available.
Health Savings Account (HSA) Anthem	If you participate in the HDHP, you can elect an HSA to use for qualified medical expenses, or you can let your account grow and use for medical expenses in retirement. If establish an HSA, you may not participate in the Health Care FSA.
Flexible Spending Accounts (FSAs) Anthem	Elect a Health Care and/or Dependent Care FSA, which allows you to set money aside on a pre-tax basis for eligible health care and/or dependent care expenses. An FSA election may be made regardless of whether you elect an SMP medical plan.
Basic Life Insurance Sun Life	The company offers basic life insurance coverage at no cost to you. This benefit is payable to your beneficiary in the event of your death.
Optional Life Insurance Sun Life	You have the option to purchase additional life insurance coverage for yourself and your spouse/dependent child(ren).
Disability Insurance/FMLA Cigna	Short term and long term disability benefits (partial income replacement) available for injuries/illnesses that keep you out of work for a period of time. You also have access to unpaid family leave benefits through the Family Medical Leave Act (FMLA).
Paid Family Time Off	This benefit provides paid time off to bond with a new child through birth, adoption or foster care.
Retirement Savings Plan Fidelity Investments	Participate in the company-sponsored 401(k) and ESOP plans. Once eligibility is met, you will be enrolled automatically and Fidelity will mail a welcome kit directly to your home from Fidelity Investments.
Aflac Voluntary Benefits	Voluntary benefits can help protect you financially in the case of a serious life event or health condition. You may choose from four plans. The cash benefits you receive from these plans can be used in any way you choose.
Wellness Program Virgin Pulse	Complete the wellness program — an annual physical and non-smoker/smoker status — each year and drive your health forward.

For more information about your benefits plan go to **SMPbenefits.com**.

Eligibility

You are eligible for SMP benefits if you are regularly scheduled to work at least 30 hours per work week. **Note:** This does not include temporary or seasonal employees.

In addition to electing coverage for yourself, you can elect to cover your eligible dependents for Medical, Dental, or Vision benefits. Eligible dependents include your:

- Legal spouse (opposite or same sex)
- Children through the end of the year in which they turn age 26.
- Unmarried children who are physically or mentally disabled.

A child who is not a biological child may be considered, if:

- He or she is claimed as a dependent on the income tax return of a step-parent, or
- Legal adoption or guardianship has been established.

The Company does require that proof of dependent status be provided for all qualified dependents to be covered under the plan.

When Coverage Becomes Effective

Coverage for yourself and your dependents becomes effective on the first day of employment with Standard Motor Products.

Note: For the retirement plan, you are eligible on the first day of the next quarter upon completion of 30 days of service.

Health Advocate

Health Advocate is a benefits assistance resource for you, your spouse, dependents, and parents, regardless of whether you are enrolled in SMP's benefits or not.

Health Advocate can assist with all of your benefits-related questions from enrollment to claims, cost of services, plan designs, Health Care Reform, and clinical questions.

Access Health Advocate at **1-866-799-2731**.

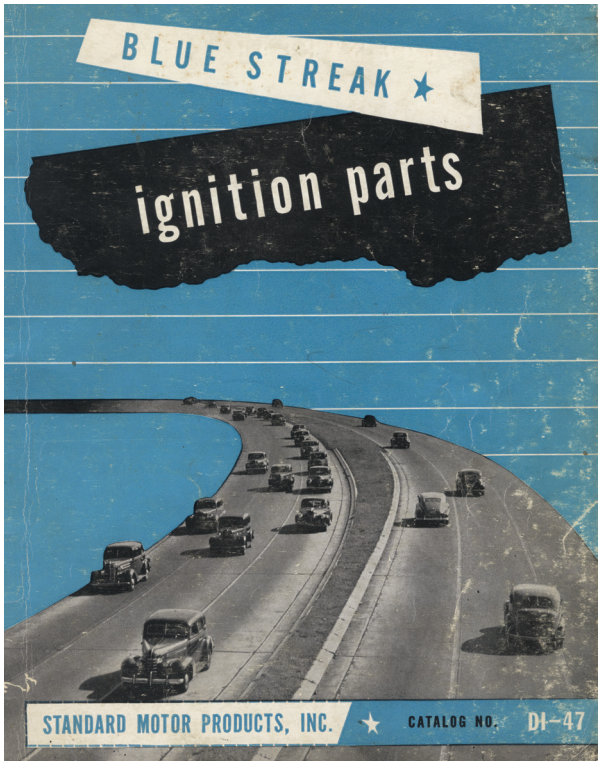
Enrollment

If you are eligible, you may enroll for benefits within 30 days of your date of hire. If you do not enroll when first eligible, you will need to wait until the annual Open Enrollment period held in the fall each year, unless you experience a qualifying life event as outlined at right.

To make your benefit elections and enroll dependents, you will need to access the ADP portal at **my.adp.com**.

- **New Users:** You will be prompted to register first. The SMP Registration Passcode is: **SMPCORP-SMPP**.
- **Registered Users:** Log in using the same Username and Password that you use to log in to view your paystubs.

Note: Health Care and Dependent Care FSA elections must be renewed every year.



Making Changes During the Year

The Internal Revenue Service (IRS) states that you may only change elections for medical, dental, vision and FSAs during the year if you experience a Qualifying Life Event (QLE). A few examples of QLEs include:

- Marriage
- Birth, adoption or placement for adoption of an eligible child
- Divorce or legal separation
- FMLA
- Termination or commencement of your spouse's coverage in general when coverage is maintained through the spouse's plan
- Shift from part-time to full-time employment status (or vice versa) by you or your spouse
- Death of spouse or dependent
- When a dependent satisfies or no longer satisfies eligibility requirements
- Taking an unpaid leave of absence (you or your spouse)
- Gain or loss of eligibility for Medicaid, a Children's Health Insurance Program (CHIP) or for a premium assistance subsidy under these programs (60-day special election period).

Allowable changes must be made within 31 calendar days of the event (unless noted otherwise). You will need to contact your local HR Representative when you experience a QLE. You will also need to provide legal documentation that supports the life event. Changes that are requested due to a "change of mind" cannot be allowed until the next open enrollment period.

Note: Since you own an HSA if contributing, changes to contribution elections may occur every 30 days without a life event.

SMP Wellness

Drive Your Health Forward

SMP partners with Virgin Pulse to provide you a comprehensive wellness program if you are enrolled in an SMP-sponsored medical plan.

Online access to the wellness portal provides:

- Nutrition and exercise education,
- A member health assessment, and
- Personalized electronic health coaching / support.

Every year, SMP requires that you take specific action toward your health and wellness.

Take Action in 2020!

In 2020, you and your spouse covered under our medical plan are required to take the following steps by October 15th, 2020 in order to avoid an increase in premium in 2021 (for those hired prior to July 15th, 2020):

1. Complete an annual physical
2. Indicate a non-smoker status OR indicate smoker status and complete the smoking cessation program

Take care of yourself, and we'll take care of you too!

Medical Benefits

You have the option to choose between two Anthem BCBS medical plans — a Preferred Provider Organization (PPO) and a High Deductible Health Plan (HDHP).

Preferred Provider Organization (PPO)

A PPO plan gives you the flexibility to go to any doctor or hospital you wish. A PPO plan also gives you the freedom to go outside the network for care whenever you like. **However, you'll pay more for your care if you use an out-of-network provider.** A PPO has higher employee contributions with lower deductible and coinsurance.

If you elect the PPO plan, you have the option to enroll in the Health Care FSA, but not the Health Savings Account (HSA).

High Deductible Health Plan (HDHP)

The HDHP has lower employee contributions with a higher deductible and coinsurance. With the exception of preventive care, a covered member must meet the annual deductible before the plan begins to pay benefits.

If you elect the HDHP, you have the option to establish a Health Savings Account (HSA), provided you meet the IRC's eligibility guidelines. If you contribute to an HSA, you cannot contribute to a Health Care FSA.

About Out-of-Network Providers

Both medical plan options have out-of-network benefits, which means you can see any provider you wish. **Keep in mind that out-of-network providers can charge in excess of Anthem BCBS' covered amount.** Neither Anthem BCBS nor SMP are responsible for the amount billed by an out-of-network provider above the allowed amount for a service. For assistance with locating an in-network provider in your area, contact Anthem BCBS or Health Advocate.

Free Preventive Care

Preventive Services for All:

- Age-appropriate immunizations
- Blood pressure screening
- Cholesterol and lipid level screening
- Depression screening
- Type 2 diabetes screening
- Height, weight, BMI
- STI: screening and counseling
- Tobacco use: screening and counseling

Specific Preventive Services for Children

- Development & behavioral counseling
- Hearing screening

Specific Preventive Services for Women

- Well-women visits
- Breast cancer screenings
- Pregnancy screenings
- Pelvic exam and Pap test

Specific Preventive Services for Men

- Prostate cancer screenings

For a detailed listing of all services that are considered to be Preventive Care, contact Anthem Customer Service at **1-866-802-0510**.

Medical Benefits

Anthem Blue Cross Blue Shield	PPO Plan	
	In-Network	Out-of-Network
Calendar Year Deductible • Individual • Family	 $1,100 $2,200	 $2,200 $4,400
Calendar Year Out-of-Pocket Maximum • Individual • Family	 $2,200 $4,400	 $5,500 $11,000
Coinsurance (Member Pays)	10%	30%
Preventive Care Well Child (to age 19), Routine Physicals (age 19+), Office Visits, Cancer Screening, Routine Hearing & Vision Exams, Immunizations	100%	Covered in-network only
Office Visits • Primary Care Physician • Specialist	 10% after deductible 10% after deductible	 30% after deductible 30% after deductible
Lab and X-Rays	10% after deductible	30% after deductible
Mental Health Office Visit (unlimited visits per plan year)	10% after deductible	30% after deductible
Emergency Care	10% after deductible	30% after deductible
Inpatient Hospital Admission	10% after deductible	30% after deductible
Outpatient Hospital Visit	10% after deductible	30% after deductible
Prescription Drug Coverage		
Retail Pharmacy (30-day supply): • Tier I • Tier II • Tier III • Tier IV	 $5 copay $30 copay $60 copay $75 copay	 $10 copay $35 copay $90 copay $120 copay
Mail Order (90-day supply): • Tier I • Tier II • Tier III • Tier IV	 $7.50 copay $45 copay $90 copay $112.50 copay	 N/A N/A N/A N/A

- **Tiered Pharmacy Surcharge:** A $10/per prescription surcharge applies for using a Level 2 Pharmacy (see page 8).
- **Mail Order:** Members are required to fill maintenance medications through IngenioRx mail order program (see page 8).

Out-of-network means the doctor/facility providing care does not have a contract with Anthem. If seeking out-of-network services, the deductible, coinsurance and out-of-pocket maximum will apply to the in-network rate. You will be responsible for any amount billed in excess of the in-network rate, therefore, your out-of-pocket maximum will likely exceed the amounts indicated.

Medical Benefits

Anthem Blue Cross Blue Shield	HDHP Plan	
	In-Network	Out-of-Network
Calendar Year Deductible • Individual • Family/Combined*	 $1,500 $3,000	 $3,000 $6,000
Calendar Year Out-of-Pocket Maximum • Individual • Family	 $3,000 $6,000	 $6,000 $12,000
Coinsurance (Member Pays)	10%	30%
Preventive Care Well Child (to age 19), Routine Physicals (age 19+), Office Visits, Cancer Screening, Routine Hearing & Vision Exams, Immunizations	100%	Covered in-network only
Office Visits • Primary Care Physician • Specialist	 10% after deductible 10% after deductible	 30% after deductible 30% after deductible
Lab and X-Rays	10% after deductible	30% after deductible
Mental Health Office Visit (unlimited visits per plan year)	10% after deductible	30% after deductible
Emergency Care	10% after deductible	30% after deductible
Inpatient Hospital Admission	10% after deductible	30% after deductible
Outpatient Hospital Visit	10% after deductible	30% after deductible
Prescription Drug Coverage		
Prescription Benefit	All non-preventive prescriptions are subject to deductible and coinsurance. There are several preventive drugs available for free under the following categories: Birth Control, Diabetes, Heart Health, High Blood Pressure, High Cholesterol, Smoking Cessation. A complete list of covered drugs is available under the Document Library at **SMPbenefits.com**.	

- **Tiered Pharmacy Surcharge:** A 10%/per prescription surcharge applies for using a Level 2 Pharmacy (see page 8).
- **Mail Order:** Members are required to fill maintenance medications through IngenioRx mail order program (see page 8).

* *Combined Deductible: If you have Employee +1 or Family coverage, all collective member claims under the plan must meet the full $3,000 deductible before the plan goes into the 10% coinsurance. Once the total member responsibility exceeds $3,000, the entire family (or employee +1) goes into coinsurance.*

Out-of-network means the doctor/facility providing care does not have a contract with Anthem. If seeking out-of-network services, the deductible, coinsurance and out-of-pocket maximum will apply to the in-network rate. You will be responsible for any amount billed in excess of the in-network rate, therefore, your out-of-pocket maximum will likely exceed the amounts indicated.

Medical Benefits

Prescription Drug Benefits

When you enroll in an Anthem BCBS medical plan, you have prescription drug coverage automatically through IngenioRx. Under both of our plans we have programs in place for efficiency and cost management.

- **Exclusive Specialty Program:** Members must fill specialty medication prescriptions through IngenioRx's specialty pharmacy. Contact **1-833-255-0645**.
- **Prior Authorization:** Providers will be required to obtain approval from Anthem when prescribing certain medications to ensure drugs are being appropriately used as recommended by the FDA.
- **Tiered Pharmacy Surcharge:** Members can fill prescriptions at Level 1 and Level 2 pharmacies. If you go to a Level 2 pharmacy, you will pay a surcharge (PPO: $10 / HDHP: 10%). Log on to **anthem.com** to find a Level 1 pharmacy near you.
- **Quantity Limits:** Members may not exceed filling a maximum covered amount of medications (number of pills) filled in a certain time period.
- **Preferred Generic:** Members must purchase the generic equivalent of a brand-name drug unless the doctor received prior authorization for the drug to be filled as a brand name. If you choose a brand name when a generic is available and the doctor does not receive an approved prior authorization, you will be responsible for paying the difference between the brand name cost and the generic cost.
- **90-Day Supply at CVS:** Members can get a 90-day supply of a maintenance medication filled at a CVS retail pharmacy for the same copay/cost as the mail order program.

Mail Order Program

SMP requires that you fill maintenance drugs using IngenioRx home delivery mail order program, which will save you and the company money!

You receive a 90-day supply of maintenance medications at home instead of going to the pharmacy every 30 days. With mail order, you may save approximately 33% on the cost of the medications. To sign up for mail order today, call **1-833-236-6196**.

Telemedicine

If you are enrolled in an SMP medical plan, you have access to telemedicine services through Teladoc for yourself and your covered dependents (spouse and children). Telemedicine allows you to receive healthcare from board-certified and licensed doctors remotely by web, mobile app or phone.

Prescriptions: If medically necessary, the doctor you meet with can write a prescription and send it to the pharmacy of your choice. **Note:** Doctors cannot issue prescriptions for substances controlled by the Drug Enforcement Administration (DEA).

The cost for consultations are applied toward your deductible.

Consultation Type	General Health	Dermatology	Behavioral Health
• PPO	$0	$75	$0
• HDHP	$45	$75	Initial visit with psychiatrist: $200 Ongoing visit with psychiatrist: $95 Psychologist or therapist: $85

Employee Monthly Medical Contributions

Below outlines how to calculate your monthly employee contributions for medical coverage. This is the cost of enrolling in the plan and will be deducted from your pay on a pre-tax basis. Need help? Visit **smpbenefits.com** to use SMP's Employee Contribution calculator or contact Health Advocate for assistance in calculating your monthly employee contribution.

Please complete both Step 1 and Step 2 to calculate your contribution.

Step 1

PPO Medical Plan

Annual Earnings on December 31, 2019	Employee Only	Employee + One	Family
$30,000 and under	$100	$220	$280
$30,001 and above	$100 base + (1% of annual earnings/12 months) **($225 max)**	$220 base + (1.5% of annual earnings/12 months) **($407.50 max)**	$280 base + (2% of annual earnings/12 months) **($530 max)**

HDHP Medical Plan

Annual Earnings on December 31, 2019	Employee Only	Employee + One	Family
$30,000 and under	$60	$160	$200
$30,001 and above	$60 base + (1% of annual earnings/12 months) **($185 max)**	$160 base + (1.5% of annual earnings/12 months) **($347.50 max)**	$200 base + (2% of annual earnings/12 months) **($450 max)**

Step 2 ▸ Increase the Contribution by 16% (or multiply by 1.16)

Wellness Surcharge ▸ If you were hire prior to July 15 and covered under our medical plan, but you did not complete the wellness program, add $50 per month to your monthly medical plan contribution.

Health Savings Account

To be eligible to contribute to a Health Savings Account (HSA), you must elect a High Deductible Health Plan (HDHP). Government regulations require that these savings accounts be tied to a high-deductible health plan (like the Anthem BCBS HDHP).

You cannot participate in our HSA if you're covered by outside health insurance or enrolled in Medicare. (Once your Medicare coverage begins, you must stop contributing to the HSA. However, you can still use your account to pay your eligible medical expenses tax-free, including Medicare premiums and other plan costs.)

How the HSA Works

Once you elect the HDHP, you'll have the opportunity to establish an HSA. All you have to do is decide how much you want to contribute on a pre-tax basis, and open your HSA with Anthem. (You may open an HSA at another financial institution, but pre-tax contributions cannot be made into HSAs outside Anthem.)

If you choose to participate, you'll receive a debit card to access the money in your HSA (checks are also available for a small fee). You can use your debit card to pay your medical bills directly, or you can pay qualified expenses out of your own pocket and reimburse yourself from the HSA with available funds.

If you prefer to think of your HSA as a long-term savings account, you may want to leave your funds alone, and pay for current qualified expenses out of your regular income. Your account will continue to grow tax-free, including interest or investment earnings, for future use, even after retirement.

You can use your HSA to pay medical bills, but only up to the amount that's currently in your account. Then, as additional deposits are made, you can access those funds. You may not use funds from your HSA to pay for medical expenses that occurred prior to opening your HSA account.

If you leave the Company, your HSA is portable; you can take it with you and access your account to pay for eligible medical expenses.

Important! If you use your HSA to pay for *ineligible* medical expenses, you will be subject to taxes and penalties.

How much you can save

For 2020, the maximum annual amount you may contribute to your HSA on a pre-tax basis is:

- Single $3,550
- Family $7,100

If you are age 55 or above, you can contribute an additional $1,000 to your HSA each year.

Note: These annual amounts are determined by federal regulations and may change from year to year.

There's no limit to how much you can eventually accumulate. Your total savings will depend on the amount you save each year, the number of years you contribute, your returns and how much you use toward current medical expenses.

Dental Benefits

Good dental health is important to your overall well-being. It is for this reason Standard Motor Products offers dental coverage through the Delta Dental PPO Plus Premier Plan.

There are many advantages when you use a dentist who participates in the Delta PPO Plus Premier network. Using in-network providers saves you money and, with over 175,000 participating providers in 258,000 locations, you won't have to look far to find a network dentist. You also have the freedom to visit a provider outside the network. If you do go outside the network, your out-of-pocket expenses will be higher and you may be required to pay 100% of your bill at the time of service and then wait for reimbursement from Delta Dental. Plus, you may have to submit your own claim forms for reimbursement.

This chart summarizes the benefits provided under the Delta Dental PPO Plan. For detailed information, refer to your Dental Summary Plan Description.

Delta Dental PPO Plan	In-Network	Out-of-Network
Calendar Year Deductible (Waived for Diagnostic, Preventive and Orthodontic Care) • Individual • Employee + One • Family	 $50 $100 $150	 $50 $100 $150
Calendar Year Out-of-Pocket Maximum	$2,000 / person	$2,000 / person
Preventive Care Includes exams, cleanings, x-rays, fluoride treatments for children, emergency treatment, space maintainers, sealants	100%	80%
Basic Care Includes laboratory tests, fillings (amalgam, silicate, acrylic), root canal, repair and relining of dentures, repair and recementation of bridgework and crowns, oral surgery, posterior composites, surgical and nonsurgical periodontics	80%	80%
Major Care Includes porcelain fillings and crowns, installation of bridgework, dentures and crowns, implants, prosthodontic services	60%	60%
Orthodontia (up to age 18)	50%	50%
Orthodontia Lifetime Maximum*	$2,000 / child	$2,000 / child
Implants (Separate Calendar Year Maximum)*	$3,000 / person	$3,000 / person
Monthly Employee Contributions (pre-tax deduction)		
• Individual • Employee + One • Family	$10 $25 $35	

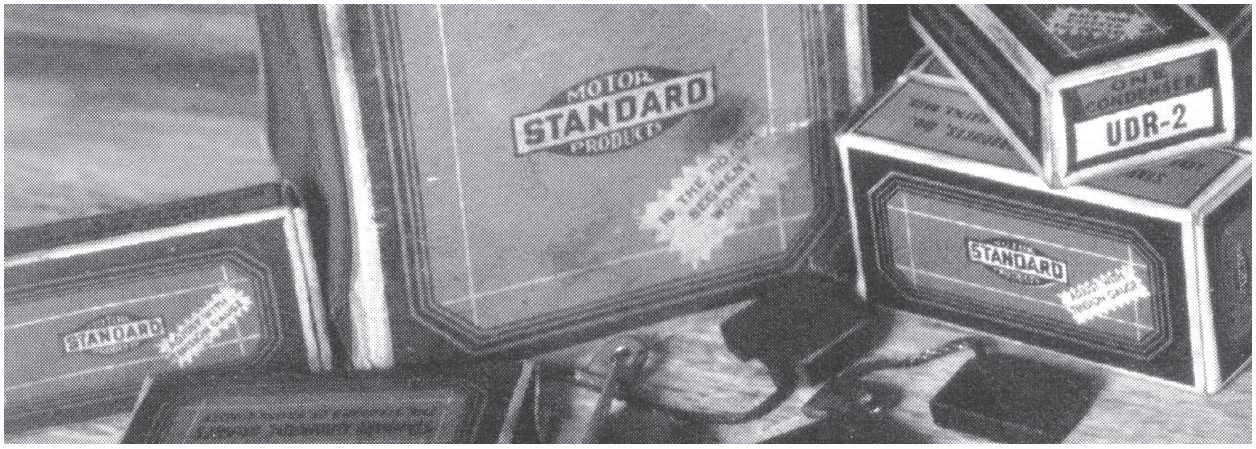
** In- and out-of-network combined*

Vision Benefits

You have the option to elect the Anthem Blue View Vision plan. Vision care providers in the Anthem Blue View network provide both eye exams and eyewear, making for a convenient "one-stop" means of obtaining eye care benefits.

You may choose to receive care from a participating Anthem Blue View Vision provider or any provider of your choice. The chart below highlights the benefits available through the Plan. For more detailed information, please refer to your Vision Summary Plan Description.

Anthem Blue View Vision Plan	Frequency	In-Network	Out-of-Network
Vision Exam	Once every calendar year	$10 copay	$40 allowance
Prescription Lenses • Single Vision • Lined Bifocal • Lined Trifocal	Once every calendar year	 $10 copay $10 copay $10 copay	 $25 allowance $40 allowance $50 allowance
Frames	Once every calendar year	$130 allowance + 20% off remaining balance	$45 allowance
Contact Lenses (in lieu of glasses) • Medically Necessary • Contact Lenses Elective Conventional • Contact Lenses Elective Disposable	Once every calendar year	 No charge $130 allowance + 15% off remaining balance $130 allowance (No additional discount)	 $210 allowance $105 allowance $105 allowance
Monthly Employee Contributions (pre-tax deduction)			
• Individual • Employee + One • Family		$6.65 $12.97 $19.29	



Flexible Spending Accounts (FSAs)

Standard Motor Products allows you to contribute a portion of your pay through payroll deduction into a Health Care and/or Dependent Care Flexible Spending Account (FSA) administered by Anthem. The money that goes into an FSA is deducted from your pay on a pre-tax basis (before Federal, Social Security and some state taxes are calculated). Because you do not pay these taxes on money that goes into an FSA, you decrease your taxable income and potentially increase your spendable income. Visit **SMPbenefits.com** or **anthem.com** for more information about FSAs.

You may enroll in an FSA even if you are not enrolled in a medical plan through SMP.

FSA Claims Run Out Period: You may submit claims with a 2020 date of service to Anthem through March 31, 2021 if you have a balance in your account beyond December 31, 2020.

Plan Carefully

Although there's no way to completely predict what the future will bring, it's a good idea to take a few minutes to review your current health care and/or dependent care expenses and estimate what your expenses will be for 2020.

Note: You are eligible to carry over up to $500 of your 2020 Health Care FSA balance into the 2021 plan year. The carryover will take place in April 2021.

Any unused amounts over the Health Care FSA carry over or in your Dependent Care FSA that are not used by the deadline will be forfeited.

Health Care FSA

You may contribute up to $2,700 per year into a Health Care FSA. With a Health Care FSA, you can pay for any IRS-allowed health care expenses for you or your eligible dependents.

These expenses include, but are not limited to:

- Deductibles
- Prescription drugs
- Copayments
- Coinsurance payments
- Dental expenses including orthodontia
- Vision care expenses (e.g., eyeglasses or contact lenses)
- Hearing care expenses (e.g., a hearing exam or a hearing aid)

Important! If you elect the HDHP and establish an HSA, you cannot participate in a Health Care FSA.

Dependent Care FSA

You may contribute up to $5,000 (household combined maximum) per year into a Dependent Care FSA.

Eligible expenses include payments to:

- Day care centers
- Preschool costs (up to, but not including kindergarten)
- After school care
- Elder care

Life and Accidental Death & Dismemberment (AD&D) Insurance

Life insurance is an important part of your financial security, especially if others depend on you for support. That's why SMP provides you with Company-Paid Group Life insurance at no cost to you. This benefit is provided through **Sun Life**.

Basic Life Insurance Coverage

- 2x your annual earnings (not to exceed $1,000,000 payable to your designated beneficiary(ies) in the event of your death.
- Your benefit reduces by 25% at age 70 and an additional 50% at age 75.

Basic AD&D Insurance Coverage

- 2x your annual earnings (not to exceed $1,000,000 payable to your designated beneficiary(ies) in the event of your death.
- A percentage of your benefit is payable to you in the event of a severe injury as a result of a covered accident; percent of benefit depends on the severity of the injury.
- Your benefit reduces by 25% at age 70 and an additional 50% at age 75.

You will need to designate a beneficiary (or beneficiaries) at **my.adp.com**. Your beneficiary is the person(s) who will receive your life insurance benefit in the event of your death.

If group life and AD&D coverage ends because your employment is terminated or membership in an eligible class is terminated, you have the right to convert to an individual non-term policy. To convert to an individual policy, you must apply for the conversion policy and pay the first premium payment within 31 days after your group coverage ends.

Supplemental Life Insurance Coverage

You can supplement your basic life insurance amount and elect to purchase additional life insurance for yourself and elect coverage for your eligible dependents.

For Yourself: Choose 1x or 2x times your basic annual earnings up to a maximum of $1,000,000. The Guaranteed Issue amount is $550,000 or 3x annual earnings, whichever is less.

You benefit amount is reduced to 75% at age 70 and 50% at age 75.

For Your Spouse: Choose from these options:

- If you elect 1x your basic annual earnings: 50% of your life insurance benefit
- If you elect 2x your basic annual earnings — Option 1: 25% of your life insurance benefit or Option 2: 50% of your life insurance benefit not to exceed $250,000. The Guaranteed Issue amount is $50,000.

For Your Dependent Child(ren): Elect $10,000 for children between age 6 months and age 19 (26 if full-time student), if you choose coverage for yourself. A reduced benefit is payable for children less than 6 months old.

Evidence of Insurability

You will be required to answer health questions if:

1. You do not elect coverage when it's first available to you and you want to elect at a later date;
2. You request an amount higher than the Guaranteed Issue amount noted above; or
3. You want to increase coverage at a later date.

Disability/FMLA

Disability benefits provide valuable financial protection in the event you become injured or ill for a period of time and cannot work. Disability benefits are provided through **Cigna**.

Short Term Disability

You may be eligible for Short Term Disability (STD) if you are absent from work for more than three days in a row due to an illness or injury that keeps you out of work.

If your disability is approved, the benefit payable is $170 per week for up to 12 weeks.

Long Term Disability

If your disability continues beyond the STD benefit period, you may be eligible for Long Term Disability (LTD).

If you are approved to continue receiving disability benefits, your benefit will begin after 90 days of disability.

You are eligible to receive up to 60% of your monthly covered earnings. The maximum monthly benefit is $25,000.

Note: Your benefit may be reduced by other income you may be receiving during your disability period.

Family Medical Leave Act

You may be eligible for up to 12 weeks of job-protected, unpaid leave under The Family and Medical Leave Act (FMLA) for certain family and medical reasons.

To file a disability or FMLA claim, contact Cigna at **1-888-842-4482**.

Additional Benefits

Fidelity Retirement Plan

SMP provides a very competitive retirement plan through Fidelity Investments, which includes a 401(k) plan and an Employee Stock Ownership Plan (ESOP).

All employees who have completed 30 days of service with SMP are eligible to enter the plan on the first day of the next calendar quarter.

You are enrolled automatically at a pre-tax rate of 4% of your eligible pay, unless you elect not to participate, or elect to contribute at a different rate. Standard Motor Products makes a 3% 401(k) company contribution based on your compensation.

Fidelity will mail a Welcome Packet to your home. You may also access this welcome packet under the Document Library of **SMPbenefits.com** along with the plan highlights.

Aflac Voluntary Benefits

Voluntary benefits can help protect you financially in the case of a serious life event or health condition.

You may choose from the policies below that best suite you and your family. You then pay for these benefits through convenient payroll deductions.

- Accident Insurance (Employee, Spouse, and Child coverage available)
- Critical Illness Insurance (Employee, Spouse, and Child coverage available)
- Hospital Indemnity (Employee, Spouse, and Child coverage available)
- Short Term Disability (Employee coverage only)

The cash benefits you receive from these plans can be used in any way you choose.

For plan information and rates, go to **www.aflac.com/smp**. To enroll online (within 30 days of your date of hire or during the annual open enrollment period), go to **aflacatwork.com**.

- User ID: SSN
- PIN: Last four digits of your Social Security Number + Last two digits of your birth year

Paid Family Time Off Policy

The purpose of this policy is to provide time off to bond with a new child. This benefit is available to all full-time employees regularly scheduled to work at least 30 hours per week (excluding temps, interns, and seasonal employees).

Type of Leave	Paid Time Off
Maternity Leave (child-bearing parent)	16 weeks
Parental Leave (non child-bearing parent)	4 weeks
Adoption Leave: • Primary Caregiver • Secondary Caregiver	 12 weeks 3 weeks
Foster Leave	1 week

Maternity leave is granted on the date of birth of the child for 16 weeks and will run concurrently with Disability and FMLA. SMP will reduce your pay by the amount of any benefit approved by Cigna Group Insurance for Disability. Paid maternity leave will not reduce any salary continuation benefit available to you for disability outside of the covered 16-week maternity benefit timeframe.

Proper documentation will be required to validate a family leave including a birth certificate, or proof of adoption or fostering. Failure to provide proper documentation may result in disciplinary action and/or termination.

See your HR representative for a copy of our policy and to request a leave with your manager.

Important Legal Notices

Your Prescription Drug Coverage and Medicare

If you have Medicare or will become eligible for Medicare in the next 12 months, a 2006 Federal law gives you more choices about your prescription drug coverage. The Company has determined that the prescription drug coverage offered to its associates is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered Creditable Coverage. A full copy of the Medicare Part D Notice is included with your enrollment materials. For additional copies, please contact your HR Representative.

Newborns' & Mothers' Health Protection Act

Under Federal law, group health plans and health insurance issuers offering group health insurance coverage 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 delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g. your physician, nurse midwife or physician's assistant) after consultation with the mother, discharges the mother or newborn earlier. Plans and issuers may not select the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of pocket costs, you may be required to obtain pre-certification.

Health Insurance Portability & Accountability Act of 1996 (HIPAA)

HIPAA requires that you be informed of your Special Enrollment rights when you and/or your eligible dependents decline health care coverage during the initial enrollment period. If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself and/or your dependents in the medical plan provided that you request coverage after your other coverage ends within the specified time frame. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption or a court order, you may be able to enroll yourself and/or your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption or placement for adoption or the court order.

If you are declining health coverage for yourself or your dependents (including your spouse) and you are not currently covered under a medical plan, you will be considered a late applicant. HIPAA allows a late applicant to enter a medical plan only during an open enrollment period.

Women's Health & Cancer Rights Act

This law requires group health plans that provide coverage for mastectomies to also cover reconstructive surgery and prostheses following mastectomies. The law mandates that a plan participant receiving benefits for a medically necessary mastectomy who elects breast reconstruction after the mastectomy, will also receive coverage for reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses, treatment of physical complications of all stages of mastectomy, including lymphedemas. This coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same annual deductibles and coinsurance provisions that apply for the mastectomy.

Important Legal Notices

HIPAA Notice: Smoker Surcharge Reasonable Alternatives

The full reward (the non-smoker rate) must be available to individuals who qualify by satisfying a reasonable alternative standard. Plans have flexibility to determine how to provide the portion of the reward corresponding to the period before an alternative was satisfied (e.g., payment for the retroactive period or pro-rata over the remainder of the year) as long as the method is reasonable and the individual receives the full amount of the reward. In some circumstances, an individual may not satisfy the reasonable alternative standard until the end of the year. In such circumstances, the plan or issuer may provide a retroactive payment of the reward for that year within a reasonable time after the end of the year, but may not provide pro-rata payments over the following year (a year after the year to which the reward corresponds).

Mental Health Parity Act (MHPA)

The Mental Health Parity Act of 1996 provided that a health care plan or policy may not provide separate lower annual or lifetime dollar maximums (considered financial maximums) on mental health benefits as compared to medical benefits. With the passage of the Emergency Economic Stabilization Act and its inclusion of the Mental Health Parity and Addiction Equity Act of 2008 (Mental Health Parity Act or MHPA), the original act was extended to include the same provisions for substance abuse disorders, not just mental health disorders. Further, the MHPA also disallows more restrictive treatment limitations (number of covered office visits, inpatient days of coverage, etc.) for both disorders.

These, along with other revisions and clarifications are effective for plan years beginning after December 31, 2009. For the Company, MHPA plan compliance will be effective for our plan year beginning January 1, 2011.

Student Leave ("Michelle's Law")

Michelle's Law protects a full-time, student-age dependent from losing medical coverage under the Benefits Plan if he/she is (1) a dependent child of a participant or beneficiary under the terms of the plan; and (2) enrolled in a plan on the basis of being a student at a postsecondary educational institution immediately before the first day of a medically necessary leave of absence from school. A dependent covered under the law is entitled to the same benefits as if the dependent continued to be enrolled as a full-time student. The law also recognizes that changes in coverage (whether due to plan design or a subsequent open enrollment election) pass through to the dependent for the remainder of the medically necessary leave of absence. Michelle's Law requires that the plan treat such a dependent as a full-time student for one year after the first day of the medically necessary leave of absence or until the date on which such coverage would otherwise terminate under the terms of the plan, whichever occurs first.

State Children's Health Insurance Program

Eligible plan participants may be eligible to receive assistance in paying their contributions for health coverage under a State Children's Health Insurance Program (SCHIP). This program is jointly financed by the federal and state government and is administered by the states. Each state determines the design of its program, eligibility criteria, benefit packages, payment levels and plan administration. If you are eligible for this benefit, you will be required to pay the full cost of the health coverage for your child and then you will be reimbursed by the state for the cost of your child's coverage. For more information please visit **www.insurekidsnow.gov** or call toll-free **1-877-KIDS-NOW**.

NOTE: Changes in eligibility for Medicaid, CHIP or premium assistance under these programs are considered Qualifying Life Events. Refer to page 3 of this Benefits Overview for further details.

Important Legal Notices

Family Medical Leave Act

The Family and Medical Leave Act (FMLA) allows up to 12 weeks of unpaid, job protected leave for specific family emergencies such as serious illness or the birth or adoption of a child. FMLA eligible associates are eligible for up to 26 weeks of FMLA leave in a 12-month period for the care of a service member who is injured in the line of duty. This leave is only available to the service member's spouse, son, daughter, parent, or next of kin. "Next of kin" is defined as the nearest blood relative of the service member. You are eligible for FMLA leave when you work at a location with 50 or more associates within a 75 mile radius, have been employed with the Company for at least 12 months and have worked a minimum of 1,250 hours in the prior 12-month period. Associates are eligible for FMLA if they meet the criteria listed above.

New York City's Paid Safe and Sick Leave Law

Under NYC's Earned Safe and Sick Time Act, employees working in NYC for more than 80 hours a year can earn up to 40 hours of safe and sick leave each year. Eligible employees have a right to safe leave, which can be used to seek assistance or take other safety measures if an employee or a family member may be the victim of any act or threat of domestic violence or unwanted sexual contact, stalking, or human trafficking. Eligible employees have the right to sick leave, which can be used for the care and treatment of yourself or a family member. Eligible employees have the right to be free from retaliation from your employer for using safe and sick leave. Eligible employees, have the right to file a safe and sick leave complaint by email, mail, telephone, or in-person. For more information, including Frequently Asked Questions, go to **nyc.gov/PaidSickLeave or call 311** and ask for information about Paid Safe and Sick Leave.

Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services. If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military. Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries. For assistance in filing a complaint, or for any other information on USERRA, contact VETS at **1-866-4-USA-DOL** or visit **www.dol.gov/vets**.

Benefit Contact Information

For all benefit-related questions, please call Health Advocate at **1-866-799-2731** or visit **healthadvocate.com/members**.

Benefit	Provider	Phone Number	Website	Mobile App Search Keyword
Medical & Prescription	Anthem BlueCross BlueShield	1-866-802-0510	anthem.com	Sydney App
Mail Order Prescriptions	IngenioRx	1-833-280-4172	anthem.com	Sydney App
Telemedicine	Teladoc	N/A	teladoc.com	Teladoc
Dental Benefits	Delta Dental	1-800-932-0783	deltadental.com	Delta Dental
Vision Benefits	Anthem Blue View Vision	1-866-723-0515	anthem.com	N/A
Health Savings Accounts (HSA)	Anthem	1-866-802-0510	anthem.com	Sydney App
Flexible Spending Accounts (FSA)	Anthem	1-866-802-0510	anthem.com	Sydney App
Life & AD&D Insurance	Sun Life	1-800-247-6875	sunlife.com	N/A
Disability/FMLA	Cigna	1-888-842-4462	mycigna.com	MyCigna
401(k) Retirement Services	Fidelity Investments	1-800-835-5095	netbenefits.com	Net Benefits
Aflac	NFP Call Center	1-877-404-6718	aflac.com/smp	N/A

For questions on how to enroll in your benefits:

Call your local SMP Human Resources Representative. You can also visit **my.adp.com** for more information.

Notes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