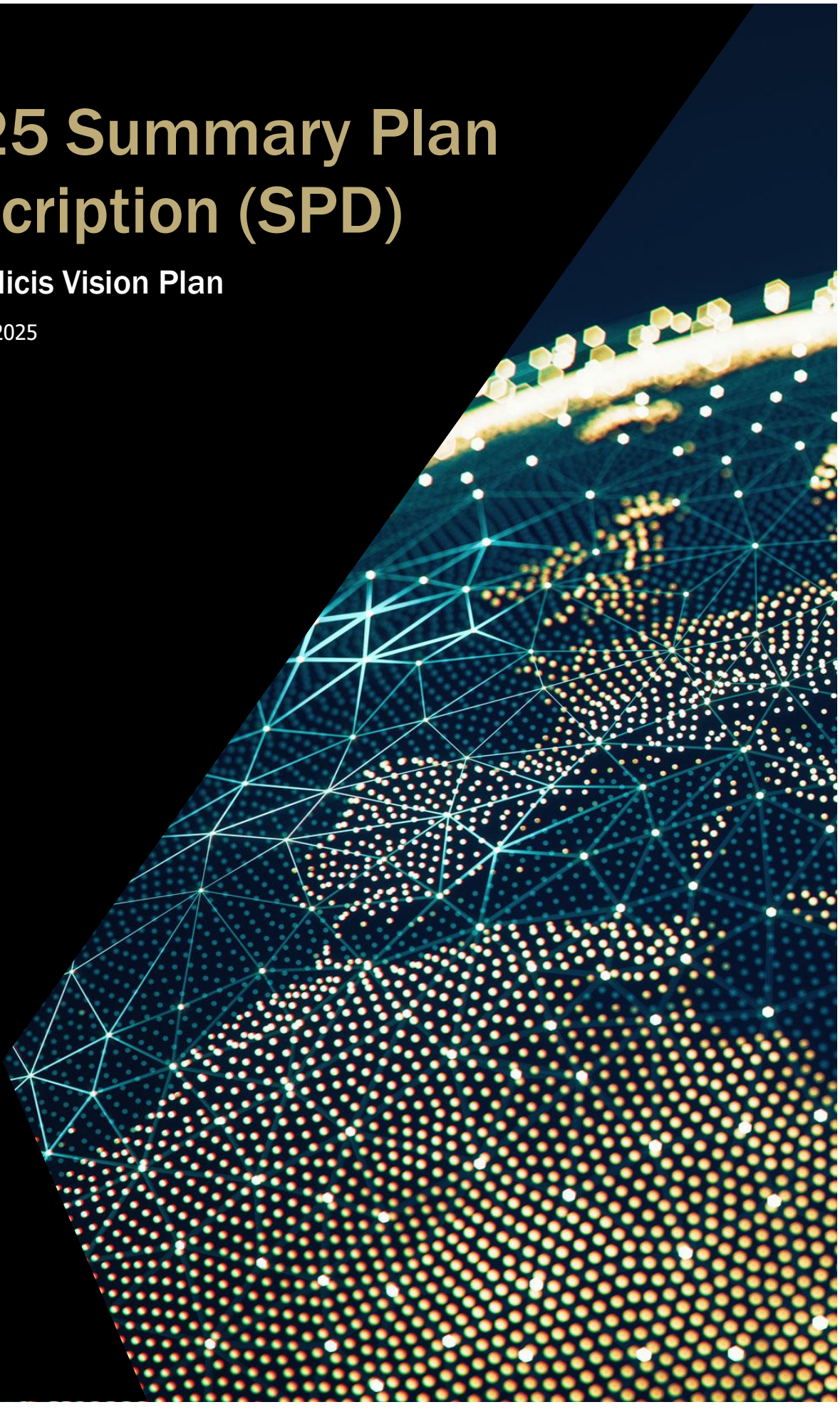
2025 Summary Plan Description (SPD)

for Publicis Vision Plan

January 1, 2025



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Your Vision Coverage

Your vision coverage is an important part of your Publicis Connections Health and Group Benefits Program (the "Program" or the "Plan") sponsored by MMS USA Holdings, Inc. (the "Company"). The Vision Service Plan (VSP) can help you manage your vision care expenses – from exams to eyeglasses and contact lenses. The plan will reimburse you for vision care services received at any vision care provider at the VSP schedule of benefits, plus additional savings within the large VSP Signature network.

This Summary Plan Description (SPD) together with the Administrative Information Summary Plan Description describes the basic features of the Vision Plan, how it operates, and how you can get the maximum advantage from it. These documents, together with other SPDs of Plan benefits, together with any plan-related document issued by an insurer, constitute a Plan Document and SPD. This document describes the Plan provisions as they exist as of January 1, 2025, while certain other information related to the Plan may be contained in the Administrative Information Summary Plan Description. If any statement, oral or written, made on behalf of the Plan disagrees with this Plan and SPD, as interpreted in the sole discretion of the Plan Administrator, the Plan Administrator's decision will govern.

Please note that the ***Company*** reserves the right to amend or terminate the plan at any time without notice. Participation in this plan does not constitute a contract of employment between you and the ***Company***.

Eligibility

Employee

You're eligible to participate in the Plan if you meet all of the following:

- You're a U.S.-based employee;
- You're a full-time or part-time employee working a minimum regular schedule of at least 21 hours per week;
- You're an employee of a subsidiary of MMS USA Holdings, Inc. (the "***Company***") that has adopted the Program;
- You are not eligible for coverage under a vision plan sponsored by a union pursuant to an agreement or understanding between the Company and a union, and
- Your class of employees has not been excluded from a predecessor plan.

Please see your local HR Representative if you're unsure of whether your business unit participates in the Program or if you are a member of an eligible class of employees.

If an individual is not considered to be an "employee" for purposes of employment taxes and wage withholding, a subsequent determination by the employer, any governmental agency or a court that the individual is a common law employee, if such determination is applicable to prior years, will not have a retroactive effect for purposes of eligibility to participate in the Program.

Your Eligible Dependents

You may elect coverage for eligible dependents. Your eligible dependents include your:

- **Spouse**, your spouse includes the individual to whom you are legally married under federal law.
- Note that under federal law a "common law spouse" will be recognized as a spouse only if relevant state law recognizes the person as a spouse despite the lack of a formal marriage.
- You will be required to provide a copy of your marriage license during the dependent verification audit.
- If you live in a state in which common law marriage is recognized and your "spouse" is your common law spouse under state law, you will be required to prove your marital relationship by providing a copy of a jointly filed federal tax return, or by completing the *Affidavit for Certification of Common Law Marriage* or by providing such other supporting documentation as may be requested by bswift (our benefits administration vendor) to verify eligibility.
- **Domestic Partners,** defined as same-sex and opposite-sex couples registered with any state or local government with any state or local government agency authorized to perform such registrations. If your domestic partnership is not registered with any state or local government agency, your same or opposite sex domestic partner also includes any individual that you have been residing within the same residence for at least six months.
- If you live in a jurisdiction that offers a domestic partner registry, you will be required to provide upon request, a copy of your domestic partner registration certificate to bswift (our benefits administration vendor) within 30 days of enrollment to verify eligibility for coverage.
- If you do not live in a jurisdiction that offers a domestic partner registry or you have not registered, you

will be required to complete and submit the *Affidavit for Certification of Domestic Partnership* to bswift (our benefits administration vendor) within 30 days of enrollment to verify eligibility for coverage in order for coverage to begin.

- **Note:** Domestic Partnerships are not recognized by the federal (and most states) government for tax purposes. This means that the value of your domestic partner's coverage will be imputed into your income, as required by tax law, if he or she is not otherwise your dependent under applicable tax law.

- **Dependent children**, include:
  - Your natural children or step-children;
  - Your legally adopted children;
  - Children placed with you for adoption;
  - Your foster children;
  - Any other children (including grandchildren) for whom you are the legal guardian (as determined by a court of competent jurisdiction); or
  - Any children of a *spouse or domestic partner* that must be covered as stipulated by a divorce decree.
  - Child(ren) of a domestic partner, not otherwise adopted by you.

Coverage for your dependent child continues (as long as your own coverage continues) until the end of the month in which he or she reaches age 26. If your dependent child is totally disabled as determined by the Program due to a mental or physical disability and he or she is continuously covered under the Program, coverage may continue beyond age 26 (provided the disability continues and you remain an eligible employee).

When you elect, or do not cancel, coverage for your eligible dependents, you are certifying that they continue to be eligible dependents under these rules. If your dependent is no longer eligible for coverage, you are expected to contact the Publicis Re:Sources USA Benefits Department as soon as possible to inform them of that fact.

From time to time, the Program will conduct eligibility audits. During an eligibility audit, you will be required to provide documentation substantiating your ***spouse***, ***domestic partner***, or dependent child(ren)'s eligibility in order for them to continue to receive benefits under the Program. The type of documentation that will be accepted will be determined by the ***Plan Administrator*** and communicated to you at the time of the audit.

Divorce Decree

The Program may be required to provide medical coverage for your child pursuant to the terms of a Divorce Decree. This coverage may apply even if you don't have legal custody of the child, the child isn't dependent on you for support, and regardless of any enrollment season restrictions that might otherwise exist for dependent coverage. If the ***Company*** receives a valid Divorce Decree, the Plan may be required to allow you to enroll the dependent child, and if you don't enroll the dependent child, the custodial parent or state

agency may enroll the affected child. Additionally, the ***Company*** may withhold from your wages any contributions required for such coverage.

A Divorce Decree may be either a National Medical Child Support Notice issued by a state child support agency, or an order or a judgment from a state court or administrative body directing the ***Company*** to cover a child under the Program. Federal law provides that a Divorce Decree must meet certain form and content requirements to be valid. The ***Company*** follows certain procedures to determine if a child support notice is "qualified". You may receive a copy of these procedures at no charge. If you have any questions, or would like a copy of the written procedures used to determine whether a Divorce Decree is valid, please contact the Publicis Re:Sources USA Benefits Department.

Dual Coverage

If your ***spouse***, ***domestic partner*** or dependent works for a participating employer that is eligible for the Program, you have some unique choices to make.

You and your ***spouse*** or ***domestic partner*** both may choose "Employee Only" for medical, dental and vision coverage. Or, you may share your coverage if one of you elects ***spouse***/***domestic partner*** or family coverage.

If one employee chooses to cover his or her ***spouse*** or ***domestic partner*** under his or her plan, the other ***spouse*** (or ***domestic partner***) must elect "No Coverage". In addition, children may only be covered as dependents under one parent.

Enrollment

When You First Become Eligible

After your hire date, the Benefits team will upload your information into their system to get you started with enrolling for benefits. You will receive an email or mail notification from bswift— their benefits administrator—when you are able to enroll, and you won't be able to enroll before that notification. You have 45 days from your hire date to enroll. If you don't enroll within this 45-day period (your deadline date is listed on the enrollment worksheet that you receive at your home), you will only receive certain basic coverages provided by the ***Company***, which doesn't include vision coverage.

Here's what you need to do to enroll:

- Once you've been notified that you can enroll, review the Health and Group Benefits general information at PublicisConnections.com. Here you'll find everything you need regarding the basics of the benefit offerings.
- Once you are familiar with the plan options, which family members you can cover, and how much you'll pay for your coverage during the upcoming ***plan year***, go to the **'View, Enroll, or Change Your Benefits'** to start enrolling. You can enroll 24 hours a day, seven days a week – except for regularly scheduled maintenance between midnight and 6:00 a.m. Eastern Standard Time on Sundays.

Remember to have the following information available for your online benefits enrollment:

- The names, dates of birth and social security numbers of your ***spouse***, ***domestic partner*** and/or dependents (if you are enrolling them for coverage). If your dependent is age one or older, you need his or her social security number to enroll. If your dependent does not have a social security number, please contact the Benefits Department immediately.

- Be sure to click the *Submit* button to save and submit your elections.
- After you submit your elections, a confirmation screen appears with your saved elections. Be sure to review and print this screen for your records. This screen is your confirmation statement. You will also receive an e-mail that your elections have been submitted. **The email you receive only acknowledges you have gone out to the Publicis Connections website and made elections. It is not your confirmation statement**.
- After you review your confirmation statement as described above, you may need to correct your benefit elections. If this is the case, you can do so as many times as necessary within your 45-day election period by accessing the enrollment site and making changes.
- Visit the **Guides/Forms** section of the Publicis Connections website if you need to complete any necessary health and group benefits certifications or documents (i.e., domestic partner affidavit) to enroll. The online benefits enrollment prompts you if you need to submit a specific form.

The coverage you elect after you first become eligible continues through the remainder of the ***plan year***, unless you:

- Have a qualified change in status and decide to change your coverage; or satisfy the requirements for enrolling under HIPAA special enrollment periods;
- Cease to be eligible under the Program.

Annual Enrollment

Each fall, you can change your coverage for the following ***plan year***. You receive information and updates about your benefits under the Program so that you can make informed benefit elections during each annual enrollment period.

This information is generally available online on the Publicis Connections website (PublicisConnections.com), and includes:

- Important tips and information on how to enroll for the upcoming ***plan year***;
- The benefit options for which you're eligible for the upcoming ***plan year***; and
- Any changes that may have taken place since the last annual enrollment period.

You must enroll at annual enrollment unless notified otherwise by the ***Company***.

The coverages you elect during the annual enrollment period take effect the following January 1 (or when you are considered ***actively at work***, whichever is later) and continue through the end of the ***plan year*** (unless you have qualified change in status and decide to change your coverage or satisfy the requirements under HIPAA for a special enrollment period).

Enrollment Pursuant to a Divorce Decree

You, a custodial parent or a state agency may enroll a dependent child pursuant to the terms of a valid divorce decree, if the Program is required by law to provide vision coverage for your child pursuant to the terms of a valid divorce decree. A child who's eligible for coverage pursuant to a divorce decree may not enroll dependents for coverage under the Program.

Coverage under the Program is subject to payment of the required contribution unless, in the case of a child who's eligible for coverage pursuant to divorce decree, payment of the required contribution is made by a state agency. The ***Company*** may withhold from your paycheck any required contributions for this coverage and send the contribution directly to the Program.

If You Don't Enroll

If you do not enroll when you are newly eligible or during the annual enrollment period, your benefit elections will not rollover into the following plan year and you will only have coverage in the Company-provided benefits such as Basic Life Insurance, Short-Term Disability, Basic Long-Term Disability, and the Employee Assistance Program. The only time your elected benefits will rollover into the next plan year is when the Company indicates that there will be a "passive" enrollment.

ID Cards

ID cards are not necessary under VSP's paperless benefit delivery model. When patients are ready to access the benefit, they simply follow these three easy steps:

1. Contact a VSP preferred provider
2. State that they are covered by VSP
3. Provide the covered member's name and last four digits of the Social Security number (or the entire identification number if unique)

VSP and the preferred provider's office handle the rest including:

- Coverage verification
- Authorization
- Claim submission
- Claims payment

For members who enjoy the sense of security that a card affords, VSP provides an online solution – a Web-based Member Vision Card that members can view, download and print on demand when you log into your account with your user ID and password on VSP.com. As shown below, the online "card" includes the member name, client number, plan and copay information, doctor network name, and VSP contact information.

When Coverage Begins

Once you enroll, coverage begins on the first of the month coinciding with or following your hire date or the date you first become eligible to participate in the plan. Your eligible dependents are covered on the same day that your coverage begins.

Paying For Your Coverage

Generally, you pay for your health (medical, dental, vision) coverage on a before-tax basis through payroll deductions each pay period. Using before-tax dollars reduces your taxable income for Federal, Social Security and (in most cases) state income taxes. In addition, your income isn't affected when determining your benefit levels for coverage under other ***Company***-sponsored Plans.

If you cover a ***domestic partner***, the portion of the premium that you pay this is attributable to your ***domestic partner's*** coverage is paid on an after-tax basis. In addition, you will have imputed income for the portion of the ***Company***-paid premium subsidy that is attributable to your ***domestic partner's*** coverage.

Using before-tax dollars can affect any Social Security benefits you may eventually receive. This is because you don't pay Social Security (FICA) taxes on before-tax dollars. For most people, the Social Security benefit reduction is just a few dollars a month. In addition, the reduction is typically more than offset by the tax savings you experience over the course of your career. If you have any concerns, or if you need additional information, contact your local Social Security Administration Office.

You pay for the entire cost of your vision coverage. Your annual enrollment materials contain your cost for this coverage for the upcoming ***plan year***. Please contact the Benefits Department if you have any further questions regarding the premium that you pay on a before-tax basis.

Changes in Coverage

Because of the tax advantages associated with certain benefits under the Program, the Internal Revenue Service (IRS) limits your ability to make changes to your benefits after initial enrollment to certain circumstances. These rules govern the types of changes that you may make during the ***plan year.***

In general, once you enroll for (or decline) coverage, your elections stay in effect for the entire ***plan year***. However, under certain circumstances, you may enroll for or change certain coverages during the year. For example, you may change your coverage if:

- You qualify for a special enrollment during the year under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- You experience a "qualified change in status" (see below) that affects you, your ***spouse's***, or your dependents' eligibility for benefits under the Program.
- The Program receives a divorce decree or other court order, judgment or decree that requires you to enroll a dependent.
- You, your ***spouse*** or your dependent qualifies for or loses Medicare or Medicaid coverage.
- You take a leave of absence under the Family and Medical Leave Act (FMLA) (however, you can't change coverage while you're on FMLA).

There are some additional circumstances under which you may make a mid-year change as described in this section.

Qualified Changes in Status

You may change certain benefit elections during the year if you experience a qualified change in status that results in a loss or gain of eligibility under the Program for yourself, ***spouse***, your ***domestic partner*** or your eligible dependent children. Changes may be made to your Vision coverage as long as the changes are consistent, they correspond with the change in status and they follow the Plan's rules. For example, in the case of birth, adoption, or placement for adoption, you may enroll your new dependent in the Vision

Plan.

A qualified change in status is any of the following circumstances that may affect coverage:

- You get divorced, legally separated or you have your marriage legally annulled.
- Your ***spouse*** or dependent dies.
- Your unmarried dependent becomes ineligible for coverage (e.g., he or she reaches the Program's eligibility age limit, or gets married).
- You get married.
- You have a baby, adopt or have a child placed with you for adoption.
- You, your ***spouse***, your ***domestic partner*** or your dependent experience a change in employment status (e.g., start or end employment, strike or lockout, begin or return from an unpaid leave of absence, change work sites, or experience a change in employment that leads to a loss or gain of eligibility for coverage).
- You, your ***spouse***, your ***domestic partner*** or your dependent experiences a change in employment status that affects eligibility for coverage (e.g., change from part-time to full-time or vice versa).
- Your, your ***spouse's***, your ***domestic partner's*** or your dependent's home address changes (outside the network service area).
- You, your ***spouse***, your ***domestic partner*** or your dependent experience a significant change in cost or coverage.

If you experience a qualified change in status and need to change your coverage during the ***plan year***, you must make your change online at PublicisConnections.com within 31 days of the event that necessitates the change. If you don't, you can't make a coverage change until the next annual enrollment period, unless you once again meet one of the conditions for a mid-year change. In addition, at the time you make your online coverage change, you must certify your qualified change in status.

Special Enrollment Rules Under HIPAA

Special enrollment rules apply under the Vision Plan only due to a loss of other coverage, or a need to enroll because of a new dependent's eligibility.

Special Enrollment Due to Loss of Other Coverage

You and your eligible dependents may enroll for Vision coverage (subject to certain conditions) if you waived your initial coverage at the time it was first offered under this Program because you (or your ***spouse*** or dependent) were covered under another plan or insurance policy. You and your dependents may enroll, provided your or your dependents' other coverage was:

- COBRA continuation coverage that has since been exhausted (In other words, you must continue COBRA coverage for the full duration of the COBRA coverage period); or
- Coverage (if not COBRA continuation coverage) that has since terminated due to a "loss of eligibility" or a loss of employer contributions.

  "Loss of eligibility" includes a loss of coverage due to:

  - Legal separation;
  - Divorce;
  - Death
  - Termination of employment; or
  - Reduction in the number of hours of employment.

  It doesn't include loss of coverage due to failure to timely pay required contributions or premiums, or loss of coverage for cause (i.e., fraud or intentional misrepresentation).

You and your dependents must meet certain other requirements as well.

- **Required Length of Special Enrollment:** You and your dependents must enroll no later than 31 days from the day the other coverage was lost.
- **Effective Date of Coverage:** If you enroll within the 31-day period, coverage takes effect retroactive to the date coverage was lost.

Special Enrollment Due to New Dependent Eligibility

You and your eligible dependents may enroll for Vision coverage under the Program (subject to certain conditions) if you acquire a dependent through marriage, birth, adoption or placement of adoption. The conditions that apply are as follows:

- **Non-Enrolled Employee:** If you're eligible but haven't yet enrolled, you may enroll upon your marriage, or upon the birth, adoption or placement for adoption of your child.
- **Non-Enrolled *Spouse*:** If you're already enrolled, you may enroll your ***spouse*** at the time of his or her marriage to you. You may also enroll your ***spouse*** if you acquire a child through birth, adoption or placement of adoption.
- **New Dependents of an Enrolled Employee:** If you're already enrolled, you may enroll a child who becomes your eligible dependent as a result of marriage, birth, adoption or placement of adoption.
- **New Dependents/*Spouse* of a Non-Enrolled Employee:** If you're eligible but not enrolled, you may enroll an individual (***spouse*** or child) who becomes eligible dependent as a result of marriage, birth, adoption or placement of adoption. However, you (the non-enrolled employee) must also be eligible to enroll, and actually enroll at the same time.
- **Required Length of Special Enrollment:** You and your dependents must enroll no later than 31 days from the date of marriage, birth, adoption or placement for adoption.
- **Effective Date of Coverage:** Coverage takes effect retroactive to the date of the gain of dependent eligibility.

Additional Mid-Year Changes

You also may change your benefit elections during the year in the following circumstances.

Cost and Coverage Changes

You may be able to change your benefit elections if you, your ***spouse*** or your dependent experiences a significant change in cost of coverage. Under this rule, for example, if you switch from part-time to full-time employment or vice versa and as a result the cost of your benefits changes, you may be able to change your coverage. You may also be able to revoke your existing elections if your coverage is significantly curtailed (that is, if there is an overall reduction in coverage to all participants), or if a new benefit option is added or eliminated.

Changes to a Dependent's Plan

You may make a mid-year election change that is on account of, and corresponds to, changes under the plan of your ***spouse***, former ***spouse***, or dependent's employer, or if the other plan has a different ***plan year***, or if the enrollment period is different from the one under this Program.

Automatic Changes

If the cost of your underlying coverage increases or decreases, the ***Company*** may automatically change the amount of your contribution that's withheld. Likewise, the ***Company*** may automatically change the amount of your deduction if it's required to do so by the terms of a divorce decree or by the terms of another judgment, decree or order that requires the Program to provide coverage for your dependents.

Special Rule for Rehired Employees

If you terminate employment and are rehired within 30 days of your termination date, the benefit elections that were in effect on the date of your termination will be automatically reinstated. If you are rehired more than 30 days after the date of your termination, you will be allowed to make new benefit elections under the Program.

Procedure for Mid-Year Changes

You must request a change in your benefit elections within 31 days of the date of the change in status. If a change in status has been experienced, you may alter your benefit options to, among other things, add or drop a dependent, or add or drop coverage for yourself or your ***spouse***. Provided you notify the Program within the required time frames, any changes in your benefit options due to a permissible mid- year event will become effective:

- In the case of a dependent's birth, on the date of such birth;
- In the case of a dependent's adoption or placement for adoption, on the date of such adoption or placement for adoption; and
- For all other events, on the date of the qualifying event.

Note that coverage cannot be paid for retroactively on a pre-tax basis (although it can be retroactively effective) except for in the case of birth, adoption or placement for adoption.

If you experience one of these qualified changes in status, you may change your Vision coverage. The changes must be consistent with and correspond to the change in status as well as follow Plan rules. For example, in the case of birth, adoption or placement for adoption, you may generally increase coverage under your life insurance and enroll your new dependent for vision coverage, but you can't drop your current coverage.

If you experience a qualified change in status and need to change your coverage you must make the change online at PublicisConnections.com, or you must notify the Benefits Department and request assistance with the change. Your change must be made within 31 days (which includes the day the event occurred) of the event that causes the change. If you don't make the change in time, you can't make a coverage change until the next annual enrollment, unless you once again meet one of the conditions for a mid-year change. If requested, you may have to provide proof of your change in status.

Coordination of Benefits

If you or your dependents have coverage under another similar plan, your benefits under this Program coordinate with benefits outside the Program to help eliminate duplicate payments for the same services. This section highlights the coordination of benefits (COB) feature.

Coordination Plans

Certain types of plans normally coordinate benefits, including the following:

- Plans or coverage provided by an employer, union, trust or other similar sponsor.
- Other group health care plans or coverage that covers you or your dependents, including student coverage provided through a school above the high school level.
- Government benefit programs provided or required by law, including Medicare or Medicaid.
- Automobile insurance plans in the case of accidents

These coordination provisions don't apply to individual or private insurance plans.

Any benefits under a plan that covers you or eligible dependents will be considered for possible coordination (even if you don't request payment from them).

How Coordination Works With Other Group Plans

If you're covered by more than one group plan, one plan is primary. The primary plan pays benefits first without considering the other plans. Then - based on what the primary plan pays - the other plans may pay a benefit (if any).

If your coverage is secondary, the Plan pays the lesser of:

- The Plan's benefit; or
- The balance left after the primary plan pays benefits.

When combined, the benefits that the two coverages pay won't exceed 100% of the eligible expense.

Determining the Order of Payment

When benefits coordinate, the plans or coverage involved determine which pays benefits first (the primary), second (the secondary), etc. Here are the plan's guidelines for determining which is primary:

- If one plan has no Coordination-of-Benefits (COB) provision, it automatically is primary.
- The plan covering the person as the employee, rather than as a dependent, laid-off employee, terminated employee, COBRA Beneficiary or retired employee is primary and pays benefits first.
- If both parents' plans cover a dependent, the plans use the "Birthday Rule" to determine which parent's plan pays first. The plan of the parent whose birthday comes earlier in the calendar year is the primary plan, and the other parent's plan is secondary. If the other plan doesn't follow the Birthday Rule, then the rules of that plan determine the order of benefits.

  In the case of a divorce or separation, the plan relies on the "Birthday Rule" to determine which parent's plan pays first. However, if there's a court order requiring a parent to take financial responsibility for health care coverage for the child, that parent's plan always is primary.

If a determination can't be made as to the order of payment, the plan that has covered the person longer is usually the primary plan.

Subrogation and Reimbursement

The Program may pay a benefit to you, or on behalf of you and/or your dependents in situations where another party was responsible for your or your dependent's illness, injury, or other loss. (An example would be a personal injury caused by someone's negligence.) If this is the case, the Program has a right of subrogation as to any funds recovered. In other words, if you or your dependents accept benefits from the Program, you must reimburse the Program in full if you receive payment from any person, entity, organization, or their insurers as a recovery for your illness or injury, no matter how that recovery is characterized (medical damages, lost wages, permanent injury damages, etc.).

The Program has the right to a full and complete subrogation of all payments it makes to or on behalf of you and/or your dependents – even if you and /or your dependents aren't or won't be fully compensated or made whole by the person or entity providing a recovery related to the injuries or damages. You and/or your dependents must fully cooperate with the Program so that it may exercise its right of subrogation. This may include (but isn't limited to) allowing the Program to pursue legal actions and claims in the name of you and/or your dependents. You and/or your dependents must sign and deliver such documents as this Program or its agents reasonably request to protect this Program's rights of subrogation, equitable lien or constructive trust. You and your dependents must also provide any relevant information and take such actions as this Program or its agents reasonably request to assist this Program in making a full recovery of the reasonable value of benefits provided. You and/or your dependents must not do anything to prejudice the Program's rights of subrogation, equitable lien or constructive trust.

The Program has the right to a full and complete reimbursement from you and/or your dependents, and should be reimbursed for all payments made from any recovery you and/or your dependents obtain from any insurance company, responsible third party, entity or organization (even if you and/or your dependents have not or will not be fully compensated or made whole for the injuries). In order to secure the rights of the Program, you and/or your dependents hereby: (1) grant to this Program a first priority lien against the proceeds of any settlement, verdict or other amounts received by them or any attorney on behalf of the covered individuals; (2) assign to this Program any benefits you and/or your dependents may have under any automobile policy or other coverage, to the extent of this Program's claim for repay; and (3) agree to the imposition of a constructive trust on the proceeds of any settlement, verdict or other amounts received by the covered individual.

In exercising its right of recovery through either subrogation or reimbursement, the Program isn't responsible for any fees, expenses, attorney's fees or representatives' fees that you and/or your dependents may incur to obtain the funds needed to reimburse the Program to pay the Program's subrogation interest. The Program's subrogation claim is paid first out of any recovery obtained.

If a settlement is reached, you must reimburse (in full) the benefits paid to you by the Program, before any other expenses are paid (including attorney's fees, up to but not exceeding your settlement amount). If the settlement is less than the benefit paid, you must notify the ***Company*** before you agree to compromise the Program's right to recover the benefit it has advanced you.

If you refuse to reimburse the Program, the Program may recover from you by other means, including offsetting future benefit payments.

Continuation or Termination of Coverage

Your coverage will continue until the end of the month in which you end your employment or cease to be eligible to participate in the plan.

Your dependents' coverage will end on the last day of the month in which (whichever occurs first):

- Your coverage ends;
- You stop making contributions; or
- Your dependent no longer meets the eligibility requirements.

If You Die While Employed

If you die while you're still employed, your contributions for Vision Coverage end on the date the death occurs. Your covered dependents are eligible to continue health care coverage under COBRA for 36 months.

If You Become Disabled

If you become disabled and are eligible to receive disability benefits under the STD program, coverage for you and your dependents continues provided you continue to receive STD benefits.

If your disability continues and you start collecting long-term disability benefits from the LTD Plan your active coverage will continue until the end of the month in which your LTD coverage commence. You and your covered dependents are then eligible to continue coverage under COBRA.

If You Take a Leave of Absence

You may decide to take either an unpaid personal leave or an unpaid FMLA leave of absence.

- **Unpaid Personal Leave:** If you take an unpaid leave of absence for 30 days or less, coverage continues for you and your eligible dependents. However, you must submit payment for the full cost of the coverage.

  If your unpaid personal leave of absence is more than 30 days, coverage for you and your dependents ends the first of the month following your 30th day of leave. You and your dependents can continue health care coverage under COBRA. If you return to active employment for the ***Company***, you must reenroll for benefit upon your return.

- **Unpaid FMLA Leave:** If you decide to take an unpaid FMLA leave, coverage continues for you and your eligible dependents as if you were still an active employee. However, you must continue to submit payment for this coverage (at the active rate). You can select a core coverage of health, dental, and vision, or you can continue all of your coverages. You may also decide to discontinue your coverage under the Plan.

Continuation of Coverage Under the Family and Medical Leave Act of 1993 (FMLA)

The ***Company*** continues your coverage under the plan during the period of FMLA leave just as if you were still employed. Continued coverage ends once you:

- Terminate employment; or
- Exhaust your approved period of FMLA leave, and don't return from your FMLA leave.

If your employment doesn't terminate during your leave, but you don't return to work once your leave ends, you can elect to continue health coverage under the COBRA continuation rules. Your COBRA continuation period begins on the last day of your FMLA leave.

If you're on an unpaid leave and fail to reimburse the ***Company***, the ***Company*** may recover the value of benefits or premiums paid to maintain your health coverage during your FMLA period of leave.

Continuation of Coverage Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

If you're absent from work because of your service in the ***uniformed services*** (including Reserve and National Guard duty), you may elect to continue health coverage for yourself and your eligible dependents under the provisions of USERRA. The period of coverage for you and your eligible dependents ends on the earlier of:

- The end of the 24-month period starting on the day your military leave of absence begins.
- The day after the day on which you're required but fail to contact your employer or return to work. Under USERRA, you must contact your employer regarding your return to work within different time periods – depending on the duration of your uniformed service:
  - **If your uniformed service is less than 31 days:** You're generally required to contact your employer regarding your return to work on the first full calendar day of the first full scheduled work period following your period of uniformed service. (Your period of uniformed service ends after you return from your place of service to your residence.)
  - **If your uniformed service is between 31 and 180 days:** You're generally required to contact your employer regarding your return to work within 14 days of your discharge.
  - **If your uniformed service is at least 181 days:** You're generally required to contact your employer regarding your return to work within 90 days of your discharge.

You may be required to pay all or a portion of the cost of your coverage:

- **If your military service is 31 days or less:** You're required to pay no more than your usual share of the cost for this period of coverage.
- **If your military service is more than 31 days:** You must pay the entire cost of the coverage (not to exceed 102% of the applicable premium similar to the manner in which the cost for COBRA continuation coverage is calculated).

You must also notify your HR Representative that you'll be absent from employment due to military service (unless you can't give notice because of military necessity or unless under all relevant circumstances, notice is impossible or unreasonable). You must also notify your HR Representative that you want to elect continuation coverage for yourself and/or your eligible dependents under the USERRA provisions.

COBRA

The Consolidated Omnibus Budget Reconciliation Act (COBRA) requires the Program to offer you and your dependents the opportunity to pay for a temporary extension of health care coverage, in certain situations where your active employee coverage is lost. This section highlights your COBRA coverage.

When You and/or Your Dependents Elect COBRA

COBRA allows you and your dependents to continue the coverage that was in effect on the day that your active employee coverage would have ended. In other words, if you didn't have active coverage, you can't elect COBRA. If coverage under the Program changes while you're on COBRA, your coverage will also change. In addition, you'll have the same annual enrollment benefit choices as Program participants.

If you elect COBRA coverage, it takes effect on the date your coverage under the Program ended, and continues for up to 18 to 36 months (depending on your situation).

COBRA applies to the medical, dental, vision, and Health Care Spending Account plans.

Snapshot of COBRA Continuation Coverage

Here's a snapshot of who's eligible for COBRA coverage continuation, under what circumstances, and how long COBRA coverage continuation lasts.

If:	Qualifying Event	Who's Eligible for COBRA Coverage	Duration of COBRA Coverage*
You	Become laid off	You and your dependents	18 months
	Have a reduction in hours	You and your dependents	18 months
	Terminate Employment	You and your dependents	18 months
	Don't return from a leave of absence after six months	You and your dependents	18 months
	Begin collecting LTD Plan benefits.	You and your dependents	18 months**
	Become disabled within the first 60 days of COBRA continuation coverage	You and your dependents	29 months
	Die	Your dependents	36 months
	Become divorced or legally separated	Your dependents	36 months
	Become entitled to Medicare while on COBRA	Your dependents	Up to 36 months***
Your Dependent	Is no longer an eligible dependent (due to age limit, divorce or legal separation)	Your dependent	36 months
	Is no longer an eligible dependent because of your death	Your dependent	36 months
	Becomes disabled within the first 60 days of COBRA continuation coverage	You and your dependent	29 months

*Duration of coverage is from the date of the qualifying event.
**You may be eligible for an additional 11 months of COBRA due to an eligible disability.
***The 36-month coverage begins on the day you become eligible for Medicare.

The *COBRA* rights of you and your dependents will be fully detailed in a notice that will be sent to you in connection with your *COBRA* event within 14 days after the *Company* notifies bswift of the COBRA event.

Employee Loses Vision Plan Coverage

If you lose coverage because of a layoff, reduction in hours, you begin collecting LTD Plan benefits, or terminate employment, COBRA continuation coverage is available to you and your dependents for up to18 months from the date of the qualifying event. bswift notifies you and your dependents of your right to continue coverage when you experience a qualifying event. Such an event makes a continuation of coverage available. You must then notify bswift (within 60 days of the later of the date you receive notice of your COBRA rights or the date the coverage is lost) of your decision to continue coverage. You can reach bswift by calling a 1-866-898-0393.

If you elect coverage within the 60-day period and pay the required premium, your coverage is retroactively reinstated. If you don't elect COBRA within the initial enrollment period, or if you don't pay the required premium in full, your coverage ends, and you won't be able to reenroll in the future.

Even if you decline COBRA, each of your eligible dependents has an independent right to elect or reject COBRA coverage. A parent or legal guardian can elect COBRA on behalf of a minor child.

If you or your covered dependent becomes disabled, as defined by Social Security, during the first 60 days of COBRA continuation coverage, the disabled beneficiary and each non-disabled COBRA beneficiary may extend the 18-month continuation period an additional 11 months, up to 29 months. For the 29-month continuation coverage period to apply, you must notify **bswift at (866) 365-2413** that you or your covered dependent is disabled within 60 days of the latest of the date of the determination, the date of the qualifying event or the date you would otherwise lose coverage under the plan due to a qualifying event, and before the end of the 18-month period of COBRA continuation coverage.

If, during the initial 18-month period, the Social Security Administration determines that you're no longer disabled, the 11-month extension doesn't apply. If your disability ends during the 11-month extension period, your COBRA coverage ends the first day of the month after 30 days have passed since the Social Security Administration's determination (provided the COBRA period doesn't exceed 29 months).

Dependent Loses Vision Plan Coverage

Your covered dependent has the right to continue his or her coverage for up to 36 months from the date of the qualifying event if he or she loses coverage because:

- You and your ***spouse*** become divorced or legally separated;
- He or she is no longer eligible for coverage under the Program (i.e., reaches the age limit);
- You become entitled to benefits under Medicare; or
- You die.

If any of the above situations occur, notify the *Company* within 31 days of the qualifying event by logging onto the Publicis Connections website (PublicisConnections.com) and following the appropriate prompts. The *Company* will then notify bswift, who will then send out the COBRA rights notice. Failure to take appropriate action via the website may result in the loss of COBRA rights. bswift in turn, notifies your dependent of his or her COBRA enrollment options. Your dependent must elect to continue coverage by notifying bswift within 60 days or the later of the date the benefits terminate due to the qualifying event or the date the dependent receives notice of his or her COBRA rights.

Newborn or Adopted Children

If, during your COBRA continuation period, you have or adopt a child, you may elect COBRA for that child. Coverage for that newborn or adopted child continues for the remainder of your 18-month (or 29-month) continuation period, as a qualified COBRA beneficiary.

Cost of COBRA Coverage

You don't have to provide medical evidence that you're insurable to choose COBRA coverage. If you elect COBRA continuation, you're responsible for paying the required premium. The cost is 102% (a 2% administrative cost is added to the actual cost of the coverage) of the total premium rate. These costs are reviewed annually and are subject to change. For benefits that are self-insured, the premium rate is based on actuarial data.

You and your dependents will be billed monthly for the coverage(s) you or your dependents elect. Payment is due by the first of the month for which you're buying coverage. If payment isn't received within 30 days of that date, the coverage will be cancelled. The first premium payable when you or a dependent initially elects COBRA coverage, however, is due within 45 days of the coverage election.

How to Apply for COBRA Coverage

To enroll in COBRA, contact bswift at **(866) 365-2413** or the Publicis Re:Sources USA Benefits Department.

If your home address changes while on COBRA, notify your HR Representative or the Publicis Re:Sources USA Benefits Department.

When COBRA Coverage Ends

COBRA continues until the earliest of the following:

- The end of the 18-month, 29-month or 36-month continuation period.
- The date the ***Company*** no longer provides health care coverage to any of its employees.
- The date a required premium for continuation of group coverage is due and not paid within the required time.
- After you elect COBRA continuation coverage, the date you and your dependents become entitled to Medicare or covered under another group health care plan (provided pre-existing condition exclusions or limitations under the new group health care plan don't apply).

Special continuation periods apply to retired participants and their dependents in the event of bankruptcy under Title 11 of the United States Code if the retired participant and his or her dependents lose substantial coverage within one year before or after the date that the bankruptcy proceedings commenced. Retired participants may continue their coverage until their death. For a ***spouse***, surviving ***spouse***, or dependent child of the retired participant, coverage ends at the earlier of the qualified beneficiary's death, or 36 months past the date of the death of the retired participant.

How Your Vision Coverage Works

Snapshot of Your Vision Coverage

The following is a snapshot of how the Vision Plan pays benefit to you when you go to a VSP doctor or out-of-network provider.

LOW OPTION BENEFIT

Covered Services	Frequency	VSP Doctor	Out-of-Network Provider*
Exam	Every calendar year	Covered in full after $15 ***co-payment***	Reimbursed up to $50 allowance
Lenses (per pair)	Every calendar year		
• Single Vision		Covered in full after $25 ***co-payment*****	Reimbursed up to $50 allowance
• Lined Bifocal		Covered in full after $25 ***co-payment*****	Reimbursed up to $75 allowance
• Lined Trifocal		Covered in full after $25 ***co-payment*****	Reimbursed up to $100 allowance
• Lenticular		Covered in full after $25 ***co-payment*****	Reimbursed up to $125 allowance
• Tinted and Photochromic lenses (prescription sunglasses)		Covered in full after $25 ***co-payment*****	Reimbursed up to $5 allowance
• UV coating, Scratch-resistant coating, Anti-reflective coating, Polycarbonate lenses, Standard Progressive lenses		Covered in full after $25 ***co-payment*****	Not covered
Frames	Every calendar year†††	$120 allowance after $25 ***co-payment***†† at VSP preferred or Affiliate providers or $70 allowance at Costco, Walmart or Sam's Club 20% discount on amount over your allowance at VSP providers	Reimbursed up to $70 allowance
Contact Lenses (in lieu of lenses and frames)	Every calendar year†††	• Reimbursed up to $125 allowance for elective contact lens exam (fitting and evaluation) and materials • 15% off cost of contact lens exam (fitting and evaluation) at VSP providers • Covered in full after $25 ***co-payment*** for medically ***necessary*****	• Reimbursed up to $125 allowance for elective contact lens exam (fitting and evaluation) and materials • Reimbursed up to $210 for medically ***necessary***

* Benefits shown are the maximum paid. Other limits may apply. See "How Benefits Are Paid" in the How Your Coverage Works section of this document.

** ***Co-payment*** applies to lenses and/or frames. If you receive lenses and frames together, you're only responsible for one ***co-payment*** of $25 for both materials.

*** Medically ***necessary*** contact lenses are those prescribed by a doctor for serious eye conditions (e.g. cataracts) when eyeglasses cannot be worn.

† Frames must be within the $45 wholesale allowance (roughly equivalent to a $120 retail cost).

†† If received from any VSP doctor within in the last 12 months of the last covered eye exam.

††† For frames or contact lenses.

Additional Pair of Prescription Glasses	Same day as your covered Wellness Exam Within 12 months of receiving your covered eye exam	30% off the cost of lenses and frames 20% off the cost of lenses and frames††	Not covered
Diabetic Eye Care Plus	Services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD). Retinal screening for eligible members with diabetes. Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details.	Covered in full after $20 copayment	Not covered
Retinal Screening	Same day as your covered Wellness Exam	No more than $39 copay on routine retinal screening as an enhancement to a WellVision Exam	Not covered
Laser VisionCare℠ Program	Anytime	Visit the WellVision Learning Source® at www.vsp.com for educational information on laser vision correction surgery.	
Services Not Covered		Eye exams as a condition of employment, medical or surgical treatment (may be covered under Medical Plan), non-prescription lenses/plano lenses (lenses with refractive correction of less than ± .50 diopter), prescription goggles, safety eyewear, replacement and repair of lost or broken lenses, vision training, services covered by Workers' Compensation, or two pairs of glasses instead of bifocals. Some brands of spectacle frames may be unavailable for purchase as Plan Benefits, or may be subject to additional limitations. Covered Persons may obtain details regarding frame brand availability from their VSP Network Doctor or by calling VSP's Customer Care Division at (800) 877-7195. There are no benefits for professional services or materials connected with: • Orthoptics or vision training and any associated supplemental testing. • Corneal Refractive Therapy (CRT) • Orthokeratology (a procedure using contact lenses to change the shape of the cornea in order to reduce myopia). • Refitting of contact lenses after the initial (90-day) fitting period. • Plano lenses (lenses with refractive correction of less than ± .50 diopter). • Two pair of glasses in lieu of bifocals. • Replacement of lenses and frames furnished under this Plan that are lost or broken, except at the normal intervals when services are otherwise available. • Medical or surgical treatment of the eyes. • Corrective vision treatment of an Experimental Nature. • Plano contact lenses to change eye color cosmetically. • Artistically-painted contact lenses. • Contact lens insurance policies or service contracts. • Additional office visits associated with contact lens pathology. • Contact lens modification, polishing, or cleaning. • Costs for services and/or materials exceeding Plan Benefit allowances. • Services or materials of a cosmetic nature. • Services and/or materials not indicated on this Schedule as covered Plan Benefits.	

HIGH OPTION BENEFIT

Covered Services	Frequency	VSP Doctor	Out-of-Network Provider*
Exam	Every calendar year	Covered in full after $10 ***co-payment***	Reimbursed up to $50 allowance
Lenses (per pair)	Every calendar		
• Single Vision		Covered in full after $10 ***co-payment*****	Reimbursed up to $50 allowance
• Lined Bifocal		Covered in full after $10 ***co-payment*****	Reimbursed up to $75 allowance
• Lined Trifocal		Covered in full after $10 ***co-payment*****	Reimbursed up to $100 allowance
• Lenticular		Covered in full after $10 ***co-payment*****	Reimbursed up to $125 allowance
• Tinted and Photochromic lenses (prescription sunglasses)		Covered in full after $10 ***co-payment*****	Reimbursed up to $5 allowance
• UV coating, Scratch-resistant coating, Anti-reflective coating, Polycarbonate lenses, Standard Progressive Lenses		Covered in full after $10 ***co-payment*****	Not covered
Frames	Every calendar year †††	$200 allowance after $10 ***co-payment***** at VSP preferred or Affiliate providers or $110 allowance at Costco, Walmart or Sam's Club 20% discount on amount over your allowance at VSP providers	Reimbursed up to $70 allowance
Contact Lenses (in lieu of lenses and frames)	Every calendar year †††	• Reimbursed up to $200 allowance for contact lens exam (fitting and evaluation) and materials • 15% off cost of contact lens exam (fitting and evaluation) at VSP providers • Covered in full after $10 ***co-payment*** for medically ***necessary*****	• Reimbursed up to $125 allowance for elective • Reimbursed up to $210 for medically ***necessary***
Additional Pair of Prescription Glasses	Same day as your covered Wellness Exam Within 12 months of receiving your covered eye exam	30% off the cost of lenses and frames 20% off the cost of lenses and frames††	Not covered
Diabetic Eye Care Plus	Services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD). Retinal screening for eligible members with diabetes. Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details	Covered in full after $20 copayment	Not covered
Retinal Screening	Same day as your covered Wellness Exam	No more than $39 copay on routine retinal screening as an enhancement to a WellVision Exam	Not covered

Laser VisionCare[SM] Program	Anytime	Visit the WellVision Learning Source® at www.vsp.com for educational information on laser vision correction surgery.

* Benefits shown are the maximum paid. Other limits may apply. See "How Benefits Are Paid" in the How Your Coverage Works section of this document.
** ***Co-payment*** applies to lenses and/or frames. If you receive lenses and frames together, you're only responsible for one ***co-payment*** of $10 for both materials.
*** Medically ***necessary*** contact lenses are those prescribed by a doctor for serious eye conditions (e.g. cataracts) when eyeglasses cannot be worn.
† Frames must be within the $76 wholesale allowance (roughly equivalent to a $200 retail cost).
†† If received from any VSP doctor within in the last 12 months of the last covered eye exam.
††† For frames or contact lenses.

Services Not Covered		Eye exams as a condition of employment, medical or surgical treatment (may be covered under Medical Plan), non-prescription lenses/plano lenses (lenses with refractive correction of less than ± .50 diopter), prescription goggles, safety eyewear, replacement and repair of lost or broken lenses, vision training, services covered by Workers' Compensation, or two pairs of glasses instead of bifocals. Some brands of spectacle frames may be unavailable for purchase as Plan Benefits, or may be subject to additional limitations. Covered Persons may obtain details regarding frame brand availability from their VSP Network Doctor or by calling VSP's Customer Care Division at (800) 877-7195. There are no benefits for professional services or materials connected with: • Orthoptics or vision training and any associated supplemental testing. • Corneal Refractive Therapy (CRT) • Orthokeratology (a procedure using contact lenses to change the shape of the cornea in order to reduce myopia). • Refitting of contact lenses after the initial (90-day) fitting period. • Plano lenses (lenses with refractive correction of less than ± .50 diopter). • Two pair of glasses in lieu of bifocals. • Replacement of lenses and frames furnished under this Plan that are lost or broken, except at the normal intervals when services are otherwise available. • Medical or surgical treatment of the eyes. • Corrective vision treatment of an Experimental Nature. • Plano contact lenses to change eye color cosmetically. • Artistically-painted contact lenses. • Contact lens insurance policies or service contracts. • Additional office visits associated with contact lens pathology. • Contact lens modification, polishing, or cleaning. • Costs for services and/or materials exceeding Plan Benefit allowances. • Services or materials of a cosmetic nature. • Services and/or materials not indicated on this Schedule as covered Plan Benefits.

VSP Doctors and Out-of-Network Providers

You can receive services from a VSP doctor or out-of-network provider.

- **VSP preferred doctors** – VSP doctors contract with VSP to provide your vision services or eyewear for a ***negotiated charge***. They offer the convenience of "one-stop shopping," and can provide everything you need (eye exams, eyeglasses and contact lenses). As long as you receive care and eyewear from a VSP doctor, you're only responsible for the ***co-payment*** amount and any amount for extra supplies and services not covered by the plan. (Some limits apply, so see the Snapshot Chart for details.)
- **VSP Participating Retail Chains**– VSP's Participating Retail Chains add more than 1,000 optical stores for your employees' convenience, such as Costco® Optical, Walmart, Sam's Club, Visionworks®, Cohen's, OPTYX, Wisconsin Vision, Heartland Vision, and RxOptical®. Members enjoy a covered-in-full benefit experience with equivalent benefits. No forms are required—your employees only pay copays, costs over coverage amounts, and/or for noncovered options. Coverage with a Participating Retail Chain may differ from coverage with a VSP Signature Network provider including lens options and discounts on non-covered items. Once your coverage is effective, go to www.vsp.com for details and participating retail chain locations.

- **Out-of-network providers** – If you prefer, you can go to an optometrist, ophthalmologist or dispensing optician who is an out-of-network provider. If you do, you pay the provider's regular charges in full. Once you submit an itemized receipt, the plan reimburses you for the eligible expense (up to the scheduled benefit amount). See the Snapshot Chart for details. Also see The Care Received From a Non-Network Provider section of this document for details about filing claims.

How to Use a VSP Doctor or Participating Retail Chain

Here's what you need to do, and what happens when you use a VSP Signature doctor.

- Before you make an eye appointment, locate a VSP doctor near you by calling VSP Member Services at **1-800-877-7195** or visiting the Web site at www.vsp.com**.**
- Call the doctor to make an appointment. Make sure you identify yourself as a VSP member. The doctor will verify your eligibility with VSP. If you are not eligible, the doctor will notify you.
- At the time of your visit, pay the required ***co-payment***. VSP takes care of all paperwork and pays the doctor for your services.

How Benefits Are Paid

The way benefits are paid depends on whether you receive care from a VSP doctor or an out-of-network provider.

VSP Doctor

At the time of your visit, pay the required ***co-payment***. VSP takes care of all paperwork and pays the doctor for your services. See the snapshot chart for more details.

Additional Pair of Prescription Glasses

If you choose contact lenses, but also wear prescription glasses, you can receive 30 % off the cost of non-covered pairs of glasses (the same day you receive the covered WellVision Exam), or 20% off the cost of non-covered pairs of glasses (lenses and a frame) within 12 months of the last covered WellVision exam.

Out-of-Network Provider

VSP pays benefits up to a certain dollar amount for covered services. You pay the remaining cost of your service. There are additional charges for certain options, such as coating and laminations, blended lenses and UV-protected lenses. **Please note:** There's no guarantee that the scheduled amount the Vision Plan pays will cover the entire cost of your exam, eyeglasses or contact lenses.

If you don't go to a network provider, your provider doesn't have to accept the Vision Plan's ***negotiated charges*** as full payment. As a result, you're responsible for any cost difference. Look for details on how to apply for benefits under the "Care Received From a Non-Network Provider."

See the SNAPSHOT OF YOUR VISION COVERAGE for more details.

Online Resources

VSP's Laser VisionCare Program

If you are considering laser vision correction, VSP can help you make an informed decision. VSP has contracted with many of the nation's finest laser surgery facilities and doctors, offering you access to laser vision correction surgery for hundreds of dollars less than what you might pay privately.

Visit the WellVision Learning Source® at www.vsp.com to learn more about this program.

Covered Services

Benefits are paid for most vision services and appliances. See the snapshot chart of the Vision Plan to see how benefits are paid for each covered service, as well as any benefit limit that may apply. Here's a list of covered services and appliances:

- Eye Exams;
- Lenses (that are prescription);
- Frames; and
- Contact lenses (that are prescription), in lieu of glasses (lenses and frame).

Expenses Not Covered

Benefits are paid for most vision services and appliances. However, some limits and exclusions do apply. You don't receive benefits for certain services or products – other than those noted under "Covered Services" including:

Some brands of spectacle frames may be unavailable for purchase as Plan Benefits, or may be subject to additional limitations. Covered Persons may obtain details regarding frame brand availability from their VSP Network Doctor or by calling VSP's Customer Care Division at (800) 877-7195.

There are no benefits for professional services or materials connected with:

- Orthoptics or vision training and any associated supplemental testing.
- Corneal Refractive Therapy (CRT)
- Orthokeratology (a procedure using contact lenses to change the shape of the cornea in order to reduce myopia).
- Refitting of contact lenses after the initial (90-day) fitting period.
- Plano lenses (lenses with refractive correction of less than ± .50 diopter).
- Two pair of glasses in lieu of bifocals.
- Replacement of lenses and frames furnished under this Plan that are lost or broken, except at the normal intervals when services are otherwise available.
- Medical or surgical treatment of the eyes.
- Corrective vision treatment of an Experimental Nature.
- Plano contact lenses to change eye color cosmetically.
- Artistically-painted contact lenses.
- Contact lens insurance policies or service contracts.
- Additional office visits associated with contact lens pathology.
- Contact lens modification, polishing, or cleaning.
- Costs for services and/or materials exceeding Plan Benefit allowances.
- Services or materials of a cosmetic nature.
- Services and/or materials not indicated on this Schedule as covered Plan Benefits.

Applying for Benefits

Here you'll find information on how to receive your vision benefits.

Care Received From a Network Provider

If you receive care from a network provider, you don't have a file a claim for benefits. Once you meet the necessary ***co-payment*** requirement, the Vision Plan automatically pays the full cost of your covered services.

Care Received From a Non-Network Provider

If you receive care from a non-network provider, you pay the provider's fee in full, and the Vision Plan reimburses you up to the scheduled benefit amount. To receive an out-of-network benefit form, visit the Forms Library at www.PublicisConnections.com.

How to File a Benefit Form

To be reimbursed for your covered expense provided by a non-network provider, you may submit an out of network claim via mail or online submission.

To submit a claim via mail, send the vision care benefit form (available from the Forms Library at www.PublicisConnections.com) to the administrator:

VSP
Out-of-Network Provider Claims
PO Box 385018

Birmingham, AL 35238-0518

Be sure to include the following (should be on the itemized receipt):

- The patient's name;
- Date services began;
- The services and materials received;
- The type of lenses received (single, bifocal, trifocal, etc.);
- Your employer's name; and
- The participant's name, mailing address, last 4 digits of employee's Social Security number and date of birth.

To submit an online out of network claim submission, log into vsp.com with your user ID and password. Complete the VSP Member Reimbursement Form and upload the receipts to attach and submit to VSP.

You will be reimbursed according to the schedule of benefits. There's no guarantee, however, that the Vision Plan's scheduled benefit amount will cover the full cost of your exam or eyewear.

If a Claim is Denied

You may make a request for any benefits to which you may be entitled. Any such request must be made in writing to VSP at the following address:

Vision Service Plan
3333 Quality Drive
Rancho Cordova, CA 95670

Your request for benefits will be considered a claim for benefits.

The claims administrator notifies you of its decision regarding your claim within 30 days after receipt. If there are special circumstances, or your claim is incomplete, the claims administrator may request an additional 45-day extension. If such extension is needed, you're notified in writing before the beginning of the extension. If the extension is due to an incomplete claim, you're notified within the initial 30-day period of the information that's needed, and you're allowed 45 days to provide the missing information.

If your claim for benefits is denied – in whole or in part – a formal appeal procedure is in place for this Plan. The procedures below apply to claims filed on or after January 1, 2004.

If your claim for benefits is denied – in whole or in part – the claims administrator provides a written explanation of the denial. The explanation includes:

- The specific reasons for the denial;
- References to the pertinent Plan provisions upon which the denial is based;
- A description of any additional information you need to provide, and why the information is needed; and
- An explanation of the Plan's claim review procedures.

You, your beneficiary, or a duly authorized representative can appeal any claim denial by filing a written request for a full and fair review to the Claim Administrator at the address below:

VSP
Attn: Claims Appeals
PO Box 2350
Rancho Cordova, CA 95741

Plan Administrative Committee Voluntary Appeal

If you are not satisfied with the appeal decision at the Claim Administrator (VSP), you have the right to request an appeal from the Plan Administrative Committee within 60 days from receipt of the VSP appeal determination. Upon receipt of an appeal the Plan Administrative Committee shall render a determination of the appeal within 30 days after the appeal has been received.

Plan Administrative Committee appeals should be in writing and sent to:

Publicis Connections Health & Group Benefits Program
Attn: Plan Administrative Committee
35 W. Wacker Dr., 12th Floor
Chicago, IL 60601

Please note plan participants may submit a written request to examine Claim and/or appeals documents free of charge. The Plan Administrative Committee will review all Claims in accordance with the rules established by the U.S. Department of Labor. Decisions on appeals by the Plan Administrative Committee will be final.

Review of Your Claim

You may request a review of the denied claim. Here's how the process works:

1. You request a review of your claim, in writing, to the Claim Administrator (VSP) within 180 days after you receive notice of the denial.
2. You (or your representative) can request to review all pertinent documents. Please submit your request in writing to the claims administrator.
3. You may submit issues and argue against the denial in writing to the Claim Administrator (VSP).

Decision on Review of Your Claim

You are entitled to a written decision of your claim review, stating clearly the reasons for the decision as well as specific references to Plan provisions on which this description is based. Normally, this decision should not take longer than 60 days after receipt of your request for a review. If it will take longer than 60 days, you are entitled to receive written notice of such delay and the cause of the delay. In no case shall a decision be rendered later than 90 days after request of review. If the decision on your claim is not furnished to you within the time limitations described above, your claim will be deemed denied.

The Plan Administrator has complete discretionary authority to make all determinations under the Program, including eligibility for benefits and factual determinations, and to interpret the terms and provisions of the Program. The Plan Administrator has delegated to the claims administrators the discretionary authority to make decisions regarding the interpretation or application of Plan provisions, to make determinations (including factual determinations) as to the rights and benefits of employees and participants under the Plan, to make claims determinations under the Plan, and to decide the appeal of denied claims. Benefits will be paid under the Plan only if the Plan Administrator, or its delegate, determines that the claimant is entitled to them. The decision of the Plan Administrator or its delegate is final and binding.

If you do not agree with the final determination on review, you have the right to bring a civil action under Section 502(a) of ERISA, if applicable.

Limitation on Legal Action Against the Plan

You may not commence any legal action, including a court proceeding under Section 502(a) of ERISA, prior to the completion of all the administrative proceedings described above. Also, even if there are other periods to commence an action prescribed by law or rule of a court or other forum, no action in any forum to enforce benefits or other rights under the Plan may be undertaken more than one year following the date you are notified of the final decision on appeal. If the claims administrator or plan administrator considers a claim, in whole or in part, after any period for action described above has elapsed, it is not waiving the Plan's rights to limit legal actions thereafter.

ERISA Rights

As a participant in the group benefit plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts and a copy of the latest annual report (Form 5500 Series) that is filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and an updated Summary Plan Description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
- Receive a copy of the procedures used by the Plan for determining a qualified medical child support order.
- Continue health care coverage for yourself, your ***spouse***, or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan for the rules governing your COBRA continuation coverage rights.

Please refer to the Administrative Information Summary Plan Description for specific ERISA information regarding your Benefit Plans.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and

pay up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the status of a domestic relations order or a medical child support order, you may file suit in a federal court.

If it should happen that plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator at:

Publicis Connections
Attn: Plan Administration Committee
35 West Wacker Drive
Chicago, IL 60601
1-800-933-3622 (Monday-Friday, 8am-8pm EST)

If you have any questions about this statement or about your rights under ERISA, including COBRA, HIPAA, and other laws affecting the Plan or need assistance in obtaining documents from the Plan Administrator, you should contact:

- The nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory; or
- The Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

The Plan Administrator has delegated to the Claims Administrators the discretionary authority to make decisions regarding the interpretation or application of Plan provisions, to make determinations (including factual determinations) as to the rights and benefits of employees and participants under the Plan, to make claims determinations under Plan and to decide the appeal of denied claims. Benefits will be paid under the Plan only if the Plan Administrator, or its delegate, determines that the claimant is entitled to them. The decision of the Plan Administrator or its delegate is final and binding.

HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that, in part, requires group health plans to protect the privacy and security of your confidential health information. As an employee welfare benefit plan under ERISA, the Plan is subject to the HIPAA privacy rules. Pursuant to the HIPAA privacy rules, the Plan will not use or disclose your protected health information without your authorization, except for purposes of treatment, payment, health care operations, Plan administration or as required or permitted by law. A description of the Plan's uses and disclosures of your protected health information and your rights and protections under the HIPAA privacy rules is set forth in the plan's Notice of Privacy Practices, which is furnished to all Plan participants and can also be accessed on the Plan's internet site at www.PublicisConnections.com.

Glossary of Terms

Company

The term "Company" collectively refers to all subsidiaries of MMS USA Holdings, Inc. that have approved participation in the Publicis Connections Health and Group Benefit Programs.

Co-payment

If you receive services from a network provider, you must meet a co-payment requirement before the Vision Plan pays benefits. See the Snapshot Chart for the co-payment that applies.

Domestic Partner

Your same or opposite sex domestic partner includes any individual that you have been residing within same residence for at least six months. You need to complete the Affidavit for Certification of Domestic Partnership (available in the Forms Library on the Publicis Connections website) before coverage begins.

You must meet all of the following to be eligible for coverage as a domestic partner:

- You have shared a monogamous, committed relationship with one another that has existed for at least six months and is expected to last indefinitely;
- You're jointly responsible for each other's welfare and financial obligations;
- You share your principal place of residence;
- You're both at least 18 years old and mentally competent to consent to the contract;
- Neither of you are married to anyone else; and
- You're not related to each other in a way that would prevent a marriage from being recognized under the laws of the state in which you live.

You also may be required to prove your interdependence (if requested). You can do so by providing two of the following documents:

- Common ownership of real property;
- Common ownership of a motor vehicle;
- Driver's license that lists a common address;
- Proof of joint bank accounts or credit accounts
- Proof of designation as the primary beneficiary for life insurance or primary beneficiary designation under a partner's will;
- Assignment of a property power of attorney or health care power of attorney.

Necessary

A service or supply furnished by a particular provider is "necessary" if VSP determines that it is appropriate for the diagnosis, the care or the treatment of the disease or injury involved.

To be appropriate, the service or supply must:

- Be care or treatment, as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply – both as to the disease or injury involved and the person's overall health condition;
- Be a diagnostic procedure, indicated by the health status of the person and be as likely to result in information that could affect the course of treatment as, and no more like to produce a negative outcome than, any alternative service or supply – both as to the disease or injury involved and the person's overall health condition; and
- As to diagnosis, care and treatment be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any alternative service or supply to meet the above tests.

Negotiated Charge

This is the maximum charge a Preferred Care Provider has agreed to make as to any service or supply for the purpose of the benefits under this Plan.

Occupational Injury or Disease

An occupational injury or disease is one that:

- Arises out of (or in the course of) any work for pay or profit; or
- Results in any way from an injury or disease that does.

A disease will be deemed to be non-occupational regardless of cause if proof is furnished that the person:

- Is covered under any type of workers' compensation law; and
- Is not covered for that disease under such law.

Plan Administrator

The person or committee designated from time to time as the fiduciary responsible for overall administration of the Plan. Except as otherwise designated in the Administrative Information Summary Plan Description or by a notice from the ***Company***, the ***Plan Administrator*** may be contacted as follows:

Publicis Re:Sources USA
Publicis Benefits Department
Attn: Plan Administrative Committee
35 W. Wacker Dr., 12th Floor
Chicago, IL 60601
1-800-933-3622

Plan Year

The year starting January 1 and ending December 31.

Spouse

Your spouse includes the individual to whom you are legally married. Note that under federal law a "common law spouse" will be recognized as a spouse only if relevant state law recognizes the person as a spouse despite the lack of a formal marriage.

Totally and Permanently Disabled

The inability by reason of illness, injury or physical condition to perform the material duties of any occupation for which you're qualified or you become qualified by reason of experience, education or training. If you're a covered person other than an eligible individual, you're considered totally and permanently disabled if you're unable by reason of illness, injury or physical condition to engage in the normal activities of a person of the same age and sex who's in good health. In addition, you must have applied for and received a permanent disability status from the Social Security Administration.

Uniformed Services

Uniformed services include military service as:

- Active duty;
- Active duty in training;
- Initial active duty for training;
- Inactive duty for training;
- Full-time National Guard duty; and
- Military fitness examinations.