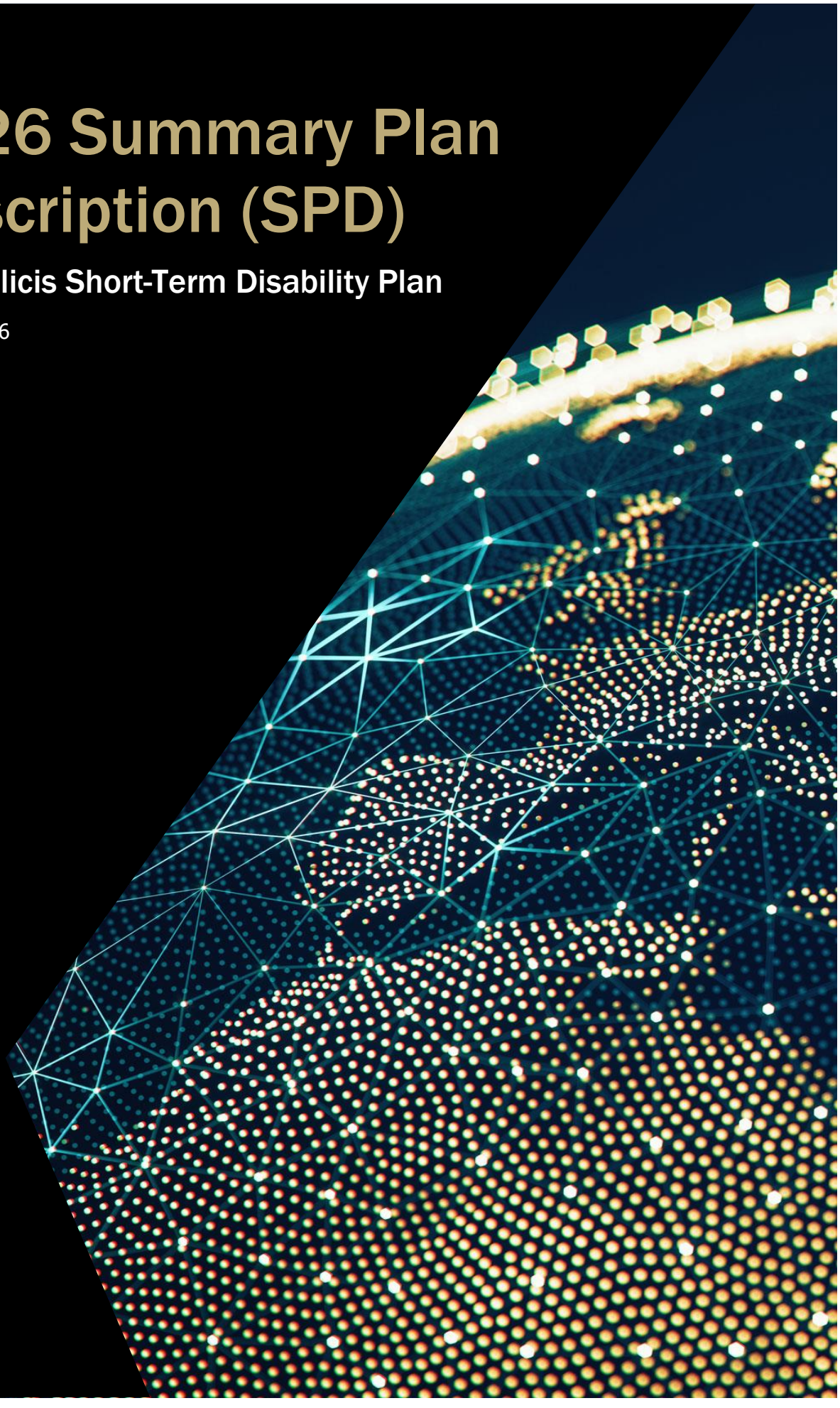
# 2026 Summary Plan Description (SPD)

## for Publicis Short-Term Disability Plan

April 1, 2026



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# Your Short-Term Disability (STD) Coverage

Your Short-Term Disability (STD) 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"). Your STD program is designed to replace a portion of your income if you're unable to work because of a short-term non-work-related ***illness*** or ***injury***. This document provides important information regarding your STD coverage.

This Summary Plan Description (SPD) together with the Administrative Information Summary Plan Description describes the basic features of the Short-Term Disability 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, 2026, 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

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

- You are a U.S.-based employee;
- You are a full-time or part-time employee working a minimum regular schedule of at least 21 hours per week;
- You are an employee of a subsidiary of the Company that has adopted the Program; and
- Your class of employees has not been excluded from this or a predecessor plan.
- You are not eligible for coverage under a health plan sponsored by a union pursuant to an agreement or understanding between the Company and a union.
- If you reside in Hawaii, you work at least 20 hours per week and earn 86.67 times the current Hawaii minimum wage a month.

Please see your local HR Representative or the Publicis Re:Sources USA Benefits Department if you're unsure of whether your company 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.

Contact Sedgwick's customer service unit with questions regarding your existing or potential claim. Contact the Benefits Department if you need an answer to a general plan, benefit or enrollment-related question. Sedgwick (AbsenceOne) is the claims administrator.

For STD or LTD questions, including information about offsets, coverage exclusions and limitations, contact Sedgwick (AbsenceOne) at 877-509-0553 or visit their website at https://www.absenceone.com/publicis.

## *When Coverage Begins*

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.

## *Paying For Your Coverage*

The ***Company*** pays the full cost of your participation in the Short-Term Disability Plan.

## STD Benefit

You may be eligible to receive a STD benefit (including any sick pay, for which you are eligible, during the 7 day ***elimination period***) over a 26-week benefit period, as long as you're an active employee at the time your disability occurs and you continue to meet the definition of short-term disability. If you do, you receive a percentage of your base pay (refer to the Base Pay Defined section of this document) based on a schedule of benefits that has been adopted by your business unit. The percentage of base pay that comprises your ***gross STD benefit*** is based on your years of service with the ***Company*** and your business unit. Contact your HR representative for specific details regarding your benefit.

# Continuation or Termination of Coverage

Coverage under this Plan terminates at the first to occur of:

- When your employment ceases; or
- When you are no longer in an eligible benefits class.

## *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 under the appropriate benefit plans 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 in the Health and Group Benefit plans will terminate effective the end of the month in which your LTD Plan benefits commence.

## *If You Take a Leave of Absence*

If you are on an approved leave of absence for any reason and become disabled during your leave period, your disability coverage will continue. Keep in mind that you must be an active employee at the time your disability occurs in order to qualify for disability benefits under the plan.

## Disability Defined

You're considered disabled if your ***illness*** or ***injury*** causes a physical or mental impairment to such a degree of severity that you're:

- Continuously unable to perform ***the material and substantial duties*** of your ***regular occupation***; and
- Not ***gainfully employed***.
- In addition, if you require a professional license or certification for your occupation and you lose that license or certification, the loss doesn't in and of itself constitute a disability under this program.

## Base Pay Defined

Your base pay determines your ***disability earnings*** from the program. Your base pay is the annual rate of pay you're receiving on the day you become disabled. It includes the contributions you make to the Publicis Connections benefit plans, or any other qualified or non-qualified Employee ***Retirement Plan*** or deferred compensation arrangement.

Your base pay doesn't include any:

- Extra compensation;
- Commissions;
- Bonuses;
- Overtime pay;
- ***Company*** contributions to your ***Retirement Plan*** or deferred compensation arrangement; or
- Severance or salary continuation/separation pay.

Remember, to be eligible for benefits, you must be an active employee on the day your disability began.

## What Is Service?

If you're an active employee and meet the definition of disabled, your service determines how long this coverage pays benefits at a percentage of base pay during the 26-week STD benefit period. Please note: You're not eligible for STD coverage if you're receiving severance or salary continuation/separation pay.

Your service is defined as your credited service and covers the length of time for which you're employed by a participating unit of the ***Company*** and are eligible for benefits. It includes any paid time off that you spend away from work (for example a holiday, vacation or paid leave of absence).

If you leave the ***Company*** and are rehired by another participating unit of the ***Company*** within 12 months of the day you terminate, you don't lose your previous credited service. If you're rehired after one year your credited service is adjusted based on the length of time you were gone.

### *What is the Elimination Period?*

The ***elimination period*** is the number of calendar days for which you must be continuously disabled before the Plan pays benefits. Your ***elimination period*** starts on the day your disability begins, provided you're an active employee at the time your disability occurs. (You're not eligible for STD coverage while you're receiving severance or salary continuation/separation pay.)

Your seven-day ***elimination period*** applies towards your 26 weeks of short-term disability benefits.

If you temporarily recover, return to work for 14 calendar days or less, and then again become disabled due to the same or related cause, the Plan treats your disability as a continuous disability. As a result, a new ***elimination period*** doesn't apply, and the Plan pays benefits under the same provisions in effect at the time your disability first occurred. However, if your base pay is more than it was prior to your return to work, the Plan doesn't take into account this increased amount when calculating your Plan benefit.

If you temporarily recover, return to work for more than 14 calendar days, and then again become disabled, the Plan treats your disability as a new disability. As a result, you must meet a new ***elimination period***.

# How the Program Pays Benefits

As long as you meet the definition of disabled, the program pays you a STD benefit for a maximum of 26 weeks, which includes any sick pay, for which you are eligible, during the 7 day ***elimination period***. Or, you may receive a ***work incentive benefit*** if you're able to work on a ***limited basis***. This section includes important information regarding how the STD program pays benefits.

## *How Your STD Plan Benefit Is Calculated*

Your base pay as of the day you become disabled determines your ***gross STD benefit*** amount. The program applies the appropriate percentage* to your base pay; it then subtracts any other deductible sources of income. What results is your STD benefit amount paid based on your regular payroll process and frequency.

You receive your STD benefit once you satisfy the ***elimination period***. If, after you satisfy the ***elimination period***, the program is scheduled to pay benefits for less than one week, it prorates your benefit for each day that you're disabled. In other words, you will be paid the STD benefit for the number of days that your disability has been approved for by Sedgwick (AbsenceOne).

## *How Your Work Incentive Benefit is Calculated*

You receive either a ***work incentive benefit*** or a STD benefit. You receive a ***work incentive benefit*** as long as you return to gainful employment with the ***Company*** on a ***limited basis***. You are paid 100% for your hours worked and STD benefits for the remainder of the hours.

## *How Long Benefits Are Paid*

The program continues to pay your STD benefit or ***work incentive benefit*** until the earlier of the following:

- The day you're no longer considered disabled;
- The end of the 26-week benefit period;
- The day you become eligible for Long-Term Disability Plan benefits;
- You are no longer able to provide sufficient evidence of your disability;
- You refuse to follow your treatment program;
- You refuse to sign a release permitting your physician to discuss your case or provide medical information to the claims administrator;
- You refuse to participate in an independent medical examination or other testing requested by the claims administrator; or
- You refuse to adhere to the modifications made to accommodate your disability.

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* Contact your HR representative for the percentage that applies to you.
Terms in ***bold/italics*** are further defined in the Glossary.

## *A Recurring Disability*

If you return to work but become disabled again due to the same or a related cause, the program may consider this a recurring disability.

As long as your disability recurs within 14 calendar days of your return to work, you receive benefits under the same coverage provisions in effect at the time your disability first occurred. In addition, you don't have to satisfy a new ***elimination period*** before the program again pays benefits.

If your disability recurs more than 14 calendar days after your return to work, the Plan:

- Requires you to satisfy a new ***elimination period*** before it again starts paying benefits;
- Applies a new 26-week benefit period; and
- Pays benefits based on the provisions in effect on the day of your most recent disability.

Your disability must recur while you're covered under the program.

## *Other Sources of Disability Income*

You may be eligible for income from other sources due to your disability. If this is the case, the Plan reduces your STD benefit or ***work incentive benefit*** by disability income that you may receive from other sources. Disability income may include any of the following:

- A sick leave plan;
- A salary continuance plan provided by or through the ***Company***; or
- Any Statutory Disability Benefit Laws for which you're eligible, regardless of whether you applied for such benefits.

The plan doesn't reduce your STD benefit or ***work incentive benefit*** by the following sources of income:

- Deferred compensation arrangements;
- Pension plans for partners;
- Military pension and disability income plans;
- Franchise disability income plans;
- Individual disability income plans;
- A ***retirement plan*** from another employer;

- Profit sharing plans;
- Thrift or savings plans;
- Individual retirement account (IRA);
- Tax sheltered annuity (TSA); or
- Stock ownership plan.

## *Exclusions*

The program doesn't pay benefits for all types of disabilities, including those that are caused by or result from:

- ***Injury***, sickness, mental illness, substance abuse or pregnancy not being treated by a physician or surgeon;
- War or act of war (declared or undeclared)
- Your commission of or attempt to commit a felony, or to which a contributing cause was being engaged in an illegal occupation;
- Disability sustained as a result of doing any work for pay or profit for another employer;
- Sickness or ***injury*** for which workers' compensation benefits are paid, or may be paid, if duly claimed;
- Any disability that takes place while you're confined to a penal or correctional institution (if the period of confinement exceeds 30 days);
- An intentional self-inflicted ***injury*** or ***illness*** unless related to mental illness.

# Applying for Benefits

You must meet certain requirements when applying for benefits. This section highlights important information regarding the claim filing process.

## *How to File Claims*

You need to initiate the claims filing process. To report a claim, call Sedgwick (AbsenceOne) at 877-509-0553, as soon as you become aware that your ***illness*** or ***injury*** will last more than seven consecutive calendar days (the ***elimination period***). Be sure to call as soon as possible after the start of your disability (before the seventh day). Representatives are available to help you between 8:00 a.m. and 9:00 p.m. Eastern Time, Monday through Friday (except holidays).

Follow these simple steps to report your claim. Remember, if you're receiving severance or salary continuation/separation pay, you're not covered under the STD program.

- Read and complete the telephonic claim submission card that you receive once you become eligible for coverage. The card outlines the claim submission process and contains a required authorization for the release of medical information to Sedgwick (AbsenceOne). Be sure to give your physician a copy of the authorization at the time that he or she certifies your disability. This authorization permits Sedgwick (AbsenceOne) to obtain any information which is required to complete the processing of your claim. If you misplace your card, Sedgwick (AbsenceOne) can send you a new authorization form once you provide notification of your claim. Completion of the authorization form is a condition for the receipt of STD benefits.

- Notify Sedgwick (AbsenceOne)of your disability. When you call Sedgwick (AbsenceOne), be prepared to provide the following:

  - Your name, address and telephone number;
  - Your Social Security number;
  - Your date of birth;
  - Your supervisor's name, telephone number and your work location;
  - Your physician's name, address, fax and telephone number;
  - A description of your ***injury*** or ***illness***; and
  - A description of your occupation.

  Your claim is identified by your Social Security Number. Be sure to reference this when you contact Sedgwick (AbsenceOne) regarding your claim. Sedgwick (AbsenceOne) determines whether or not you're eligible for a disability benefit. All STD claims must be reported using this process.

Once benefits begin, additional medical information may be necessary to support your continued disability and to verify that you're still under the ***appropriate and regular care*** of an attending physician. Your condition and your physician's prognosis determine how often this information is needed as well as if any additional resources (i.e., nurses, staff physicians, rehabilitation specialists or independent medical examinations) will be needed. As a result, Sedgwick (AbsenceOne) may require periodic medical examinations by a physician and/or review organization, at no cost to you. If you fail to comply with such a request or you fail to show up for a scheduled appointment, the program may suspend or end benefits.

## *Timing of Claim Payments*

As soon as the claims administrator has all of the necessary documentation to support your disability claim and approves your claim, the program pays benefits through your regular payroll process and frequency. You continue to receive benefits for a maximum of 26 weeks, as long as you continue to meet the definition of disabled.

If you die while you're receiving benefits, the program pays any due and unpaid amounts (up to the date of your death) to your named beneficiary. If there's no surviving beneficiary, the program makes payment to the surviving person(s) in the following order:

- Your spouse; or, if none,
- Your children (including your legally adopted children); or, if none,
- Your parents; or, if none,
- Your brothers or sisters; or, if none,
- Your estate.

If any benefit is payable to your estate, a minor or an individual who is not competent to provide a valid release, the program may pay up to $1,000 to any relative or beneficiary whom the Plan deems to be entitled to this amount.

## *What Happens If a Claim is Overpaid?*

The program may overpay a claim if:

- You receive a retroactive payment from another source of disability income;
- The program inadvertently makes an error when calculating your benefit;
- If you return to work during a period for which benefits were paid; or
- A fraud occurs.

If the program overpays a claim, the ***Company*** takes the necessary steps to collect overpayments and offsets any future benefits. The method by which to make a repayment is determined by the program. You receive a letter that outlines the source of overpayment, the total amount to be

recovered and the method of recovery. The overpayment amount equals the amount in excess of what should have been paid under the program's provisions.

The ***Company*** takes the following steps to collect any overpayments:

- For two weeks after your seven-day ***elimination period***, you continue to receive your regular pay.
- If your disability isn't approved within this two-week grace period, your regular pay stops, pending the claims administrator's determination of your claim.
- If your disability isn't approved, or it's approved for a shorter period than the two-week grace period, you're required to refund the ***Company*** the amount by which you were overpaid.

## *If a Claim Is Denied*

The claims administrator notifies you of its decision regarding your claim within 45 days after receipt. If there are special circumstances, or your claim is incomplete, the claims administrator may request two additional 30-day extensions. If such extensions are needed, you're notified in writing before the beginning of each extension. If the extension is due to an incomplete claim, you're notified within the initial 45-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 claims administrator at the address below:

AbsenceOne
P.O. Box 14030
Lexington, KY 40512

In addition, you can request and receive (free of charge) reasonable access to and copies of all documents, records and other information related to your denied claim. Relevant documents include:

- Documents, records and other information that were relied upon in making the benefit determination;

- Documents, records and other information that were submitted, considered or generated in the course of making the benefit determination (regardless of whether they were actually relied upon);

- Documents, records and other information that the claims administrator employed;

- Identification of medical or vocational experts whose advise was obtained by the Program Administrator in relation to your claim (regardless of whether that advice was relied upon); and

- Any policy statements or guidance on the denied treatment option or benefit for your diagnosis (regardless of whether it was relied upon).

You may submit in writing any comments or issues that outline the basis of your appeal, as well as any documents, records or other information related to your claim. You may also submit any additional medical information to support your inability to work. You may have representation throughout the review process. You must request and file for a review within 180 days of the day you receive notice of your denied claim.

The review of your claim takes into account all of your comments, documents, records and other information (regardless of whether such information is submitted or considered in the initial benefit determination). The individual or committee of the claims administrator who reviews your claim is independent from the individual or committee who initially determines your claim and no deference is given to the initial benefit determination. If the initial claims determination is based – in whole or in part – on a medical judgment, the individual or committee that conducts the review consults with an appropriate health care professional in the field of medicine involved. This professional is independent from the medical professional who initially reviewed your claim.

The claims administrator holds a full and fair review and makes a decision no later than 45 days after receiving your request for the review. If there are special circumstances, the claims administrator may request an additional 45 days. If such an extension is needed, you're notified in writing before the beginning of the extension. After the claims administrator's review, you receive the decision in writing. The notification includes: (*following page*)

- The specific reasons for the decision;

- The specific references to the pertinent Plan provisions on which the decision is based;

- A statement that you're entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim;

- If the Plan has voluntary appeal procedures, a statement that describes those procedures; and

- If applicable, the provisions of internal procedures or clinical information or a statement that upon request and free of charge, copies of such information shall be provided.

The Plan Administrator has complete discretionary authority to make all determinations under the Plan, including eligibility for benefits and factual determinations, and to interpret the terms and provisions of the Plan. The Plan Administrator has delegated to the claims administrator 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.

## *Assistance with Your Questions*

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

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

The Plan Administrator has delegated to the claims administrator 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.

# Additional Information

Here's some additional information you may need to know regarding your STD coverage.

## *Authorization and Documentation You Need to Supply*

Upon request from the claims administrator, you need to provide the following:

- Signed authorization for the claims administrator to obtain all reasonably necessary medical, financial or other non-medical information that supports your disability claim. If you fail to submit this information, the program may deny, suspend or terminate your benefits.

- Proof that you've applied for other deductible income benefits (i.e., Workers' Compensation, State Disability Benefits, or Social Security benefits, when applicable).

- Notification of when you receive or are awarded a benefit from another source of disability income, including the:

  - Nature of the income benefit;
  - Amount you're receiving;
  - Period to which the benefit applies; and
  - Duration for which the benefit is being paid (if you're receiving installment payments).

## *Assignment of Benefits*

You can't assign your benefits or transfer your benefits to anyone else.

## *Fraud*

You commit a fraudulent insurance act if you:

- Knowingly and with intent defraud the ***Company***, any insurance company or other person;

- File an application for insurance or statement of claim that contains any material false information; or

- Conceal any factual material to mislead others.

Such fraudulent insurance acts are a crime and will result in the denial of benefits. Such acts also may be subject to criminal and civil penalties. Such penalties include:

- Fines;
- Denial or termination of insurance benefits;
- Recovery of any amounts paid;
- Civil damages;
- Criminal prosecution; or
- Confinement in state prison.

# Glossary

The following terms are related to your STD coverage. Knowing the meaning of these terms may help you better understand your STD coverage.

## *Actively at Work*

Active work, actively at work or actively working means you must be:

- Working at the ***Company***'s usual place of business or on an assignment for the purpose of furthering the ***Company***'s business;
- Performing the ***material and substantial duties*** of your ***regular occupation*** on a full-time basis; and
- Not receiving severance or salary continuation pay.

You're considered actively at work during a scheduled vacation or a holiday.

## *Appropriate and Regular Care*

You're considered to be receiving appropriate and regular care if you're visiting a ***doctor*** as frequently as medically required to meet your basic health needs. The effect of your care should be demonstrable medical value for your disabling condition(s) to effectively attain and/or maintain maximum medical improvement.

## *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.

## *Disability Earnings*

The wage or salary that you earn from your gainful employment after your disability begins. It includes:

- Commissions;
- Bonuses or similar pay; and
- Any other income you may receive or are entitled to receive.

Your ***disability earnings*** don't include Social Security, sick pay, salary continuation/separation payments or any other disability payment you receive as a result of your disability. Any lump sum payment is prorated based on the time over which it accrues or the period for which it's paid.

## *Doctor*

A person legally licensed to practice medicine, psychiatry, psychology or psychotherapy. You or a member of your immediate family can't be your ***doctor***.

A licensed medical practitioner is considered to be a ***doctor*** if applicable state law requires that such a practitioner be recognized for purposes of certification of disability. In addition, the treatment provided by the practitioner must be within the scope of his or her license.

## *Elimination Period*

The number of calendar days at the beginning of a continuous period of disability for which no benefits are payable.

## *Gainfully Employed*

You're considered gainfully employed if you perform any occupation for wage, remuneration or profit on a full or part-time basis.

## *Generally Accepted Medical Practice*

Care and treatment that's consistent with relevant guidelines of national medical, research and health care coverage organizations and governmental agencies as determined by the program.

## *Gross STD Benefit*

This is the benefit based on the schedule of benefits that applies to your unit. Contact your HR Representative for the appropriate schedule.

## *Hospital or Health Care Facility*

A duly licensed institution accredited as a hospital by the Joint Commission on Accreditation of Healthcare Organizations that's licensed to provide full-time care and treatment for the condition(s) that causes your disability. A full-time staff of licensed physicians and registered nurses also must operate the facility. A hospital or health care facility doesn't include any facility that primarily provides custodial, educational or rehabilitative care.

## *Illness*

A sickness or disease that causes a disability. The disability must not begin before your coverage effective date.

## *Injury*

A bodily injury that's caused by an accident and results in disability. Your disability must not begin before your coverage effective date.

## *Limited Basis*

You're considered to be working on a limited basis if you suffer a 20% loss in earnings as a result of your inability to work for the normal number of hours or in the position you held prior to becoming disabled.

## *Material and Substantial Duties*

The necessary functions of your ***regular occupation*** which can't be reasonably omitted or altered.

## *Regular Occupation*

The occupation that you perform for income or wages on the day of your disability. It's not limited to the specific position you hold at the ***Company***.

## *Retirement Plan*

A plan that provides retirement benefits to employees.

## *Work Incentive Benefit*

This is the benefit based on if you are able to work part-time while out on a disability. You may be able to work a modified work schedule for which you would be paid your normal base pay during the time you are working and paid the ***Gross STD Benefit*** while on disability.