Publicis Connections Health & Group Benefits Program

Administrative Information: Summary Plan Description

January 1, 2024

ADMINISTRATIVE INFORMATION

The Publicis Connections Health and Group Benefits Program (the Program) is governed by ERISA (the Employee Retirement Income Security Act of 1974). This section provides important legal and administrative information you may need regarding the Program.

If you have any questions about the administrative details surrounding the Program, you can contact your HR Representative.

See below for more details.

Administrative Details

Plan	Plan Type	Plan Number	Claims Administrator Insurer & File Claims Address	Type of Insured[1]	Global Group/ Contract Number[2]	Contribution	Benefits Insured	Administrative Services
Medical								
Standard PPO Blue Cross Blue Shield	Health	501	**Blue Cross and Blue Shield of Illinois** P.O. Box 805107 Chicago, IL 60680-4112	Self Insured	095837	Employee and Employer	No	Contract Administrator and Claims Payor
Premier PPO Blue Cross Blue Shield	Health	501	**Blue Cross and Blue Shield of Illinois** P.O. Box 805107 Chicago, IL 60680-4112	Self Insured	015695	Employee and Employer	No	Contract Administrator and Claims Payor
High Deductible Health Plan With Health Savings Account (HSA) Plan	Health	501	**Blue Cross and Blue Shield of Illinois** P.O. Box 805107 Chicago, IL 60680-4112	Self Insured	119287	Employee and Employer	No	Contract Administrator and Claims Payor
Prescription Drug CVS/Caremark	Health	N/A	**CVS/Caremark** P.O. Box 52136 Phoenix, AZ 85072	Self Insured	0139	Employee and Employer	No	Contract Administrator and Claims Payor
Dental								
PPO Basic	Health	502	**Delta Dental of New York, Inc**. P.O. Box 2105 Mechanicsburg, PA 17055-2105	Self Insured	04811	Employee and Employer	No	Contract Administrator and Claims Payor
PPO Comprehensive	Health	502	**Delta Dental of New York, Inc.** P.O. Box 2105 Mechanicsburg, PA 17055-2105	Self Insured	04811	Employee and Employer	No	Contract Administrator and Claims Payor
Vision Service Plan								
Low Plan	Health	506	**VSP** P.O. Box 997105 Sacramento, CA 95899-7105	Fully Insured	12227971	Employee	Yes	Insurer Administrator and Claims Payor
High Plan	Health	506	**VSP** P.O. Box 997105 Sacramento, CA 95899-7105	Fully Insured	12227971	Employee	Yes	Insurer Administrator and Claims Payor
Employee Assistance Plan								
Employee Assistance Plan	Health	507	**Workplace Solutions** 19 E. Schaumburg Road, 1st Floor Schaumburg, IL 60194 1-800-327-5071	N/A	N/A	Employer	Yes	Contract Administrator
Life Insurance								
Employee Term Life (Basic Employee Life)	Welfare	503	**MetLife Group Life Claims** P.O. Box 6100 Scranton, PA 18505-6100	Fully Insured	191110	Employer	Yes	Insurer Administrator and Claims Payor
Optional Employee Term Life (Supplemental Employee Life)	Welfare	503	**MetLife Group Life Claims** P.O. Box 6100 Scranton, PA 18505-6100	Fully Insured	191110	Employee	Yes	Insurer Administrator and Claims Payor
Optional Dependent Term Life (Spouse and Child Life)	Welfare	503	**MetLife Group Life Claims** P.O. Box 6100 Scranton, PA 18505-6100	Fully Insured	191110	Employee	Yes	Insurer Administrator and Claims Payor
Optional Employee and Dependent Accidental Death & Dismemberment (Voluntary AD&D)	Welfare	503	**MetLife Group Life Claims** P.O. Box 6100 Scranton, PA 18505-6100	Fully Insured	191110	Employee	Yes	Insurer Administrator and Claims Payor
Disability								
Short Term Disability	Welfare	504	**The Hartford Group Benefits—Disability Claims** P.O. Box 14306 Lexington, KY 40512-4306	Self Insured	342283*	Employer	No	Contract Administrator
Long Term Disability	Welfare	504	**The Hartford Group Benefits—Disability Claims** P.O. Box 14306 Lexington, KY 40512-4306	Fully Insured	377715*	Employee and Employer	Yes	Insurer Administrator and Claims Payor
Flexible Spending Accounts (FSAs)								
Health Care Flexible Spending Account	Welfare	501	**HealthEquity | WageWorks** P.O. Box 14053 Lexington, KY, 40512	N/A	N/A	Employee	No	Contract Administrator
Dependent Care Flexible Spending Account	Welfare	501	**HealthEquity | WageWorks** P.O. Box 14053 Lexington, KY, 40512	N/A	N/A	Employee	No	Contract Administrator
Transportation								
Transportation Reimbursement Incentive Program (TRIP)	Welfare	N/A	**HealthEquity | WageWorks** P.O. Box 14053 Lexington, KY, 40512	N/A	N/A	Employee	No	Contract Administrator
Legal								
MetLife Legal Plans	Welfare	508	**MetLife Legal Plans** 1111 Superior Avenue Cleveland, OH 44114	Fully Insured	1012150	Employee	Yes	Insurer Administrator

Plan	Plan Type	Plan Number	Record Keeper	Contract Number	Contributions	Administrative Services
Publicis 401(k) Plan	401(k) Defined Contribution Plan	002	Fidelity Institutional Retirement Services Company, Inc. 82 Devonshire Street Boston, MA 02109	08063	Employee and Employer	Contract Administrator
Bcom3 Cash Balance Plan (Frozen)[3]	Defined Benefit (Cash Balance Plan)	001	BCom3 Cash Balance Plan Service Center PO Box 9920 Providence, RI 02940-4020	N/A	Employer	Contract Administrator

[1] Insurers perform all functions that are generally done by insurers, including the payment of claims as well as contractual and legal obligations.
[2] Regional group numbers may differ. Contact your HR Representative for your regional contract number.
[*] Different group numbers apply for New York and New Jersey salaried and hourly employees.
[3] Please contact Publicis Benefits Connection at 1-800-933-3622, weekdays 9am-5pm ET, if you're unsure if you are a participant in this plan.

Official Program Name

When dealing with or referring to the Program (e.g., in the event of a claim appeal or other correspondence), you will receive a more rapid response if you identify the Program fully and accurately. The official name of the Program is the Publicis Connections Health and Group Benefits Program (Program). It's also commonly known as your Health and Group Benefits.

Types of Welfare Benefit Plans

Your Publicis Connections Health and Group Benefits Program is intended to be an "employee welfare benefit plan" within the meaning of ERISA Section 3(1), and includes a group health program (offering medical, dental, prescription drug and vision benefits), an Employee Assistance Plan, Disability Plans, a Life and Accident Plan, a group Legal Plan, a Flexible Spending Account (FSA) Plan including health and dependent care FSA components, and a Transportation Reimbursement Incentive Program (TRIP). The short-term disability program, dependent care flexible spending account and Transportation Reimbursement Incentive Program are not employee benefit plans under ERISA and the benefits thereunder are not covered by ERISA.

Type of Administration of Welfare Benefit Plans

Benefits furnished under the Program are administered by the providers from which benefits are purchased, or in the case of certain self-funded benefits, by the Plan Administrator (or a third-party administrator, as may be designated by the Plan Administrator from time to time). The name of each provider is set out above. Unless otherwise indicated, all benefits furnished under the Plan are provided under the insurance policies, administrative contracts, and/or plan documents identified above, and the respective providers identified above provide all necessary administrative services.

Plan Costs for Certain Welfare Benefit Plans

Unless otherwise indicated herein, the Program provides for cost sharing between the Program or Plan Sponsor and employees. The dollar values of the participant contributions will be communicated to you prior to any initial, open, or special enrollment period. Upon the terms and conditions set forth in the Program or Plan Sponsor's Flexible Benefits Account Plan, Participants may also elect to contribute to their health and/or dependent care flexible spending accounts.

Funding Policy for Welfare Benefit Plans

Benefits furnished through your Publicis Connections Health and Group Benefits Program are provided through the purchase of insurance policies and other provider contracts, unless otherwise indicated herein. The Program or Plan Sponsor will collect the applicable employee premiums and will pay when due all premiums required to keep such policies and contracts in force. Funding is derived from the funds of the Program or Plan Sponsor and contributions made by the employees. To the extent you are required to make contributions toward the cost of a particular benefit feature, your contributions will be used in their entirety prior to using Program or Plan Sponsor contributions to pay for the cost of such benefit. Accordingly, any claims experience dividends, refunds, or other adjustments in premiums, fees, or other Plan costs related to benefits provided under the Plan may be used to reduce the amount of contributions made by the Program or Plan Sponsor. The level of any employee contributions is set by the Program or Plan Sponsor, which will be communicated to you when you first enroll in the Program, and during each open and special enrollment period. The Program or Plan Sponsor reserves the right to modify employee contribution amounts. Employee contributions will be used to fund, or reimburse the Program or Plan Sponsor for funding, the cost of the Plan benefits as soon as practicable after they have been received from the employee or withheld from the employee's pay through payroll deduction.

HIPAA Privacy and Security Provisions for Welfare Benefit Plans

1. Disclosure of Information

(a) The Program or Plan Sponsor may only use and/or disclose Protected Health Information (as such term is defined in 45 C.F.R. §160.103) as permitted by the "Standards for Privacy of Individually Identifiable Health Information" under the Health Insurance Portability and Accountability Act of 1996, P.L.104-191, as amended by the Health Information Technology for Economic and Clinical Health Act ("HITECH Act") portion of the American Recovery and Reinvestment Act of 2009, and applicable guidance (the "Privacy Rule").

(b) The Plan will disclose Protected Health Information to the Program or Plan Sponsor only upon its receipt of a certification by the Program or Plan Sponsor that the Program or Plan Sponsor agrees to:

- Not use or further disclose the information other than as permitted or required by the Plan documents or as required by law;
- Ensure that any agents, including subcontractors, to whom it provides Protected Health Information and electronic Protected Health Information received from the Plan agree to the same restrictions and conditions that apply to the Program or Plan Sponsor with respect to such information;
- Not use or disclose the Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Program or Plan Sponsor;
- Report to the Plan any use or disclosure of the Protected Health Information that is inconsistent with the uses or disclosures permitted by the Privacy Rule of which it becomes aware;
- Make available Protected Health Information based on HIPAA's access requirements in accordance with 45 C.F.R. §164.524;
- Make available Protected Health Information for amendment and incorporate any amendments to Protected Health Information in accordance with 45 C.F.R. §164.526;
- Make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. §164.528, including an accounting of disclosures of any electronic health record (as defined in HIPAA);
- Make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Rule;
- If feasible, return or destroy all Protected Health Information received from the Plan that the Program or Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
- Ensure that adequate separation of the Plan and the Program or Plan Sponsor is established as required by 45 C.F.R. 164.504(f)(2)(iii) as described below.

2. Certification of the Program or Plan Sponsor

The Plan (or a health insurance issuer or HMO with respect to the Plan, if applicable) will disclose Protected Health Information to the Program or Plan Sponsor only upon the receipt of a certification by the Program or Plan Sponsor that the Plan has been amended to incorporate the provisions of 45 C.F.R. §164.504(f)(2)(ii), and that the Program or Plan Sponsor agrees to the conditions of disclosure set forth in Section K.1. The Plan will not disclose and may not permit a health insurance issuer or HMO to disclose

Protected Health Information to the Program or Sponsor as otherwise permitted herein unless the statement required by 45 C.F.R. §164.520(b)(1)(iii)(C) is included in the appropriate notice. The Program or Plan Sponsor hereby certifies that this Section K constitutes an amendment of the governing Plan documents that complies with HIPAA and that the Program or Plan Sponsor will comply with the conditions of disclosure set forth herein.

3. Separation of Plan and the Program or Plan Sponsor

- Only designated employees in the human resources department of the Program or Plan Sponsor ("Permitted Employees") will be given access to the Protected Health Information. Despite the foregoing, any employee or person not described above who receives Protected Health Information relating to payments under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business, will also be included in the definition above of Permitted Employees.
- The Permitted Employees may only use the Protected Health Information for Plan administrative functions that the Program or Plan Sponsor performs for the Plan.

4. Security of Electronic Protected Health Information

In accordance with 45 C.F.R. §164.314(b)(2), to the extent as may be required by law, the Program or Plan Sponsor agrees to:

- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic Protected Health Information that the Program or Plan Sponsor may create, receive, maintain, or transmit on behalf of the Plan;
- Ensure that the adequate separation required by 45 C.F.R. §164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;
- Ensure that any agents, including subcontractors, to whom it provides electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect the information; and
- Report to the Plan any security incident of which it becomes aware with respect to electronic Protected Health Information.

Claims Procedures for Welfare Benefit Plans

Except as provided in Paragraphs 1 or 2 below, claims for benefits under each benefit furnished under the Health and Group Benefits Program will be reviewed in accordance with procedures contained in the policies, contracts, summary plan descriptions or other written materials for such benefit ("Component Documents"). However, all issues or disputes solely regarding eligibility for coverage or participation and all other general inquiries or requests should be directed to the Plan Administrator. If a non-insurance related claim under the Plan is denied in whole or in part, you or your beneficiary will receive written notification.

The notification will include the reasons for the denial, with reference to the specific provisions of the Plan on which the denial was based, a description of any additional information needed to process the claim and an explanation of the claims review procedure. If we fail to respond within 90 days, your claim is treated as denied. (This period may be extended to 180 days under certain circumstances.) Within 60 days after denial, if you want to appeal such denial, you or your beneficiary may submit a written request for reconsideration of the application to the Plan Administrator.

Any such request should be accompanied by documents or records in support of your appeal. You or your beneficiary may review pertinent documents and submit issues and comments in writing. The Plan Administrator will review the claim and provide, within 60 days, a written response to the appeal. (This period may be extended to 120 days under certain circumstances.) In this response, the Plan Administrator will explain the reason for the decision, with specific reference to the provisions of the Plan

on which the decision is based. The Plan Administrator has the exclusive right to interpret the provisions of the Plan. Decisions of the Plan Administrator are final, conclusive and binding. The Plan Administrator has final claims adjudication authority under the Plan. However, the Plan Administrator may delegate duties and authority to others to accomplish those duties. For instance, the applicable administrator listed in the table of benefits herein is the claims administrator for the respective benefits furnished under the Program; each has sole and complete discretionary authority to determine claims and appeals in accordance with the terms of the documents or instruments governing the plan in which you are enrolled.

The insurer of each "insured" ERISA plan sponsored by the Employer has sole and complete discretionary authority to administer and interpret the provisions of the plan it insures. Please see the table of benefits herein to determine whether a plan is insured and for corresponding contact information for the applicable insurer or claims administrator.

Authorized Representatives

If you wish to designate an authorized representative to act on your behalf with respect to your claim for benefits, you must do so in writing. Please be advised that no rights under the Plan, including but not limited to the right to receive any benefit or any right to pursue a claim or cause of action, are assignable. Any payment by the Plan directly to a provider pursuant to a written election or purported assignments submitted by a participant or a dependent is provided at the discretion of the Plan Administrator as a convenience to the participant or dependent and does not imply an enforceable assignment of any benefits or the right to pursue a claim or cause of action.

Claims Procedure for Disability Benefits

The following claims procedure will apply specifically to claims made for disability benefits under one or more benefits furnished under the Program, including any rescission of disability coverage under such benefits with respect to a participant or beneficiary (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time). For this purpose, rescission means a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage. **To the extent that this procedure is inconsistent with the claims procedures contained in the policies, contracts, summary plan descriptions or other written materials for such benefits furnished under the Program, the claims procedures in such other policies, contracts, summary plan descriptions, or other written materials will supersede this procedure as long as such other claims procedures comply with DOL Regulation §2560.503-1.**

Timing of Adverse Benefits Determination

If a claim under the disability benefits furnished under the Program is denied in whole or in part, you or your beneficiary will receive written notification of the adverse benefit determination within a reasonable period of time, but no later than 45 days after the Plan Administrator's receipt of the claim. The Plan Administrator may extend this period for up to 30 additional days provided the Plan Administrator determines that the extension is necessary due to matters beyond the Plan Administrator's control and the claimant is notified of the extension before the end of the initial 45-day period and is also notified of the date by which the Plan Administrator expects to render a decision. The 30-day extension can be extended by an additional 30 days if the Plan Administrator determines that, due to matters beyond its control, it cannot make the decision within the original extended period. In that event, you will be notified before the end of the initial 30-day extension of the circumstances requiring the extension and the date by which the Plan Administrator expects to render a decision. The extension notice will explain the standards on which your entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information, if any, you must submit. If you must provide additional information, you will be provided with at least 45 days to provide the additional information. The period from which you are notified of the additional required information to the date you respond is not counted as part of the determination period.

Adverse Benefits Determination Notice
A denial notice will include:

- the specific reason(s) for your adverse benefit determination;
- reference to the specific Plan provision on which the determination is based;
- a description of any additional material or information necessary for you to fix your claim and an explanation of why such material or information is necessary;
- a description of the review procedures, including a statement of your right to bring a lawsuit following an adverse benefit determination on review;
- a discussion of the decision, including, an explanation of the basis for disagreeing with or not following:
    (i) The views presented by the health care professionals treating you and vocational professionals who evaluated you;
    (ii) The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
    (iii) A disability determination regarding you presented by you to the Plan made by the Social Security Administration.
- if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;
- either the specific internal rules, guidelines, protocols, standards, or other similar criteria of the plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards, or other similar criteria of the plan do not exist; and
- a statement that you are 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 for benefits. A document, record, or other information will be considered "relevant" to your claim if such document, record, or other information:
    (i) Was relied upon in making the benefit determination;
    (ii) Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination;
    (iii) Demonstrates compliance with the administrative processes and safeguards designed to ensure and verify that benefit determinations are made in accordance with governing plan documents and that, where appropriate, the Plan provisions have been applied consistently with respect to similarly situated claimants; or
    (iv) Constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for your diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

If you live in a county with a significant population of non-English speaking persons, the Plan will provide, in the non-English language(s), a statement of how to access oral and written language services in those languages.

Appeal Process
If you disagree with a claim determination, you can contact the Plan Administrator in writing to formally request an appeal. If the appeal relates to a claim for payment, your request should include:

- The subject individual's name and the identification number from the ID card, if any.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your appeal request must be submitted to the Plan Administrator within 180 days after you receive the claim denial.

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination. The Plan Administrator may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent health claim information. Upon request and free of charge you have the right to reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits.

In addition, prior to the appeal determination noted below, the Plan Administrator will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan, insurer, or other person making the benefit determination (or at the direction of the Plan, insurer or such other person) in connection with the claim as soon as possible and sufficiently in advance of the date on which the appeal determination is required to be provided to give you a reasonable opportunity to respond prior to that date. Before an adverse benefit determination on appeal based on a new or additional rationale, the Plan Administrator will provide you, free of charge, with the rationale; the rationale will be provided as soon as possible and sufficiently in advance of the date on which the appeal determination is required to be provided to give you a reasonable opportunity to respond prior to that date.

Timing of Appeal Determination
You will be notified of the Plan Administrator's decision upon review within a reasonable period of time, but no later than 45 days after the Plan Administrator receives your appeal request. The 45-day period may be extended for an additional 45-day period if the Plan Administrator determines that special circumstances (such as the need to hold a hearing) require an extension of time. You will be provided with written notice prior to the expiration of the initial 45-day period. Such notice will state the special circumstances requiring the extension and the date by which the Plan Administrator expects to render a decision.

Appeal Determination Notice
If denied, your review decision on appeal will include the following:

- the specific reason(s) for the adverse determination;
- reference to the specific Plan provision on which the benefit determination is based;
- a statement that you are entitled to receive, without charge, reasonable access to any document (i) relied on in making the determination, (ii) submitted, considered, or generated in the course of making the benefit determination, (iii) that demonstrates compliance with the administrative processes and safeguards required in making the determination, or (iv) that constitutes a statement of policy or guidance with respect to the Plan concerning the claim without regard to whether the statement was relied on;
- either the specific rule or guideline used in making your benefits determination or a statement that such a rule or guideline was relied upon in making the determination and that a copy of such rule or guideline will be provided free of charge upon request or, alternatively, a statement that such rules, guidelines, protocols, standards, or other similar criteria of the plan do not exist;
- if the adverse determination is based on medical necessity or experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment applying the terms of the Plan to your medical condition, or a statement that such explanation will be provided without charge on request;
- a statement describing the Plan's optional appeals procedures, and your right to receive information about such procedures, as well as your right to bring a lawsuit and any applicable contractual limitations period that applies to your right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim;
- a discussion of the decision, including, an explanation of the basis for disagreeing with or not following:
    (i) The views presented by the health care professionals treating you and vocational professionals who evaluated you;

(ii) The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
(iii) A disability determination regarding you presented by you to the Plan made by the Social Security Administration.

If you live in a county with a significant population of non-English speaking persons, the plan will provide, in the non-English language(s), a statement of how to access oral and written language services in those languages.

Should the Plan fail to establish or follow ERISA required disability claims procedures, you may be entitled to pursue legal remedies under ERISA without exhausting your administrative remedies.
The Plan Administrator has the exclusive right to interpret the provisions of the Plan. Decisions of the Plan Administrator are final, conclusive, and binding. The Plan Administrator has final claims adjudication authority under the Plan. However, the Plan Administrator may delegate duties and authority to others to accomplish those duties. For instance, the applicable administrator listed in the table of benefits herein is the claims administrator for the respective benefits furnished under the Program; each has sole and complete discretionary authority to determine claims and appeals in accordance with the terms of the documents or instruments governing the plan in which you are enrolled.

The insurer of each "insured" ERISA plan sponsored by the Employer has sole and complete discretionary authority to administer and interpret the provisions of the plan it insures. Please see the table of benefits herein to determine whether a plan is insured and for corresponding contact information for the applicable insurer or claims administrator.

Claims Procedure for a Group Health Plan

The following claims procedure will apply specifically to claims made under any group health plan covered under the Plan. **To the extent that this procedure is inconsistent with the claims procedures contained in the policies, contracts, summary plan descriptions or other written materials for a group health plan covered under the Plan, the claims procedures in such other policies, contracts, summary plan descriptions, or other written materials will supersede this procedure as long as such other claims procedures comply with DOL Regulation §2560.503-1 and the Affordable Care Act.**

Adverse Benefit Determinations

Post-Service Claims
Post-Service Claims are those claims that are filed for payment of benefits after health care has been received. If your Post-Service Claim is denied, you will receive a written notice from the Plan Administrator within 30 days of receipt of the claim, as long as all needed information was provided with the claim. The Plan Administrator will notify you within this 30- day period if additional information is needed to process the claim, and may request a one-time extension not longer than 15 days and hold your claim until all information is received.

Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame and the claim is denied, the Plan Administrator will notify you of the denial within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

Pre-Service Claims
Pre-Service Claims are those claims that require notification or approval prior to receiving health care. If your claim is a Pre-Service Claim, and it is submitted improperly, the Plan Administrator will notify you of the improper filing and how to correct it within 5 days. If your Pre-Service Claim is submitted properly with all needed information, you will receive written notice of the claim decision from the Plan Administrator

within 15 days of receipt of the claim. The Plan Administrator will notify you within this 15-day period if additional information is needed to process the claim, and may request a one-time extension not longer than 15 days and hold your claim until all information is received. Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, the Plan Administrator will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

Urgent Claims
Urgent Care Claims are those claims that require notification or approval prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a doctor with knowledge of your health condition, could cause severe pain. In these situations:

- You will receive notice of the benefit determination in writing or electronically within 72 hours after the Plan Administrator receives all necessary information, taking into account the seriousness of your condition.
- Notice of denial may be oral with a written or electronic confirmation to follow within 3 days.

If you file an Urgent Care Claim improperly, the Plan Administrator will notify you of the improper filing and how to correct it within 24 hours after the Urgent Care Claim is received. If additional information is needed to process the claim, the Plan Administrator will notify you of the information needed within 24 hours after the claim was received. You then have 48 hours to provide the requested information. You will be notified of a determination no later than 48 hours after:

- The Plan Administrator's receipt of the requested information; or
- The end of the 48-hour period within which you were to provide the additional information.

Concurrent Care Claims
If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care Claim as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. The claims administrator will make a determination on your request for the extended treatment within 24 hours from receipt of your request. If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care Claim and decided according to the timeframes described above.

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to post-service or pre-service timeframes, whichever applies.

Adverse Benefits Determination Notice
A denial notice for a group health plan will include:

- the specific reason(s) for your adverse benefit determination;
- reference to the specific Plan provision on which the determination is based;
- a description of any additional material or information necessary for you to fix your claim and an explanation of why such material or information is necessary;
- a description of the review procedures, including a statement of your right to bring a lawsuit following an adverse benefit determination on review;
- either the specific rule or guideline used in making your benefits determination or a statement that such a rule or guideline was relied upon in making the determination and that a copy of such rule or guideline will be provided free of charge upon request;

- if the adverse benefit determination is based on a medical judgment, either an explanation of such judgment, or a statement that such explanation will be provided to you free of charge upon request; and
- in the case of an Urgent Care Claim, a description of the expedited review process to which you may be entitled.

In addition to the notice standards described above, to the extent required by the Affordable Care Act, all adverse benefit determination notices will include the following: (a) information identifying the claim involved, including the date of service, the health care provider, the claim amount, the diagnosis code, the treatment code, and the corresponding meaning of those codes; (b) the reason or reasons for the adverse benefit determination that includes the denial code and its corresponding meaning and a description of the Plan's standard, if any, that was used to deny the claim (for notices of final internal adverse benefit determinations, the description will include a discussion of the decision); (c) a description of available internal appeals and external review processes, including how to initiate an appeal; and (d) contact information for any applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act to assist individuals with the internal claims and appeals and external review processes.

How to Appeal a Claim Decision
If you disagree with a claim determination, you can contact the Plan Administrator in writing to formally request an appeal. If the appeal relates to a claim for payment, your request should include:

- The patient's name and the identification number from the ID card, if any.
- The date(s) of health care service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to the Plan Administrator within 180 days after you receive the claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination.

The Plan Administrator may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent health claim information. Upon request and free of charge you have the right to reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits.

Appeals Determinations

Pre-Service and Post-Service Claim Appeals
You will be provided with written or electronic notification of the decision on your appeal as follows:
For appeals of Pre-Service Claims, the first level appeal will be conducted and you will be notified by the Plan Administrator of the decision within 15 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified by the Plan Administrator of the decision within 15 days from receipt of a request for review of the first level appeal decision.

For appeals of Post-Service Claims, the first level appeal will be conducted and you will be notified by the Plan Administrator of the decision within 30 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified by the Plan Administrator of the decision within 30 days from receipt of a request for review of the first level appeal decision.

For procedures associated with Urgent Claims, see “Urgent Claim Appeals” below.

If you are not satisfied with the first level appeal decision of the Plan Administrator, you have the right to request a second level appeal from the Plan Administrator. Your second level appeal request must be submitted to the Plan Administrator within 60 days from receipt of first level appeal decision.
Please note that the Plan Administrator’s decision is based only on whether or not benefits are available under the group health plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your doctor.

Urgent Claim Appeals
Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations, the appeal does not need to be submitted in writing. You or your doctor should call the Plan Administrator as soon as possible, and provide the Plan Administrator with the information identified above under “How to Appeal a Claim Decision.” The Plan Administrator will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination taking into account the seriousness of your condition.

Appeal Determination Notice
If denied, your review decision on appeal will include:

- the specific reason(s) for the adverse determination;
- reference to the specific Plan provision on which the benefit determination is based;
- a statement that you are entitled to receive, without charge, reasonable access to any document (i) relied on in making the determination, (ii) submitted, considered, or generated in the course of making the benefit determination, (iii) that demonstrates compliance with the administrative processes and safeguards required in making the determination, or (iv) that constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment without regard to whether the statement was relied on;
- either the specific rule or guideline used in making your benefits determination or a statement that such a rule or guideline was relied upon in making the determination and that a copy of such rule or guideline will be provided free of charge upon request;
- if the adverse determination is based on medical necessity or experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment applying the terms of the Plan to your medical condition, or a statement that such explanation will be provided without charge on request;
- a statement describing the Plan’s optional appeals procedures, and your right to receive information about such procedures, as well as your right to bring a lawsuit; and
- the following statement: “You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.”

If you file an internal appeal for medical benefits, you will continue to be covered pending the outcome of the internal appeal. This means that the Plan shall not terminate or reduce any ongoing course of treatment without providing advance notice and the opportunity for review.

Voluntary External Review
If the Group Medical Feature in which you are enrolled is not subject to a State external review process and is not a “grandfathered” plan for purposes of the Affordable Care Act, and your internal appeal of a claim for benefits (not related to employee classifications or non-covered benefits) under such plan is denied, you will have the right to request an external (i.e., independent) review if you do so within four months after receiving notice of an adverse benefit determination or final internal adverse benefit determination. Within five business days after receiving your request, a preliminary review will be completed to determine whether: (i) you are/were covered under the Plan; (ii) the denial was based on

your ineligibility under the terms of the Plan; (iii) you have exhausted the Plan's internal process, if required; and (iv) you provided all information necessary to process the external review. Within one business day after completing the preliminary review, you will be notified in writing if your appeal is not eligible for an external review or if it is incomplete. If your appeal is complete but not eligible, the notice will include the reason(s) for ineligibility. If your appeal is not complete, the notice will describe any information needed to complete the appeal. You will have the remainder of the four-month filing period or 48 hours after receiving the notice, whichever is greater, to cure any defect. If eligible for an external review, your appeal will be assigned to an independent review organization (IRO). If the IRO reverses the Plan's denial, the IRO will provide you written notice of its determination.

In addition, you will have the right to an expedited external review in the following situations:

- Following an adverse benefit determination involving a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal.
- Following a final internal adverse benefit determination involving (i) a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function or (ii) an admission, availability of care, continued stay, or health care item or service for which you received emergency services but have not been discharged from a facility.

The IRO will provide notice of its final external review decision as expeditiously as your medical condition or circumstances require, but not more than 72 hours after the IRO receives the request.

Program or Plan Sponsor and Plan Administrator

Each of the Plans listed in this document is sponsored by MMS USA Holdings, Inc. (the "Company"). The Company sponsors the Plans and is the official Plan Administrator of each Plan. If you have any questions that your HR Representative or that a specific carrier can't answer satisfactorily, you may contact the Plan Administrator at:

Publicis Re:Sources USA
Publicis Groupe Benefits Department
Attn: Plan Administration Committee
35 West Wacker Drive
Chicago, IL 60601
1-800-933-3622, weekdays 9am-5pm ET

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.

The Plan Administrator files an annual return/report (Form 5500) with the Internal Revenue Services (IRS) for each Plan that's subject to such reporting requirement. The IRS makes Form 5500 available to the U.S. Department of Labor, which in turn makes the form available for public inspection. As a participant in the Plans, you receive a summary of the annual return/report containing certain information found in the full annual return/report. You may also request from the Plan Administrator a copy of the complete annual return/report (Form 5500).

Employer Identification Number (EIN)
The Company's employer identification number (EIN) is 36-2677628 (MMS USA Holdings, Inc.).

Employers
Subsidiaries of MMS USA Holdings, Inc. who have adopted the Program are the employers with respect to its employees. Any other entity of MMS USA Holdings, Inc. whose participation in the Program is approved also will be the employer with respect to its employees. You may examine or receive from the Plan Administrator, upon written request, information as to whether a particular entity is a participating employer in the Program, and if so, that employer's address or a complete list of employers sponsoring the Program.

Plan Year
The plan year for recordkeeping and accounting purposes is January 1 through December 31.

Agent for Service of Legal Process
The agent for service of legal process on the Program is:

Publicis Re:Sources USA
Publicis Legal Department
35 West Wacker Drive
Chicago, IL 60601

Legal process on the Program may also be served on the Plan Administrator.

Permanency of the Program
The Company intends to continue the Plans. However, the Company has full and sole authority to—at any time and for any reason—make changes to the Plans or terminate the Plans (or any coverage provided under them and to increase or decrease contributions under the Plans). Such changes or terminations may be caused by a variety of circumstances. The Company takes such action through board of directors' resolutions or through an administrative committee or other persons authorized by the board of directors to take such action.

Your Duties and Responsibilities
Operating a successful benefit program is a cooperative effort. To receive benefits under this Program, all participants and beneficiaries must cooperate with the reasonable requests of the Plan Administrator or its designated agents in enforcing the Program's terms. You can find the contact list of insurance carriers here: https://www.publicisconnections.com/Resources/Contacts. Your responsibilities include such actions as:

- Promptly providing all of the information that the Plan Administrator may request.
- Notifying the Plan Administrator immediately of any changes in that information (including any change of address, name, etc.).
- Notifying the Plan Administrator immediately if you feel that any report related to your benefits is inaccurate. Their contact information is in this document or here.
- Keeping your beneficiary designation up to date. Life insurance beneficiaries can be designated by logging into your benefits account on the bswift enrollment site.

- Retirement plan beneficiaries can be designated by logging into NetBenefits. Be sure to make any changes that may affect the identity of your beneficiary (i.e., divorce) or make any qualified changes in family status (as defined in each Summary Plan Description) within 31 days of the event.
- Giving the Plan Administrator as much advance notice as possible (and no later than the dates stated on this site) of your intentions (i.e., leave of absence, separation from service, retirement, etc.).
- Making sure that the Plan Administrator has your current address and the current address of every beneficiary and alternate payee who may have an interest in your benefits.

Failure to notify the Plan Administrator of these events may result in a loss or reduction of benefits under the Program.

In the event that a benefits check issued by a Claims Administrator of a self-insured Welfare Program feature is not cashed within 12 months from the date of issue, the check will be voided and the check will be applied to the payment of current benefits and administrative fees under the Program or benefits furnished under the Program. In the event that a participant or other beneficiary as defined by ERISA does not receive a check that was issued and requests payment within one year of the amounts in the issued check, the Claims Administrator will make payment under the terms and conditions of the Program or benefits furnished under the Program as in effect when the claim was originally processed. Unclaimed funds may be applied only to the delivery of benefits (including administrative fees) under the Program or benefits furnished under the Program to the extent required by ERISA. The Program shall have no liability for checks not cashed within one year; the amount of the check will be deemed a forfeiture, and no funds shall escheat to any state.

Official Documents

In setting forth the terms of the Program, every attempt has been made to make the Summary Plan Descriptions as detailed and accurate as possible. However, insurance policies or contracts do govern some of the benefit options. So, to the extent a conflict arises between the content of these documents and the insurance policies and contracts, the policies and contracts shall generally govern.