2027 U.S. Freelancer Benefits Guide

If you are eligible for U.S. freelancer benefits:

- **Read this freelancer benefits guide** to help you make informed choices with your 2027 benefits.
- **Visit the Freelancer page at Publicis Connections** or more information and guidance on Publicis benefits.
- **Select your 2027 benefits.** If you decide not to make any changes, your 2026 elections will carry over to 2027. If this is your first year enrolling in benefits, you must enroll or you will not have coverage.

PUBLICIS | PUBLICIS CONNECTIONS

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At Publicis Groupe, we offer medical and other valuable benefits to our freelancers and temporary eligible employees. Voluntary benefit options include supplemental medical insurance, transportation and parking benefits, legal benefits, pet insurance, and auto and home insurance.

Here's how it works:

1 REVIEW YOUR OPTIONS

Review this freelancer benefits guide and www.publicisconnections.com for the full range of benefits available to you.

2 ENROLL IN MEDICAL, COMMUTER TRANSIT/PARKING, LEGAL, AND SUPPLEMENTAL MEDICAL INSURANCE

When you're ready to enroll in 2027 benefits, go to the **bswift benefits enrollment portal** to compare your medical plan option and estimate 2027 costs. You can also elect or change your TRIP commuter benefits, Legal or Supplemental Medical Insurance

3 ENROLL IN VOLUNTARY BENEFITS

For voluntary benefits (legal, pet insurance, auto/home, etc.), contact the respective insurance provider on the **Contacts page** at the end of this guide to make your elections for 2027.

IMPORTANT

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices for prescription drug coverage. Please see Creditable Prescription Drug Coverage and Medicare Notice in Legal Notices at the back of this guide for more details.

Your Benefit Options

You'll be able to choose from a variety of plans that offer quality coverage.

We encourage you to take the time to understand all your options and then make the best decisions for your needs.

This freelancer benefits guide provides instructions on how to make benefits elections for 2027 as well as an overview of the benefits available to you and helpful tips to support your decision-making.

For access to the latest 2027 health plan summaries and notices, please visit the Publicis Connections Site at www.publicisconnections.com.

Need Assistance?

If you need assistance, contact the Publicis Connections Service Center at 1-800-933-3622 on weekdays from 8 a.m. to 8 p.m. ET.

Reminder: While federal law no longer mandates that you have health coverage, your state may still require you to do so to avoid tax penalties.

Eligibility for Benefits

Your eligibility:
You must be actively employed for 90 consecutive calendar days in order to be eligible for Publicis medical and voluntary benefits.

If this is your first time enrolling, please keep in mind: When you become eligible for Publicis benefits, you'll receive an email or mailed letter from bswift — our benefits enrollment system — 45 days before your benefits coverage would start. You'll have 45 days to enroll in Publicis benefits, otherwise you'll forfeit your coverage until the next Benefits Open Enrollment, which is typically in Q4 each year.

Eligible dependents include:

1. Your spouse (unless legally separated or divorced from you) or domestic partner.
2. Your own or legally adopted children, including:
   - Those up to age 26 regardless of student or marital status (or those age 26 and older who are mentally or physically disabled and dependent upon you for support).
   - You are legally obligated to support them in anticipation of adoption (whether or not the adoption is final).
   - You are required to provide health coverage for them under a Qualified Medical Child Support Order (QMCSO)

You may also enroll your children under age 21 if one of the following conditions applies:

- You are legally obligated to support them in anticipation of adoption (whether or not the adoption is final).
- You are required to provide health coverage for them under a Qualified Medical Child Support Order (QMCSO).

Important Note on Dependent Verification

After you enroll, bswift will contact you via email (or home mailing), using your information on file to request supporting documentation for dependent verification. This notification will include:

- Examples of acceptable documentation
- Instructions on how to upload the required forms to your bswift benefits account

Your verification deadline is 30 calendar days from the date that you submit your enrollment in the benefits system. You'll need to submit the required documents by this specified deadline, or your requested coverage will be retroactively terminated as of the date of coverage. This would result in your dependents being removed as if they had no coverage at all.

How to Enroll or Make Changes to Your Benefit Elections

1. To view, enroll or make changes to your medical or commuter benefit elections, log into the bswift benefits enrollment portal and click through either **Medical**,**TRIP, Legal or Supplemental Medical Insurance**.
   - **Important:** click **SUBMIT** each time to update your choice.*
2. To enroll or make changes to your voluntary benefits such as pet, homeowner's/renter's, etc., contact the respective insurance provider on the Contacts page at the end of this guide.

For First-time Users

If you are enrolling for the first time, go to the bswift benefits enrollment portal and click the **First Time User** to create a user ID and password for your bswift benefits account.

Important: Have a valid email address saved to your bswift profile, and make sure all your personal information is accurate (found under **My Profile**).

Voluntary Benefits Elections

For voluntary benefits, including pet insurance and auto/home, etc., contact the respective Voluntary Benefit carriers to make your elections for 2027.

**Note: It can take 1 - 2 pay periods for your changes to go into effect, and first-time enrollees will receive a debit card in the mail within three weeks.*

KEY WORDS TO KNOW:

Deductible: The amount you pay before the plan begins to pay benefits.

Health Savings Account (HSA): An account funded by you that lets you use tax-advantaged dollars to pay for eligible health care expenses.

Out-of-Pocket Costs: Expenses you pay yourself, such as deductibles, copays and uncovered services.

Out-of-Pocket Maximum: The maximum amount you pay for covered services in a year.

Plan Coinsurance: Percentage of the charge that your plan will pay, typically after you have met the deductible.

Prescriptions: Medications are grouped into tiers, and the tier that your medication falls into determines your portion of the drug cost.

Generic Medications (Tier 1): These medications are typically available at a lower cost than their brand-name alternatives, and are comparable to the brand-name medication in dosage, strength, quality and performance.

Preferred Brand-Name Medications (Tier 2): These medications are sold under a specific trade name and typically have the second-lowest cost to you.

Non-Preferred Brand-Name Medications (Tier 3): These medications consist of selected brand-name drugs, many of which appear on this tier because they have a reasonable, more cost-effective alternative on Tier 1 or Tier 2. Your cost is typically the greatest for medications on this tier.

Enrolling for Transportation and Parking Benefits

- On the bswift Open Enrollment Welcome page, go to the TRIP benefit and click on the "View Plan Option" button.
- Follow the steps to enter your changes.
- Be sure to click **SUBMIT** at the end of the transaction to save the change so it is sent for processing* (i.e., start/change/stop the deduction via Payroll and to update HealthEquity.)

Changing Your Benefit Elections

In general, you are not able to make changes to your benefit elections until the next annual Open Enrollment period unless you experience a Qualified Life Event, as defined by the IRS. However, if you have a Qualified Life Event, you will be able to make benefit changes that are consistent with your Qualified Life Event. Changes to your coverage must be made within 31 calendar days of the event. Otherwise, you cannot make coverage changes until the next annual Open Enrollment period.

To learn more go to the Qualifed Live Events page on Publicis Connections.

HELPFUL INFORMATION ABOUT DEDUCTIBLES

If you cover any family member(s) in addition to yourself:

- Once one family member meets the individual deductible, benefits begin to be paid for that family member.
- Once one family member meets the individual out-of-pocket maximum, the plan pays covered benefits in full for that family member.

SHOPPING TIP

Consider combining medical insurance with supplemental medical insurance such as hospital indemnity and accident insurance. These options, which are described in the next section, are intended to supplement your medical plan's coverage. The combined coverage could offer effective protection against out-of-pocket expenses at a lower plan cost.

Your Medical Insurance

Medical coverage offers valuable benefits to help you stay healthy and pay for care if you or your covered family members become sick or injured. In addition to enrolling in a medical plan, you also have the option to open a Health Savings Account (HSA) with a financial institution of your choosing, as bswift does not administer HSAs.

$3,500 Deductible Plan

Your medical coverage option is administered by UnitedHealthcare, and the prescription drug benefits are administered by CVS Caremark. For the lowest cost, be sure to find doctors, hospitals and other health care providers in the UnitedHealthcare (UHC) national provider network. With the UHC network, you will have access to providers nationwide. Visit the bswift benefits enrollment portal for plan costs.

Special Note on Medical Insurance

Medical coverage offers valuable benefits to help you stay healthy and pay for care if you or your covered family members become sick or injured. While federal law no longer mandates that you have health coverage, your state may still require you to do so to avoid tax penalties. If your state requires health coverage to avoid incurring tax penalties, be sure you're covered, either through Publicis-sponsored medical coverage or through another option available to you, such as your spouse's employer benefits or a government program like Medicare or Medicaid.

Medical Plan Summary

$3,500 Deductible Plan		
HSA Eligible	Yes	
HSA Maximum Annual Employee Contribution	$4,500 for individual $9,000 for family	
	In-Network	**Out-of-Network**
Preventive Doctor's Visit	Covered at 100% in-network	Deductible and coinsurance
Deductible		
Individual	$3,500	$5,700
Family	$6,000	$11,400
Out-of-Pocket Maximum		
Individual	$6,550	$13,100
Family	$13,100	$26,200
Coinsurance	70% after deductible	50% after deductible
Office Visit (Primary Care/Specialist)	70% after deductible	50% after deductible
Retail Prescriptions	You pay 100% of charges until annual deductible is met; plan then pays coinsurance levels noted below	
Generic (Tier 1)	70%	70%
Preferred Brand Name (Tier 2)	70%	70%
Non-Preferred Brand Name (Tier 3)	70%	70%
Mail Order Prescriptions	In-Network: 70% Out-of-Network: Not covered	

In-Network vs. Out-of-Network

You have the flexibility to see any medical provider you choose; however, you will pay more with out-of-network providers. Using in-network providers will lower your out-of-pocket costs and you'll save more on services. Visit UHC to find an in-network doctor or hospital near you.

Health Savings Account

You can save money on your health care costs through the use of a Health Savings Account (HSA), which allows you to set aside money to pay for eligible health care expenses. With the HSA, your contributions go into your account tax-free, grow tax-free and can be withdrawn tax-free when used for eligible expenses. Your account balance rolls over to the next year and you can take it with you when you leave the company or retire.

How the HSA Works

If you elect coverage, you have the option to open an HSA. For more information on opening and contributing to an HSA, consult your HSA financial institution.

In general, your HSA works like a bank account that you manage to pay for your health care expenses. You can contribute up to the 2027 annual IRS limits of $4,500 for individual coverage or $9,000 for family coverage. If you will be age 55 or older during the plan year, you can contribute an additional $1,000. You may change your contribution amount or stop contributing at any time.

Unused money can be carried over each year and invested for the future — you can even take it with you if you leave the company.

IRS rules

The HSA is subject to IRS rules. Federal law does not permit you to have contributions made to an HSA if any of the following are true:

- You are enrolled in Medicare.
- You are covered by any health insurance (including TRICARE) that is not a qualified high-deductible health plan.
- You can be claimed as a dependent on another person's tax return.
- You have access to reimbursement under a Health Care Flexible Spending Account (FSA) established by another employer for you, your spouse or another family member.

Please consult with a tax advisor if you are unsure of your eligibility to contribute to an HSA.

Supplemental Medical Insurance

Aetna

Supplemental Medical insurance can help protect you from significant or unexpected out-of-pocket expenses. Keep in mind that these plans are intended to supplement a medical plan.

Consider your anticipated medical needs for the calendar year, along with the cost of the insurance plans available to you. If you do not make any elections before the deadline, you will waive your voluntary benefits coverage.

The following two supplemental medical plans may be available to you. These plans are available in most but not all states.

Accident Insurance

Accident insurance supplements your medical plan by providing cash benefits in cases of accidental injuries. Benefits include hospital stays, fractures, dislocations, physical therapy and more. The cash benefits can be used to help offset out-of-pocket medical expenses (deductibles, coinsurance, etc.) or other expenses (lost income, household bills, etc.) arising from a covered accident. Accident insurance pays in addition to your medical plan, and benefits are payable regardless of any other insurance programs. Eligible employees and dependents will be able to elect coverage during Open Enrollment regardless of prior health history.

Hospital Indemnity Insurance

You might not realize that most primary health insurance plans do not cover all hospital costs. Hospital Indemnity insurance can complement your medical coverage by easing the financial impact of a hospitalization due to an accident or illness. Coverage is available for employees, spouses and families. Benefits are paid directly to employees unless otherwise specified and regardless of any other insurance. Eligible employees and dependents will be able to elect coverage during Open Enrollment regardless of prior health history.

Critical Illness Insurance

Critical Illness insurance helps protect against the financial impact of certain illnesses, such as heart attack, stroke, cancer and more. A lump-sum payment is paid directly to you and can be used to help offset out-of-pocket medical expenses (deductibles, coinsurance, etc.) or other expenses (lost income, household bills, etc.) arising from the critical illness. Critical Illness insurance pays in addition to your medical plan, and benefits are payable regardless of any other insurance programs. Eligible employees and dependents will be able to elect coverage during Open Enrollment regardless of prior health history.

Other Valuable Benefits

Transportation and Parking Benefits

HealthEquity

With this benefit, you can set aside pretax dollars for commuting (bus, train, ferry, streetcar, vanpools) and parking expenses. The 2027 IRS limit for pre-tax benefits is $350/month; however, you can still contribute more on your commuter card, which will be post-tax contributions The maximum contribution limits for transportation and parking benefits expenses are subject to change annually.

You may change your Transportation and Parking Benefits contribution at any time throughout the year. You may submit a claim for reimbursement at any time, but the amount requested may not exceed certain maximum amounts deposited to your account each month.

If you leave the company, you will have to forfeit your parking balance on your last day as well as your commuter balance after 90 days. For more information on these accounts, visit www.publicisconnections.com.

Legal Benefits

MetLife® Hyatt

The Legal Assistance Plan offers you economical access to attorneys for common legal services, such as will preparation, estate planning, family law and more. You, your spouse and your dependents will have access to a nationwide network of 14,000 experienced attorneys. You also have the flexibility to use a non-plan attorney and be reimbursed for covered services according to a set fee schedule.

Legal advice will be just a phone call away. A knowledgeable client service representative can help you locate a plan attorney in your area. You'll also have convenient online access to resources that will assist with court appearances, document review and preparation, and real estate matters.

Pet Insurance

Nationwide

For pet owners, the cost of providing unexpected veterinary care if medical issues arise could add up to hundreds or even thousands of dollars. Pet insurance is a cost-effective way to protect you from the risk of these expenses and provide medical care for your pet with peace of mind.

Nationwide offers several policy options to meet a variety of needs and budgets. With this coverage, you are free to use any veterinarian worldwide.

Auto and Home Insurance

MetLife Auto & Home

Purchasing auto and home insurance through MetLife provides you with savings of up to 15%. MetLife gives you access to a variety of personal insurance policies, including home,* landlord's rental dwelling, condo, mobile home, renters, recreational vehicle, boat and personal excess liability.

There is a phone number listed on the Contacts page of this guide that you can use to get a no-obligation comparison quote from MetLife Auto & Home, one of the nation's leading auto insurance companies.

***Home insurance is not offered in Massachusetts and Florida as part of this MetLIfe Auto & Home benefit. .*

Contacts

Benefit	Administrator	Phone Number	Website
Medical	UnitedHealthcare	1-833-313-2025	www.uhc.com
Prescription Drugs	CVS Caremark	1-866-212-4752	www.caremark.com
Supplemental Medical Insurance Plans	Aetna	1-800-933-3622	**To make 2027 medical plan TRIP commuter transit/ parking elections, legal and/or supplemental medical insurance elections:** Complete your 2027 elections on the bswift enrollment website at www.publicisbenefitsconnection.bswift.com. **For Voluntary Benefits (pet insurance, auto/home, etc.):** Contact the respective Voluntary Benefit carriers to make your elections for 2027.
Transportation and Parking Benefits	HealthEquity	1-877-924-3967	
Legal Benefits	MetLife® Hyatt	1-800-438-6388	
Pet Insurance	Nationwide	1-855-525-1458	
Auto and Home Insurance	MetLife	1-800-438-6388	

Legal Notices

Publicis reserves the right to change, amend or terminate any benefits plan at any time for any reason. Participation in a benefits plan is not a promise or guarantee of future employment. Receipt of benefits documents does not constitute eligibility.

The Benefits Decision Guide, combined with these legal notices, provides an overview of the benefits available to you and your family. In the event of a discrepancy between the information presented in the Benefits Decision Guide and official plan documents, the official plan documents will govern.

Statement of Material Modifications

This enrollment guide constitutes a Summary of Material Modifications (SMM) or Summary of Material Reductions (SMR), as applicable, to the summary plan description (SPD). It is meant to supplement and/or replace certain information in the SPD, so retain it for future reference along with your SPD. Please share these materials with your covered family members.

Summary of Benefits Coverage

A Summary of Benefits Coverage (SBC) for each of the employer-sponsored medical plans is available on bswift.

Important Notice From Publicis About Creditable Prescription Drug Coverage and Medicare

The purpose of this notice is to advise you that the prescription drug coverage listed below under the Publicis medical plan is expected to pay out, on average, at least as much as the standard Medicare prescription drug coverage will pay in 2027. This is known as "creditable coverage."

Why this is important: If you or your covered dependent(s) are enrolled in any prescription drug coverage during 2027 listed in this notice and are or become covered by Medicare, you may decide to enroll in a Medicare prescription drug plan later and not be subject to a late enrollment penalty — as long as you had creditable coverage within 63 days of your Medicare prescription drug plan enrollment. You should keep this notice with your important records.

If you or your family members aren't currently covered by Medicare and won't become covered by Medicare in the next 12 months, this notice doesn't apply to you.

Please read the notice below carefully. It has information about prescription drug coverage with Publicis and prescription drug coverage available for people with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

Notice of creditable coverage

You may have heard about Medicare's prescription drug coverage (called Part D) and wondered how it would affect you. Prescription drug coverage is available to everyone with Medicare, through Medicare prescription drug plans. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans also offer more coverage for a higher monthly premium.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible, and each year from October 15 through December 7. Individuals leaving employer/union coverage may be eligible for a Medicare Special Enrollment Period.

If you are covered by the Publicis prescription drug plan listed below, you'll be interested to know that coverage is, on average, at least as good as standard Medicare prescription drug coverage for 2027. This is called creditable coverage. Coverage under this plan will help you avoid a late Part D enrollment penalty if you are or become eligible for Medicare and later decide to enroll in a Medicare prescription drug plan.

- UHC $3,400 Deductible Plan alt. OOP Maximum w/HSA

If you decide to enroll in a Medicare prescription drug plan and you are an active employee or family member of an active employee, you may also continue your employer coverage. In this case, the employer plan will continue to pay primary or secondary, as it had before you enrolled in a Medicare prescription drug plan. If you waive or drop Publicis coverage, Medicare will be your only payer. You can re-enroll in the employer plan at annual enrollment or if you have a special enrollment event for the Publicis plan.

You should know that if you waive or leave coverage with Publicis and you go 63 days or longer without creditable prescription drug coverage (once your applicable Medicare enrollment period ends), your monthly Part D premium will go up at least 1% per month for every month that you did not have creditable coverage. For example, if you go 19 months without coverage, your Medicare prescription drug plan premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll in Part D.

You may receive this notice at other times in the future — such as before the next period you can enroll in Medicare prescription drug coverage, if this Publicis coverage changes, or upon your request.

For more information about your options under Medicare prescription drug coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the *Medicare & You* handbook. Medicare participants will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. Here's how to get more information about Medicare prescription drug plans:

Visit www.medicare.gov for personalized help.

Call your state Health Insurance Assistance Program (see a copy of the *Medicare & You* handbook for the telephone number).

Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov or call 1-800-772-1213 (TTY: 1-800-325-0778).

Remember: Keep this notice. If you enroll in a Medicare prescription drug plan after your applicable Medicare enrollment period ends, you may need to provide a copy of this notice when you join a Part D plan to show that you are not required to pay a higher Part D premium amount.

For more information about this notice or your prescription drug coverage, contact:

Publicis Benefits
375 Hudson Street,
New York, NY 10014

HIPAA Special Enrollment Notice

Notice of special enrollment rights for health plan coverage

If you decline enrollment in a health plan for you or your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in a health plan without waiting for the next Open Enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 31 days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption or placement for adoption. You must request health plan enrollment within 31 days after the marriage, birth, adoption or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 31-day time frame, coverage will be effective on the date of the birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in a medical plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

Note: If your dependent becomes eligible for special enrollment rights, you may add the dependent to your current coverage or change to another health plan. Any other currently covered dependents may also switch to the new plan in which you enroll.

Women's Health and Cancer Rights Act (WHCRA) Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses.
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this Plan. If you would like more information on WHCRA benefits, call UnitedHealthcare.

Newborns' and Mothers' Health Protection Act (NMHPA or "Newborns' Act") Notice

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, call UnitedHealthcare.

CHIP/Medicaid Notice

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your state for more information on eligibility.

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: Health Insurance Premium Payment (HIPP) Program https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 916-445-8322 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943 / State Relay 711 CHP+: www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991 / State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/healthinsurancebuy-program HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidt-plrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – Medicaid**
Website: https://medicaid.georgia.gov/health-insurancepremium-payment-program-hipp Phone: 678-564-1162 ext. 2131	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone: 1-800-403-0864
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-785-296-3512
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 1-402-473-7000 Omaha: 1-402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dwss.nv.gov Medicaid Phone: 1-800-992-0900	Website: www.dhhs.nh.gov/oii/hipp.htm Phone: 1-603-271-5218 Toll-free Number for the HIPP Program: 1-800-852-3345 ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://www.nyhealth.gov/health_care/medicaid Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347 or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA – Medicaid**
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: http://mywvhipp.com/ Toll-free Phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badger-careplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2022, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov.

Michelle's Law Notice

Extended dependent medical coverage during student medical leaves

The Publicis Plan may extend medical coverage for dependent children if they lose eligibility for coverage because of a medically necessary leave of absence from school. Coverage may continue for up to a year, unless your child's eligibility would end earlier for another reason.

Extended coverage is available if a child's leave of absence from school — or change in school enrollment status (for example, switching from full-time to part-time status) — starts while the child has a serious illness or injury, is medically necessary, and otherwise causes eligibility for student coverage under the plan to end. Written certification from the child's physician stating that the child suffers from a serious illness or injury and the leave of absence is medically necessary may be required.

If your child will lose eligibility for coverage because of a medically necessary leave of absence from school and you want his or her coverage to be extended, call a Publicis Benefits Marketplace Service Center counselor at 1-844-851-5421 as soon as the need for the leave is recognized by Publicis. In addition, contact your child's health plan to see whether any state laws requiring extended coverage may apply to his or her benefits.

HIPAA Privacy Notice

Please carefully review this notice. It describes how medical information about you may be used and disclosed and how you can get access to this information.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on the use and disclosure of individual health information by Publicis health plans. This information, known as protected health information (PHI), includes almost all individually identifiable health information held by a plan — whether received in writing, in an electronic medium, or as an oral communication. This notice describes the privacy practices of the medical plan. The plans covered by this notice may share health information with each other to carry out treatment, payment, or health care operations. These plans are collectively referred to as the Plan in this notice, unless specified otherwise.

The Plan's duties with respect to health information about you

The Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Plan's legal duties and privacy practices with respect to your health information. If you participate in an insured plan option, you will receive a notice directly from the insurer. It's important to note that these rules apply to the Plan, not Publicis as an employer — that's the way the HIPAA rules work. Different policies may apply to other Publicis programs or to data unrelated to the Plan.

How the Plan may use or disclose your health information

The privacy rules generally allow the use and disclosure of your health information without your permission (known as an authorization) for purposes of health care treatment, payment activities, and health care operations. Here are some examples of what that might entail:

- Treatment includes providing, coordinating, or managing health care by one or more health care providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. For example, the Plan may share your health information with physicians who are treating you.
- Payment includes activities by this Plan, other plans, or providers to obtain premiums, make coverage determinations, and provide reimbursement for health care. This can include determining eligibility; reviewing services for medical necessity or appropriateness; engaging in utilization management activities, claims management, and billing; and performing "behind the scenes" plan functions, such as risk adjustment, collection, or reinsurance. For example, the Plan may share information about your coverage or the expenses you have incurred with another health plan to coordinate payment of benefits.
- Health care operations include activities by this Plan (and, in limited circumstances, by other plans or providers), such as wellness and risk assessment programs, quality assessment and improvement activities, customer service, and internal grievance resolution. Health care operations also include evaluating vendors; engaging in credentialing, training, and accreditation activities; performing underwriting or premium rating; arranging for medical review and audit activities; and conducting business planning and development. For example, the Plan may use information about your claims to audit the third parties that approve payment for Plan benefits.

The amount of health information used, disclosed, or requested will be limited and, when needed, restricted to the minimum necessary to accomplish the intended purposes, as defined under the HIPAA rules. If the Plan uses or discloses PHI for underwriting purposes, the Plan will not use or disclose PHI that is your genetic information for such purposes.

How the Plan may share your health information with Publicis

The Plan, or its health insurer or HMO, may disclose your health information without your written authorization to Publicis for Plan administration purposes. Publicis may need your health information to administer benefits under the Plan. Publicis agrees not to use or disclose your health information other than as permitted or required by the Plan documents and by law. Publicis Connections employees are the only Publicis employees who will have access to your health information for Plan administration functions.

Workers' compensation	Disclosures to workers' compensation or similar legal programs that provide benefits for work-related injuries or illness without regard to fault, as authorized by and necessary to comply with the laws
Necessary to prevent serious threat to health or safety	Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, if made to someone reasonably able to prevent or lessen the threat (or to the target of the threat); includes disclosures to help law enforcement officials identify or apprehend an individual who has admitted participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody
Public health activities	Disclosures authorized by law to persons who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects
Victims of abuse, neglect, or domestic violence	Disclosures to government authorities, including social services or protected services agencies authorized by law to receive reports of abuse, neglect, or domestic violence, as required by law or if you agree or the Plan believes that disclosure is necessary to prevent serious harm to you or potential victims (you'll be notified of the Plan's disclosure if informing you won't put you at further risk)
Judicial and administrative proceedings	Disclosures in response to a court or administrative order, subpoena, discovery request, or other lawful process (the plan may be required to notify you of the request or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information)
Law enforcement purposes	Disclosures to law enforcement officials required by law or legal process, or to identify a suspect, fugitive, witness, or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosures about a death that may have resulted from criminal conduct; and disclosures to provide evidence of criminal conduct on the Plan's premises
Decedents	Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death, and to funeral directors to carry out their duties
Organ, eye, or tissue donation	Disclosures to organ procurement organizations or other entities to facilitate organ, eye, or tissue donation and transplantation after death
Research purposes	Disclosures subject to approval by institutional or private privacy review boards, subject to certain assurances and representations by researchers about the necessity of using your health information and the treatment of the information during a research project
Health oversight activities	Disclosures to health agencies for activities authorized by law (audits, inspections, investigations, or licensing actions) for oversight of the health care system, government benefits programs for which health information is relevant to beneficiary eligibility, and compliance with regulatory programs or civil rights laws
Specialized government functions	Disclosures about individuals who are armed forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates
HHS investigations	Disclosures of your health information to the Department of Health and Human Services to investigate or determine the Plan's compliance with the HIPAA privacy rule

Here's how additional information may be shared between the Plan and Publicis, as allowed under the HIPAA rules:

- The Plan, or its insurer, may disclose "summary health information" to Publicis, if requested, for purposes of obtaining premium bids to provide coverage under the Plan or for modifying, amending, or terminating the Plan. Summary health information is information that summarizes participants' claims information, from which names and other identifying information have been removed.
- The Plan, or its insurer, may disclose to Publicis information on whether an individual is participating in the Plan or has enrolled or disenrolled in an insurance option or HMO offered by the Plan.

In addition, you should know that Publicis cannot and will not use health information obtained from the Plan for any employment-related actions. However, health information collected by Publicis from other sources — for example, under the Family and Medical Leave Act, Americans with Disabilities Act, or workers' compensation programs — is not protected under HIPAA (although this type of information may be protected under other federal or state laws).

Other allowable uses or disclosures of your health information

In certain cases, your health information can be disclosed without authorization to a family member, a close friend or another person you identify who is involved in your care or payment for your care. Information about your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You'll generally be given the chance to agree or object to these disclosures (although exceptions may be made — for example, if you're not present or if you're incapacitated). In addition, your health information may be disclosed without authorization to your legal representative.

Except as described in this notice, other uses and disclosures will be made only with your written authorization. For example, in most cases, the Plan will obtain your authorization before it communicates with you about products or programs if the Plan is being paid to make those communications. If we keep psychotherapy notes in our records, we will obtain your authorization in some cases before we release those records. The Plan will never sell your health information unless you have authorized us to do so. You may revoke your authorization as allowed under the HIPAA rules. However, you can't revoke your authorization with respect to disclosures the Plan has already made.

You will be notified of any unauthorized access, use, or disclosure of your unsecured health information as required by law.

The Plan will notify you if it becomes aware that there has been a loss of your health information in a manner that could compromise the privacy of your health information.

Your individual rights

You have the following rights with respect to your health information the Plan maintains. These rights are subject to certain limitations, as discussed below. This section of the notice describes how you may exercise each individual right.

Right to request restrictions on certain uses and disclosures of your health information and the Plan's right to refuse

You have the right to ask the Plan to restrict the use and disclosure of your health information for treatment, payment, or health care operations, except for uses or disclosures required by law. You have the right to ask the Plan to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care. You also have the right to ask the Plan to restrict use and disclosure of health information to notify those persons of your location, general condition, or death — or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to the Plan must be in writing.

The Plan is not required to agree to a requested restriction. If the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Plan (including an oral agreement), or unilaterally by the Plan for health information created or received after you're notified that the Plan has removed the restrictions. The Plan may also disclose health information about you if you need emergency treatment, even if the Plan has agreed to a restriction.

An entity covered by these HIPAA rules (such as your health care provider) or its business associate must comply with your request that health information regarding a specific health care item or service not be disclosed to the Plan for purposes of payment or health care operations if you have paid out of pocket and in full for the item or service.

Right to receive confidential communications of your health information

If you think that disclosure of your health information by the usual means could endanger you in some way, the Plan will accommodate reasonable requests to receive communications of health information from the Plan by alternative means or at alternative locations.

If you want to exercise this right, your request to the Plan must be in writing and you must include a statement that disclosure of all or part of the information could endanger you.

Right to inspect and copy your health information

With certain exceptions, you have the right to inspect or obtain a copy of your health information in a "designated record set." This may include medical and billing records maintained for a health care provider; enrollment, payment, claims adjudication, and case or medical management record systems maintained by a plan; or a group of records the Plan uses to make decisions about individuals. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. The Plan may deny your right to access, although in certain circumstances, you may request a review of the denial.

If you want to exercise this right, your request to the Plan must be in writing. Within 30 days of receipt of your request (60 days if the health information is not accessible on site), the Plan will provide you with one of these responses:

- The access or copies you requested.
- A written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint.
- A written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.

You may also request your health information be sent to another entity or person, so long as that request is clear, conspicuous and specific. The Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The Plan also may charge reasonable fees for copies or postage. If the Plan doesn't maintain the health information but knows where it is maintained, you will be informed where to direct your request.

If the Plan keeps your records in an electronic format, you may request an electronic copy of your health information in a form and format readily producible by the Plan. You may also request that such electronic health information be sent to another entity or person, so long as that request is clear, conspicuous, and specific. Any charge that is assessed to you for these copies must be reasonable and based on the Plan's cost.

Right to amend your health information that is inaccurate or incomplete

With certain exceptions, you have a right to request that the Plan amend your health information in a designated record set. The Plan may deny your request for a number of reasons. For example, your request may be denied if the health information is accurate and complete, was not created by the Plan (unless the person or entity that created the information is no longer available), is not part of the designated record set, or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal, or administrative proceedings).

If you want to exercise this right, your request to the Plan must be in writing, and you must include a statement to support the requested amendment. Within 60 days of receipt of your request, the Plan will take one of these actions:

- Make the amendment as requested.
- Provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint.
- Provide a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.

Right to receive an accounting of disclosures of your health information

You have the right to a list of certain disclosures of your health information the Plan has made. This is often referred to as an "accounting of disclosures." You generally may receive this accounting if the disclosure is required by law, in connection with public health activities, or in similar situations listed in the table earlier in this notice, unless otherwise indicated below.

You may receive information on disclosures of your health information for up to six years before the date of your request. You do not have a right to receive an accounting of any disclosures made in any of these circumstances:

- For treatment, payment, or health care operations.
- To you about your own health information.
- Incidental to other permitted or required disclosures.
- Where authorization was provided.
- To family members or friends involved in your care (where disclosure is permitted without authorization).
- For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances.
- As part of a "limited data set" (health information that excludes certain identifying information).

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official.

If you want to exercise this right, your request to the Plan must be in writing. Within 60 days of the request, the Plan will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request. You may make one request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You'll be notified of the fee in advance and have the opportunity to change or revoke your request.

Right to obtain a paper copy of this notice from the Plan upon request

You have the right to obtain a paper copy of this privacy notice upon request. Even individuals who agreed to receive this notice electronically may request a paper copy at any time.

Changes to the information in this notice

The Plan must abide by the terms of the privacy notice currently in effect. This notice takes effect on January 1, 2023. However, the Plan reserves the right to change the terms of its privacy policies, as described in this notice, at any time and to make new provisions effective for all health information that the Plan maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If changes are made to the Plan's privacy policies described in this notice, you will be provided with a revised privacy notice mailed to your home address on file.

Complaints

If you believe your privacy rights have been violated or your Plan has not followed its legal obligations under HIPAA, you may complain to the Plan and to the Secretary of Health and Human Services. You won't be retaliated against for filing a complaint.

To file a complaint, contact:

Re:Sources USA Legal Dept.
Attn: Robert Vyverberg
35 W. Wacker Drive
Chicago, IL 60601

Contact

For more information on the Plan's privacy policies or your rights under HIPAA, contact:

Publicis Connections
35 W. Wacker Drive
Chicago, IL 60601