PUBLICIS GROUPE | benefits connection

Publicis Benefits Connection Health & Group Benefits Program

Employee Assistance Program: Summary Plan Description

January 1, 2021

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About The Employee Assistance Program (EAP)

The Employee Assistance Program (EAP) coverage is an important part of your Publicis Benefits Connection Health and Group Benefits Program (the "Program" or the "Plan") sponsored by MMS USA Holdings, Inc. (the "***Company***"). Publicis offers an employee assistance program through **Workplace Solutions** – an independent, professional counseling and consulting organization. Counselors can help you, or any member of your household, address concerns about a range of personal matters. All discussions with an EAP counselor are completely confidential, or as otherwise required by law.

This Summary Plan Description (SPD) together with the Administrative Information Summary Plan Description describes the basic features of the EAP, how it operates and how you can get the maximum advantage from it. These documents, together with other SPDs of Plan benefits, together with any plan-related document issued by an insurer, constitute a Plan Document and SPD. This document describes the Plan provisions as they exist as of January 1, 2021, while certain other information related to the Plan may be contained in the Administrative Information Summary Plan Description. If any statement, oral or written, made on behalf of the Plan disagrees with this Plan and SPD, as interpreted in the sole discretion of the Plan Administrator, the Plan Administrator's decision will govern.

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

Contact Workplace Solutions at 1-800-327-5071 or your local HR Representative, if you need more information or if you have questions regarding the EAP.

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

- You're a U.S.-based employee, dependent of an employee, or household member
- You're an employee of a subsidiary of MMS USA Holdings, Inc. (the "***Company***") that has adopted the Program;
- Your class of employees has not been excluded because you participate in another EAP program. Please see your local HR Representative if you're unsure of whether your business unit participates in the Program or if you are a member of an eligible class of employees.

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

When Coverage Begins
Coverage begins on your hire date or the date you first become eligible to participate in the plan. Your eligible dependents are covered on the same day that your coverage begins.

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

- **Spouse**, your spouse includes the individual to whom you are legally married (determined in accordance with federal law).
- Note that under federal law a "common law spouse" will be recognized as a spouse only if relevant state law recognizes the person as a spouse despite the lack of a formal marriage.
- You may be required to provide (if requested) a copy of your marriage license.
- If you live in a state in which common law marriage is recognized and your "spouse" is your common law spouse under state law, you will be required to prove your marital relationship by providing a copy of a jointly filed federal tax return, or by completing the *Affidavit for Certification of Common Law Marriage* or by providing such other supporting documentation as may be requested by bswift (our benefits administration vendor) to verify eligibility.
- **Domestic Partners**, defined as same-sex and opposite-sex couples registered with any state or local government agency authorized to perform such registrations. If your domestic partnership is not registered with any state or local government agency, your same or opposite sex domestic partner also includes any individual that you have been residing within the same residence for at least six months and who meets the other requirements designated in the Glossary of Terms herein.
- If you live in a jurisdiction that offers a domestic partner registry, you will be required to provide upon request, a copy of your domestic partner registration certificate to bswift (our benefits administration vendor) within 30 days of enrollment to verify eligibility for coverage.
- If you do not live in a jurisdiction that offers a domestic partner registry or you have not registered, you will be required to complete and submit the *Affidavit for Certification of Domestic Partnership* to bswift (our benefits administration vendor) within 30 days of enrollment to verify eligibility for coverage in order for coverage to begin.
- **Note:** Domestic Partnerships are not recognized by the federal (and most states) government for tax purposes. This means that the value of your domestic partner's coverage will be imputed into your income, as required by tax law, if he or she is not otherwise your dependent under applicable tax law."
- **Dependent children**, include:
    - Your natural children or step-children;
    - Your legally adopted children;
    - Children placed with you for adoption;
    - Your foster children;
    - Any other children (including grandchildren) for whom you are the legal guardian (as determined by a court of competent jurisdiction); or
    - Any children of a *spouse or domestic partner* that must be covered as stipulated by a divorce

decree.
- Child(ren) of a domestic partner, not otherwise adopted by you.

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

When you elect, or do not cancel, coverage for your ***spouse***, ***domestic partner***, or dependent child(ren), you are certifying that they continue to be eligible under these rules. If your ***spouse***, ***domestic partner***, or dependent child(ren) is no longer eligible for coverage, you are expected to contact the Re:Sources USA Benefits Department as soon as possible to inform them of that fact. From time to time, the Program will conduct eligibility audits. During an eligibility audit, you will be required to provide documentation substantiating your ***spouse***, ***domestic partner***, or dependent child(ren)'s eligibility in order for them to continue to receive benefits under the Program. The type of documentation that will be accepted will be determined by the ***Plan Administrator*** and communicated to you at the time of the audit.

Paying For Your Coverage
The ***Company*** pays the full cost of your participation in the Employee Assistance Plan.

Continuation or Termination of Coverage
Your coverage will continue for 60 days beyond the date you terminate employment or cease to be eligible to participate in the plan.

Your dependents' coverage will end 60 days after the date (whichever occurs first):

- Your coverage ends; or
- Your dependent no longer meets the eligibility requirements.

If You Die While Employed
If you die while you're still employed, your covered dependents are eligible to continue coverage for 60 days.

If You Become Disabled
If you become disabled and are eligible to receive disability benefits under the STD program, coverage for you and your dependents in the appropriate benefit plans continues provided you continue to receive STD benefits.

If your disability continues and you start collecting long-term disability benefits from the LTD Plan, coverage for you and your dependents will terminate 60 days following the day your LTD Plan benefits commence.

If You Take a Leave of Absence
You may decide to take either an unpaid personal leave or an unpaid FMLA leave of absence.

- **Unpaid Personal Leave:** If you take an unpaid personal leave of absence for 30 days or less, coverage continues for you and your eligible dependents.

- If your unpaid personal leave of absence is more than 30 days, coverage for you and your dependents ends 60 days following your 30 day of leave.

- **Unpaid FMLA Leave:** If you decide to take an unpaid FMLA leave, EAP coverage continues for you and your eligible dependents as if you were still an active employee.

Continuation of Coverage Under the Family and Medical Leave Act of 1993 (FMLA)
The ***Company*** continues your coverage under the plan during your period of FMLA leave just as if you were still employed. Continued coverage ends once you:

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

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

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

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

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

COBRA

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

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

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

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

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

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

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

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

Employee Loses EAP Plan Coverage
If you lose coverage because of a layoff, reduction in hours, you begin collecting LTD Plan benefits or terminate employment, COBRA continuation coverage is available to you and your dependents for up to 18 months from the date of the qualifying event, bswift notifies you and your dependents of your right to continue coverage when you experience a qualifying event. Such an event makes continuation of coverage available. You must then notify bswift (within 60 days of the later of the date you receive notice of your COBRA rights or the date the coverage is lost) of your decision to continue coverage. You can reach bswift by calling **1-866-365-2413**.

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

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

If you or your covered dependent becomes disabled, as defined by Social Security, during the first 60 days of COBRA continuation coverage, the disabled beneficiary and each non-disabled COBRA beneficiary may extend the 18-month continuation period an additional 11 months, up to 29 months. For the 29-month continuation coverage period to apply, you must notify bswift at **1-866-365-2413** that you or your covered dependent is disabled within the initial 18-month continuation coverage period and within 60 days of the Social Security determination of disability.

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

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

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

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

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

Cost of COBRA Coverage
If you elect COBRA continuation, you're responsible for paying the required premium. The cost is 102% (a 2% administrative cost is added to the actual cost of the coverage) of the total premium rate. These costs are reviewed annually and are subject to change. For benefits that are self-insured, the premium rate is based on actuarial data.

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

How to Apply for COBRA Coverage
To enroll in COBRA, contact bswift at **1-866-365-2413** or the Re:Sources USA Benefits Department.

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

When COBRA Coverage Ends

COBRA continues until the earliest of the following:

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

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

How the Employee Assistance Program Works
The Publicis EAP, provided by Workplace Solutions, is designed to promote a healthy lifestyle and help you and your eligible household members achieve better work/life balance. Counselors are available to help you clarify your concern(s) and the best way to resolve them. The EAP can assist with a wide range of problems beginning with a thorough assessment. Next steps may include short- term counseling and referrals to appropriate resources. If your concern requires more in-depth counseling, you may be referred to a professional counselor on your medical plan for continued help. If this occurs, your expenses would be congruent with your Publicis Benefits Connection Medical coverage or otherwise elected carrier. You may also be able to use your health care flexible spending account for reimbursement.

Participation is voluntary and confidential.

Your confidentiality is protected according to rules established by federal and state law and professional ethical standards. With very limited exceptions, disclosure of information to any source without prior written consent is prohibited. EAP records cannot become part of your personnel file and your job security can never be jeopardized for requesting assistance from the EAP.

Types of Services Offered

Counseling Solutions: to offer you guidance and support to assist you with anything that troubles you. Counselors are available 24/7 by calling 1-800-327-5071. Some commonly presented concerns include:

- Personal and professional stress
- Relationship difficulties
- Lifestyle or health changes
- Addictive behaviors
- Emotional health concerns such as depression and anxiety
- Parenting and family matters

Work-Life Solutions: to help you make time for what matters most. No-cost consultation for assistance with resources and referrals related to topics including:

- Child Care
- Summer Camps
- Back-up Care
- Senior Housing Options
- Adult Day Care Options
- Home Safety
- Caregiver Support
- Adoption Resources
- Education Resources
- Tutoring Programs
- College Searches
- Financial Aid Resources
- Travel Planning
- Pet Care Services
- Home Maintenance

Legal-Financial Solutions: Two types of legal services are available – consultation and referral:
To those requiring legal assistance who do not want or need to retain an attorney, your needs may be addressed through a free telephonic service: Access to free consultation for up to 30 minutes with a qualified attorney.

For those who have a need for in-person legal consultation, you can receive a referral to a conveniently-located attorney with appropriate expertise: Access to a free consultation up to 30 minutes; discounted fees may apply if further assistance is required.

Financial Solutions: Free telephonic consultation with a financial counselor qualified to address a range of financial topics, including:

- Bankruptcy prevention
- Comprehensive financial fitness
- Wills and estate planning
- Home buying
- Budgeting
- Credit report review
- Debt reduction and management
- Foreclosure prevention
- Long-term goal setting

ID Recovery: Access to a consultation with a Certified Consumer Credit Counselor who can help to objectively assess your situation, create an action plan, and provide the knowledge and tools to effectively implement that plan. Referrals can be made to ID Theft Recovery Professionals when needed and appropriate.

Communication/Education:

- Free Monthly webinars for your personal and professional development
- E-Newsletters
- Comprehensive website
- LifeSpeak on Demand includes streaming video modules facilitated by experts well versed in wellness, family and professional topics

Contact Workplace Solutions

There are two ways to contact Workplace Solutions:

- Call 1-800-327-5071, 24/7 – to speak with a counselor; or

- For online tools and a wealth of information, log on through the Publicis Benefits Connection or Workplace Solution's secure website at:
    - Employee Assistance Program (EAP) (passcode: Publicis)
    - LifeSpeak on-demand resources (no passcode needed)

ERISA Rights

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

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts and a copy of the latest annual report (Form 5500 Series) that is filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and an updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

- Receive a copy of the procedures used by the Plan for determining a qualified medical child support order (QMCSO) upon request.

- Continue health care coverage for yourself, your spouse or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan for the rules governing your COBRA continuation coverage rights.

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

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

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

Assistance With Your Questions
If you have any questions about your Plan, you should contact the Plan Administrator at:

Publicis Benefits Department
Attn: Plan Administration Committee 35 West
Wacker Drive
Chicago, IL 60601
1-800-933-3622 (Monday-Friday, 9am-5pm EST)

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

- The nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory; or
- The Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.
- You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

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

HIPAA

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

Glossary of Terms

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

- Working at the ***Company's*** usual place of business, or on an assignment for the purpose of furthering the ***Company's*** business;

- Performing the material and substantial duties of your regular occupation on a full-time basis; and

- Not receiving severance or salary continuation pay.

You're considered ***actively at work*** if you're on an approved leave of absence under FMLA or an approved personal leave of absence of less than 31 days or during a scheduled vacation or holiday.

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

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

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

- You have shared a monogamous, committed relationship with one another that has existed for at least six months and is expected to last indefinitely;
- You are jointly responsible for each other's welfare and financial obligations;
- You share your principal place of residence;
- You are both at least 18 years old and mentally competent to consent to the contract;
- Neither of you are married to anyone else; and
- You are not related to each other in a way that would prevent a marriage from being recognized under the laws of the state in which you live.
- You also may be required to prove your interdependence (if requested). You can do so by providing two of the following documents:
- Common ownership of real property;
- Common ownership of a motor vehicle;
- Driver's license that lists a common address;
- Proof of joint bank accounts or credit accounts;
- Proof of designation as the primary beneficiary for life insurance or primary beneficiary designation under a partner's will;
- Assignment of a property power of attorney or health care power of attorney.
- Domestic partnerships are not recognized by the federal government for tax purposes.

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

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

Plan Year
The year starting January 1 and ending December 31.