Publicis Benefits Connection Health & Group Benefits

Summary Plan Description

Long-Term Disability Plan

January 1, 2021

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Your Long-Term Disability (LTD) Coverage

Your Long-Term Disability (LTD) 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"). If an ***illness*** or ***injury*** prevents you from working for more than 180 days, your LTD coverage is available to continue to provide income replacement benefits following that period. This document provides important information regarding your LTD coverage.

This Summary Plan Description (SPD) together with the Administrative Information Summary Plan Description describes the basic features of the Long-Term Disability Plan, how it operates and how you can get the maximum advantage from it. These documents, together with other SPDs of Plan benefits, together with any plan-related document issued by an insurer, constitute a Plan Document and SPD. This document describes the Plan provisions as they exist as of January 1, 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 the plan at any time without notice. Participation in this plan does not constitute a contract of employment between you and the ***Company***.

Terms in ***bold/italics*** are further defined in the Glossary.

Eligibility

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

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

Please see your local HR Representative or the Re:Sources USA Benefits Department if you're unsure of whether your company participates in the Program or if you are a member of an eligible class of employees.

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

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

For STD or LTD questions, including information about offsets, coverage exclusions and limitations, contact The Hartford at 1-800-549-6514 or visit their website at www.thehartfordatwork.com.

Enrollment

When You First Become Eligible

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

The coverage you elect after you're first hired continues through the remainder of the plan year, unless you:

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

Annual Enrollment

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

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

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

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

The coverages you elect during the annual enrollment period take effect the following January 1 (or the date you are considered ***actively at work***, whichever is later) and continue through the end of the plan year (unless you have a qualified change in status and decide to change your coverage) or satisfy the requirements under HIPAA for a special enrollment period. You must be ***actively at work*** in order for any changes to your long-term disability, life and optional AD&D insurance to take effect.

If You Don't Enroll

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

When Coverage Begins

Coverage begins on the first of the month coinciding with or following your hire date or the date you first become eligible to participate in the plan.

Paying For Your Coverage

The ***Company*** pays the full cost of your participation in Basic Long-Term Disability Coverage (also known as Core Long-Term Disability Coverage).

You pay the full cost of your participation in Supplemental Long-Term Disability Coverage through after-tax payroll deductions.

Changes in Coverage

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

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

- You qualify for a special enrollment during the year under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- You experience a "qualified change in status" (see below) that affects you, your spouse's or your dependents' eligibility for benefits under the Program.
- You take a leave of absence under the Family and Medical Leave Act (FMLA) (however, you can't change coverage while you're on FMLA).

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

Qualified Changes in Status

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

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

- You get divorced, legally separated or you have your marriage legally annulled.
- Your spouse or dependent dies.
- Your unmarried dependent becomes ineligible for coverage (e.g., he or she reaches the Program's eligibility age limit, becomes or ceases to be a student or gets married).
- You get married.
- You have a baby, adopt or have a child placed with you for adoption.
- You, your spouse, your domestic partner or your dependent experience a change in employment status (e.g., start or end employment, strike or lockout, begin or return from an unpaid leave of absence, change work sites or experience a change in employment that leads to a loss or gain of eligibility for coverage).

- You, your spouse, your domestic partner or your dependent experiences a change in employment status that affects eligibility for coverage (e.g., change from part-time to full-time or vice versa).
- You, your spouse, your domestic partner or your dependent experiences a significant change in cost or coverage.

If you experience a qualified change in status and need to change your coverage during the plan year, you must make your change online at PublicisConnections.com within 31 days after the event that necessitates the change. If you don't make the change in time, you can't make a coverage change until the next annual enrollment, unless you once again meet one of the conditions for a mid-year change. Please note that you will be required to provide supporting documentation of your change. The change will be effective on the date of the qualifying event**.**

Additional Mid-Year Changes

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

Cost and Coverage Changes

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

Changes to a Dependent's Plan

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

Automatic Changes

If the cost of your underlying coverage increases or decreases, the ***Company*** may automatically change the amount of your contribution that's withheld.

Special Rule for Rehired Employees

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

Procedure for Mid-Year Changes

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

- In the case of a dependent's birth, on the date of such birth;

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

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

If you experience one of these qualified changes in status, you may change your Supplemental Long Term Disability coverage. The changes must be consistent with and correspond to the change in status as well as follow Plan rules. For example, in the case of birth, adoption or placement for adoption, you may generally elect or increase coverage under your Supplemental Long-term Disability coverage, but you can't drop your current coverage.

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

Continuation or Termination of Coverage

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

- When your employment ceases;
- When you are no longer in an Eligible Class; or
- When you fail to make any required contribution.

If You Become Disabled

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

If your disability continues and you start collecting long-term disability benefit payments from the LTD Plan, your active coverage will terminate at the end of the month in which your LTD Plan benefits commence. If elected, you will no longer have to pay for Supplemental LTD coverage when you are out on LTD.

If You Take a Leave of Absence

Your disability coverage will end if you take a leave of absence of any kind. You must be ***actively at work*** at the time your disability occurs in order to qualify for disability benefits under the plan.

Snapshot of Your Coverages

The LTD Plan pays a monthly LTD Plan benefit if you're still ***disabled*** and unable to work after your 180 day short term disability benefit period. Or, the Plan may offer you a work incentive benefit if you're still able to work on a ***limited basis***.

Coverage	Benefit Levels	Payment Method
Long-term Disability Insurance		
Core	Up to 40% of base pay up to an annual base pay equal to $300,000 with a maximum monthly benefit of $10,000.	Publicis Benefits Connection pays the full cost of coverage.
Supplemental Level One	Benefit equal to additional 20% to an annual base pay of $300,000 (for total coverage of 60% of your base pay) with a maximum combined monthly benefit of $15,000.	You pay the cost of coverage with after-tax payroll deductions.
Supplemental Level Two	Benefit equal to 60% coverage of base pay above $300,000, with a maximum combined monthly benefit of $25,000.	You pay the cost of coverage with after-tax payroll deductions.

LTD Plan Benefit

Your coverage provides continued income replacement benefits if you're still disabled and unable to work after your 180 day short term disability benefit period. In addition, you must have been ***actively at work*** on the day your disability began to be eligible for benefits.

Your LTD Plan Core benefit replaces up to 40% of your base pay. The Plan reduces your LTD Plan benefits by other sources of disability income (refer to the Other Sources of Disability section of this document), and limits your monthly benefit to $10,000.

You are also eligible to select Supplemental Level One LTD coverage which replaces an additional 20% of your base pay. The Plan reduces your LTD Plan benefits by other sources of disability income (refer to the Other Sources of Disability section of this document), and limits your monthly benefit to an additional $5,000 for a monthly combined (Core plus Supplemental Level One) maximum of $15,000.

Depending on your pay, you may be eligible to select Supplemental Level Two LTD coverage when you're first eligible and at each annual enrollment. You will be notified if you're eligible for the supplemental LTD coverage option when you submit your elections online

Please note: Level One coverage provides 60% of your base pay amount up to $300,000 and Level Two coverage provides 60% of your base pay amount above $300,000. If your base pay is

less than $300,000, you only need to select Level One coverage for the highest coverage level available for supplemental LTD. If your base pay is more than $300,000, you only need to select Level Two coverage for the highest coverage level available (an additional 20% benefit on the first $300,000 of base pay and 60% on base pay over $300,000, to a maximum of $500,000 in base pay).

The Plan pays a minimum LTD Plan benefit equal to the greater of:

- $100 per month; or
- 10% of your gross LTD monthly benefit.

The minimum benefit doesn't apply if you're ***gainfully employed***.

Who Pays for Coverage?

If you are disabled due to ***illness*** or ***injury*** for more than 180 days, LTD coverage may continue to provide income replacement benefits. The ***Company*** provides a core amount of LTD insurance at no cost to you. Your ***Company***-provided LTD coverage is equal to 40% of your base pay up to a maximum base pay of $300,000 with a maximum benefit of $10,000 per month.

To supplement your ***Company***-provided LTD coverage, you may purchase additional amounts of LTD coverage. You pay for these supplemental coverages through after-tax payroll deductions. Your supplemental LTD coverage levels are:

- **Level One:** Benefit equal to 20% of your base pay amount up to $300,000 (for total coverage of 60% of your base pay) with a maximum combined monthly benefit of $15,000.
- **Level Two:** Benefit equal to 60% of your base pay amount above $300,000 with a maximum combined monthly benefit of $25,000.

Even though you continue to pay the cost of this coverage during your ***elimination period***, you don't pay for this coverage once you start receiving Plan benefits.

Disability Defined

You're considered disabled if – during the ***elimination period*** and the following 36 months – your ***illness*** or ***injury*** causes a physical or mental impairment to such a degree of severity that you're:

- Continuously unable to perform the material and substantial duties of your regular occupation; and
- Not gainfully employed.

Once you receive LTD Plan benefits for 36 months, you're considered disabled if your ***illness*** or ***injury*** causes physical or mental impairment to such a degree of severity that you're:

- Continuously unable to perform any occupation for which you are or become qualified by training or experience; and
- Not gainfully employed.

You're also considered disabled if – during and after the ***elimination period*** – you're ***gainfully employed***, but your ***illness*** or ***injury*** causes you physical or mental impairment to such a degree of severity that you're unable to earn more than 80% of your base pay (please refer to the How Do We Define Earnings section) from any occupation for which you're qualified by education, training or experience. On each annual anniversary of your disability, the Plan increases your monthly earnings by the lesser of:

- The current annual percentage increase in the Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W); or
- 10%.

If your ***disability earnings*** are more than 80% of your base pay, the Plan doesn't consider you to be disabled. In addition, if you require a professional license or certification for your occupation and you lose that license or certification, the loss doesn't, in and of itself, constitute a disability under this Plan.

How Do We Define Earnings?

Monthly earnings equals the monthly wage or frozen salary that you were receiving from your employer in effect as of September 30 of the calendar year prior to your date of disability. Your monthly earnings are used to determine your Plan benefit. Your monthly earnings include the contributions you make to the ***Company***'s benefit plans, or any other qualified or non-qualified Employee ***Retirement Plan*** or deferred compensation arrangement.

Your monthly earnings do not include any:

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

Remember, to be eligible for benefits, you must have been ***actively at work*** on the day your disability began.

What Is The Elimination Period?

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

If you become disabled because of an ***illness*** or ***injury***, benefits begin once you're disabled for 180 consecutive days. For a catastrophic disability, the Plan pays a catastrophic disability benefit (please refer to the Catastrophic Disability benefit section) – which is in addition to the LTD Plan benefit, once you're disabled for a total of 180 consecutive days.

Your 26-week short term disability period applies to your ***elimination period***. And you can work and still satisfy the ***elimination period***, provided you continue to meet the definition of disabled.

If you temporarily recover, return to work for 45 calendar days or less, and then again become disabled due to the same or related cause, the Plan treats your disability as a continuous disability. As a result, a new ***elimination period*** doesn't apply, and the Plan pays benefits under the same provisions in effect at the time your disability first occurred. However, if your base pay is more than it was prior to your return to work, the Plan doesn't take into account this increased amount when calculating your Plan benefit.

If you temporarily recover, return to work for more than 90 calendar days, and then again become disabled, the Plan treats your disability as a new disability. As a result, you must meet a new ***elimination period***.

Evidence of Insurability (EOI)

You may decide to enroll for LTD coverage more than 31 days after you're first eligible. If you do, you must provide satisfactory evidence of insurability (EOI) before your coverage begins.

How to Provide EOI

You may want to enroll for LTD coverage more than 31 days after you're first eligible:

- During a future annual enrollment period; or
- Because of a qualified change in status. (Please refer to the Changes in Coverage section).

If this is the case, you must provide satisfactory EOI before your coverage takes effect. To provide EOI you must:

- Complete the Group Disability Insurance Application Form (Contact your HR Representative or The Hartford regarding the form).
- Submit to a medical examination, if requested;
- Submit verification of monthly earnings;
- Provide any additional information requested;
- Furnish all such evidence at your own expense;
- Once you complete, sign and date the Form, submit it to your HR Representative. He or she sends your completed Form to the claims administrator for evaluation.
- The claims administrator either approves, rejects or requests additional medical information.

Evaluating Your EOI

The claims administrator, after evaluating your EOI, either approves, rejects or requests additional medical information.

- **Approval of Coverage:** If the claims administrator approves your EOI, you're notified via a stamped "approved" copy of your application. You also receive the effective date of your coverage. Be sure to attach your approved application to your insurance certificate.
- **Rejection of Coverage:** If the claims administrator rejects your EOI, you receive notification that you're not eligible for this coverage.
- **Request for Additional Information:** You may receive notification that additional medical information is needed before the claims administrator can approve your EOI application. If this is the case, the claims administrator sends the notice directly to you. Once the claims administrator evaluates the additional information, you're then notified whether your EOI is approved or rejected.

How the Plan Pays Benefits

As long as you meet the definition of disabled, the Plan pays you a LTD Plan benefit. Or, you may receive a work incentive benefit if you're able to work on a ***limited basis***. This section includes important information regarding how the LTD Plan pays benefits.

How Your LTD Plan Benefit Is Calculated

The Plan uses your coverage option as well as your base pay as of the day you become disabled to determine your LTD Plan benefit amount. The Plan then subtracts any other deductible sources of income. What results is the LTD Plan benefit amount that you receive on a monthly basis. This amount is not further adjusted for subsequent cost-of-living increases (including cost-of-living increases that may apply to other deductible sources of income).

You receive your LTD Plan benefit once you satisfy the ***elimination period*** (your 26-week short term disability benefit period applies to this ***elimination period***). If, after you satisfy the ***elimination period***, the Plan is scheduled to pay benefits for less than one month, it prorates your benefit for each day that you're disabled.

How the Plan Calculates Your Work Incentive Benefit

The snapshot chart provides an overview of the formulas that the Plan uses to calculate your work incentive benefit during and after your first 12 months of gainful employment. You receive this benefit on a monthly basis after:

- You satisfy the ***elimination period***; or
- A period during which you receive LTD Plan benefits.

During the first 12 months of your disability, the benefits plus the ***disability earnings*** will be capped at 100% of pre-disability base pay. After 12 months, the benefits will be reduced by 50% of ***disability earnings***.

Core Benefit

How Your LTD Monthly Benefit is Calculated

Your LTD Monthly Benefit will be based on your monthly earnings as reported to us by your employer and for which premium has been paid.

An LTD monthly benefit will be provided after the end of the ***elimination period*** if you are disabled according to the occupation qualifier provision.

The claims administrator will calculate your ***gross LTD monthly benefit*** amount as follows:

1. Multiply your monthly earnings by 40%.

2. The maximum ***gross LTD monthly benefit*** is $10,000.

3. Compare the calculations from Item 1 and Item 2. The lesser of these two amounts is your ***gross LTD monthly benefit***.

4. Subtract the deductible sources of income from your ***gross LTD monthly benefit***. The resulting figure is your ***net LTD monthly benefit***.

If a benefit is payable for less than one month, it will be paid on the basis of 1/30th of the ***net LTD monthly benefit*** for each day of disability.

Supplemental Level One

What is Your LTD Monthly Benefit and How Is It Calculated?

Your LTD monthly benefit will be based on your monthly earnings as reported to us by your employer and for which premium has been paid.

An LTD monthly benefit will be provided after the end of the ***elimination period*** if you are disabled according to the occupation qualifier provision.

The claims administrator will calculate your ***gross LTD monthly benefit*** amount as follows:

1. Multiply your monthly earnings by 60%.

2. The maximum ***gross LTD monthly benefit*** is $15,000.

3. Compare the calculations from Item 1 and Item 2. The lesser of these two amounts is your ***gross LTD monthly benefit***.

4. Subtract the deductible sources of income from your ***gross LTD monthly benefit***. The resulting figure is your ***net LTD monthly benefit***.

If a benefit is payable for less than one month, it will be paid on the basis of 1/30th of the ***net LTD monthly benefit*** for each day of disability.

Supplemental Level Two

What is Your LTD Monthly Benefit and How Is It Calculated?

Your LTD monthly benefit will be based on your monthly earnings as reported to us by your employer and for which premium has been paid.

An LTD monthly benefit will be provided after the end of the ***elimination period*** if you are disabled according to the occupation qualifier provision.

The claims administrator will calculate your ***gross LTD monthly benefit*** amount as follows:

1. Multiply your monthly earnings by 60%.

2. The maximum ***gross LTD monthly benefit*** is $25,000.

3. Compare the calculations from Item 1 and Item 2. The lesser of these two amounts is your ***gross LTD monthly benefit***.

4. Subtract the deductible sources of income from your ***gross LTD monthly benefit***. The resulting figure is your ***net LTD monthly benefit***.

If a benefit is payable for less than one month, it will be paid on the basis of 1/30th of the ***net LTD monthly benefit*** for each day of disability.

Work Incentive Benefit

A work incentive benefit will be provided if you are disabled and ***gainfully employed*** after the end of the ***elimination period***, or after a period during which you received LTD monthly benefits.

The work incentive benefit will be calculated during the first 12 months of gainful employment as follows:

1. The ***net LTD monthly benefit*** amount and ***disability earnings*** amount will be added together and compared to monthly earnings.

2. If the total amount in Item 1 exceeds 100% of monthly earnings, the work incentive benefit amount will be equal to the ***net LTD monthly benefit*** reduced by the amount of the excess.

3. If the total amount in Item 1 does not exceed 100% of monthly earnings, the work incentive benefit will be equal to the ***net LTD monthly benefit*** amount.

After the first 12 months of gainful employment, the work incentive benefit will be equal to the ***net LTD monthly benefit*** amount less 50% of ***disability earnings***.

The work incentive benefit will cease on the earliest of the following:

1. The date you are no longer disabled; or

2. The end of the maximum period payable.

How Long Benefits Are Paid

The Plan continues to pay your LTD Plan benefit or work incentive benefit until the earlier of the following:

- The day you're no longer considered disabled;
- The end of the maximum period payable; or
- The day you die.

Plan benefits are also subject to any benefit duration limits that may pertain to your particular disability.

Remember, the Plan pays you a LTD Plan benefit, or you receive a work incentive benefit if you're able to work on a ***limited basis***.

Maximum Period Payable

This is the longest period of time that the Plan makes payments to you for any one period of disability. The maximum period payable that applies depends on when your disability begins, as shown in the chart below.

Age on Date Disability Commences	Maximum Period Payable
Age 60 or Younger	Until Your 65 Birthday
Age 61 – 64	60 Months
Age 65 – 69	The greater of to age 70 or 12 months
Age 70 or Older	12 Months

If you're eligible for a catastrophic disability benefit, you will receive this benefit for up to 12 months.

A Recurring Disability

If a disability for which benefits were payable ends but returns due to the same or a related cause within 45 days, the Plan considers this a recurring disability. Your recurrent disability is subject to the Plan's provisions that were in effect at the time your prior disability began. In addition, you don't have to satisfy a new ***elimination period*** before the Plan again pays benefits.

If your disability recurs more than six months after the end of your previous disability, the Plan:

- Requires you to satisfy a new ***elimination period*** before it again starts paying benefits;
- Applies a new maximum period payable; and
- Pays benefits based on the provisions in effect on the day of your most recent disability.
- Your disability must recur while you're covered under the Plan.

Other Sources of Disability Income

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

- Disability benefits that are paid, payable or for which there is a right under:
  - The Social Security Act, including any amounts for which your dependents may qualify because of your disability;
  - Workers' Compensation or Occupational Disease Act or Law or any other law which provides compensation for an occupational ***injury*** or ***illness***;
  - Occupational accident coverage provided by or through the ***Company***;
  - Any Statutory Disability Benefit Law;
  - The Railroad Retirement Act;
  - The Canada Pension Plan, Quebec Pension Plan or any other similar disability or pension plan or act;
  - The Canada Old Age Security Act; or
  - Any Public Employee Retirement System Plan or any State Teachers' Retirement System Plan, or any plan provided as an alternative to any of the above acts or plans.
- Disability benefits that are paid under:
  - Any group benefit Plan provided by or through the ***Company***; and
  - Any sick leave or salary continuance Plan provided by or through the ***Company***.
- Retirement benefits that are paid under the Social Security Act, including any amount that your dependents may qualify for because of your retirement.
- Retirement and disability benefits under a ***Retirement Plan*** provided by the ***Company***, except for amounts that are attributable to your contributions.
- Disability benefits that are paid under any no fault auto motor vehicle coverage.

You may receive a benefit from another source of income in the form of a single lump sum through a compromise settlement or as an advance on future liability. If this is the case, the Plan determines the reduction amount to apply to your Plan benefit by taking the lump sum amount and dividing it by the number of months for which the settlement or advance is provided. If the number is unknown, the Plan divides the amount of the settlement or advance by the expected remaining number of months for which you're scheduled to receive Plan benefits (up to 60).

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

- Deferred compensation arrangements;
- Pension plans for partners;
- Military pension and disability income plans;
- Franchise disability income plans;
- Individual disability income plans;
- Credit Disability insurance
- A ***retirement plan*** from another employer;
- Profit sharing plans;
- Thrift or savings plans;
- Individual retirement account (IRA);
- Tax sheltered annuity (TSA); or
- Stock ownership plan.

Additional Benefits and Services

You're eligible for certain additional benefits and services to help supplement the benefits you receive from the Plan. This section highlights the benefits and services available.

Survivor Income Benefit

If you die after receiving benefits for at least 12 consecutive months, the Plan pays a survivor income benefit to your named beneficiary (if any).

This benefit equals the monthly amount you received the month before your death. The Plan pays this amount three times – once a month for three months once the claims administrator receives proof of your death.

If you don't name a beneficiary or if no such beneficiary exists, the Plan makes payment to the surviving person(s) in the following order:

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

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

Catastrophic Disability Benefit

The Plan pays you an additional catastrophic disability benefit equal to 10% of your base pay if you're receiving LTD Plan benefits and the claims administrator receives proof that you're catastrophically disabled. Catastrophic disability benefits begin once you satisfy the catastrophic disability benefit ***elimination period***. You're considered catastrophically disabled if, due to an ***illness*** or ***injury***:

- You're unable to perform (without human assistance or regular supervision from another person) at least two of the six ***activities of daily living***;
- Your intellectual capacity is deteriorating and as a result you need substantial supervision because you pose a health or safety hazard to yourself and/or to others; and
- You're not gainfully employed.

The maximum catastrophic disability benefit that you can receive is the lesser of:

- Your LTD Plan maximum benefit (this is dependent upon the coverage option you select); or
- $5,000 per month.

Your catastrophic disability benefits end on the earliest of the following:

- The day you're no longer catastrophically disabled;
- The day you become ineligible for LTD Plan benefits; or
- The end of the catastrophic disability maximum period payable.

Coverage for such a catastrophic disability begins on your coverage effective date under the LTD Plan. However, the Plan delays this type of coverage if – on your coverage effective date – you can't safely and completely perform one or more of the ***activities of daily living***. If this type of coverage is delayed, it begins on the day:

- You can safely and completely perform all of the ***activities of daily living*** without another person's assistance or verbal cueing; or
- Your intellectual capacity is no longer lost or deteriorating and as a result you don't need another person's assistance or verbal cueing to protect yourself and/or others.

This benefit isn't subject to any Plan provisions which would otherwise increase or reduce the benefit amount (i.e., deductible sources of income).

Caregiver Respite Benefit

You're eligible for a caregiver respite benefit for each day of a ***respite interval***.

However, the benefit is subject to the following conditions:

- You must be receiving a catastrophic disability benefit.
- The benefit is payable if you receive ***informal home care*** for at least six continuous months starting with the day you're disabled.
- The benefit is payable if you receive ***companion care*** in your home or a private residence during a ***respite interval***.
- The benefit is equal to the daily ***companion care*** cost you incur, up to $100 a day.

You receive the benefit, provided you submit proof of the costs (satisfactory to the Program Administrator) that you incur for ***companion care*** during the ***respite interval***.

Caregiver Training Benefit

You're eligible for a ***caregiver training*** benefit if an ***informal caregiver*** incurs an expense to be trained to provide you ***informal home care***. However, the benefit is subject to the following conditions:

- You must be receiving a catastrophic disability benefit.
- A home health care provider, nursing home or ***hospital*** must provide the ***caregiver training*** while you're receiving the catastrophic disability benefit. The home health care provider must be accredited by either the Joint Commission on Accreditation of Health Care Organizations or a Community Health Accreditation Program. If you're in a nursing home or ***hospital***, the ***caregiver training benefit*** is only payable if the training makes it possible for you to return to your residence where you can be cared for by the ***informal caregiver***.
- The benefit is equal to the cost of the ***caregiver training***, up to $500.

You receive the benefit, provided you submit proof of the costs you incur for ***caregiver training***.

Emergency Alert System Benefit

This benefit helps pay for the actual cost to rent or lease an emergency alert system. This communication system is located in your home so that you can receive medical attention in case of a medical emergency. As a result, you're able to remain in your home alone. However, the benefit is subject to the following conditions:

- You must be receiving a catastrophic disability benefit.
- The benefit is payable for a medically necessary emergency alert system.
- Your condition must be such that you can't be left alone without an emergency alert system in place.
- The benefit is equal to the lesser of $25 per month or the actual cost to rent or lease the emergency alert system.

The Plan pays to you (in arrears) every six months. You receive the benefit, provided you submit proof of the costs you incur. The Plan doesn't pay benefits for any installation, service or maintenance charges. This includes charges for normal telephone service while the system is installed or for a home security system.

Claim Services

If you're eligible for disability benefits from the LTD Plan, you may be eligible for other services.

- **Worksite Modification Benefits:** The claims administrator, in its sole discretion, may offer a worksite modification benefit. The claims administrator assists you and the ***Company*** to identify modifications that are likely to help you remain at work or return to work. If modifications are identified, you, the ***Company*** and the claims administrator sign a written agreement. The benefit you receive is limited to $1,500 per month or two times your net monthly benefit.
- **Vocational Rehabilitation Service:** You're eligible for rehabilitation services if the claims administrator determines that these services are reasonably required to assist you to return to gainful employment. Vocational rehabilitation services can include:
  - Job modification;
  - Job retraining;
  - Job placement; or
  - Other activities.

  Your education, training, work experience and physical and/or mental capacity – as determined by the claims administrator – determine whether or not you're eligible for vocational rehabilitation services. To be considered:

  - Your disability must prevent you from performing your ***regular occupation***;

- You must have the physical and/or mental capacities needed to successfully complete a rehabilitation program; and

- There must be a reasonable expectation that rehabilitation services will help you return to gainful employment.

- **Social Security Assistance:** When necessary, the claims administrator provides an advocate to you to apply for and secure Social Security disability awards. If the claims administrator determines that Social Security Assistance is appropriate, it's provided at no additional cost.

Exclusions

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

- A declared or undeclared war, or an act of war.
- A pre-existing condition.
- An attempted suicide (while sane or insane).
- An intentional self-inflicted ***injury*** or ***sickness***.
- A commission of or attempt to commit an act that's considered felonious in the jurisdiction in which it occurs.
- A disability (after the ***elimination period***), if it's due to a diagnosed condition that manifests itself primarily with ***self-reported symptoms***.
- A disability (after 36 months after the ***elimination period***), if it's due to a ***mental disorder*** of any type.

  If you're confined in the ***hospital*** or institution that's licensed to provide care and treatment for the ***mental disorder***, your period of confinement doesn't count toward the 36-month limit.

- Substance abuse (drug or alcohol), unless you're participating in a substance abuse treatment program that's approved by the state. (You may not know whether a program is approved by the state. Although the claims administrator doesn't verify proper licensing for each substance abuse claim, it does require proof of proper licensing by a facility when there's probable cause to do so.)

  If you're participating in a substance abuse treatment program, you or the ***Company*** must bear the cost of the program. In addition, the Plan doesn't pay benefits beyond the earliest of the following:

  - The Plan pays 36 monthly LTD plan benefits;
  - You reach the maximum period payable;
  - You refuse to participate in an appropriate available treatment program, or you leave the treatment program before its completion;
  - You no longer follow the requirements of your treatment plan; or
  - You complete the initial treatment plan exclusive of any aftercare or follow-up services.

- Elective cosmetic or plastic surgery, except when medically necessary or required as a result of an Injury sustained in an accident or required as a result of a severe complication(s) following a previous cosmetic procedure;
- The Plan doesn't pay benefits for any disability that takes place while you're confined to a penal or correctional institution (if the period of confinement exceeds 30 days).

- The Plan doesn't pay benefits if it is determined that you are eligible to participate in vocational rehabilitation services designed to assist in returning you to employment and you refuse to participate.
- Benefits will not be payable if Your Employer is willing to make reasonable accommodation to allow You to return to Your Regular Occupation with a loss of income no greater than 20% of Monthly Earnings, and You refuse to return to work.

Applying for Benefits

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

How to File Claims

The claims administrator for the STD Plan and the LTD Plan are the same. Therefore, the claims administrator is aware when you're reaching your maximum period payable under the STD Plan and are approaching the end of the ***elimination period*** under the LTD Plan. If you're eligible for STD benefits, you don't need to submit a new claim for LTD benefits. The Hartford notifies you when monthly benefits will begin according to the provision of the LTD Plan. If additional information is needed, The Hartford contacts you, your ***doctor*** or the ***Company***.

If you need to file a claim for LTD benefits, an authorized representative may act on your behalf to pursue a claim or appeal a denial of benefits. If your disability is likely to continue beyond the ***elimination period***, the ***Company*** sends you the following approximately 30 days before the end of your ***elimination period***:

- A completed LTD Employer's Statement;
- The LTD Employees' Statement Form;
- The Physician's Statement Form;
- The initial claim submission instructions; and
- A return envelope.

The ***Company*** or your HR Representative completes the LTD Employer's Statement before sending it to you. You need to complete the LTD Employee's Statement Form, as well as the identification section of the Physician's Statement Form. Your ***doctor*** completes the Physician's Statement Form and returns the completed form to you. You should submit the completed LTD Employer's Statement, your LTD Employees' Statement Form and the Physician's Statement Form to The Hartford.

The ***Company*** or your HR Representative also provides The Hartford with:

- The sources, amounts and beginning/ending dates of any other disability or retirement benefits which you may receive;
- A job description that includes the physical requirements of your job;
- Verification from the ***Company*** that you're covered by the Plan; and
- Any additional information that might impact your claim.

The ***Company*** or your HR Representative mails the forms to the claims administrator at least 21 days before the end of your ***elimination period***. If additional information is needed to make the initial evaluation of your claim, the claims administrator may contact you, the ***Company*** or your ***doctor*** to obtain this information.

Once the claims administrator receives all the necessary paperwork, the claims administrator assigns your claim a number. Once you satisfy the ***elimination period*** and if you qualify for benefits, the Plan starts paying monthly benefits (in arrears) according to policy provisions.

Additional information may be needed to support your continued disability and to verify that you're still under the ***appropriate and regular care*** of a ***doctor***. Your condition and your ***doctor's*** prognosis of your condition determine how frequently this information is needed. In addition, the claims administrator may require an independent medical examination or test as evidence of your disability. If so, the claims administrator pays the costs associated with the exam or test.

Timing of Claim Payments

As soon as the claims administrator has all of the necessary documentation to support your disability claim, the Plan pays you a monthly benefit as long as you continue to meet the definition of disabled.

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

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

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

What Happens If a Claim is Overpaid?

The Plan may overpay a claim when:

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

If the Plan overpays a claim, the claims administrator determines the method by which to make a repayment, which could include a lump sum reimbursement, a repayment schedule which you and the claims administrator agreed upon or an application of future benefits toward the overpayment. You will receive a letter that details the source of overpayment, the total amount of the overpayment and the method of recovery. The overpayment amount equals the amount the claims administrator paid in excess of the amount the claims administrator should have paid under the Plan's provisions.

If a Claim Is Denied

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

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

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

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

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

Benefit Management Services
Maitland Claim Office
The Hartford
P.O. Box 14306
Lexington, KY 40512-4306

Mailing address for appeals:
The Hartford – Appeal Unit
P.O. Box 14087
Lexington, KY 40512-4087

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

- Documents, records and other information that were relied upon in making the benefit determination;
- Documents, records and other information that were submitted, considered or generated in the course of making the benefit determination (regardless of whether they were actually relied upon);
- Documents, records and other information that the claims administrator employed;
- Identification of medical or vocational experts whose advise was obtained by the Program

Administrator in relation to your claim (regardless of whether that advice was relied upon); and

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

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

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

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

- The specific reasons for the decision;
- The specific references to the pertinent Plan provisions on which the decision is based;
- A statement that you're entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim;
- If the Plan has voluntary appeal procedures, a statement that describes those procedures;
- A statement that concerns your right to bring a lawsuit under ERISA; and
- If applicable, the provisions of internal procedures or clinical information or a statement that upon request and free of charge, copies of such information shall be provided.

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

Limitation on Legal Action Against the Plan

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

ERISA Rights

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

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts and a copy of the latest annual report (Form 5500 Series) that is filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series), and an updated Summary Plan Description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
- Receive a copy of the procedures used by the Plan for determining a qualified medical child support order (QMCSO).
- 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 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 Connection
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, 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.

Additional Information

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

Authorization and Documentation You Need to Supply

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

- Signed authorization for the claims administrator to release all reasonably necessary medical, financial or other non-medical information that supports your disability claim. If you fail to submit this information, the Plan may deny, suspend or terminate your benefits.
- Proof that you've applied for other deductible income benefits (i.e., Workers' Compensation or Social Security benefits, when applicable).
- Notification of when you receive or are awarded a benefit from another source of disability income, including the:
  - Nature of the income benefit;
  - Amount you're receiving;
  - Period to which the benefit applies; and
  - Duration for which the benefit is being paid (if you're receiving installment payments).

Assignment of Benefits

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

Subrogation – Right of Recovery

When the Plan pays a claim, it reserves any and all rights to subrogation and/or reimbursement to the fullest extent allowed by law and customary practice. Any party to this contract can't perform any act that prejudices such rights without prior agreement with the claims administrator. The claims administrator bears any expense associated with its pursuit of subrogation or recovery.

Fraud

You commit a fraudulent insurance act if you:

- Knowingly and with intent defraud the ***Company,*** any insurance Company or other person;
- File an application for insurance or statement of claim that contains any material false information; or
- Conceal any factual material to mislead others.

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

- Fines;

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

Glossary 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 a scheduled vacation or holiday.

Activities of Daily Living

The following are considered activities of daily living:

- **Eating:** Feeding oneself by getting food into the body from a plate, cup, or table or by a feeding tube or intravenously.
- **Toileting:** Getting to and from the toilet, getting on and off the toilet and performing all the associated personal hygiene.
- **Transferring:** Moving into or out of a bed, chair or wheelchair.
- **Bathing:** Washing oneself by sponge bath in either a tub or shower, including the task of getting into or out of the tub or shower.
- **Dressing:** Putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.
- **Continence:** The ability to maintain control of bowel and bladder function. If you're unable to maintain control, then the ability to perform the associated personal hygiene (including caring for a catheter or colostomy bag).

Appropriate and Regular Care

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

Caregiver Training

Training that the ***informal caregiver*** receives to care for you in your home.

Companion Care

Medically necessary custodial care that's furnished during a ***respite interval*** for a minimum of eight hours per day by a home health care provider who is either accredited by the Joint Commission on accreditation of Health Care Organizations or a Community Health Accreditation Program.

Terms in ***bold/italics*** are further defined in the Glossary.

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.

Disability Earnings

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

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

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

Doctor

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

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

Elimination Period

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

Gainfully Employed

You're considered gainfully employed if you perform any occupation for wage, remuneration or profit on a full or part-time basis. The occupation that you perform must be one for which you're qualified by education, training or experience. The claims administrator must approve your occupation as one that qualifies you as gainfully employed and reserves the right to modify approval in the future.

Generally Accepted Medical Practice

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

Gross LTD Monthly Benefit

This is the benefit, based on the coverage option you select, as shown in the snapshot chart.

Hospital or Health Care Facility

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

Illness

A sickness or disease that causes a disability.

Informal Caregiver

The person who is primarily responsible for providing you with ***informal home care***. The person that's paid to care for you can't be an informal caregiver.

Informal Home Care

Medically necessary custodial care that's provided by an ***informal caregiver*** at your home or private residence. This type of care is provided in lieu of a nursing home confinement. It's also care you receive at your home from a paid provider.

Injury

A bodily injury that's caused by an accident and results in disability.

Limited Basis

You're considered to be working on a limited basis if you're ***gainfully employed*** and unable to earn more than 80% of your monthly earnings in any occupation for which you're qualified by education, training or experience.

Material and Substantial Duties

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

Mental Disorder

A disorder that's found in the current diagnostic standards manual of the American Psychiatric Association.

Net LTD Monthly Benefit

This is the gross LTD plan benefit less any deductible sources of income that may apply.

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.

Pre-Existing Condition

A condition for which medical advice, treatment or services was received, prescribed or recommended within three months prior to your effective date of insurance, or for which you had symptoms which would cause a reasonably prudent person to seek advice, treatment or services for the condition. A condition is no longer considered pre-existing if it causes a disability which begins after you have been insured under the policy for a period of 12 consecutive months.

Regular Occupation

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

Respite Interval

A period of one or more consecutive days during which an ***informal caregiver*** is temporarily relieved of the ***informal home care*** duties. Two respite intervals are permitted per calendar year, subject to a cumulative total of 14 days per calendar year. You lose any unused days on December 31. You can't carry unused days over into any future calendar year.

Retirement Plan

A plan that provides retirement benefits to employees.

Self-Reported Symptoms

Any symptom for which you make your ***doctor*** aware of and can't be verifiable or quantifiable using tests, procedures or clinical examinations that are generally accepted in the practice of medicine. Examples of such symptoms include, but are not limited to: fatigue, pain, headaches, stiffness, soreness, tinnitus (ringing in the ear), dizziness, numbness or loss of energy.