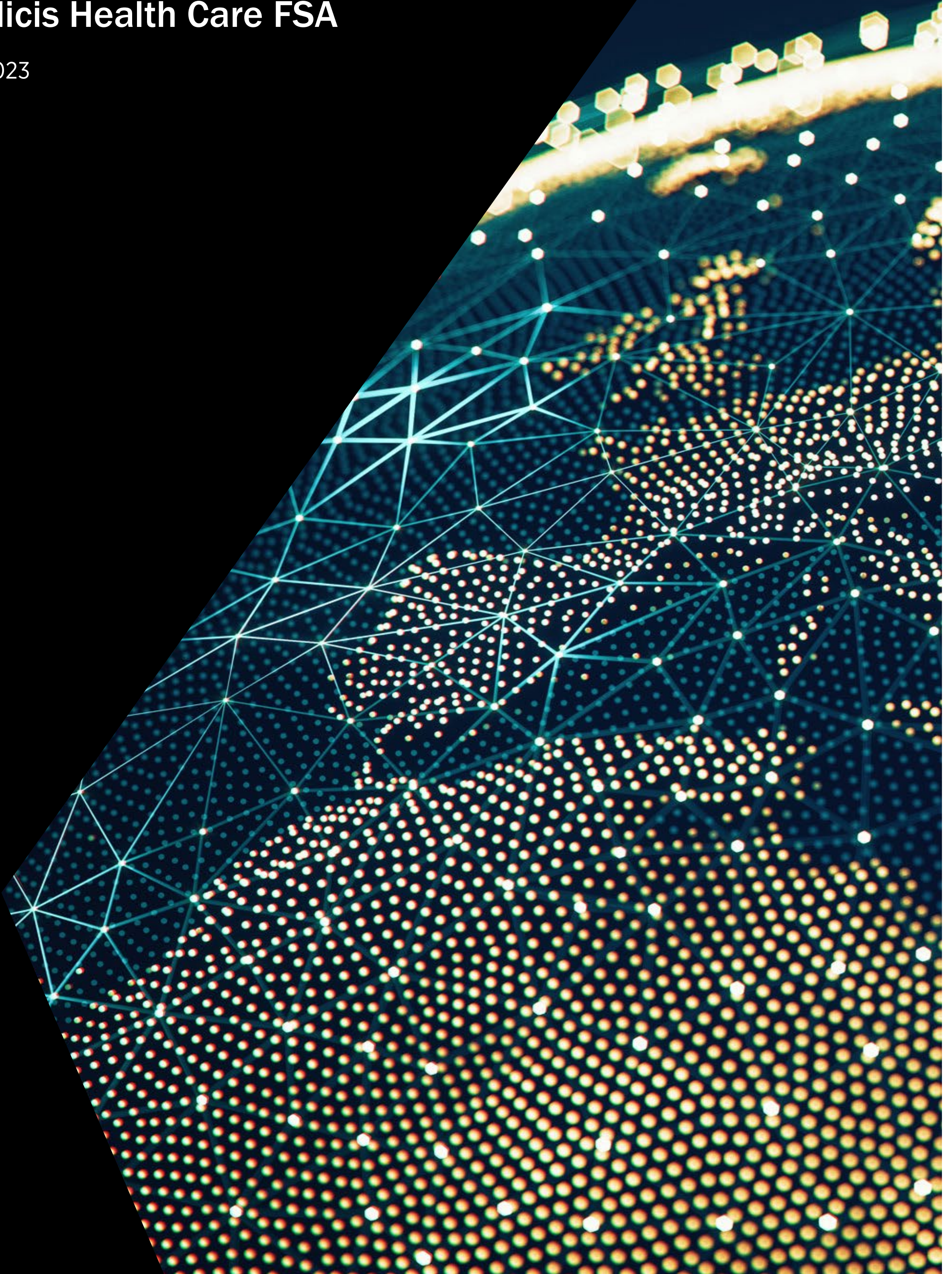
2023 Summary Plan Description (SPD)

for Publicis Health Care FSA

January 1, 2023



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Your Health Care FSA Coverage

Your Health Care Flexible Spending Account (HCFSA) coverage is an important part of your Publicis Connections Health and Group Benefits Program (the "Program" or the "Plan") sponsored by MMS USA Holdings, Inc. (the "***Company***"). Through the Health Care Flexible Spending Account (HCFSA), the ***Company*** offers a way to pay, with before-tax dollars, certain medical, dental, vision and hearing expenses not covered under Publicis Connections Health and Group Benefits plans, or any other ***Company***-sponsored plan. Expenses may be incurred by you and anyone you claim as a dependent. That's why the ***Company*** offers eligible employees the option of participation in the Health Care FSA.

This Summary Plan Description (SPD) together with the Administrative Information Summary Plan Description describes the basic features of the Health Care FSA (referred to as the "Medical Coverage" or "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, while certain other information related to the Plan may be contained in the Administrative Information Summary Plan Description. This document describes the Plan provisions as they exist as of January 1, 2023. If any statement, oral or written, made on behalf of the Plan disagrees with this Plan and SPD, as interpreted in the sole discretion of the ***Plan Administrator***, the ***Plan Administrator's*** decision will govern.

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

Eligibility

Employee

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

- You're a U.S.-based employee;
- You're a full-time or part-time employee working a minimum regular schedule of at least 21 hours per week;
- You're an employee of a subsidiary of MMS USA Holdings, Inc. (the "***Company***") that has adopted the Program; and
- Your class of employees has not been excluded from a predecessor plan.

Please see your local HR Representative or Publicis Connections 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.

Eligible Dependents

In addition to yourself, you can use the Health Care FSA to pay for out-of-pocket qualified medical expenses for your spouse and/or dependent as defined below:

- Your spouse as defined under federal law;
- Your eligible dependents including your children through the end of the year in which they turn age 26, without regard to the child's marital or student status, as provided under the Patient Protection and Affordable Care Act, as modified by the Health Care and Education Reconciliation Act of 2010.
- Any other person (including a domestic partner) who meets the Internal Revenue Service (IRS) definition of a tax dependent (without regard to the income limit) which means an individual whose primary residence is your home, who is a member of your household, for whom you provide more than one-half of their support, and who is not the qualifying child of any other individual.

When you elect, or do not cancel, coverage for your dependents, you are certifying that they continue to be eligible dependents under these rules. If your dependent is no longer eligible for coverage, you are expected to contact the Publicis Re:Sources USA Benefits Department as soon as possible to inform them of that fact.

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. 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***, which doesn't include Health Care FSA coverage.

The amount you elect to contribute to the Health Care FSA 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;
- 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 re-enroll at annual enrollment unless notified otherwise by the ***Company***. <u>If you want to participate in the Flexible Spending Accounts, you need to re-enroll each year.</u> Your contribution elections to the Flexible Spending Accounts don't roll over from one ***plan year*** to the next.

The Health Care FSA election you make during the annual enrollment period takes 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 qualified change in status and decide to change your coverage).

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 be deemed to have made no Health Care FSA election for that plan year.

When Coverage Begins

Coverage begins on the first of the month coinciding with or following your hire date and after you have submitted an election. Coverage for qualified medical expenses for your dependents begins on the same day that your coverage begins.

Paying For Your Coverage

You make contributions to your Health Care FSA on a before-tax basis through payroll deductions each pay period. Using before-tax dollars reduces your taxable income for Federal, Social Security, and (in most cases) state income taxes. In addition, your income isn't affected when determining your benefit levels for coverage under other ***Company***-sponsored Plans.

Using before-tax dollars can affect any Social Security benefits you may eventually receive. This is because you don't pay Social Security (FICA) taxes on before-tax dollars. Provided you make a Health Care FSA election, for most people, the Social Security benefit reduction is just a few dollars a month. In addition, the reduction is typically more than offset by the tax savings you experience over the course of your participation in the plan. If you have any concerns, or if you need additional information, contact your local Social Security Administration Office.

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 in or change your Health Care FSA election during the year. For example, you may change your election if:

- You experience a "qualified change in status" (see below) that affects you, your ***spouse's*** or tax dependents' eligibility for benefits under the Program.
- You, your ***spouse*** or your tax dependent qualifies for or loses Medicare or Medicaid coverage.
- You take a leave of absence under the Family and Medical Leave Act (FMLA) (however, you can't change coverage while you're on paid 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, ***spouse***, or your eligible dependent. Changes may be made to your Health Care FSA. You may begin or increase contributions or drop or decrease contributions to the Health Care FSA 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, adoption or placement for adoption, you may increase the amount you put aside under your Health Care FSA.

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.
- You get married.
- You have a baby, adopt, or have a child placed with you for adoption.
- You, your ***spouse***, 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 health care 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. You can find more information at the qualified life event page on PublicisConnections.com. 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.

Important Note: If you initiate a qualifying event change and update your HCFSA goal, please keep in mind that the qualifying event update is only applicable to services that occur post the effective date of the change (even if you had an HCFSA election in place prior to the qualifying event update).

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, 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 with the first of the month following your change or date of the qualifying event, or if due to the birth or adoption of a child, as of the date of the birth or adoption.

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 increase the amount you put aside under your Health Care Flexible Spending Account, but you cannot decrease or drop your Health Care FSA election.

If you experience a qualified change in status and need to change your coverage, you must make the change online at PublicisConnections.com. 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.

Depending on the reason for the change in status, you may also begin, increase, decrease or stop contributions to the Health Care Flexible Spending Account (if the change is consistent with the change in status).

Continuation or Termination of Coverage

Your coverage will continue until the end of the month in which you end your employment, cease to be eligible to participate in the plan, revoke your election to participate in the Plan, or when you retire or die.

If You Die While Employed

If you die while you're still employed, your contributions to the Health Care FSA end on the date death
occurs. Your covered dependents are eligible to continue Health Care FSA coverage through the end of the ***plan year*** through COBRA.

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 continues provided you continue to receive STD
benefits.

If your disability continues and you start collecting long term disability benefits from the LTD Plan,

your contributions to the Health Care FSA will end on the date the LTD disability benefits are effective.

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 leave of absence for 30 days or less, coverage continues for you and your eligible dependents. However, you must submit payment for the full cost of the coverage.

  If your unpaid personal leave of absence is more than 30 days, coverage for you and your dependents ends the first of the month following your 30th day of leave. You and your dependents can continue Health Care FSA coverage under COBRA through the end of the ***plan year***. If you return to active employment for the ***Company***, you must reenroll for benefits upon your return.

- **Unpaid FMLA Leave:** If you decide to take an unpaid FMLA leave, coverage continues for you and your eligible dependents as if you were still ***actively at work***. However, you must continue to submit payment for this coverage (at the active rate). You can select a core coverage of health, dental and vision, or you can continue all of your coverages. You may also decide to discontinue your coverage under the Plan.

Continuation of Coverage Under the Family and Medical Leave Act of 1993 (FMLA)

The federal Family and Medical Leave Act (FMLA) allows eligible employees to take a specific amount of unpaid leave for serious illness, the birth or adoption of a child, to care for a spouse, child, or parent who has a serious health condition, to care for family members wounded while on active duty in the armed forces, or to deal with any qualifying exigency that arises from a family member's active duty in the armed forces. This leave is also available for family members of veterans for up to five years after a veteran leaves service if he or she develops a service-related injury or illness incurred or aggravated while on active duty.

If you take an FMLA leave, you may continue your Health Care FSA coverage for you and any covered dependents as long as you continue to pay your portion of the cost for your benefits during the leave. If you take a paid leave of absence, the cost of group health coverage will continue to be deducted from your pay on a pre-tax basis. If your Health Care FSA coverage terminates during your leave, you may be reinstated if you return to work in the same year that your leave began. You will have a choice to resume contributions to the spending accounts at the same level in effect before your leave, or you may elect to increase your contributions to "make up" for contributions you missed during your leave period. If you simply resume your prior contribution level, the amount available for reimbursement for the year will be reduced by the contributions missed during your leave. Regardless of whether you choose to resume your former contribution level, or make up for missed contributions, expenses incurred while your account participation is suspended will not be reimbursed.

If you experience a change in status event while you are on leave, or upon your return from leave, you may make appropriate changes to your elections (for example, if you have a baby and want to increase your Health Care FSA coverage amount.)

If your employment doesn't terminate during your leave, but you don't return to work once your leave ends, you can elect to continue Health Care FSA coverage under the COBRA continuation rules. Your

COBRA continuation period begins on the last day of 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 elect to continue Health Care FSA coverage under the provisions of USERRA. 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 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 may be required to pay all or a portion of the cost of your coverage:

- **If your military service is 31 days or less:** You're required to pay no more than your usual share of the cost for this period of coverage.
- **If your military service is more than 31 days:** You must pay the entire cost of the coverage (not to exceed 102% of the applicable premium similar to the manner in which the cost for COBRA continuation coverage is calculated).

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 elect continuation 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, your spouse and your tax dependents the opportunity to pay for a temporary extension of Health Care FSA 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.

If you elect COBRA coverage for Health Care FSA coverage, it takes effect on the date your coverage under the Program ended, and continues for as long as the monthly premiums are paid up to the end of the plan year.

Employee Loses Health Care FSA Coverage

If you lose coverage because of a layoff, reduction in hours or termination of employment, Health Care FSA COBRA continuation coverage is available to you, your spouse and your tax dependents for the remainder of the ***plan year.*** bswift notifies you and your dependents of your right to continue coverage when you experience a qualifying event. Such an event makes a 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 at **1-866-365-2413**.

For a qualifying event which is:

- a divorce or legal separation of the employee and spouse
- a dependent loses eligibility for coverage

A COBRA election will be available. You or a representative acting on your behalf (such as a family member) are responsible for providing the required notice.

If the above situation occurs, notify the *Company* within 31 days of the qualifying event by logging onto the Publicis Connections website 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 or the later of the date the benefits terminate due to the qualifying event or the date the dependent receives notice of his or her COBRA rights.

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.

Cost of COBRA Coverage

If you elect COBRA continuation, you're responsible for paying the required Health Care FSA contribution plus an additional administrative cost of 2%.

You must submit your monthly Health Care FSA contribution by the first day of each month for the remainder of the plan year. If the contribution isn't received within 30 days of that date, the coverage will be cancelled. The first contribution when you or a dependent initially elect 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 Publicis Connections. If your home address changes while on COBRA, notify your HR Representative.

When COBRA Coverage Ends

COBRA continues until the earliest of the following:

- The end of the ***plan year***.
- The date the ***Company*** no longer provides Health Care FSA coverage to any of its employees.
- The date a required contribution for continuation of group coverage is due and not paid within the required time.

How Your Health Care FSA Plan Works

In this document you'll find a brief overview of your coverage option, as well as how the features of your Health Care FSA plan works.

The Health Care FSA is an account that allows you to put money aside to reimburse yourself for "eligible" health care expenses. Expenses must be incurred during the Plan Year and while you were covered under the Plan. An expense is considered incurred when the care or service is provided—not when your provider issues a bill, nor when you receive or pay that bill.

About Your Plan Option

The Health Care FSA can provide a savings opportunity. By using before-tax dollars to pay for certain ***eligible health care expenses***, you may save significantly on taxes each year.

FSAs let you set aside a predetermined dollar amount to cover allowable unreimbursed expenses. You contribute to the accounts through payroll deduction on a before-tax basis (before federal income taxes and Social Security are deducted). When you incur an ***eligible health care expense***, you are reimbursed from your account with tax-free dollars. Thus, the cost of these services may be "discounted" by your applicable income tax rate.

Review the General Information chart on p. 13 to determine eligible expenses, qualified dependents and maximum annual contribution amounts.

For more information regarding eligible expenses, visit the HealthEquity website: HealthEquity.com, and navigate to the participant section to the listing.

Health Care FSA Debit Card

Participants are issued a HealthEquity Healthcare debit card ("cards") by HealthEquity. The cards are provided by the Administrator and the Plan for payment of Medical Expenses, subject to the following terms:

- **Card only for medical expenses -** Each Participant issued a card shall certify that such card shall only be used for Medical Expenses. The Participant shall also certify that any Medical Expense paid with the card has not already been reimbursed by any other plan covering health benefits and that the Participant will not seek reimbursement from any other plan covering health benefits.

- **Card issuance -** Such card shall be issued upon the Participant's Effective Date of Participation and reissued upon reaching the expiration date for each Plan Year the Participant remains a Participant in the Health Flexible Spending Account. Such card shall be automatically cancelled upon the Participant's death or termination of employment, or if such Participant has a change in status that results in the Participant's withdrawal from the Health Flexible Spending Account.

- **Maximum dollar amount available -** The dollar amount of coverage available on the card shall be the amount elected by the Participant for the Plan Year.

- **Only available for use with certain service providers -** The cards shall only be accepted by such merchants and service providers as have been approved by the Administrator.

- **Card use -** The cards shall only be used for Medical Expense purchases at these providers, including, but not limited to, the following:
  - Co-payments for doctor and other medical care;
  - Purchase of prescription drugs;
  - Purchase of medical items such as eyeglasses, syringes, crutches, etc.
- **Substantiation -** Such purchases by the cards shall be subject to substantiation by the Administrator, usually by submission of a receipt from a service provider describing the service, the date and the amount. The Administrator shall also follow the requirements set forth in Revenue Ruling 2003-43 and Notice 2006-69. All charges shall be conditional pending confirmation and substantiation.
- **Correction methods -** If such purchase is later determined by the Administrator to not qualify as a Medical Expense, the Administrator, in its discretion, shall use one of the following correction methods to make the Plan whole. Until the amount is repaid, the Administrator shall take further action to ensure that further violations of the terms of the card do not occur, up to and including denial of access to the card:
  - Repayment of the improper amount by the Participant;
  - Withholding the improper payment from the Participant's wages or other compensation to the extent consistent with applicable federal or state law
  - Claims substitution or offset of future claims until the amount is repaid; and
  - If above actions fail to recover the amount, consistent with the Employer's business practices, the Employer may treat the amount as any other business indebtedness.

General Information

Here's a snapshot of the Health Care FSA.

Benefit/Plan Feature	Health Care FSA
Eligible Expenses	• Medical, dental, vision and hearing expenses not covered under your medical, dental, and vision coverage – or another ***Company***-sponsored plan and considered medical expenses under IRS section 213. • Deductibles and copayments.
Qualified Dependents	• Anyone you claim as a dependent for tax purposes, including your ***spouse*** and your unmarried dependent children or stepchildren.
Maximum Annual Contribution	• $3,050 per year

Changing Your Contributions

In general, you can't change your contributions during the year unless you have a qualified change of status that affects your participation. See the "Changes in Coverage" section for more details.

Forfeiture of Contributions

If you don't use the entire balance in your account by the end of the year, or before your eligibility to participate in the Health Care FSA ends, the IRS requires you to forfeit the remaining funds. **This money is not available for future expenses or a refund.** The ***Company*** uses the forfeited funds to offset administrative costs. This IRS-imposed forfeiture rule simply means you need to carefully estimate how much to contribute to your FSAs each year. See the "How to Use the Account" section below for help estimating your expenses.

You have until March 31 of the following year to submit claims for expenses incurred during the previous January 1 through December 31 period. This run-out period enables you to submit any eligible expense you may incur before the end of the year.

How to Use the Account

- **Estimate your expenses:** When you enroll, and at each annual enrollment, you determine in advance how much you expect to spend on health care expenses for the upcoming year. It's important to estimate carefully. Because of the FSA's tax advantages, IRS rules apply. As a result, you forfeit any unused FSA funds at the end of the year. See the "Forfeiture of Contributions" section above for more details.

  To help estimate your annual expenses and determine your tax savings visit the HealthEquity website at HealthEquity.com.

- **Determine how much to contribute:** You then decide how much to contribute to your account for the upcoming year, on a before-tax basis. You may contribute a minimum of $120 and up to $3,050 each year into your account.

After you decide on the dollar amount, divide the amount by 24 pay periods. This amount is deducted (before taxes) in even amounts from your semi-monthly paychecks. These funds are then credited to your account until you file a claim for reimbursement. (Mid-year elections will be calculated based on the remaining pay periods in the calendar year.)

Remember, you forfeit any contributions that remain in your account for which you do not incur eligible expenses by the end of the year.

- **Incur expenses:** The account reimburses you for eligible expenses incurred during the ***plan year***. Any expenses incurred before your enrollment doesn't qualify for reimbursement.
- **Receive reimbursement:** Submit a claim form along with the appropriate supporting documentation. You're reimbursed for the eligible expense with before-tax dollars, up to the total amount you elect to contribute for the year – even if you incur the expense at the beginning of the year. See Applying for Reimbursement for more information.
- **If you terminate employment:** Only the expenses incurred while you're an active employee and contributing to the account are eligible for reimbursement, unless you continue your participation in the Health Care FSA through COBRA.

Eligible Expenses

You may submit bills for any expense for medical care, as defined in Section 213 of the Internal Revenue Code (except long-term care premiums and expenses associated with long-term care and other health care premiums), which you are obligated to pay and which are not covered by any plan.

This may include amounts that are not paid by your employer-sponsored health care plan, such as deductibles, co-payments, expenses in excess of plan dollar limits, or those which exceed customary and reasonable fees. You may also submit bills for medical, dental, and vision expenses that are not reimbursed by another plan so long as they are medical expenses you could have claimed on your individual income tax return (Form 1040).

Expenses eligible to be reimbursed from the Health Care FSA include expenses for the diagnosis, cure, treatment or prevention of disease, and for treatments affecting any part or function of the body. Expenses must be to alleviate or prevent a physical or mental defect or illness. Expenses incurred solely for cosmetic reasons or expenses that are merely beneficial to a person's general health (except smoking cessation and physician-directed weight reduction programs) are not eligible for reimbursement.

You may submit claims for equipment, supplies and diagnostic devices, such as bandages, crutches or blood sugar test kits, obtained over-the-counter if they are used for the diagnosis, treatment or prevention of disease.

The following items are examples of eligible expenses under the Health Care FSA, if the items are not covered by any other health plan. There may be other expenses that qualify for reimbursement. If you would like to confirm whether an expense is eligible, you can contact HealthEquity at 1-877-924-3967 or refer to IRS Publication 502: "Medical and Dental Expenses" by visiting www.irs.gov/pub/irs-pdf/p502.pdf.

General Expenses

- Medical plan deductibles, copayments and coinsurance amounts
- Charges that exceed reasonable and customary limits
- Dental and orthodontia expenses
- Copayments for prescription medications
- Vision care expenses including exams, eyeglasses, contact lenses and the cost of laser vision correction surgery
- Contact lens maintenance (drops, solutions, etc.)
- Routine checkups and physicals
- Routine foot care
- Services for alcoholism or drug addiction performed outside of a hospital or skilled nursing facility
- Medically necessary cosmetic surgery that meaningfully promotes the proper functioning of the body or prevents or treats illness or disease

- Hearing aids/batteries
- Birth control pills, devices and procedures
- Private duty nursing services
- Well-baby care and immunizations
- Tobacco cessation programs prescribed by your physician (not including over-the-counter programs)
- Occupational/physical therapy for alleviation of an illness or injury
- Laser eye surgery
- Chiropractor expenses for medical care not covered by your medical plan
- Infertility treatments
- Psychology and psychoanalysis medical expense amounts
- Massage therapy used to treat injury or trauma (must be recommended by a physician and condition and length of treatment must be documented)
- Weight-loss program prescribed to treat an existing disease (must document condition)
- Speech Therapy

Equipment and Supplies

- Back support devices
- Cost of installing stair-seat elevator for person with heart condition
- Invalid chair
- Orthopedic shoes (excess cost over normal shoes)
- Special mattress for relief of arthritis of spine (excess cost over regular mattress)
- Reclining chair if prescribed by doctor (excess cost over regular chair)
- Repair of special phone equipment for the deaf
- Wig advised by doctor as essential to mental health of person who has lost all hair from disease
- Menstrual care products, such as tampon, pad, liner, cup, sponge, or similar product used by individuals with respect to menstruation or other genital-tract secretions

Medical Treatments

- Acupuncture or related procedures
- Healing services
- Sterilization
- Vasectomy
- Radial keratotomy

Miscellaneous Items

- Braille books (excess cost of Braille books over cost of regular edition)
- Convalescent home (for medical treatment only)
- Fees paid to health institute for exercises that are prescribed by a physician and are supported by a doctor’s statement that exercises are necessary for alleviation of physical or mental defect or illness
- Kidney donor’s or possible donor’s expenses
- Nurse’s board and wages, including Social Security taxes you pay on wages
- Remedial reading for child suffering from dyslexia
- Seeing-eye dog and its maintenance
- Special school costs for physically and mentally handicapped children (except for room and board)
- Telephone/teletype costs and television adapter for closed-caption services for a deaf person

Expenses Not Eligible

The following items are examples of expenses that aren't eligible for reimbursement under the Health Care FSA. There may be other expenses that don't qualify. If you would like to confirm whether or not an expense is eligible, you can contact HealthEquity at 1-877-924-3967 or refer to IRS Publication 502: "Medical and Dental Expenses" at https://www.irs.gov/pub/irs-pdf/p502.pdf

- Cosmetic surgery, electrolysis, teeth bleaching and hair transplants that aren't medically necessary
- Expenses not permitted as tax deductions on your federal income tax return
- Exercise fees, athletic fees or health club memberships for general health
- Expenses incurred before your participation in the FSA begins
- Marriage counseling
- Maternity clothes or diaper services
- Household help (even if recommended by your doctor because you're unable to do housework)
- Custodial or domiciliary care
- Funeral and burial expenses
- Illegal services and supplies
- Meals and lodging at a non-medical facility (lodging may be eligible up to $50 per day if the expense is incurred primarily for and essential to medical care and there is no significant element of personal recreation)
- Premiums
    - Premiums paid by the Employee, a spouse or other Dependents for coverage under any health plan
    - Premiums paid for Medicare
    - Premiums paid for Long Term-Care Insurance
    - Premiums paid for policies that provide coverage for loss of earnings, accidental death, loss of limbs, loss of sight, etc.

Applying for Reimbursement

Reimbursement from your FSA is available only after the service for which you're seeking reimbursement has been performed and you have received reimbursement from all other sources. To obtain reimbursement for your health care expenses, you must file a claim for reimbursement.

How to File Claims

Expenses eligible for reimbursement from another medical or dental plan must be submitted to that plan first. After a payment determination is made, you can submit the unreimbursed expense for reimbursement to HealthEquity, your FSA Claims administrator.

The full annual amount you elect to contribute to your HCFSA (less any previous reimbursements) is available for reimbursement of ***eligible health care expenses***, regardless of the amount contributed to date. Contributions continue to be deducted from your pay to cover any claims already fully reimbursed from the Health Care FSA.

You can file claims online by logging into HealthEquity.com or obtain a paper claim form by visiting the benefits website: publicisconnections.com/FormsGuides.

For paper claims, complete the employee portion of the claim form, and make sure you sign it. Be sure to include the following along with the claim form:

- The explanation of benefits (EOB) from the insurance company; or
- An itemized bill for services not covered by insurance, including the name of the service provider, name of the patient, date of service, cost of the service, and description of the services rendered.

Paper claim forms should be submitted to:

Claims Administrator
P.O. Box 14053
Lexington, KY 40512

or faxed to:

1-877-353-9236

If you file a claim online the system will prompt you to either download a scanned PDF of the documents listed above.

Filing Deadline

You may file claims at any time after you incur the expense. You have until March 31 of the following year to submit claims for expenses incurred between January 1 and December 31 of the previous year.

Remember, you forfeit any money that remains in your FSA after March 31 of the following calendar year.

If a Claim Is Denied

You may make a request for any benefits to which you may be entitled. Any such request must be made in writing to HealthEquity at the following address:

HealthEquity – Claim Denial Inquiry
P.O. Box 14053
Lexington, KY 40512

Your request for benefits will be considered a claim for benefits.

If your claim is denied, in whole or in part, you will receive a written explanation of the denial from HealthEquity (or its designee) no later than 30 days after receipt of your written claim. This time period may be extended up to an additional 15 days. In that case, you will be notified of the extension before the end of the initial 30-day period.

This explanation will include:

1. The reason for the denial
2. The specific reference within the Plan provisions upon which the denial is based
3. A description and explanation of any additional information or material that PayFlex needs to perfect your claim; and
4. Details about the steps you'll need to take if you wish to submit your claim for further review.

Review of Your Claim

You may request a review of the denied claim. Here's how the process works:

1. You request a review of your claim, in writing to the claims administrator within 180 days after you receive notice of the denial.
2. You (or your representative) can request to review all pertinent documents. Please submit your request in writing to the claims administrator.
3. You may submit issues and argue against the denial in writing to the claims administrator.

Decision on Review of Your Claim

You are entitled to a written decision of your claim review, stating clearly the reasons for the decision as well as specific references to Plan provisions on which this description is based. Normally, this decision should not take longer than 60 days after receipt of your request for a review. If it will take longer than 60 days, you are entitled to receive written notice of such delay and the cause of the delay. In no case shall a decision be rendered later than 180 days after request of review. If the decision on your claim is not furnished to you within the time limitations described above, your claim will be deemed denied.

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. If you do not agree with the final determination on review, you have the right to bring a civil action under Section 502(a) of ERISA, if applicable.

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 Administrator and do not receive them within 30 days you may file suit in 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 Connections
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 Benefit 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 the ERISA by calling the publication hotline of the Employee Benefits Security Administration.

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

A Word About Taxes

FSA contributions reduce your taxable income - meaning you pay less in taxes. Your HCFSA contributions are not subject to federal income taxes, Social Security (FICA) taxes and in many cases, state and local income taxes. Rules vary, and state and local taxes are subject to frequent change.

Regarding the Tax-Saving Approaches

It's important to note that any tax savings that may result from your participation in the HCFSAs depend on your own personal situation and income level. Tax information included on this site is only general information. Because tax laws are complicated and subject to frequent change, you should talk with a qualified tax advisor before you decide whether to use the HCFSAs or to take a tax deduction.

By law, the ***Company*** can't offer you tax advice or advise you on you FSA-related decisions. This law is designed to protect you by ensuring that you always get the most up-to-date advice and that advice is only available from a qualified tax advisor.

An Example of the How HCFSA Helps You Save

This chart illustrates the potential tax savings when using the HCFSA:

If You Contribute:	Your Tax Savings Could Be:
$500	$125
$1,000	$250
$1,500	$375
$2,000	$500
$3,050	$762

These tax savings are based on the combined federal income tax rate and the Social Security (FICA) rate of 25%. If your income tax rate is higher, and/or you also pay state and local taxes, you will save even more in taxes by using the FSA. The example assumes a $50,000 annual pay rate and that the contribution amounts would be spent on eligible expenses regardless whether the employee elected Health Care Flexible Spending. Please be advised that this calculation is only an estimate and is not tax advice. Be sure to consult a tax advisor to determine actual savings you may achieve by making pre-tax contributions. Actual tax savings depends on several variables, including local tax rates and your individual tax bracket.

As you can see, contributing to the HCFSA can make your spendable pay go further. Consider this: By using the FSA to pay for $3,050 of eligible health care and dependent care expenses, you could save at least $762 in taxes for the year. In other words, you spend $2,288 to pay for $3,050 worth of eligible HCFSA expenses.

Effect of Before-Tax Contributions on Your Other Benefits

Before-tax contributions reduce the Social Security taxes you pay. Therefore, the eventual Social Security benefit you may be eligible to receive will be reduced. Because Social Security benefits are based on your career earnings, in most cases, this reduction will be minimal. For more information, contact your local Social Security Administration office.

Alternate Tax-Savings Approaches

You may be eligible to take a deduction or tax credit on your income tax return for eligible health care and/or dependent care expenses.

Health Care FSA vs. the Income Tax Reduction

Under current tax laws, expenses reimbursable through your Health Care FSA are normally deductible on your federal income tax return if they exceed 10% of your adjusted gross income. When you use your HCFSA to reimburse these expenses, you give up the opportunity to take a tax deduction for these same items.

When you are considering whether or not to enroll in the FSA, decide whether you want to take the deduction on your income tax return, or reimburse the expenses through the HCFSA. Generally, if you don't itemize deductions, or if your health care expenses are less than 10% of your adjusted gross income, it may be better to use the Health Care FSA.

Situations Affecting Your Use of the FSA

Because of the tax advantages of using the Health Care FSA, there are some situations that will affect your use of your account. Also, see A Word About Taxes for more about how the account interacts with your taxes.

If Both You and Your Spouse Use a Health Care FSA

If you participate in the Health Care FSA and your ***spouse*** participants in a similar FSA through his or her employer, you and your ***spouse*** may not use both of your respective accounts to reimburse the same eligible health-related expenses. In addition, if you use your Health Care FSA to reimburse expenses, you give up the opportunity to take an income tax deduction on those same items when you file your taxes. You'll want to consult a tax advisor if you and your ***spouse*** use a Health Care FSA.

If You Contribute to the Dependent Care FSA

One additional consideration when estimating your expenses: the health care and dependent care FSAs are treated separately. This means you can't use money deposited in your health care FSA to pay dependent care expenses, and vice versa.

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. As an employee welfare benefit plan under ERISA, the Plan is subject to the HIPAA privacy rules. 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: PublicisConnections.com

Glossary of Terms

Actively at Work

You are considered actively at work if you are:

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

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

Company

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

Domestic Partner

Your same or opposite sex domestic partner includes any individual that you have been residing with in 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 Connections website) before coverage begins.

You must meet all of the following to be eligible for coverage as 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're jointly responsible for each other's welfare and financial obligations;
- You share your principal place of residence;
- You're both at least 18 years old and mentally competent to consent to the contract;
- Neither of you are married to anyone else; and
- You're 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.

Eligible Health Care Expenses

All references to eligible expenses assume that charges are for covered services.

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 Re:Sources USA
Publicis Benefits Department
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.

Spouse

The individual to whom you are legally married under 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.