IPG

BENEFITS GUIDE

2025

Find the Best Fit for You

At IPG, we partner with you to create a healthy and active lifestyle through our benefits program. Your physical health, emotional wellbeing, and financial protection are our priority. As you explore this guide and learn about the plans available to you, consider ways you can take advantage of your benefits to improve your life and access the care you need anytime, anywhere. We are here to support you in making wise health care decisions for you and your family. If you have any questions, reach out to the carriers listed on **page 39** or contact your Human Resources Representative.

Benefit Yourself

Look for the **dollar sign** throughout the guide for cost saving tips and free benefits.

A Look Inside

Below is a list of benefit topics you will find in this guide and where to find them.

Benefit Basics

Who's Eligible for Health and Welfare Benefits?

Employees
You are eligible to participate in the benefit plans if you are regularly scheduled to work at least 20 hours per week. Coverage begins one month from your date of hire.

Note: *Temporary employees working an average of 30 hours or more per week in the prior 12 months, and their dependent children, are eligible for medical only. Spouses and domestic partners of temporary employees are not eligible.*

Dependents
Eligible dependents include:

- Your legal spouse or domestic partner
- Your disabled dependent children of any age
- Your dependent children up to age 26 for medical, dental, and vision coverage
- Children for whom you have legal guardianship
- For life insurance, your unmarried dependents up to age 23, if full-time student up to the age of 26

Important Information About Domestic Partner Coverage
A domestic partner is a person of the same or opposite sex who is not your legal spouse and has a single, dedicated relationship with you. To be eligible for domestic partner coverage, you and your domestic partner must meet certain requirements. In addition, the children of your domestic partner can be enrolled as your eligible dependents under the medical, dental, and vision plans, whether or not you have legally adopted them.

Keep in mind, under current tax laws, the cost of coverage for domestic partners and children of domestic partners generally cannot be paid on a pre-tax basis (even for medical, dental and vision benefits, which otherwise allow you to pay on a pre-tax basis). If you elect coverage for your domestic partner and/or his or her children, the portion of your cost for their coverage will be deducted from your paycheck on an after-tax basis. The Company's portion of the cost of their coverage will be considered imputed income to you, and the value of that imputed income will be included in your wages for tax purposes. The Health Care Spending Account or Health Savings Account generally cannot be used to pay for expenses incurred on behalf of domestic partners and their children.

If your domestic partner or the children of your domestic partner are your tax dependents under IRS rules, you may be able to pay for their health benefits on a pre-tax basis. For example, if you have adopted your domestic partner's child, you may pay for the child's medical, dental, and vision benefits on a pre-tax basis (if the child is otherwise eligible) and you may use the Health Care Spending Account or Health Savings Account to pay for expenses incurred on behalf of that child.

Please contact your local Human Resources Representative for more details about domestic partner coverage.

Making Changes During the Year

Qualified life status events are significant life changes that can trigger changes to your health insurance benefits. These events typically involve changes in your personal or family circumstances, such as:

- **Marital Status Changes:** Marriage, divorce, or annulment.
- **Family Additions:** Birth or adoption of a child.
- **Employment Changes:** Job loss, job gain, or change in hours.
- **Legal Guardianship:** Obtaining or losing legal guardianship of a child.
- **Loss of Coverage:** Losing coverage under another person's plan (e.g., spouse's plan).

Important Notes:

- **Time Limit:** You generally have 30 days from the date of the qualifying life status event to make changes to your benefits.
- **Documentation:** You may be required to provide documentation (e.g., birth certificate, marriage certificate) to verify the event and eligibility for any changes.
- **Benefit Changes:** Changes must be directly related to the qualifying life status event. For example, if you have a child, you can add them to your plan, but you cannot change your plan type or coverage level.

Enrolling Dependents?

When you add dependents to your coverage, you must provide the following information:

- Legal name
- Date of birth
- Social Security number
- Supporting documentation, such as a marriage certificate, birth certificate, adoption papers, and tax documents

If you do not provide the required information, your dependents may be dropped from coverage.

ENROLLMENT BASICS

Enrolling in benefits is easy, secure, and convenient. To keep your information safe, the Company uses knowledge-based authentication (KBA). KBA asks a variety of questions derived from public data records to verify your identity.

Log onto **interpublicbenefitsonline.ehr.com** to enroll. The site is your 24/7 resource for all your benefits tools and information. Review coverage, download plan documents, compare the medical plans side-by-side, and more!

When Coverage Begins

Coverage begins under the benefit plan depending on when you enroll:

1. **When first eligible**
   One month from your date of hire (you must enroll within 30 days). **Example:** If you are hired on July 15, your benefits will be effective on August 15.
2. **During open enrollment**
   The benefits you elect during open enrollment go into effect on January 1, 2025.
3. **After a change in family status**
   Retroactive to the date of a birth or adoption of a child and changes are made within 30 days of the status change.
4. **When you are rehired**
   No waiting period if you are rehired within 30 days and less than six months (If you're hired after 30 days, you will have to re-elect your benefits).

If you are not actively at work on January 1, 2025, some plan coverages may be impacted until you return. This does not apply to employees who are out on paid time off (PTO). Check specific plan details or contact your Human Resources Representative if you have any questions.

Cost of Coverage

For the following plans, you pay your share of the cost of coverage on either a pre-tax basis or an after-tax basis (different rules apply to domestic partners and children of domestic partners. See page 3 for more information.) The amount you pay will be deducted automatically from your paycheck (except where indicated) throughout the year. The amount deducted from each paycheck generally is for the prior coverage period (i.e., from your last paycheck to the current pay date).

Pre-Tax Benefits	Post-Tax Benefits
Medical	Optional Long-Term Disability
Dental	Optional Employee, Spouse, and Child Life Insurance
Vision	Optional AD&D Insurance
Flexible Spending Accounts (FSA)	Identity Theft Assistance
Health Savings Account (HSA)	Group Legal Plan
Transportation Accounts	Home and Auto Insurance
	Accident Insurance and Critical Illness Insurance

Company Paid Benefits

You automatically receive the following benefits at no cost to you:

- Employee Assistance Program (EAP)
- Basic Short- and Long-Term Disability
- Basic Life Insurance
- Business Travel Accident Insurance

HIPAA Special Enrollment Rights

If you decline medical, dental, or vision coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in the Company's plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Special enrollment rights also may exist in the following circumstances:

- If you or your dependents experience a loss of eligibility for Medicaid or a state Children's Health Insurance Program (CHIP) coverage and you request enrollment within 60 days after that coverage ends; or
- If you or your dependents become eligible for a state premium assistance subsidy through Medicaid or a state CHIP with respect to coverage under this plan and you request enrollment within 60 days after the determination of eligibility for such assistance.

Note: The 60-day period for requesting enrollment applies only in these above two listed circumstances relating to Medicaid and state CHIP. As described previously, a 30-day period applies to most special enrollments.

For more details about Changes in Status and the types of changes you may be eligible to make, please visit **interpublicbenefitsonline.ehr.com**. (**Please note:** Since you can enroll or make changes to the Transit and Parking Accounts on a monthly basis, Changes in Status do not apply to these accounts.)

Continuation of Benefits

An eligible employee who loses coverage or leaves the Company for reasons other than termination of employment on account of gross misconduct, may be eligible to continue medical, dental, vision, and EAP benefits pursuant to the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA). In most circumstances, an individual may continue the above benefits for up to 18 months by paying the full cost of coverage plus a 2% administrative fee. You will receive notification of your COBRA rights following your coverage end date. You can access the COBRA notice on **cobra.ehr.com**, or call **1-877-29-COBRA (26272)**.

Please note: *If you enroll in COBRA and you or your spouse are eligible for Medicare due to age, the medical plan will coordinate benefits as if Medicare is your primary coverage as of your termination date, even if you are not enrolled in Medicare. Please visit* **medicare.gov** *or call* **1-800-MEDICARE** *for more information.*

Losing Coverage if You Provide False Information

You may be asked to provide documentation to support a covered person's status, such as a birth certificate or a marriage certificate. If you or your spouse or dependent knowingly submit false information when enrolling in, changing, or claiming benefits, or if you fail to notify the Global Benefits Department that a spouse or dependent is no longer eligible for coverage, participation for you and your dependents may be immediately, retroactively, and permanently canceled. Providing false or misleading information may result in disciplinary action, up to and including termination of employment. Pending claims may not be paid, and you will have to reimburse the applicable plan for any previous claims incurred that should not have been paid. The Company reserves the right to audit your spouse and dependent enrollment information at any time.

Medicare Eligibility

If you are actively working and become eligible for Medicare due to age, your medical coverage through IPG continues to be primary. This is also true for a covered spouse under the plan, however, the same rule does not apply to domestic partners. Please visit **medicare.gov** for more information.

When Coverage Ends

Your benefits coverage ends the date you terminate, retire, or are no longer eligible for coverage. Your dependents' coverage will end if your coverage ends, or when they no longer meet the eligibility requirements under the Plan. Benefit deductions are not pro-rated. If you do not work a full pay cycle, benefit deductions will not be withheld. (See the FAQ on the following page for more details.)

Your IPG Virtual Benefits Fair

Explore your benefits with a fun, interactive virtual benefits fair available all year long:

- Visit provider booths to learn more about your plans
- Add flyers, plan documents, and other valuable information to your swag bag to email to yourself or your family members
- Find answers to your questions
- Watch videos
- Discover ways to make the most of your benefits

Visit **myIPGbenefits.com** to get started.

HOW TO ENROLL AND LEARN MORE ABOUT YOUR BENEFITS PLAN

For additional information, as well as other plan information, including Plan Summaries, SBCs, or SPDs, visit Inside Interpublic or **interpublicbenefitsonline.ehr.com**.

FAQs

Read below for answers to frequently asked questions (FAQs) on benefits enrollment. Please reach out to your local HR representative for questions or more information.

When is open enrollment?
Open enrollment is an annual event, usually held each November that allows you to change, modify or elect new benefits that become effective on January 1 of the following year.

Am I required to sign up for health insurance?
The federal government no longer requires individuals to have health insurance. However, a handful of states and the District of Columbia have instituted a health insurance coverage mandate, and most carry a penalty for not doing so. If you live in California, Massachusetts, New Jersey, Rhode Island, or Washington, D.C., you must have insurance or pay a penalty. Vermont's mandate does not include a penalty for noncompliance.

IPG does not offer a financial incentive to employees who decline group health coverage.

When is the deadline to enroll as a new hire?
You have 30 days from your date of hire.

How do I know if I'm eligible for benefits?
Employees regularly scheduled to work at least 20 hours per week are eligible for the benefits program.

If I work less than full time (temp) can I still get benefits?
Temporary employees working an average of 30 hours or more per week in the prior 12 months and their dependent children are eligible for medical only.

What happens if I do not enroll/miss open enrollment?
If you miss your open enrollment deadline, you could lose coverage for you and your eligible dependents. Missing this deadline also means that you could be unable to make changes or enroll in benefits until the next open enrollment period.

How do I enroll?
Enrolling in benefits is easy and convenient. Simply log on to **interpublicbenefitsonline.ehr.com** to enroll.

Can I elect dependent only coverage?
Dependents are not eligible for coverage unless the employee has enrolled.

When do my benefits begin?
If you enroll during the annual open enrollment period, your benefits will begin on January 1, 2025.

If you enrolled as a New Hire outside of annual open enrollment, your benefits will begin one month from your date of hire. For example, if you are hired on July 15, your benefits will be effective on August 15. If benefit deductions do not begin when coverage is first effective, employees will be charged retroactively back to their eligibility date. If the eligibility starts mid-pay cycle, the full deduction for that period will still apply.

When can I expect to receive my ID card?
If you enroll in IPG benefits, you can expect to receive ID card(s) within 7-10 days after the date your benefits begin. ID cards are only issued by UnitedHealthcare, Cigna, Kaiser, and Express Scripts. Alternatively, visit vendor websites or apps for more information.

What happens to my benefits if I leave the company?
Your benefits coverage ends the date you terminate, retire, or are no longer eligible for coverage.

Your dependents' coverage will end if your coverage ends, or when they no longer meet the eligibility requirements under the Plan.

Benefit deductions are not prorated. If you do not work a full pay cycle, benefit deductions will not be withheld. For example, if an employee terminates on 5/6, no deductions will be taken from the 5/15 paycheck. If deductions are taken due to timing of the termination, a refund will be issued in the next pay cycle. *IPG Savings Plan, IPG Best, and Commuter deductions will still be withheld from the final check.*

In most cases, you may be eligible to continue medical, dental, vision, and EAP benefits pursuant to the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA).

What happens to my Health Care, Limited Purpose, and Dependent Care Flexible Spending Account (FSA) when I terminate?
Your FSA account(s) will terminate as of the date your employment terminates.

An employee whose participation in an FSA terminates mid-year may exhaust any remaining balance in his or her account through the reimbursement of pre-termination expenses. Or elect COBRA to exhaust the balance with post-termination expenses incurred later in the same plan year.

What happens to my Transportation Account when I terminate?
You lose access to your commuter benefits account and any remaining funds on the official date of your termination.

What happens to my Health Savings Account (HSA) account when I terminate?

The HSA is yours and will stay with you even after you leave the Company. Once funds are deposited into the HSA, the account can be used to pay for qualified medical expenses tax-free, even if you no longer have CDHP coverage. Contact Optum directly for more information.

What happens to my benefits if I transfer to a non-US agency?

Coverage for an eligible employee and covered dependent who transfers to a non-US agency ends on the last day of employment with the US agency.

A transfer to a non-US agency does terminate participation in the IPG Savings Plan. Please contact your local HR Representative or Empower for more information.

Where can I see what I'm enrolled in and what options are available?

Log onto **interpublicbenefitsonline.ehr.com**. The site is your 24/7 resource for all your benefits tools and information. Review coverage, download plan documents, compare the medical plans side-by-side, and more. Contact your local HR Representative if you any other questions.

I have a provider question; can I contact them directly?

Yes, you can contact the provider directly. Refer to the contact information on page 39 of this guide.

Where do I update my home address?

Log onto **TalentWise.Interpublic.com**. Workday is enabled by Single Sign On (SSO), no username or password credentials are needed.

Which family members can I add to my benefits?

Eligible dependents include:

- Your legal spouse or domestic partner
- Your disabled dependent children of any age
- Your dependent children up to age 26 for medical, dental, and vision coverage
- Children for whom you have legal guardianship
- For life insurance, your unmarried dependents up to age 23, if full-time student up to the age of 26

Can I change my plan selection at any time?

After your open enrollment or initial new hire enrollment period, you may only change your benefits if you have a qualifying life event/change in family status. Changes must be made within 30 days of the event/family status change.

Log on to **interpublicbenefitsonline.ehr.com** for more information or contact your local HR Representative.

What is a Qualifying Life Event/Change in Family Status?

A qualifying life event/change in family status is a change in your life, such as marriage or the birth of a child, that has an effect on your health insurance options or requirements. The IRS states that a qualifying event must have an impact on your insurance needs or change what health insurance plans you qualify for. Retroactive Events: Changes due to retroactive events (e.g., a marriage reported today but effective 4/1) will result in adjustments back to the effective date. These may appear as additional deductions or refunds in future checks. No more than twice the normal bi-weekly deduction will be withheld from any one paycheck. Refer to page 3 of this guide for more information.

Do I have to provide proof when adding a dependent for coverage?

When enrolling a new dependent you will be required to provide supporting documentation to prove your dependent's eligibility. Examples of documentation include birth certificates, marriage certificate, and adoption papers.

Helpful Benefit Terms & Definitions

To better understand your coverage, it's helpful to be familiar with benefits vocabulary. Take a moment to review these terms, which may be referenced throughout this guide.

Annual Maximum Benefit – The most the PDP Dental Plan will pay toward your costs for preventive care, basic services, and major services each year.

Base Annual Salary – The initial rate of compensation you receive for work performed. It excludes benefits, bonuses, or other potential compensation.

Beneficiary – The recipient you choose who will receive benefits if you die while covered under the savings plan, life insurance, and AD&D insurance.

Coinsurance – The percentage paid for a covered service, shared by you and the plan. Coinsurance can vary by plan and provider network. Review the plans carefully to understand your responsibility.

Copay – A fixed dollar amount you pay the provider at the time of service; for example, a $30 copay for an office visit or a $10 copay for a generic prescription.

Consumer-Driven Health Plan – A medical plan that is usually characterized by higher deductibles and out-of-pocket maximums and lower monthly premiums.

Deductible – The amount you pay each calendar year before the plan begins paying benefits. Not all covered services are subject to the deductible; for example, the deductible does not apply to preventive care services.

Health Savings Account – A tax-advantaged savings account that is used with a consumer-driven health plan.

HIPAA – Health Insurance Portability and Accountability Act, which provides privacy standards to protect patients' medical information.

Imputed Income – The value of the amount of Company provided life insurance coverage above $50,000, and the Company's portion of the cost for domestic partner-related coverage under medical and dental.

Limited Purpose FSA – A health care flexible spending account that works in conjunction with a health savings account. It can only be used for eligible vision and dental expenses.

In-Network Care – Care provided by contracted doctors within the plan's network of providers. This enables participants to receive care at a reduced rate compared to care received by out-of-network providers.

Out-of-Network Care – Care provided by a doctor or at a facility outside of the plan's network. Your out-of-pocket costs may increase, and services may be subject to balance billing.

Out-of-Pocket Maximum – The maximum amount you pay per year before the plan begins paying for covered expenses at 100%. This limit helps protect you from unexpected catastrophic expenses.

Preventive Care – Routine health care, including annual physicals and screenings, to prevent disease, illness, and other health complications. In-network preventive care is covered at 100%.

Urgent Care – Urgent care is not the same as emergency care. Visit urgent care for sudden illnesses or injuries that are not life-threatening. Urgent care centers are helpful when care is needed quickly to avoid developing more serious pain or problems.

ACA
Affordable Care Act

AD&D
Accidental Death & Dismemberment

CDHP
Consumer-Driven Health Plan

FMLA
Family and Medical Leave Act

FSA
Flexible Spending Account

HSA
Health Savings Account

LFSA
Limited Purpose Flexible Spending Account

LTD
Long-Term Disability

PPO
Preferred Provider Organization

STD
Short-Term Disability

Support When You Need It

Employee Assistance Program

We understand that life can sometimes be complicated. You are automatically provided an Employee Assistance Program (EAP) through **CCA@YourService**. The EAP is available at no cost to **all employees, their families, and anyone important in your daily lives.** By calling **1-800-833-8707** anytime of the day or night, you can receive confidential referrals to resources and assistance for nearly any personal matter you may be experiencing. All employees and their family members are eligible for up to 8 free counseling sessions per issue per 12-month period — in person or virtually — for any matter on your mind. Work-life specialists can provide you with access to such services as financial and legal consultation, parenting and family services, pet care, convenience services, and more.

You can also visit the website: **myccaonline.com** (Company Code: **IPGUS**), to find these helpful tools:

- Resource locators
- Real estate calculators
- Legal and financial resources
- Health and wellness tools, including healthy recipes
- Articles and videos on just about anything to support you in your daily life!

MSK Direct

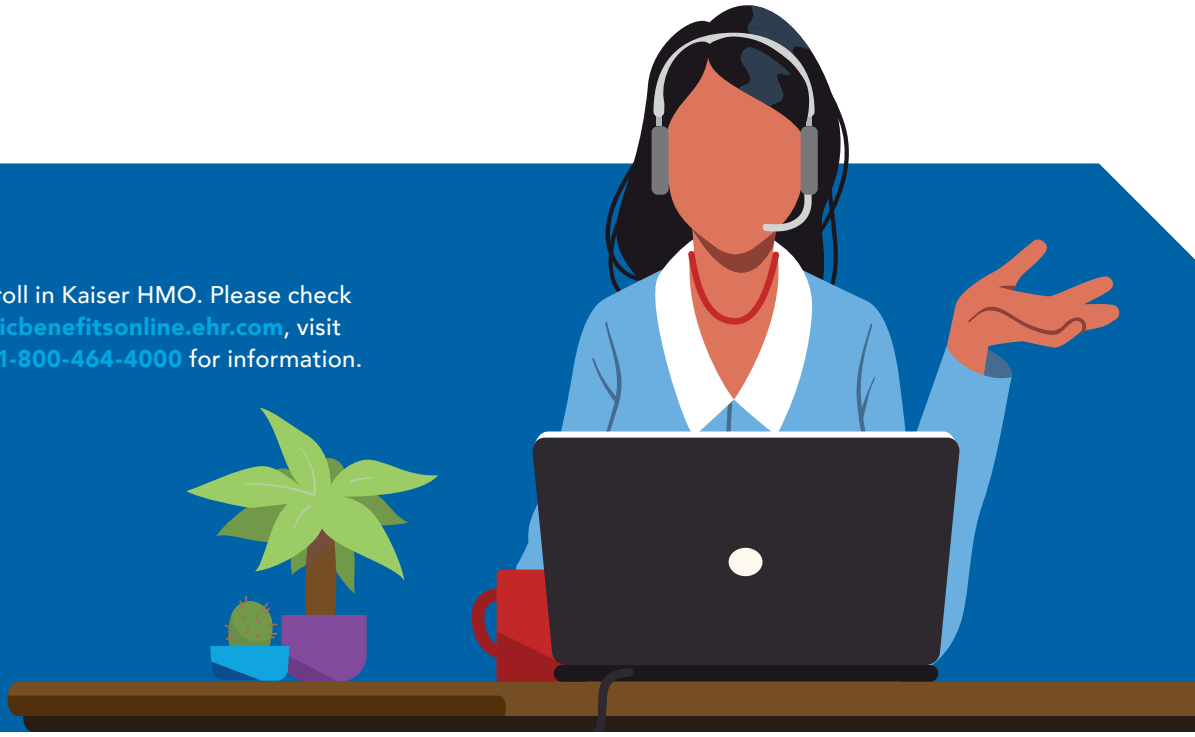
MSK Direct offers employees and their families direct access to a team of dedicated professionals who specialize in cancer care. The team includes experienced nurses, social workers, and advisors who help guide patients through the process of receiving care at Memorial Sloan Kettering Cancer Center.

All IPG employees and their family members have access to MSK Direct at no additional cost. However, care provided by MSK will be subject to the standard copays and deductibles of each individual's insurance plan. UHC participants can access MSK as an in-network provider.

Access MSK Direct by calling **1-833-825-4562**, Monday through Friday from 8:30 a.m. to 5:30 p.m. (Eastern Time). Messages left outside of these hours of operation will be returned the next business day. Your UHC Cancer Support Program nurses can also provide information on MSK Direct.

Live in California?

You also have the option to enroll in Kaiser HMO. Please check the Plan Summary at **interpublicbenefitsonline.ehr.com**, visit **kaiserpermanente.org** or call **1-800-464-4000** for information.



Medical Coverage – Healthy Body, Healthy Mind

Good health is the foundation for a productive life at home and at work. To keep you and your family healthy all year long, you are offered three medical plan options administered by UnitedHealthcare (UHC): PPO 1, PPO 2, and Consumer-Driven Health Plan (CDHP) with Health Savings Account (HSA). California employees also have the option of enrolling in a Kaiser Permanente HMO medical plan.

PPO 1 and PPO 2

The PPO 1 and PPO 2 are traditional PPO plans. You have the flexibility to choose an in-network or out-of-network provider each time you need care, but keep in mind that you will save money when you visit in-network providers. You do not have to choose a primary care physician, and no referrals are required to receive care from a specialist. Most in-network office visits are covered with a copay. These options have lower deductibles and copays but higher monthly premiums.

CDHP with HSA

The CDHP with HSA combines a consumer-driven health plan (CDHP) with a Health Savings Account (HSA). You can receive care from any provider, but you will receive better benefits when you visit in-network providers. The monthly premiums are lower than the PPO plans, but the annual deductibles and out-of-pocket maximums are higher.

With the CDHP and HSA, you are responsible for 100% of your out-of-pocket medical and prescription costs until you reach the annual deductible. The entire deductible must be met (even if your family is enrolled and only one person has medical claims) before the plan starts to pay. However, no family member will pay more than the individual out-of-pocket maximum.

After you meet the deductible, you will share expenses with the plan in the form of coinsurance. The plan will pay a higher percentage of the cost of care if you choose to use in-network providers. If you reach the out-of-pocket maximum, the plan picks up the cost of all covered services from that point forward for the rest of the year.

Medical Savings

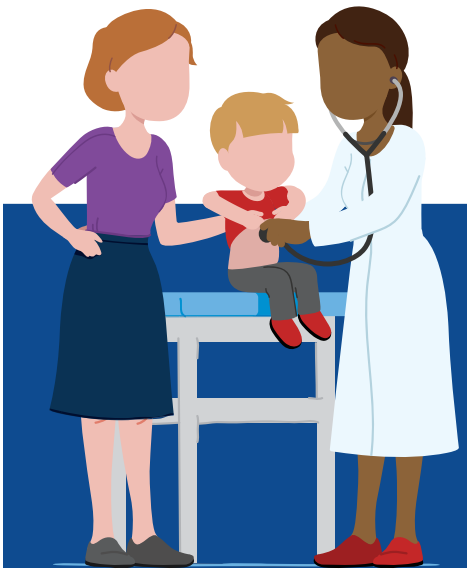
Getting an annual checkup with your doctor is a great way to stay healthy. The best part – it's free when you stay in-network!

Inclusive Care for All UHC Members

IPG is committed to supporting our LGBTQ+ employees and their families by providing benefits that meet everyone's individual needs. UHC members and their dependents enrolled in a UnitedHealthcare medical plan have access to:

- **UHC Advocates:** Personalized support from trained advocates who assist members in navigating the health care system, answering questions about benefits, and connecting them to necessary resources, including a personal Advocate that is specially trained to support members of the transgender community.
- **Transgender Support:** Access to specialized care for transgender individuals, including mental health services and medical treatment options.
- **Gender Affirmation:** Coverage for gender-affirming surgeries and procedures, along with behavioral health services and resources to help members understand their options and navigate the process.
- **Covered services** for HIV screenings, pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP), and antiretroviral therapy (ART).
- **Family Building Benefits:** Support for LGBTQ+ families through fertility treatments is available through UHC. In order to ensure inclusive access, all employees also have access to Maven for additional family building resources (i.e. adoption, surrogacy, fertility preservation).

For more information, speak with a dedicated Advocate at **1-866-679-0946** 7am – 6:30pm CT, Monday – Friday.



Where should you receive care?

For lower out-of-pocket costs, stay in-network with providers and hospitals who have negotiated rates with the UnitedHealthcare Choice Plus Network.

If you live in MA, ME, or NH, you will use the UHC Harvard Pilgrim Network to find in-network providers. The UHC Harvard Pilgrim Network includes Choice Plus Network providers in these states. Visit **myuhc.com** to find in-network care or call **1-866-679-0946**.

Health Savings Account (HSA)

Accompanying the CDHP is a Health Savings Account (HSA), administered by Optum Bank, a unique tax savings account that you can use to pay for current or future eligible health care expenses. When you enroll online, and if you are eligible, an HSA will be opened for you with Optum Bank. IPG pays the monthly account maintenance fee for active employees. HSAs offer a triple tax advantage:

1. **Contributions are made with pre-tax* payroll deductions.**

   When you open an HSA, you contribute pre-tax funds up to the IRS maximum. You can change or stop your contributions at any time throughout the year.

2. **Use the HSA dollars to pay for eligible expenses tax-free.**

   Examples of eligible expenses include doctor and hospital visits, deductibles, coinsurance, prescriptions and over-the-counter medicines, vision and dental care for yourself and your eligible dependents.

3. **Unused funds can be invested, earning interest tax-free.**

   Unlike FSAs, HSA balances roll over from year to year; there's no "use-it-or-lose-it" policy. Also, HSAs are portable and go with you, even if you change companies or retire.

4. **Combine existing HSAs.**

   You may roll over any existing HSAs into your IPG account.

** Pre-tax applies to federal taxes, but not all state taxes.*

Examples of Eligible Expenses

You can use your HSA dollars to pay for:

- Deductibles, copays, and coinsurance
- Over-the-counter medications
- Vision care, including LASIK laser eye surgery and glasses
- Dental care, including orthodontia
- Fertility treatments
- Lab fees
- Weight loss programs
- Chiropractor visits
- Medicare premiums
- And more

Complete list of qualified IRS expenses can be found at irs.gov and publications 969 and 502.

HSA Contributions

Contributions to the HSA come from you and the Company. The combined contribution amount is subject to the IRS contribution limits. Both your contribution plus the Company's seed contribution count toward the annual contribution limit.

Please note that your and the Company's contribution cannot be posted unless you open your HSA with Optum Bank.

Coverage Type	2025 IRS Maximum	IPG's Seed Contribution	2025 Employee Maximum Contribution
Single	$4,300	$300	$4,000
Family	$8,550	$600	$7,950

If you are age 55 or older, you are eligible to make an HSA catch-up contribution of $1,000 annually.

How the CDHP with HSA Works

Jack enrolls in employee-only coverage for the CDHP with HSA. Below is an example of how the CDHP with HSA will work for him.

Month	January	April	September
Scenario	Jack has not reached his deductible and must cover all of his out-of-pocket costs for a doctor's office visit and prescription.	Jack has to visit the ER and has not yet met the deductible. He must cover the full cost of the visit.	Jack reaches the deductible after another visit to the doctor. For the remainder of the year, the 20% coinsurance will apply until he reaches the out-of-pocket maximum.
In-Network Billed Amount	Office Visit: $150 Generic Prescription: $25	ER Visit: $1,250	Office Visit: $150 Generic Prescription: $25
Jack's Total Cost	**$175**	**$1,250**	**$35**
Plan Pays	$0	$0	$140

How the CDHP and HSA Work Together

HSA Contributions → **Deductible** → **Coinsurance** → **Plan Pays 100%** → **Money left in your HSA at the end of the year will roll over to help cover future medical expenses.**

- **HSA Contributions:** You make pre-tax contributions to your HSA at the beginning of the year. (Up to the IRS limits of $4,300 for an individual and $8,550 for a family in 2025.)
- **Deductible:** You pay for covered services up to your deductible amount*. The money from your HSA can help pay for these expenses.
- **Coinsurance:** After your deductible has been met you pay a percentage of covered services for the rest of the calendar year.
- **Plan Pays 100%:** Once your out-of-pocket maximum is reached the Plan pays 100% for covered charges.

** Remember, in-network preventive care services are covered at 100% throughout the calendar year and do not affect your deductible.*

Is the CDHP with HSA the One for You?

The CDHP with HSA is a cost-effective option, but is it right for you? To help you decide, here is a side-by-side in-network comparison of the UHC medical plans.

Features	PPO 1	PPO 2	CDHP with HSA
Payroll Deductions	Highest	Mid-Range	Lowest
In-Network Plan Design	Copay-based plan with the lowest deductible. Plan covers 80%.	Copay-based plan with the mid-range deductible. Plan covers 80%.	Pay full cost until deductible is met. Plan then covers 80%.
In-Network Deductible	$750 individual $1,500 family	$1,250 individual $2,500 family	$2,000 individual $4,000 family
Out-of-Pocket Maximums	$4,000 individual $8,000 family	$5,000 individual $10,000 family	$6,000 individual $12,000 family
Copays	Office visit: $30 Specialist visit: $50	Office visit: $30 Specialist visit: $50	No copay; after deductible is met, you pay 20%
Best for Employees who…	…want a simple plan design based on a traditional copay/coinsurance structure and don't mind higher monthly premiums for a low deductible.	…want a simple plan design based on a traditional copay/coinsurance structure and don't mind a higher deductible.	…are looking for short- and long-term savings opportunities. …are willing to spend extra time managing health care services and investments.

Important Notes About the HSA

- To be eligible for contributions (yours or IPG's) to an HSA, you must not have any other medical coverage unless that other coverage also qualifies as "high deductible" coverage or is an exempt benefit under the federal tax laws. For example:
  - Neither you nor your spouse may participate in a Health Care Flexible Spending Account (FSA), unless it is a Limited Purpose FSA or it prohibits reimbursements before you satisfy the minimum deductible determined by the IRS. (You may also contribute to a Dependent Care FSA.)
  - You may not be enrolled in Medicare, TRICARE, tribal benefits, a spouse's plan, or other benefit programs. Keep in mind that some disqualifying benefit programs, such as Medicare Part A, require that you take action to avoid being covered.
  - You are not eligible to contribute to an HSA or to receive contributions if you are claimed as a dependent on someone else's tax return.

  If you do not meet these requirements, you can still enroll in the CDHP, but you will not be eligible to make or receive HSA contributions. If the plan's administrator determines that you are not eligible for HSA contributions, IPG will not make HSA contributions on your behalf and you will be required to return prior HSA contributions and interest. You will not be allowed to change to a different health plan until the next open enrollment period. This means that you would be subject to the CDHP's deductible and cost-sharing even though you are not eligible for the HSA contribution.

Setting Up Your HSA

To set up your account, Optum Bank may reach out to you for information. This step must be completed in order to receive the Company's contribution and to start saving. Be on the lookout for an email or a letter in the mail from Optum Bank with next steps.

- Your HSA is an individual account in your name. The account is not maintained, sponsored, or endorsed by IPG, and it is not subject to the Employee Retirement Income Security Act of 1974, as amended (ERISA). If you elect the CDHP, IPG will contract with Optum Bank to establish an HSA in your name and to make contributions to that account. The IPG contribution will only be made to the Optum Bank account. Optum Bank may contact you via email or a letter in the mail to request additional information to set up your account. In order for you to receive the Company's contribution, please work with Optum Bank by providing the necessary information. You are free to transfer all or part of your account balance to any other bank or custodian (fees may apply) and to make contributions to an HSA with another bank or custodian.
- You are solely responsible for managing your HSA to ensure that contributions qualify for favorable tax treatment and that funds are used only for eligible medical expenses. Medical and dental expenses that are eligible to be reimbursed from an HSA are described in IRS Publication 502, available on the IRS website, **irs.gov**. Making or receiving contributions to an HSA when you are not eligible, or withdrawing HSA funds for expenses that are not qualified, will generally result in tax penalties.
- You are also solely responsible for deciding how your HSA will be invested, if at all. IPG does not select, approve, or review the investment options available under for HSAs.

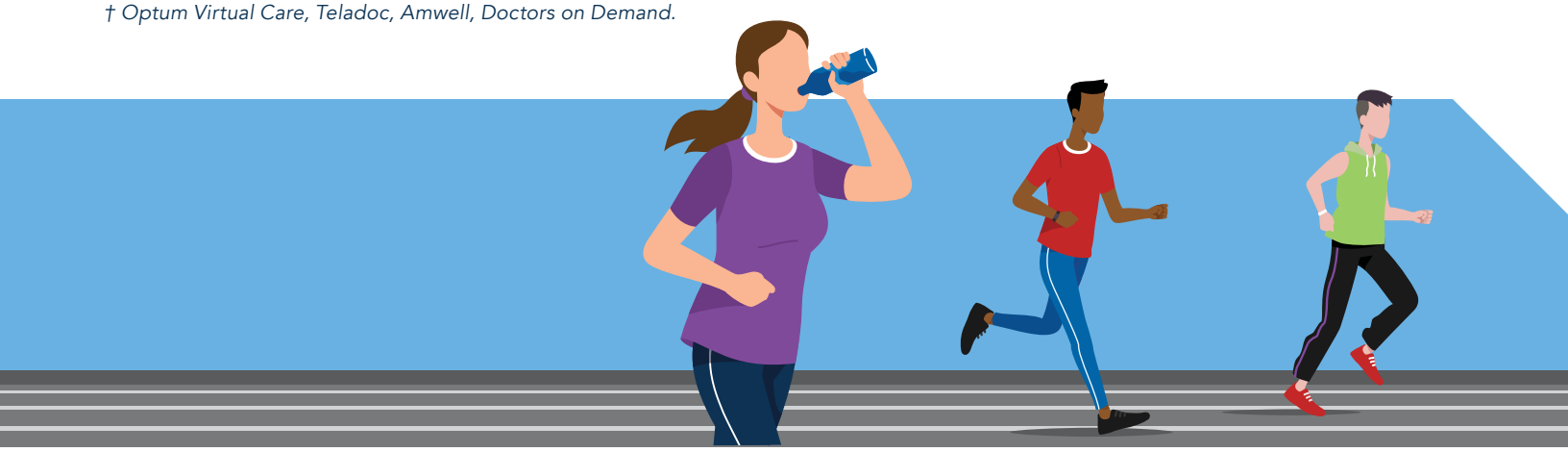
2025 Medical Plans

Plan Features	UHC PPO 1		UHC PPO 2		CDHP with HSA	
	IN-NETWORK	OUT-OF-NETWORK**	IN-NETWORK	OUT-OF-NETWORK**	IN-NETWORK	OUT-OF-NETWORK**
Annual Deductible	$750 individual $1,500 family	$1,500 individual $3,000 family	$1,250 individual $2,500 family	$2,500 individual $5,000 family	$2,000 individual $4,000 family (Includes prescriptions)	$4,000 individual $8,000 family *(Includes prescriptions)*
Annual Out-of-Pocket Maximum (Includes Annual Deductible)	$4,000 individual $8,000 family	$8,000 individual $16,000 family	$5,000 individual $10,000 family	$10,000 individual $20,000 family	$6,000 individual $12,000 family (Includes prescriptions)	$12,000 individual $24,000 family (Includes prescriptions)
Coinsurance (Plan Pays)	80% after deductible	60% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Preventive Care	No charge	60%	No charge	60%	No charge	60% after deductible
Office Visit	PCP: $30 Specialist: $50	60%	PCP: $30 Specialist: $50	60%	80% after deductible	60% after deductible
Emergency Room	$250 copay, then plan pays 80% (copay waived if admitted)*		$250 copay, then plan pays 80% (copay waived if admitted)*		80% after deductible	
Inpatient Hospital Services	$500 copay per confinement, then plan pays 80%	$700 copay per confinement, then plan pays 60%	$600 copay per confinement, then plan pays 80%	$800 copay per confinement, then plan pays 60%	80% after deductible	60% after deductible
Outpatient Mental Health Services	$30 copay	60% after deductible	$30 copay	60% after deductible	80% after deductible	60% after deductible
Talkspace	$30 copay		$30 copay		Subject to deductible, then coinsurance	
Virtual Visits†	$15 copay		$15 copay		Subject to deductible, then coinsurance	

** For out-of-network emergency room benefit, $250 copay applies only if a true emergency; otherwise, the applicable plan out-of-pocket coinsurance will apply. True emergencies will be covered at in-network levels.*

*** Out-of-network eligible expenses are based on Reasonable and Customary (R&C) rates.*

† Optum Virtual Care, Teladoc, Amwell, Doctors on Demand.



Out-of-Pocket Medical Cost Examples

When deciding which plan will be the best fit for you and your family, you'll want to consider the total cost of coverage: what you pay in premiums and what you pay providers. Below are three examples of health care users: low, moderate, and high.

Low Health Care User

Liz is in her early 20s and just starting out in her career. Outside of her annual preventive screenings (covered at 100%), Liz typically visits her doctor twice during the year to treat a sinus infection and minor injury. She also typically fills two generic prescriptions during the year.

	PPO 1 Plan	PPO 2 Plan	CDHP with HSA Plan
APPROXIMATE TOTAL MEDICAL COSTS	$350	$350	$350
Liz's Share of Provider Costs*	$60	$60	$350
Company HSA Contribution	N/A	N/A	($300)
Liz's Annual Premium for Employee Only Coverage	$2,832	$2,256	$1,212
LIZ'S ESTIMATED TOTAL ANNUAL COST*	$2,892	$2,316	$1,312
HSA pre-tax savings opportunity	$0	$0	$3,850

Moderate Health Care User

Javier and his wife, Alice, have faced several health challenges as they've gotten older. Javier has high blood pressure and needs follow-up care after a minor heart attack last year. Alice was diagnosed with diabetes and is under regular treatment. Javier and Alice are moderate health care users; they receive their annual preventive screenings, see specialists each quarter, have an occasional emergency room visit, and fill multiple prescriptions each month.

	PPO 1 Plan	PPO 2 Plan	CDHP with HSA Plan
APPROXIMATE TOTAL MEDICAL COSTS	$4,400	$4,400	$4,400
Javier Share of Provider Costs*	$1,880	$1,880	$4,080
Company HSA Contribution	N/A	N/A	($600)
Javier's Annual Premium for Employee + Spouse Coverage	$6,480	$5,172	$4,116
JAVIER'S ESTIMATED TOTAL ANNUAL COST*	$8,360	$7,052	$7,596
HSA pre-tax savings opportunity	$0	$0	$7,700

High Health Care User

Katie and her husband, Josh, have three children and are frequent health care users. They have continuous health care needs for the oldest child with asthma and the youngest has Autism Spectrum Disorder. Katie takes thyroid medication; her husband has sleep apnea, high cholesterol, and had cardiovascular surgery. There are annual exams for everyone, specialist appointments, therapies, seasonal colds, monthly prescriptions, and occasional surprises.

	PPO 1 Plan	PPO 2 Plan	CDHP with HSA Plan
APPROXIMATE TOTAL MEDICAL COSTS	$50,000	$50,000	$50,000
Katie's Share of Provider Costs*	$7,000	$8,000	$12,000 *(out-of-pocket maximum)*
Company HSA Contribution	N/A	N/A	($600)
Katie's Annual Premium for Family Coverage	$9,468	$7,584	$5,712
KATIE'S ESTIMATED TOTAL ANNUAL COST*	$16,468	$15,584	$17,112
HSA pre-tax savings opportunity	$0	$0	$7,700

** These costs are estimates only and are not exact figures.*

Health Tools for UHC Members

NEW FOR 2025!
Digital Physical Therapy with Hinge Health

Hinge Health is digital clinic designed to help support preventive, acute, chronic, and surgery recovery for back, muscle and joint health. You will receive unlimited visits from a team of licensed Doctors of Physical Therapy (DPT) and specialists (orthopedic surgeons, nurses, nutritionists and board-certified health coaches). Your therapist will work with you to design a program specific to your needs.

Your program may include: Exercise therapy sessions personalized to address your specific pain — taking as little as 10 minutes to complete through the Hinge Health app — and unlimited 1-on-1 health coaching via text, email or call to tailor the program to your needs.

Take Charge of Your Health with Rally

We support your efforts to adopt healthy lifestyle choices through a free, interactive program called Rally. This digital health tool helps you improve your wellness by making simple changes to your daily routine. Follow the easy steps to register and take a quick survey to receive your Health Score. Rally will recommend simple missions to help you improve your diet, fitness, and mood. The more you check in with Rally and track your progress the more Rally Coins you'll earn. Use these coins to enter to win cool prizes. Download the **Rally app** or visit **myuhc.com**.

Virtual Visits

UHC members have the ability to see and speak with a doctor anywhere, anytime on a mobile device or computer through the UHC website or mobile app. Doctors are able to diagnose a wide range of non-emergency medical conditions and prescribe medications, if needed. Scheduling a virtual appointment is easy to do, and you can be confident that you and your family receive safe, quality care. Visit **myuhc.com** or use the UHC app and schedule an appointment with a virtual provider. Be sure to complete your health history before your appointment.

*To schedule an appointment, you must register for an account through the UHC mobile app or on **myuhc.com**. Before your first appointment, you'll submit a medical history. Virtual visits are for minor medical issues only. For emergencies, call 911.*

Talkspace Brings Support to You

With Talkspace online therapy, you can regularly communicate with a therapist, safely and securely from your phone or desktop. **Effective 10/1/2024**, texting will no longer be available as part of the Talkspace offering. Members currently receiving asynchronous/text-based services will be able to continue through September 2024, and they will then transition to real-time, virtual face-to-face therapy sessions. Live video sessions are available when needed.

Talkspace is private, confidential, and convenient. Start by downloading the Talkspace app on your mobile phone or desktop computer. Then, simply register (first time only) and choose a provider at **talkspace.com/connect**.

Benefits will be applied according to the plan design and where you are in meeting your deductible. A provider's specific cost is listed on the site. You can use a credit card, HSA, or FSA card to pay the appropriate copay or provider fee according to your plan enrollment.

NEW FOR 2025! Calm Health

Calm Health is available to UHC members and their dependents (age 16 and older) at no additional cost.

This new wellbeing app provides UHC members access to content from Calm, as well as new features including mental health screenings, self guided learning modules, evidence-based content and referrals. Download the Calm Health app at **myuhc.com**.

Find the Right Treatment Path with 2nd.MD

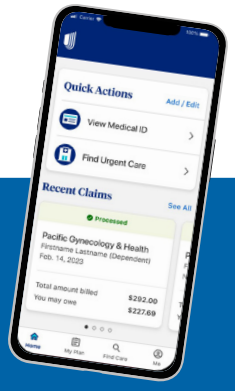
You and your family members enrolled in a UHC medical plan have access to 2nd.MD at no cost. With 2nd.MD, you can connect with board-certified specialists for a 20- to 30-minute consultation via phone or video, all within a matter of days.

Whether you are dealing with illness, injury, or chronic pain, 2nd.MD makes it easy to get the answers you need. 2nd.MD experts are industry leaders across hundreds of sub-specialties and thousands of conditions, like:

- Knee, hip, and back surgery
- Cancer
- Heart disease and stroke
- Digestive problems
- Immunological disorders (type 1 diabetes, rheumatoid arthritis)
- Mental health issues

2nd.MD's services are available at no cost to you and your dependents enrolled in a UHC medical plan. To activate your account and request a consult:

- Visit **2nd.md/login**,
- Call **1-866-269-3534**, or
- Download the 2nd.MD app via App Store or Google Play



Access UHC on the Go

Manage your UHC medical benefits from your computer, tablet, or mobile device.

1. Visit myuhc.com to access everything you need to get the most out of your benefits:
   - View plan and claim details
   - Find and price care
   - Improve your health with wellness tips
   - Chat with a nurse or member service advocates
   - Review your HSA balance via the Optum Bank link (if applicable)
2. Download the UnitedHealthcare app, a simple, convenient connection to information you need.
   - Scan Medical ID cards for easier registration
   - Monitor account balances
   - View copays and coinsurance
   - Access key plan details
   - Locate physicians and facilities
   - Monitor claim processing and payment

Medical Support Programs

Your UHC medical plan includes a variety of programs and resources that help you manage certain conditions.

Program/Resource	Description	Contact
Applied Behavioral Analysis (ABA)	• Support for families dealing with Autism Spectrum Disorder (ASD). • Services include diagnostic evaluations, medication management, treatment, and therapy. • Get paired with a provider that best meets your needs.	Call **1-866-894-5795** when you or a family member needs care. Also, visit **liveandworkwell.com**.
Bariatric Resource Services (BRS)	• Members receive high-quality specialty care from top providers at leading regional bariatric programs. • The BRS program combined with Centers of Excellence (COEs) is designed to increase the potential for success before and after surgery.	Call **1-866-679-0946** for information.
Cancer Care with Memorial Sloan Kettering Direct (MSK Direct)	• Concierge program for employees dealing with a cancer diagnosis who want to receive care at MSK or have a virtual consultation, including second opinions for cancer treatment.	Call Memorial Sloan Kettering Cancer Care at **1-833-825-4562**.
Cancer Support Program	• Get support from an experienced cancer nurse advocate while navigating through treatments for all types of cancer.	Call the Cancer Support Program **1-866-936-6002**.
Congenital Heart Disease Services	• Congenital heart disease usually involves complex surgical interventions. This program provides information and access to Centers of Excellence, recommendations for treatment options, and access to specialized nurses and physicians.	Call **1-866-679-0946** for information.
Decision Support*	• Offers advice and education for members with severe joint or back/spine pain or who need total knee or hip replacements or spinal surgery.	Call the Treatment Decision Support at **1-888-866-8295**.

Fertility Solutions Program	• This program combined with Centers of Excellence (COEs) is designed to increase the potential for successful outcomes.
	• You can receive coverage for infertility treatment:
	  • $20,000 lifetime maximum, if using a COE
	  • $8,000 lifetime maximum, if using a non-COE
	  • Fertility Drugs ($6,000 separate from the medical plan allowance)
	  • Covered medical expenses include IUI, IVF, and Assisted Reproductive Technologies (ART).
		Call the Fertility Solutions Program for help at **1-866-774-4626**.

Health Advocate	• 24-hour access to registered nurses who can answer your health questions and help you find a network doctor near you. You can also connect with a customer care professional who can answer questions about benefits and claims, available Monday through Friday, 8 a.m. to 11 p.m. Eastern Time.	Call **1-866-679-0946** or email **Advocate4Me@uhc.com**.
Maternity Support Program (MSP)* through Maven	• Offers pre-conception coaching, pre-natal care management and education, and post-partum support.	Visit **mavenclinic.com/join/IPG** or download the Maven app.

Mental Health and Substance Abuse Care	• Receive support for eligible inpatient and outpatient mental health and substance abuse care for:
	  • Depression
	  • Stress management
	  • Alcohol and drug dependency
	  • Eating disorders
	  • Autism diagnosis and treatment
	  • And more
	• All mental health and substance abuse expenses are subject to the same copays and coinsurance as other conditions.
		Call **1-866-679-0946** for information. Also visit **liveandworkwell.com**.
		Call the Substance Use Support Hotline at **1-855-780-5955.**

Neonatal Resource Services (NRS)	• Supports those with high-risk pregnancies through onsite and telephonic case management to help you choose the right NICU providers.	Call **1-866-679-0946** for information.
Talkspace	• Online therapy, regularly communicate with a therapist, safely and securely from your phone or desktop.	Visit **talkspace.com/connect**.
Transplant Resource Services	• Education, support, and guided access to Transplant Centers of Excellence from experienced nurses and physicians.	Call **1-866-679-0946**.

** If you meet all program criteria, you could receive a $100 gift card.*

Prescription Drug Coverage

All medical plans include prescription drug coverage through Express Scripts. Medications are categorized in tiers, as shown in the table below. Use the mail-order program to save money on your maintenance medications. Remember to give your ID card to your pharmacist when you fill a new prescription. Visit **express-scripts.com** or call **1-888-418-2589** for more information.

Type of Medication	Retail Pharmacy (30-day supply)	Mail-Order Program (90-day supply)
Generic	$10 copay	$20 copay
Preferred Brand	40% ($45 min, $100 max)	40% ($85 min, $225 max)
Non-Preferred Brand*	50% ($65 min, $130 max)	50% ($155 min, $305 max)
Annual Out-of-Pocket Maximum (OOPM)*	$2,000 individual/$4,000 family	

** Ancillary fees applied can exceed maximum.*

CDHP with HSA

You will pay the full cost of your prescription drugs until you meet the annual deductible ($2,000 / $4,000) the CDHP has an OOPM of $6,000 / $12,000. Then, your medications will be covered with the copays listed in the table. This plan provides coverage for certain preventive medications without having to meet the deductible.

As a CDHP user, you have access to a preventive drug list, which can be found at **interpublicbenefitsonline.ehr.com**.

How to Get Your Prescription Filled

Retail	Mail-Order
Short-Term Prescriptions	Maintenance Medication (Long-Term Rx)
Up to 30-day supply	90-day supply
Usually filled immediately	Arrives to your door within 14 days after your order

Specialty Pharmacy

Specialty medications are managed by Accredo, Express Scripts' specialty pharmacy. Accredo is responsible for providing home delivery of the specialty medications needed to treat complex conditions. In addition, Accredo provides access to support from licensed pharmacists and registered nurses, expedited/scheduled delivery, and helpful refill reminder calls.

How It Works

Your physician submits the prescription order to Express Scripts and Express Scripts will automatically route it to the specialty pharmacy, Accredo. If any type of prior authorization or clarification is required, Accredo will work with the physician in order to obtain any necessary information. This information will be used to determine if the specialty medication is appropriate for approval. Once the medication is approved, Accredo will process the prescription as submitted by the physician. **Note:** Accredo must receive the patient's permission to ship.

In the event your physician were to submit the prescription to your local retail pharmacy, the prescription would be denied and you would be instructed by your local pharmacy to contact Accredo at **1-800-903-8224**.

SaveOnSP Helps You Save On Specialty Rx

SaveOnSP works with Accredo to leverage manufacturer's copay assistance programs to provide savings to PPO members (CDHP members are not eligible). Since the copays for most specialty drugs are increasing significantly, SaveOnSP lowers your out-of-pocket costs for specialty medication. Enrollment in this program is voluntary, however, you will pay a higher copay if you do not enroll. A representative from the SaveOnSP program will automatically reach out to you if you are prescribed a drug that is part of this program. **Note:** If the patient does not enroll, they will pay 30% of the cost of the drug. This amount will not apply to OOP.

Save with the Mail-Order Program

Express Scripts' mail-order program saves you both time and money. If you are on daily medication for a chronic condition, such as asthma, diabetes, or high blood pressure, you are required to fill your prescription with the mail-order program. You'll receive a 90-day supply delivered right to your door. **If you do not switch to the mail order option after three fills at a retail pharmacy, you will be responsible for the full cost of the drug.**

Pharmacy Programs and Benefits

Split Fill
When receiving certain specialty drugs for the first time (e.g., cancer drugs), you will be provided half the allotted amount with the first fill. Then, after confirming the drug is effective for you, you can move to "full-fills" and receive the entire prescription. This will help reduce the amount of unused prescription drugs you purchase.

Step Therapy Program
Designed to help manage prescription drug costs, this program will apply when a generic or lower-cost equivalent prescription drug is available for certain brand name medications:

- Anti-inflammatories
- Sedatives
- Proton pump inhibitors
- Nasal steroids
- Topical acne medications
- Oral tetracyclines
- Topical corticosteroids

If you receive a prescription for one of these medications, your pharmacist will contact your doctor to request approval to dispense a generic alternative:

- **If approved,** you will pay the generic copay and then refill the prescription with the generic or the brand name drug.
- **If not approved,** you must pay the full cost of the medication initially and for all refills.

RationalMed® Program
This drug safety intervention program can help ensure you are receiving the correct medications and dosages; it not only improves your care, but also reduces costs. Through review of claims and diagnosis data, Express Scripts will share information with your doctor and pharmacist to alert them of any potential drug risks, omissions, or other gaps in care.

Rx Breast Cancer Prevention Program
We have reduced – and in certain cases eliminated – the copay for certain medications used for prevention of invasive breast cancer for members at high risk. For details regarding eligibility and which drugs are covered, contact Express Scripts at **1-888-418-2589**.

Drug Formulary

Express Scripts provides a list of prescription drugs, both generic and brand name, that identify drugs that offer the greatest overall value. For more information or to view the formulary, follow the steps below.

From your computer or mobile device:

1. Go to **express-scripts.com** or download the mobile app.
2. Click on **"Create Online Account"**.
3. Enter your information – be sure to have your member ID number ready – and create a log in.
4. Click on **"Register Now"** and you are on your way.

Prescription Drug Limitations

The Prescription Drug Plan does not cover over-the-counter (OTC) medications (medications that do not require a prescription).

Note that when receiving medications for acute illnesses (e.g., migraine headaches), you will be able to fill your prescription for your treatment cycle, but not beyond it.

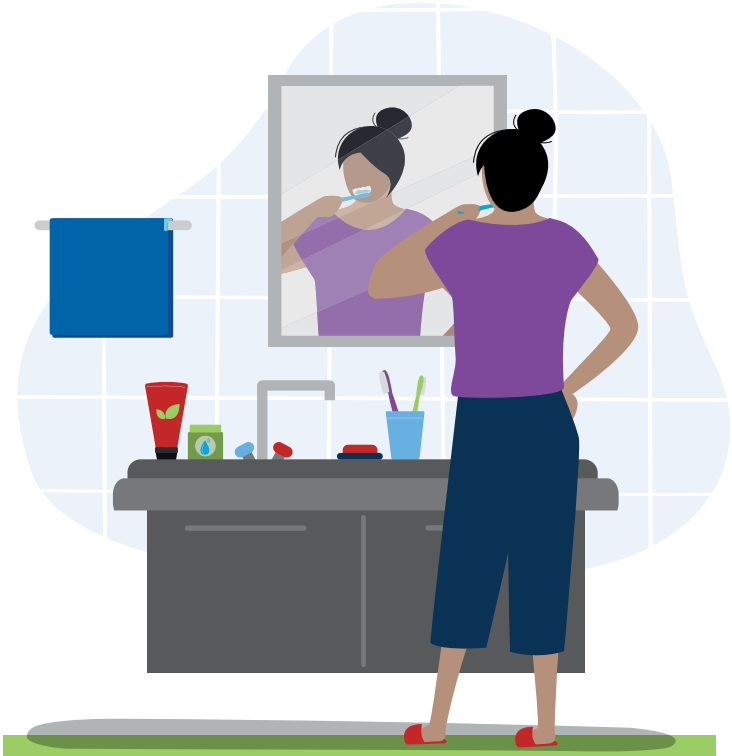
Other limitations may apply. For more information, please contact Express Scripts directly.

Prescription drugs are subject to formulary changes (i.e. moving from preferred to non-preferred, during the year). This may affect the cost of the drug.

Dental Coverage for a Bright Smile

You can choose between two dental options: the MetLife Preferred Dentist Program (PDP) and the Cigna DHMO. Both plans offer preventive care at no cost to you and have benefits for basic and major restorative service. There are a few differences between the plans:

- **How the PDP works:** The PDP allows you to take control of your choices when you need dental care. You have the freedom to visit both in-network and out-of-network providers; however, you will save money by staying in-network. You also have the freedom of visiting any in-network provider without selecting a Primary Care Dentist (PCD). Visit **metlife.com/mybenefits** for more information.
- **How the DHMO works:** When you enroll in the DHMO, you must choose an in-network provider; however; you are not limited by annual plan maximums. Most preventive services are covered at little to no cost when you visit an in-network DHMO provider. The Cigna DHMO is a dental plan that offers dental care and services through a network of participating dental providers. In most states, you must use a dentist in the DHMO network to receive coverage under this plan. There is no out-of-network benefit available, except in emergencies. This means you pay the entire cost for your dental care received out-of-network. You must select a dentist in the network prior to obtaining care, and you must show your dental ID card to your in-network dentist to receive services. Register on **mycigna.com** after your benefits begin on 1/1 for more information.



Money Saving Dental Tips

- Use the free preventive care to keep your mouth and gums healthy all year long.
- Use your FSA, LFSA, or HSA dollars to help pay for qualifying dental care out-of-pocket expenses.

Plan Features	MetLife PDP		Cigna DHMO
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK ONLY
Annual Deductible *(waived for Preventive Services)*	$50 individual $100 family	$150 individual $300 family	None
Annual Maximum Benefit *(per person)*	$2,500, including out-of-network expenses	$1,500, including in-network expenses	None
Diagnostic and Preventive Services *(e.g., X-rays, cleanings, exams)*	100% *(deductible waived)*	80% *(deductible waived)*	Some procedures are covered at 100%, while others require a copay; refer to the Cigna DHMO Patient Charge Schedule for a list of covered procedures and copays.
Basic and Restorative Services *(e.g., fillings, extractions, root canals)*	80% after deductible	65% after deductible	
Major Services *(e.g., dentures, crowns, bridges, implants)*	60% after deductible	50% after deductible	
Orthodontia	50%, no deductible	50%, no deductible	
Orthodontia Lifetime Maximum	$2,500, including out-of-network expenses	$1,500, including in-network expenses	None

Vision Coverage to See Clearly

Keep your eyes in good health with regular eye exams. You have the option of choosing between two VSP plans: VSP or VSP Plus. With your vision coverage, VSP offers an extensive network of optometrists and vision care specialists. You'll save money by visiting in-network providers. Find an in-network provider at **vsp.com**.

Money Saving Vision Tips

Use FSA, LFSA, or HSA dollars to pay for your exam copay and new eyeglasses or contacts.

Plan Features	VSP In-Network	VSP Plus In-Network	Out-of-Network
Eye Exams *(every calendar year)*	$25 copay for exam and glasses	$10 copay for exam and glasses	$45 allowance
Lenses *(every calendar year)*	Single vision, lined bifocal, and lined trifocal are covered in full after glasses copay.	Single vision, lined bifocal, and lined trifocal are covered in full after glasses copay.	Single Vision: $30 allowance Bifocals: $50 allowance Trifocals: $65 allowance
Lens Enhancements *(every calendar year)*	Standard progressive lenses: $0 Premium progressive lenses: $95 - $105 Custom progressive lenses: $150 - $175 Impact-resistant lenses for dependent children: $0	Standard progressive lenses: $0 Premium progressive lenses: $95 - $105 Custom progressive lenses: $150 - $175 Impact-resistant lenses for dependent children: $0	Up to $50
Frames	After glasses copay ($170 for featured frame brands) $150 allowance; 20% discount on amount over allowance, or $80 Walmart/Sam's Walmart®/ Sam's Club®/Costco® allowance One set every other calendar year per covered person	After glasses copay ($270 for featured frame brands) $250 allowance; 20% discount on amount over allowance, or $135 Walmart/Sam's Walmart®/ Sam's Club®/Costco® allowance One set every calendar year per covered person	$70 allowance
Contacts *(in lieu of eyeglasses every calendar year)*	$150 allowance*, plus 15% discount on contact lens exam	$250 allowance*, plus 15% discount on contact lens exam	$150 allowance*

** Annual allowance does not roll over to a new plan year. Allowance is for contact lens exam (fitting and evaluation) and contacts.*

VSP also offers discounts and preferred member pricing, in-network only, on the following:

- **Laser Vision Correction**
  - Average 15% off regular price or 5% off promotional price from contracted facilities
- **Glasses and Sunglasses**
  - Average 30% savings on lens options, like progressives and anti-reflective coating
  - 20% off additional glasses and sunglasses (from any VSP doctor within 12 months of the last covered eye exam)
- **Retinal Screening**
  - No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam
- **Essential Medical Eye Care**
  - $20 copay for additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more
  - $0 copay retinal screening for eligible members with diabetes

For more details or to find an in-network provider contact VSP directly at **1-800-877-7195** or visit **vsp.com**.

VSP EasyOptions

The VSP Plus Plan offers EasyOptions℠, a feature that lets each plan member choose the enhanced eyewear option that is right for them. Members may choose one of the following options:

- $50 increase to a possible total of $300 frame allowance
- Light-reactive lenses fully covered
- Anti-glare coating fully covered
- Progressive lenses fully covered
- $50 increase to a possible total of $300 contact lens allowance

Your 2025 Monthly Cost for Coverage

IPG shares in the cost of health care coverage. Below is your cost for monthly coverage based on the plan and coverage level you choose.

	Employee	Employee + Spouse*	Employee + Child(ren)*	Family*
MEDICAL				
UHC PPO 1	$286.00	$655.00	$594.00	$956.00
UHC PPO 2	$228.00	$523.00	$480.00	$766.00
UHC CDHP with HSA	$113.00	$416.00	$390.00	$577.00
Kaiser N CA	$224.06	$497.25	$452.19	$716.58
Kaiser S CA	$224.06	$497.25	$452.19	$716.58
DENTAL				
MetLife PDP	$19.00	$43.00	$39.00	$62.00
Cigna DHMO	$10.35	$23.67	$24.77	$39.26
VISION				
VSP	$7.70	$10.85	$11.61	$18.57
VSP Plus	$18.44	$26.00	$27.82	$44.41

* **Please note:** *If you are covering a domestic partner and/or the children of a domestic partner, you must pay for their coverage on an after-tax basis. The Company's portion of the cost for their coverage will be considered imputed income to you, and the value of that imputed income will be included in your wages for tax purposes.*

Are You Leaving Money on the Table?

Since most people focus only on the core benefits, medical, dental, and vision, they may be missing out on free or low-cost benefits that IPG offers. These benefits include:

- **Tax-Free FSA Dollars:** Pay for health care and dependent care expenses while lowering your taxable income. You'll keep more money in your wallet. (**See pages 24-26**)
- **Tax-Free Transportation and Parking Dollars:** Buy transit passes and parking cards with pre-tax dollars, and keep the change. (**See page 27**)
- **Income Protection:** IPG automatically provides short-term disability, long-term disability, and life insurance at no cost to you. (**See pages 28-31**)
- **Accident Protection:** Receive Business Travel Accident Insurance at no cost to you when traveling on Company business. (**See page 33**)
- **Savings Plan:** Retirement plan where the Company matches contributions based on your personal contribution level. (**See page 35**)

Tax Savings Accounts

Flexible Spending Accounts (FSAs)

IPG offers two flexible spending account (FSA) choices through HealthEquity/WageWorks as a smart and convenient way to stretch your benefit dollars and receive real tax savings: Health Care Spending Account (full purpose and limited purpose) and Dependent Care Spending Account.*

Expenses such as deductibles and copays can add up quickly, and dependent care costs can be even more expensive. FSAs let you pay these expenses with pre-tax dollars, so you save money. Your contributions will be deducted from your paychecks in equal installments throughout the year and deposited into your account(s). Visit **healthequity.com** for more information.

** Pre-tax applies to federal taxes, but not all state taxes.*

Don't forget!

- The FSA plans are not interchangeable.
- You must enroll in each separately and funds are non-transferrable.
- These are "use-it-or-lose-it" plans. Funds do not roll over and must be applied to expenses incurred during the 2025 plan year.
- You have until March 31, 2026 to submit claims.

Health Care FSA
HealthEquity/WageWorks offers a better way to save and spend on expenses at health care providers and eligible over-the-counter items. Through the Health Care FSA (HCFSA) you can pay for health care related expenses by swiping your Health Care Card at the point of service or submit a claim for reimbursement. Once enrolled you may contribute a minimum of $120 up to a maximum of $3,200 per plan year on a pre-tax basis. Remember, health care related expenses must be incurred during the plan year to be eligible. If you leave the Company and terminate coverage, expenses must be incurred prior to the termination date. Visit **healthequity.com/fsa-qme** for more information.

Limited Purpose FSA
With the Limited Purpose FSA, CDHP with HSA participants have another tax-advantaged account to save for eligible expenses. You are allowed to set aside a minimum of $120 up to a maximum of $3,200 per plan year on a pre-tax basis to pay for eligible dental and vision expenses with your Health Care Card or pay out-of-pocket and submit a reimbursement claim. Dental and vision expenses must be incurred during the plan year to be eligible. Any funds remaining at the end of the plan year will be forfeited. Since the LFSA is a "use-it-or-lose-it account," consider using these funds first to pay for dental and vision expenses before using your HSA dollars. Visit **healthequity.com/fsa-qme** for more information.

Dependent Care FSA
The Dependent Care FSA (DCFSA) through HealthEquity/WageWorks is a smart way to save and spend pre-tax dollars on eligible dependent care expenses while you work. Eligible dependents under the program include your children up to the age of 13 or family members of any age if they are physically or mentally incapable of self-care. You may contribute a minimum of $120 up to a maximum of $5,000 ($2,500 if married and filing an individual tax return.) There are two convenient ways to pay: out-of-pocket and submit a claim for reimbursement, or have HealthEquity/WageWorks pay your provider directly. Claims will not be paid until service is rendered and are reimbursed up to the amount in your account at the time. Visit **healthequity.com/fsa-qme** for more information.

FSA Enrollment

Each year you want to participate in the FSAs, you must actively enroll. Your current elections do not roll over. Once you enroll in the FSA, you can only change your contribution amount if you experience a qualified status change. Remember, each account functions separately. You cannot transfer funds from one FSA to another. Expenses incurred by domestic partners are not covered under the FSA plans. You do not need to be enrolled in a medical plan through IPG to enroll in an FSA.

Please note: *If you are on a leave of absence, your Dependent Care FSA deductions stop, and you cannot submit claims. Enrollment resumes once you return to an eligible work schedule.*

How FSAs Work

1

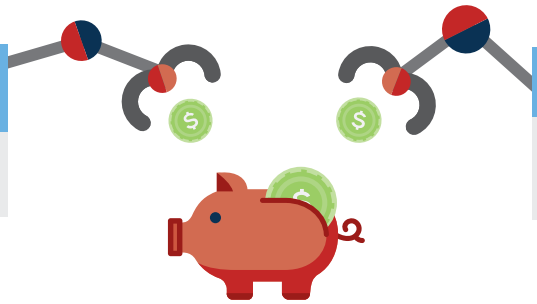
CONTRIBUTE

HEALTH CARE FSA AND LIMITED PURPOSE FSA*

Up to $3,200 per year pre-tax**

DEPENDENT CARE FSA*

Up to $5,000 per year pre-tax**
($2,500† if married filing separately)



Eligible Expenses

Health Care FSA: Medical, pharmacy, dental and vision deductibles, copays, and other out-of-pocket costs.

Limited Purpose FSA:
Dental and vision costs ONLY

INCUR EXPENSES BY
DECEMBER 31, 2025

2

USE IT OR LOSE IT

Eligible Expenses

Daycare for children under age 13, disabled children of any age, and dependent adults

Daytime summer camp

Nursery school

INCUR EXPENSES BY
DECEMBER 31, 2025

Use your FSA debit card at the point of service (for Health Care FSA and Limited Purpose FSA expenses only)

INCUR EXPENSES BY
DECEMBER 31, 2025

3

COLLECT

Submit receipts and documentation for reimbursement at **wageworks.com**

SUBMIT ALL CLAIMS BY
MARCH 31, 2026

** FSAs are subject to discrimination testing under IRS rules and the maximum amount that you can contribute in a plan year may be reduced. You will be notified if any changes in your contributions need to be made.*

*** Pre-tax applies to federal taxes, but not all state taxes.*

FSA Worksheet

The worksheet below can help you figure out how much you should contribute to your FSAs.

Health Care Expenses	Amount
Annual deductible and coinsurance (medical and dental)	$
Copays (office visits and prescription drugs)	$
Expenses above health care benefit limits	$
Out-of-pocket vision care expenses	$
Out-of-pocket dental or orthodontia expenses	$
Other expenses not paid by your health care plans	$
ANNUAL TOTAL	$

You may contribute between $120 – $3,200 to the Health Care FSA.

Health Care

- Deductible, copays, and your share of coinsurance
- Prescriptions and over-the-counter medications with a prescription from your doctor
- **Dental care –** cleanings, fillings, exams, and even orthodontia
- **Eye care –** eyeglasses, exams, contact lenses, LASIK, and contact lens care
- Alternative medicine treatments such as chiropractors and acupuncturists

Limited Purpose FSA – Dental and Vision Expenses	Amount
Annual deductible and coinsurance for dental	$
Out-of-pocket vision care expenses	$
Out-of-pocket dental or orthodontia expenses	$
ANNUAL TOTAL	$

You may contribute between $120 – $3,200 to the Limited Purpose FSA.

Limited Purpose

- **Dental care –** cleanings, fillings, exams, and even orthodontia
- **Eye care –** eyeglasses, exams, contact lenses, LASIK, and contact lens care

Dependent Care Expenses*	Amount
Day care provider	$
Home care of your child or other dependent	$
Preschool tuition up to kindergarten	$
After school care	$
Elder care expenses	$
ANNUAL TOTAL	$

You may contribute between $120 – $5,000 (or $2,500 if you are married and filing separate tax returns) to the Dependent Care FSA.

Dependent Care

- Licensed nursery school or qualified child care center
- After school care
- Adult day care center of household services for care or an elderly or disabled dependent adult living with you
- Day camp
- Nannies or babysitters inside your house during working hours

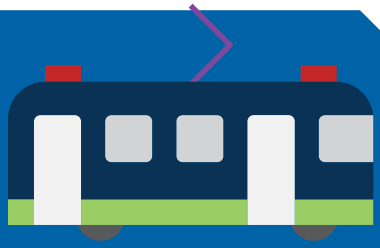
For a complete list of eligible expenses, refer to IRS Publications 502 and 503 at **irs.gov**.

** Before enrolling in the Dependent Care FSA, talk to your tax specialist about how your enrollment will impact the federal dependent tax credit.*

Transportation Management Program

With the Transportation Management Program through HealthEquity/WageWorks, you can pay for your transit and parking expenses with pre-tax dollars, which lowers your taxable income. You can contribute up to $325 in pre-tax dollars each month. If your pass costs more, the amount over $325 will be deducted from your paycheck on an after-tax basis. All commuter orders must be placed by the 10th of each month at 11:59pm ET for the following month. (No exceptions can be made for missed commuter order deadlines.)

How the Transportation Accounts Work



Buy My Pass
Choose the pass you want to buy and HealthEquity/WageWorks will deliver it to your home each month. You can also ask HealthEquity/WageWorks to pay the provider directly on a continuous basis. You can change this at any time.

HealthEquity/WageWorks Transit Card
Use the HealthEquity/WageWorks Commuter Card to pay for transit passes and tickets at most commuting-related point of purchase locations. You decide the amount of money to load onto your card each month to cover your monthly commuting costs. If the pass is not available, you may be eligible to receive reimbursement for your expenses.

How the Parking Accounts Work

Pay My Parking
HealthEquity/WageWorks will send a payment directly to your parking garage each month on your behalf. All you have to do is make a one-time request that can be canceled any time.

Pay Me Back
You can also choose to pay for your parking expenses out of pocket and be reimbursed. Complete a claim form and provide proof of service each month. If your parking provider doesn't supply receipts, you can submit an online claim instead.

Parking Account
Receive reimbursement for your eligible work-related parking expenses. Covered expenses include the cost for a parking facility at or near your place of work, or a mass transit facility, such as a train or bus station. Keep in mind that you cannot use the Parking Account for your dependents.

HealthEquity/WageWorks Parking Card
Use the HealthEquity/WageWorks Commuter Card associated with your account to pay for parking. You choose the amount, up to $325 per month, to load on your card to pay for parking costs. If an order is placed for both the HealthEquity/WageWorks Transit Card and HealthEquity/WageWorks Parking Card, two separate cards will be received – one labeled **"Transit"** and one labeled **"Parking."**

** Pre-tax applies to federal taxes, but not all state taxes.*

Access Your HealthEquity/WageWorks FSA or Transportation Account

1. Visit **healthequity.com** and click on **"Employee Registration"** under **"Log In/Registration."**
2. Enter the required information to authenticate your access, i.e. ID Code = last 4 digits of the Social Security number, home zip code, and date of birth.
3. Create a username and password and ensure your address information is correct.
4. Enter a phone number and email address.
5. For reimbursement directly to your bank account, please enter your information in the appropriate boxes.
6. Read the User Agreement and confirm your acceptance.

Protect Yourself and Your Loved Ones

Basic Life Insurance

You automatically receive basic employee life insurance coverage through MetLife at no cost to you. The benefit is one times your annual base pay, up to a maximum amount of $250,000, rounded to the next highest $1,000.

Keep in mind that coverage amount over $50,000 is considered imputed income and is subject to taxes which is reflected in your paycheck. To avoid this, you can choose a maximum coverage amount of $50,000. Carefully consider the tax implications of your options before you choose.

Optional Life Insurance

You may purchase additional life insurance for yourself, your spouse and your children at group rates, as described in the table below. Evidence of Insurability (EOI) may be required if you add or increase your elections outside of your initial enrollment period.

Covered Person	Life Insurance Amount	Guarantee Issue Amount*
Employee	Up to 8x annual salary. (in addition to the basic life coverage amount)	**Newly Eligible:** 3x pay or $500,000 **Established Participant:** Can only increase your coverage by 1x pay per year (up to a maximum of 3x pay) per year without EOI.
Spouse/Domestic Partner	Up to $100,000 in $10,000 increments (cannot exceed employee coverage amount)	**Newly Eligible:** $50,000 **Established Participant:** Can only increase your coverage by $10,000 but cannot exceed $50,000
Children**	Choose either $5,000 or $10,000 per child (covers all eligible dependents with one cost)	$10,000

** Guarantee issue amount is the maximum amount of coverage you can elect without needing to submit Evidence of Insurability.*
*** You may cover your children from the age of 15 days old to age 23 years old. If a full-time student up to age 26 years old.*

Please note: *The cost of coverage under employee optional life insurance is determined based on age ranges set by MetLife. Since the cost of coverage for 2025 is based on your age at enrollment, your cost could increase during the year if your age increases to the next higher age range during the year. In addition, if your pay increases or decreases during the year, your coverage amount will be adjusted accordingly since your coverage amount is a multiple of your pay.*

Evidence of Insurability

You may be required to provide Evidence of Insurability (EOI) if you elect a coverage amount over the guarantee issue amount. You will be notified if you need to provide proof of good health. If satisfactory EOI is not provided, the coverage requiring EOI will remain at the lowest threshold that does not require EOI.

Beneficiary Designation

You must choose a beneficiary for life and AD&D insurance. Keep your beneficiaries up-to-date by logging on to **interpublicbenefitsonline.ehr.com**.

You are automatically the beneficiary if your spouse/domestic partner or child dies while covered under these Plans.

Accidental Death & Dismemberment (AD&D) Insurance Plan

You also have the option to purchase additional protection for AD&D. This plan provides coverage if you suffer certain injuries or die as the result of an accident. This elected plan will pay benefits in addition to life insurance. Depending on the type of physical loss, you may receive part or all of your benefit. In the event of your death, your beneficiary would receive the full benefit amount. You can elect AD&D coverage for yourself and your family through AIG in the following amounts to a maximum of 10x your base salary:

- $50,000
- $75,000
- $100,000
- $150,000
- $200,000
- $250,000
- $500,000
- $750,000
- $1,000,000

If you choose family coverage, keep in mind that your spouse and children's coverage amount are different from yours:

Spouse/Domestic Partner

- **If you have no children:** 60% of coverage amount you choose
- **If you have children:** 50% of coverage amount you choose

Children from birth up to 26 years old*

- **If no spouse/domestic partner:** 20% of coverage amount you choose up to $200,000
- **If spouse/domestic partner:** 15% of coverage amount you choose up to $150,000

** Coverage begins at birth as long as premiums are paid within 30 days of birth.*

Money Saving Life Insurance Tips

Enroll in the amount of life and AD&D insurance you need on **interpublicbenefitsonline.ehr.com**. Take advantage of the group rates offered to get the best deal on your coverage. While it may seem like a stretch to your monthly budget, investing in insurance gives you peace of mind and the financial protection you need.

Note: *Exclusions may apply. For example, an accident resulting from a non-commercial flight would not be covered. Please consult the policy for details.*

How AD&D Works

If you choose AD&D coverage and you or a family member suffers an injury or dies as a result of an accident, the Plan will pay the following benefits:

If you or your covered family member suffers a loss of:	You	Your spouse or domestic partner	Your children
Life	100% of your coverage amount	100% of your coverage amount	100% of your coverage amount
Two or more of the following: hand, foot, sight in one eye, or speech and hearing	100% of your coverage amount	100% of your coverage amount	200% of your coverage amount; except for loss of one hand and sight in one eye
One hand, one foot, sight in one eye, speech or hearing	50% of your coverage amount	50% of your coverage amount	100% of your coverage amount
Thumb and index finger of the same hand	25% of your coverage amount	25% of your coverage amount	50% of your coverage amount

Please note: *If you do not designate a beneficiary, the beneficiaries you designate under the life insurance plan will be your beneficiaries under the AD&D insurance plan.*

Disability Income Protection

Protecting your income in the event of a disability is an important part of your financial wellbeing. Most of us insure our homes, automobiles, and other assets, yet we often overlook our most valuable asset – our ability to earn an income. Your regular monthly obligations such as your mortgage or rent, utility bills, food, and other necessities, continue even if you are unable to work. Eligible employees automatically receive short-term and long-term disability coverage at no cost.

Short-Term Disability (STD)

The Short-Term Disability (STD) plan, administered by The Hartford, protects your income in the event of an illness or injury. The STD Plan pays a percentage of your weekly base earnings for up to 26 weeks when you are unable to work due to a qualifying non-work-related illness or injury. Benefits eligible employees become eligible for STD at no cost after one month of service.

Years of Service	Number of Weeks with 100% of Pay	Number of Weeks with 50% of Pay
1 month – 4 years	6 weeks	20 weeks
5 – 9 years	8 weeks	18 weeks
10+ years	13 weeks	13 weeks

STD benefits will be reduced by any benefits you may be eligible to receive under a state disability plan.

To receive STD payments, you must report your illness (where applicable) to your supervisor, your Human Resources Representative, and to the Plan Administrator, The Hartford Insurance Company in order to receive approval. Contact your Human Resources Representative for details.

Coordination with Other Benefits
Please note that STD and Employee and Family Leave (EFL), if applicable, benefits paid through IPG will be reduced by any benefits you may be eligible to receive under a state disability or paid family leave plan. Many states currently have state disability and/or paid family leave plans. Each state has its own application procedure, so it is important to contact your Human Resources Representative for details.

For additional information on STD and EFL, contact your HR Representative or The Hartford at **1-866-432-6723** and note **Policy #395044**.

Long-Term Disability (LTD)

The Long-Term Disability (LTD) plan is designed to begin when your STD benefits end. If you have an illness or injury that prevents you from working for more than 180 days, LTD pays a portion of your monthly income.

You automatically receive basic long-term disability at no cost to you. You also have the option of purchasing optional LTD coverage for an additional 10% LTD benefit. Benefits are payable while you remain disabled up to age 65, or longer if you are disabled after age 60. LTD benefits are offset with other sources of income, such as Social Security and workers' compensation.

Long-Term Disability Options	
Basic Long-Term Disability	50% of pay, up to a monthly maximum benefit of $5,000
Optional Long-Term Disability	60% of pay, up to a monthly maximum benefit of $25,000 (including the Basic Long-Term Disability benefit)

What You Need to Know about Optional LTD

Cost of Coverage

The cost of coverage under employee optional long-term disability is determined based on age ranges set by The Hartford. Since the cost of coverage for 2025 is based on your age at enrollment, your cost could increase during the year if your age increases to the next higher age range during the year. In addition, if your pay increases or decreases during the year, your coverage amount will be adjusted accordingly since your coverage amount is a percentage of your pay.

Evidence of Insurability (EOI): You may be required to provide EOI, also known as proof of good health, if you enroll after your initial eligibility period or select optional long-term disability during a qualified family status change. If satisfactory EOI is not provided, the coverage requiring EOI will remain at the basic LTD level.

Duration of Benefits: If you are disabled and begin receiving long-term disability plan benefits, the payments will continue while you are disabled up to the following limits:

Age when Disabled	Maximum Duration of Benefit Payments
Before age 63	To Normal Retirement Age* or 42 months, if greater
63	To Normal Retirement Age* or 36 months, if greater
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 and over	12 months

** Normal Retirement Age means the Social Security Normal Retirement Age as stated in the 1983 revision of the United State Social Security Act.*

Coordination with Other Benefits

LTD benefits are coordinated with any benefits you receive from other group disability plans (like Social Security or workers' compensation). If you are eligible to receive benefits under the long-term disability plan, the total benefit you receive from all disability plans will equal either 50% or 60% of your pay, based on whether you choose to elect employee optional long-term disability coverage.

Any long-term disability benefits you receive from an individual policy you purchase on your own outside the IPG Benefits Program are paid in addition to any benefits you are eligible to receive under the IPG long-term disability plan. Benefits from an individual policy will be paid according to that policy and will not offset any benefits you receive from the long-term disability plan.

Additional Voluntary Benefits

Round out your coverage with benefits that offer financial protection and assistance with all areas of life. You have an opportunity to enroll in these plans during the annual open enrollment period. Deductions for these options appear as IPG Best on your paystub and are after-tax. Please refer to the plan summaries for exclusions and limitations.

Critical Illness

Critical Illness coverage provides a way for you to stay ahead of the medical and out-of-pocket expenses that can accompany certain covered medical events. Most medical plans provide coverage for hospital and medical expenses associated with critical illnesses. Expenses for conditions such as stroke, heart attack, kidney failure, major organ transplant, or coma can be financially devastating. With Critical Illness coverage, you can be prepared financially for costs like:

- Copays, deductibles, and coinsurance
- Possible transportation and lodging needs
- Childcare and other domestic help expenses
- Possible loss of income

You'll receive a lump sum to use any way you want.

Accident Insurance

Accidents happen when you least expect it. You never know when you will break a bone or injure your back. With Accident Insurance through MetLife, you can be prepared to cover the out-of-pocket expenses that may occur due to a non-work-related injury. Accident Insurance provides a lump sum payment based on the accident/injuries sustained, so you can have the peace of mind knowing you are financially covered. The benefit is paid directly to you, and you decide the best way to spend it. It's that simple. Whether it's to pay medical expenses, the mortgage, car payments, or even utility bills, you decide. Other advantages of Accident Insurance include the following:

- You'll receive cash benefits for expenses that may not be covered under your medical insurance
- There are no health questions to answer
- You can insure your spouse and children
- There is no limit to the amount of accidents you can claim under the policy (with exception to policy rules)

Life Insurance with Long-Term Care (LTC)

At any time, you or someone you love could be diagnosed with a chronic illness or disability and suddenly need long-term assistance. Long-Term Care (LTC) coverage is an optional, voluntary benefit that can offer significant help — and peace of mind — if you need to pay for costly in-home or nursing care.

With LTC insurance through Trustmark*, you're provided a monthly dollar benefit to help pay for the costs of long-term care not covered by your health insurance, disability insurance, Medicare, or Medicaid. The plan also provides a life insurance benefit that's separate from — and in addition to — other life insurance you may have (such as IPG's Life Insurance & Accident Insurance offerings). Simply answer a few short medical questions and receive coverage up to $300,000.

For more information, call **1-866-564-5454** or email **ipgbest@corestream.com**. To enroll, visit **ipgbest.com**.

** The LTC Benefit is an acceleration of the death benefit and is not Long-Term Care Insurance (except in LA and VA, where the LTC benefit is Long-Term Care Insurance). It begins to pay after 90 days of confinement or services, and to qualify you must meet conditions of eligibility for benefits. The LTC benefits provided by this policy may not cover all of the policyholder's LTC expenses. Pre-existing condition limitation may apply. Your policy will contain complete details.*

Identity Theft Assistance

Protecting your personal information has become a major concern. Identity Theft Assistance helps you every step of the way – from monitoring your credit to assisting you in restoring your credit if you are the victim of identity theft. You'll also receive help with the following:

- Notifying agencies and creditors
- File reports quickly with the Federal Trade Commissions, creditors and the Social Security Administration

Help restore your identity with legal consultations, replacing checks and credit cards, and providing translation services.

Save Money on Everyday Items

IPG Best offers online discounts from a variety of retailers and programs. The next time you're in the market for appliances, furniture, computers, or anything else, check out **IPGbest.com** to save money.

Hospital Indemnity Insurance

While your medical insurance provides coverage for hospital services, expenses from a hospital stay can be costly. With Hospital Indemnity Insurance through MetLife, you will receive a lump sum benefit depending on the length of your hospital stay. Funds are paid directly to you, and you can use them to pay medical expenses, out-of-pocket costs like childcare or transportation, and any other needs you may have.

You have two Hospital Indemnity plan options: the Low Plan and the High Plan.

Type of Benefit	Benefit Limits	Benefit	Low Plan	High Plan
Admission Benefit	1 time per sickness / injury	Admission	$500	$1,000
		ICU Supplemental Admission (paid concurrently with the admission benefit)	$500	$1,000
Confinement Benefit	15 days per calendar year (ICU Supplemental Confinement will pay an additional benefit for 15 of those days)	Confinement	$100	$200
		ICU Supplemental Confinement (paid concurrently with the confinement benefit)	$100	$200
Newborn Confinement Benefit	2 days per confinement	Newborn Confinement	$25	$50
Inpatient Rehabilitation Benefit	15 days per calendar year	Inpatient Rehabilitation (for injury or sickness)	$100	$200

Group Legal

You have the option of purchasing a legal services program by MetLife Legal Plans through after-tax payroll deductions. With a wide network of attorneys, you have the freedom to choose where to receive legal services. When you stay in-network, most legal assistance is covered at 100%. With this program, you have access to attorney resources and referral services for legal advice and support including:

- Preparation of wills and trusts
- Adoption proceedings
- Family law
- Debt matters
- Real estate needs
- Document Preparation

Your coverage includes unlimited in-network telephone advice and office consultations.

Find an Attorney

Contact MetLife Legal Plans to find an in-network attorney near you:

Web site: **info.legalplans.com**
Call: **1-800-821-6400**

Group Home and Auto Insurance

Farmers GroupSelect (formerly known as MetLife Group Home and Auto) provides you with access to insurance coverage for your personal insurance needs. Policies available include auto, condo, renter's, boat, personal excess liability, and more.

To review more information about the benefits available to you as an employee, visit **IPGbest.com**. Or, for your free no-obligation quotes call Farmers GroupSelect at **1-800-438-6381**.

Pet Insurance

Your pets can also receive coverage to stay healthy. Voluntary Pet Insurance helps you be financially prepared, as veterinary bills can add up quickly. With Pet Insurance from Nationwide, you can save money on everything from wellness to unexpected veterinary expenses.

More than one pet? You'll save even more when you enroll additional pets. Sign up at **IPGbest.com** to receive a 5% discount.

Additional Support and Resources

Business Travel Accident

When you travel for business, you are automatically enrolled in Business Travel Accident Insurance, which covers any accidents or losses incurred when traveling for business. Your dependents are also covered when they travel with you on authorized business or while they are involved in relocation.

Covered Person	Business Travel Accident Amount
Employee	10x base earning with a minimum of $100,000 up to a maximum of $1,000,000
Spouse	$50,000
Children	$25,000

Family Building Support with Maven

Maven provides 24/7 virtual support for the family building journey and all paths to parenthood including preconception, fertility, adoption, surrogacy, pregnancy, postpartum, returning to work, and pediatrics. You can use Maven to book coaching and educational video appointments with providers across more than 30 specialties, including OB-GYNs, Mental Health Specialists, and Sleep Coaches; get personalized resources for you and your family; and connect with other working parents.

Employees have access to these services at no cost:

- **Personal Care Advocate**
  A personal health care advocate who can answer questions about your benefits, recommend the right practitioners for your needs and refer you to in-person, in-network doctors.
- **On-demand video and virtual appointments with top-rated practitioners**
  Unlimited coaching and education video appointments and messaging with Maven OB-GYNs, Mental Health Specialists, Prenatal Nutritionists, Lactation Consultants, Career Coaches, and many others.
- **A library of expert content, personalized to your journey**
  Receive trustworthy content tailored to you on topics like prenatal health, postpartum depression, and returning to work with confidence.
- **Maven Milk**
  Breastmilk shipping service for new parents that have to travel when they return to work.

Employee and Family Leave

To further support employees when they need to care for their loved ones, IPG offers Employee and Family Leave (EFL). After one month of service, employees are eligible for twelve weeks of leave paid at 100%. EFL can be used to:

- Provide 100% pay for any qualified FMLA leave that is otherwise unpaid (e.g., baby bonding, adoption, caring for a family member as defined under FMLA)
- Provide 100% pay for the employee's own health condition that is covered under FMLA but does not meet the requirement of the STD policy (e.g., intermittent medical treatment lasting for less than five continuous days)
- Supplement 50% STD days when the leave is for an employee's own medical condition

Any applicable state benefits that an employee receives, e.g., Paid Family Leave, will be offset from EFL payments.

Maven Wallet

We know that planning a family can be expensive and overwhelming. To ease the financial burden and give you peace of mind, take advantage of the Family Building Benefit, through Maven Wallet.

Employees are eligible for:

- Up to $10,000 per year for egg or sperm freezing
- Up to $10,000 per adoption or surrogacy event

Employees are automatically eligible for this plan, however, to be eligible to be reimbursed for egg and sperm freezing expenses you must be enrolled in an IPG medical plan.

Maven Wallet allows for easy expense management through the app where you can upload receipts and receive status updates for your submissions.

Reimbursements for surrogacy or elective egg or sperm freezing costs are included in wages for tax purposes and are subject to withholding. Except for certain adoption-related reimbursements that are excluded from taxable income, the net amount paid will be less than 100% of qualified expenses. Please access the Maven Wallet document at mavenclinic.com for a complete list of eligible expenses, exclusions, and other important tax information.

Get on track to reach your 401(k) goals and look forward to your financial future.

What's your story? It's more than a question. It represents your personal journey toward your financial future and all the experiences you expect to have once you get there. Through IPG's partnership with Empower, the record keeper and administrator of the IPG Savings Plan, you have access to online tools and resources to help you reach your goals and be financially prepared for your next chapter.

You can contribute pre-tax, Roth 401(k), or a combination of both, up to the annual Internal Revenue Service (IRS) maximums. If you will be 50 or older, you can also make additional "catch-up" (pre-tax and/or Roth 401(k) contributions. Be sure to check **empowermyretirement.com** for the limits as they change annually.

Still not sure? Consider the following:

Matching contributions are like free money, and combined with your savings, they are another way to add more to your future.

You receive 50% of the first 6% of your eligible pay that you contribute each pay period

And you will receive 75% of the first 6% of your eligible pay that you contribute each pay period after 10 years of service

Remember, while you are always 100% vested in your own contributions, you become 100% vested in the matching contributions after completing three years of eligible service.

Now do the math!

To receive the maximum matching contribution, you must contribute at least 6% of your eligible compensation each pay period. If you reach your contribution limit before the end of the year, you could miss out on company matching contributions.

If you contribute a higher percentage each pay period and reach your contribution limit before year-end, you would receive less company match than if you had spread your contributions out over the year. For example, let's say you contribute 30% of your eligible compensation each pay period and reach the IRS limit in September. You would receive the company match for the pay periods when you make contributions—through September—but you would not receive any matching contributions for the pay periods after you reach the limit.

It's your story.

Remember, if you participated in a plan with a prior employer, it is your responsibility to ensure you do not contribute more than the IRS maximum for the year. If you exceed the IRS annual limit, you must contact Empower no later than March 1 of the following calendar year to receive a refund of excess contributions. If you are rehired within 30 days and payroll deductions haven't resumed, contact your HR partner or Empower. It is your responsibility to review your paystub to ensure that the contribution you elected is deducted accurately.

Choose how and when you want to access financial education!

While you're always the author of your own story, there are a variety of educational opportunities at **empowermyretirement.com** intended to help you write an uplifting chapter for your financial story.

As your financial goals change, your investments should, too.

IPG offers different paths to help you build a long-term investment portfolio to fit your financial goals, time horizon, and feelings about risk. Regardless of your investing experience and comfort level, you can stay on the path to your retirement income goals as they evolve. To find out which path that's right for you and to learn more about your investment options or for details on the Professional Management Program and Online Advice, log on to **empowermyretirement.com** or call **1-844-866-4IPG** (1-844-866-4474).

Managing your story.

Log on to **empowermyretirement.com** or call **1-844-866-4IPG** (**1-844-866-4474**) to add your personal email to ensure you receive account information no matter where you are. Add a beneficiary, person(s) who would receive your benefits should something happen to you. You should keep your personal email address and beneficiaries as up-to-date as possible.

Important Legal Notices

IPG is required to provide employees with the following regulatory information annually. Please review this information carefully as you consider your benefit options.

HIPAA Privacy Provisions

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in Interpublic's Notice of Privacy Practices, which was distributed to you and is available upon request from your Human Resources Representative. A copy is also available on Inside Interpublic under Legal Notices.

Women's Health and Cancer Rights Act of 1998 (WHCRA)

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan you elect. If you would like more information on WHCRA benefits, call your Human Resources Representative.

Newborns and Mothers Health Protection

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

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (1-855-692-7447)

CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program
Website: http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/ State Relay 711
CHP+: https://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – Medicaid and CHIP
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: 678-564-1162, Press 2

INDIANA – Medicaid
Health Insurance Premium Payment Program
All other Medicaid
Website: https://www.in.gov/medicaid/
http://www.in.gov/fsaa/dfr
Family and Social Services Administration
Phone: 1-800-403-0864
Member Services Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid
Medicaid Phone: 1-800-338-8366
Hawki Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki
Hawki Phone: 1-800-257-8563
HIPP Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid and CHIP
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP)
Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kynect.ky.gov
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Website: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/health-care-coverage/
Phone: 1-800-657-3672

MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll-free number for the HIPP program: 1-800-852-3345, ext. 15218

NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Phone: 1-800-356-1561
CHIP Premium Assistance Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710 (TTY: 711)

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid and CHIP
Website: http://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html
Phone: 1-800-692-7462
CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx
CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid
Website: https://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/
Email: upp@utah.gov
Phone: 1-888-222-2542
Adult Expansion Website: https://medicaid.utah.gov/expansion/
Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/
CHIP Website: https://chip.utah.gov

VERMONT – Medicaid
Website: https://dvha.vermont.gov/members/medicaid/hipp-program
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/
http://mywvhipp.com/
Medicaid Phone: 304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

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

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

OMB Control Number 1210-0137 (expires 1/31/2026)

Contact Information

Benefit	Provider	Telephone	Web Site
Medical Coverage **Group Plan: 702551**	UnitedHealthcare	**1-866-679-0946**	**myuhc.com** United Behavioral Health: **liveandworkwell.com** (Access Code: **702551**)
Prescription Drug Coverage **Group Plan: K8VA**	Express Scripts	**1-888-418-2589**	**express-scripts.com**
Dental Insurance Coverage **PDP: 36082** **DHMO: 3340140**	MetLife	**1-800-942-0854**	**metlife.com/mybenefits**
	Cigna	**1-800-244-6224**	**cigna.com**
Vision **Group Plan: 12197388**	VSP	**1-800-877-7195**	**vsp.com**
Health Savings Account	Optum Bank	**1-800-791-9361**	**optumbank.com**
Flexible Spending and Transportation Accounts	HealthEquity/WageWorks	**1-877-924-3967**	**healthequity.com**
Life Insurance **Policy: 29548**	MetLife	**1-800-638-6420**	**metlife.com/mybenefits**
Business Travel **Travel Guard Services** **Policy Number: GTP 9133350A**	AIG Travel	Within US: **1-877-244-6871** Outside US: **1-715-346-0859**	N/A
Disability Insurance	The Hartford	**1-866-432-6723**	**thehartford.com/mybenefits**
IPG Savings Plan 401(k)	Empower	**1-844-866-4474**	**empowermyretirement.com**
Employee Assistance Program	CCA@YourService	**1-800-833-8707**	**myccaonline.com** Company Code: **IPGUS**
Accident and Critical Illness Insurance	MetLife	**1-800-438-6388**	**metlife.com/mybenefits**
Life Insurance with Long-Term Care (LTC)	Trustmark	**1-866-564-5454**	**ipgbest.com**
Legal Plan **Group Plan: 456**	MetLife Legal Plan	**1-800-821-6400**	**info.legalplans.com**
Identity Theft Assistance **Group Plan: 925**	ID Theft Assist	**1-866-262-5844**	**idtheftassist.com**
Home and Auto Discount	Liberty Mutual	**1-888-933-3788**	**libertymutual.com/interpublicgroup**
	Farmers GroupSelect℠	**1-800-438-6381**	**myautohome.farmers.com**
Pet Insurance	Nationwide	**1-877-738-7874**	**petinsurance.com**
COBRA	Benefit Connect	**1-877-29-COBRA**	**cobra.ehr.com**
Voluntary Benefits	IPG Best	**1-866-564-5454**	**IPGbest.com**
Family Building	Maven	N/A	**mavenclinic.com/join/IPG** or download the Maven app

This Benefits Guide provides a high-level general description of various benefit plans and programs that are offered or made available by The Interpublic Group of Companies, Inc. ("the Company") to its employees and employees of participating companies in the upcoming year. The purpose of the Benefits Guide is to assist you in making elections during open enrollment for the upcoming plan year. Each benefit plan and program is subject to more detailed terms and conditions that are explained in summary plan descriptions and formal plan documents; and specific tax rules that vary from state to state are not discussed in this benefit guide. You should not rely on the Benefits Guide for completeness. It is important to consult with a tax adviser on your specific tax circumstance, review your summary plan descriptions and other communications about benefit programs; they contain important information. In the event of any discrepancy between a provision of this Benefits Guide or a summary plan description and a provision of a plan document, the plan document will govern. The Company reserves the right to change, amend, or terminate any or all of the benefit plans at any time and for any reason, and without notice.