ROBERT HALF WELFARE BENEFIT PLAN & SUMMARY PLAN DESCRIPTION

AMENDED AND RESTATED, EFFECTIVE JANUARY 1, 2021

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INTRODUCTION

This employee benefit plan is formally known as the Robert Half Welfare Benefit Plan and Summary Plan Description (the "Plan") and was originally established on October 1, 1989. This amended and restated Plan is effective on January 1, 2021, unless certain provisions have a different effective date as described elsewhere in the Plan.

The purpose of the Plan is to consolidate the multiple insured and/or self-insured health and welfare benefit plans sponsored and maintained by Robert Half into a single, comprehensive health and welfare plan, for ease of administration and reporting. This type of Plan is sometimes referred to as a "wrap" plan.

While this document is designed to accomplish such consolidation, it is not the only document comprising the Plan. Rather, the entire Plan document is actually a series of documents, consisting of this document plus the various contracts and/or booklets that describe the specific benefits, rights and features under the various welfare benefit programs that are consolidated in this Plan (the "Component Documents"). Although this Plan describes your health and welfare benefits in effect as of January 1, 2021, your benefits will change from time to time in the future at Robert Half's discretion. To the extent future written annual enrollment materials, summaries of material modifications or employee communications contain Plan changes approved by Robert Half in order to comply with legal requirements or to communicate Plan design changes to you, such documents will be incorporated by reference into the Plan. Together, this document, the Component Documents and future written Plan communications incorporated by reference comprise both the official "Plan document" and the "summary plan description" as such terms are defined under the Employee Retirement Income Security Act of 1974, as amended, ("ERISA").

This Plan will be maintained for the exclusive purpose of providing benefits to Eligible Employees, former employees and, where applicable, their Dependents or Domestic Partners, and is intended to comply with all applicable laws, including the Internal Revenue Code of 1986, as amended, and ERISA.

Compliance with Plan Changes due to COVID. During the National Emergency Concerning the Novel Coronavirus Disease ("COVID") Outbreak (the "COVID Outbreak"), Congress passed several pieces of legislation, such as the Families First Coronavirus Response Act, the Coronavirus Aid, Relief and Economic Security Act, the Consolidated Appropriations Act, 2021 and the American Rescue Plan Act of 2021 (the "Federal Laws") to provide relief to participants in employee benefit plans and their plan sponsors. For example, early in 2020, Congress required that employer-provided group health plans pay for COVID testing, including lab fees and other fees associated with the doctor's office, urgent care clinic, or emergency room where the test was administered ("COVID-19 Testing") and to not impose any participant cost-sharing or prior authorization requirements for COVID-19 Testing for the duration of the COVID Outbreak. Robert Half also voluntarily waived participant cost sharing for in-network treatment related to COVID-19, including inpatient care and telehealth services during the COVID Outbreak.

Robert Half implemented all mandatory legislative and regulatory changes to the Plan as contained in the Federal Laws and regulatory guidance issued during 2020 and 2021, including but not limited to paying 100% of the cost of COBRA coverage for COBRA continues who were involuntarily terminated during 2020 or 2021 in accordance with the American Rescue Plan Act of 2021. Robert Half also extended certain timeframes that apply to health and welfare plans and their participants affected by the COVID Outbreak. The extension of these timeframes applies to the period beginning on March 1, 2020 and ending on the earlier of: (1) one year from the date an individual was first eligible for relief, or (2) 60 days after the announced end of the COVID Outbreak.

The following deadlines occurring during the COVID Outbreak have been delayed:

- 30-day deadline for exercising HIPAA special enrollment rights for a group health plan;
- Filing a claim for benefits;
- Appealing an adverse benefit determination;
- Filing a request for external review following receipt of an adverse benefit determination,
- Filing a request to perfect a request for external review upon a finding that the initial request was incomplete;
- Notifying a group health plan of a COBRA qualifying event or determination of disability;
- Electing COBRA continuation coverage under a group health plan; and
- Beginning COBRA premium payments and/or making ongoing, monthly COBRA premium payments.

Most of the mandatory relief issued due to the COVID Outbreak will expire by its terms or if later, upon the announced end of the COVID Outbreak.

ARTICLE I

DEFINITIONS

The following terms, when used in this Plan, will have the following meaning, unless a different meaning is clearly required by the context. Capitalized terms are used throughout the Plan for terms defined by this and other sections.

1.1 Affiliated Employer

"Affiliated Employer" means any entity that is considered with the Employer to be a single employer in accordance with Code section 414(b), (c) or (m). Any participating Affiliated Employers are listed in Appendix C.

1.2 Appendix

"Appendix" or "Appendices" means each of the appendices to the Plan. Each Appendix and any document included or incorporated therein will be considered a part of the Plan and may be amended by the Employer at any time for any reason without consent of any person except as otherwise provided by law.

1.3 Code

"Code" means the Internal Revenue Code of 1986, as amended, and including all regulations issued under that law.

1.4 Component Document and Component Program

"Component Document" means a written document that describes and/or relates to a Component Program identified in Appendix A and is incorporated herein by reference, including, without limitation, any insurance, administrative services only, claims service only, third-party administration, preferred provider organization ("PPO"), and health maintenance organization ("HMO") contracts, similar or related managed care organization contracts, benefit brochures and certificates and benefit descriptions or summaries entered into or approved by the Plan Administrator, as amended from time to time. Component Documents do not constitute separate plans under ERISA or this Plan.

"Component Program" means a program of benefits governed by ERISA and the terms of this Plan.

Appendix A lists the Component Programs for which temporary employees are eligible and which are incorporated by reference herein. To the extent a Component Document applicable to temporary employees fails to comply with ERISA or any other federal law applicable to a Component Program offered to temporary employees, this Plan shall govern.

1.5 Covered Person

"Covered Person" means an Eligible Employee, Domestic Partner or eligible Dependent who elects coverage under the Plan and has not for any reason become ineligible to participate in the Plan.

1.6 Dependent

A person is a "Dependent" of an Eligible Employee with respect to a Plan benefit if such person is classified as a "Dependent" under the applicable Component Document. The Plan Administrator reserves the right to require such evidence as it deems necessary that a Dependent satisfies this definition.

1.7 Domestic Partners

"Domestic Partners" are defined as same-sex and opposite-sex couples who are registered with any state or local government domestic partner registry. In the absence of a registration with a state or local government domestic partnership registry, "Domestic Partner" means a person who meets the criteria set forth in the Robert Half Domestic Partner Benefits Guidelines, as may be amended from time to time. Domestic partner registry certificates are accepted as fully equivalent to marriage certificates. The Plan Administrator reserves the right to require such evidence as it deems necessary that a Domestic Partner satisfies this definition, except to the extent prohibited by applicable law or regulation.

1.8 Eligible Employee

"Eligible Employee" means any full-time or part-time U.S.-based Employee, normally scheduled to work 20 hours or more per week (30 hours or more per week for Salaried Professional Service Employees who do not work in Hawaii)) and who meets the eligibility requirements of a Component Program. The term "Eligible Employee" also includes those employees and former employees designated by the Compensation Committee of the Robert Half International Inc. Board of Directors as eligible to participate in the Plan on terms and conditions specified by the Compensation Committee.

1.9 Employee

"Employee" means any individual who is employed by an Employer, but (unless specifically included as an "Employee" under a Component Document) does not include any of the following:

(a) Persons classified and treated by an Employer as independent contractors or any other person who is not treated by an Employer as an employee for purposes of withholding federal employment taxes, regardless of any contrary Internal Revenue Service, governmental or judicial determination relating to such employment status or tax withholding. In the event that a person is engaged in an independent contractor or similar capacity and is subsequently classified by an Employer, the Internal Revenue Service or a court as an employee, such person, for purposes of this Plan, shall be deemed an Employee from the actual (and not the effective) date of such classification.

(a) Nonresident aliens who receive no United States source income from an Employer.

(b) Individuals included in a unit covered by a collective bargaining agreement unless the Employer and the collective bargaining unit have agreed upon coverage under a Component Document; and

(c) Individuals characterized as leased Employees (as defined by Code Section 414(n)) or any individuals who would be leased Employees but for the fact they are common law Employees of an Employer; and

(d) Temporary employees classified as such on the Employer's payroll records.

In the event a person listed in one or more subsections above is specifically included as an "Employee" under a Component Document, such person will be considered an Employee under this Plan only with respect to the benefit described within such Component Document, and not necessarily with respect to other benefits hereunder.

1.10 Employee Contributions

"Employee Contributions" means amounts determined by the Employer (from time to time) to fund the Covered Person's cost of coverage under a Component Document for himself and/or eligible Dependent(s).

1.11 Employer

"Employer" means the Plan Sponsor, with respect to its Eligible Employees, and any participating Affiliated Employers that adopt the Plan, with respect to their Eligible Employees.

1.12 ERISA

"ERISA" means the Employee Retirement Income Security Act of 1974, as amended, and including all regulations issued under that Act.

1.13 FMLA

"FMLA" means the Family and Medical Leave Act of 1993, as amended, and including all regulations issued under that Act.

1.14 Plan

"Plan" means this Robert Half Welfare Benefit Plan & Summary Plan Description, as amended from time to time.

1.15 Plan Administrator

"Plan Administrator" means the Robert Half International Inc. Benefit Plan Committee ("Benefits Committee") as appointed by the Employer with the authority, discretion and responsibility to manage and direct the operation and administration of the Plan. The Plan Administrator may delegate fiduciary responsibility for administration of Component Programs to an insurer, other person or entity as specified in the applicable Component Documents or Appendix A.

1.16 Plan Sponsor

"Plan Sponsor" means Robert Half International Inc. or any successor in interest.

1.17 Plan Year

"Plan Year" means the 12-month period beginning each January 1 and ending the ensuing December 31.

1.18 USERRA

"USERRA" means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended, and including all regulations issued under that Act.

ARTICLE II

PARTICIPATION

2.1 Eligibility and Enrollment

(a) Eligibility

Eligible Employees, Domestic Partners and Dependents participate in this Plan with respect to a particular benefit provided under a Component Document on the date specified in such Component Document.

(b) Enrollment

An Eligible Employee may elect participation in the Plan, for himself, his Domestic Partner and for any eligible Dependent(s), with respect to any or all benefits described in Article III by completing the

appropriate enrollment forms when first eligible to participate. If an Eligible Employee does not elect to participate (or elects to participate only with respect to some, but not all, benefits) when first eligible, he may not elect to participate (or elect to participate in those benefits not selected) until the beginning of the next Plan Year, subject to Section 2.2 and any change in enrollment rules provided under a Component Document or a cafeteria plan maintained by the Employer under Section 125 of the Code.

2.2 Compliance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA")

The Plan will comply with the special enrollment and nondiscrimination provisions of HIPAA, with respect to those benefits subject to HIPAA. See also Articles IX and X.

2.3 Termination of Participation

Participation in a benefit provided under a Component Document will terminate as provided in the Component Document. Participation by a Covered Person in this Plan will terminate when the Covered Person is no longer covered for a benefit provided by any Component Document.

Notwithstanding the foregoing, and unless expressly provided to the contrary in a Component Document, coverage under a Component Program may be terminated where the Plan Administrator determines that the Covered Person is ineligible for coverage; that enrollment was obtained, or benefits claimed or provided, pursuant at least in part to a misrepresentation pertaining to such Covered Person; that the Covered Person failed to supply information reasonably requested by the Plan Administrator; that premiums were not timely paid; that the Covered Person failed to assist the Plan in its efforts to enforce its subrogation or reimbursement rights; or for any other reason where the Plan Administrator deems disenrollment is appropriate on account of the actions or inactions of the Covered Person (or any other person who acts or fails to act on behalf of the Covered Person). Where a Dependent is disenrolled due to such conduct, the Plan Administrator may in its discretion disenroll the Eligible Employee and/or his other Dependents where it appears such person(s) were complicit in the misrepresentation. Where an Eligible Employee is disenrolled due to such conduct, however, all enrolled Dependents also will be disenrolled.

Where coverage is terminated pursuant to the preceding paragraph, it may be terminated prospectively, and retroactively if the Plan Administrator determines that premiums were not timely paid or that the Covered Person was ineligible for coverage (coverage may be terminated retroactively to the date of the action giving rise to the termination or, where termination is due to ineligibility or failure to timely pay premiums, to the date of the Covered Person's enrollment or, if later, the date the person became ineligible; provided, however, that with respect to Component Programs subject to the Patient Protection and Affordable Care Act of 2010 (the "Affordable Care Act"), coverage will be terminated retroactively only in the event of fraud or material misrepresentation (both of which are hereby expressly prohibited by this Plan), and upon appropriate notice to the Covered Person as provided under the Affordable Care Act.

2.4 Continuation Coverage Rights

(a) Health Care Coverages

Certain health care coverages under this Plan may be subject to coverage continuation rights under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"), or similar state or federal law. Where that is the case, such coverage rights are described in the applicable Component Documents and to the extent not described in an applicable Component Document, are described in Article XI. A Covered Person who is eligible for, and elects to continue health coverage under COBRA or another applicable coverage continuation law, may continue to participate in this Plan to the extent provided under the coverage continuation law.

(b) FMLA

Notwithstanding any other Plan provision providing for an earlier termination of coverage, in the event participation in a health care benefit offered through this Plan would terminate due to the Eligible Employee taking a leave of absence pursuant to the FMLA, eligibility for such benefit will be continued for the lesser of: the period of the leave or the maximum period of leave required under the FMLA; provided, however, other provisions of this Plan or the Employer's employment policies may provide for more generous continued eligibility. Coverage will continue only as long as any required Employee Contributions are timely made. Eligible Employees on leave must make the same contribution as is required for active Eligible Employees. Coverage under other welfare benefits (other than health benefits) will continue or terminate during a period of FMLA leave to the same extent as such benefits continue or terminate during periods of leave under similar circumstances (that is, paid or unpaid leave, as the case may be) that is not FMLA leave.

(c) USERRA

Notwithstanding any other Plan provision regarding termination of coverage, in the event participation in health benefits offered through this Plan would terminate due to the Eligible Employee taking a USERRA leave of absence, such benefits will be continued for the lesser of the period of leave or 24 months; provided, however, coverage will continue only as long as any required Employee Contributions are timely made. Eligible Employees on a USERRA leave of less than 31 days must make the same Employee Contributions as are required for active Eligible Employees; Eligible Employees on a USERRA leave of 31 days or longer must pay up to 102% of the full cost (Employee Contributions and Employer contributions) of coverage, as determined by the Plan Administrator.

(d) State Mandated Continuation Coverage Rights

In addition to the continuation coverage rights discussed above, some states and localities provide additional continuation coverage rights; the Plan will comply with such requirements to the extent applicable.

ARTICLE III

BENEFITS

3.1 Benefits Incorporated by Reference

Each Covered Person may elect to receive coverage under the benefits listed in Appendix A, subject to any additional eligibility conditions provided under the applicable Component Document. The terms, conditions and limitations of benefits offered under this Plan are contained in the applicable Component Documents referenced in the Appendices and the Component Documents are incorporated herein in full, as amended from time to time. The benefits and the method of providing them may change from time to time and will be reflected in the applicable Component Documents.

ARTICLE IV

FUNDING

4.1 Contributions

The benefits listed in Appendix A will be funded by Employer contributions or Employee Contributions, or a combination thereof, as determined from time to time by the Employer. Contributions will be paid to an insurance carrier or other third-party administrator or, with respect to a self-funded benefit will be paid directly to or on behalf of a Covered Person.

If an insurer, health maintenance organization, pharmacy benefit manager or other party pays any rebate (including any medical loss ratio rebate pursuant to the Affordable Care Act, allowance, credit, or other amount with respect to the Plan or an insurance policy relating to a Component Document (a "Recovery"), whether such Recovery be paid in cash or effected as a credit against future premium or similar payments in the current or ensuing year, the Recovery amount will not be an asset of the Plan, but instead will be retained by the Employer as part of the Employer's general assets, except as provided below or as otherwise may be required by law. Therefore, a Recovery will not reduce or offset contributions or other amounts paid by Covered Persons and will not otherwise be shared with Covered Persons. If a Recovery exceeds the total amounts paid by the Employer for medical coverage under the Plan for the relevant period, the excess amount may not be retained by the Employer but instead will be treated as an asset of the Plan to the extent required by applicable law.

4.2 Employee Contributions

Any Employee Contributions may be deducted from an Eligible Employee's wages on a pre-tax basis (or after-tax basis if permitted by the Employer) and will be subject to the policies of the Employer and the terms and conditions of the Component Program(s) and the Robert Half Cafeteria Plan, and will be forwarded by the Employer to an insurance carrier or other third-party administrator.

With respect to self-insured benefits provided under the Plan, contributions from a Covered Person will be deemed to be applied first to the payment of benefits. The intent of this provision is to establish that, in a case where such contributions from all Covered Persons do not exceed the amount of self-insured benefits paid under the Plan, any administrative expenses related to the self-insured benefits will be deemed paid other than from contributions from Covered Persons.

ARTICLE V

ADMINISTRATION

5.1 Plan Administrator

The Benefits Committee is the Plan Administrator of this Plan. The Plan Administrator may delegate some or all its duties and authority to one or more Employees, to a subcommittee, to a third-party claims administrator or such other persons as the Plan Administrator deems appropriate. The Plan Administrator may delegate duties and authority with respect to the different Component Programs to different persons, insurers or entities with respect to each Component Program. Entities that have accepted fiduciary responsibility for Plan administration are listed in Appendix A.

5.2 Duties and Authority of Plan Administrator

Except to the extent an insurance company, under the terms of a Component Document, or any other third-party administrator retains the duties and responsibilities described below, the following duties and responsibilities will be the Plan Administrator's:

(a) Administrative Duties

The Plan Administrator will administer the Plan consistent with the nondiscrimination rules described later in this Article, for the exclusive purpose of providing benefits to Covered Persons and their beneficiaries. The Plan Administrator will perform all such duties as are necessary to supervise the administration of the Plan and to control its operation in accordance with the terms thereof, including, but not limited to, the following:

(1) make and enforce such rules and regulations as necessary or proper for the efficient administration of the Plan;

(2) interpret the provisions of the Plan and determine any question arising under the Plan relating to its administration or operation, including questions of fact;

(3) determine eligibility of any individual to be or become a Covered Person other than the eligibility of those employees and former employees designated as eligible by the Compensation Committee of the Board of Directors;

(4) authorize the recovery of benefit payments made in error; and

(5) delegate and allocate, specific responsibilities, obligations and duties imposed by the Plan, to one or more Employees, officers or such other persons as the Plan Administrator deems appropriate.

(b) General Authority

The Plan Administrator will have all the powers necessary or appropriate to carry out its duties, including the discretionary authority to interpret the provisions of the Plan and the facts and circumstances of claims for benefits, and to decide questions of fact relating to the Plan. Any interpretation or construction of or action by the Plan Administrator with respect to the Plan and its administration will be conclusive and binding upon all parties and persons affected hereby, subject to the exclusive claims and appeal procedures set forth in Appendix D.

5.3 Forms

All forms and other communications from any Covered Person to the Plan Administrator required or permitted under the Plan will be in the form and delivered in the manner prescribed from time to time by the Plan Administrator or its delegate. Acceptable forms of communication may include, but are not limited to, first class mail, email, voice response technology, web or online enrollment systems, or any other method prescribed by the Plan Administrator or its delegate. Required or permitted forms or communications from Covered Persons will be deemed to have been given and delivered only upon actual receipt by the Plan Administrator or its delegate. However, to the extent the terms of a Component Document provide for different or contrary rules in this regard, and such terms are permitted by law, the terms of the Component Document will control.

5.4 Examination of Documents

The Plan Administrator will make available to each Covered Person or beneficiary this Plan document, including the Appendices and Component Documents, for examination at reasonable times during normal business hours. In the event a Covered Person requests copies of documents, the Plan Administrator will timely provide all requested documents and may charge a reasonable amount to cover the cost of furnishing such documents.

5.5 No Assets

Notwithstanding any Plan provision to the contrary, no assets will be segregated for the purposes of providing benefits under the Plan. The Employer will pay benefits under this Plan out of its general assets, to the extent such benefits are not paid under the terms of insurance contracts.

5.6 Reports

The Plan Administrator will file or cause to be filed all annual reports, returns, and financial and other statements required by a federal or state statute, agency or authority within the time prescribed by law or regulation for filing said documents; and to furnish such reports, statements or other documents to such Covered Persons as required by federal or state statute or regulation, within the time prescribed for furnishing such documents.

5.7 Claims and Appeals Procedures

A Covered Person may submit a claim for Plan benefits in a manner and within the time period specified in the applicable Component Documents. Claims will be evaluated by the Plan Administrator or such other person or entity specified in the applicable Component Documents listed in Appendix A and will be approved or denied in accordance with the terms of the Plan including the Component Documents.

In addition, the Plan Administrator has established a claims procedure for the Plan in accordance with ERISA Section 503 and regulations prescribed by the Secretary of Labor. The Plan's claims and appeal procedures are contained in Appendix D and will apply only to the extent an applicable Component Document does not apply at least as extensive procedures. If the claim and appeal rules in Appendix D apply, they will be construed and applied in a manner consistent with applicable federal regulations as in effect on the date the claim is received.

Unless specifically provided otherwise in a Component Document or pursuant to applicable law, a claim for benefits under this Plan must be made within one year after the date the expense was incurred that gives rise to the claim. It is the responsibility of the Participant or the Participant's authorized representative to make sure this requirement is met.

Unless specifically provided otherwise in a Component Document or pursuant to applicable law, a suit for benefits under this Plan must be brought within one year after the date of a final decision on the claim in accordance with the applicable claims procedures.

5.8 Expenses

Unless specified otherwise in a Component Document, the Employer will pay all reasonable expenses that are necessary to operate and administer the Plan.

5.9 Bonding and Insurance

To the extent required by law, every fiduciary of the Plan and every person handling Plan funds will be bonded. The Plan Administrator will take such steps as are necessary to assure compliance with applicable bonding requirements. The Plan Administrator may apply for and obtain fiduciary liability insurance insuring the Plan against damages by reason of breach of fiduciary responsibility and insuring each fiduciary against liability to the extent permissible by law at the Employer's expense.

5.10 Nondiscrimination Rules

The Plan will comply with all applicable nondiscrimination rules under the Code and any other applicable law. Should the Plan be subject to nondiscrimination testing under the Code or any other applicable law, the Plan Administrator may make any decisions or elections, whether voluntary or required by law, necessary to facilitate such testing.

5.11 Qualified Medical Child Support Orders

The Plan will honor the terms of a Qualified Medical Child Support Order with respect to Component Programs that are subject to such Order. Qualified Medical Child Support Orders are typically issued in or after divorce proceedings, and may create or recognize the right of a child to be covered under a Component Plan providing health benefits.

The qualification of medical child support orders will be evaluated by the Plan Administrator, insurance carrier or such other person or entity specified in the applicable Component Documents and will be approved or denied. Covered Persons may obtain a copy of the procedures governing Qualified Medical Child Support Orders from the Plan Administrator.

ARTICLE VI

RIGHT TO RECOVERY, REIMBURSEMENT, SUBROGATION AND SET-OFF

6.1 Applicability

The provisions of this Article VI apply to the extent the reimbursement and subrogation terms of an applicable Component Document do not supply greater rights to the Plan. If the reimbursement and subrogation terms of an applicable Component Document supply greater rights, the terms of such Component Document will apply. For purposes of this Article VI, a Component Document is "applicable" if benefits under the Component Document are the subject of a reimbursement or subrogation claim by this Plan. For purposes of this Article VI, a law will not be considered an "applicable law" if it is preempted by ERISA.

6.2 Corrective Payments

To the extent permitted by applicable law, whenever payments that should have been made under this Plan in accordance with the coordination of benefits provisions have been made under any Other Plans, this Plan will have the right to pay to any persons making such other payments any amounts they determine to be warranted in order to satisfy the intent of the coordination of benefits provisions. Amounts so paid will be deemed to be benefits paid under this Plan, and to the extent of such payments, this Plan will be fully discharged from liability.

6.3 Reimbursement

To the extent permitted by applicable law, whenever this Plan makes payments that together with the payments the Covered Person has received or is entitled to receive from any Other Plan or Person, exceed the maximum amount necessary to satisfy the intent of this provision; or exceed, under the terms of this Plan, the benefits properly payable to or on behalf of the Covered Person, Plan, provider, or person to or for or with respect to whom the payments were made, this Plan will have the right to recover such payments, to the extent of such excess, from among one or more of the following, as the Plan Administrator in its sole discretion will determine:

(a) The Covered Person;

(b) If the Covered Person is an eligible Dependent or former eligible Dependent, the Covered Person or former Covered Person with respect to whom the Covered Person is or was an eligible Dependent;

(c) Any Other Plan, provider, or person to or for or with respect to whom such payments were made;

(d) Any insurance company or Other Plan or Person that should have made the payment; and

(e) Any other organizations.

Alternatively, the Plan Administrator or its designee may set-off the amount of such payments, to the extent of such excess, against any amount owing, at that time or in the future, under this Plan to one or more of the Covered Person, Plans, persons, providers, insurance companies, or other organizations as listed above.

For example, but not by way of limitation, if this Plan pays a claim submitted by a Covered Person or by a health care provider who treated the Covered Person, and the Plan Administrator or its designee later determines that the claim was for an expense not covered under this Plan, the Plan is entitled to recover the payment from the Covered Person or the provider, or to recover part of the payment from the Covered Person and part from the provider, or set-off the amount of the payment from amounts the Plan may owe

in the future to the Covered Person or the provider, or both. This same rule applies if the Plan makes payment to a Covered Person or a provider of an expense that is a Covered Expense, but the amount so paid exceeds the amount the Plan requires be paid.

These reimbursement provisions also apply where this Plan makes payments of covered expenses incurred for treatment of an injury or sickness for which any Other Plan or Person is or may be liable, and where this Plan's subrogation provisions do not provide this Plan with a right to recover amounts this Plan pays or may pay for treatment of the injury or sickness. If the Other Plan or Person makes payment to or on behalf of a Covered Person as compensation for the injury or sickness, and this Plan is not subrogated with respect to the payment, this Plan is entitled to reimbursement from the Covered Person (or anyone who received such payment on behalf of the Covered Person), from the payment made by the Other Plan or Covered Person, in an amount equal to the lesser of (i) the benefits paid by this Plan for treatment of the injury or sickness, or (ii) the amount of the payment made by the Other Plan or Covered Person. This provision will not apply where the Other Plan is a medical plan with respect to which this Plan, pursuant to its coordination of benefits provisions, is the primary payer of the Covered Person's covered expenses.

These reimbursement provisions will not be construed to prevent the Plan, in its sole discretion, from obtaining full reimbursement from the Covered Person (or, in the Plan's sole discretion) any other person who received payment on behalf of the Covered Person, such as a parent or guardian) by, for example, apportioning the obligation to reimburse the Plan among the Covered Person and any other person, such as the Covered Person's legal counsel. The preceding sentence is specifically intended to avoid requiring the Plan, in order to obtain full reimbursement, to seek reimbursement from any person (such as the Covered Person's legal counsel) other than the Covered Person (or the Person, such as a parent or legal guardian, who received payment on behalf of the Covered Person) where the Plan can be made whole entirely from amounts actually received by the Covered Person (or the Person, such as a parent or legal guardian, who received such amounts on behalf of the Covered Person). This same rule will apply to the Plan's rights to set-off as described above.

In addition, where an Other Plan or Person pays compensation to or on behalf of a Covered Person for an injury or sickness for which an Other Plan or Person is or may be liable, and the Covered Person incurs (either before or after payment of such compensation) otherwise covered expenses for treatment of the injury or sickness, a special rule applies. In such a case, such otherwise covered expenses that were incurred after the date on which the compensation was paid, or which were incurred before such date but not paid by the Plan as of such date, will be excluded from coverage under the Plan to the extent of the excess (if any) of the compensation received by or on behalf of the Covered Person, over the covered expenses which the Plan has already paid for treatment of the injury or sickness.

This Plan will not be responsible for any costs or expenses (including attorneys' fees) incurred by or on behalf of a Covered Person in connection with any recovery from any Other Plan or Person unless this Plan agrees in writing to pay a part of those expenses. The characterization of any amounts paid to or on behalf of a Covered Person, whether in a settlement agreement or otherwise, will not affect this Plan's right to reimbursement and to characterize otherwise covered charges as excludable covered expenses pursuant to these provisions.

6.4 Subrogation

To the extent permitted by applicable law, the Plan will be subrogated, to the extent of benefits paid or payable by this Plan, to any monies (*i.e.*, "first dollar" monies) paid or payable by any Other Plan or Person by reason of the injury or sickness which occasioned or would occasion the payment of benefits by this Plan, whether or not those monies are sufficient to make whole the Covered Person to whom or on whose behalf this Plan made its payments or to whom or on whose behalf this Plan's payments are payable. The Plan will not be responsible for any costs or expenses, including attorneys' fees, incurred by or on behalf of a Covered Person in connection with any efforts to recover monies from any Other Plan, unless this Plan agrees in writing to pay a portion of those expenses. The characterization of any

amounts paid to or on behalf of a Covered Person, whether under a settlement agreement or otherwise, will not affect this Plan's right to subrogation and to claim, pursuant to such right, all or a portion of such payment.

These subrogation provisions will not be construed to prevent the Plan, in its sole discretion, from obtaining full satisfaction of its subrogation lien from the Covered Person (or, in the Plan's sole discretion) any other Person who received payment on behalf of the Covered Person, such as a parent or guardian) by, for example, apportioning liability for satisfaction of the subrogation lien among the Covered Person and any other Person, such as the Covered Person's legal counsel.

This Plan will also be subrogated to the extent of benefits paid under this Plan to any claim a Covered Person may have against any Other Plan or Person for the injury or sickness that occasioned the payment of benefits under this Plan. Upon written notification to the Covered Person, this Plan may (but will not be required to) collect the claim directly from the Other Plan or Person in any manner this Plan chooses without the Covered Person's consent. This Plan will apply any monies collected from the Other Plan or Person to payments made under this Plan and to any reasonable costs and expenses (including attorneys' fees) incurred by this Plan in connection with the collection of the claim up to the amount of the award or settlement. Any balance remaining will be paid to the Covered Person as soon as administratively practical. The Plan Administrator may, within its sole discretion, apportion the monies such that this Plan receives less than full reimbursement.

6.5 Implementation

The Plan Administrator will determine which of the Plan's rights and remedies it is within the best interests of this Plan to pursue. The Plan Administrator may agree to recover less than the full amount of excess payments or to accept less than full reimbursement if (1) this Plan has made, or caused to be made, such reasonable, diligent and systematic collection efforts as are appropriate under the circumstances; and (2) the terms of such agreement are reasonable under the circumstances based on the likelihood of collecting such monies in full or the approximate expenses this Plan would incur in an attempt to collect such monies.

6.6 Subrogation/Reimbursement Agreement

To the extent permitted by applicable law, except as otherwise provided herein (*e.g.*, the coordination rules regarding automobile insurance), if a Covered Person incurs an injury or sickness under circumstances where compensation may be payable to the Covered Person by some Other Plan or Person (as defined in this Article), the Plan may agree to pay benefits for that injury or sickness to the extent otherwise payable under the Plan, provided the Covered Person or someone legally qualified and authorized to act for the Covered Person in writing:

(a) Consents to the Plan's subrogation of any recovery or right of recovery the Covered Person has with respect to the injury or sickness;

(b) Promises not to take any action that would prejudice the Plan's subrogation rights;

(c) Promises to reimburse the Plan for any such benefits payments to the extent that the Covered Person receives a recovery from an Other Plan or Person, irrespective of how the recovery is made or characterized, and irrespective of whether the recovery is sufficient to make the Covered Person whole. This reimbursement must be made within 30 days after the Covered Person (or anyone on the Covered Person's behalf) receives the payment; and

(d) Promises to cooperate fully with the Plan in asserting its subrogation rights and supply the Plan with any and all information and execute any and all forms the Plan may need for this purpose.

In the event the Covered Person fails to, or refuses to, execute whatever assignment, form or document requested by the Plan Administrator or its designee, the Plan will be relieved of any and all legal, equitable or contractual obligation for any benefits or Covered Expense incurred by the Covered Person and each member of the Covered Person's family, including claims then incurred but unpaid.

Nothing in this Reimbursement Agreement provision will be construed to prevent application of the provisions of the Reimbursement provisions above, regarding the Plan's exclusion of otherwise Covered Expenses which have not been paid at the time the Covered Person receives compensation for the injury or sickness that gave rise to the expenses.

6.7 Constructive Trust

In the event the Plan, pursuant to these reimbursement and subrogation provisions, is entitled under such provisions to be reimbursed for benefits it has paid for treatment of a Covered Person's sickness or injury, and where the Covered Person or someone (including an individual, estate or trust) on behalf of the Covered Person receives or is entitled to receive compensation for such sickness or injury from some other source, the Plan will have a constructive trust on such compensation to the extent of the benefits paid by this Plan. Such constructive trust will be imposed upon the person or entity then in possession of such compensation.

6.8 Right to Receive and Release Necessary Information

For the purpose of determining the applicability of and implementing the terms of this Plan or any Other Plan, the Plan Administrator may, without the consent of or notice to any person, release to or obtain from any insurance company or other organization or person any information which the Plan Administrator deems to be necessary for such purposes, with respect to any person claiming benefits under this Plan. Any person claiming benefits under this Plan will furnish to the Plan Administrator such information as may be necessary to implement this provision.

6.9 Special Definitions

For purposes of this Article VI, the following special definitions will apply:

(a) "Covered Person" means a Covered Person as defined in Article I, or a participating coverage continuation beneficiary who meets the eligibility requirements for coverage as specified in this Plan and is properly enrolled under the Plan.

(b) "Other Plan" includes, but is not limited to, any of the following providing payments on account of an injury or sickness:

(1) Any group, blanket or franchise health insurance, or coverage similar to same;

(2) A group contractual prepayment or indemnity Plan, or coverage similar to same;

(3) A Health Maintenance Organization (HMO), whether group practice or individual practice association;

(4) A labor-management trusteed plan or a union welfare plan;

(5) An employer or multiemployer plan or employee welfare benefit plan;

(6) A governmental medical benefit program;

(7) Insurance required or provided by statute;

(8) Automobile, no-fault, homeowners or general liability insurance (not merely the medical expense benefit provisions of such insurance);

(9) Settlement or judgment proceeds (regardless of the manner in which such proceeds are characterized).

The term "Other Plan" does not include any individual health insurance policies or contracts, or public medical assistance programs such as Medicaid, except as otherwise provided herein. The term "Other Plan" will be construed separately with respect to each policy, contract, or other arrangement for benefits or services and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of Other Plans into consideration in determining its benefits and that portion which does not.

(c) "Person" means any individual, association, partnership, corporation or any other organization.

ARTICLE VII

AMENDMENT AND TERMINATION

7.1 Employer's Right to Amend. The Robert Half Benefit Plan Committee reserves the right to amend the Plan at any time and for any reason. Amendment authority relating to Eligible Employees designated by the Compensation Committee will be assumed by the Compensation Committee of the Employer's Board of Directors. All amendments shall be made in writing and shall be approved by the applicable entity in accordance with their normal procedures for transacting business and shall be deemed approved and adopted by any Affiliated Employer.

7.2 Employer's Right to Terminate. The Employer reserves the right to discontinue or terminate the Plan at any time and for any reason without prior notice. The decision to terminate the Plan shall be made in writing and shall be approved by the Employer in accordance with its normal procedures for transacting business. Affiliated Employers may withdraw from participation in the Plan, but they may not terminate the Plan.

ARTICLE VIII

GENERAL PROVISIONS

8.1 Plan Interpretation

This Plan includes the attached Appendices and Component Documents and to the extent future written annual enrollment materials, summaries of material modifications or employee communications contain Plan changes approved by Robert Half in order to comply with legal requirements or to communicate Plan design changes to Eligible Employees, such documents will be incorporated by reference into the Plan. This Plan will be read in its entirety and not be severed except as provided in Section 8.8. In the case of a conflict between the Plan and any other plan document, the terms of this Plan shall govern. In the case of a conflict between the Plan and Component Documents incorporated herein by reference, the terms of such Component Documents shall govern.

8.2 Participation by Affiliated Employers

The Employer may permit any of its Affiliated Employers to participate in one or more benefits under the Plan.

8.3 Non-Alienation of Benefits

No benefit, right or interest of any Covered Person will be subject to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, seizure, attachment or legal, equitable or other process or be liable for, or subject to, the debts, liabilities or other obligations of such person, except as otherwise required by law. However, the Plan will recognize and comply with any Qualified Medical Child Support Order.

8.4 No Additional Rights

No person will have any rights under the Plan, except as, and only to the extent, expressly provided for in the Plan. Neither the establishment or amendment of the Plan or the creation of any fund or account, or the payment of benefits, nor any action of the Employer will be held or construed to confer upon any person any right to be considered or continued as an Employee, or, upon dismissal, any right or interest in any account or fund other than as herein provided. The Employer expressly reserves the right to discharge any Employee at any time.

8.5 Representations

The Employer does not represent or guarantee that any particular federal or state income, payroll, personal property, Social Security or other tax consequences will result from participation in this Plan. A Covered Person should consult with professional tax advisors to determine the tax consequences of participation.

8.6 Notice

All notices, statements, reports and other communications from the Employer to any Employee or other person required or permitted under the Plan will be deemed to have been duly given when delivered (including facsimile transmission, email, telex, and telegrams) to, or when mailed by first-class mail, postage prepaid and addressed to, such Employee, or other person at the address last appearing on the Employer's records.

8.7 Masculine and Feminine, Singular and Plural

Whenever used herein, a pronoun will include the opposite gender and the singular will include the plural, and the plural will include the singular, whenever the context will plainly so require.

8.8 Severability

If any provision of the Plan or a Component Document incorporated herein is held invalid or unenforceable, its invalidity or unenforceability will not affect any other provisions of the Plan or such Component Document, and the Plan or Component Document will be construed and enforced as if such provision had not been included therein.

8.9 Governing Law

This Plan will be construed in accordance with applicable federal law and to the extent otherwise applicable, the laws of the State of California.

8.10 Facility of Payment

In the event any benefit under this Plan will be payable to a Covered Person who is under legal disability or is in any way incapacitated so as to be unable to manage his financial affairs, the Plan Administrator may direct payment of such benefit to a duly appointed guardian, committee or other legal representative of such person, or in the absence of a guardian or legal representative, to a custodian for such person under a Uniform Gifts to Minors Act or to any relative of such person by blood or marriage, for such Covered

Person's benefit. Any payment made in good faith pursuant to this provision will fully discharge the Employer and the Plan of any liability to the extent of such payment.

8.11 Correction of Errors

In the event an incorrect amount is paid to or on behalf of a Covered Person, any remaining payments may be adjusted to correct the error. The Plan Administrator or its delegate may take such other action it deems necessary and equitable to correct any such error.

8.12 Workers' Compensation

This Plan is not in place of and does not affect any requirement for coverage by workers' compensation insurance, unless this Plan specifically provides that it is in place of, and affects, a requirement for such insurance.

8.13 Indemnification

The Employer, to the maximum extent permitted by law and its governing instruments, shall indemnify and hold harmless, directly from its own assets (including the proceeds of any liability insurance policy), Employees, managers and officers of Employers from and against all loss, damages, liability and reasonable costs and expenses incurred in carrying out their responsibilities under the Plan, unless due to the fraud or willful misconduct of such persons.

ARTICLE IX

HIPAA PRIVACY PROTECTIONS

9.1 Background

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") imposes upon the portion of this Plan providing health benefits, and certain other entities, certain responsibilities to ensure that Protected Health Information ("PHI") pertaining to Covered Persons remains confidential, subject to limited exceptions in which PHI may be disclosed. "Protected Health Information" means health information (including oral information) that:

(a) is created or received by health care providers, health plans, or health care clearinghouses;

(b) relates to an individual's past, present or future physical or mental health condition, the provision of health care to an individual or the past, present or future payment for the provision of health care to an individual; and

(c) identifies the individual or creates a reasonable basis to believe that the information, including demographic information, can be used to identify the individual.

9.2 Applicability and Effective Date

The rules contained in this Article do not apply to the Plan or the Employer until such date as the HIPAA Privacy Regulations (45 C.F.R. § 160.101 et seq.) apply to the Plan. The rules only apply to the portions of the Plan that provide medical care (e.g., medical, dental and vision care), and only to the extent such benefits are not "excepted benefits" under the HIPAA Privacy Regulations. The Plan Administrator may make a "hybrid entity designation" under which it has identified portions of the Plan that engage in functions covered by the HIPAA privacy rules, and the portions that do not. To the extent permitted by

law, where the Plan includes one or more fully insured health care Component Program(s), and one or more self-insured health care benefit Component Program(s), the mere fact that fully insured and self-insured health care benefits are bundled under this Plan will not be construed to subject any fully insured medical benefit (absent the Employer's acquisition of PHI with respect to the fully insured health care benefit) under this Plan to the same HIPAA privacy requirements that apply to the self-insured health care Component Program(s).

9.3 Disclosure of PHI

Provided that the Plan (or the Employer on behalf of the Plan) provides to Covered Persons a HIPAA Privacy Notice that, among other things, states the Plan may disclose PHI to the Employer, the Plan may disclose PHI (relating to a Covered Person) to the Employer, as further described below, without the consent or authorization of the Covered Person. In no event may the Plan disclose PHI to the Employer, without the consent or authorization of the Covered Person or his authorized representative, for purposes of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Employer.

The Plan may disclose PHI to the Employer, without the consent or authorization of the Covered Person, subject to the Employer's obligations described below in Section 9.4 for Plan administrative functions such as wellness initiatives under the Plan, quality assurance, claims processing, auditing, and monitoring. However, only the minimum amount of PHI necessary to accomplish a particular Plan administration function may be disclosed to the person(s) performing such functions.

In addition to disclosing PHI to the Employer to allow the Employer to perform Plan administrative functions, the Plan may disclose certain limited summary health information to the Employer, without the consent or authorization of the Covered Person, for purposes such as obtaining premium bids for health insurance or reinsurance, or for modifying, amending or terminating the Plan. "Summary health information" is health information that summarizes claims history, expenses, or types of claims by individuals, but from which has been removed at least 18 specific identifiers, including names, dates (except year), telephone numbers, Social Security numbers, medical record numbers, and other identifiers. In addition, the Plan may disclose enrollment and disenrollment information to the Employer without the consent or authorization of the Covered Person.

9.4 Obligations of Employer Regarding Receipt and Use of PHI

As a condition of receiving PHI from the Plan for Plan administrative functions the Employer specifically agrees to:

(a) not use or further disclose the PHI other than as permitted by this Plan or as required by law, or as permitted by the Covered Person to whom the PHI relates;

(b) ensure that any agents or subcontractors to whom it shares or provides the PHI received from the Plan agree to these same restrictions and conditions;

(c) not use the PHI for employment-related actions or in connection with any of its other benefit plans without the consent or authorization from the Covered Person to whom the PHI relates;

(d) report to the Plan any improper uses or disclosures of the PHI;

(e) provide Covered Persons access to PHI that relates to them, allow them to request amendments to the PHI, and upon request provide Covered Persons an accounting of all disclosures of their PHI by the Employer (except for those disclosures with respect to which no accounting is required);

(f) make available to appropriate federal authorities the Employer's internal practices, books, and records relating to the use and disclosure of PHI received from the Plan; and

(g) return or destroy (to the extent feasible) all copies of the PHI received from the Plan once the Employer's need for which the PHI was requested no longer exists or, if this is not feasible, limit further uses and disclosures of the PHI.

9.5 Use and Disclosure of PHI By the Employer; Dispute Resolution

When the Employer obtains PHI from the Plan for Plan administrative functions, the PHI will be provided to members of the Employer's designated HIPAA team, including the Employer's director of operational support; the director of human resources; benefits planning personnel; information technology support personnel and information technology administrators. The persons in these positions or departments, except as otherwise provided in a specific authorization granted by the Covered Person or his authorized representative to the Employer, will have access to and may use the PHI solely to perform Plan administrative functions that the Employer performs for or with respect to the Plan.

The Employer may use PHI that it receives from the Plan to carry out Plan administrative functions and may use summary health information for the purposes described in section above titled, "Disclosure of PHI." The Employer may also disclose PHI relating to a Covered Person, without the consent or authorization of the Covered Person, as required or as otherwise permitted by law. For example, the law allows PHI to be disclosed, without the consent or authorization of the Covered Person, to law enforcement, public health, and judicial agencies in certain circumstances. PHI pertaining to a minor Covered Person may, to the extent permitted by local law, be disclosed to the Covered Person's parent or guardian without the consent or authorization of the minor. There are other situations in which PHI may be disclosed without the Covered Person's consent. For more information please review the Plan's Privacy Notice or see the Plan's Privacy Official.

In the event a Covered Person or any other person believes that the Employer or any of its agents have misused PHI disclosed to it or to them by the Plan, such persons may notify the Employer's Privacy Official (contact the Plan Administrator for more information regarding how to contact the Privacy Official), or may file a complaint as described in the Plan's Privacy Notice, a copy of which should have already been received (an additional copy is available from the Plan Administrator). If the complaint is filed with the Privacy Official the Privacy Official will investigate the complaint and the events and circumstances related to it, as provided in the Employer's Privacy Policy and Procedure.

ARTICLE X

HIPAA SECURITY PROTECTIONS

10.1 Background

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") imposes upon this Plan and certain other entities certain responsibilities to ensure that Protected Health Information ("PHI") that is *electronic* Protected Health Information ("ePHI") pertaining to covered persons remains confidential, subject to limited exceptions in which ePHI may be disclosed.

"Protected Health Information" means health information that:

(a) is created or received by health care providers, health plans, or health care clearinghouses;

(b) relates to an individual's past, present or future physical or mental health condition, the provision of health care to an individual or the past, present or future payment for the provision of health care to an individual; and

(c) identifies the individual or creates a reasonable basis to believe that the information, including demographic information, can be used to identify the individual.

"Electronic Protected Health Information" is PHI that is transmitted by or maintained in electronic media, as defined in 45 C.F.R. § 160.103.

10.2 Applicability and Effective Date

The rules contained in this Article do not apply to the Plan or the Employer until such date as the HIPAA Security regulations contained in 45 C.F.R. § 160.101 *et seq.* apply to the Plan. To the extent permitted by law, where the Plan includes one or more fully insured health care Component Program(s), and one or more self-insured health care benefit Component Program(s), the mere fact that fully insured and self-insured health care benefits are bundled under this Plan will not be construed to subject any fully insured medical benefit (absent the Employer's acquisition of PHI with respect to the fully insured health care benefit) under this Plan to the same HIPAA privacy requirements that apply to the self-insured health care benefit Component Program(s).

10.3 Disclosure of ePHI

Provided that the Plan (or the Employer on behalf of the Plan) provides to covered persons a HIPAA Privacy Notice that, among other things, states the Plan may disclose PHI to the Employer, the Plan may disclose ePHI (relating to a covered person) to the Employer, as further described below, without the consent or authorization of the covered person. In no event may the Plan disclose ePHI to the Employer without the consent or authorization of the covered person or his authorized representative, for purposes of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Employer (although the Plan may disclose summary ePHI or enrollment-related ePHI to the Employer, without authorization, as further described below).

The Plan may disclose ePHI to the Employer, without the consent or authorization of the covered person, subject to the Employer's obligations described below (in the section titled, *Employer Obligations with Respect to ePHI Obtained from the Plan*) for Plan administrative functions such as wellness initiatives under the Plan, quality assurance, claims processing, auditing, and monitoring. However, only the minimum amount of ePHI necessary to accomplish a particular Plan administration function may be disclosed to the person(s) performing such functions.

In addition to disclosing ePHI to the Employer to allow the Employer to perform Plan administrative functions, the Plan may disclose certain limited electronic summary health information to the Employer, without the consent or authorization of the covered person, for purposes such as obtaining premium bids for health insurance or reinsurance, or for modifying, amending or terminating the Plan. "Summary health information" is health information that summarizes claims history, expenses, or types of claims by individuals, but from which has been removed at least 18 specific identifiers, including names, dates (except year), telephone numbers, Social Security numbers, medical record numbers, and other identifiers. In addition, the Plan may disclose electronic enrollment and disenrollment information to the Employer without the consent or authorization of the covered person.

10.4 Obligations of Employer Regarding Receipt and Use of ePHI

As a condition of receiving ePHI from the Plan for Plan administrative functions the Employer specifically agrees to:

(a) implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains, or transmits on behalf of the Plan;

(b) Ensure that the adequate separation, between the ePHI and persons who have no legitimate need to access such ePHI, as required by 45 C.F.R. § 164.504(f)(2)(iii), is supported by reasonable and appropriate security measures;

(c) Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and

(d) Report to the Plan any security incident of which it becomes aware.

ARTICLE XI

COVERAGE CONTINUATION RIGHTS

11.1 Background

Eligible Employees and Dependents have the opportunity to continue their group health coverage (e.g., medical, dental and vision, as the case may be) in certain instances where coverage would otherwise terminate. Such continuation coverage is as described in the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), and is therefore sometimes referred to as "COBRA Continuation Coverage."

11.2 Entitlement and Qualifying Events

Under COBRA, a Covered Person may elect to continue health coverage if his coverage would otherwise terminate due to a "qualifying event." Qualifying events are:

(a) A covered Eligible Employee's termination of employment, for reasons other than gross misconduct, or reduction in work hours;

(b) Death of the covered Eligible Employee;

(c) Divorce or legal separation of the covered Eligible Employee and his spouse;

(d) A covered Dependent ceasing to satisfy the Plan's definition of Dependent; or

(e) A covered Eligible Employee's entitlement to Medicare.

11.3 COBRA Qualified Beneficiaries

A Qualified Beneficiary is an individual who is entitled to COBRA Continuation Coverage. In addition to those individuals covered under the Plan immediately preceding a qualifying event, a child born to a Qualified Beneficiary who is a former Eligible Employee or who is adopted by or placed for adoption with a former Employee, during the Eligible Employee's period of Continuation Coverage, is also a Qualified Beneficiary.

11.4 Maximum Coverage Continuation Periods

Generally, coverage under COBRA may continue for up to:

(a) Eighteen (18) months for an Eligible Employee or Dependent whose coverage would cease because of the Eligible Employee's termination of employment or reduction in work hours; or

(b) Twenty-nine (29) months (i.e. 18 plus 11) for a disabled individual who:

(1) becomes entitled to the 18 months of continued coverage available after an Employee's termination of employment or reduction in work hours;

(2) is determined by the Social Security Administration to have been disabled on the date of that termination of employment or reduction in work hours or at any time during the first 60 days of COBRA Continuation Coverage; and

(3) notifies the Plan of that disability determination within 60 days after the person receives it and while still purchasing the first 18 months of COBRA Continuation Coverage.

Please note that a COBRA Qualified Beneficiary is eligible for this additional 11 months of coverage, even if not disabled, if he is entitled to COBRA Continuation Coverage due to the same qualifying event that entitles a disabled person to the additional 11 months of coverage.

(c) Thirty-six (36) months, for a divorced or widowed spouse, or a child who has ceased to be a "Dependent" under the terms of the Plan.

11.5 Special Second Election Period for Certain Trade-Displaced Individuals Who Did Not Elect COBRA Coverage

Special COBRA rights apply to Eligible Employees who lose health coverage as a result of termination or reduction of hours and who qualify for a "trade readjustment allowance" or "alternative trade adjustment assistance" under a federal law called the Trade Act of 1974. These Employees are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage) during a special second election period. This special second election period lasts for 60 days or less. It is the 60-day period beginning on the first day of the month in which the former Eligible Employee begins receiving a trade readjustment allowance (or would be eligible to begin receiving the allowance but for the requirement to exhaust unemployment benefits) or begins receiving alternative trade adjustment assistance, but only if the election is made within the six months immediately after the Eligible Employee's group health plan coverage ended.

11.6 Multiple Qualifying Events

If a Dependent is eligible to choose and chooses to continue coverage under these provisions after an Eligible Employee's termination of employment or reduction in work hours, and then another COBRA qualifying event (other than termination of employment or reduction in work hours) occurs during the original COBRA Continuation Coverage period, that Dependent may continue coverage for up to 36 months, measured from the date of the initial qualifying event. However, for an event to operate as a *second* qualifying event, it must be an event that would have triggered a loss of coverage had it been the *initial* qualifying event. In no case will any period of COBRA Continuation Coverage exceed 36 months. The Plan Administrator must be notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent, in writing, to the appropriate person described in Section 11.9. Please note that for the Eligible Employee's Medicare entitlement to be considered a second qualifying event for eligible Dependents, the Plan must provide that Medicare entitlement causes a loss of coverage for Dependents.

11.7 Special Continuation of Coverage Period for Medicare Entitlement

When an Eligible Employee becomes entitled to Medicare and then, within 18 months thereafter, experiences a qualifying event that is loss of coverage due to termination of employment or reduction in work hours, the COBRA Continuation Coverage period for the Dependent spouse or Dependent children may continue for up to 36 months from the date of the Medicare entitlement.

11.8 Early Termination of COBRA Coverage

Once a COBRA Qualified Beneficiary elects to continue coverage, coverage may continue for the period described above, unless:

(a) In the case of a person entitled to 29 months of COBRA Continuation Coverage (due to his or another person's disability), the Social Security Administration determines that he (or such other person) is no longer disabled, in which case the extended Continuation Coverage will cease on the first day of the month that begins more than 30 days after the Social Security Administration makes such a determination;

(b) If the person becomes entitled to Medicare, after the date he elects Continuation Coverage;

(c) The person fails to make a required monthly payment within the 30-day grace period pursuant to this provision;

(d) The person becomes covered—after the date he elects Continuation Coverage—under another employer group health plan (because of employment or otherwise) and that coverage contains no exclusion or limitation with respect to any pre-existing condition;

(e) The person becomes covered—after the date he elects Continuation Coverage—under another group health plan (because of employment or otherwise) that contains an exclusion or limitation with respect to a pre-existing condition which is nullified, waived or does not apply because of the Health Insurance Portability and Accountability Act (HIPAA) rules; or

(f) The Plan is terminated and the Employer maintains no group health plan for any of its active Employees.

11.9 Notification of A Qualifying Event

The Plan will offer COBRA Continuation Coverage to qualified beneficiaries only after the Plan Administrator (or designated COBRA administrator) has been notified that a qualifying event has occurred. When the qualifying event is the Eligible Employee's termination of employment, reduction of hours of employment, death, the Employer's commencement of a proceeding in bankruptcy with respect to a retiree (if applicable), or enrollment in Medicare (Part A, Part B, or both), the Employer must notify the COBRA Administrator of the qualifying event within 30 days of any of these events.

A COBRA Qualified Beneficiary must notify the COBRA Administrator within 60 days of a divorce or legal separation, of a child ceasing to meet the Plan's definition of "Dependent", or of the Social Security Administration's determination of disability. In addition, if the person is a disabled individual who obtained 29 months of COBRA Continuation Coverage, he must notify the Plan Administrator of any determination by the Social Security Administration that he is no longer disabled. Notification to the Plan Administrator must be made within 30 days of the date such determination is made.

Notice for the qualifying events described above must be sent, in writing (describing the qualifying event and the date it occurred) to the Plan Administrator or designated COBRA administrator.

11.10 Benefits That May Continue

If a COBRA Qualified Beneficiary elects COBRA Continuation Coverage, the coverage will be identical to the health coverage then being provided under the Plan to Eligible Employees or, if in the case of a Dependent, to covered Dependents of Eligible Employees. COBRA Qualified Beneficiaries do not have to prove insurability to choose continuation coverage, but are required to pay for it.

11.11 Application and Payment Procedures

After a COBRA qualifying event (and the provision of any notice required by COBRA Qualified Beneficiary, as described in Section 11.9), the Plan Administrator (or designated COBRA administrator) will send or cause to be sent a more detailed notice and an application for continued coverage. To continue coverage under COBRA, a COBRA Qualified Beneficiary must complete and return the application to

the Plan Administrator or its designee within 60 days from the later of the date the application is sent or the date coverage would otherwise terminate.

Payment for the period from the date coverage would otherwise terminate through the 45th day after COBRA Continuation Coverage is elected must be made by that 45th day (for example, if a person elects COBRA Continuation Coverage on the 30th day of the 60-day election period, he must make his first payment by the 75th day after he elected COBRA Continuation Coverage, and the payment must be for the period of COBRA Continuation Coverage from the date he would otherwise lose coverage to that 75th day). Thereafter, payments must be made within thirty (30) days after the monthly premium due date to be considered timely. The Plan will terminate coverage as of the qualifying event, but will reinstate it retroactively to the date of the qualifying event if a timely election for COBRA Continuation Coverage, and timely initial payment, are made.

The monthly cost of COBRA Continuation Coverage will be set for 12-month periods, and will not exceed 102% of the total cost of coverage, which includes the cost of coverage attributable to both Employer and Employee contributions under the Plan for similarly situated Covered Persons. However, if a person qualifies for periods of extended coverage due to a disability (whether his or another Qualified Beneficiary's), the monthly COBRA premium during the period of extended coverage may be 150% of the cost of coverage under the Plan for similarly situated Covered Persons, depending on whether the disabled person continued coverage during the extended coverage period.

Please note that the terms of the Component Documents might set forth slightly different procedures for applying and paying for COBRA Continuation Coverage, or providing notice of certain qualifying events, or for other rights and obligations regarding COBRA Continuation Coverage. In that case the terms of the Component Document will control over this Article XI, to the extent the terms of the Component Document are consistent with applicable law.

11.12 Questions and More Information

A Covered Person may contact the Plan Administrator or designated COBRA administrator if he has any questions concerning COBRA continuation rights. Covered Person(s) may also obtain information about their rights under ERISA, including COBRA, the Health Insurance Portability or Accountability Act (HIPAA), and other laws affecting group health plans, by contacting the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

Each Covered Person must keep the Plan Administrator informed of any changes in the addresses of family members. A copy of any notices sent to the Plan Administrator should be retained by the Covered Person.

ARTICLE XII

STATEMENT OF ERISA RIGHTS

12.1 Covered Persons' Rights

As an Eligible Employee covered under the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all covered Eligible Employees will be entitled to:

(a) Receive Information About Your Plan and Benefits:

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

(2) Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

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

(b) Continue Group Health Plan Coverage:

(1) Continue health care coverage for yourself, covered spouse or other Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your covered Dependents may have to pay for such coverage. Review this document and the Component Documents for the rules governing your COBRA continuation coverage rights.

(2) Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your Plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your Plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA Continuation Coverage, when your COBRA Continuation Coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

(c) Prudent Actions by Plan Fiduciaries:

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

(d) Enforce Your Rights;

(1) If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

(2) If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are frivolous.

(e) Assistance with Your Questions:

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefit Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefit Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefit Security Administration.

SIGNATURE PAGE

IN WITNESS WHEREOF, the Employer approves the adoption of this amendment and restatement of the Plan, effective January 1, 2021.

ROBERT HALF INTERNATIONAL INC.

By: Leslie Rife

Name: Leslie Rife

Title: VP Benefits and Wellbeing

12/22/2021

APPENDIX A

COMPONENT DOCUMENTS

The terms, conditions and limitations of the Component Programs offered by this Plan are contained in Component Documents and administered by the insurance companies or third-party administrators listed in this Appendix A. Temporary employees are only eligible for the Component Programs listed at the end of this Appendix A.

Component Programs, Component Documents, third-party administrators and insurers may change from time to time. If you have questions or need further information about any of the Component Programs, please contact the Robert Half Benefits Service Center by phone at 1(855) 744-2363. Benefit counselors are available Monday through Friday, 5 a.m. to 5 p.m. PST. Please go to RobertHalfBenefits.com/Contacts for the most up to date contact information.

Component Programs	Insurance Carrier or Administrator	Insured or Self-Insured
Offered to SPS and Staff Employees Medical		
Anthem Blue Cross - Prudent Buyer PPO (California) - BlueCard PPO (National)	Anthem Blue Cross www.anthem.com	Self-Insured
Cigna Open Access Plus	Cigna HealthCare of California, Inc. www.myCigna.com	Self-Insured
Kaiser Permanente HMO – in the following locations: - Northern California - Southern California - Colorado - Georgia - Hawaii - Mid-Atlantic - Northwest (Washington and Oregon)	Kaiser Foundation Health Plan, Inc. www.kp.org	Insured
HMSA CompMED Plan (Hawaii only)	Hawaii Medical Service Association (HMSA)	Insured
Expatriate Medical – Medical Benefits Abroad	Cigna International	Insured
General and Combination Health Care Flexible Spending Accounts	HSA Bank(effective January 1, 2022)	Self-Insured
Pharmacy / Prescription drug coverage	Express Scripts www.express-scripts.com	Self-Insured
Offered to SPS and Staff Employees Dental		

Component Programs	Insurance Carrier or Administrator	Insured or Self-Insured
Delta Dental PPO – Standard and Enhanced	Delta Dental www.deltadental.com	Self-Insured
Expatriate Dental	Cigna International	Insured
Vision		
Group Vision Care Plan – Standard	Vision Service Plan Insurance Company www.vsp.com	Insured
	Davis Vision www.davisvision.com	Insured
Disability		
Long-Term Disability	Lincoln Financial	Insured
Short-Term Disability	Broadspire (ASO only)	Self-insured
Life and AD&D		
Expatriate Basic Group Term Life Insurance	Cigna International	Insured
Basic Group Term Life	Lincoln Financial	Insured
Voluntary Group Term Life Insurance	Lincoln Financial	Insured
Basic AD&D	Lincoln Financial	Insured
Voluntary AD&D	Lincoln Financial	Insured
Other		
Employee Assistance Plan (EAP)	Magellan	Insured
Expatriate Employee Assistance Plan	Cigna International	Insured
Business Travel Accident Insurance	Chubb	Insured
Offered to Temporary Employees ONLY		
Medical		
Minimum Essential Coverage (MECs) (Preventive Care Plus Plan)	First Health FirstHealthLBP.com	Self-Insured
Minimum Value Plan (MVP) (High-Deductible Medical Plan)	Cigna myCigna.com	Self-Insured
HMSA CompMED Plan (Hawaii only)	Hawaii Medical Service Association (HMSA)	Insured

Component Programs	Insurance Carrier or Administrator	Insured or Self-Insured
Kaiser Permanente HMO (Hawaii only)	Kaiser Foundation Health Plan, Inc. www.kp.org	Insured
Pharmacy / Prescription drug coverage (bundled with MEC & MVP)	FBG Rx	Self-Insured
Dental	Ameritas Ameritas.com	Insured
Vision	Ameritas Ameritas.com	Insured
Life/AD&D	Nationwide Nationwide.com	Insured
Short-Term Disability	Nationwide Nationwide.com	Insured
Employee Assistance Plan (EAP) o	Magellan	Insured

APPENDIX B

PLAN DESCRIPTION

Plan Name:	**Robert Half Welfare Benefit Plan & Summary Plan Description**
Plan Number:	501
Type of Plan:	Welfare benefit plan
Plan Year:	12-month period beginning January 1 and ending December 31
Plan Sponsor:	Robert Half International Inc. 2613 Camino Ramon San Ramon, CA 94588
Plan Sponsor Tax Identification Number:	94-1648752
Plan Administrator and Named Fiduciary:	Robert Half International Inc. Benefit Plan Committee except that each insurer is a named fiduciary with respect to its insured products under the Plan and third-party administrators for self-insured Component Programs are named fiduciaries for hearing and deciding claims and appeals to the extent the Robert Half International Inc. Benefit Plan Committee has delegated named fiduciary status pursuant to an administrative services agreement.
Sources of Contributions:	Employee Contributions and Employer contributions.
Funding Medium:	Contributions under the Plan may consist of both Employer contributions and Employee Contributions. Employee Contributions for coverage are withheld through payroll deduction.
Type of Administration:	Administered according to the Component Documents. Some benefits under the Plan are insured by one or more insurance companies. Appendix A describes the various benefits, whether they are insured or self-insured, and the identity of the insurance companies and/or third-party administrators. The Employer may maintain a stop-loss or reinsurance policy to protect the Employer against catastrophic loss under the comprehensive self-

Plan Name:	**Robert Half Welfare Benefit Plan & Summary Plan Description**
	insured medical benefit programs offered under this Plan. However, the stop-loss insurance merely reimburses the Employer for benefits it funds under the program and is not to be construed as "insuring" the medical benefits offered hereunder..
Agent for Service of Legal Process:	General Counsel Robert Half International Inc. 2884 Sand Hill Road Menlo Park, CA 94025

APPENDIX C

LIST OF PARTICIPATING AFFILIATED EMPLOYERS

Protiviti Inc.

Protiviti Government Services, Inc.

Payroll Entities (100% owned by Robert Half International Inc.)

APPENDIX D

CLAIMS AND APPEALS PROCEDURES

I. Claims and Appeals

(a) In General

The Plan Administrator will process claims for benefits in accordance with ERISA Section 503 and regulations prescribed by the Secretary of Labor and in a manner consistent with applicable federal regulations as in effect on the date the claim is received. This Appendix D will apply only to the extent an applicable Component Document for a Covered Benefit does not apply at least as extensive claims and appeals procedures.

Any time a claim for benefits receives an adverse determination from the Plan Administrator, the Covered Person or the Covered Person's authorized representative ("Claimant") will be given written notice of such action within the "applicable period" after the claim is filed, unless special circumstances require an extension of time for processing. If there is an extension, the Claimant will be notified of the extension and the reason for the extension within the initial applicable period. If any urgent care or pre-service claim is approved, the Claimant will be notified of such approval and provided sufficient information to understand the import of the approval.

An "adverse determination" means a denial, reduction or termination of a benefit or Component Program, or failure to provide or make payment (in whole or in part) for a benefit offered under a Component Program, where the action is based on a determination of an individual's eligibility, a determination that a benefit is not a covered benefit, the imposition of an exclusion or limitation, or a determination that a benefit is experimental, investigational or not medically necessary or appropriate.

The "applicable period" is the time frame needed to decide the claim or appeal, provided however that the time frame may be no longer than the time frame permitted by federal regulations.

References to "Plan Administrator" in this Appendix D shall include the Plan Administrator's delegee, an insurance company or third-party administrator, as applicable. Insurance companies and third-party administrators responsible for the administration of claims and appeals are listed in Appendix A.

(b) Categories of Claims, "Applicable Periods," and Extensions

(1) "Urgent" Health Care Claims

Urgent health care claims are requests for verification or approval of coverage for health care or treatment where, if the request were not handled expeditiously the delay could jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function, or in the opinion of a physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. The "applicable period" for an urgent care claim is no longer than the period necessary to decide the matter (that is, "as soon as possible"), but in no event longer than 72 hours. Whether a claim involves "urgent care" (as defined in federal regulations) will be determined by the Claimant's attending physician, and the Plan Administrator will defer to the judgment of the Claimant's physician.

If the Plan Administrator cannot render a decision within this timeframe because the Claimant has not provided sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, the Plan Administrator must notify the Claimant within 24 hours of the specific information needed to complete the claim. The Claimant must be given at least 48 hours to provide the required information. Within 48 hours after the earlier of (1) the Plan's receiving the required information or (2) the expiration of the period afforded to the Claimant to provide the information, the Plan Administrator must notify the Claimant of its benefit determination. The Claimant may agree to extend these deadlines.

An appeal of an adverse determination regarding an urgent care claim (where the claim is still an urgent care claim) must be decided as soon as possible, but no later than 72 hours after the Plan Administrator receives the request for review or appeal.

(2) "Pre-Service" Health Care Claims

A pre-service health care claim is any request for approval of health care coverage for a service or item that under the terms of the Plan requires advance approval. The "applicable period" for a pre-service claim is 15 days after receipt of the claim by the Plan. The Plan Administrator may extend the review period for an additional 15 days if necessary due to circumstances beyond the control of the Plan. The Plan Administrator must notify the Claimant within the timeframe of the reason for the extension and the date the Plan Administrator expects to render its decision.

If the Claimant has not followed the Plan's procedures for filing a pre-service claim, the Plan must notify the Claimant within 5 days of the proper procedures to be followed in order to complete the claim. Further, if the Plan cannot render a decision within 15 days because the Claimant has not provided sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, the notice of extension must describe the specific information needed to complete the claim; the Claimant must be given at least 45 days from receipt of the notice to provide the required information; and the Plan has 15 days from the date of receiving the Claimant's information to render its decision. The Claimant may agree to extend these deadlines.

(3) "Concurrent" Health Care Claims

A concurrent health care claim may be either an urgent care claim or a pre-service claim. Generally, it is a claim for an ongoing course of health care treatment to be provided over a period of time or number of treatments. An adverse determination involving concurrent care must be made sufficiently in advance of any reduction or termination in treatment to allow the Covered Person to appeal the adverse determination. If a course of treatment involves urgent care, a request by the Claimant to extend the course of treatment must be decided as soon as possible, but not later than 24 hours after receipt of the request by the Plan, provided that the request is made at least 24 hours prior to the expiration of treatment.

Expiration of an approved course of treatment is not an adverse determination under these rules. However, any reduction or termination by the Plan of the course of treatment (other than by Plan amendment or termination) before the end of the period of time or number of treatments originally prescribed is an adverse determination and may be appealed. Notice must be provided a reasonable time before the treatments will stop; however, the Plan is not required to allow the Claimant the 180 days to appeal the Plan's decision, before the Plan may terminate the treatment. Coverage must continue during the

pendency of an appeal of an adverse determination involving a concurrent care claim to the extent required by, and in accordance with, applicable federal law.

(4) "Post-Service" Health Care Claim

A post-service health care claim is a claim that is not an urgent care, pre-service or concurrent care claim. The "applicable period" for a post-service claim is 30 days after receipt of the claim by the Plan. The Plan Administrator may extend the review period for an additional 15 days if necessary due to circumstances beyond the control of the Plan. The Plan Administrator or its delegate must notify the Claimant within the timeframe of the reason for the extension and the date by which the Plan expects to render its decision.

If the Plan Administrator cannot render a decision within 30 days because the Claimant has not provided sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, the notice of extension must describe the specific information needed to complete the claim The Claimant must be given at least 45 days from receipt of the notice to provide the required information. The Plan Administrator has 30 days from the date of receiving the Claimant's information to render its decision. The Claimant may agree to extend these deadlines.

(5) Disability Benefit Claim

The "applicable period" for a disability benefit claim is 45 days after receipt of the claim by the Plan. If the Plan requires additional time to process the claim, it may extend the applicable period by up to two (2) thirty-day extensions, but the Plan Administrator will notify the Claimant of the need for the extension prior to the beginning of any such extension period.

(6) Special Rule for Retroactive Health Care Coverage Rescissions

Where health care coverage subject to the Affordable Care Act is rescinded retroactively (for reasons other than failure to pay premiums or due to routine administrative delays in processing coverage additions and deletions), the Plan will supply written notice of the rescission to each affected participant not fewer than 30 days prior to the effective date of the rescission, in addition to any other notice that may be required by these provisions.

(7) Other Claims

The "applicable period" for a benefit claim not described in subsections (1) to (5) above is 90 days after receipt of the claim by the Plan. If the Plan Administrator requires additional time to process the claim, it may extend the applicable period by up to 90 days, but the Plan Administrator must notify the Claimant of the need for the extension prior to the beginning of any such extension period.

(c) Form and Content of Notice of Adverse Determination on Claims

If a claim is denied in whole or in part, notice of such adverse determination must be provided to the Claimant. Notice must be written or electronic; oral notice is permitted with respect to urgent care claims, but only if written or electronic confirmation is furnished to the Claimant within three (3) days after the oral notice is provided.

A culturally and linguistically appropriate written notice must be furnished to the Claimant and shall include the following:

- the specific reason or reasons for the adverse determination;
- reference to the specific Plan provisions on which the determination is based;
- if applicable, a description of any additional information needed for the Claimant to perfect the claim and an explanation of why such information is needed;
- a description of the Plan's claim review procedures and time limits applicable to such procedures, including the Claimant's right to bring a civil action under Section 502(a) of ERISA;
- (for health care and disability claims) a copy of any internal rule, guideline, protocol or other similar criteria relied on in making the adverse determination and a statement that such criteria will be provided without charge upon request;
- (for health care and disability claims) if the adverse determination is based on medical necessity or experimental treatment or a similar exclusion or limit, an explanation of the scientific or clinical judgment, applying the terms of the Plan to the Claimant's medical circumstances, and a statement that this explanation will be provided without charge upon request;
- in the case of an adverse determination involving urgent care, a description of the expedited review process available to such claims; and
- for disability claims filed on or after April 1, 2018, an explanation of the Plan Administrator's basis for agreeing or disagreeing with the following:
    - the views of the physician or medical practitioner treating the Claimant and vocational professionals who evaluated the Claimant;
    - the views of medical or vocational experts whose advice was obtained by the Plan Administrator, without regard to whether the advice was relied upon in deciding the claim; and
    - a disability determination made by the Social Security Administration regarding the Claimant.

(d) Right to Request Review

Any person who has had a claim for benefits denied in whole or in part by the Plan Administrator or is otherwise adversely affected by the Plan Administrator's actions, will have the right to file an appeal. Such appeal must be in writing, and be made within 180 days (for health care and disability benefit claims) or 60 days (for other claims) after such person is advised of the Plan Administrator's action. If a written appeal is not made within such 180-day (or 60-day, as the case may be) period, the Claimant will forfeit his right to appeal. The Claimant or a duly authorized representative of the Claimant may review all pertinent documents and submit issues and comments to the Plan Administrator in writing, setting forth all the grounds upon which an appeal is based.

(e) Review of Appeal

The Plan Administrator will then review the appeal. If a health care or disability claim was denied based on medical judgment, the person handling the appeal must consult with a health care

professional with an appropriate level of training and expertise in the field of medicine involved, and such professional may not be the same professional who was consulted with respect to the adverse determination on the claim.

The person or entity deciding the appeal may hold a hearing if it deems it necessary and will issue a written or electronically disseminated decision affirming, modifying or setting aside its former action. The decision on appeal must be made within 72 hours for a claim involving urgent health care, 30 days for a pre-service health care claim, 45 days for a disability claim, or 60 days for a post-service health care claim or claim for a benefit other than a health care or disability benefit; the time period begins to run on the date the appeal is received by the Plan. The Claimant may agree to extend these deadlines.

The decision on appeal may be delayed for up to 45 days (in the case of a disability benefit claim) or 60 days (in the case of other claims) where special circumstances require the delay, and such delay is permitted by federal regulations. The Plan Administrator will provide notice of the extension, and the reason therefor, to the Claimant prior to the end of the initial review period.

For disability claims filed on or after April 1, 2018, the Claimant will receive, free of charge, any new or additional evidence considered, relied upon or generated by the Plan Administrator in connection with its review of an appeal, and any new or additional rationale the Plan Administrator intends to rely upon in deciding the appeal, sufficiently in advance of the final decision on the appeal to allow the Claimant an opportunity to respond prior to the Plan Administrator's decision.

A culturally and linguistically appropriate written copy of the decision on appeal will be furnished to the Claimant. The decision will set forth:

- the specific reason or reasons for the adverse determination;
- reference to the specific Plan provisions on which the determination is based;
- a statement that the Claimant is entitled to receive upon request and without charge reasonable access to and copies of any document (1) relied on in making the determination; (2) submitted, considered or generated in the course of making the benefit determination; (3) that demonstrates compliance with the administrative processes and safeguards required in making the determination; or (4) in the case of a group health Plan or disability Plan, constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment without regard to whether the statement was relied on;
- a statement of any voluntary appeals procedures and the Claimant's right to receive information about the procedures as well as the Claimant's right to bring a civil action under Section 502(a) of ERISA;
- a copy of any internal rule, guideline, protocol or other similar criteria relied on in making the adverse determination or a statement that it will be provided without charge upon request;
- if the adverse determination is based on medical necessity or experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that this will be provided without charge upon request; and

- for disability benefit appeals filed on or after April 1, 2018, an explanation of the basis for agreeing or disagreeing with the following:
    - the views of the physician or medical practitioner treating the Claimant and vocational professionals who evaluated the Claimant;
    - the views of medical or vocational experts whose advice was obtained by the Plan Administrator, without regard to whether the advice was relied upon in deciding the appeal; and
    - a disability determination made by the Social Security Administration regarding the Claimant.

The decision on appeal will be final and binding upon the Claimant and all other persons involved, except to the extent otherwise provided under applicable law.

II. Additional Requirements for Non-Grandfathered Health Care Coverage under the Affordable Care Act

The rules that govern processing of claims and appeals that are denied in whole or in part, differ depending on a number of factors including the nature of the benefits involved and whether the coverage is considered "grandfathered." To the extent health coverages under the Plan are not grandfathered under the Affordable Care Act, the following additional rules apply to health care claims:

(a) Additional Requirements for Notice of Initial Adverse Determination and Notice of Final Action on Internal Appeal

Any notice of initial adverse determination or notice of final action on an internal appeal must include the following additional information:

- the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and the treatment code and their corresponding meanings (the Plan will supply this information related to the diagnosis and treatment codes as soon as practicable following such a request, and will consider such request to be a request for an internal appeal or, as applicable, external review);
- the standard, if any, used in denying the claim in whole or in part (i.e., a discussion of an applied "medical necessity" standard);
- a description of the available internal and external appeals procedures, including information about how to initiate an appeal; and
- the availability of—and contact information for—any applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act to assist individuals with the internal claims and appeals and external review procedures.

The notices described above must be supplied in a "culturally and linguistically appropriate" manner, pursuant to and to the extent required by applicable federal regulations.

(b) Additional Requirements Related to Access to Information Pending Decision on Appeal

In connection with any appeal of an adverse determination, the Claimant or a duly authorized representative of the Claimant will have the right to examine the Claimant's claim file, and to present evidence and testimony as part of the review process. The Claimant will receive, free of

charge, any new or additional evidence considered, relied upon or generated by the Plan in connection with its review of an appeal of an adverse determination, and any new or additional rationale the Plan intends to rely upon in deciding the internal appeal, sufficiently in advance of the final decision on the internal appeal to allow the Claimant an opportunity to respond prior to the decision.

(c) Additional Requirements Related to External Review of Final Action on Internal Appeal

Different external review rules apply depending on whether the relevant health care coverage is subject to a state insurance law external review requirement that meets standards specified in federal regulations, or whether the coverage is not subject to such a state law.

Where the relevant health care coverage is subject to a state standard that complies with applicable federal regulations, such state standard will apply to the insurer (where the coverage is insured) or the Plan (where the coverage is self-insured). Where the relevant health care coverage is not subject to a state standard, or subject to a state standard that does not meet federal regulatory requirements, then the following rules apply to the Plan to the extent and as of the date required by applicable federal regulations:

(1) A Claimant may file a request for external review within 4 months of receipt of notice of an adverse determination (to the extent permitted by applicable law, however, the Plan may require the Claimant to exhaust any reasonable internal appeal process); for this purpose, and to the extent permitted by applicable federal regulations, an "adverse determination" means an adverse determination as defined elsewhere in these provisions, but only to the extent it involves medical judgment or a retroactive recession of coverage.

(2) Within 5 business days following receipt of the request for external review, the Plan will determine whether:

- the Claimant was covered under Plan and applicable health care coverage when the health care item or service was requested (or provided, where the review is a for a post-service claim);
- the adverse determination was not due to ineligibility of the Claimant;
- the Claimant exhausted any required internal appeal process; and
- the Claimant has provided all required information.

(3) The Plan will issue notice to the Claimant within one business day after the Plan's preliminary review of the request for external review. If the Claimant is not eligible for external review, the notice must include reasons for ineligibility and contact information for the Employee Benefit Security Administration. If the request for external review is not complete, the notice must describe information that is needed and allow the Claimant to complete or perfect his request within the four-month filing period described above or 48 hours, whichever is later.

(4) If the request for external review is appropriate, the Plan will refer the appeal to an Independent Review Organization (IRO), with which the Plan has contracted in accordance with applicable federal regulations. The IRO will conduct its review and supply appropriate notices in accordance with applicable federal standards. If the IRO reverses the Plan's decision, the Plan will provide coverage or payment upon receipt of notice of the IRO's decision, without delay and without regard to the Plan's intention to seek judicial review.

(5) The Plan will make available, to the extent required by and in accordance with applicable federal law, an expedited external review process where a Claimant receives an adverse determination or final internal adverse determination and where completion of an expedited internal appeal or standard external review would seriously jeopardize the life or health of the Claimant.

(d) No Conflicts of Interest

The Plan Administrator will adjudicate claims in a manner ensuring the independence and impartiality of those involved in decision-making.

III. Important Time Frames

Unless specifically provided otherwise in a Component Document or pursuant to applicable law, a claim for benefits under this Plan must be made within one year after the date the expense was incurred that gives rise to the claim. It is the responsibility of the Claimant or the Claimant's authorized representative to make sure this requirement is met.

Unless specifically provided otherwise in a Component Document or pursuant to applicable law, a suit for benefits under this Plan must be brought within one year after the date of a final decision on the claim in accordance with the applicable claims procedures.