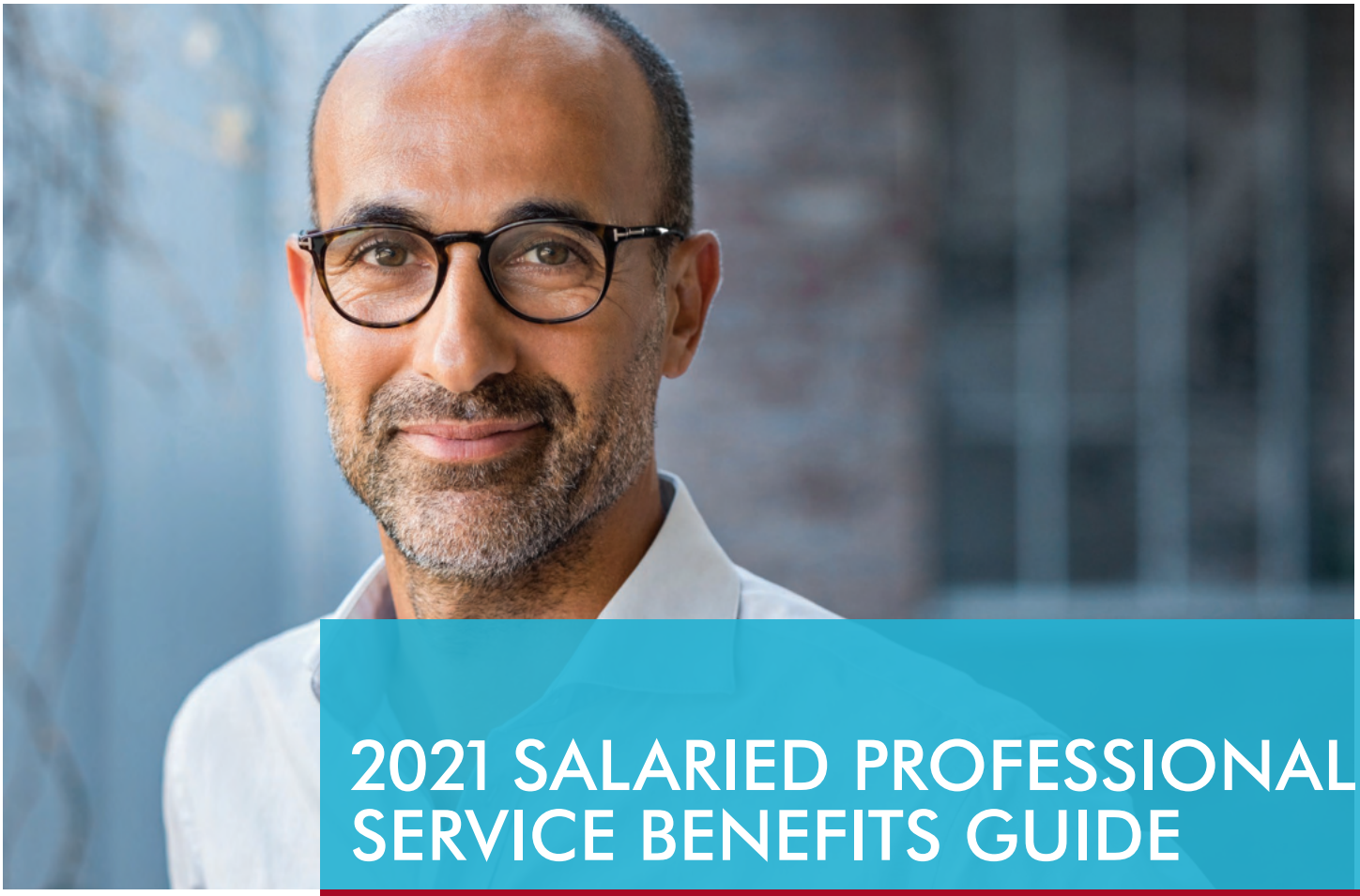


2021 SALARIED PROFESSIONAL SERVICE BENEFITS GUIDE

Effective January 1 – December 31, 2021

Robert Half® protiviti®

SPS, updated April 5, 2021

TABLE OF CONTENTS

INTRODUCTION

At Robert Half and Protiviti, you're part of a team that supports you and a business that rewards your efforts. Our comprehensive benefits programs are designed to support your physical, emotional and financial well-being, particularly in these challenging times.

Read through this document and see how our benefit programs can help you and your family stay healthy, balanced and happy:

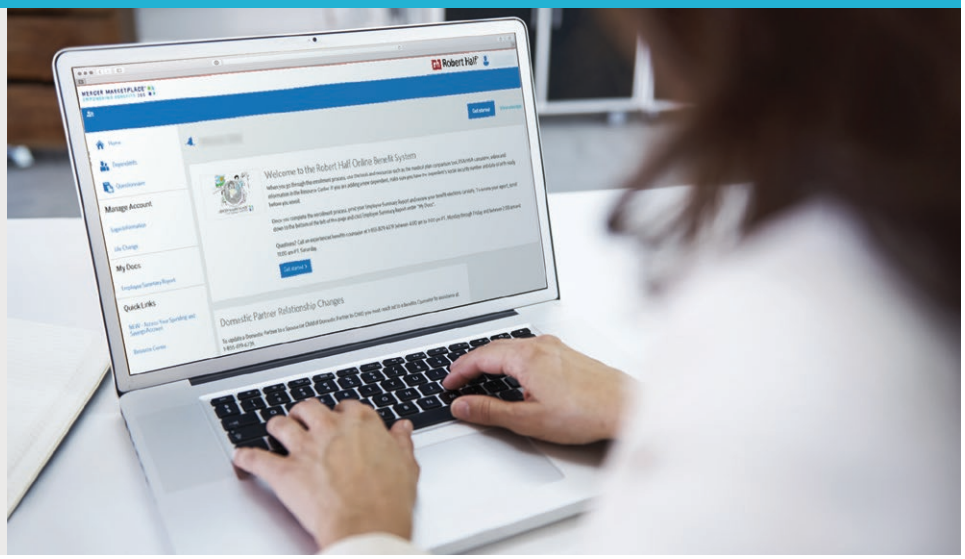
- Review your benefit choices
- Understand how the plans work
- Learn about the tools and resources available with each plan
- Select the benefits that are best for you

Then make sure to enroll by the deadline. For more details on the benefits available to you and your family, visit **roberthalfbenefits.com**.

Our Benefits Partner: the Mercer Marketplace 365

Through the Mercer Marketplace 365, you can compare benefit plans — including details and costs — and choose the best fit for your needs and those of your family.

The Mercer Marketplace 365 provides resources to help you understand your options, such as the medical plan comparison tool that lets you model various benefits scenarios.



HIGHLIGHTS OF 2021 CHANGES

Below is a summary of the changes effective January 1, 2021. Visit the enhanced **roberthalfbenefits.com** for complete plan details.

2021 COVERAGE COSTS

We know cost is always a primary concern for you and your family. **For 2021, we're pleased to offer the same — or enhanced coverage — with no increased cost for most of the benefit plans.**

This is the fourth consecutive year that employees enrolled in the $1,500 and $2,500 deductible plans offered by Anthem and Cigna will not experience a rate increase, and the second consecutive year for the other Anthem and Cigna medical plans. It's also the third year in a row with no dental rate increases! Rates are available through the Mercer Marketplace 365 starting November 3, 2020.

Note: Costs for auto/home insurance, pet insurance, and universal life insurance are individually rated — the insurance companies will provide rates directly to individuals.

SUPPLEMENTAL MEDICAL INSURANCE

Enhanced accident, critical illness and hospital indemnity insurance will now be provided through Cigna.

ANTHEM MEDICAL PLANS

New ID cards will be issued, which will reflect a new group number for the Anthem medical plans.

KAISER MEDICAL PLANS

Kaiser is making the following plan changes:

- **California:**
  - All plans: Home birth and midwives now covered when medically necessary; birthing centers no longer covered
  - All plans: Peak flow meters, glucometers and associated diabetic testing supplies no longer subject to the annual deductible
  - $900 Deductible Plan: Acupuncture now covered at 80% with no deductible
- **Colorado:**
  - All plans: Members will now be part of one Colorado service area. As part of this consolidation, you will receive a new ID card for 2021; however, your member ID number won't change. Additionally, there will be a new member service phone number: 1.800.632.9700 or 1.303.338.3800.
  - All plans: Referrals will be required for certain specialists; please consult with your primary care physician (PCP)
  - All plans: Peak flow meters, glucometers and associated diabetic testing supplies no longer subject to the annual deductible
- **Georgia:**
  - All plans: Peak flow meters, glucometers and associated diabetic testing supplies no longer subject to the annual deductible
  - All plans: Specific tests now covered at no charge (HbA1c for diabetics, Low Density Lipoprotein lab test for people with heart disease, and INR lab test for liver failure and bleeding disorders)
  - $400 and $900 Deductible Plans: Lightbox therapy to treat seasonal affective disorder (SAD) covered at 100%
- **Hawaii:**
  - Cardiac rehabilitation therapy covered when medically necessary
  - Dental services related to accidents are no longer covered
  - If a brand drug is prescribed when there's a generic drug available, and the prescription is deemed medically necessary, you pay the brand-formulary cost. If the prescription is not deemed medically necessary, you pay the full cost.

- **Mid-Atlantic:**
  - All plans: Diabetes, HIV, and AIDS drugs limited to $150 for up to a 30-day supply and $450 for up to a 90-day supply
  - All plans: Peak flow meters no longer subject to the annual deductible for those with asthma; glucometers and test strips no longer subject to the annual deductible
  - All plans: Specific tests now covered at no charge (HbA1C for diabetics, Low Density Lipoprotein Lab test for people with heart disease, and INR lab test for liver failure and bleeding disorders)
- **Northwest:**
  - All plans: Peak flow meters, glucometers and lancets no longer subject to the annual deductible
- **Washington:**
  - All plans: Travel and lodging now covered for transplants (more than 100 miles from home)
  - All plans: Peak flow meters, glucometers and associated diabetic testing supplies no longer subject to the annual deductible

SAFEGUARDRX

SafeGuardRx is a new, free program for Anthem and Cigna members. It provides remote Bluetooth-enabled glucose monitors and inhaler devices to support prescription adherence and health engagement for eligible, high-risk diabetic and pulmonary care patients.

HAWAII MEDICAL SERVICE ASSOCIATION (HMSA) MEDICAL PLAN

HMSA is making the following plan changes:

- Nutritional counseling will be called "Medical Nutrition Therapy" and will be expanded to cover other conditions (e.g., chronic kidney disease) at no cost when you choose in-network providers
- Outpatient internal implants will be covered at no cost when you choose in-network providers

EMPLOYEE ASSISTANCE PROGRAM

The EAP now includes up to 10 visits per year per topic with a counselor. You also have access to virtual therapy through BetterHelp, which offers options for video, phone, texting, and live chat sessions.

HEALTH SAVINGS ACCOUNT (HSA)

The IRS increased annual HSA contribution limits to $3,600 for individual coverage and $7,200 for family coverage.

FLEXIBLE SPENDING ACCOUNT (FSA)/COMMUTER BENEFITS

The IRS is expected to increase annual contribution limits for the FSAs and commuter benefits. At the time of publication, IRS limits have not yet been released. Visit **roberthalfbenefits.com** for current limits.

UNIVERSAL LIFE INSURANCE

During Open Enrollment, the guarantee issue amount for voluntary universal life insurance offered through Allstate has increased to $200,000. You can also enroll dependents now up to age 26.

Important!

During Open Enrollment, you may choose to purchase voluntary universal life insurance coverage up to $200,000 without providing Evidence of Insurability (EOI) for you and your dependents (now up to age 26). If you currently have coverage, you can increase coverage up to $200,000 total without providing EOI.

After Open Enrollment, you'll need to provide EOI for any voluntary universal life insurance coverage amount. If you purchase or increase your coverage during Open Enrollment, no additional documentation is needed.

Visit **roberthalfbenefits.com** for comprehensive information about all the benefits available to you and your family.

WHO'S ELIGIBLE

EMPLOYEES

You're an eligible employee for Robert Half's benefits program if you're a regular, full-time employee in the Salaried Professional Service (SPS) program who works a minimum of 30 hours per week.

However, if you're an employee living in Hawaii, you become eligible for medical benefits (even as a part-time employee) if you work four consecutive weeks for 20 hours or more per week.

If you're a part-time employee working less than 20 hours, you're eligible to enroll in commuter benefits and the following voluntary insurance products: identity protection, auto and home insurance, and pet insurance. There is no minimum hours requirement to be eligible for these benefits. (See pages 23 and 26 for more information about these benefits.)

All employees are automatically covered for EAP services on date of hire.

You become eligible for most benefits on the first day of the month following or coinciding with 30 days of continuous, active full-time employment. For commuter benefits and the voluntary insurance products listed above, you become eligible to enroll on your hire date. Note that the date you become eligible for a benefit plan is considered your "eligibility date."

Important

Staff and Protiviti employees and temporary professionals in Hawaii have different eligibility requirements. For details, see the **2021 Robert Half Staff and Protiviti Benefits Guide** or the **2021 Hawaii Temporary Professional Benefits Guide**.

Enrollment Tip

To be covered, your dependents must be enrolled in the same plans you choose for yourself.

DEPENDENTS

When you enroll for benefits, you can also enroll your eligible dependents, including your:

- Lawful spouse or qualifying domestic partner[1]
- Children up to age 26[2]

[1] *To qualify for benefits coverage, domestic partners must have entered into a legally recognized civil union or be registered with a state or local government domestic partnership registry. In the absence of a civil union or registration, domestic partners must satisfy the criteria set forth in Robert Half's Domestic Partner Benefits Guidelines. Any requirements for proof of relationship or waiting periods are applied similarly to domestic partners and spouses. COBRA-like continuation coverage is available to domestic partners and their children to the same degree and in the same manner as COBRA coverage is available to spouses and their children.*

[2] *If your child is mentally or physically disabled, coverage may continue beyond age 26, once proof of the ongoing disability is provided. Children may include natural children, adopted children, stepchildren, foster children and children for whom you have been appointed the legal guardian by a court, as well as children of qualifying domestic partners.*

HOW TO ENROLL OR MAKE CHANGES

Enrollment Tip

Have your dependent's Social Security number (except for newborns) and date of birth ready before logging on to the **Mercer Marketplace 365** website or calling the service center.

ONLINE	PHONE	MOBILE
Visit the Mercer Marketplace 365 website at **mercermarketplace.com/roberthalf**	Call **1.855.879.6739** Monday – Friday: 4 a.m. – 6 p.m. Pacific time	Download the Mercer Marketplace 365 app from your app store. (company ID: ROBHAF)

The Mercer Marketplace 365 is the online platform where you enroll or make changes to all of your benefits, including Anthem, Cigna, Kaiser and other products we offer. You can compare benefit plans — including details and costs — and choose the best fit for your needs and those of your family.

The Mercer Marketplace 365 provides resources to help you understand your options, such as the medical plan comparison tool that lets you model various benefits scenarios.

WHEN TO ENROLL

You can enroll for benefits:

- When you first become an eligible employee
- During Open Enrollment
- During the calendar year, within 30 days of a qualified life event

UPON HIRE

Eligible employees must enroll for benefits within 30 days following their hire date.

If you don't enroll within 30 days, you won't be able to enroll for benefits until the next Open Enrollment period, unless you experience a qualified life event as defined by the IRS. (See During the Year below for more details.)

DURING OPEN ENROLLMENT

Open Enrollment is your annual opportunity to enroll for benefits or make changes to your existing benefits. Generally, benefits you elect during Open Enrollment will be effective January 1 through December 31 of the following year unless you experience a qualified life event that permits you to change your coverage or makes you ineligible for coverage.

DURING THE YEAR

If you experience a status change that affects your eligibility for benefits or an IRS-qualified life event during the year, you may enroll for coverage in new plans and make changes to existing coverage within 30 days of the event. Contact the Mercer Marketplace 365 through **mercermarketplace.com/roberthalf** or call **1.855.879.6739** to start the process.

Qualified Life Events

Examples of qualified life events, per IRS guidelines, include but are not limited to the following. For details, visit **roberthalfbenefits.com/life-events**.

- Marriage
- Divorce
- Birth, adoption of a child or becoming a court-appointed legal guardian
- Death of a dependent
- Loss of dependent eligibility for coverage
- Loss of coverage due to a change in employment status

Your benefit elections or changes must be consistent with the event. Documentation of the event may be required. Changes you make generally will be effective on the first day of the month following or coinciding with a qualified life event, except for:

- The birth of a baby or adoption: Coverage begins on the date of birth or the date the child is put in custody for adoption.
- Removing dependents from coverage: Coverage ends for your dropped dependent on the last day of the month.
- Death, divorce, legal separation or termination of a domestic partnership: Coverage ends the day after the event date.*

** For medical coverage through HMSA (in Hawaii), coverage ends at the end of the month for these qualified life events.*

WHEN COVERAGE BEGINS

Your Robert Half benefits coverage becomes effective on your eligibility date, provided you enrolled by the deadline. (See When to Enroll on page 7 for information about the enrollment deadline.)

- **If you enroll in benefits as a new hire**, your coverage (and your deductions) are effective as of your eligibility date. The first deduction(s) may not begin to be taken from your paycheck until one or two pay periods after you enroll, which means you may owe retroactive deductions. These retroactive deductions will be taken from your paychecks in addition to the regular per-pay-period deductions you see on the **Mercer Marketplace 365** website. To minimize retroactive deductions, consider enrolling early.
- **If you enroll during Open Enrollment**, your benefits will generally be effective beginning January 1 of the following year.

For more information regarding coverage following a qualified life event, contact the Mercer Marketplace 365 at **1.855.879.6739**.

WHAT COVERAGE COSTS

The amount you'll pay varies depending on the options you elect and whom you choose to cover — yourself only, yourself and your spouse/domestic partner or child(ren), or your whole family. You can find 2021 costs for all the benefit options on the **Mercer Marketplace 365** website.

Regardless of the medical plan you choose, it's important to note that Robert Half pays the majority of the overall cost.

WHEN COVERAGE ENDS

If your employment ends, or if you terminate coverage due to a qualified life event, your medical, dental and vision coverage ends on the last day of the month. Identity protection, legal coverage, and auto and home insurance also end on the last day of the month. You and your household members will have access to all EAP services for 36 months following your termination or loss of eligibility for benefits.

Supplemental medical insurance options, HSA, FSAs, disability coverage, basic and supplemental life and accidental death and dismemberment insurance, commuter benefits, universal life insurance, and pet insurance end on the termination date.

FSA AND COMMUTER BENEFITS

If your employment ends, or if you terminate the plan as part of a qualified life event change, your FSA and/or commuter benefits coverage ends on your termination date. Your debit card will be deactivated as of your termination date. You will need to file claims using the Mercer Marketplace 365 website, mobile app and/or claim forms. The deadlines to file claims are:

- **FSAs:** You have 90 days from the end of the plan year (March 31, 2022) to submit claims received within the 2021 plan year up to the termination date. You can't file claims for services received after the termination date.
- **Commuter benefits:** You have 90 days from the termination date to submit claims for services. Claims must be submitted within 180 days of the date the claim was incurred.

Note: You will forfeit any funds remaining in your FSA or commuter account after all qualified claims have been paid.

COBRA COVERAGE

If you leave Robert Half or become ineligible for benefits, your current coverage will end. You and/or your covered dependents may elect to continue medical, dental, vision, and Health Care Flexible Spending Account benefits through COBRA. COBRA — the Consolidated Omnibus Budget Reconciliation Act — generally allows you and your dependents to continue your insurance under the Robert Half policy for 18 months after you cease to be an active employee. If your dependent(s) loses coverage due to your death or divorce, or because he or she reaches the dependent age limit, his or her coverage may be continued for up to 36 months. Through COBRA, you can elect each benefit and coverage level separately, and your coverage will be identical to what you had in place on your last day of employment or eligibility. However, your cost will be the full premium (both your and Robert Half's portions) plus a 2% administration fee for TRI-AD, our COBRA administrator. Therefore, COBRA costs more than what you have been paying. You may want to visit the federal health insurance marketplace at **healthcare.gov** to compare plans and costs — you might find a more cost-effective option elsewhere. For questions about COBRA coverage, contact TRI-AD at **1.866.268.0142 (Option 4)**.

Conversion of Coverage

You or your covered dependent may convert basic life insurance and/or supplemental life insurance to an individual whole life insurance policy if your or your covered dependent's life insurance ends under the Robert Half policy.

You or your covered dependent may convert this insurance by applying and paying the first premium for an individual policy within 31 days after any part of your or your insured dependent's life insurance coverage ends. For more information, refer to your Certificate of Coverage or call **1.855.879.6739**.

Survivor Health Care Benefits

Surviving dependents of a deceased employee will receive three months of COBRA medical, dental, and vision coverage paid for by Robert Half, as long as the dependents were covered under the Robert Half health plans at the time of the employee's death.

YOUR MEDICAL OPTIONS

Robert Half offers a variety of medical plan options and provider networks through the Mercer Marketplace 365. You can choose the plan design and network combination that makes the most sense for you and your family. There are four plan options to choose from:

- $400 Deductible Plan
- $900 Deductible Plan
- $1,500 Deductible Plan*
- $2,500 Deductible Plan*

** These plans are compatible with a Health Savings Account (HSA). See page 13 for additional information.*

Visit **roberthalfbenefits.com** for plan details and to access your Summaries of Benefits and Coverage (SBCs).

CHOOSING YOUR MEDICAL PLAN CARRIER

For each of the medical plan options, you can choose one of the following three carriers:

	Anthem	Cigna	KAISER PERMANENTE
Coverage locations?	All locations except Hawaii	All locations except Hawaii	Select locations by ZIP code: California, Colorado, Georgia, Hawaii, northern Idaho, Oregon, Washington and the mid-Atlantic region (Maryland, Virginia and Washington D.C.)
Use any provider?	Yes, in- or out-of-network benefits	Yes, in- or out-of-network benefits	Kaiser providers only (no out-of-network benefits)
Prescription drug coverage?	Yes, through Express Scripts	Yes, through Express Scripts	Yes, through Kaiser
Help managing chronic conditions?	Yes, through Anthem Total Health, Total You at **1.844.594.6178**.*	Yes, through Cigna Health Matters® Care Management Complete at **1.800.244.6224**.*	Yes, through Kaiser — see your ID card for the correct phone number
Need to locate an in-network provider?	Visit **anthem.com/ca** and log in, or: ■ Click **Find a Doctor/Find Care**. ■ Click **Guests**. ■ Enter type of care and state, and select National PPO (BlueCard PPO) network. ■ Enter the additional information requested to narrow your results.	Visit **cigna.com**: ■ Select **Find a Doctor, Dentist, or Facility**, then **Employer or School**. ■ Choose how you want to search and enter the required information when requested. ■ When asked to select a plan, choose the Open Access Plus, OA Plus, Choice Fund OA Plus network.	Visit **kp.org**: ■ Scroll down and click **Find Doctors & Locations**.

How the Anthem and Cigna Medical Plans Work

When you use an in-network provider...	When you use an out-of-network provider...
You'll pay fewer out-of-pocket expenses — you'll benefit from discounted rates	You'll pay more out of pocket for services because you won't benefit from discounted rates

See Medical Benefits at a Glance — Anthem and Cigna Plans (Except in Hawaii) on page 16 for more details.

How the Kaiser Plans Work

When you use an in-network provider...	When you use an out-of-network provider...
You'll pay fewer out-of-pocket expenses — you'll benefit from discounted rates	You'll pay 100%. There are no out-of-network benefits, except for emergencies.

See Medical Benefits at a Glance — Kaiser Plans (Except in Hawaii) on page 17 and Medical Benefits at a Glance — Hawaii on page 18 for more details.

Do You Live in Hawaii?

See page 18 for an overview of your medical plan options. You can also go to the Mercer Marketplace 365 website at **mercermarketplace.com/roberthalf** or call **1.855.879.6739** for more information about these plans.

Virtual Medical Visits

Available to employees enrolled in Anthem, Cigna or Kaiser plans.

Consider using your carrier's virtual care programs — like Anthem's LiveHealth Online, Cigna's MDLIVE or Kaiser's on-demand video visits — where you can see a doctor on your computer or mobile device and get answers 24/7.

$400 DEDUCTIBLE PLAN AND $900 DEDUCTIBLE PLAN

The $400 Deductible Plan and $900 Deductible Plan include the following features:

Free in-network preventive medical care. Preventive care is covered fully with no deductible and no copay or coinsurance, as long as you receive this care from in-network providers.

Annual deductible. You pay for your initial costs out of pocket (for most services) until you meet your annual deductible:

- $400 Deductible Plan: The annual deductible doesn't apply to office visits and prescription drugs. Instead, you pay a flat-dollar copay, and the plan covers the rest of the eligible expense. The annual deductible applies to all other services, including hospitalization and the emergency room.
- $900 Deductible Plan: The annual deductible applies to services including office visits, hospitalization and emergency room services. The annual deductible doesn't apply to prescription drugs.

Note: If more than one family member is covered, the plans begin to pay benefits for an individual family member when he or she reaches the individual deductible amount or when the combined expenses of all family members reach the family deductible amount, whichever happens first.

Coinsurance. Once the deductible is met, you and the plan will each pay a designated percentage of the cost for care, which is called coinsurance.

Out-of-pocket maximum. The plan protects you financially by limiting the total amount you will pay each year for medical care. Once you meet your out-of-pocket maximum, the plan pays 100 percent of your eligible expenses for the remainder of the year, as long as you use network providers. (For out-of-network providers, the plan will pay 100 percent of the "usual and customary" charge. You're responsible for any amount in excess of the usual and customary charge.)

Note: If more than one family member is covered, the plans begin to pay 100 percent of eligible expenses for an individual family member when he or she reaches the individual out-of-pocket maximum amount or when the combined expenses of all family members reach the family out-of-pocket maximum amount, whichever happens first.

Enrollment Tip

When choosing a medical plan, use the medical plan comparison tool on the Mercer Marketplace 365 website (**mercermarketplace.com/roberthalf**) to help you make the right choice for you and your family. You can compare your health plan choices in addition to estimating your cost for each plan. The cost comparisons will factor in the deductible amount, expected services and contribution amounts. (The medical plan comparison tool is only available when you're enrolling as a new hire, during Open Enrollment or following a qualified life event.)

You can also call Health Advocate at **1.866.695.8622** to get personalized help making benefit choice decisions.

Enrollment Tip

If you choose one of the medical plan options that is compatible with an HSA, you can contribute to your HSA on a pre-tax basis to help pay for out-of-pocket expenses, including the annual deductible.

$1,500 DEDUCTIBLE PLAN AND $2,500 DEDUCTIBLE PLAN (HSA-COMPATIBLE PLANS)

The $1,500 Deductible Plan and $2,500 Deductible Plan help you take charge of your health and financial savings. In addition to providing benefits, these plans are compatible with a Health Savings Account (HSA), which lets you save pre-tax dollars to pay your current and future medical and prescription drug expenses — including your deductible.

The plan benefits include:

Free in-network preventive medical care. Preventive care is 100 percent covered with no deductible and no coinsurance, as long as you receive this care from in-network providers.

Annual deductible. You pay for your initial costs for medical and prescription services until you satisfy your annual deductible. The annual deductible applies to all non-preventive services, including office visits, hospitalization, emergency room services and prescription drugs.

Note: When more than one family member is covered, the plans begin to pay benefits for an individual only when the family annual deductible amount is reached.

Coinsurance. Once the deductible is met, you and the plan will each pay a designated percentage of the cost for care, which is called coinsurance.

Out-of-pocket maximum. The plan protects you financially by limiting the total amount you will pay each year for medical care. Once you meet your out-of-pocket maximum, the plan pays 100 percent of your eligible expenses for the remainder of the year, as long as you use network providers. (For out-of-network providers, the plan will pay 100 percent of the "usual and customary" charge. You're responsible for any amount in excess of the usual and customary charge.)

Note: The plan begins to pay 100 percent of covered in-network care only after the family annual out-of-pocket amount is reached.

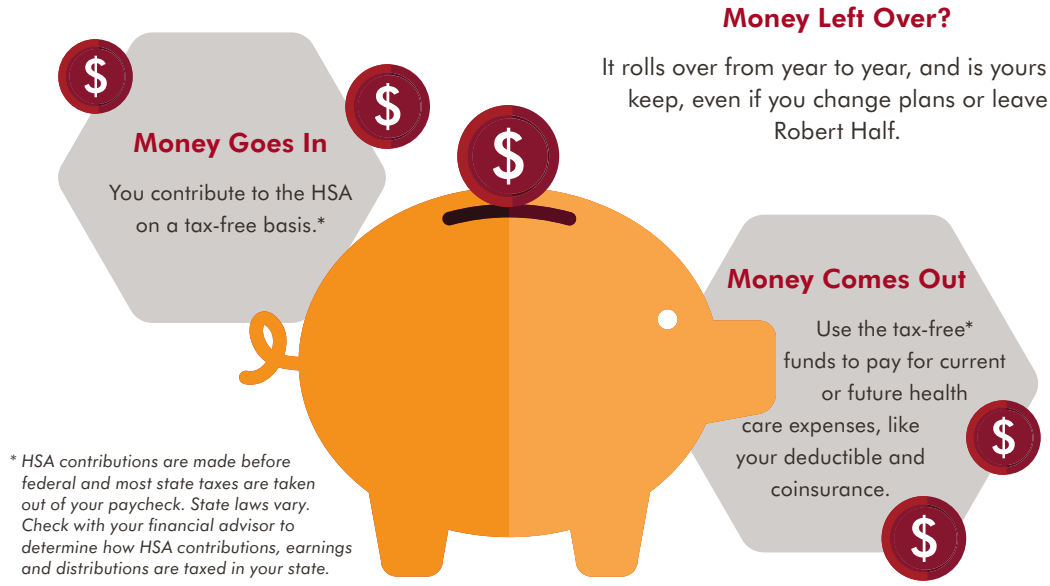
For California Participants Enrolled in a Kaiser Plan

If you live in California and enroll in family coverage in Kaiser's $1,500 Deductible or $2,500 Deductible Plan, the amount that an individual within a family will pay for the calendar-year deductible will be limited to $2,800 in 2021. See page 17 for details about the Kaiser California plan.

HEALTH SAVINGS ACCOUNT (HSA)

If you enroll in the $1,500 Deductible Plan or the $2,500 Deductible Plan, you have access to a unique tax-advantaged savings account called a Health Savings Account, or HSA. You can use this account to pay for eligible health care expenses for you and your eligible dependents on a tax-free basis for federal income tax purposes (state laws may vary). Robert Half's HSA is administered by TRI-AD.

Here's how the HSA works:



** HSA contributions are made before federal and most state taxes are taken out of your paycheck. State laws vary. Check with your financial advisor to determine how HSA contributions, earnings and distributions are taxed in your state.*

Key Features

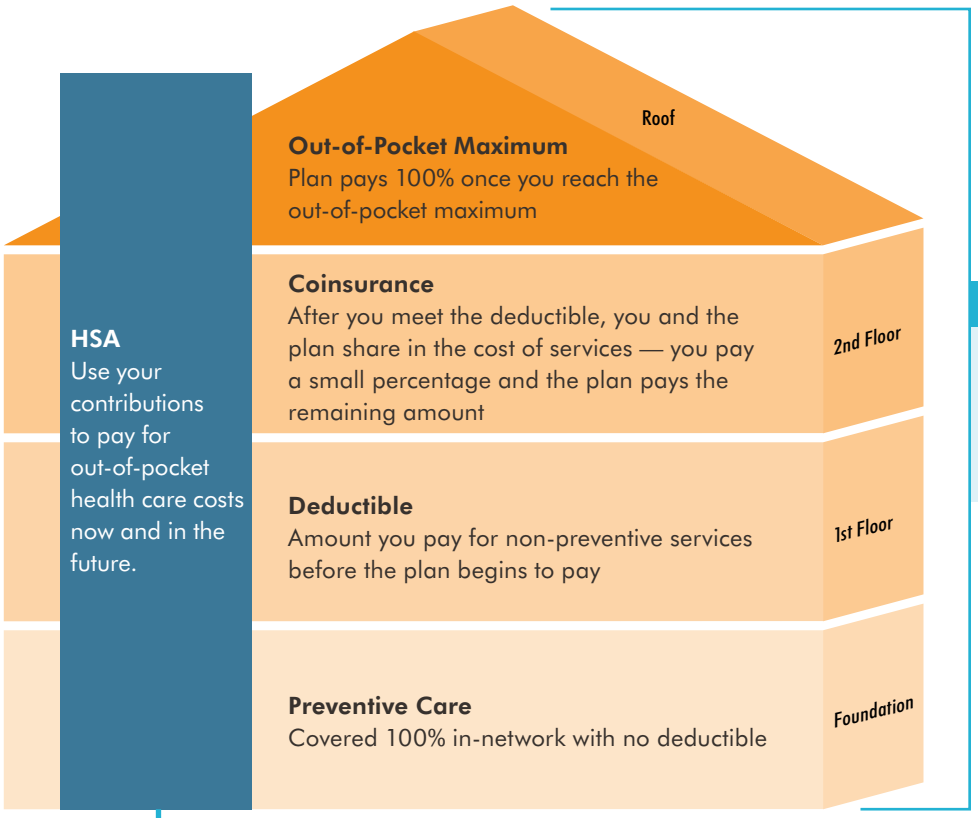
Enjoy the triple tax advantage	Own the account	Control how you use it	Invest your savings	Save for medical expenses in the future
The money you put into your HSA 1) is before federal tax, 2) is not taxed if used for qualified expenses and 3) can receive earnings, which aren't subject to federal tax.[1]	Your HSA funds are yours, even if you change medical plans or leave Robert Half.	Use your HSA funds for qualified expenses, or pay out of pocket and save your funds for a later date.	You have the option to invest in a variety of mutual funds once your HSA balance reaches a minimum level.[2]	By building up your HSA from year to year, you'll be able to use the money for future medical expenses.

[1] *Tax-free status applies to federal taxes but varies by state. Currently, California and New Jersey don't allow favorable tax treatment of HSAs. New Hampshire and Tennessee tax dividends and earnings after a certain dollar amount. Check with your financial advisor to determine how HSA contributions, earnings and distributions are taxed in your state.*

[2] *Information about investment options through TRI-AD is available online at* **yourflexbenefits.mercermarketplace365.com**.

How the HSA and Your Medical Plan Work Together

Think of the $1,500 Deductible Plan and $2,500 Deductible Plan like a house. Each level builds on the other to create a comprehensive medical plan. Preventive care is the foundation, the deductible and coinsurance are the first and second floors, and the out-of-pocket maximum is the roof. Here's how they all work together:



Medical Plan

The levels of the house represent the four basic parts of the $1,500 Deductible Plan or $2,500 Deductible Plan.

HSA

You can contribute to this tax-advantaged account to help pay for eligible medical, dental, vision and prescription drug expenses, now or in the future.

Medical Plan Election	2021 Annual Total Contribution Limit
$1,500 Deductible Plan ■ Individual ■ Family	 $3,600* $7,200*
$2,500 Deductible Plan ■ Individual ■ Family	 $3,600* $7,200*
** If you're age 55 or older, or will turn age 55 during the plan year, you can add $1,000 to your contribution amount.*	

Note: HSA contributions and limits are subject to change each year.

Setting Up Your HSA

- An HSA will be opened for you if you elect to enroll in an HSA-compatible plan through Mercer Marketplace 365 (even if you elect to contribute $0 to your HSA). The HSA is administered by TRI-AD, and the custodial bank is UMB Healthcare Services.
- Once your account is set up, you'll receive an HSA welcome email that will include useful information about your account. You'll also receive an HSA debit card in the mail, which will allow you to conveniently pay for eligible expenses at the point of service.

Enrollment Tip

When you open an HSA, TRI-AD is required to verify your identity as part of the Patriot Act. You'll need to provide a valid physical mailing address, not a P.O. box. If there are questions about your personal information as a result of the Patriot Act inquiries, UMB Healthcare Services will contact you directly by mail.

If your identity isn't verified by UMB Healthcare Services or if you fail to comply with the information requests, your HSA will be closed if you haven't resolved issues with your account after 90 days, and contributions will be refunded within 60 days after your account is closed. For help re-electing an HSA, contact the Mercer Marketplace at **1.855.879.6739** or **mercermarketplace.com/roberthalf**.

Our HSA Partners

The HSA is administered by TRI-AD.

TRI-AD

The custodial bank is UMB Healthcare Services.

UMB | Healthcare Services

You may receive communications from both partners regarding your HSA.

Using Your HSA to Pay for Eligible Expenses

There are three ways to use your HSA to pay for eligible expenses:

- Use your HSA debit card to pay directly at the point of service
- Pay for services out of pocket and submit a claim for reimbursement
- Use your HSA debit card to pay bills you receive from your provider's office

If you don't want to use the money in your HSA, you can also choose to pay for services out of pocket and not submit a claim for reimbursement. This way you save the money in your HSA for future medical needs.

You can use your HSA for out-of-pocket expenses that would generally qualify for the medical, dental and vision expense income-tax deduction:

- ✓ Deductibles
- ✓ Office visits
- ✓ Prescription drugs
- ✓ Hospital stays and lab work
- ✓ Speech/occupational/physical therapy
- ✓ Dental care
- ✓ Vision care

For a complete list of eligible expenses, see IRS Publication 502 at **irs.gov/publications/p502/index.html**.

Save Your Receipts

Be sure to save your receipts — they're your records of eligible expenses. Also, you may be asked to provide them as proof of payment.

Use Your HSA Funds for Qualified Dependents

Your HSA funds can be used for care for you and any of your qualified dependents as defined by the IRS, as long as their expenses aren't otherwise reimbursed. Your dependents include your:

- Spouse (including same-sex spouse)
- Children who are considered IRS tax dependents and, if age 19 through age 24, are full-time students ("children" may include stepchildren, foster children, children placed for adoption and legally adopted children)
- Incapacitated children of any age who are permanently and totally disabled

It's your responsibility to ensure you're using your HSA dollars only for qualified expenses — TRI-AD doesn't monitor or adjudicate HSA claims. Please consult your tax advisor to see if your dependent meets the definition of an eligible dependent for purposes of using your HSA for dependent care.

MEDICAL BENEFITS AT A GLANCE — ANTHEM AND CIGNA PLANS (EXCEPT IN HAWAII)

Below is a snapshot of some of the benefits covered under each medical plan option and your out-of-pocket costs.

Benefits	$400 Deductible Plan		$900 Deductible Plan		$1,500 Deductible Plan (HSA Compatible)		$2,500 Deductible Plan (HSA Compatible)	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Plan Features								
Calendar-year deductible Individual Family	 $400 $800	 $2,500 $5,000	 $900 $1,800	 $3,000 $6,000	 $1,500 $3,000[1,2]	 $3,000 $6,000[1,2]	 $2,500 $5,000[1,2]	 $4,500 $9,000[1,2]
Calendar-year out-of-pocket maximum[3] Individual Family	 $2,200 $4,400	 $4,400 $8,800	 $3,000 $6,000	 $6,000 $12,000	 $3,000 $6,000[4]	 $6,000 $12,000	 $4,500 $6,850[4]	 $9,000 $13,700
Preventive Care								
Annual exams, immunizations, screenings and other eligible preventive care	No charge	You pay 40% after deductible	No charge	You pay 40% after deductible	No charge	You pay 40% after deductible	No charge	You pay 50% after deductible
Office Visits								
Primary care	You pay $20 copay (no deductible)	You pay 40% after deductible	You pay 20% after deductible	You pay 40% after deductible	You pay 20% after deductible	You pay 40% after deductible	You pay 30% after deductible	You pay 50% after deductible
Specialist	You pay $40 copay (no deductible)	You pay 40% after deductible	You pay 20% after deductible	You pay 40% after deductible	You pay 20% after deductible	You pay 40% after deductible	You pay 30% after deductible	You pay 50% after deductible
Hospital Facility								
Inpatient and outpatient	You pay 20% after deductible	You pay 40% after deductible	You pay 20% after deductible	You pay 40% after deductible	You pay 20% after deductible	You pay 40% after deductible	You pay 30% after deductible	You pay 50% after deductible
Emergency room	You pay $150 copay, then 20% after deductible[5]	You pay $150 copay, then 20% after deductible[5]	You pay 20% after deductible	You pay 20% after deductible	You pay 20% after deductible	You pay 20% after deductible	You pay 30% after deductible	You pay 30% after deductible
Retail Prescriptions[6] (up to a 30-day supply) — through an Express Scripts participating pharmacy								
Generic	$10 (no deductible)		You pay 30% (no deductible; min. $10/max. $20)		You pay 20% after deductible[7]		You pay 30% after deductible[7]	
Brand formulary	$30 (no deductible)		You pay 30% (no deductible; min. $25/max. $50)		You pay 20% after deductible[7]		You pay 30% after deductible[7]	
Brand non-formulary	$60 (no deductible)		You pay 45% (no deductible; min. $40/max. $80)		You pay 20% after deductible[7]		You pay 30% after deductible[7]	
Mail-Order Prescriptions[6] (up to a 90-day supply) — through Express Scripts or Smart90 participating pharmacies (go to express-scripts.com and log in for information about the mail-order program or Smart90)								
Generic	$25 (no deductible)	Not covered	You pay 30% (no deductible; min. $25/ max. $50)	Not covered	You pay 20% after deductible	Not covered	You pay 30% after deductible	Not covered
Brand formulary	$75 (no deductible)	Not covered	You pay 30% (no deductible; min. $62.50/ max. $125)	Not covered	You pay 20% after deductible	Not covered	You pay 30% after deductible	Not covered
Brand non-formulary	$150 (no deductible)	Not covered	You pay 45% (no deductible; min. $100/ max. $200)	Not covered	You pay 20% after deductible	Not covered	You pay 30% after deductible	Not covered

[1] *The plans begin to pay benefits for an individual only when the family deductible amount is reached.*

[2] *Family deductible amounts apply if you choose one of the following coverage levels: employee + spouse, employee + child(ren) or employee + family.*

[3] *All copays, coinsurance and deductibles apply to the out-of-pocket maximum.*

[4] *The plan begins to pay 100% of covered in-network care and prescriptions only after the full family annual out-of-pocket amount is reached.*

[5] *Copay waived if admitted. For the $400 Deductible Plan through Cigna only, neither the deductible nor coinsurance apply — only the copay will be required for this service.*

[6] *All prescriptions will be filled with the generic version of the prescription unless otherwise specified by a physician. If you request a brand prescription when a generic is available, you'll pay the applicable copay, plus the difference in cost between the generic and the brand.*

[7] *Prescriptions included on the preventive drug list are covered at the in-network coinsurance level prior to meeting the deductible.*

MEDICAL BENEFITS AT A GLANCE — KAISER PLANS (EXCEPT IN HAWAII)

Below is a snapshot of some of the benefits covered under the Kaiser medical plans and your out-of-pocket costs. These plans aren't available in Hawaii — see page 18 for medical plans available in Hawaii. Benefits for the various Kaiser plans vary slightly, but this chart gives you a general overview of each plan. (Note: Special limits apply to the family deductible and out-of-pocket maximums for Kaiser California only, as noted below.)

Benefits	$400 Deductible Plan	$900 Deductible Plan	$1,500 Deductible Plan (HSA Compatible)	$2,500 Deductible Plan (HSA Compatible)
	In-Network[1]	In-Network[1]	In-Network[1]	In-Network[1]
Plan Features				
Calendar-year deductible Individual Family	$400 $800	$900 $1,800	$1,500 $3,000 (For Kaiser California: Limited to $2,800 for an individual within a family)[2]	$2,500 $5,000 (For Kaiser California: Limited to $2,800 for an individual within a family)[2]
Calendar-year out-of-pocket maximum[3] Individual Family	$2,200 $4,400	$3,000 $6,000	$3,000 $6,000 (For Kaiser California: Limited to $3,000 for an individual within a family)[2]	$4,500 $6,850 (For Kaiser California: Limited to $4,500 for an individual within a family)[2]
Preventive Care				
Annual exams, immunizations, screenings and other eligible preventive care	No charge	No charge	No charge	No charge
Office Visits				
Primary care	You pay $20 copay	You pay 20% after deductible	You pay 20% after deductible	You pay 30% after deductible
Specialist	You pay $40 copay	You pay 20% after deductible	You pay 20% after deductible	You pay 30% after deductible
Hospital Facility				
Inpatient and outpatient	You pay 20% after deductible	You pay 20% after deductible	You pay 20% after deductible	You pay 30% after deductible
Emergency room	CA: You pay 20% (no deductible) All other states: You pay $150 copay (waived if admitted) plus 20% after deductible	You pay 20% after deductible	You pay 20% after deductible	You pay 30% after deductible
Retail Prescriptions[4,5] (up to a 30-day supply)				
Generic	$10	You pay 30% (max. $20)	You pay 20% after deductible[6] (max. $50)	You pay 30% after deductible[6] (max. $50)
Brand formulary	$30	You pay 30% (max. $50)	You pay 20% after deductible[6] (max. $100)	You pay 30% after deductible[6] (max. $100)
Brand non-formulary	Same as formulary, when approved through exception process	Same as formulary, when approved through exception process	Same as formulary, when approved through exception process	Same as formulary, when approved through exception process
Mail-Order Prescriptions[4,5] (up to a 90-day supply)				
Generic	$20	You pay 30% (max. $20)	You pay 20% after deductible (max. $50)	You pay 30% after deductible (max. $50)
Brand formulary	$60	You pay 30% (max. $50)	You pay 20% after deductible (max. $100)	You pay 30% after deductible (max. $100)
Brand non-formulary	Same as formulary, when approved through exception process	Same as formulary, when approved through exception process	Same as formulary, when approved through exception process	Same as formulary, when approved through exception process

[1] *Kaiser offers in-network benefits only.*

[2] *Family deductible amounts apply if you choose one of the following coverage levels: employee + spouse, employee + child(ren) or employee + family.*

[3] *All copays, coinsurance and deductibles apply to the out-of-pocket maximum.*

[4] *All prescriptions will be filled with the generic version of the prescription unless otherwise specified by a physician. If you request a brand prescription when a generic is available, you'll pay the applicable copay, plus the difference in cost between the generic and the brand.*

[5] *Depending on your service area, prescription benefits under the Kaiser plans may vary.*

[6] *Prescriptions included on the preventive drug list are covered at the in-network coinsurance level prior to meeting the deductible.*

MEDICAL BENEFITS AT A GLANCE — HAWAII STAFF

Benefits	Kaiser Hawaii Gold Be Fit	HMSA CompMed	
	In-Network	In-Network	Out-of-Network
Annual deductible	Individual: $200 Family: $400	None	None
Annual out-of-pocket maximum (medical)	Individual: $2,200 Family: $4,400	Individual: $2,500 Family: $7,500	
Lifetime maximum benefit	None	None	
Preventive care	No charge	No charge	No charge
Physician office visit	You pay $15 copay	You pay $14 copay	You pay $14 copay
Hospital			
Inpatient	You pay 10% after deductible	You pay 20%	You pay 20%[1]
Outpatient	You pay 10% after deductible	You pay 20%	You pay 20%[1]
Emergency room	You pay 20% (no deductible)	You pay $20 copay plus 20%	You pay $20 copay plus 20%[1]
Prescription Drugs			
Annual out-of-pocket maximum (prescription drugs)	N/A	Individual: $3,600 Family: $4,200	
Retail (up to a 30-day supply)	■ Generic Maintenance: You pay $10 copay ■ Other Generics: You pay $20 copay ■ Brand: You pay 50%[2] ■ Specialty: You pay 50% (after $250 individual/$500 family deductible for specialty drugs)	■ Generic: You pay $7 copay ■ Preferred Brand: You pay $30 copay[3] ■ Non-Preferred Brand: You pay $30 copay plus $45 for other brand-name cost sharing[3] ■ Preferred Specialty: You pay $100 copay ■ Non-Preferred Specialty: You pay $200 copay	■ Generic: You pay $7 copay plus 20% ■ Preferred Brand: You pay $30 copay plus 20%[3] ■ Non-Preferred Brand: You pay $30 copay, plus 20%, plus $45 for other brand-name cost sharing[3] ■ Specialty: Not covered
Mail order (up to a 90-day supply)	■ Generic Maintenance: You pay $20 copay ■ Other Generics: You pay $40 copay ■ Brand: You pay 50%[2] ■ Specialty: You pay 50% (after $250 individual/$500 family deductible for specialty drugs)	■ Generic: You pay $11 copay ■ Preferred Brand: You pay $65 copay[3] ■ Non-Preferred Brand: You pay $65 copay plus $135 for other brand-name cost sharing[3] ■ Specialty: Not covered	Not covered

[1] *All copays shown are based on eligible charges. An eligible charge is the amount HMSA's participating providers have agreed to accept as payment in full for services rendered. All services received from a non-participating provider will likely result in significantly higher out-of-pocket expenses, since the member is responsible for any difference between HMSA's eligible charge and the non-participating provider's actual charge. Please note: Eligible charges don't include the excise tax or other taxes. You're responsible for all taxes related to your medical coverage.*

[2] *If a brand drug is prescribed when there's a generic drug available, and the prescription is deemed medically necessary, you pay the brand-formulary cost. If the prescription is not deemed medically necessary, you pay the full cost.*

[3] *When a prescribed brand-name drug has a generic equivalent that is listed on the Hawaii Drug Formulary of Equivalent Drug Products, you'll be responsible for the appropriate copayment, plus the difference in cost between the generic and brand-name drugs. This applies regardless of whether you chose not to use the generic drug or whether it wasn't available at your pharmacy.*

USE YOUR HEALTH SUPPORT RESOURCES

In addition to the coverage provided by your medical plan, you may have access to health support tools and resources to help meet your health care needs. There are additional tools available on **mercermarketplace.com/roberthalf**.

Best Doctors/ Teladoc	When you choose a Robert Half medical plan, you'll have access to *Best Doctors/Teladoc*. This service provides confidential second opinions and diagnostic reviews from some of the country's premier physicians to help you receive the most appropriate care for your situation. They can also help you find the best doctor to help treat your particular illness or injury. This benefit is 100 percent confidential and offered at no charge to enrolled employees and dependents. For more information about *Best Doctors/Teladoc*, call **1.866.904.0910** or go to **members.bestdoctors.com**.
Health Advocate	You and your eligible family members, including parents and parents-in-law, have access to *Health Advocate*, a leading national health advocacy and assistance company. You don't need to enroll in a Robert Half medical plan to use *Health Advocate*. *Health Advocate* provides many important services to help you and your family members resolve health care-related issues, balance your life and work, and make healthy lifestyle changes. You have access to personal health advocates who can assist you and your eligible dependents with the following services: ■ Finding a doctor or hospital ■ Resolving billing and claim issues ■ Getting a second opinion for a diagnosis and expediting appointments ■ Understanding conditions, test results, prescriptions and treatment options ■ Finding elder care and support services ■ Understanding Medicare ■ And more… Call *Health Advocate* at **1.866.695.8622**, visit online at **healthadvocate.com/roberthalf** or send an email to **answers@healthadvocate.com**.
Virtual visits ■ LiveHealth Online (Anthem members) ■ MDLIVE (Cigna members) ■ On-demand video visits (Kaiser members)	Consider using your carrier's virtual care programs — like Anthem's LiveHealth Online, CIGNA's MDLIVE or Kaiser's on-demand video visits — where you can see a doctor on your computer or mobile device and get answers 24/7. *"Telemedicine has made a believer out of me! They saved me a late-night run to urgent care when my daughter was suffering with a chronic ear infection. She could stay in the comfort of our home while I talked with the doctor. He even prescribed her medication over the phone!"* — A virtual visits user
Compare costs for care (Anthem and Cigna members)	Have you tried Anthem's or Cigna's cost comparison tools? They can help you find the best value for a procedure in your area. For example, an MRI at a hospital might run $2,000, while services at an imaging center might cost only $800 for the same service. ■ If you're an Anthem member, go to **anthem.com/ca** and log in to use the *Cost & Care Finder* tool. Search for the procedure you need and the tool will help guide you. ■ If you're a Cigna member, visit **myCigna.com** or download the myCigna mobile app, and use the health care professional directory. The search will provide a list of providers, as well as integrated cost and quality information. Kaiser offers members an online calculator that provides cost estimates for many commonly used treatments and services. Use *Estimates* — Kaiser's treatment cost calculator — to get an estimate of your out-of-pocket costs.
Mail-order program and Smart90 (for maintenance medication at local pharmacy)	Anthem and Cigna members can use the mail-order program or Smart90 to fill maintenance medications. (Smart90 is a program that allows you to receive a 90-day supply of your maintenance medication(s) at a participating Walgreens or CVS/Target pharmacy.) After two refills, if you purchase your maintenance medication(s) at a retail pharmacy and not through the mail-order program or a participating Smart90 pharmacy, you'll pay 100% of the cost of your medication(s). (To estimate a drug's cost, use the Price a Medicine tool at **express-scripts.com**. You need to log in to use the tool.) For information on the mail-order program or Smart90, or to find a participating Smart90 pharmacy, go to **express-scripts.com** and log in.
RationalMed	Robert Half has purchased access to an integrated data engine called RationalMed (through Express Scripts). This service, which is free to you, identifies risks, such as adverse drug reactions, by integrating medical, pharmacy and laboratory claims data. It also sends safety interventions and alerts to caregivers to help you and your family members avoid additional risks.

YOUR DENTAL OPTIONS

You have two plan options through Delta Dental to help you pay for routine preventive and other dental care for you and your family:

- Delta Dental Enhanced Plan
- Delta Dental Standard Plan

How the Dental Plans Work

When you use an in-network provider...	When you use an out-of-network provider...
You'll pay fewer out-of-pocket expenses — you'll benefit from discounted rates	You may pay more out of pocket for services because you won't benefit from discounted rates

Below is a snapshot of the dental plan benefits and your out-of-pocket costs.

Find a Dentist

When you use in-network dentists, you will pay fewer out-of-pocket expenses and benefit from discounted rates. To search for dentists in the Delta Dental PPO network, go to **deltadentalins.com**.

Benefits	Delta Dental Enhanced Plan	Delta Dental Standard Plan
	In-Network and Out-of-Network	In-Network and Out-of-Network
Calendar-year deductible Individual Family	 $50 $150	 $50 $150
Calendar-year maximum	$2,000 per person	$1,500 per person
Preventive services*	No charge	No charge
Basic services	You pay 20% after the deductible	You pay 20% after the deductible
Orthodontia		
Services	You pay 50% after the deductible	Not covered
Lifetime maximum	$2,500 per person	
Eligibility	Up to age 19	

** Preventive services apply toward the calendar-year maximum.*

YOUR VISION OPTIONS

Robert Half provides you with vision coverage through Davis Vision and VSP.

These vision plans include reimbursement for eye exams, and eyeglasses or contact lenses.

How the Vision Plans Work

When you use an in-network provider...	When you use an out-of-network provider...
You'll pay fewer out-of-pocket expenses — you'll benefit from discounted rates	You may pay more out of pocket for services because you won't benefit from discounted rates

Below is a snapshot of the vision plan options and your out-of-pocket costs.

Benefits	Davis Vision		VSP	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Eye exam (every calendar year)	$10 copay	Up to $40 allowance	$10 copay	Up to $45 allowance
Eyeglass lenses (every other calendar year)	$25 frames/lenses copay includes: ■ Single vision ■ Lined bifocal ■ Trifocal lenses	■ Single vision: Up to $40 allowance ■ Bifocal: Up to $60 allowance ■ Trifocal: Up to $80 allowance ■ Lenticular: Up to $100 allowance	$25 frames/lenses copay includes: ■ Single vision ■ Lined bifocal ■ Trifocal lenses	■ Single vision: Up to $30 allowance ■ Bifocal: Up to $50 allowance ■ Trifocal: Up to $65 allowance ■ Lenticular: Up to $100 allowance
Lens options	After $25 frames/lenses copay: ■ Standard progressive lenses: Plan covers 100% ■ Premium progressive lenses: $40 copay ■ Custom progressive lenses: $90 copay	Progressive lenses: Up to $60 allowance	After $25 frames/lenses copay: ■ Standard progressive lenses: Plan covers 100% ■ Premium progressive lenses: $95 – $105 copay ■ Custom progressive lenses: $150 – $175 copay	Progressive lenses: Up to $50 allowance
Eyeglass frames (every other calendar year)	■ **Visionworks Store:** Frames covered in full[1] **OR** ■ **Davis Vision Frame Collection:** - Select fashion & designer frames covered in full[2] (value up to $160) - Premier frames covered in full after $25 copay OR $130 retail allowance toward any frame from provider, plus 20% off balance[3]	Up to $50 allowance	After $25 materials copay (see above), plan covers up to: ■ $130 retail allowance for some frames ■ $150 allowance for featured frame brands 20% discount on amounts over allowance	Up to $70 allowance
Contact lenses (once every calendar year in lieu of lenses and frames)	Up to $130 allowance; 15% discount on amounts over allowance	Up to $105 allowance for elective contact lenses; up to $225 if medically required	Up to $130 allowance	Up to $105 allowance

[1] *The free frame benefit is available at all Visionworks locations nationwide and includes all frames except Maui Jim eyewear.*

[2] *The Davis Vision Collection is available at most participating independent provider locations. Collection is subject to change. Collection is inclusive of select toric and multifocal contacts.*

[3] *Additional discounts not applicable at Walmart, Sam's Club or Costco locations.*

Find an In-Network Provider

When you use in-network vision providers, you will pay fewer out-of-pocket expenses and benefit from discounted rates. To search for in-network vision care providers, go to:

- **davisvision.com** and select "Find a Provider"— results will include Visionworks locations
- **vsp.com** and select "Find a VSP Doctor"

Enrollment Tip

If you select a Kaiser medical plan, you automatically receive some vision care coverage.

FLEXIBLE SPENDING ACCOUNTS (FSAs)

Flexible Spending Accounts (FSAs) allow you to pay for eligible health care or dependent care expenses on a pre-tax basis through payroll deductions.

Unlike HSAs that roll over every year, **FSAs are considered "use it or lose it" accounts. Unused funds are forfeited at the end of the calendar year**.

All three types of FSAs are administered by our FSA partner, TRI-AD. For more information, refer to the FSA materials in the Resource Center on the Mercer Marketplace 365 website.

	Dependent Care FSA	Health Care FSA	Combination Health Care FSA
Who can participate	All benefits-eligible employees	All benefits-eligible employees	HSA participants only (for those enrolled in the $1,500 Deductible Plan or $2,500 Deductible Plan)
How much you can contribute annually *2020 limits (indexed by IRS)*	■ Up to $5,000 for individuals or married couples filing joint tax returns ■ Up to $2,500 if you are married and file separate tax returns	Up to $2,750	Up to $2,750
	FSA contributions for highly compensated employees may be limited depending on the outcome of certain nondiscrimination tests imposed on FSAs by the IRS.		
Eligible expenses	Day care, preschool and after-school care for a dependent child under age 13 or for a tax dependent who is physically or mentally incapable of self-care	Medical, prescription drug, dental and vision expenses not paid by your insurance — see IRS Publication 502[1] for a complete list	Dental and vision expenses only until you meet the IRS deductible limit of: ■ $1,400 for individual coverage ■ $2,800 for family coverage Once you meet the IRS deductible limit and submit the appropriate verification form for approval, funds can also be used for medical expenses.
Availability of funds	Funds are available as they are withheld from your pay and deposited into your account.	The full amount is available to you at the start of the year or the month after you join the plan.	The full amount is available to you at the start of the year or the month after you join the plan.
Accessing your account	You will receive a Dependent Care Reimbursement Account debit card from TRI-AD, or you can file claims directly for reimbursement.	You will receive a Health Care FSA debit card from TRI-AD, or you can file claims directly for reimbursement.	For dental and vision expenses, you can use the same TRI-AD debit card that you use for your HSA expenses, or you can file claims directly for reimbursement. You can also use the TRI-AD debit card for medical expenses (once eligible, and if you submit the Deductible Verification form).
	If you enroll in more than one FSA, you'll receive only one debit card to use for both health care and dependent care expenses.		
Substantiation of claims	If you receive a request to substantiate a claim, please do so, or your card will be deactivated, and unsubstantiated funds will become taxable.		
"Use it or lose it"	**Any FSA funds not used by December 31 are forfeited, so plan carefully!** Go to **mercermarketplace.com/roberthalf** to use the FSA expense calculator to help you estimate your expenses for the year. You have until March 31, 2022 to submit claims for reimbursement on any eligible expenses you incur during 2021.		
If your employment ends or you terminate the plan as part of a qualified life event change	■ Your FSA coverage ends on your termination date, and your debit card will be deactivated. ■ You have 90 days from the end of the plan year (March 31, 2022) to submit claims for services received within the 2021 plan year up through your termination date. ■ You can't file claims for services received after your termination date. ■ You forfeit any funds remaining in your account after all qualified claims have been paid. See When Coverage Ends on page 9 for information about coverage ending.		

[1] *You can find IRS Publication 502 at* **irs.gov/publications/p502/index.html**.

COMMUTER BENEFITS

You can set aside pre-tax money through payroll contributions for commuting costs, such as public transportation, vanpools and parking. This program is administered by TRI-AD. Remember, you can change or cancel your contributions at any time during the year. For more information about commuter benefits, go to **roberthalfbenefits.com** or **mercermarketplace.com/roberthalf**.

Feature	Description
Who can participate	All regular full- and part-time employees (excluding those living in Hawaii)
How much you can contribute pre-tax for eligible expenses *2021 limits (indexed by IRS)*	■ For parking, up to $270 a month ■ For mass transit (bus, vanpool, subway, train), up to $270* a month Note: If you're paid weekly, the maximum number of deductions per month will be four deductions. If you're paid biweekly, the maximum number of deductions per month will be two deductions. (In months with an additional pay cycle, deductions won't be taken on the fifth weekly or third biweekly pay cycle.) ** If you live in Massachusetts, state law limits the pre-tax amount to $145 per month for transit and $270 per month for parking. You may contribute up to the maximum monthly IRS limit, but any amount over the state's pre-tax limit will be deducted from your paycheck after-tax.* 
Accessing your account	You'll receive a commuter benefits debit card to pay for eligible parking and transportation expenses. When you use your card, the amount is deducted automatically from your account, provided you have available funds. Claims for reimbursement must be submitted within 180 days from the date of service. Commuter funds can't be refunded or transferred between transit and parking accounts. Monthly claims cannot exceed the IRS monthly maximum. If you try to use your debit card to pay for an expense that exceeds the monthly maximum, the expense will be denied. If you manually submit a commuter claim for an amount that exceeds the monthly allowed maximum, the claim will be paid up to the monthly maximum amount and any amount above the maximum will be denied, and you will need to re-file for the denied amount. If you enroll as a new hire, your coverage is effective as of your date of hire. Funds aren't available until after deductions are taken, so you may need to pay out of pocket and file a claim for reimbursement until funds are available. (Or you can wait and submit claims back to your date of hire once funds become available.) If you enroll in commuter benefits for 2021, but don't re-enroll for 2022, you can continue to submit claims and access your account balance as long as the expenses were incurred within 180 days of your claim.
Funds roll over	If you don't use all the funds in your commuter account each month, unused funds will carry forward and can be used for future valid commuter expenses, as long as you remain an active employee. However, you only have 180 days from the date the claim was incurred to submit it for reimbursement.
Claims at termination	If your employment ends, or if you terminate the plan as part of a qualified life event change, your commuter benefits coverage ends on the termination date. You have 90 days from the termination date to submit claims for expenses incurred no more than 180 days before termination. Claims will not be approved for services incurred after your termination date, nor if the claim is older than 180 days. You forfeit any funds remaining in your account after all qualified claims have been paid. See When Coverage Ends on page 9 for information on how to file a claim and coverage ending.

Important

Note: If you're also enrolled in an HSA or FSA, the debit card you receive is the same one that you'll use for your commuter benefit transactions.

Did You Know?

Commuter benefits are effective as of your hire date.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

The EAP offers free, one-on-one counseling and referrals for Robert Half employees and their household members. These confidential services are effective as of your date of hire and include:

- Marriage or family counseling
- Parental guidance
- Child and senior care
- Legal consultation
- Financial counseling
- Emotional health assistance
- Alcohol or drug abuse counseling
- Work/life balance counseling

Call **1.800.424.4485** as many times as you need; you may also receive up to ten sessions per topic with a counselor. Sessions include face-to-face and virtual therapy through BetterHelp, which offers options for video, phone, texting, and live chat sessions.

Robert Half pays the full cost of the EAP, which is provided through Magellan Health.

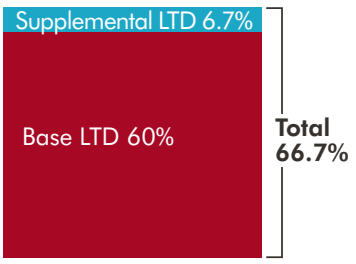
DISABILITY BENEFITS

When you need to miss work due to an illness or accident, disability benefits can replace a percentage of your lost income, up to a maximum benefit.

Robert Half provides company-paid short-term disability (STD) and long-term disability (LTD) benefits if you're a regular, full-time employee and you're unable to work due to illness, injury or pregnancy.

If you want additional LTD coverage, you may purchase supplemental LTD insurance.

Note: Your portion of the cost of medical and other benefits is your responsibility even if you take a leave of absence, such as for a short-term disability. These costs will be deducted from any pay you may receive while on leave. For more details, please refer to the Leave of Absence Manual and applicable policy documents on your internal company site or call Broadspire, Robert Half's leave administrator, at **1.877.603.9687**.

	STD	LTD	Supplemental LTD
Who pays for the benefit	Robert Half	Robert Half	You
Administrator	Broadspire	Lincoln Financial	Lincoln Financial
Elimination period	Benefits begin after seven days of disability	Benefits begin after 180 days of disability	Benefits begin after 180 days of disability
Amount of the benefit	▪ Days 8 – 90: 70% of your regular base salary ▪ Days 91 – 180: 60% of your base salary Currently, STD benefits will be offset by other disability payments, such as state disability insurance in California, Hawaii, New Jersey, New York and Rhode Island.	60% of your benefits-eligible earnings[1,2]	Total of 66.7% of your benefits-eligible earnings (includes 60% from Robert Half-paid LTD benefit)[1,2] 
Benefit maximum	$3,500 per week	$15,000 per month	$25,000 per month (includes $15,000 from Robert Half-paid LTD benefit)
Taxation of benefit	Post-tax; benefit is non-taxable but imputed income does apply	Post-tax; benefit is non-taxable but imputed income does apply	Post-tax; benefit is non-taxable

[1] *Benefits-eligible earnings are your average base pay plus your bonus and commissions over a 12-month look-back period starting from October and ending in September. If you're a new employee, your benefits-eligible earnings are your base pay.*

[2] *Disabilities that begin in the first 12 months of coverage and are due to a pre-existing condition will not be payable under the plan. A condition will be considered pre-existing if you received a physician's advice or treatment within three months prior to your effective date of coverage. See your plan booklet for full details.*

LIFE AND ACCIDENT INSURANCE

When the unexpected happens, you and your family are protected with life and accident insurance provided through Lincoln Financial.

BASIC LIFE AND AD&D INSURANCE

Robert Half provides company-paid basic life and basic accidental death and dismemberment (AD&D) insurance if you're a regular, full-time employee.

Plan	Coverage
Basic Life Insurance	Two times your base pay plus bonus and commissions, to a maximum of $1 million
Basic AD&D Insurance	Two times your base pay plus bonus and commissions, to a maximum of $1 million

Important

The IRS requires that the cost for your basic life insurance coverage in excess of $50,000 be considered taxable income to you. The value of this coverage, called "imputed income," is reported on your federal W-2 form each year.

SUPPLEMENTAL LIFE INSURANCE

If you want additional coverage, you can purchase supplemental life insurance for yourself and your eligible dependents.

You pay the full cost of supplemental insurance on an after-tax basis. If you want to purchase coverage for your dependents, you must also purchase coverage for yourself.

	Supplemental Employee Life	Supplemental Spouse Life	Supplemental Child Life
Coverage amounts available	$25,000 increments, up to $2 million	$5,000 increments, up to $250,000 or 100% of your own supplemental employee life insurance (whichever is less)	■ 14 days – 6 months: $1,000 ■ 6+ months: $5,000 increments, up to $20,000
Guarantee issue amounts	$1 million	$50,000	Not required
	If you elect supplemental life insurance when you're first eligible, you'll need to complete a Statement of Health, also known as Evidence of Insurability (EOI), only for amounts above the guarantee issue amounts. Any future increases in coverage will require EOI. If you (and/or your dependents) do not elect coverage when first eligible but elect at a later date, you'll be required to provide EOI for any amount. Coverage won't be effective until the insurance company approves it in writing.		
Age reductions	For supplemental life insurance, benefit amounts reduce to: ■ 65% of original coverage when you reach age 65, and ■ 50% of original coverage when you reach age 70.		

SUPPLEMENTAL AD&D INSURANCE

If you want additional coverage, you can purchase supplemental AD&D insurance for yourself or you and your family.

You pay the full cost of supplemental insurance on an after-tax basis.

	Supplemental Employee AD&D	Supplemental Family AD&D
Coverage amounts available	$25,000 increments, up to $2 million	■ Spouse only benefit: 60% of your benefit ■ Child(ren)* only benefit: 20% of your benefit ■ Spouse benefit (if child(ren) are also covered): 50% of your benefit ■ Child(ren)* benefit (if spouse is also covered): 15% of your benefit
Other	If you elect supplemental AD&D insurance, you won't be required to complete a Statement of Health, also known as Evidence of Insurability (EOI). Exclusions apply, and additional benefits are available under this plan. Please review the Summary of Benefits Coverage for more details.	
Age reduction	For supplemental AD&D insurance, benefit amounts reduce to: ■ 65 percent of original coverage when you reach age 65, and ■ 50 percent of original coverage when you reach age 70.	

** Coverage is available for eligible children ages 14 days to 26 years.*

BUSINESS TRAVEL ACCIDENT INSURANCE

Robert Half provides business travel accident insurance so you have peace of mind when traveling for work. Business travel accident insurance pays a lump-sum benefit in the event of an accidental death or permanent disability while traveling for work.

If your trip includes any personal travel, business travel accident insurance will continue for up to seven days when the personal portion of your trip is taken in conjunction with an approved business trip.

Business travel accident insurance is provided through Chubb. For help when traveling internationally on business, call **1.410.453.6330**. UnitedHealthcare Global Emergency Travel will help you deal with any issues related to an accident.

BUSINESS TRAVEL MEDICAL INSURANCE

Robert Half provides business travel medical insurance through Cigna International. This plan covers any emergency medical treatment that's required when you're traveling on business outside your country of residence or on permanent assignment.

If your trip includes any personal travel, business travel medical insurance will continue for up to seven days when the personal portion of your trip is taken in conjunction with an approved business trip.

For medical treatment when traveling internationally on business, call **1.410.453.6330**. UnitedHealthcare Global Emergency Travel will help coordinate any care you need.

ADDITIONAL VOLUNTARY BENEFITS

You can enroll in additional voluntary insurance products through the Mercer Marketplace 365. Because these products are offered at competitive group rates, you could save money compared with purchasing them on your own.

Voluntary benefits are available to regular full-time employees. While part-time employees are generally eligible for voluntary benefits, you must meet the eligibility requirements on page 6 to be eligible for supplemental medical insurance, voluntary universal life insurance, and the legal plan. All regular full-time and part-time employees are eligible to elect identity protection, auto and home insurance, and pet insurance beginning on your date of hire.

SUPPLEMENTAL MEDICAL INSURANCE

Supplemental medical insurance can help protect you from significant or unexpected out-of-pocket expenses incurred when you undergo a procedure or use a service your medical plan doesn't cover. These supplemental options are not designed to replace the traditional medical plans.

The following supplemental medical insurance products, provided through Cigna, are available to you as part of our voluntary benefits offerings. You pay the full cost of these plans through post-tax payroll deductions.

Here's how the supplemental medical insurance plans work:

- **Cash benefits are paid directly to you.** Benefits aren't subject to copays, deductibles, coinsurance, or network requirements.
- **You choose how to spend your insurance benefits.** You can pay for medical costs, travel expenses to see a specialist, childcare, or help around the house — it's completely up to you.
- **"Get it" and forget it.** Premiums are deducted from your paycheck, so you're covered when you need it.
- **Take it with you.** You can take your coverage with you if you leave Robert Half.

Complete details about these products and their costs are available on the Mercer Marketplace 365 website at **mercermarketplace.com/roberthalf**.

Hospital Indemnity Insurance	Make sure you're prepared for a possible hospital stay. Hospital indemnity insurance provides a cash payment for expenses that your medical plan may not cover. Benefits include coverage for hospital admissions, including for chronic conditions, intensive care unit (ICU) care, and observation. Coverage is available for you and your eligible dependents.
Accident Insurance	Let's face it: Accidents happen. When they do, accident insurance provides a cash payment in cases of injuries. You can use this money to help pay for uncovered medical expenses — such as your deductible or coinsurance — or ongoing living expenses, like your mortgage, rent, daycare or transportation. Benefits include initial and emergency care, hospitalization benefits, fractures and dislocations, follow-up care, and accidental death and dismemberment. Coverage is available for you and your eligible dependents.
Critical Illness Insurance	Everyone has different needs when coping with critical illness. Critical illness insurance helps protect against the financial impact of heart attack, cancer, stroke and other conditions. You receive a cash payment that you can use for uncovered medical expenses or ongoing living expenses, like your mortgage, rent, daycare or transportation. There's even a paid benefit for completing annual health screenings, including up to $50 for routine health exams and $200 for mammograms. There are two coverage options for you: $15,000 or $30,000. Coverage for eligible dependents is equal to 50% of your coverage amount.

When you purchase accident, critical illness or hospital indemnity coverage through Cigna, you have access to My Secure Advantage™, which offers financial wellness solutions for all types of personal challenges. These solutions include:

- Personal coaching to help you manage financial difficulties
- Identity theft protection with fraud resolution
- Online access to state-specific wills, powers of attorney and a variety of other important legal documents

Is Supplemental Medical Insurance Right for You?

Take a moment to consider if there are gaps in your medical coverage, such as:

- Your deductible is more than your savings
- You may incur extra childcare expenses if you're ill or injured

Additionally, if you're enrolled in a $1,500 Deductible or $2,500 Deductible Plan, you might consider supplemental medical insurance. These plans provide great complementary coverage that can reduce your out-of-pocket medical costs.

UNIVERSAL LIFE INSURANCE

Losing a loved one can be devastating. Final expenses and daily bills only add to your worries. Universal life insurance provides protection throughout your lifetime, accumulates cash value, and offers flexible payment options tailored to your family's needs.

Coverage limits

- Employee (ages 18 and above): Up to $250,000
- Spouse (ages 18 and above) and Child(ren) (ages 24 hours through 25 years): Up to $150,000
- Employee coverage required to enroll Spouse and/or Child(ren), and coverage is limited to 100% of Employee amount.

Guaranteed issue limits for new hires and qualifying life events[1]

You can enroll for coverage without Evidence of Insurability (EOI) up to the following limits:

- Employee (ages 18 through 70): Up to $150,000[2]
- Spouse (ages 18 through 70)
  - Working spouse: Up to $75,000[2]
  - Non-working spouse: Up to $10,000[2]
- Child(ren) (ages 24 hours through 18 years): Up to $20,000[2]

EOI will be required for:

- Employees and spouses over age 70
- Child(ren) ages 19 through 25
- Anyone enrolling in over the guaranteed issue limit

Accelerated death benefit for terminal illness rider

If you experience a terminal illness, you may be eligible to receive part of your death benefit (up to 75% or $100,000, whichever is less). This rider is included with your plan for ages 0 through 75, and is subject to the terms and conditions of your certificate.

[1] *Special note on exclusions and limitations: Although guaranteed issue, all exclusions and limitations will still apply to any coverage issued.*

[2] *Rates are determined by age as of the effective date and smoker status.*

It is possible that coverage will expire when either no premiums are paid following the initial premium or subsequent premiums are insufficient to continue coverage. The coverage is provided by policy form GUL23P and rider GULBR or state variations thereof, underwritten by American Heritage Life Insurance Company, Home Office, Jacksonville, FL, a subsidiary of The Allstate Corporation.

OTHER PLANS

Voluntary Benefit	Description
Allstate Identity Protection (formerly known as InfoArmor®)	Allstate Identity Protection (formerly known as InfoArmor) delivers a powerful new approach to online privacy with unique tools and proactive monitoring that help you see your personal data, manage it with real time alerts, and protect your identity. Monitor your financial transactions, social media, student loans, retirement accounts, and more. If fraud occurs, our highly trained in-house experts fully manage and restore your identity, and our $1 million insurance policy covers any of your associated out-of-pocket costs. Visit **www.myaip.com/mercermarketpp** or call **1.800.789.2720** to find out more.
Legal benefits (MetLife)	MetLife offers you access to attorneys for common legal matters, such as will preparation, estate planning, elder care matters, identity theft and more. You, your spouse and your dependents can select an attorney from our nationwide network of more than 15,000 experienced attorneys for advice and consultation, to draft or review documents or to provide representation in court, if necessary. You also have the ability to use an attorney outside of the legal plan network and get reimbursed for covered services according to a set fee schedule. A client service representative can help you locate a network attorney in your area. Through the member website, you'll also have access to an attorney locator to find attorneys on your own, self-help legal documents to complete simple legal matters and a Law Firm E-Panel that you can submit questions to. Visit **info.legalplans.com** to find out more.
Auto and home insurance (MetLife)	Compared with purchasing auto and home insurance on your own, purchasing group auto and home insurance through the Mercer Marketplace 365 could provide you with savings of up to 15 percent. MetLife gives you access to a variety of personal insurance policies, including home,* landlord's rental dwelling, condo, mobile home, renters, recreational vehicle, boat and personal excess liability. ** Home insurance is not part of the benefit offering from MetLife Auto and Home in Massachusetts and Florida.*
Pet insurance (Nationwide)	If you're a pet owner, you know how quickly animals become part of your family and how important it is to offer them the care and love they need. With coverage from Nationwide®, you can continue providing the best care possible. Call **1.800.540.2016** or go to **PetBenefitsPortal.com** for a free quote.

All registered trademarks are the property of their respective owners.

Discount Perks

Through PerkSpot, you'll have 24/7 access to exclusive prices, discounts and offers from hundreds of local and national merchants, such as health clubs, movie theaters, restaurants, retailers and all major cell phone providers. Offers are updated frequently.

Using PerkSpot is free. Once you enroll, you can sign up to receive email alerts for discounts and savings of up to 40 percent.

CONTACT INFORMATION

If you have questions or need information about the Robert Half employee benefits program, please contact the Mercer Marketplace 365 at **1.855.879.6739**. Benefit counselors are available Monday through Friday, 4 a.m. to 6 p.m. Pacific time.

General Benefits Questions?

Contact the Mercer Marketplace 365:

1.855.879.6739

mercermarketplace.com/roberthalf

Plan	Carrier/Vendor	Group Numbers	Telephone	Website
Medical/Prescription	Anthem	174285	1.844.594.6178	**anthem.com/ca**
	Cigna	2498728	1.800.CIGNA24	**cigna.com** **mycigna.com** (for Cigna members)
	Express Scripts	N/A	1.844.604.9159	**express-scripts.com**
	Kaiser	Northern CA: 602943 Southern CA: 230182 CO: 35663 GA: 10191 HI: 50011 Mid-Atlantic: 23109 Northwest (OR and WA): 19884 WA: 20956	See your Kaiser ID card for pre-enrollment questions, call: 1.877.580.6125 (all regions except WA) 1.888.901.4636 (WA only)	**kp.org/mercermarketplace**
	HMSA	24453-1-0	1.808.948.6111	**hmsa.com**
Health Savings Account (HSA)	TRI-AD	N/A	1.866.268.0142	**yourflexbenefits.mercermarketplace365.com**
Best Doctors/Teladoc	Best Doctors/Teladoc	N/A	1.866.904.0910	**members.bestdoctors.com**
Health Advocate	Health Advocate	Account ID: Robert Half International	1.866.695.8622	**healthadvocate.com/members**
Accident Insurance	Cigna	AI961568	1.800.CIGNA24	**cigna.com** or **mycigna.com** (for Cigna members)
Critical Illness Insurance	Cigna	CI961489	1.800.CIGNA24	**cigna.com** or **mycigna.com** (for Cigna members)
Hospital Indemnity Insurance	Cigna	HC960819	1.800.CIGNA24	**cigna.com** or **mycigna.com** (for Cigna members)
Dental	Delta Dental	17450	1.800.765.6003	**deltadentalins.com**
Vision	Davis Vision	2386914	1.800.383.2199	**davisvision.com** (Robert Half code: 7649)
	VSP	30052408	1.800.877.7195	**vsp.com**
Flexible Spending Accounts (FSAs)	TRI-AD	N/A	1.866.268.0142	**yourflexbenefits.mercermarketplace365.com**
Life and AD&D Insurance	Lincoln Financial	SA3-860-06675-01	1.855.879.6739 (answered by the Mercer Marketplace 365)	**mylincolnportal.com** (use company code ROBERTHALF to register)
Disability	Broadspire	STD: PD3-860-066675	1.877.603.9687	**myleavetech.com** (use your work email address to activate your Broadspire portal account)
	Lincoln Financial	LTD: GF-860-066675	1.800.291.0112	**mylincolnportal.com** (use company code ROBERTHALF to register)
Employee Assistance Program (EAP)	Magellan Health	MERC0-006	1.800.424.4485	**magellanascend.com**
Business Medical Insurance/Business Travel Accident Insurance	UnitedHealthcare Global Emergency Travel	6477-61-03	1.800.318.2596	**members.uhcglobal.com**
Universal Life Insurance	Allstate Benefits	V6971 (weekly), V7944 (bi-weekly) and V7945 (semi-monthly)	1.800.521.3535	**allstatevoluntary.com/mercermarketplace**
Commuter Benefits	TRI-AD	N/A	1.866.268.0142	**yourflexbenefits.mercermarketplace365.com**
Identity Theft Protection	Allstate	793	1.800.789.2720	**www.myaip.com/mercermarketpp**
Auto and Home Insurance	MetLife	N/A	1.800.438.6388	**metlife.com/group-auto/mpe**
Legal Assistance	MetLife	N/A	1.800.438.6388	**info.legalplans.com**
Pet Insurance	Nationwide	4201	1.800.540.2016	**petbenefitsportal.com**
Discount Mall	PerkSpot	N/A	1.866.606.6057	**roberthalf.perkspot.com**
401(k) Plan	Fidelity	N/A	1.800.835.5097	**netbenefits.fidelity.com**

This document is a Summary of Material Modification, as required by ERISA. Together this guide, benefit descriptions, contracts and summary plan descriptions comprise the official Plan document, which legally governs the administration of each benefit plan.

Robert Half reserves the right to terminate, suspend, withdraw or modify the benefits described in this document, in whole or in part, at any time. No statement in this or any other document, and no oral representation, should be construed as a waiver of this right.