ROBERT HALF
CAFETERIA PLAN AND
SUMMARY PLAN DESCRIPTION

Amended and Restated
Effective as of January 1, 2021

ROBERT HALF
CAFETERIA PLAN AND SUMMARY PLAN DESCRIPTION

INTRODUCTION

This employee benefit plan is called the Robert Half Cafeteria Plan and Summary Plan Description (the "Plan"). This Plan amends and restates the cafeteria plan maintained by Robert Half International Inc. ("Robert Half") and is effective as of January 1, 2021.

The Plan is intended to qualify as a cafeteria plan under the provisions of § 125 of the Internal Revenue Code. The Plan provides you with an opportunity to choose among several employee benefits ("Benefit Plan Options") according to your individual needs and allows you to use pre-tax dollars to pay for them. You save social security and income taxes on the amount of your pre-tax contributions. Alternatively, to the extent described in your enrollment materials, you may pay for certain benefits with After-tax Contributions as deductions from your salary. If you are a Temporary Employee, this Plan permits you to make After-tax Contributions to pay for Benefit Plan Options for Temporary Employees offered by Robert Half.

The Plan offers a Health Care Flexible Spending Account ("Health Care FSA") which includes a General Purpose FSA and a Combination FSA. The Health Care FSA is intended to qualify as a Code § 105 self-insured medical expense reimbursement plan and the benefits provided under the Health Care FSA are intended to be eligible for exclusion from your income for federal income tax purposes under Code § 105(b). The Health Care FSA is subject to the requirements of ERISA, HIPAA, and COBRA.

The Plan also offers a Dependent Care Flexible Spending Account ("Dependent Care FSA"), which is intended to qualify as a Code § 129 dependent care assistance plan, and the benefits provided under the Dependent Care FSA are intended to be eligible for exclusion from your income for federal income tax purposes under Code § 129. You may establish a Health Savings Account ("HSA") if you elect one of the High Deductible Health Plans offered by Robert Half. The HSA is not an employee welfare benefit plan subject to ERISA.

A description of each component of your Plan follow this introduction and important information relating to the Plan is contained in Appendix A. This document and the attached Appendices constitute the official Plan document required under Code § 125 and a Summary Plan Description to the extent required by ERISA. It describes the basic features of the Plan and how it operates. Although this Plan describes your benefits in effect on January 1, 2020, your benefits may change in the future at Robert Half's discretion. To the extent future enrollment materials, summaries of material modifications, or employee communications contain Plan changes approved by Robert Half, such documents will be incorporated by reference into this Plan. Certain terms in this Plan are capitalized and are either defined at the end of or within the document. If there is a conflict between the official Plan document and other communications relating to the Plan, this Plan document will govern.

Participation in the Plan does not give you the right to be retained in employment nor does it give you any other rights not specified in the Plan. If you have any questions regarding your rights and responsibilities under the Plan, you may also contact the Plan Administrator or the applicable third-party administrator (identified in Appendix A). Robert Half retains the right to amend or terminate this Plan at any time.

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.

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 and the extension of certain time frames applicable to ERISA plans. More information on these extensions is contained in the Robert Half Welfare Benefit Plan and Summary Plan Description.

Finally, Congress, the Internal Revenue Service (the "IRS") and the Department of Labor (the "DOL") provided plan sponsors and participants with several types of optional legislative and regulatory relief to apply during the COVID Outbreak, such as offering Plan participants opportunities to revoke, increase or decrease their health care/dependent care flexible spending account elections, carry over unused balances in health care/dependent care flexible spending account and more. To the extent, Robert Half elected to implement any optional changes applicable to this Plan, this Plan notes those changes in the applicable section of the Plan.

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

ROBERT HALF

CAFETERIA PLAN

TABLE OF CONTENTS

INTRODUCTION I-1

ARTICLE I PURPOSE OF THE PLAN 1

1.1. Plan Purpose 1

1.2. Plan Components 1

ARTICLE II CAFETERIA PLAN COMPONENT 1

2.1. Participation in the Cafeteria Plan Component 1

2.2. Commencement of Participation 2

2.3. Termination of Participation 2

2.4. Cafeteria Plan Election Periods 3

2.5. Election Changes 4

2.6. Funding the Cafeteria Plan Component 4

2.7. Participation in the Cafeteria Plan Component and Leaves of Absence 4

ARTICLE III HEALTH CARE FLEXIBLE SPENDING ACCOUNT 6

3.1. Participation in the Health Care FSA 6

3.2. Termination of Participation 6

3.3. Changes to my Health Care FSA Election 7

3.4. My Health Care FSA and Leaves of Absence 7

3.5. Maximum Annual Health Care FSA Reimbursement 7

3.6. Funding of Health Care FSA 8

3.7. Amounts Available for Health Care FSA Reimbursement During the Plan Year 8

3.8. Reimbursement Options under the Health Care FSA 8

3.9. Definition of Eligible Medical Expense 9

3.10. Timing of Eligible Medical Expense 10

3.11. Forfeitures and Qualified Reservist Distributions 10

3.12. Denial of a Claim for Benefits under the Health Care FSA 11

3.13. COBRA Continuation Coverage and Health Care FSA 11

3.14. HIPAA and the Health Care FSA 13

ARTICLE IV ERISA RIGHTS FOR HEALTH CARE FSA PARTICIPANTS 17

4.1. Receive Information About Your Plan and Benefits 17

4.2. Continue Group Health Plan Coverage 17

4.3. Prudent Actions by Plan Fiduciaries 17

4.4. Enforce Your Rights 17
4.5. Assistance with Your Questions 17
ARTICLE V DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT 18
5.1. Participation in the Dependent Care FSA 18
5.2. Termination of Participation 18
5.3. Changes to My Dependent Care FSA 18
5.4. My Dependent Care Spending Account and an Approved Leave of Absence 19
5.5. Maximum Annual Dependent Care FSA Reimbursement 19
5.6. Funding of Dependent Care FSA 19
5.7. Eligible Employment-Related Expenses 19
5.8. Reimbursement Options under the Dependent Care FSA 20
5.9. Timing of Eligible Employment-Related Expenses 20
5.10. Forfeitures 21
5.11. Unclaimed Dependent Care FSA Reimbursements 21
ARTICLE VI HEALTH SAVINGS ACCOUNT 21
6.1. Eligibility for HSA Benefits 21
6.2. Contributions to HSA; Maximum Annual Limits 21
6.3. Tax Treatment of HSA Contributions and Distributions 21
6.4. Changes to Amount of Pre-tax Contributions to your HSA 21
6.5. Custodial Agreement; HSA Is Not an ERISA Plan 21
ARTICLE VII PLAN ADMINISTRATION 22
7.1. Allocation of Authority 22
ARTICLE VIII AMENDMENT OR TERMINATION OF PLAN 22
8.1. Employer's Right to Amend 22
8.2. Employer's Right to Terminate 23
ARTICLE IX GENERAL PROVISIONS 23
9.1. Not an Employment Contract 23
9.2. Applicable Laws 23
9.3. Requirement for Proper Forms 23
9.4. Tax Effects 23
9.5. Gender and Number 23
9.6. Incorporation by Reference 23
9.7. Severability 23
9.8. Effect of Mistake 23
ARTICLE X DEFINITIONS 24

10.1. "Affiliated Employer" 24
10.2. "After-tax Contribution(s)" 24
10.3. "Benefit Plan Option(s)" 24
10.4. "Cafeteria Plan Component" 24
10.5. "Change in Status" 24
10.6. "Code" 24
10.7. "Combination FSA" 24
10.8. "Compensation" 24
10.9. "Dependent Care Flexible Spending Account" or "Dependent Care FSA" 24
10.10. "Dependent" 24
10.11. "Effective Date" 25
10.12. "Eligible Employment-Related Expenses" 25
10.13. "Eligible Medical Expenses" 25
10.14. "Employee" 25
10.15. "Employer" 26
10.16. "ERISA" 26
10.17. "Flexible Spending Account(s)" 26
10.18. "General Purpose FSA" 26
10.19. "Health Care Flexible Spending Account" or "Health Care FSA" 26
10.20. "Health Savings Account" or "HSA" 26
10.21. "HSA Benefits" 26
10.22. "HSA-Eligible Employee" 26
10.23. "Highly Compensated Individual" 26
10.24. "Key Employee" 26
10.25. "Matching Contributions" 27
10.26. "Participant" 27
10.27. "Plan" 27
10.28. "Plan Administrator" 27
10.29. "Plan Year" 27
10.30. "Pre-tax Contribution(s)" 27
10.31. "Qualified Benefit" 27
10.32. "Qualifying Individual" 27
10.33. "Qualifying Services" 27
10.34. "Run-Out Period" 27
10.35. "Salary Reduction Agreement" 28

10.36. "Spouse" 28
10.37. "Student" 28
10.38. "Temporary Employee" 28
SIGNATURE PAGE 29
APPENDIX A PLAN INFORMATION SUMMARY 30
APPENDIX B CLAIMS REVIEW PROCEDURE 31
APPENDIX C ELECTION CHANGE SUMMARY 33
APPENDIX D LIST OF PARTICIPATING AFFILIATED EMPLOYERS 37

ARTICLE I

PURPOSE OF THE PLAN

1.1. **Plan Purpose**. The purpose of the Plan is to allow you to pay for certain Benefit Plan Options with Pre-tax or After-tax Contributions. The Benefit Plan Options to which you may contribute under this Plan are listed in the summaries at the beginning of this Plan and in your initial or annual enrollment materials.

1.2. **Plan Components**. This Plan has four components:

(a) A Cafeteria Plan Component. The Cafeteria Plan Component allows you to pay your share of the cost of coverage for your chosen Benefit Plan Options with Pre-tax or After-tax Contributions.

(b) The Health Care Flexible Spending Account ("Health Care FSA"). The Health Care FSA allows you to elect to use a specified amount of Pre-tax Contributions for reimbursement of Eligible Medical Expenses incurred during a Plan Year. The Health Care FSA includes the General Purpose and Combination FSAs. Participation in a HSA means you may only elect to participate in the Combination FSA, which initially only provides for the reimbursement of dental or vision expenses but will convert to a General Purpose FSA, upon the satisfaction of the IRS minimum required deductible for high deductible health plans under Code §223(c)(2)(A)(i). The General Purpose FSA provides for the reimbursement of Eligible Medical Expenses, not just preventive, vision or dental expenses

(c) The Dependent Care Flexible Spending Account ("Dependent Care FSA"). The Dependent Care FSA allows you to elect to use a specified amount of Pre-tax Contributions for reimbursement of Eligible Employment-Related Expenses.

(d) The Health Savings Account ("HSA"). You may establish an HSA when you enroll in a Robert Half High Deductible Health Plan. If you do so, you will elect to make a specified amount of Pre-tax Contributions to your HSA, and your Employer may make Matching Contributions.

ARTICLE II

CAFETERIA PLAN COMPONENT

2.1. **Participation in the Cafeteria Plan Component**. If you are eligible to participate in any of the Benefit Plan Options, you also will be eligible to participate in this Cafeteria Plan Component no later than the first day of the month coinciding with or next following the date that your Salary Reduction Agreement is received by Robert Half. The Cafeteria Plan Component allows you to pay for certain Benefit Plan Options on a pre-tax basis (before income and Social Security taxes are withheld) or on an after-tax basis.

The terms of eligibility of this Cafeteria Plan Component do not override the terms of eligibility of each of the Benefit Plan Options. For the details regarding each of the Benefit Plan Options, please refer to the Robert Half Welfare Benefit Plan and Summary Plan Description. If you do not have a copy of that document, you should contact the Plan Administrator for information on how to obtain a copy.

2.2. Commencement of Participation. You become a Participant by completing a Salary Reduction Agreement on which you agree to pay for the Benefit Plan Options that you choose with Pre-tax or After-tax Contributions. You must complete the Agreement and submit it as directed during one of the election periods described in Section 2.5 below. You may also enroll during the year if you previously elected not to participate and you experience a Change in Status event that allows you to become a Participant during the year. If that occurs, you must complete an Election Change Form during the Election Change Period described in Section 2.6 below. In no event can you become a Participant in this Cafeteria Plan Component prior to the date you complete and properly submit the Salary Reduction Agreement to the appropriate person(s).

Enrollment may also be accomplished by telephone, voice response technology, electronic communication, web or online enrollment systems, or any other method prescribed by Robert Half or a third party administrator.

You may elect to contribute Pre-tax or After-tax Contributions for the following Benefit Plan Options:

a) Medical Coverage – Pre-tax Contributions for Employees and Temporary Employees who work in Hawaii or After-tax Contributions for Temporary Employees;

b) Dental Coverage – Pre-tax Contributions for Employees and Temporary Employees who work in Hawaii or After-tax Contributions for Temporary Employees;

c) Vision Coverage – Pre-tax Contributions for Employees and Temporary Employees who work in Hawaii or After-tax Contributions for Temporary Employees;

d) Employee Basic Group Term Life Insurance – 100% Employer paid;

e) Employee Supplemental Group Term Life Insurance – After tax Contributions;

f) Employee Basic AD & D – 100% Employer paid;

g) Employee Supplemental AD & D – After-tax Contributions;

h) Supplemental Long-term Disability Insurance –After- tax Contributions;

i) Health Care FSA (General Purpose or Combination) – Pre-tax Contributions for Employees;

j) Dependent Care FSA – Pre-tax Contributions for Employees; and

k) Health Savings Account – Pre-tax Contributions for Employees.

2.3. Termination of Participation. Your coverage under the Cafeteria Plan Component ends on the earliest of the following to occur:

(a) The effective date of your election not to participate;

(b) The date you no longer satisfy the eligibility requirements of this Cafeteria Plan Component or any of the Benefit Plan Options;

(c) The date you terminate employment, or the last day through which contributions are paid; or

(d) The date the Plan is either terminated or amended to exclude you or the class of Employees or Temporary Employees of which you are a member.

If your employment with Robert Half is terminated during the Plan Year or you otherwise cease to be eligible, your active participation in the Cafeteria Plan Component will ***automatically*** cease, and you will not be able to make any more Pre-tax or After-tax Contributions except as otherwise provided pursuant to Robert Half policy or individual arrangement (e.g., a severance arrangement where you are permitted to continue paying for a Benefit Plan Option out of severance pay on a pre- or after-tax basis). If you are rehired or again become eligible within a 31-day period or less of your termination or loss of eligibility, your Cafeteria Plan Component elections that were in effect when you terminated employment or lost eligibility will be reinstated and remain in effect for the remainder of the Plan Year (unless you are allowed to change your election as the result of a Change in Status event) on the rehire or re-eligibility date. If you are rehired or again become eligible more than 31 days after you terminated employment or lost eligibility, you will need to enroll and may make new elections for that Plan Year (subject to any limitations imposed by the Benefit Plan Options or the Employer).

2.4. Cafeteria Plan Election Periods. The Cafeteria Plan Component has three election periods: (i) the Initial Election Period, (ii) the Annual Election Period, and (iii) the Election Change Period, which is the 30-day period following the date you have a Change in Status event. The following is a summary of the Initial Election Period and the Annual Election Period.

(a) **Initial Election Period**

If you want to participate in the Cafeteria Plan Component when you are first hired, you must enroll during the Initial Election Period described in the enrollment materials you will receive. The election that you make during the Initial Election Period is effective for the remainder of the Plan Year and generally cannot be changed during the Plan Year unless you have a Change in Status event described in Section 2.6 below or Appendix C.

If you do not make an election during the Initial Election Period, you will be deemed to have elected not to participate in this Cafeteria Plan Component for the remainder of the Plan Year. Failure to make an election generally results in no coverage under the Benefit Plan Options; however, your Employer may provide coverage under certain Benefit Plan Options automatically. These automatic benefits are called Default Benefits. Any Default Benefit provided by your Employer will be identified in the enrollment materials. In addition, your share of the contributions for Default Benefits may be automatically withdrawn from your pay on a pre-tax basis, depending on the type of benefit. You will be notified in the enrollment materials whether there will be corresponding Pre-tax or After-tax Contributions withheld for such Default Benefits. If you are a Temporary Employee, you are not eligible to receive Default Benefits.

(b) **Annual Election Period**

The Cafeteria Plan Component also has an Annual Election Period during which you may enroll if you did not enroll during the Initial Election Period or you wish to change your elections for the next Plan Year. The Annual Election Period will be identified in the enrollment materials distributed to you prior to the Annual Election Period. The elections that you make during the Annual Election Period are effective the first day of the next Plan Year and cannot be changed during the entire Plan Year unless you have a Change in Status event described in Section 2.6 below or Appendix C.

If you fail to complete, sign, and file a Salary Reduction Agreement or otherwise complete the steps required by Robert Half for effective enrollment during the Annual Election Period, you may be deemed to have elected to continue participation in the Cafeteria Plan Component with the same Benefit Plan Option elections that you had on the last day of the Plan Year in which the Annual Election period occurred (adjusted to reflect any increase/decrease in applicable premium/contributions). This is called an Evergreen Election. Evergreen Elections apply to all Benefit Plan Options other than the HSA and the Health Care and Dependent Care FSAs. The Plan Year is the calendar year.

2.5. Election Changes. Generally, you cannot change your elections under this Plan during the Plan Year outside an Annual Election Period. There are, however, a few exceptions.

First, your elections will automatically terminate if you terminate employment or lose eligibility under this Plan or a Benefit Plan Option that you have chosen.

Second, you may voluntarily change your elections during the Plan Year if you satisfy the following conditions (as prescribed by federal law):

(a) You experience a Change in Status event that affects your eligibility under this Cafeteria Plan and/or Benefit Plan Option; or

(b) You experience a significant cost or coverage change as defined in IRS regulations; and

(c) You complete and submit a written Election Change Form within the prescribed Election Change Period.

Change in Status events and cost or coverage changes recognized by this Plan, and the rules surrounding election changes in the event you experience a Change in Status event or cost or coverage change are described in Appendix C - Election Change Summary. Appendix C also contains special rules only applicable to certain election changes to your Health Care and Dependent Care FSAs permitted by the IRS due to Covid-19 during the 2020 Plan Year.

Third, an election under this Cafeteria Plan Component may be modified downward during the Plan Year by Robert Half if you are a Key Employee or Highly Compensated Individual (as defined by the Code), to prevent the Plan from becoming discriminatory under the Code.

If coverage under a Benefit Plan Option ends, the corresponding Pre-tax or After-tax Contributions for that coverage will automatically end. No election is needed to stop the contributions.

2.6. Funding the Cafeteria Plan Component. The enrollment materials you receive will indicate whether you may elect to pay for a Benefit Plan Option with Pre-tax or After-tax Contributions.

When you submit your Salary Reduction Agreement, an amount equal to your share of the annual cost of your chosen Benefit Plan Options, divided by the applicable number of pay periods you have during that Plan Year, is deducted from each paycheck after your election effective date.

2.7. Participation in the Cafeteria Plan Component and Leaves of Absence. The following is a general summary of the rules regarding participation in the Cafeteria Plan Component for Employees during a leave of absence.

(a) If you go on an unpaid leave under the Family and Medical Leave Act of 1993 (FMLA), Robert Half will continue to maintain your Benefit Plan Options that provide health coverage on the same terms and conditions as though you were still active to the extent

required by FMLA (e.g., Robert Half will continue to pay its share of the contribution to the extent you opt to continue health coverage).

(b) Robert Half may elect to continue all health coverage for Participants while on paid leave (provided Participants on non-FMLA paid leave are required to continue coverage). If so, you will pay your share of the contributions by the method normally used during any paid leave (for example, with Pre-tax Contributions if that is what was used before the FMLA leave began).

(c) In the event of unpaid FMLA leave, if you opt to continue your group health coverage, you may complete a benefits continuation request in such form as may be determined by Robert Half and pay your share of the contribution in one of the following ways:

(i) With After-tax Contributions while you are on leave.

(ii) You may pre-pay all or a portion of your share of the contribution for the expected duration of the leave with Pre-tax Contributions from your pre-leave compensation by making a special election to that effect before the date such compensation would normally be made available to you. However, pre-payments of Pre-tax Contributions may not be utilized to fund coverage during the next Plan Year.

(iii) By other arrangements agreed upon between you and Robert Half. For example, Robert Half may fund your health coverage during the leave and withhold amounts from your compensation upon your return from leave.

The payment options provided by Robert Half will be established in accordance with Code § 125, FMLA and Robert Half's internal policies and procedures regarding leaves of absence and will be applied uniformly to all Participants. Alternatively, Robert Half may require all Participants to continue coverage during the leave. If so, you may elect to discontinue your share of the required contributions until you return from leave. Upon return from leave, you will be required to repay the contribution not paid during the leave in a manner agreed upon with Robert Half.

(d) If your coverage ceases while on FMLA leave (e.g., for non-payment of required contributions), you will be permitted to reenter the Plan and the affected Benefit Plan Option(s) upon return from such leave on the same basis as you were participating in the plans prior to the leave, or as otherwise required by the FMLA. Your coverage under the Benefit Plan Options providing health coverage may be automatically reinstated provided that coverage for Employees on non-FMLA leave is automatically reinstated upon return from leave, unless you are required to make a new election to your Health Care and Dependent Care FSAs.

(e) Robert Half may, on a uniform and consistent basis, continue your group health coverage for the duration of the leave following your failure to pay required contributions. Upon return from leave, you will be required to repay Robert Half in a manner agreed upon by you and Robert Half.

(f) If you are commencing or returning from unpaid FMLA leave, your election under this Plan for Benefit Plan Options providing non-health benefits shall be treated in the same manner that elections for non-health Benefit Plan Options are treated with respect to Participants commencing and returning from unpaid non-FMLA leave.

(g) If you go on an unpaid non-FMLA leave of absence (e.g., personal leave, sick leave, etc.) that does not affect eligibility in this Plan or a Benefit Plan Option offered under this Plan, then you will continue to participate and the contribution due will be paid by pre-payment before going on leave, by After-tax Contributions while on leave, or with catch-up contributions after the leave ends, as may be determined by Robert Half. If you go on an unpaid leave that affects eligibility under this Plan or a Benefit Plan Option, the election change rules described herein will apply. Robert Half will have discretion to determine whether taking an unpaid non-FMLA leave of absence affects eligibility.

ARTICLE III

HEALTH CARE FLEXIBLE SPENDING ACCOUNT

3.1. Participation in the Health Care FSA. If you are eligible for health care coverage, you may participate in the Health Care FSA no later than the first day of the month coinciding with or next following the date that you submit your Salary Reduction Agreement. If you are a Temporary Employee, you are not eligible to participate in the Health Care FSA. The Health Care FSA is subject to ERISA.

If you are eligible to participate in the Health Care FSA, you must elect to participate in either the General Purpose FSA or the Combination FSA. If you elect to participate in a Robert Half High Deductible Health Plan, and you establish an HSA, you may not elect to participate in the General Purpose FSA under federal law. You may elect to participate in the Combination FSA, which initially only provides for the reimbursement of preventive care and vision or dental expenses, but will convert to a General Purpose FSA upon the satisfaction of the IRS minimum required deductible for high deductible health plans under Code §223(c)(2)(A)(i). The General Purpose FSA provides for the reimbursement of Eligible Medical Expenses, not just preventive care and vision or dental expenses.

You become a Participant in the Health Care FSA by electing to do so during the Initial or Annual Election Periods described in Section 2.5. Once you become a Participant, your Dependents also become covered. You must make an election to participate in the Health Care FSA during each Annual Election Period because your Health Care FSA elections do not automatically carry over from one Plan Year to the next.

You may also become a Participant if you experience a Change in Status event that permits you to enroll midyear (see Section 2.6 and Appendix C for more details regarding midyear election changes).

If the Plan Administrator or third party administrator receives a medical child support order relating to your Health Care FSA, it will notify you in writing, and after receiving the order, it will inform you of its determination of whether or not the order is qualified. If the Plan Administrator or third party administrator determines that a medical child support order is qualified (a "QMCSO"), the Health Care FSA will provide the health benefit coverage specified in the order to the person or persons ("alternate recipients") named in the order to the extent the QMCSO does not require coverage the Health Care FSA does not otherwise provide. Upon request to the Plan Administrator or third party administrator, you may obtain, without charge, a copy of the Plan's procedures governing QMCSOs.

3.2. Termination of Participation. Your coverage under the Health Care FSA ends on the earliest of the following:

(a) The effective date of your permitted election not to participate;

(b) The last day of the Plan Year unless you make an election during the Annual Election Period;

(c) The date you no longer satisfy the Health Care FSA eligibility requirements;

(d) The day you terminate employment; or

(e) The date the Plan is terminated or you or the class of Employees of which you are a member are specifically excluded from the Plan. You may be entitled to elect COBRA Continuation Coverage (as described in Section 3.14 below).

Coverage for your Dependents ends on the earliest of the following to occur:

(f) The date your coverage ends;

(g) The date that your Dependents cease to be an eligible Dependent; or

(h) The date the Plan is terminated.

3.3. Changes to my Health Care FSA Election. You can change your election under the Health Care FSA in the following situations:

(a) For any reason during the Annual Election Period. You can change your election during the Annual Election Period for any reason. The election change will be effective on the first day of the Plan Year following the Annual Election Period.

(b) Following a Change in Status Event. You may change your Health Care FSA election during the Plan Year if you experience a Change in Status event. See Section 2.6 and Appendix C for more information on midyear election changes. NOTE: You may not make Health Care FSA election changes as a result of any cost or coverage changes described in Appendix C.

3.4. My Health Care FSA and Leaves of Absence. Refer to Section 2.8 to determine what, if any, specific changes you can make on account of a leave of absence. If your Health Care FSA coverage ceases during an FMLA leave, you may, upon returning from FMLA leave, elect to be reinstated in the Health Care FSA at either:

(a) The same coverage level in effect before the FMLA leave (with increased contributions for the remaining period of coverage); or

(b) At the same coverage level that is reduced pro-rata for the period of FMLA leave during which you did not make any contributions.

Under either scenario, expenses incurred during the period that your Health Care FSA coverage was not in effect are not eligible for reimbursement under this Health Care FSA.

3.5. Maximum Annual Health Care FSA Reimbursement. You may elect any annual reimbursement amount subject to the applicable statutory maximum per calendar year and the minimum amount set by the third-party administrator for the Health Care FSA, listed in Appendix A.

Any change in your Health Care FSA election also will change the maximum available reimbursement for the period of coverage after the election. Such maximum available reimbursements will be determined on

a prospective basis only by a method determined by the Plan Administrator or third-party administrator that is in accordance with applicable law. The Plan Administrator or third-party administrator will notify you of the applicable method when you make your election change.

3.6. Funding of Health Care FSA. When you complete the Salary Reduction Agreement, you specify your annual contribution amount to the Health Care FSA. Thereafter, each paycheck will be reduced by an amount equal to a pro-rata share of your annual contribution amount. Benefits under the Health Care FSA are paid as needed from Robert Half's general assets.

3.7. Amounts Available for Health Care FSA Reimbursement During the Plan Year. So long as your Health Care FSA coverage is effective, you will be able to access the annual amount of your Health Care FSA election at any time during the Plan Year without regard to how much you have contributed, but the amount available for reimbursement will be reduced by the amount of previous reimbursements received during the Plan Year.

3.8. Reimbursement Options under the Health Care FSA. Under this Health Care FSA, you have two reimbursement options. You can complete and submit a claim form for reimbursement to the third-party administrator or you can use an electronic payment card ("Debit Card") to pay any Eligible Medical Expenses. In order to be eligible for the Debit Card, you must agree to abide by the terms and conditions of the Debit Card Program (the "Program") and the Debit Cardholder Agreement (the "Cardholder Agreement"), including any fees applicable to participate in the program, limitations as to card usage, the Plan's right to withhold and offset for ineligible claims, etc. The Cardholder Agreement is part of the terms and conditions of your Plan.

Pay Me Back Claim: When you incur an Eligible Medical Expense, you may file a claim for reimbursement in accordance with the procedures established by the third-party administrator, listed in Appendix A.

Reimbursement for expenses that are determined to be Eligible Medical Expenses will be made as soon as possible after receiving the claim and processing it. You must submit all claims for reimbursement for Eligible Medical Expenses incurred during the Plan Year or prior to your earlier termination of coverage and before the expiration of the Run-Out Period. The Run-Out Period for all Employees ends each March 31st.

Debit Card: The Debit Card allows you to pay for an Eligible Medical Expense at the time that you incur the expense.

(a) The card will be turned off when you terminate employment or coverage under the Plan. You may not use the card during any applicable COBRA Continuation Coverage period. You must certify that you are using your Debit Card properly as specified in the Cardholder Agreement and that the amounts in your Health Care FSA will only be used for Eligible Medical Expenses and that you have not been reimbursed for the expense and that you will not seek reimbursement for the expense from any other source. Failure to abide by these rules will result in termination of card use privileges.

(b) When you incur an Eligible Medical Expense at a doctor's office or pharmacy, such as a co-payment or prescription drug expense, you swipe the card at the provider's office as you would a typical credit or debit card. The provider is paid for the expense up to the maximum reimbursement amount available under the Health Care FSA when you swipe the card.

(c) You must obtain and retain a receipt each time you swipe the card that includes the following information:

(i) The type of service or treatment provided. If the expense is for a prescription drug, the receipt must indicate the prescription number or the name of the drug and a copy of the prescription recognized under applicable state law;

(ii) The date the expense was incurred; and

(iii) The amount of the expense.

You must retain this receipt for one year following the close of the Plan Year in which the expense is incurred.

3.9. Definition of Eligible Medical Expense. The definition of an Eligible Medical Expense will vary depending on whether you are participating in the General Purpose or Combination FSA.

General Purpose FSA. Eligible Medical Expense means an expense that has been incurred by you or your Dependent(s) that satisfies the following conditions:

(a) The expense is for "medical care" as defined by Code § 213(d); and

(b) The expense has not been reimbursed by any other source, and you will not seek reimbursement for the expense from any other source.

The Code generally defines "medical care" as any amounts incurred to diagnose, treat, or prevent a specific medical condition or for purposes of affecting any function or structure of the body. Not every health-related expense constitutes an expense for "medical care." For example, an expense is not for "medical care," if it is merely for the beneficial health of you and/or your Dependents (e.g., vitamins or nutritional supplements that are not taken to treat a specific medical condition). You may, in the discretion of the third-party administrator, be required to provide additional documentation from a health care provider showing that you have a medical condition and/or the particular item is necessary to treat a medical condition. Expenses for cosmetic purposes are also not reimbursable unless they are necessary to correct an abnormality caused by illness, injury, or birth defect.

In addition, the following expenses, which might otherwise constitute "medical care" as defined by the Code, are not reimbursable under any Health Care FSA (per IRS regulations):

(c) Health insurance premiums;

(d) Expenses incurred for qualified long-term care services;

(e) Any other expenses that are specifically excluded by the Plan.

Combination FSA. Eligible Medical Expense means expenses incurred by you or your Dependents for medical care as defined in Code §213(d) and that satisfies the conditions described above for the General Purpose FSA, provided, however, that such expenses are initially limited to expenses for preventive, vision or dental care prior to meeting the IRS minimum required deductible for high deductible health plans. Once the IRS deductible has been met and the TPA informed, the Combination FSA funds can also be used for medical expenses, not just preventive care and vision or dental expenses.

The Combination FSA pays benefits solely for Eligible Medical Expenses for which you have not been previously reimbursed and will not seek reimbursement elsewhere. However, in the event that an Eligible Medical Expense may be reimbursed from both the Combination FSA and the HSA, you may choose to seek reimbursement from either the Combination FSA or the HSA, but not both.

3.10. Timing of Eligible Medical Expense. Eligible Medical Expenses must be incurred during the Plan Year and while you are participating in the Health Care FSA. "Incurred" means that the service or treatment giving rise to the expense has been provided. Except as provided below, you may not be reimbursed for any expenses incurred before the Health Care FSA becomes effective, before your Salary Reduction Agreement becomes effective, for any expenses incurred after the close of the Plan Year, after a separation from service or loss of eligibility (except for expenses incurred during an applicable COBRA continuation period).

3.11. Forfeitures and Qualified Reservist Distributions. In accordance with optional relief in the Consolidated Appropriations Act, 2021 to address the impact of the COVID Outbreak, amounts remaining in an Employee's Health Care FSA which are not applied to pay Eligible Medical Expenses with respect to the 2020 Plan Year shall be carried over and shall be available to pay Eligible Medical Expenses with respect to the 2021 Plan Year. In addition, amounts remaining in an Employee's Health Care FSA which are not applied to pay Eligible Medical Expenses with respect to the 2021 Plan Year shall be carried over and shall be available to pay Eligible Medical Expenses with respect to the 2022 Plan Year.

Unless the COVID Outbreak exception applies, any amount allocated to a Health Care FSA shall be forfeited if it has not been used to reimburse Eligible Medical Expenses incurred during the Plan Year and submitted for reimbursement before the expiration of the Run-Out Period. Amounts so forfeited shall be used to offset administrative expenses and Plan costs, and/or applied in a manner that is consistent with ERISA.Another exception to this forfeiture rule is the Qualified Reservist Distribution Robert Half has established a Qualified Reservist Distribution for the Health Care FSA. If you are called or ordered to active duty, you may be eligible for a Qualified Reservist Distribution from your Health Care FSA. This means that you may be able to request a distribution of the remaining balance, if any, in your Health Care FSA in the event that you are called or ordered to active military duty.

In order to be eligible for a Qualified Reservist Distribution, you must:

- be a member of a "reserve component" (as defined in 37 USC § 101), which means a member of the Army National Guard; the Reserve for the U.S. Army, Navy, Marine Corps, Air Force, or Coast Guard; Air National Guard of the United States; or the Reserve Corps of the Public Health Service;
- be called or ordered to active military duty for (i) 180 days or more or (ii) for an indefinite period;
- provide a copy of your order or call to active duty; and
- be a Participant in the Health Care FSA on the date you are called or ordered to duty.

If you believe you are eligible for a Qualified Reservist Distribution, you must contact the Plan Administrator to request a distribution request form as soon as possible. A request for a Qualified Reservist Distribution must be made in writing on the form provided by the Plan Administrator. You must submit a copy of your order or call to active duty along with your request. Requests for a Qualified Reservist Distribution must be made on or after the date of the order or call to duty but before the last day of the Plan Year (or grace period, if applicable) during which the order or call to duty occurred. You will receive your

Qualified Reservist Distribution within a reasonable period of time, but no later than sixty (60) days after your request has been received.

A Qualified Reservist Distribution will be made based on all salary reduction amounts credited to your Health Care FSA for the applicable Plan Year that have not been applied to provide Health Care FSA reimbursements submitted before the Qualified Reservist Distribution request is submitted. You will forfeit any right to reimbursement for Eligible Medical Expenses incurred after the date of the Qualified Reservist Distribution.

Claims incurred and submitted but not yet reimbursed at the time the Qualified Reservist Distribution Request is received will be treated like any other claim submitted for reimbursement under the Health Care FSA.

The Plan Administrator will determine what this amount is on a uniform basis, consistent with applicable law. Notwithstanding any other provision of this Plan, an individual who has selected a Qualified Reservist Distribution shall be considered to have made such election as an alternative to COBRA or USERRA coverage continuation for the Health Care FSA (except as may otherwise be required by applicable law).

Unlike your reimbursements from your Health Care FSA for Eligible Medical Expenses, the amount of your Qualified Reservist Distribution is taxed as income and will be reported as income on your W-2.

Qualified Reservist Distributions do not apply to amounts in your Dependent Care FSA.

3.12. Denial of a Claim for Benefits under the Health Care FSA. If your claim for benefits under the Health Care FSA is denied, you will have the right to a full and fair review process. You should refer to Appendix B for the claims review procedures applicable to the Health Care FSA.

3.13. COBRA Continuation Coverage and Health Care FSA. Federal law requires most employers sponsoring group health plans to offer employees and their families the opportunity for a temporary extension of health care coverage (called "COBRA Continuation Coverage") at group rates in certain instances where coverage under the plans would otherwise end. COBRA Continuation Coverage applies to the Health Care FSA.

When Coverage May Be Continued

Only "Qualified Beneficiaries" are eligible to elect COBRA Continuation Coverage if they lose coverage as a result of a "Qualifying Event." A "Qualified Beneficiary" is the Participant, covered Spouse and/or covered Dependent at the time of a Qualifying Event. Under COBRA, Qualifying Events include termination of employment, for reasons other than gross misconduct, or reduction in work hours; death; divorce or legal separation; a covered Dependent ceasing to satisfy the Plan's definition of Dependent; or entitlement to Medicare.

A Qualified Beneficiary may elect COBRA Continuation Coverage for Health Care FSA coverage only if year-to-date deposits in the Health Care FSA exceed year-to-date claims paid.

Type of Continuation Coverage

If you choose COBRA Continuation Coverage, you may continue the level of coverage you had in effect immediately preceding the Qualifying Event. However, if Plan benefits are modified for similarly situated active Employees, then they will be modified for you and other Qualified Beneficiaries as well. After electing COBRA Continuation Coverage, you will be eligible to make a change in your benefit election

with respect to the Health Care FSA upon the occurrence of any event that permits a similarly situated active Employee to make a benefit election change during a Plan Year.

If you do not choose COBRA Continuation Coverage, your coverage under the Health Care FSA will end on the date you would otherwise lose coverage.

Notice Requirements

You or your covered Dependents (including your Spouse) must give written notice to the COBRA Administrator for the Health Care FSA (identified in Appendix A) of a divorce, legal separation, or a child losing Dependent status under the Plan. Notice must be given within 60 days of the later of: (a) the date of the event, or (b) the date on which coverage is lost because of the event. Your written notice must identify the Qualifying Event, the date of the Qualifying Event, and the Qualified Beneficiaries impacted by the Qualifying Event. When the COBRA Administrator is notified that one of these events has occurred, it will in turn notify you that you have the right to choose COBRA Continuation Coverage by sending you the appropriate election forms. Notice to an Employee's Spouse is treated as notice to any covered Dependents who reside with the Spouse. You may be required to provide additional supporting documentation.

An Employee or covered Dependent is responsible for notifying the COBRA Administrator if he or she becomes covered under another group health plan.

Election Procedures and Deadlines

Qualified Beneficiaries are entitled to make separate elections for COBRA Continuation Coverage under the Plan, if they are not otherwise covered as a result of another Qualified Beneficiary's election. To elect COBRA Continuation Coverage, you must complete the applicable Election Form(s) within 60 days from the date you would lose coverage for one of the reasons described above or the date you are sent notice of your right to elect COBRA Continuation Coverage, whichever is later, and send it to the COBRA Administrator identified in the Plan Information Summary. Failure to return the applicable Election Form within the 60-day period will be considered a waiver of your COBRA Continuation Coverage rights.

Cost

You will have to pay the entire cost of your COBRA Continuation Coverage. The cost of your COBRA Continuation Coverage will not exceed 102% of the applicable premium for the period of COBRA Continuation Coverage. The first contribution after electing COBRA Continuation Coverage will be due 45 days after you make your election. Subsequent contributions are due the first day of each month; however, you have a 30-day grace period following the due date in which to make your contributions. Failure to make contributions within this time period will result in automatic termination of your COBRA Continuation Coverage.

When Continuation Coverage Ends

The maximum period for which Health Care FSA coverage may be continued is the end of the Plan Year in which the Qualifying Event occurs. You will be notified of the applicable maximum duration of COBRA Continuation Coverage when you have a Qualifying Event. Regardless of the maximum period, COBRA Continuation Coverage may end earlier for any of the following reasons:

(a) If the contribution for your COBRA Continuation Coverage is not paid on time or it is significantly insufficient (Note: if your payment is insufficient by the lesser of 10% of the required premium, or $50, you will be given 30 days to cure the shortfall);

(b) If you become covered under another group health plan;

(c) If you become entitled to Medicare; or

(d) If the Employer no longer provides group health coverage to any of its Employees.

3.14. HIPAA and the Health Care FSA. Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), group health plans such as the Health Care FSA are required to take steps to ensure that certain "protected health information" is kept confidential. Below is a summary of the HIPAA Privacy and Security Rules that apply to the Health Care FSA.

(a) **Scope and Purpose**. The Health Care FSA will use protected health information ("PHI") to the extent of, and in accordance with, the uses and disclosures permitted by HIPAA. Specifically, the Health Care FSA will use and disclose PHI for purposes related to health care treatment, payment for health care, and health care operations as set forth below.

(b) **Use and Disclosure of PHI.**

(i) General. The Health Care FSA will use PHI to the extent of and in accordance with the uses and disclosures permitted by HIPAA, including but not limited to health care treatment, payment for health care, health care operations, and as required by law. The Privacy Notice will list the specific uses and disclosures of PHI that will be made by the Health Care FSA.

(ii) Disclosure to the Employer. The Health Care FSA will disclose PHI to the Employer only upon receipt of written certification from the Employer that:

(A) The Plan document has been amended to incorporate the provisions in this Section 3.14; and

(B) The Employer agrees to implement the provisions in subsection (d) below.

(c) **Conditions Imposed on Employer**. Notwithstanding any provision of the Health Care FSA to the contrary, the Employer agrees:

(i) Not to use or disclose PHI other than as permitted or required by this Section 3.14 or as required by law;

(ii) To ensure that any agents, including a subcontractor to whom the Employer provides PHI received from the Health Care FSA, agree to the same restrictions and conditions that apply to the Employer with respect to PHI received or created on behalf of the Health Care FSA;

(iii) Not to use or disclose an Individual's PHI for employment-related purposes (including hiring, firing, promotion, assignment, or scheduling) unless authorized by the Individual;

(iv) Not to use or disclose an Individual's PHI in connection with any other non-health benefit program or employee benefit plan of the Employer unless authorized by the Individual;

(v) To report to the Health Care FSA and the Privacy Officer any use or disclosure of PHI that is inconsistent with this Section 3.14;

(vi) To provide Individuals with access to PHI in accordance with 45 C.F.R. § 164.524;

(vii) To make PHI available for amendment, and to incorporate any amendments to PHI in accordance with 45 C.F.R. § 164.526;

(viii) To make information available that is required to provide an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528;

(ix) To make internal practices, books and records relating to the use and disclosure of PHI received from the Health Care FSA available to the Secretary of Health and Human Services for purposes of determining the Health Care FSA's compliance with HIPAA;

(x) If feasible, to return or destroy all PHI received from the Health Care FSA that the Employer maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible; and

(xi) To ensure adequate separation between the Health Care FSA and Employer as required by 45 C.F.R. § 164.504(f)(2)(iii) and described in this Section 3.14.

(d) **Designated Employees Who May Receive PHI**. In accordance with the Privacy Rules, only certain employees who perform Health Care FSA administrative functions may be given access to PHI. Those employees who have access to PHI from the Health Care FSA are listed in the Robert Half Privacy Policy by position.

(e) **Restrictions on Employees with Access to PHI**. The employees who have access to PHI may only use and disclose PHI for Plan administration functions that the Employer performs for the Health Care FSA as set forth in the Privacy Notice, including but not limited to, quality assurance, claims processing auditing, and monitoring.

(f) **Policies and Procedures**. The Employer will implement policies and procedures setting forth operating rules to implement the provisions hereof.

(g) **Organized Health Care Arrangement**. The Plan Administrator intends the Health Care FSA to form part of an Organized Health Care Arrangement along with any other benefit under a covered health plan (under 45 C.F.R. § 160.103) provided by the Employer.

(h) **Privacy Official**. The Employer shall designate a Privacy Official, who will be responsible for the Health Care FSA's compliance with HIPAA. The Privacy Official may contract with or otherwise utilize the services of attorneys, accountants, brokers, consultants, or other third-party experts as the Privacy Official deems necessary or advisable. In addition,

and notwithstanding any provision of this Health Care FSA to the contrary, the Privacy Official shall have the authority to and be responsible for:

(i) Accepting and verifying the accuracy and completeness of any certification provided by Employer under this Section 3.14;

(ii) Transmitting the certification to any third parties as may be necessary to permit them to disclose PHI to Employer;

(iii) Establishing and implementing policies and procedures with respect to PHI that are designed to ensure compliance by the Health Care FSA with the requirements of HIPAA;

(iv) Establishing and overseeing proper training of Employer personnel who will have access to PHI;

(v) Any other duty or responsibility that the Privacy Official, in his or her sole capacity, deems necessary or appropriate to comply with the provisions of HIPAA and the purposes of this Section 3.14.

(i) **Noncompliance**. The Employer shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions for personnel who do not comply with the provisions of this Section 3.14.

(j) **Definitions**. As used in this Section 3.14, each of the following capitalized terms shall have the respective meaning given below:

"**Individual**" means the person who is the subject of the health information created, received, or maintained by the Plan or Employer.

"**Organized Health Care Arrangement**" means the relationship of separate legal entities as defined in 45 C.F.R. § 160.103.

"**Privacy Notice**" means the notice of privacy practices distributed to Employees in accordance with 45 C.F.R. § 164.520, as amended from time to time.

"**Privacy Rules**" means the privacy provisions of HIPAA and the regulations in 45 C.F.R. Parts 160 and 164, as amended from time to time.

"**Protected Health Information or PHI**" means individually identifiable health information as defined in 45 C.F.R. § 160.103.

(k) **Interpretation and Limited Applicability**. This Section 3.14 serves the sole purpose of complying with the requirements of HIPAA and shall be interpreted and construed in a manner to effectuate this purpose. Neither this Section 3.14 nor the duties, powers, responsibilities, and obligations listed herein shall be taken into account in determining the amount or nature of the benefits provided to any person covered under this Health Care FSA, nor shall they inure to the benefit of any third parties. To the extent that any of the provisions of this Section 3.14 are no longer required by HIPAA, they shall be deemed deleted and shall have no further force or effect.

(l) **Services Performed for the Employer**. Notwithstanding any other provision of this Health Care FSA to the contrary, all services performed by a business associate for the Health Care FSA in accordance with the applicable service agreement shall be deemed to be performed on behalf of the Health Care FSA and subject to the administrative simplification provisions of HIPAA contained in 45 C.F.R. parts 160 through 164, except services that relate to eligibility and enrollment in the Health Care FSA. If a business associate of the Plan performs any services to the Health Care FSA that relate to eligibility and enrollment, those services shall be deemed to be performed on behalf of the Employer in its capacity as Plan Sponsor and not on behalf of the Health Care FSA.

(m) **Security of Electronic PHI**. The Employer will ensure the following with respect to electronic PHI:

(i) That administrative, physical, and technical safeguards reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the Health Care FSA in accordance with the applicable rules and regulations under HIPAA.

(ii) That reasonable and appropriate security measures are implemented to support adequate separation as required herein.

(iii) That any agents, including a subcontractor to whom the Employer provides PHI received from the Health Care FSA, agree to the same restrictions and conditions that apply to the Employer under this Section 3.14.

(iv) That any security incidents of which it becomes aware that are inconsistent with this Section 3.14 are reported to the Health Care FSA and the Security Official.

The Employer shall also designate a Security Official, who will be responsible for the Health Care FSA's compliance with the security provisions of HIPAA. The Security Official may contract with or otherwise utilize the services of attorneys, accountants, brokers, consultants, or other third-party experts as the Security Official deems necessary or advisable. In addition, and notwithstanding any provision of this Health Care FSA to the contrary, the Security Official shall have the authority to and be responsible for:

(v) Accepting and verifying the accuracy and completeness of any certification provided by the Employer under this Section 3.14;

(vi) Transmitting the certification to any third parties as may be necessary to permit them to disclose electronic PHI to Employer;

(vii) Establishing and implementing policies and procedures with respect to electronic PHI that are designed to ensure compliance by the Health Care FSA with the security requirements of HIPAA;

(viii) Establishing and overseeing proper training of Employer personnel who will have access to electronic PHI;

(ix) Any other duty or responsibility that the Security Official, in his or her sole capacity, deems necessary or appropriate to comply with the security provisions of HIPAA and the purposes of this Section 3.14.

ARTICLE IV

ERISA RIGHTS FOR HEALTH CARE FSA PARTICIPANTS

The Health Care FSA is a group health plan subject to ERISA and you are entitled to certain rights and protections under ERISA. ERISA provides that all Health Care FSA Participants shall be entitled to:

4.1. Receive Information About Your Plan and Benefits. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work-sites and union halls, all documents governing the Health Care FSA, including contracts, 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 Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the Health Care FSA, including contracts and collective bargaining agreements, the latest annual report (Form 5500 series), updated Plan document and SPD and the Health Care FSA's summary annual report. The Plan Administrator may impose a reasonable charge for the copies.

4.2. Continue Group Health Plan Coverage. You may continue health care coverage for yourself, Spouse or Dependents if there is a loss of coverage under the Health Care FSA as a result of a Qualifying Event. You or your eligible Dependents will have to pay for such coverage. You should review Section 3.13 for more information concerning your COBRA Continuation Coverage rights under the Health Care FSA.

4.3. Prudent Actions by Plan Fiduciaries. In addition to creating rights for Health Care FSA Participants, ERISA imposes duties upon the people who are responsible for the operation of the Health Care FSA. The people who operate your Health Care FSA, called "fiduciaries" of the Health Care FSA, have a duty to do so prudently and in the interest of Participants. No one, including your Employer, your union, or any other person, may terminate you or otherwise discriminate against you in any way to prevent you from obtaining reimbursement from the Health Care FSA, or from exercising your rights under ERISA.

4.4. Enforce Your Rights. If your claim for a welfare benefit under an ERISA-covered plan 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 Administrator or its delegate 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 Administrator or its delegate 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 or its delegate 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 Plan Administrator or its delegate. If you have a claim for benefits that 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 Administrator'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 Health Care FSA fiduciaries misuse the Health Care FSA's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

4.5. Assistance with Your Questions. If you have any questions about the Health Care FSA, you should contact the Plan Administrator or the third-party administrator listed in Appendix A. If you have any questions about this statement or about your rights under ERISA, or if you need assistance

obtaining documents from the Plan Administrator, you should contact the nearest office of the U.S. Department of Labor, Employee Benefits Security Administration listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave., N.W., Washington, D.C., 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

ARTICLE V

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

5.1. Participation in the Dependent Care FSA. You may participate in the Dependent Care FSA no later than the first day of the month coinciding with or next following the date that you submit your Salary Reduction Agreement. If you are a Temporary Employee, you are not eligible to participate in the Dependent Care FSA. You become a Participant in the Dependent Care FSA by electing to do so during the Initial or Annual Election Periods described in Section 2.5. If you have made an election to participate and you want to participate during the next Plan Year, you will be required to make an election during the Annual Election Period, even if you do not change your current election.

You also may become a Participant if you experience a Change in Status event or cost or coverage change that permits you to enroll midyear (See Section 2.6 and Appendix C for more details regarding midyear election changes and the effective date of those changes).

Dependent Care Flexible Spending Account. If you elect to participate in the Dependent Care FSA, the third-party administrator will establish a "Dependent Care Spending Account" bookkeeping entry to keep a record of your contributions and reimbursements during the Plan Year. Benefits under the Dependent Care FSA are paid as needed from Robert Half's general assets.

5.2. Termination of Participation. Your coverage under the Dependent Care FSA ends on the earliest of the following.

(a) The date you elect not to participate;

(b) The last day of the Plan Year unless you make an election during the Annual Election Period;

(c) The date you no longer satisfy the Dependent Care FSA eligibility requirements;

(d) The day your employment terminates; or

(e) The date the Plan is terminated or you or the class of eligible Employees of which you are a member are specifically excluded from the Plan.

5.3. Changes to My Dependent Care FSA. You can change your election under the Dependent Care FSA in the following situations:

(a) For any reason during the Annual Election Period. You can change your election during the Annual Election Period for any reason. The election change will be effective the first day of the Plan Year following the end of the Annual Election Period.

(b) Following a Change in Status Event or Cost or Coverage Change. You may change your Dependent Care FSA election during the Plan Year only if you experience an applicable Change in Status event or there is a significant cost or coverage change. See Section 2.6 and Appendix C for more information on mid-year election changes.

5.4. My Dependent Care Spending Account and an Approved Leave of Absence. Your coverage under the Dependent Care FSA is suspended while you are on a leave of absence. Expenses incurred during the period that your Dependent Care FSA coverage was not in effect are not eligible for reimbursement.

5.5. Maximum Annual Dependent Care FSA Reimbursement. You may elect any annual reimbursement amount subject to the statutory maximum annual Dependent Care FSA amount and the minimum reimbursement amount of $60. The maximum amount is currently $5,000 per calendar year if you:

(a) Are married and file a joint return;

(b) Are married, but your Spouse maintains a separate residence for the last 6 months of the calendar year, you file a separate tax return, and you furnish more than one-half the cost of supporting your Dependents who are Qualifying Individuals; or

(c) Are single.

If you are married and reside together, but file a separate federal income tax return, the maximum Dependent Care FSA reimbursement amount is determined by the IRS, currently $2,500. In addition, the amount of reimbursement that you receive on a tax-free basis during the Plan Year cannot exceed the lesser of your Earned Income (as defined in Code § 32) or your Spouse's Earned Income.

Your Spouse will be deemed to have Earned Income of $250 if you have one Qualifying Individual and $500 if you have two or more Qualifying Individuals (described below), for each month in which your Spouse is:

(d) Physically or mentally incapable of caring for himself or herself; or

(e) A full-time Student.

5.6. Funding of Dependent Care FSA. When you complete your Salary Reduction Agreement, you elect an annual amount of Pre-tax Contributions to be used for work-related Dependent Care expenses. Thereafter, each paycheck will be reduced by an amount equal to a pro-rata share of the annual amount. Benefits under the Dependent Care FSA are paid as needed from Robert Half's general assets.

5.7. Eligible Employment-Related Expenses. You may be reimbursed for work-related dependent care expenses. Eligible Employment-Related Expenses must meet all of the following conditions:

(a) The expense is incurred for services rendered after the effective date of your Dependent Care FSA election and during the calendar year to which it applies.

(b) Expenses must be incurred for a Qualifying Individual. A Qualifying Individual is:

(i) An individual under age 13 who is a "qualifying child" of the Employee as defined in Code § 152(a)(1). Generally speaking, a "qualifying child" is a child (including a brother, sister, step sibling) of the Employee or a descendant of such child (e.g. a niece, nephew, grandchild) who shares the same principal place of abode with you for more than half the year and does not provide over half of his support.

(ii) A Spouse or other tax dependent (as defined in Code § 152) who is physically or mentally incapable of caring for himself and who has the same principal place of abode as you for more than half of the year.

Note: There is a special rule for children of divorced parents. If you are divorced, the child is a Qualifying Individual of the "custodial" parent (as defined in Code § 152).

(c) The expense is incurred for the care of a Qualifying Individual (as described above), or for related household services, and is incurred to enable you (and your Spouse, if applicable) to be gainfully employed. Expenses for overnight stays or overnight camps are not eligible. Tuition expenses for kindergarten (of above) do not qualify.

(d) If the expense is incurred for services outside your household and such expenses are incurred for the care of a Qualifying Individual who is age 13 or older, such Dependent must regularly spend at least 8 hours per day in your home.

(e) If the expense is incurred for services provided by a dependent care center (i.e., a facility that provides care for more than 6 individuals not residing at the facility), the center must comply with all applicable state and local laws and regulations.

(f) The expense is not paid or payable to a "child" (as defined in Code § 152(f)(1)) of yours who is under age 19 the entire year in which the expense is incurred, or to an individual for whom you or your Spouse is entitled to a personal tax exemption as a Dependent.

(g) You must supply the taxpayer identification number for each dependent care service provider to the IRS with your annual tax return by completing IRS Form 2441.

You are encouraged to consult your personal tax advisor or IRS Publication 17 "Your Federal Income Tax," for further guidance as to what is or is not an Eligible Employment-Related Expense.

5.8. Reimbursement Options under the Dependent Care FSA. When you incur an Eligible Employment-Related Expense, you may file a claim for reimbursement in accordance with the procedures established by the third-party administrator listed in Appendix A.

Reimbursement for expenses that are determined to be Eligible Employment-Related Expenses will be made as soon as possible after receiving the claim and processing it. You must submit all claims for reimbursement for Eligible Employment-Related Expenses incurred during the Plan Year or prior to your termination of coverage before the expiration of the Run-Out Period. The Run-Out Period for all Participants ends each March 31st.

5.9. Timing of Eligible Employment-Related Expenses. Eligible Employment-Related Expenses must be incurred ***during*** the Plan Year. You may not be reimbursed for any Eligible Employment-Related Expense before your Salary Reduction Agreement becomes effective, incurred after the close of the Plan Year or after your participation in the Dependent Care FSA ends.

5.10. Forfeitures. In accordance with optional relief in the Consolidated Appropriations Act, 2021 to address the impact of the COVID Outbreak, amounts remaining in an Employee's Dependent Care FSA which were not applied to pay Eligible Employment-Related Expenses with respect to the 2020 Plan Year shall be carried over and shall be available to pay Eligible Employment-Related Expenses with respect to the 2021 Plan Year. Unless the COVID Outbreak exception applies, any amount allocated to a Dependent Care FSA shall be forfeited if it is not used to reimburse you for Eligible Employment-Related Expenses incurred during the Plan Year and submitted before the expiration of the Run-Out Period. Such forfeitures shall be used as determined by Robert Half.

5.11. Unclaimed Dependent Care FSA Reimbursements. Any Dependent Care FSA reimbursements that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Plan Year in which the Eligible Employment-Related Expense was incurred shall be forfeited.

ARTICLE VI

HEALTH SAVINGS ACCOUNT

6.1. Eligibility for HSA Benefits. If you elect health coverage under a Robert Half High Deductible Health Plan, you may establish an HSA and make Pre-tax Contributions that Robert Half will forward to the trustee/custodian. If you are a Temporary Employee, you are not eligible to make Pre-tax Contributions to an HSA under this Plan. The amount of your Pre-tax Contributions can be increased, decreased, or revoked prospectively at any time during the Plan Year, effective no later than the first day of the next calendar month following the date the election change is filed. Your Employer may match your contributions to your HSA on a per-pay-period basis.

If you elect to participate in a Robert Half High Deductible Health Plan and contribute to your HSA, your participation in the Health Care FSA is restricted to participation in the Combination FSA. You may not contribute to both the General Purpose Health Care FSA and an HSA in the same Plan Year.

6.2. Contributions to HSA; Maximum Annual Limits. The annual amount of Pre-tax Contributions to your HSA, combined with your Matching Contributions may not exceed the annual statutory maximum for the Plan Year in which Pre-tax and Matching Contributions are made.

Additional HSA catch-up contributions may be made by Participants who are age 55 or older in an amount not to exceed the statutory maximum for the Plan Year set by the IRS and subject to change each year).

In addition, your maximum annual contribution shall be prorated for the number of months in which you are an HSA-Eligible Individual.

6.3. Tax Treatment of HSA Contributions and Distributions. The federal income tax treatment of your HSA (including contributions and distributions) is governed by Code § 223.

6.4. Changes to Amount of Pre-tax Contributions to your HSA. The amount of Pre-tax Contributions to your HSA can be increased, decreased, or revoked prospectively at any time during the Plan Year. The Change in Status rules in Appendix C do not apply to your HSA.

6.5. Custodial Agreement; HSA Is Not an ERISA Plan. The HSA is not an employer-sponsored employee welfare benefit plan subject to ERISA. It is a savings account that is established and maintained by an HSA custodian outside this Plan to be used primarily for reimbursement of "qualified eligible medical expenses" under Code § 223(d)(2). The Employer has no authority or control over the funds deposited in your HSA or distributions from your HSA.

ARTICLE VII

PLAN ADMINISTRATION

7.1. Allocation of Authority. The Robert Half Benefit Plan Committee is the Plan Administrator (as defined in ERISA) that controls and manages the operation and administration of the aspects of the Plan that are subject to ERISA. The Plan Administrator shall have the exclusive right to interpret the Plan and to decide all matters arising under the Plan, including the right to make determinations of fact, and construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan. The Plan Administrator also may employ the services of claims administrators, third party administrators or insurance companies, to administer the Plan as listed in Appendix A. If the Plan Administrator appoints a claims administrator, third party administrator or insurance company to perform any Plan administration or other fiduciary functions, any reference to the term "Plan Administrator" shall be deemed a reference to such claims administrator, third party administrator or insurance company, but only with respect to such delegated functions. All determinations of the Plan Administrator with respect to the Plan will be conclusive and binding on all persons. Without limiting the generality of the foregoing, the Plan Administrator shall have the following powers and duties, unless delegated to a third party:

(a) To require any person to furnish such reasonable information as he may request to properly administer and provide benefits under the Plan;

(b) To make and enforce Plan rules and regulations, as well as prescribe the use of forms and processes as necessary for efficient Plan administration;

(c) To adjudicate questions concerning the Plan and its administration, the eligibility of any Employee to participate in the Plan, and to make, correct or revoke Plan elections;

(d) To determine benefit amounts payable to any person under the Plan; to inform the Employer, as appropriate, of those amounts; and to ensure that Participants receive a full and fair review of their claims under the Health Care FSA, whether denied in whole or in part;

(e) To designate other persons to carry out any duty or power which may or may not otherwise be a fiduciary responsibility of the Plan Administrator under the terms of the Plan;

(f) To keep records of acts and determinations, and to keep records, books of account, data, and other documents as may be necessary for proper Plan administration; and

(g) To take all necessary steps to operate and administer the Plan in accordance with its provisions and ERISA, to the extent applicable.

ARTICLE VIII

AMENDMENT OR TERMINATION OF PLAN

8.1. Employer's Right to Amend. The Robert Half Benefit Plan Committee reserves the right to amend the Plan at any time any and for any reason. All amendments shall be made in writing and shall be approved the Robert Half Benefit Plan Committee in accordance with their normal procedures for

transacting business. Any amendment made by the Robert Half Benefit Plan Committee shall be deemed approved and adopted by any Affiliated Employer.

8.2. 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 IX

GENERAL PROVISIONS

9.1. Not an Employment Contract. Neither this Plan nor any action taken with respect to it shall confer upon any person the right to continue employment with any Employer.

9.2. Applicable Laws. The provisions of the Plan shall be construed, administered, and enforced according to applicable federal law and the laws of the State of California, to the extent not preempted.

9.3. Requirement for Proper Forms. All Participant communications in connection with the Plan, such as election or reimbursement forms of any kind, shall become effective only when duly executed on any paper, electronic or telephonic forms as may be required and furnished by, and filed with, the Plan Administrator or the third party administrator.

9.4. Tax Effects. The Employer does not make any warranty or other representation as to whether any Pre-tax Contributions made to or on behalf of any Participant, Dependent, or beneficiary under the Plan will be treated as excludable from gross income for local, state, or federal income tax purposes. If for any reason it is determined that any amounts paid for the benefit of a Participant, Dependent, or beneficiary are includable in an Employee's gross income for local, federal, or state income tax purposes, then under no circumstances shall the Employee have any recourse against the Employer with respect to any increased taxes or other losses or damages suffered by the Employee. The Plan is designed and intended to operate as a "cafeteria plan" under Code § 125.

9.5. Gender and Number. Masculine pronouns include the feminine as well as the neuter genders, and the singular shall include the plural, unless indicated otherwise by the context.

9.6. Incorporation by Reference. The actual terms and conditions of some of the Benefit Plan Options offered under this Plan are contained in other plan documents and shall govern in the event of a conflict with this Plan. Each plan document for a Benefit Plan Option, as amended, is hereby incorporated by reference into this Plan.

9.7. Severability. Should a court of competent jurisdiction subsequently invalidate any part of this Plan, the remainder thereof shall be given effect to the maximum extent possible.

9.8. Effect of Mistake. In the event of a mistake as to the eligibility or participation of an Employee, or the allocations made to the account of any Participant, or the amount of distributions made or to be made to a Participant or other person, the Plan Administrator or third party administrator shall, to the extent it deems possible and in accordance with applicable law, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as will accord to such Participant or other person the credits to the account or distributions to which he is properly entitled under the Plan.

Such action by the Plan Administrator may include the withholding of any amounts due the Plan or the Employer from Compensation paid by the Employer.

ARTICLE X

DEFINITIONS

10.1. "**Affiliated Employer**" means any entity who is considered with the Employer to be a single employer in accordance with Code § 414(b), (c), (m) or (o).

10.2. "**After-tax Contribution(s)**" means amounts withheld from an Employee's or Temporary Employee's Compensation pursuant to a Salary Reduction Agreement after all applicable state and federal taxes have been deducted. Such amounts are withheld for purposes of purchasing one or more of the Benefit Plan Options available under the Plan.

10.3. "**Benefit Plan Option(s)**" means those Qualified Benefits available to a Participant under this Plan.

10.4. "**Cafeteria Plan Component**" is described in Article II of the Plan.

10.5. "**Change in Status**" means any of the events described in Section 2.6 and Appendix C, as well as any other events included under subsequent changes to Code § 125 or regulations issued under Code § 125, that the Plan Administrator and the third party administrator decide to recognize on a uniform and consistent basis as a reason to change a Salary Reduction Agreement midyear.

10.6. "**Code**" means the Internal Revenue Code of 1986, as amended.

10.7. "**Combination FSA**" shall have the meaning assigned to it by Section 3.1 of the Plan.

10.8. "**Compensation**" means the cash wages or salary paid to an Employee or Temporary Employee by the Employer.

10.9. "**Dependent Care Flexible Spending Account**" or "**Dependent Care FSA**" shall have the meaning assigned to it by Section 5.2 of the Plan.

10.10. "Dependent"

(a) For purposes of the Dependent Care FSA, Dependent means a "qualifying individual" (as defined in Code § 21(b)), including any individual who is: (i) a tax dependent of the Participant as defined in Code § 152 who is under the age of 13 (age 14 for purposes of amounts permitted to be carried over from the 2020 to the 2021 Plan Year) and who is the Participant's qualifying child as defined in Code § 152(a)(1), (ii) a tax dependent of the Participant as defined in Code § 152, but determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B) thereof, who is physically or mentally incapable of caring for himself or herself and who has the same principal place of abode as the Participant for more than half the year, or (iii) a Participant's Spouse who is physically or mentally incapable of caring for himself or herself and who has the same principal place of abode as the Participant for more than half the year.

(b) For purposes of the Health Care FSA, Dependent means (1) a Participant's Spouse and any other individual determined to be a tax dependent of the Participant under Code § 152

determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof and (2) any child (defined in Code § 152(f)) of the Participant who as of the end of the taxable year has not attained age 27. Dependent also includes a Participant's unmarried child for whom the Participant is responsible to provide health care coverage pursuant to a Qualified Medical Child Support Order, as defined in ERISA Section 609(a).

10.11. "**Effective Date**" of this amended and restated Plan means January 1, 2021.

10.12. "**Eligible Employment-Related Expenses**" means those expenses that would be considered to be employment-related expenses under Code § 21(b)(2) (relating to expenses for household and dependent care services necessary for gainful employment) if paid for by the Employee to provide Qualifying Services other than amounts paid to:

(a) an individual with respect to whom a dependent deduction is allowable under Code § 151(a) to the Participant or his Spouse;

(b) the Participant's Spouse; or

(c) a child of the Participant who is under 19 years of age at the end of the taxable year in which the expenses were incurred.

10.13. "**Eligible Medical Expenses**" means those expenses that are eligible for reimbursement under the Health Care FSA, incurred by the Employee, or the Employee's Spouse or Dependents, after the date of the Employee's participation in the Health Care FSA and during the Plan Year to the extent that the expense satisfies the conditions set forth in Section 4.10 and is for medical care as defined by Code § 213(d). The Code generally defines "medical care" as any amount incurred to diagnose, treat, or prevent a specific medical condition or for purposes of affecting any function or structure of the body. Dental and prescription drug expenses as well as over-the-counter medications without a prescription and menstrual care products purchased on or after January 1, 2020 constitute medical care. Not every health-related expense constitutes an expense for medical care. For example, an expense is not for medical care, if it is merely for the beneficial health of a Participant (e.g., vitamins or nutritional supplements that are not taken to treat a specific medical condition). Expenses for cosmetic purposes also are not medical care and therefore not reimbursable unless they are necessary to correct an abnormality caused by illness, injury, or birth defect.

For purposes of the Health Care FSA, the following expenses are not considered Eligible Medical Expenses even if they otherwise constitute medical care under Code § 213(d):

(a) Expenses for qualified long-term care services (as defined in Code § 7702B);

(b) Expenses for health insurance premiums; and

(c) Any other expenses that are specifically excluded by the Health Care FSA and/or the Plan.

For purposes of this Plan, an expense is incurred when the Participant is furnished the medical care or services giving rise to the claimed expense, regardless of when the expense is paid.

10.14. "**Employee**" means an individual who the Employer classifies as a common-law Employee, is on the Employer's U.S. payroll, is a regular full-time or part-time 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) but does not include any of the following: (a) Temporary Employees; (b) any leased employee (including, but not limited to, those individuals defined in Code § 414(n)); (c) an individual classified by the Employer as a contract worker or independent contractor; or (d) any Employee covered under a collective bargaining agreement, except as otherwise provided for in the collective bargaining agreement. Any other person who is not treated by an Employer as an employee for purposes of withholding federal employment taxes is not an Employee, 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.

10.15. "**Employer**" means Robert Half International Inc., or Robert Half, and any Affiliated Employer who adopts the Plan. For purposes of the right to amend or terminate the Plan, Employer means Robert Half International. Inc.

10.16. "**ERISA**" shall mean the Employee Retirement Income Security Act of 1974, as amended.

10.17. "**Flexible Spending Account(s)**" shall be the funding mechanism by which amounts are withheld from an Employee's Compensation and retained for future Health Care and Dependent Care FSA payments. No money shall actually be allocated to any individual Participant account(s); any such account(s) shall be of a memorandum nature, maintained for accounting purposes, and shall not be representative of any identifiable trust assets. No interest will be credited to or paid on amounts credited to the Participant account(s).

10.18. "**General Purpose FSA**" shall have the meaning assigned to it by Section 3.1 of the Plan.

10.19. "**Health Care Flexible Spending Account**" or "**Health Care FSA**" shall have the meaning assigned to it by Section 3.2 of the Plan. The Health Care FSA includes a General Purpose and a Combination FSA.

10.20. "**Health Savings Account**" or "**HSA**" means a health savings account established under Code § 223. Such arrangements are individual custodial accounts, each separately established and maintained by an Employee with a qualified custodian. The HSA is funded with Pre-tax Contributions and Matching Contributions (if applicable) under this Plan. The HSA is not an employee welfare benefit plan under ERISA.

10.21. "**HSA Benefits**" shall have the meaning assigned to it by Section 6.1 of the Plan.

10.22. "**HSA-Eligible Employee**" means an Employee who is eligible to contribute to an HSA under Code § 223 and who has elected to participate in a Robert Half High Deductible Health Plan and who has not elected any disqualifying non-high deductible health plan coverage.

10.23. "**Highly Compensated Individual**" means an individual defined under Code §§ 105(h), 125(e) or 414(q), as amended, as a "highly compensated individual" or a "highly compensated employee."

10.24. "**Key Employee**" means an individual who is a "key employee" as defined in Code § 125(b)(2), as amended.

10.25. "**Matching Contributions**" are Employer matching contributions to the HSAs of HSA-Eligible Employees. The maximum amount of Matching Contributions will be determined by the Employer and may vary based on the Robert Half High-Deductible Health Plan elected. Matching Contributions will be deposited in the HSAs of HSA-Eligible Employees as soon as practicable following the end of each pay period. Matching Contributions are not subject to the Code's comparability rules.

10.26. "**Participant**" means an Employee or Temporary Employee who elects to participate in the Plan and completes and timely submits the required Salary Reduction Agreement(s).

10.27. "**Plan**" means the Robert Half Cafeteria Plan and Summary Plan Description, as amended from time to time.

10.28. "**Plan Administrator**" means the Robert Half International Inc. Benefit Plan Committee appointed by Robert Half with the authority, discretion, and responsibility to manage and direct the operation and administration of the Plan's components that are subject to ERISA..

10.29. "**Plan Year**" shall be the calendar year.

10.30. "**Pre-tax Contribution(s)**" means any amount withheld from the Employee's Compensation pursuant to a Salary Reduction Agreement before any applicable state and federal taxes have been deducted. The amounts are withheld for purposes of purchasing one or more of the Benefit Plan Options available under the Plan. The total amount of Pre-tax Contributions for a Plan Year shall not exceed the premiums or contributions attributable to all of the Benefit Plan Options offered under the Plan, and for purposes of Code § 125, shall be treated as Employer contributions.

10.31. "**Qualified Benefit**" means any benefit excluded from the Employee's taxable income under the Code other than §§ 106(b), 117, 124, 127, or 132 and any other benefit permitted by Income Tax Regulations (e.g., any group-term employee life insurance coverage that is includable in gross income by virtue of exceeding the dollar limitation on nontaxable coverage under Code § 79).

10.32. "**Qualifying Individual**" means an individual defined as a "Qualifying Individual" in Subsection 5.8(b) of the Plan.

10.33. "**Qualifying Services**" means services relating to the care of a Qualifying Individual that enable the Participant or his Spouse to remain gainfully employed which are performed:

(a) in the Participant's home; or

(b) outside the Participant's home for (1) the care of a Dependent of the Participant who is under age 13 (age 14 for purposes of amounts permitted to be carried over from the 2020 to the 2021 Plan Year), or (2) the care of any other Qualifying Individual who resides at least eight hours per day in the Participant's household. If the expenses are incurred for services provided by a daycare center (i.e., a facility that provides care for more than six individuals not residing at the facility) the center must comply with all applicable state and local laws and regulations.

10.34. **"Run-Out Period"** means the period after the end of the Plan Year or your termination of coverage during which the third-party administrator must receive claims for expenses incurred during a Plan Year or prior to your earlier termination of coverage. The Run-Out Period begins after the end of the Plan Year or after your coverage termination and the last day of the Run-Out Period is March 31st of the subsequent year.

10.35. "**Salary Reduction Agreement**" means the actual or deemed agreement pursuant to which an Employee or Temporary Employee elects to contribute his share of the cost of chosen Benefit Plan Options with Pre-tax or After-tax Contributions. The Employer maintains a web-based program through its third-party administrator within which Employees and Temporary Employees can make their elections and complete their enrollment. Submission of elections in the web-based program is deemed to be consent to salary reductions as elected.

10.36. "**Spouse**" means an individual who is legally married to a Participant under state law, but for purposes of the Dependent Care FSA, shall not include an individual who, although legally married to the Participant under state law, files a separate federal income tax return, maintains a separate principal residence from the Participant during the last six months of the taxable year, and does not furnish more than one-half of the cost of maintaining the principal place of abode of the Qualifying Individual.

10.37. "**Student**" means an individual who, during each of five (5) or more calendar months during the Plan Year, is a full-time Student at any college or university, the primary function of which is the conduct of formal instruction, and which routinely maintains a regular faculty and curriculum and normally has an enrolled Student body in attendance at the location where its educational activities are regularly presented.

10.38. "**Temporary Employee**" means an individual who the Employer classifies as a common-law temporary employee on its U.S. payroll records. Temporary Employees (other than Temporary Employees who work in Hawaii) may elect to contribute their share of the cost of chosen Benefit Plan Options with After-tax Contributions only. Any other person who is not treated by an Employer as an employee for purposes of withholding federal employment taxes is not an Employee, 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.

SIGNATURE PAGE

IN WITNESS WHEREOF, the Employer has caused this amendment and restatement of the Plan to be adopted effective as of January 1, 2021.

Robert Half International Inc.

By: Leslie Rife

Name: Leslie Rife

Title: VP Benefits and Wellbeing

12/22/2021

APPENDIX A
THIRD PARTY ADMINISTRATOR

1.	Name, address, and phone number of Plan Sponsor/ Administrator: *The Plan Administrator shall have the exclusive right to interpret the Plan and to decide all matters arising under the aspects of the Plan subject to ERISA, including the right to make determinations of fact, and construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan, except to the extent the Plan Administrator has delegated its responsibilities to one of the third-party administrators listed below.*	Robert Half International Inc. 2613 Camino Ramon San Ramon, CA 94583
2.	Plan Year	Calendar Year (1/1 - 12/31)
3.	Third-Party Administrators and Trustee/Custodian of HSAs	
	• Midyear Election Changes	• For questions regarding midyear election changes, contact the Benefits Call Center (Empyrean) 1.855.RHI.BENE.
	• Health Care FSA – General Purpose FSA and Combination FSA • Dependent Care FSA	• For questions regarding your Health Care and Dependent Care FSAs contact the Benefits Call Center (Empyrean) 1.855.RHI.BENE**.**
	• COBRA Administrator	• Empyrean Benefits Services Benefits Call Center (Empyrean) 1.855.RHI.BENE.
	• HSA Trustee/Custodian	• For questions regarding your HSA, contact Benefits Call Center (Empyrean) 1.855.RHI.BENE.
		•

APPENDIX B

CLAIMS REVIEW PROCEDURE

The procedure set forth below only apples to the Health Care FSA offered under this Plan because it is subject to ERISA.

Step 1: *Notice of denial is received from third-party administrator*. If your claim is denied, you will receive written notice from the third-party administrator that your claim is denied. You will receive this notice as soon as reasonably possible, but no later than 30 days after receipt of the claim. For reasons beyond the control of the third-party administrator, the third-party administrator may take up to an additional 15 days to review your claim. You will be provided written notice of the need for additional time prior to the end of the 30-day period. If the reason for the additional time is that you need to provide additional information, you will have 45 days from the notice of the extension to obtain that information. The time period during which the third-party administrator must make a decision will be suspended until the earlier of the date that you provide the information or the end of the 45-day period.

Step 2: *Review your notice carefully*. Once you have received your notice from the third-party administrator, review it carefully. The notice will contain:

a. The reason(s) for the denial and the Plan provisions on which the denial is based;

b. A description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information;

c. A description of the Plan's appeal procedures and the time limits applicable to such procedures; and

d. A right to request all documentation relevant to your claim.

Step 3: *If you disagree with the decision, file an appeal*. If you do not agree with the decision of the third-party administrator, you may file a written appeal. Your appeal must be received within 180 days of the date you received notice that your claim was denied. You should submit all information identified in the notice of denial as necessary to perfect your claim and any additional information that you believe would support your claim to the third-party administrator listed in Appendix A.

Step 4: *Second notice of denial is received from third-party administrator*. If the claim is again denied, you will be notified in writing by the third-party administrator as soon as possible, but no later than 30 days after receipt of the appeal.

Step 5: *Review your notice carefully*. You should take the same action that you take in Step 2 described above. The notice will contain the same type of information that is provided in the first notice of denial provided by the third-party administrator.

Step 6: *If you still disagree with the third-party administrator's decision, file a second level appeal with the Plan Administrator*. If you still do not agree with the third-party administrator's decision and you wish to appeal, you must file a written appeal with the Plan Administrator within the time period set forth in the first level appeal denial notice from the third-party administrator. You should gather any additional information that is identified in the notice as necessary to perfect your claim and any other information that you believe will support your claim.

If the Plan Administrator denies your second level appeal, you will receive notice within 30 days after the Plan Administrator receives your claim. The notice will contain the same type of information that was referenced in Step 1 above.

Important Information

Other important information regarding your appeals:

a. Each level of appeal will be independent from the previous level (i.e., the same person(s), or subordinates of the same person(s), involved in a prior level of appeal will not be involved in the later appeal);

b. On each level of appeal, the third-party administrator will review relevant information that you submit even if it is new information; and

c. You cannot file suit in federal court until you have exhausted these appeals procedures.

APPENDIX C

MID-YEAR ELECTION CHANGE SUMMARY

The following is a brief summary of some of the mid-year election changes that are permitted under the Cafeteria Plan Component and Health Care and Dependent Care FSAs on account of certain life events. You should contact the third-party administrator listed in Appendix A for additional information or if you have questions. This summary does not apply to the HSA. The amount of Pre-tax Contributions to your HSA can be increased, decreased, or revoked prospectively at any time during the Plan Year.

Please note that mid-year election changes that are permitted under this Plan may not be permitted under the Benefit Plan Option (e.g., the insurance carrier may not allow a change). If a change is not permitted under a Benefit Plan Option, no election change is permitted under this Plan.

1. **Change in Status.** Mid-year election changes may be allowed if you or your Dependent experience one of the Change in Status events set forth below. The election change must be on account of, and correspond with, the Change in Status event as determined by the third-party administrator listed in Appendix A. The below are examples of Changes in Status:

    - legal marriage or divorce;
    - death of a spouse, partner or dependent child;
    - birth or adoption of a child;
    - spouse's termination of employment or a new job;
    - change of employment status from full-time to part-time or vice versa (with a change in benefits eligibility);
    - taking an unpaid leave of absence;
    - open enrollment of a spouse's plan.

    Mid-year enrollments resulting from birth, placement for adoption, or adoption are effective on the date of the event; other election changes are generally effective on the first day of the month following the date of the event. As a general rule, a desired election change will be found to be consistent with a Change in Status event if the Change in Status event affects eligibility for coverage. A Change in Status affects eligibility for coverage if it results in an increase or decrease in the number of individuals who may benefit under the Plan. In addition, you must also satisfy the following specific requirements in order to change your election mid-year based on that Change in Status:

    - *Loss of Dependent Eligibility*. For accident and health benefits (e.g., health, dental, and vision coverage), a special rule governs which types of mid-year election changes are consistent with the Change in Status. For a Change in Status involving a divorce, annulment or legal separation, the death of a Spouse or Dependent, or a Dependent ceasing to satisfy the eligibility requirements for coverage, an election to cancel accident or health benefits for any individual other than the Spouse or Dependent involved would fail to correspond with that Change in Status. Therefore, you may only cancel accident or health coverage for your affected Spouse or Dependent. However, there are instances in which you may be able to increase your Pre-tax Contributions to pay for COBRA coverage of a Dependent. Contact the third-party administrator listed in Appendix A (currently Mercer Marketplace 365) for more information.

Divorce example*: Employee Mike is married to Sharon, and they have one child. The employer offers a calendar-year cafeteria plan that allows employees to elect employee-only coverage, employee-plus-one-dependent coverage, family coverage, or no health coverage. Before the plan year, Mike elects family coverage for himself, Sharon, and their child. Mike and Sharon subsequently divorce during the plan year; Sharon loses eligibility for coverage under the plan, while the child is still eligible for coverage under the plan. Mike now wishes to cancel his previous election and elect no health coverage. The divorce between Mike and Sharon is a Change in Status. An election to cancel coverage for Sharon is consistent with this Change in Status. However, an election to cancel coverage for Mike and/or the child is not consistent with this Change in Status. In contrast, an election to change to employee-plus-one-dependent coverage would be consistent with this Change in Status*. Mike may change his election midyear to the amount required for employee-plus-one dependent coverage provided he makes a timely change.

- ***Example of gain of coverage eligibility under another employer's plan*.** For a Change in Status in which you, your Spouse, or Dependent gain eligibility for coverage under another employer's benefit plan as a result of a change in marital status or a change in employment status, an election to cease or decrease coverage for yourself or your Dependents under the Plan would correspond with that Change in Status *only* if coverage becomes effective or is increased under the other employer's plan.

- *Dependent Care FSA.* With respect to the Dependent Care FSA, an election change is permitted only if (1) such change or termination is made on account of and corresponds with a Change in Status that affects eligibility for coverage under the Dependent Care FSA; *or* (2) the election change is on account of and corresponds with a Change in Status that affects the eligibility of Dependent Care FSA expenses for the available tax exclusion.

  Dependent Care FSA Example: Employee Mike is married to Sharon, and they have a 12 year-old daughter. The employer's plan offers a dependent care FSA as part of its cafeteria plan. Mike elects to reduce his salary by $2,000 during a plan year to fund dependent care for his daughter. In the middle of the plan year, his daughter turns 13 years old and is no longer eligible to participate in the dependent care FSA. This event constitutes a Change in Status. Mike's election to cancel coverage under the dependent care FSA would be consistent with this Change in Status.

- *Revocation of Medical Coverage Election due to a Reduction in Hours.* You may revoke your current election for medical coverage under the Robert Half Welfare Benefit Plan (but not your Health Care FSA election) midyear to purchase a "qualified health plan" on a Health Exchange that provides minimum essential coverage if you meet the following two conditions:

  1. Your hours are reduced so that you are expected to average less than 30 hours per week but the reduction in hours does not affect your eligibility for medical coverage under the Robert Half Welfare Benefit Plan; and
  2. Your revocation of medical coverage under the Robert Half Welfare Benefit Plan is due to your enrollment in another qualified health plan that provides minimum essential coverage provided your new medical coverage begins no later than the first day of the second month following the month in which you revoked your medical coverage under the Robert Half Welfare Benefit Plan.
     For example, if you revoked your Robert Half-provided medical coverage on March 15th, your new coverage must begin no later than May 1st.

2. **Special Enrollment Rights.** If you or your Dependent are entitled to special enrollment rights under a group health plan, an election change to correspond with the special enrollment right under HIPAA is permitted. For example, if you declined enrollment in medical coverage for yourself or your Dependents because of outside medical coverage and eligibility for such coverage is subsequently lost due to legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of COBRA period, you may be able to elect medical coverage under the Robert Half Plan for yourself and your Dependents who lost such coverage. Furthermore, if you gain a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you also may be able to enroll yourself, your Spouse, and your newly acquired Dependent, provided that a request for enrollment is timely made.

   If you (1) lose coverage under a Medicaid Plan under Title XIX of the Social Security Act; (2) lose coverage under State Children's Health Insurance Program (SCHIP) under Title XXI of the Social Security Act; or (3) become eligible for group health plan premium assistance under Medicaid or SCHIP, you are entitled to special enrollment rights under your group health plan, and an election change to correspond with the special enrollment right is permitted. For example, if you declined Robert Half medical coverage for yourself or your Dependents because of medical coverage under Medicaid or SCHIP and eligibility for such coverage is subsequently lost, you may be able to elect medical coverage under a Benefit Option for yourself and your Dependents who lost such coverage.

   If you and/or your Dependent gains eligibility for group health plan premium assistance from SCHIP or Medicaid, you may also be able to enroll yourself, and your Dependents, provided that a request for enrollment is made within the 60 days from the date of the loss of other coverage or eligibility for premium assistance.

   You may revoke your current election for medical coverage (but not the Health Care FSA) midyear to purchase a qualified health plan through a Health Insurance Marketplace if you meet the following two conditions:

   1. You are eligible to enroll in a qualified health plan during your Health Insurance Marketplace's open enrollment period or "special enrollment period" (as defined by the Department of Health & Human Services); and
   2. Your revocation of medical coverage under the RH Plan is due to your enrollment in another qualified health plan offered by your Health Insurance Marketplace, provided your Marketplace coverage begins no later than the day immediately following your last day of coverage under the RH Plan.

3. **Certain Judgments, Decrees, and Orders.** If a judgment, decree, or order from a divorce, separation, annulment, or custody change requires a Dependent child (including a foster child who is your tax dependent) to be covered under this Plan, an election change to provide coverage for the Dependent child identified in the order is permissible. If the order requires that another individual (such as your former Spouse) cover the Dependent child, and such coverage is actually provided, you may change your election to revoke coverage for the Dependent child.

4. **Entitlement to Medicare or Medicaid.** If you or your Dependents become entitled to Medicare or Medicaid, an election to cancel employer-provided health coverage is permitted. Similarly, if you or your Dependents otherwise entitled to Medicare or Medicaid lose eligibility for such coverage, you may elect to begin or increase health coverage with your employer.

5. **Change in Cost.** If the cost of a Benefit Plan Option significantly increases, you may choose to make an increase in your Pre-tax Contributions, revoke the election and receive coverage under another Benefit Plan Option that provides similar coverage, or drop coverage altogether *if no similar coverage exists*. If the cost of a Benefit Plan Option significantly decreases, and you elected to participate in a more expensive Benefit Plan Option, you may revoke our prior election midyear and elect to receive coverage provided under the Benefit Plan Option that decreased in cost. In addition, if you elected not to participate in the Plan, you may elect to participate in the Benefit Plan Option that decreased in cost. For *insignificant* increases or decreases in the cost of Benefit Plan Options, however, Pre-tax Contributions will automatically be adjusted to reflect the minor change in cost. The third-party administrator will have final authority to determine whether the requirements of this section are met. Please note that none of the above "Change in Cost" exceptions are applicable to a Health Care FSA.

6. **Change in Coverage**. If coverage under a Benefit Plan Option is significantly curtailed, you may elect to revoke your election and elect coverage under another Benefit Plan Option that provides similar coverage. If the significant curtailment amounts to a complete loss of coverage, you may also drop coverage if no other similar coverage is available. Further, if the employer adds or significantly improves a Benefit Plan Option during the Plan Year, you may revoke your election and elect to receive, on a prospective basis, coverage provided by the newly added or significantly improved option, so long as the newly added or significantly improved option provides similar coverage.

   Also, you may make a mid-year election change that is on account of and corresponds with a change made under another employer plan (including a plan of the Employer or another employer), so long as: (a) the other employer plan permits its participants to make an election change permitted under the applicable Treasury regulations; or (b) the Plan Year for this Plan is different from the Plan Year of the other employer plan. Finally, you may change your election to add coverage under this Plan for yourself or your Dependents if such individual(s) loses coverage under any group health coverage sponsored by a governmental or educational institution. The Plan Administrator will have final discretion to determine whether the requirements of this section are met. (Please note that none of the above "Change in Coverage" exceptions are applicable to the Health Care FSA.)

7. **Special Mid-year Election Changes due to COVID-19 Pandemic in 2020**. During the COVID Outbreak, the IRS issued optional relief to Plan sponsors so that you would have the ability to make mid-year election changes to your Health Care and/or Dependent Care FSAs for any reason. In Plan Year 2020 Robert Half provided this optional relief and you were able to revoke your then current election, make a new election, or decrease or increase the current election(s) applicable to your Health Care and/or Dependent Care FSAs on a prospective basis. Robert Half allowed these mid-year election changes beginning on August 10, 2020 and ending on August 21, 2020. Robert Half did not allow these mid-year election changes for the 2021 Plan Year.

   You may change the amount of your election to an amount no less than the amount already reimbursed by your Health Care and/or Dependent care FSAs.

APPENDIX D

LIST OF PARTICIPATING AFFILIATED EMPLOYERS

Robert Half International Inc.

Protiviti Inc.

Protiviti Government Services, Inc.

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