LOOK INSIDE TO START EXPLORING YOUR OPTIONS!

2018 BENEFITS GUIDE

Helping You Maximize Your Robert Half Benefits

Effective January 1 – December 31, 2018

For Temporary Professionals (excludes HI)

Robert Half®

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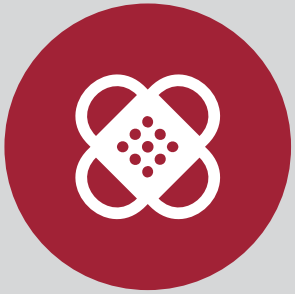

Please review the benefit options presented in this 2018 Benefits Guide so that you can make choices that work best for you.

This guide provides an overview of the benefit plans you are eligible for as a Robert Half temporary professional. If there is any discrepancy between the information presented here and the applicable official plan document, the official plan document will govern how your benefits are determined and administered. Robert Half, in its sole discretion, reserves the right to amend or terminate in writing at any time, the Benefits program, this guide, the summary plan description and/or any plan or benefit offered under the program. Nothing in this guide shall be construed as changing the at-will employment of any participant, or as a guarantee of any rights or benefits under the program.

WELCOME

Robert Half offers qualified U.S. temporary professionals and their dependents access to various benefit options through The American Worker, including multiple Medical plans, Dental, Vision, Short-Term Disability, Life, Accidental Death and Dismemberment (AD&D) and Critical Illness and Accident coverage. You can choose the benefits that meet your needs:

MEDICAL
- High-Deductible Medical Plan*
- Preventive Care Plus Plan

GROUP HOSPITAL INDEMNITY PLANS

DENTAL

VISION

SHORT-TERM DISABILITY

LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D)

CRITICAL ILLNESS AND ACCIDENT

401(K)

COMMUTER BENEFITS

**To be eligible for the High-Deductible Medical Plan, you must have worked an average of 30 or more hours per week during a 12-month look-back period.*

Key Changes for 2018

Our new benefits administrator, The American Worker, is replacing Benefits in a Card. It offers benefit programs specifically designed for temporary professionals like you. Make sure you take advantage of its comprehensive services:

- **An enhanced benefits website** [**RHAWPbenefits.com**]: The user-friendly website makes it easy for you to enroll and view information about your benefits. It includes new features, such as seeing your deductions by benefit period, claims and even making payments for any missed premiums.
- **Customer service number:** If you have questions, call The American Worker at **1.855.495.1192** Monday through Friday, 5 a.m. – 5 p.m. PT.
- **Text to enroll:** Text RHAWPOE to 24587 during Open Enrollment.

Lower costs for most plans, especially for the Preventive Care Plus Plan.

Group Hospital Indemnity Plans (fixed-indemnity plans) will offer enhanced benefits for substance abuse, mental illness and skilled nursing.

The Dental plan will have a $20 per-visit deductible and will now cover select major services.

The Short-Term Disability benefit has increased from a maximum of $100 per week to a flat $250 per week.

Critical Illness and **Accident Insurance** will be combined into one benefit plan.

Carriers and **rates** are changing, except for the High-Deductible Medical Plan.

With the transition to The American Worker, coverages under most of the plans remain the same. However, there are some changes, so make sure you review the details in this guide.

PLEASE NOTE

The High-Deductible Medical Plan and Preventive Care Plus Plan are not available in Hawaii. Please contact Mercer Marketplace at **1.855.879.6739** for information about health care benefits available to temporary professionals in Hawaii.

Due to state laws, not all plans are available in all states. Residents of Massachusetts are advised that enrollment in the medical plans offered by Robert Half may not satisfy state health insurance requirements and could subject them to a state tax penalty.

ELIGIBILITY

Eligibility and Enrollment

Benefits are available to temporary professionals who have worked on a job assignment for Robert Half. The chart below outlines eligibility details. If you have questions about eligibility or when your coverage will begin, call The American Worker at **1.855.495.1192**.

PLAN	WHEN YOU BECOME ELIGIBLE	YOUR ELIGIBLE DEPENDENTS	WHEN YOU ENROLL	BENEFITS EFFECTIVE DATE
High-Deductible Medical Plan	After you've worked an average of 30 hours per week for 12 consecutive months	Children (your spouse or domestic partner is not eligible)	During 2018 Open Enrollment	January 1, 2018
			Within 30 days of becoming eligible	The first of the month when you become eligible
Preventive Care Plus Plan	When you receive your first Robert Half pay statement	Children (your spouse or domestic partner is not eligible)	During 2018 Open Enrollment	January 1, 2018
			Within 30 days of becoming eligible	On the Monday of the week in which a deduction is taken from your paycheck
Group Hospital Indemnity Plans **Dental** **Vision** **Short-Term Disability** **Life and AD&D** **Critical Illness and Accident Insurance**	When you receive your first Robert Half pay statement	Spouse or domestic partner (where applicable) Children (where applicable)	During 2018 Open Enrollment	January 1, 2018
			Within 30 days of becoming eligible	On the Monday of the week in which a deduction is taken from your paycheck

ENROLLMENT

DEPENDENT ELIGIBILITY RULES

Keep in mind the following if you enroll your:

Spouse or domestic partner:

- If your spouse or domestic partner is also a Robert Half temporary professional, neither of you may be insured **both** as a temporary professional and as a dependent. If both of you would like to enroll in the Preventive Care Plus Plan or the High-Deductible Medical Plan, you both must enroll as a temporary professional.
- Your spouse or domestic partner isn't eligible for coverage under the Preventive Care Plus Plan or the High-Deductible Medical Plan.

Children:

- Children include your and/or your spouse's/domestic partner's biological or adopted children, stepchildren and children for whom you and/or your spouse/domestic partner have been granted formal legal guardianship.
- Children are eligible up to age 26 if they don't have other employer-provided coverage available through their own employer (or their spouse's employer).*

**If your child is physically or mentally disabled, coverage may continue beyond age 26, once proof of ongoing disability is provided and approved by the carrier.*

WHEN TO ENROLL

You must enroll within 30 days of when you become eligible, regardless of whether or not this falls within an Open Enrollment period. **Click here** to see the chart. If you don't enroll within 30 days of your eligibility date, you must wait until the next Open Enrollment period, unless you experience a qualified life event.

If you experience a qualified life event during the year, you may enroll for coverage in new plans and make changes to existing coverage within 30 days of the event. Your benefit elections or changes must be consistent with the event, and documentation of the event may be required.

You have 30 days from the date of the qualified life event (60 days in the event of a Children's Health Insurance Program [CHIP]/Medicaid event) to contact The American Worker to make a change in your coverage. If you fail to do so, you must wait until the next annual Open Enrollment period, or the occurrence of an additional qualified life event, to make a change in your benefits.

Qualified life events include (but are not limited to):

- Birth of a child
- Adoption or legal guardianship of a child
- Adding or removing a child as a dependent*
- Dependent reaches age limit
- Marriage or domestic partnership
- Legal separation, divorce or termination of domestic partnership
- Spouse, domestic partner or children gain or lose benefit coverage
- Death of spouse, domestic partner or child
- You or a dependent loses coverage under the CHIP or Medicaid program
- You or a dependent becomes eligible for state-based premium assistance under the CHIP or Medicaid program

**Dependent children must be under the age of 26 or disabled (certification required).*

ENROLLMENT

HOW TO ENROLL

Eligible temporary professionals can enroll in coverage online, by phone or via text through The American Worker:

Online:

- Go to **RHAWPbenefits.com**.
- Select **New User?** and enter the following:
  - » Your employee ID, which can be found on your paycheck stub or by calling Robert Half Customer Service at **1.888.744.9202**
  - » Group #: 156504
  - » Your last name
  - » Your 5-digit ZIP code
- Enroll in coverage.

By Phone:

- Call **1.855.495.1192** Monday through Friday, 5 a.m. – 5 p.m. PT.

Via Text:

- Text RHAWPOE during Open Enrollment to 24587.

DO YOU LIVE IN HAWAII?

If you live in Hawaii, your benefits are administered by the Mercer Marketplace and differ from the benefits in this guide. For details about your 2018 benefits, including your 2018 Benefits Guide, go to **roberthalfbenefits.com**.

How to Enroll:

You will enroll for benefits coverage through the Mercer Marketplace. There are two easy ways to enroll:

- Online at **mercermarketplace.com/roberthalf**
- By phone at **1.855.879.6739**

If you have questions or need assistance with enrolling in your benefits, call the Mercer Marketplace at **1.855.879.6739**. Benefit counselors are available Monday through Friday, 2 a.m. – 5 p.m. HAST.

COVERAGE & PAYMENTS

WHEN COVERAGE ENDS

Your benefits coverage will end on the earliest of:

- The date you're no longer eligible for benefits
- The first day for which no benefits premium has been paid*
- The date the group policy terminates

Your dependents' benefits coverage will end on the earliest of:

- The date your benefits coverage terminates
- The first day for which no benefits premium has been paid for your dependent
- The date the coverage for dependents is terminated under the group policy
- The date your dependent ceases to be a dependent as defined in the policy

BENEFITS REINSTATEMENT

If you stop working for Robert Half, your benefits coverage will end as stated in the "When Coverage Ends" section. If you start working for Robert Half again after four weeks, a new enrollment window will be opened for you and you will be able to elect coverage as if you were a new hire.

PAYING FOR YOUR BENEFITS

Premiums for all elected benefits are deducted from your paycheck each week; however, how the premium is applied and when your coverage is effective vary by plan.

COBRA CONTINUATION COVERAGE

The Preventive Care Plus Plan, High-Deductible Medical Plan and Dental and Vision coverage are subject to federal COBRA continuation requirements. In general, this allows you to continue your insurance under the group policy for 18 months after you cease to be an active temporary professional (i.e., four weeks after the end of your most recent job assignment). If your dependent would lose coverage due to your death or divorce, or because he or she reaches the eligible dependent age limit, his or her coverage may be continued for up to 36 months.

If you haven't been paid by Robert Half for a period of four consecutive weeks, your coverage will be terminated, and you will be offered COBRA continuation, retroactive to the last day for which your premium has been paid. For information about COBRA continuation, contact The American Worker at **1.855.495.1192**.

**Coverage in the High-Deductible Medical Plan will end at the end of the month after four consecutive weeks of no pay.*

COVERAGE & PAYMENTS

FOR ALL PLANS EXCEPT THE HIGH-DEDUCTIBLE MEDICAL PLAN:

Coverage:

- Coverage is provided weekly, with benefit periods running Monday through Sunday.
- Deductions are taken from your paycheck for each elected benefit, and coverage is effective the Monday of the week you receive your first paycheck with benefit deductions.
- Your coverage will continue uninterrupted as long as deductions for all of your benefits are taken from your paycheck each week.

If you receive a paycheck without any deductions or with deductions for only some of your benefits, coverage for any benefit without a deduction is suspended. Coverage remains suspended for any benefit without a deduction until the Monday of the week you receive a paycheck with a deduction for that benefit. To avoid having coverage suspended, you must make a missed premium payment directly to The American Worker every time a deduction is not taken from your paycheck.

Making up missed premium payments allows you to maintain coverage when you do not have any deductions or only have deductions for some of your benefits. You have four weeks from the date your paycheck has no deduction to make a payment. If you do not pay for a missed deduction within four weeks, you will not be able to pay for it at a later date, and you will not have coverage.

For example, if you are enrolled in Dental and Vision and receive a paycheck with only a Dental deduction (and no Vision deduction), you will have Dental coverage for the week in which the deduction was taken. However, your Vision coverage will be suspended for the week in which the deduction was NOT taken. If you want Vision coverage for that week, you must pay your Vision premium directly to The American Worker within four weeks of the date you received the paycheck without a Vision deduction.

Missed Deductions:

- You can pay for missed deductions online, by phone or by mail using an electronic or personal check, credit or debit card or money order.
- You can make a one-time payment or set up automatic payments that will be processed when a benefit deduction is not taken from your paycheck.

If you previously set up automatic payments, you are responsible for contacting The American Worker to discontinue this arrangement. If you do not, your account will continue to be charged (for up to four weeks) and you will not receive a refund.

If you have NO payroll deductions for four consecutive weeks, your coverage will be automatically terminated back to the end of the last benefit period (Sunday) for which a premium was paid.

FOR THE HIGH-DEDUCTIBLE MEDICAL PLAN ONLY:

Coverage is provided monthly from the first through the last day of the month; however, deductions are taken weekly.

To prevent a lapse in coverage, you can make up to four direct payments to Robert Half while not on assignment. If you receive a paycheck without a deduction, you are required to make a missed premium payment. To learn how, contact Robert Half at **1.855.744.6947** or **benefits@roberthalf.com**.

CANCELING YOUR BENEFITS

You may cancel your benefits at any time by contacting The American Worker at **1.855.495.1192** even if you do not have a qualified life event. However, once you cancel, all benefits will be terminated. If coverage is canceled, you can't reenroll until the next Open Enrollment period for coverage effective January of the following year or you have a qualified life event.

MEDICAL

Through the High-Deductible Medical Plan and the Preventive Care Plus Plan, you can choose the level of coverage that's right for you and your family. Each plan has unique features to consider:

	COVERAGE	ELIGIBLE DEPENDENTS
High-Deductible Medical Plan* Comprehensive medical and prescription drug coverage	▸ Provides 100% coverage for non-preventive, in-network services after the deductible is met ▸ Provides 100% in-network coverage for all ACA-required preventive services ▸ Includes prescription drug coverage ▸ Access to the national Cigna PPO Network	Children; your spouse or domestic partner is not eligible
Preventive Care Plus Plan Preventive care, prescription drug, EAP and telemedicine coverage only	▸ Provides 100% in-network coverage for all ACA-required preventive services ▸ Includes some generic prescription drug coverage ▸ No coverage for non-preventive services, such as emergency room care, hospital stays or non-preventive doctor's office visits ▸ Includes telemedicine services and an employee assistance program (EAP)	Children; your spouse or domestic partner is not eligible

**To be eligible for the High-Deductible Medical Plan, you must have worked an average of 30 hours per week for 12 consecutive months.*

IMPORTANT REMINDER

The individual mandate, a part of the Affordable Care Act (ACA), requires most Americans to have medical insurance and imposes tax penalties for failing to have qualifying coverage. Robert Half offers two employer-sponsored plans that help you satisfy the individual mandate: the Preventive Care Plus Plan and, if you're eligible, the High-Deductible Medical Plan.

You also have access to medical coverage through state or federal health insurance marketplaces. You can access these through GoHealth at **gohealthcoverage.com/hub**. Plans available through GoHealth aren't connected with Robert Half in any way.

MEDICAL

HIGH-DEDUCTIBLE MEDICAL PLAN

The High-Deductible Medical Plan provides comprehensive medical coverage through Cigna. It is designed to satisfy the individual mandate of the ACA, which requires you to enroll in health insurance that meets the ACA minimum essential coverage requirements or pay a tax penalty. With the High-Deductible Medical Plan, you will pay the cost of non-preventive services until you meet the deductible, then the plan pays 100 percent in network. Visit **myCigna.com** to find providers in the Cigna PPO Network.

Prescription drug coverage is provided through FBG Rx. When you use in-network pharmacies, prescriptions are paid at 100 percent after you meet the deductible. There are more than 63,000 in-network pharmacies nationwide, including almost all chain and independent pharmacies. Prescriptions are not covered at out-of-network pharmacies. To find a pharmacy, call **1.855.495.1192**.

Please note: You and Robert Half share your coverage costs. You pay the full cost of coverage for your dependents. Your payments for coverage, including your payroll deductions, are made on an after-tax basis.

THE FOLLOWING CHART PROVIDES A BRIEF OVERVIEW OF COVERAGE UNDER THE HIGH-DEDUCTIBLE MEDICAL PLAN:

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLE		
Individual	$6,000	$10,000
Family	$12,000	$20,000
OUT-OF-POCKET MAXIMUM		
Individual	$6,000	$11,000
Family	$12,000	$22,000
PREVENTIVE CARE	Covered at 100%	Covered at 90% after deductible
OFFICE VISIT		
Primary Care Physician	Covered at 100% after deductible	Covered at 90% after deductible
Specialist	Covered at 100% after deductible	Covered at 90% after deductible
EMERGENCY ROOM BENEFIT	Covered at 100% after deductible	Covered at 100% after the in-network deductible
INPATIENT HOSPITAL	Covered at 100% after deductible	Covered at 90% after deductible
DIAGNOSTIC TESTING (includes CT, MRI and PET scans)	Covered at 100% after deductible	Covered at 90% after deductible
ORGAN TRANSPLANT	Covered at 100% after deductible	Not covered
MENTAL DISORDERS & SUBSTANCE ABUSE	Covered at 100% after deductible	Covered at 90% after deductible
MOST OTHER SERVICES	Covered at 100% after deductible	Covered at 90% after deductible
PRESCRIPTION DRUGS		
Generic	Covered at 100% after deductible	Not covered
Preferred Brand	Covered at 100% after deductible	Not covered
Non-Preferred Brand	Covered at 100% after deductible	Not covered
Specialty	Covered at 100% after deductible	Not covered

Please note: Due to state laws, not all products are available in all states. Residents of Massachusetts are advised that enrollment in the medical plans offered by Robert Half may not satisfy state health insurance requirements and could subject them to a state tax penalty.

MEDICAL

PREVENTIVE CARE PLUS PLAN

The Preventive Care Plus Plan, administered by The American Worker, provides preventive care services that meet the ACA's requirements for minimum essential coverage and satisfies the individual mandate of the ACA. The plan covers preventive care services at 100 percent when you use an in-network provider. The plan does not include coverage for non-preventive services, such as emergency room care, hospital stays or non-preventive doctor's office visits.

BELOW ARE ADDITIONAL FEATURES OF THE PLAN:

First Health Network: You must use in-network providers to receive care; **services provided by out-of-network providers are not covered**. Through First Health Network:

- You can access a network of more than 490,000 providers across the country by visiting **firsthealthlbp.com**.
- To simplify the process, your provider will submit claims for you.

Teladoc: Teladoc gives you access to U.S. board-certified doctors 24/7 by phone, online or via your mobile device.* For certain minor, non-preventive services, Teladoc doctors can diagnose, treat and prescribe medication, when necessary, for a variety of issues. Using Teladoc:

- You can access medical care from anywhere without taking time off work.
- You'll hear back quickly, as the median call-back time is just 10 minutes.
- You'll reduce your out-of-pocket expenses by avoiding an urgent care or emergency room visit.

Prescription Drug Coverage:

- Copays of $5, $10 or $15 are available for preferred generic drugs at in-network pharmacies (limited to the formulary drug list); there is no coverage at non-network pharmacies.
- You'll receive a discount for non-preferred generic and brand-name drugs at in-network pharmacies.
- More than 63,000 in-network pharmacies nationwide, including almost all chain and independent pharmacies.
- For questions or to locate a pharmacy, call The American Worker at **1.855.495.1192**.

Employee Assistance Program (EAP): Plan members have access to the EAP through Magellan Health.

- You can access up to five free, one-on-one counseling sessions per issue and unlimited referrals for you and your household members.
- Confidential services include marriage or family counseling, parental guidance and child and eldercare.
- To access the EAP, visit **magellanhealth.com/member** or call **1.800.327.9645**.

**There are certain state requirements. In Arkansas and Delaware, an initial consultation must be done via video. In Idaho, consultations are only available via video.*

Please note: Due to state laws, not all products are available in all states. Residents of Massachusetts are advised that enrollment in the medical plans offered by Robert Half may not satisfy state health insurance requirements and could subject them to a state tax penalty.

MEDICAL

COVERED SERVICES

Below is an overview of services covered by the Preventive Care Plus Plan. The U.S. Preventive Services Task Force periodically updates the list of covered services and sets the requirements such as age, gender and/or health conditions for services to be covered. For a current list, visit **healthcare.gov/preventive-care-benefits**. Plan limitations and exclusions apply.

	SERVICES COVERED BY PREVENTIVE CARE PLUS PLAN
All Adults	▸ **Screenings:** Abdominal aortic aneurysm, alcohol misuse, blood pressure, cholesterol, colorectal cancer, depression, diabetes (type 2), hepatitis B, hepatitis C, HIV, lung cancer, obesity, syphilis, tobacco use ▸ **Counseling:** Alcohol misuse, diet, obesity, sexually transmitted infection prevention, tobacco use ▸ **Immunizations:** Diphtheria, hepatitis A, hepatitis B, herpes zoster, human papillomavirus (HPV), influenza (flu shot), measles, meningococcal, mumps, pertussis, pneumococcal, rubella, tetanus, varicella (chickenpox) ▸ **Other:** Aspirin use to prevent cardiovascular disease
Women, Including Pregnant Women or Women Who May Become Pregnant	▸ **Screenings:** Anemia, breast cancer mammography, cervical cancer, chlamydia infection, domestic and interpersonal violence, gonorrhea, HIV, human papillomavirus (HPV), osteoporosis, Rh incompatibility, sexually transmitted infection, syphilis, tobacco use, urinary tract or other infections ▸ **Counseling:** Breast cancer chemoprevention, breast cancer genetic testing (BRCA), breastfeeding, contraception, domestic and interpersonal violence, gestational diabetes, HIV ▸ **Other:** Breastfeeding supplies for pregnant and nursing women, FDA-approved contraceptive methods, folic acid supplements, well-woman visits for recommended services
Children	▸ **Screenings:** Autism, blood pressure, cervical dysplasia, depression, developmental dyslipidemia, hearing, hematocrit or hemoglobin, hemoglobinopathies or sickle cell, hepatitis B, HIV, hypothyroidism, lead, obesity, phenylketonuria, sexually transmitted infection, tuberculin, vision ▸ **Assessments:** Alcohol and drug use, behavioral, oral health risk ▸ **Counseling:** Obesity, sexually transmitted infection prevention ▸ **Immunizations:** Diphtheria, haemophilus influenza type B, hepatitis A, hepatitis B, human papillomavirus (HPV), inactivated poliovirus, influenza (flu shot), measles, meningococcal, pertussis, pneumococcal, rotavirus, tetanus, varicella (chickenpox) ▸ **Other:** Fluoride chemoprevention supplements, gonorrhea preventive medication for the eyes of newborns, height, weight and body mass index (BMI) measurements, iron supplements, medical history

GROUP HOSPITAL INDEMNITY PLANS

GROUP HOSPITAL INDEMNITY PLANS (FIXED-INDEMNITY PLANS)

The Group Hospital Indemnity Plans are supplemental options and are not designed to replace traditional medical plans. These plans do not meet the ACA's requirements for minimum essential coverage and do not satisfy the ACA's individual mandate. This means you may be required to pay a tax penalty unless you enroll in a qualifying medical plan in addition to the Group Hospital Indemnity Plan.

	COVERAGE	ELIGIBLE DEPENDENTS
Group Hospital Indemnity Plans Coverage for basic health care services	▸ Provide limited coverage for doctor's office visits, diagnostic X-rays and lab work, hospital stays and surgical procedures ▸ Pay in addition to other coverage you may have ▸ No deductibles, copays, pre-existing condition limitations or waiting periods	Children, spouse or domestic partner

The Group Hospital Indemnity Plans provide supplemental payments for health care expenses that your medical plan may not cover, including doctor's office visits, diagnostic X-rays and lab work, hospital stays and surgical procedures. The plans pay in addition to other coverage you may have and can help cover out-of-pocket expenses, such as deductibles and coinsurance, when receiving medical treatment. The plans do not require you to stay in-network, so you can visit any provider you choose for services.

New Hampshire and Vermont residents are not eligible for the Group Hospital Indemnity Plans. Group Hospital Indemnity Plan benefits vary slightly for residents in the state of Washington. A schedule of benefits for Washington residents is available by calling 1.855.495.1192.

THE FOLLOWING CHART PROVIDES A BRIEF OVERVIEW OF COVERAGE UNDER OUR THREE GROUP HOSPITAL INDEMNITY PLAN OPTIONS:

	STANDARD	PREFERRED	ELITE
DOCTOR'S OFFICE BENEFIT	Pays $50/day, 6 days/person/year	Pays $75/day, 6 days/person/year	Pays $75/day, 6 days/person/year
OUTPATIENT DIAGNOSTIC LAB	Pays $50/testing day, 3 days/person/year	Pays $50/testing day, 3 days/person/year	Pays $50/testing day, 3 days/person/year
OUTPATIENT DIAGNOSTIC X-RAY	Pays $100/testing day, 2 days/person/year	Pays $100/testing day, 2 days/person/year	Pays $100/testing day, 2 days/person/year
OUTPATIENT DIAGNOSTIC ADVANCED STUDIES	Not covered	Pays $200/testing day, 3 days/person/year	Pays $200/testing day, 3 days/person/year
PREVENTIVE CARE	Pays $75/day, 1 day/person/year	Pays $75/day, 1 day/person/year	Pays $75/day, 1 day/person/year
SURGICAL INDEMNITY Daily Inpatient Daily Inpatient Maximum Daily Outpatient Daily Outpatient Minor Outpatient Benefit Maximum	 Pays $500/day 1 day/person/year Pays $250 Pays $50 1 day/person/year	 Pays $1,500/day 1 day/person/year Pays $750 Pays $150 1 day/person/year	 Pays $3,000/day 1 day/person/year Pays $1,500 Pays $300 1 day/person/year
ANESTHESIA	Pays 30% of surgical benefit	Pays 30% of surgical benefit	Pays 30% of surgical benefit
DAILY IN-HOSPITAL INDEMNITY	Pays $100/day, 500-day lifetime maximum	Pays $200/day, 500-day lifetime maximum	Pays $500/day, 500-day lifetime maximum
HOSPITAL ADMISSION	Pays $500 lump sum/ confinement	Pays $1,000 lump sum/ confinement	Pays $2,000 lump sum/ confinement
INTENSIVE CARE UNIT	Pays $200/day, 30 days/person/year	Pays $400/day, 30 days/person/year	Pays $1,000/day, 30 days/person/year
SUBSTANCE ABUSE	Pays $50/day, 30 days/person/year	Pays $100/day, 30 days/person/year	Pays $250/day, 30 days/person/year
MENTAL ILLNESS	Pays $50/day, 30 days/person/year	Pays $100/day, 30 days/person/year	Pays $250/day, 30 days/person/year
SKILLED NURSING	Pays $50/day, 60 days/person/stay	Pays $100/day, 60 days/person/stay	Pays $250/day, 60 days/person/stay

The Group Hospital Indemnity Plans are underwritten by Nationwide Life Insurance Company.

DENTAL

DENTAL

The Dental Plan covers preventive and diagnostic services at 100 percent with no waiting period, after the per-visit deductible. It also provides coverage for basic and major dental services after the per-visit deductible and satisfying the applicable waiting period. You can use any provider, but you will pay less when you use a provider in the plan's network, as in-network providers offer discounted rates. To locate providers in your area, visit **Ameritas.com** and select "Find a Provider." Then select "Dental," click on "Network Provider" and choose the "Classic (PPO)" network.

THE FOLLOWING CHART PROVIDES A BRIEF OVERVIEW OF COVERAGE UNDER THE DENTAL PLAN. PLEASE NOTE THAT IF YOU TRANSITION TO THIS PLAN FROM THE DENTAL PLAN THROUGH BENEFITS IN A CARD, THE WAITING PERIOD FOR BASIC SERVICES WILL BE WAIVED.

CALENDAR-YEAR MAXIMUM	Up to $500/covered member/year
DEDUCTIBLE	$20/visit

COVERED SERVICES	WAITING PERIOD	COINSURANCE
PREVENTIVE & DIAGNOSTIC Routine exams, cleanings, X-rays, etc.	None	Covered at 100% (U&C charges*)
BASIC TREATMENT Restorative amalgams and composites, endodontics, periodontics, extractions, etc.	3 months	Covered at 80% (U&C charges*)
MAJOR TREATMENT Onlays, crowns, prosthodontics, etc.	12 months	Covered at 50% (U&C charges*)

**The amount paid for a dental service in a geographic area is based on what providers in the area usually charge for the same or similar dental service.*

The Dental Plan is provided by Ameritas Life Insurance Corp.

VISION

VISION

The Vision Plan covers annual exams at 100 percent after you meet the $10 exam deductible. It also provides coverage for corrective eyewear, including lenses, frames and contacts. You can use any provider, but you will pay less when you use a VSP Choice Provider. To locate providers in your area, visit **Ameritas.com** and select "Find a Provider." Then select "Vision: VSP," click on "Look up VSP providers" and choose the "Choice" network.

THE FOLLOWING CHART PROVIDES A BRIEF OVERVIEW OF COVERAGE UNDER THE VISION PLAN:

DEDUCTIBLE	$10 exam, $25 eyeglass lenses or frames*

COVERED SERVICES	VSP CHOICE NETWORK	OUT-OF-NETWORK
ANNUAL EYE EXAM	Covered in full	Up to $45
LENSES (per pair)		
Single Vision/Bifocal	Covered in full	Up to $30/Up to $50
Trifocal/Lenticular	Covered in full	Up to $65/Up to $100
CONTACTS		
Fit and Follow-up Exams	15% discount	No benefit
Elective	Up to $130	Up to $105
Medically Necessary	Covered in full	Up to $210
FRAMES	$130**	Up to $70
FREQUENCY	Based on date of service	
Exam/Lenses/Frames	12 months/12 months/24 months	

**Deductible applies to a complete pair of glasses or frames, whichever is selected.*
***The Costco allowance is the wholesale equivalent.*

The Vision Plan is provided by Ameritas Life Insurance Corp.

SHORT-TERM DISABILITY

You can use Short-Term Disability when you are unable to work due to a lengthy illness, a disabling injury, pregnancy or the birth of a child.

THE FOLLOWING CHART PROVIDES A BRIEF OVERVIEW OF THE SHORT-TERM DISABILITY COVERAGE:

WEEKLY BENEFIT	Pays $250 lump sum
MAXIMUM BENEFIT PERIOD	26 weeks
WAITING PERIOD	7 days (accidents and illnesses)

Short-Term Disability is underwritten by Nationwide Life Insurance Company.

New Hampshire and Vermont residents are not eligible for Short-Term Disability.

LIFE AND AD&D INSURANCE

Basic Life and Accidental Death and Dismemberment (AD&D) coverage can help ease the financial burden on your family in the event you are severely injured or paralyzed due to an accident or if you pass away as the result of an accident or illness.

THE FOLLOWING CHART PROVIDES A BRIEF OVERVIEW OF THE LIFE AND AD&D INSURANCE AVAILABLE:

LIFE AND AD&D INSURANCE	
Employee	Pays $20,000
DEPENDENT LIFE INSURANCE	
Spouse	Pays $5,000
Child	Pays $2,500
Infant (10 days to 6 months)	Pays $500

Life and AD&D Insurance is underwritten by Nationwide Life Insurance Company.

New Hampshire and Vermont residents are not eligible for Life and AD&D Insurance.

HOW TO DESIGNATE A BENEFICIARY

You can designate a beneficiary when you enroll for your benefits with The American Worker online at **RHAWPbenefits.com** or by calling **1.855.495.1192**.

CRITICAL ILLNESS AND ACCIDENT

CRITICAL ILLNESS AND ACCIDENT INSURANCE PACKAGE

The Critical Illness and Accident Insurance Package pays cash if you're diagnosed with certain conditions or suffer an accidental injury. Some expenses won't be covered under a comprehensive health insurance plan, and Critical Illness and Accident coverage can provide cash benefits to help ease the financial burden. You can elect coverage for yourself, your spouse or domestic partner and your children.

THE FOLLOWING CHART PROVIDES A BRIEF OVERVIEW OF THE CRITICAL ILLNESS AND ACCIDENT INSURANCE COVERAGE AVAILABLE:

ACCIDENTAL INJURY CARE	Pays $1,000 maximum/occurrence
CRITICAL ILLNESS* (first occurrence) Employee Spouse Child	 Pays $5,000 Pays $2,500 Pays $1,250
DAILY HOSPITAL INDEMNITY	Pays $100/day, 500-day lifetime maximum
INTENSIVE CARE UNIT	Pays $200/day, 30 days/person/year
SUBSTANCE ABUSE	Pays $50/day, 30 days/person/year
MENTAL ILLNESS	Pays $50/day, 30 days/person/year
SKILLED NURSING	Pays $50/day, 60 days/person/stay

The Critical Illness and Accident Insurance Package is underwritten by Nationwide Life Insurance Company.

New Hampshire and Vermont residents are not eligible for the Critical Illness and Accident Insurance Package.

*CRITICAL ILLNESS BENEFIT DESCRIPTION:

The plan pays a one-time, lump-sum benefit in the event an insured person is diagnosed with their first occurrence of end-stage renal failure, heart attack, life-threatening cancer, major organ transplant or stroke. The diagnosis must occur after the coverage is effective and while the policy is in force.

The plan pays 100 percent of the Critical Illness benefit if a covered person is diagnosed, after the effective date, with the first occurrence of any covered Critical Illness event, except cancer.

- The plan pays only 10 percent of the Critical Illness benefit if a covered person is diagnosed with the first occurrence of cancer less than 90 days after the effective date of coverage.
- If the cancer diagnosis occurs more than 90 days after the effective date, 100 percent of the Critical Illness benefit will be paid.

401(k)

401(k)

There is no waiting period to enroll in the 401(k) Plan. In general, you are eligible if you are a Robert Half employee and your Robert Half earnings in the prior calendar year are below the annual IRS compensation limit for determining "highly-compensated employees." Below are some key features of the 401(k) Plan. For more information, go to **netbenefits.com** or call **1.800.835.5097**.

Tax Savings Now

Your pre-tax contributions are deducted from your pay before income taxes are taken out. This means you can actually lower the amount of current income taxes you pay each period — and it could cost you less to save than it would if you saved in a taxable savings account. Please note, however, that Social Security and Medicare taxes, as well as state disability insurance, are withheld from your contributions. What's more, you pay no taxes on any of your investment earnings until you withdraw them from your 401(k) Plan account. As a result, you can keep more of your money working for your future.

Easy Ways to Invest

The 401(k) Plan makes it easy to invest. You can choose one or more investments on your own, or direct your entire account to a Fidelity Freedom K® Fund based on the year you expect to retire. Or, for a fee, try Fidelity® Portfolio Advisory Service at Work and hand over the day-to-day investment decisions to professionals at Fidelity.

Convenience

Your contributions come out of your paycheck automatically.

Portability

Your 401(k) Plan account is yours to keep. If you decide to leave Robert Half, you generally can roll over your vested account balance to another employer's retirement plan or to an Individual Retirement Account (IRA).

COMMUTER BENEFITS

COMMUTER BENEFITS

If you work in the San Francisco Bay area, New York City or Washington, D.C., you are eligible for commuter benefits. You can set aside pre-tax dollars through payroll contributions for commuting costs, such as public transportation, van pools and parking. Commuter benefits do not expire. This plan is administered by Employee Benefit Specialists (EBS). For more information about commuter benefits, go to **ebsbenefits.lh1ondemand.com** or call **1.888.327.2770**.

HOW MUCH YOU CAN CONTRIBUTE	$260/month each for mass transit and parking
ACCESSING YOUR ACCOUNT	▸ You will receive a transit benefits debit card, and eligible parking and transportation expenses will be deducted automatically from your account. ▸ Claims for reimbursement must be submitted within 180 days from the date of service.
YOUR TAX IMPLICATIONS	You make contributions to your commuter account on a pre-tax basis.

CONTACTS

The American Worker administers most benefit programs on behalf of Robert Half. For the 401(k) Plan, Commuter Benefits and Voluntary Benefits, eligibility and enrollment are handled by the contacts in the table below.

PLAN	CARRIER(S)	CARRIER CONTACT(S)
High-Deductible Medical Plan	Cigna	myCigna.com
	FBG Rx	1.855.495.1192
Preventive Care Plus Plan	First Health	FirstHealthLBP.com
	Teladoc	1.855.495.1192
	Prescription Drugs	1.855.495.1192 RHAWPbenefits.com
	Magellan EAP	1.800.327.9645 magellanhealth.com/member
Group Hospital Indemnity	Nationwide	1.855.495.1192 RHAWPbenefits.com
Dental	Ameritas	1.855.495.1192 Ameritas.com
Vision	Ameritas	1.855.495.1192 Ameritas.com
Short-Term Disability	Nationwide	1.855.495.1192 RHAWPbenefits.com
Life & AD&D	Nationwide	1.855.495.1192 RHAWPbenefits.com
Critical Illness & Accident	Nationwide	1.855.495.1192 RHAWPbenefits.com
COBRA	The American Worker	1.855.495.1192 RHAWPbenefits.com

PLAN	CARRIER(S)	CARRIER CONTACT(S)
401(k)	Fidelity	1.800.835.5097 netbenefits.com
Commuter Benefits (San Francisco, New York City and Washington, D.C. only)	Employee Benefit Specialists	1.888.327.2770 ebsbenefits.lh1ondemand.com
Other Benefits • Auto Insurance • Homeowner's/ Renter's Insurance • Identity Theft Services • Long-Term Care Insurance • Pet Insurance	Mercer	1.866.795.2054 rhiprovoluntaryplans.com

Important Legal Notices

This guide provides an overview of the benefit plans you are eligible for as a Robert Half temporary professional. If there is any discrepancy between the information presented in this guide and the applicable official plan document, the official plan document will govern how your benefits are determined and administered. Robert Half, in its sole discretion, reserves the right to amend or terminate in writing at any time, the Benefits program, this guide, the summary plan description and/or any plan or benefit offered under the program. Nothing in this guide shall be construed as changing the at-will employment of any participant, or as a guarantee of any rights or benefits described in this guide.

Federal laws require that Robert Half provide you with certain notices that inform you about your rights regarding eligibility, enrollment and coverage under group health and welfare plans. The following notices explain these rights; please read them carefully and keep them where you can find them.

THE AFFORDABLE CARE ACT (ACA) AND YOUR PLANS

High-Deductible Medical Plan: Enrollment in this plan means that you have satisfied the individual mandate under the ACA. If you do not enroll in this plan, you will not be eligible for a federal tax credit that lowers your monthly premium and/or a reduction in certain cost-sharing if you purchase coverage on a health care exchange.

Preventive Care Plus Plan: This plan is designed to provide you with minimum essential coverage under both the ACA and federal income tax rules. Enrollment in this plan means that you have satisfied the individual mandate under the ACA. If you do not enroll in this plan, you may be eligible for a federal tax credit that lowers your monthly premium and/or a reduction in certain cost-sharing if you enroll in a health plan through a health care exchange.

Group Hospital Indemnity: This program is not intended nor recommended to replace any comprehensive program of insurance in which you currently participate, or intend to participate. This plan is not designed to replace or provide major medical or catastrophic coverage. This guide is for summary purposes only. The insurance benefits of the Group Hospital Indemnity Plans are underwritten by Nationwide Life Insurance Company. Additional information will be provided upon enrollment in the program. **Plan exclusions and limitations apply.**

The Group Hospital Indemnity Plans (a) do not qualify as minimum essential coverage under the ACA and (b) do not satisfy the ACA's individual mandate.

New Hampshire and Vermont residents are not eligible for the Group Hospital Indemnity Plans, Short-Term Disability, Life and AD&D Insurance or Critical Illness and Accident Insurance offered by The American Worker.

Massachusetts residents are eligible for the Group Hospital Indemnity and Preventive Care Plus Plans, but neither of these plans meet Minimum Creditable Coverage requirements and do not satisfy the individual mandate that you have health insurance in Massachusetts.

Hawaii residents are not eligible for any of the benefits described in this guide.

IMPORTANT NOTICE TO EMPLOYEES FROM ROBERT HALF ABOUT NONCREDITABLE PRESCRIPTION DRUG COVERAGE AND MEDICARE (JANUARY 1, 2018)

The purpose of this notice is to advise you that the prescription drug coverage under the Robert Half Preventive Care Plus Plan and High-Deductible Medical Plan is not, on average, at least as good as standard Medicare prescription drug coverage for 2018. This is called noncreditable coverage. If you have drug coverage only through one of the 2018 plans listed in this notice through Robert Half, you may have to pay a Part D late enrollment penalty if you enroll in a Medicare prescription drug plan after your applicable Medicare enrollment period ends. If you or your family members aren't currently covered by Medicare and won't become covered by Medicare in the next 12 months, this notice doesn't apply to you.

WHY THIS IS IMPORTANT

The rest of this notice tells you where to find more information to help you make decisions about your prescription drug coverage.

You may have heard about Medicare's prescription drug coverage (called Part D), and wondered how it would affect you. Prescription drug coverage is available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible, and each year from October 15 through December 7. Individuals leaving employer/union coverage may be eligible for a Medicare Special Enrollment Period.

If you decide to enroll in a Medicare prescription drug plan and you are an active employee or family member of an active employee, you may also continue your employer coverage. In this case, the employer plan will continue to pay primary or secondary as it had before you enrolled in a Medicare prescription drug plan. If you waive or drop Robert Half coverage, Medicare will be your only payer. You can re-enroll in the employer plan at annual enrollment or if you have a special enrollment event.

You should know that if you go 63 days or longer without creditable prescription drug coverage (after your applicable Medicare enrollment period ends), your monthly Part D premium will go up at least 1% per month for every month that you did not have creditable coverage. For example, if you go 19 months without coverage, your Medicare prescription drug plan premium will always be at least 19% higher than what most other

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people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll in Part D.

You may receive this notice at other times in the future — such as before the next period you can enroll in Medicare prescription drug coverage, if this coverage changes or upon your request.

TO LEARN MORE ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. Medicare participants will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans.

Here's how to get more information about Medicare prescription drug plans:

- Visit **medicare.gov** for personalized help.
- Call your State Health Insurance Assistance Program (see a copy of the Medicare & You handbook for the telephone number).
- Call **1.800.MEDICARE** (**1.800.633.4227**). TTY users should call **1.877.486.2048**.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at **socialsecurity.gov** or call **1.800.772.1213** (TTY **1.800.325.0778**).

For more information about this notice or your prescription drug coverage, contact Robert Half HR Solutions Center at **1.855.744.6947** or **benefits@roberthalf.com**.

HIPAA SPECIAL ENROLLMENT NOTICE

NOTICE OF SPECIAL ENROLLMENT RIGHTS FOR HEALTH PLAN COVERAGE

If you decline enrollment in the Robert Half Preventive Care Plus Plan — or, if eligible, the Robert Half High-Deductible Medical Plan — for you or your eligible dependents because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in a Robert Half medical plan without waiting for the next open enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 31 days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption or placement for adoption. You must request health plan enrollment within 31 days after the marriage, birth, adoption or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 31-day time frame, coverage will be effective on the date of birth, adoption or placement for adoption. For all other events, coverage will be effective on the first of the month following your request for enrollment. In addition, you may enroll in the Robert Half Preventive Care Plan (or, if eligible, the Robert Half High-Deductible Medical Plan) if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective on the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

Note: If your dependent becomes eligible for a special enrollment rights, you may add the dependent to your current coverage or change to another health plan.

WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA) NOTICE

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA).

For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under your plan. If you would like more information on WHCRA benefits, contact Robert Half HR Solutions Center at **1.855.744.6947** or **benefits@roberthalf.com**.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT (NMHPA OR "NEWBORNS' ACT") NOTICE

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

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obtain authorization from the plan or the insurer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, contact Robert Half HR Solutions Center at **1.855.744.6947** or **benefits@roberthalf.com**.

ROBERT HALF HIPAA PRIVACY NOTICE

Please carefully review this notice. It describes how medical information about you may be used and disclosed and how you can get access to this information.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on the use and disclosure of individual health information by Robert Half health plans. This information, known as protected health information, includes almost all individually identifiable health information held by a health plan — whether received in writing, in an electronic medium or as an oral communication. This notice describes how the Robert Half Welfare Benefit Plan and its component health plans for temporary professional employees (the High-Deductible Medical Plan, the Preventive Care Plus Plan, the Dental Plan and the Vision Plan [collectively the "Plan"], as well as any third-party that administers the Plan on Robert Half's behalf, may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes required by law.

THE PLAN'S DUTIES WITH RESPECT TO HEALTH INFORMATION ABOUT YOU

The Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Plan's legal duties and privacy practices with respect to your health information. If you participate in an insured plan option, you will receive a notice directly from the Insurer. It's important to note that these rules apply to the Plan, not Robert Half as an employer — that's the way the HIPAA rules work. Different policies may apply to other Robert Half programs or to data unrelated to the Plan.

HOW THE PLAN MAY USE OR DISCLOSE YOUR HEALTH INFORMATION

The privacy rules generally allow the use and disclosure of your health information without your permission (known as an authorization) for purposes of health care treatment, payment activities and health care operations. Here are some examples of what that might entail:

- Treatment includes providing, coordinating or managing health care by one or more health care providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. For example, the Plan may share your health information with physicians who are treating you.
- Payment includes activities by this Plan, other plans or providers to obtain premiums, make coverage determinations and provide reimbursement for health care. This can include determining eligibility, reviewing services for medical necessity or appropriateness, engaging in utilization management activities, claims management and billing; as well as performing "behind the scenes" plan functions, such as risk adjustment, collection or reinsurance. For example, the Plan may share information about your coverage or the expenses you have incurred with another health plan to coordinate payment of benefits.

Health care operations include activities by this Plan (and, in limited circumstances, by other plans or providers), such as wellness and risk assessment programs, quality assessment and improvement activities, customer service and internal grievance resolution. Health care operations also include evaluating vendors; engaging in credentialing, training and accreditation activities; performing underwriting or premium rating; arranging for medical review and audit activities; and conducting business planning and development. For example, the Plan may use information about your claims to audit the third parties that approve payment for Plan benefits.

The amount of health information used, disclosed or requested will be limited and, when needed, restricted to the minimum necessary to accomplish the intended purposes, as defined under the HIPAA rules. If the Plan uses or discloses PHI for underwriting purposes, the Plan will not use or disclose PHI that is your genetic information for such purposes.

HOW THE PLAN MAY SHARE YOUR HEALTH INFORMATION WITH ROBERT HALF

The Plan, or its health insurer or HMO, may disclose your health information without your written authorization to Robert Half for Plan administration purposes. Robert Half may need your health information to administer benefits under the Plan. Robert Half agrees not to use or disclose your health information other than as permitted or required by the Plan documents and by law. Only a limited number of Robert Half employees will have access to your health information and only to the extent required for plan administration functions.

Here's how additional information may be shared between the Plan and Robert Half, as allowed under the HIPAA rules:

- The Plan, or its insurer or HMO, may disclose "summary health information" to Robert Half, if requested, for purposes of obtaining premium bids to provide coverage under the Plan or for modifying, amending or terminating the Plan. Summary health information is information that summarizes participants' claims information, from which names and other identifying information have been removed.
- The Plan, or its insurer or HMO, may disclose to Robert Half information on whether an individual is participating in the Plan or has enrolled or disenrolled in an insurance option or HMO offered by the Plan.

In addition, you should know that Robert Half cannot and will not use health information obtained from the Plan for any employment-related actions. However, health information collected by Robert Half from other sources — for example, under the Family and Medical Leave Act,

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Americans with Disabilities Act or workers' compensation programs — is not protected under HIPAA (although this type of information may be protected under other federal or state laws).

OTHER ALLOWABLE USES OR DISCLOSURES OF YOUR HEALTH INFORMATION

In certain cases, your health information can be disclosed without authorization to a family member, close friend or other person you identify who is involved in your care or payment for your care. Information about your location, general condition or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You'll generally be given the chance to agree or object to these disclosures (although exceptions may be made — for example, if you're not present or if you're incapacitated). In addition, your health information may be disclosed without authorization to your legal representative.

The Plan also is allowed to use or disclose your health information without your written authorization for the following activities:

- **Workers' compensation:** Disclosures to workers' compensation or similar legal programs that provide benefits for work-related injuries or illness without regard to fault, as authorized by and necessary to comply with the laws
- **Necessary to prevent serious threat to health or safety:** Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, if made to someone reasonably able to prevent or lessen the threat (or to the target of the threat); includes disclosures to help law enforcement officials identify or apprehend an individual who has admitted participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody
- **Public health activities:** Disclosures authorized by law to persons who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects
- **Victims of abuse, neglect or domestic violence:** Disclosures to government authorities, including social services or protected services agencies authorized by law to receive reports of abuse, neglect or domestic violence, as required by law or if you agree or the Plan believes that disclosure is necessary to prevent serious harm to you or potential victims (you'll be notified of the Plan's disclosure if informing you won't put you at further risk)
- **Judicial and administrative proceedings:** Disclosures in response to a court or administrative order, subpoena, discovery request or other lawful process (the Plan may be required to notify you of the request or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information)
- **Law enforcement purposes:** Disclosures to law enforcement officials required by law or legal process or to identify a suspect, fugitive, witness or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosures about a death that may have resulted from criminal conduct; and disclosures to provide evidence of criminal conduct on the Plan's premise
- **Decedents:** Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties
- **Organ, eye or tissue donation:** Disclosures to organ procurement organizations or other entities to facilitate organ, eye or tissue donation and transplantation after death
- **Research purposes:** Disclosures subject to approval by institutional or private privacy review boards, subject to certain assurances and representations by researchers about the necessity of using your health information and the treatment of the information during a research project
- **Health oversight activities:** Disclosures to health agencies for activities authorized by law (audits, inspections, investigations or licensing actions) for oversight of the health care system, government benefits programs for which health information is relevant to beneficiary eligibility and compliance with regulatory programs or civil rights laws
- **Specialized government functions:** Disclosures about individuals who are Armed Forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates
- **HHS investigations:** Disclosures of your health information to the Department of Health and Human Services to investigate or determine the Plan's compliance with the HIPAA privacy rule

Except as described in this notice, other uses and disclosures will be made only with your written authorization. For example, in most cases, the Plan will obtain your authorization before it communicates with you about products or programs if the Plan is being paid to make those communications. If the Plan keeps psychotherapy notes in its records, it will obtain your authorization in some cases before the Plan releases those records. The Plan will never sell your health information unless you have authorized us to do so. You may revoke your authorization as allowed under the HIPAA rules. However, you can't revoke your authorization with respect to disclosures the Plan has already made. You will be notified of any unauthorized access, use or disclosure of your unsecured health information as required by law.

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The Plan will notify you if it becomes aware that there has been a loss of your health information in a manner that could compromise the privacy of your health information.

YOUR INDIVIDUAL RIGHTS

You have the following rights with respect to your health information the Plan maintains. These rights are subject to certain limitations, as discussed below. This section of the notice describes how you may exercise each individual right. See the table at the end of this notice for information on how to submit requests.

RIGHT TO REQUEST RESTRICTIONS ON CERTAIN USES AND DISCLOSURES OF YOUR HEALTH INFORMATION AND THE PLAN'S RIGHT TO REFUSE

You have the right to ask the Plan to restrict the use and disclosure of your health information for treatment, payment or health care operations, except for uses or disclosures required by law. You have the right to ask the Plan to restrict the use and disclosure of your health information to family members, close friends or other persons you identify as being involved in your care or payment for your care. You also have the right to ask the Plan to restrict use and disclosure of health information to notify those persons of your location, general condition or death — or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to the Plan must be in writing.

The Plan is not required to agree to a requested restriction. If the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Plan (including an oral agreement) or unilaterally by the Plan for health information created or received after you're notified that the Plan has removed the restrictions. The Plan may also disclose health information about you if you need emergency treatment, even if the Plan has agreed to a restriction.

An entity covered by these HIPAA rules (such as your health care provider) or its business associate must comply with your request that health information regarding a specific health care item or service not be disclosed to the Plan for purposes of payment or health care operations if you have paid out of pocket and in full for the item or service.

RIGHT TO RECEIVE CONFIDENTIAL COMMUNICATIONS OF YOUR HEALTH INFORMATION

If you think that disclosure of your health information by the usual means could endanger you in some way, the Plan will accommodate reasonable requests to receive communications of health information from the Plan by alternative means or at alternative locations.

If you want to exercise this right, your request to the Plan must be in writing and you must include a statement that disclosure of all or part of the information could endanger you.

RIGHT TO INSPECT AND COPY YOUR HEALTH INFORMATION

With certain exceptions, you have the right to inspect or obtain a copy of your health information in a "designated record set." This may include medical and billing records maintained for a health care provider; enrollment, payment, claims adjudication and case or medical management record systems maintained by a plan; or a group of records the Plan uses to make decisions about individuals. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal or administrative proceedings.

The Plan may deny your right to access, although in certain circumstances, you may request a review of the denial. If you want to exercise this right, your request to the Plan must be in writing. Within 31 days of receipt of your request (60 days if the health information is not accessible on site), the Plan will provide you with one of these responses:

- The access or copies you requested
- A written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint
- A written statement that the time period for reviewing your request will be extended for no more than 31 more days, along with the reasons for the delay and the date by which the Plan expects to address your request

You may also request your health information be sent to another entity or person, so long as that request is clear, conspicuous and specific. The Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The Plan also may charge reasonable fees for copies or postage. If the Plan doesn't maintain the health information but knows where it is maintained, you will be informed where to direct your request.

If the Plan keeps your records in an electronic format, you may request an electronic copy of your health information in a form and format readily producible by the Plan. You may also request that such electronic health information be sent to another entity or person, so long as that request is clear, conspicuous and specific. Any charge that is assessed to you for these copies must be reasonable and based on the Plan's cost.

RIGHT TO AMEND YOUR HEALTH INFORMATION THAT IS INACCURATE OR INCOMPLETE

With certain exceptions, you have a right to request that the Plan amend your health information in a designated record set. The Plan may deny your request for a number of reasons. For example, your request may be denied if the health information is accurate and complete, was not created by the Plan (unless the person or entity that created the information is no longer available), is not part of the designated record set or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal or administrative proceedings).

If you want to exercise this right, your request to the Plan must be in writing, and you must include a statement to support the requested amendment. Within 60 days of receipt of your request, the Plan will take one of these actions:

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- Make the amendment as requested
- Provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint
- Provide a written statement that the time period for reviewing your request will be extended for no more than 31 more days, along with the reasons for the delay and the date by which the Plan expects to address your request

RIGHT TO RECEIVE AN ACCOUNTING OF DISCLOSURES OF YOUR HEALTH INFORMATION

You have the right to a list of certain disclosures of your health information the Plan has made. This is often referred to as an "accounting of disclosures." You generally may receive this accounting if the disclosure is required by law, in connection with public health activities or in similar situations listed in the table earlier in this notice, unless otherwise indicated below.

You may receive information on disclosures of your health information for up to six years before the date of your request. You do not have a right to receive an accounting of any disclosures made in any of these circumstances:

- For treatment, payment or health care operations
- To you about your own health information
- Incidental to other permitted or required disclosures
- Where authorization was provided
- To family members or friends involved in your care (where disclosure is permitted without authorization)
- For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances
- As part of a "limited data set" (health information that excludes certain identifying information)

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official.

If you want to exercise this right, your request to the Plan must be in writing. Within 60 days of the request, the Plan will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 31 more days, along with the reasons for the delay and the date by which the Plan expects to address your request. You may make one request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You'll be notified of the fee in advance and have the opportunity to change or revoke your request.

RIGHT TO OBTAIN A PAPER COPY OF THIS NOTICE FROM THE PLAN UPON REQUEST

You have the right to obtain a paper copy of this privacy notice upon request. Even individuals who agreed to receive this notice electronically may request a paper copy at any time.

CHANGES TO THE INFORMATION IN THIS NOTICE

The Plan must abide by the terms of the privacy notice currently in effect. However, the Plan reserves the right to change the terms of its privacy policies, as described in this notice, at any time and to make new provisions effective for all health information that the Plan maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If changes are made to the Plan's privacy policies described in this notice, you will be provided with a revised privacy notice.

COMPLAINTS

If you believe your privacy rights have been violated or your Plan has not followed its legal obligations under HIPAA, you may complain to the Plan's Privacy Officer and to the Secretary of Health and Human Services. You won't be retaliated against for filing a complaint. To file a complaint with the Department of Health and Human Services, go to **www.hhs.gov/ocr/privacy**. To complain to the Plan's Privacy Officer, call Robert Half's toll-free hotline at **1.888.875.4901**.

CONTACT

For more information on the Plan's privacy policies or your rights under HIPAA, contact Robert Half HR Solutions Center at at **1.855.744.6947** or **benefits@roberthalf.com**.

EXCHANGE NOTICE

HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

PART A: General Information

When key parts of the health care law took effect in 2014, a new way to buy health insurance became available: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers one-stop shopping to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in November of 2017 for coverage starting as early as January 1, 2018.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Important Legal Notices

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.69% of your household income for the year, or if the coverage your employer provides does not meet the minimum value standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer- offered coverage. Also, this employer contribution — as well as your employee contribution to employer-offered coverage — may be excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

1 An employersponsored health plan meets the minimum value standard if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Robert Half HR Solutions Center at **1.888.677.6613** or **benefits@roberthalf.co**m.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **healthcare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer Name: Robert Half International Inc.	4. Employer Identification Number (EIN): 94-1648752	
5. Employer address: 2613 Camino Ramon	6. Employer phone number: 1.855.744.6947	
7. City: San Ramon	8. State: CA	9. Zip code: 94583
10. Who can we contact about employee health coverage at this job? Robert Half HR Solutions Center		
11. Phone number (if different from above)	12. Email address: benefits@roberthalf.com	

CHIPRA/CHIP NOTICE

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

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

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1.877. KIDS NOW** or **insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at **askebsa.dol.gov** or call **1.866.444.EBSA (3272)**.

Important Legal Notices

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of August 10, 2017. Contact your State for more information on eligibility.

ALABAMA – Medicaid
Website: http://myalhipp.com/ Phone: 1.855.692.5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1.866.251.4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/ Phone: 1.855.MyARHIPP (1.855.692.7447)
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1.800.221.3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1.800.359.1991/ State Relay 711

KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1.785.296.3512
KENTUCKY – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1.800.635.2570

FLORIDA – Medicaid
Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1.877.357.3268
GEORGIA – Medicaid
Website: http://dch.georgia.gov/medicaid — click on Health Insurance Premium Payment (HIPP) Phone: 1.404.656.4507

INDIANA – Medicaid
Healthy Indiana Plan for low.income adults 19.64 Website: http://www.in.gov/fssa/hip/ Phone: 1.877.438.4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1.800.403.0864
IOWA – Medicaid
Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1.888.346.9562

NEW HAMPSHIRE – Medicaid
Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 1.603.271.5218
NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609.631.2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1.800.701.0710

LOUISIANA – Medicaid
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1.888.695.2447
MAINE – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1.800.442.6003 TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1.800.862.4840
MINNESOTA – Medicaid
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1.800.657.3739
MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 1.573.751.2005
MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1.800.694.3084
NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: 1.855.632.7633 Lincoln: 1.402.473.7000 Omaha: 1.402.595.1178
NEVADA – Medicaid
Medicaid Website: https://dwss.nv.gov/ Medicaid Phone: 1.800.992.0900

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1.800.541.2831
NORTH CAROLINA – Medicaid
Website: https://dma.ncdhhs.gov/ Phone: 1.919.855.4100
NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1.844.854.4825
OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1.888.365.3742
OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1.800.699.9075
PENNSYLVANIA – Medicaid
Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1.800.692.7462
RHODE ISLAND – Medicaid
Website: http://www.eohhs.ri.gov/ Phone: 1.855.697.4347
SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov Phone: 1.888.549.0820

Important Legal Notices

SOUTH DAKOTA – Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1.888.828.0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1.800.562.3022 ext. 15473
TEXAS – Medicaid	WEST VIRGINIA – Medicaid
Website: http://gethipptexas.com/ Phone: 1.800.440.0493	Website: http://mywvhipp.com/ Toll.free phone: 1.855.MyWVHIPP (1.855.699.8447)
UTAH – Medicaid and CHIP	WISCONSIN – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1.877.543.7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1.800.362.3002
VERMONT– Medicaid	WYOMING – Medicaid
Website: http://www.greenmountaincare.org/ Phone: 1.800.250.8427	Website: https://wyequalitycare.acs.inc.com/ Phone: 1.307.777.7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1.800.432.5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1.855.242.8282	

To see if any other states have added a premium assistance program since August 10, 2017, or for more information on special enrollment rights, contact either:

Employee Benefits Security Administration Centers for Medicare & Medicaid Services

U.S. Department of Labor
dol.gov/agencies/ebsa
1.866.444.EBSA (3272)

U.S. Department of Health and Human Services
cms.hhs.gov
1.877.267.2323, Menu Option 4, Ext. 61565