AVNET
Reach Further™

Summary Plan Description

Avnet, Inc.
Insured Benefits Plan

Effective: January 1, 2019

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ARTICLE 1

INTRODUCTION

1.1 Introduction

Avnet, Inc. (the "Company") has established and maintains the Avnet Insured Plan ("Plan") for the benefits of its eligible employees and their eligible dependents.

This document, along with the Attachments serves as both the written Plan document and the Summary Plan Description ("SPD") required by federal law known as Employee Retirement Income and Security Act ("ERISA"). It is very important to review this document and its Attachments carefully to confirm a complete understanding of the benefits available, as well as your responsibilities, under the Plan.

The Plan provides benefits through the component benefit programs identified in Appendix A. The benefits are described in the documents and contracts identified in Appendix A. Notwithstanding any implication or statement to the contrary in any of the documents incorporated herein by reference, the Plan is a single plan. The documents incorporated herein by reference may, from time to time, refer to such benefits as a plan or plans. Such references shall not, however, create separate plans for such benefits. The documents listed in Appendix A are incorporated by reference into this document as if set forth fully herein.

Some of the component benefit programs require completion of initial elections, and/or other administrative tasks. To facilitate efficient operation of the Plan, the Plan may allow forms (including, for example, election forms and notices), whether required or permissive, to be sent and/or made by electronic means.

Each of the component benefit programs is summarized in an insurance or HMO contract, a plan document, or another governing document. When the Plan refers to an insurance or HMO contract, it also refers to any attachments to such contract, as well as documents incorporated by reference into such contract (such as the application and the certificate of insurance or HMO booklet). A copy of each contract (including the booklet), plan document, or other governing document is attached to this document in the Attachments. If you have not received a copy of the Attachments, contact the Plan Administrator.

Avnet, Inc. intends to continue this Plan, but reserves the right, in its sole discretion, to modify, change, revise, amend or terminate the Plan at any time, for any reason, and without prior notice.

ERISA Status

The Plan provides benefits that are subject to the requirements of ERISA. This document and its Attachments constitute the written plan document required by Section 402 of ERISA. This document and its Attachments also serve as the summary plan description as required by Section 102 of ERISA.

ARTICLE 2

DEFINITIONS

"Attachments" means the documentation identified in Appendix A and attached to this document, which together with this document, constitute the written plan and the SPD.

"Board" means the Avnet Executive Board (AEB) or Board of Directors of the Company.

"CHIP" means the Children's Health Insurance Program Reauthorization Act of 2009.

"COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

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

"Company" means Avnet, Inc., and each successor in interest to the Company resulting from merger, consolidation, or transfer of substantially all of its assets that elects to continue this Plan. Except as otherwise clearly indicated by the context (such as the definition of "Board"), the term "Company" as used herein shall include each adopting affiliate. Each adopting affiliate shall be deemed to have delegated to the Board all authority to amend or terminate the Plan and to appoint and remove the Plan Administrator.

"Covered Person" means either the Employee or an enrolled Dependent, but this term applies only while the person is enrolled and eligible for Benefits under the Plan. References to "you" and "your" throughout this document are references to a Covered Person.

"Dependent" means an individual who meets the eligibility requirements specified in the Plan. The term child means a child born to an Employee, a child legally adopted by an Employee, a child for whom an Employee is a legal guardian, or a stepchild.

A Dependent does not include anyone who is also enrolled as an Employee. No one can be a Dependent of more than one Employee.

"EAP" means the Employee Assistance Program.

"Eligible Employee" means an Employee who satisfies the eligibility provisions of Article 3, including the eligibility provisions of the applicable component benefit program.

"Employee" means a regular Employee of the Company who either (a) is employed on a full-time basis and works an average of at least 30 hours per week, or (b) is employed on a part-time basis and works an average of at least 20 hours per week, and is currently in Active Service. An Employee must live and/or work in the United States.

An eligible Employee does not include any employee who:

- is temporary (e.g., a seasonal intern) or classified by the Employer as a leased employee or independent contractor;
- is part-time and works an average of less than 20 hours per week for the Employer;
- is covered by a collective bargaining agreement, unless the collective bargaining agreement provides for eligibility under this Plan;
- is employed by a business unit or division that is not eligible to participate in the Plan; or
- does not have U.S.-source income.

If an individual who is classified as ineligible is subsequently reclassified (e.g., an individual classified as an independent contractor is reclassified as an employee), the reclassification will apply prospectively only. Reclassification, whether by the Company, a court, or otherwise, shall not result in retroactive coverage for any individual.

"ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

"FMLA" means the Family and Medical Leave Act of 1993.

"GINA" means the Genetic Information Nondiscrimination Act of 2008.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.

"HITECH" means the Health Information Technology for Economic and Clinical Health Act.

"HMO" means a health maintenance organization.

"MHPA" means the Mental Health Parity Act of 1996.

"MHPAEA" means the Mental Health Parity and Addiction Equity Act of 2008.

"NMHPA" means the Newborns' and Mothers' Health Protection Act of 1996, as amended.

"Plan" means the Avnet Insured Plan.

"Plan Administrator" means Avnet, Inc. Benefits Department

"Plan Sponsor" means Avnet, Inc.

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

"PPACA" means the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010.

"Spouse", for purposes of the Plan, means an individual to whom an Employee is lawfully married. In accordance with IRS Revenue Ruling 2013-17, an individual to whom an Employee is married will be recognized as the Employee's Spouse if (and only if) the marriage to that individual was legal and valid when it was entered into, under the laws of the jurisdiction where it was entered into.

A Spouse does not include a domestic partner or a partner through civil union or other similar formal relationship that is not treated as a marriage under applicable state law.

"USERRA" means the Uniformed Services Employment and Reemployment Rights Act of 1994.

"WHCRA" means the Women's Health and Cancer Rights Act of 1998.

ARTICLE 3

ELIGIBILITY AND PARTICIPATION REQUIREMENTS

3.1 Eligibility and Participation

You will become an Eligible Employee for Plan coverage on the day you complete the waiting period if you are a regular Employee of the Company who works an average of at least 20 hours per week and is currently in Active Service. An Employee must live and/or work in the United States.

In order to participate in the Plan, an Employee must be employed by a participating business unit of the Company. Most of the Company's business units based in the United States participate in the Plan. However, certain business units do not. For more information, please contact HR Now at (888) 99-HR-NOW (888.994.7669).

Eligible Dependents may also participate in the Plan. An eligible Dependent is considered to be:

- Your Spouse.
- Your or your Spouse's child who is under age 26.
- An unmarried child age 26 or over who is or becomes disabled and dependent upon you.

You will become eligible for Dependent Plan coverage on the later of:

- the day you become eligible for yourself; or
- the day you acquire your first Dependent.

Certain component benefit programs require enrollment (either once or annually) for coverage. Information about enrollment procedures, including when coverage begins and ends for the various component benefit programs, is found in the Attachments. You begin participating in the Plan upon your election to participate in a component benefit program in accordance with the terms and conditions established for that program or, if earlier, upon meeting the eligibility criteria and becoming covered under a component benefit program that does not require enrollment or an election.

3.2 Enrollment

While some of the Plan's component benefits are provided automatically to Eligible Employees, other component benefits require you to complete an election in Workday to enroll yourself and/or your eligible Dependents. New employees must generally enroll within certain time periods after being hired, as described in the Attachments. Thereafter, enrollment is generally limited to the annual open enrollment period that occurs before January 1 each year, unless circumstances give rise to special enrollment rights as described in Section 3.3 below.

3.3 Special Enrollment

In certain circumstances and with respect to particular component benefit programs, enrollment may occur at times outside the open enrollment period (this is referred to as "special enrollment"), as explained in the Attachments. The Plan's Special Enrollment Notice also contains important information about your potential special enrollment rights. Contact the Plan Administrator if you need another copy.

3.4 When Participation Begins

Once you, as an Eligible Employee, have completed the necessary Workday enrollment, your coverage under the Plan may begin. Requirements may vary depending on the component benefit program. For information about when coverage begins, please read the eligibility and participation information contained in the Attachments.

3.5 Termination of Participation

Your entitlement to benefits automatically ends at midnight on the date that coverage ends, even if you are hospitalized or are otherwise receiving treatment on that date.

When your coverage ends, the Plan will still pay claims for covered services that you received before your coverage ended. However, once your coverage ends, benefits are not provided for health services that you receive after coverage ended, even if the underlying condition occurred before your coverage ended.

Your coverage under the Plan will end on the earliest of:

- The last day of the month your employment with the Company ends.
- The date the Plan is terminated.
- The date of your death.
- The last day of the month you stop making the required contributions.
- The last day of the month you are no longer eligible (e.g., one year of consecutive medical leave).

Coverage for your eligible Dependents will end on the earliest of:

- The date your coverage ends.
- The last day of the month you stop making the required contributions.
- The last day of the month your Dependents no longer qualify as Dependents under this Plan.
- The last day of the month following the month of your death.

It is your responsibility to provide accurate information and to make accurate and truthful statements regarding family status, age, relationships, etc., and to update previously provided information and statements. Failure to do so may be considered an intentional misrepresentation of material fact, and may result in termination of coverage, which may be retroactive.

Benefits under all component programs (for all Covered Persons) will cease upon termination of the Plan.

Other circumstances can result in the termination of benefits. The insurance contracts (including the certificate of insurance or HMO booklets), plans, and other governing documents in the applicable Attachments provide additional information.

3.6 Qualified Medical Child Support Orders

The Plan will extend medical benefits to an Eligible Employee's non-custodial child as required by any qualified medical child support order ("QMCSO") under Section 609(a) of ERISA, including a National Medical Support Notice. The Plan has procedures for determining whether an order qualifies as a QMCSO. Covered Persons and beneficiaries can obtain, without charge, a copy of such procedures from the Avnet Benefits Department.

3.7 Continuation Coverage Under COBRA

If a Covered Person's coverage under a component benefit program ceases because of certain "qualifying events" specified in COBRA (such as termination of employment, reduction in hours, divorce, death, or a child's ceasing to meet the definition of dependent), then the Covered Person may have the right to purchase continuation coverage for a temporary period of time. COBRA rights are explained in detail in the initial COBRA notice. If you need another copy of the initial COBRA notice, please call TRI-AD at 888-844-1372.

Note also that state law may provide conversion coverage.

3.8 Continuation Coverage Under USERRA

Solely to the extent required by USERRA, a Covered Person who is an Eligible Employee who enters military service shall have the right to continue coverage under the Plan for the period prescribed under the Uniformed Services Act. Continuation of coverage shall be conditioned upon payment of any required premiums. This Section shall be interpreted and applied to give an Eligible Employee only those rights as are prescribed under USERRA and rulings and regulations issued thereunder.

3.9 Coverage During an FMLA Leave

Special rules apply if you take a leave for family or health reasons that qualifies for protection under the FMLA.

Your Plan coverage will be continued during a leave of absence if:

- that leave qualifies for protection under the FMLA; and
- you are an Eligible Employee under the FMLA.

The cost of your Plan coverage (if any) during such leave is shared by you and the Company. You have the option to pre-pay, pay as you go, or pay upon your return from leave. Please contact HR Now at (888) 99-HR-NOW (888.994.7669), to arrange payment of your continued Plan coverage.

Upon your return to Active Service following a leave of absence that qualifies under the FMLA, any canceled coverage (health, life or disability) will be reinstated as of the date of your return.

You will not be required to satisfy any eligibility or benefit waiting period, to the extent that they had been satisfied prior to the start of such leave of absence.

More information about the FMLA is posted on HR Now site.

ARTICLE 4

PLAN BENEFITS

4.1 Benefits and Contributions

The Plan makes available to Eligible Employees and their eligible family members medical, vision, and EAP insurance benefits. A summary of each component benefit program available under the Plan is provided in the insurance contract (including the certificate of insurance or HMO booklet), plan document, or other governing documents, as set forth in the applicable Attachment.

The cost of the benefits provided through the component benefit programs will be funded in part by the Company and in part by pre-tax employee contributions. The Company will determine and periodically communicate the Eligible Employee's share of the cost of the benefits provided through each component benefit program, and it may change that determination at any time.

The Company will make its contributions in an amount that (in the Company's sole discretion) is at least sufficient to fund the benefits or a portion of the benefits that are not otherwise funded by employee contributions. The Company will pay its contribution and employee contributions to an insurer or HMO. Employee contributions toward the cost of a particular benefit will be used in their entirety prior to using Company contributions to pay for the cost of such benefit.

4.2 Rebates, Refunds, and Similar Payments

Any refund, rebate, dividend, experience adjustment, or other similar payment under a group insurance or HMO contract shall be allocated consistent with applicable fiduciary obligations under ERISA.

4.3 Right to Recover Benefit Overpayments and Other Erroneous Payments

If, for any reason, any benefit under the Plan is erroneously paid or exceeds the amount appropriately payable under the Plan to a Covered Person, the Covered Person shall be responsible for refunding the overpayment to the Plan. In addition, if the Plan makes any payment that, according to the terms of the Plan, should not have been made, the Plan Administrator, the Company (or designee), or the applicable insurance company or HMO may recover that incorrect payment, whether or not it resulted from the insurance company's, HMO's, or Plan Administrator's (or its designee's) own error, from the person to whom it was made or from any other appropriate party. As may be permitted in the sole discretion of the Plan Administrator, the refund or repayment may be made in one or a combination of the following methods: (a) in the form of a single lump-sum payment, (b) as a reduction of the amount of future benefits otherwise payable under the Plan, (c) as automatic deductions from pay or (d) any other method as may be required or permitted in the sole discretion of the Plan Administrator or the applicable insurance company or HMO. The Plan may also seek recovery of the erroneous payment or benefit overpayment from any other appropriate party to the fullest extent permitted by applicable law.

With respect to component benefit programs provided through insurance or an HMO, the contract language may contain information regarding the Plan's right to subrogate or seek reimbursement of erroneously paid benefits (including payments in excess of the amount appropriately payable).

4.4 Covered Person's Responsibilities

Each Eligible Employee shall be responsible for providing the Plan Administrator and the Company and, if required by an insurance company or HMO with respect to a fully insured benefit, the insurance company or HMO with his or her current address and, if required, with the address of any individual covered through the Eligible Employee. Any notices required or permitted to be given to a Covered Person hereunder shall be deemed given if directed to the address most recently provided by the Eligible Employee and mailed by first-class United States mail. The insurance companies, the HMOs, the Plan Administrator, and the Company shall have no obligation or duty to locate a Covered Person.

4.5 Right to Information and Fraudulent Claims

Any person claiming benefits under the Plan shall furnish the Plan Administrator or, with respect to a fully insured benefit, the insurance company or HMO, with such information and documentation as may be necessary to verify eligibility for or entitlement to benefits under the Plan.

The Plan Administrator (and, with respect to a fully insured benefit, the insurance company or HMO) shall have the right and opportunity to have a Covered Person examined when benefits are claimed, and when and as often as it may be required during the pendency of any claim under the Plan. The Plan Administrator and, with respect to a fully insured benefit, the insurance company or HMO also shall have the right and opportunity to have an autopsy done in the case of death, where it is not forbidden by law.

If a person is found to have falsified any document in support of a claim for benefits or coverage under the Plan, or failed to have corrected information which such person knows or should have known to be incorrect, or failed to bring such misinformation to the attention of the Plan Administrator or the insurance company or HMO, the Plan Administrator may, without the consent of any person and to the fullest extent permitted by applicable law, terminate the person's Plan coverage, including retroactively. In addition, the insurance company or HMO may refuse to honor any claim for benefits under the Plan for the Covered Person related to the person submitting the falsified information. Such person shall be responsible to provide restitution, including monetary repayment to the Plan, with respect to any overpayment or ineligible payment of benefits.

4.6 Mental Health Parity

Solely to the extent required by the MHPA, the Plan shall provide mental health benefits to the same extent as other medical benefits. The Plan shall also comply with the MHPAEA. This Section shall be interpreted and applied to give a Covered Person only those rights as prescribed under the MHPA and the MHPAEA, and the rulings and regulations issued thereunder.

4.7 Women's Health and Cancer Rights Act

Solely to the extent required under WHCRA, certain component benefit programs of the Plan shall provide certain benefits related to benefits received in connection with a mastectomy.

- In the case of a Covered Person who is receiving benefits under the Plan in connection with a mastectomy and who elects breast reconstruction, the coverage shall be provided in a manner determined in consultation with the attending physician and the patient for reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

- Such reconstructive benefits are subject to annual plan deductibles and coinsurance provisions such as other medical and surgical benefits covered under the Plan.

This Section shall be interpreted and applied to give Covered Persons only those rights as prescribed under WHCRA, and the rulings and regulations issued thereunder.

4.8 Newborns' and Mothers' Health Protection Act

Solely to the extent required by the NMHPA, certain component benefit programs of the Plan shall provide that coverage for childbirth may not be limited to a hospital stay of less than 48 hours for normal delivery, or less than 96 hours for cesarean section, or require the provider to obtain approval for shorter hospital stays. The requirement shall not apply if the attending provider, in consultation with the mother, decides to discharge the mother or newborn earlier than the time prescribed by the NMHPA. This Section shall be interpreted and applied to give Covered Persons only those rights as prescribed under the NMHPA, and the rulings and regulations issued thereunder.

4.9 Genetic Information Nondiscrimination Act of 2008

Solely to the extent required, the Plan shall comply with GINA. This Section shall be interpreted and applied to give Covered Persons only those rights as prescribed under GINA, and the rulings and regulations issued thereunder.

4.10 Children's Health Insurance Program Reauthorization Act of 2009

The Plan shall also comply with CHIP. This Section shall be interpreted and applied to give Covered Persons only those rights as prescribed under CHIP, and the rulings and regulations issued thereunder.

ARTICLE 5

PLAN ADMINISTRATION

5.1 Plan Administration

The administration of the Plan is under the supervision of the Plan Administrator. The Plan will be administered in accordance with its terms.

The principal duty of the Plan Administrator is to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan. The Plan Administrator shall perform its duties as the Plan Administrator and in its sole discretion shall determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained. The administrative

duties of the Plan Administrator include, but are not limited to, interpreting the Plan, prescribing applicable procedures, determining eligibility for and the amount of benefits, authorizing benefit payments, and gathering information necessary for administering the Plan. The Plan Administrator may delegate any of these administrative duties among one or more persons or entities, provided that such delegation is in writing, expressly identifies the delegate(s), and expressly describes the nature and scope of the delegated responsibility.

The Company will bear its incidental costs of administering the Plan.

5.2 Discretionary Authority

The Plan Administrator, and any other fiduciary with respect to the Plan to the extent that such individual or entity is acting in its fiduciary capacity, shall have full and sole discretionary authority to interpret all plan documents and to make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of this Plan (including component benefit programs), and to determine all questions arising in connection with the administration, interpretation, and application of the Plan (including component benefit programs), including the eligibility and coverage of individuals and the authorization or denial of payment or reimbursement of benefits. Any construction of the terms of any plan document and any determination of fact adopted by the Plan Administrator shall be final and legally binding on all parties.

Any interpretation, determination, or other action of the Plan Administrator shall be subject to review only if it is arbitrary or capricious or otherwise an abuse of discretion. Any review of a final decision or action of the Plan Administrator shall be based only on such evidence presented to or considered by the Plan Administrator at the time it made the decision that is the subject of review. Accepting any benefits or making any claim for benefits under this Plan constitutes agreement with and consent to any decisions that the Plan Administrator makes, in its sole discretion and, further, constitutes agreement to the limited standard and scope of review described by this Section.

5.3 Role of Insurance Company or HMO

Certain benefits under the Plan are fully insured and provided by contract with insurance companies or HMOs as shown on Appendix B.

The insurance companies or HMOs are responsible for (a) determining eligibility for and the amount of any benefits payable under their respective component benefit programs; and (b) prescribing claims procedures to be followed and the claims forms to be used by Covered Persons pursuant to their respective component benefit plans.

The insurance companies or HMOs, not the Company, are responsible for paying claims with respect to these programs. The Company shares responsibility with the

insurance companies or HMOs for administering these program benefits.

Insurance premiums for Covered Persons may be paid in part by the Company out of its general assets and in part by Employees (generally through payroll deductions and, if applicable, pursuant to the terms of a cafeteria plan). A schedule of the applicable premiums may be provided during the initial and subsequent open enrollment periods and on request for each of the component benefit programs, as applicable.

5.4 Your Questions

If you have any general questions regarding the Plan (including, for example, whether you are eligible to participate in the Plan or a particular component benefit program offered through the Plan), please contact HR Now at (888) 99-HR-NOW (888.994.7669), or email benefits@avnet.com.

If you have any question regarding the amount of any benefit payable under the fully insured component benefit plans, please contact the appropriate insurance company or HMO.

ARTICLE 6

CIRCUMSTANCES THAT MAY AFFECT BENEFITS

6.1 Denial, Loss, and Recovery of Benefits

Various circumstances can result in the termination, reduction, recovery (through subrogation or reimbursement), or denial of benefits. The applicable insurance contracts (including the certificate of insurance or HMO booklets), plans, and other governing documents in the Attachments provide additional information about the termination, denial, or loss of benefits.

6.2 Plan Termination

Your benefits and the benefits of your eligible family members will cease when your participation in the Plan terminates, including upon termination of the Plan.

ARTICLE 7

AMENDMENT OR TERMINATION OF THE PLAN

7.1 Amendment or Termination

The Company, as Plan Sponsor, has the right to amend or terminate the Plan at any time. The Plan may be amended or terminated by a written instrument duly adopted by the Company or any of its delegates. For this purpose, amending the Plan includes making changes to a component benefit program. Terminating a component benefit program (including terminating an insurance or HMO contract through which such benefits are provided) is not a termination of the Plan. Rather, it is an amendment to the Plan.

The designated Company officer may sign insurance or HMO contracts for the Plan on behalf of the Company, including amendments to those contracts, and may adopt (by a written instrument) amendments to the Plan that he or she considers to be administrative in nature or advisable to comply with applicable law.

The Appendices to the Plan and the documents listed therein, may be amended at any time without the need for formal amendment of this Plan document.

ARTICLE 8

CLAIMS AND APPEALS PROCEDURES

8.1 Claims and Appeals for Fully Insured Benefits

For purposes of determining the amount of, and entitlement to, benefits of the component benefit programs provided under insurance or HMO contracts, the respective insurer or HMO is the named fiduciary under that component benefit of the Plan, with the full power to interpret and apply the terms of the Plan as they relate to the benefits provided under the applicable insurance or HMO contract.

To obtain benefits from the insurer or HMO of a component benefit program, the Covered Person must follow the claims procedures under the applicable insurance or HMO contract, which may require the Covered Person to complete, sign, and submit a written claim on the insurer's or HMO's form.

The insurance contract (including the certificate of insurance or HMO booklet) in the applicable Attachment provides information about how to file a claim and appeal a denied claim, and details regarding the insurance company's or HMO's claims procedures.

The insurance company or HMO will decide a Covered Person's claim and any appeals, in accordance with its reasonable claims procedures, as required by ERISA.

If the Covered Person does not appeal on time, then he or she may lose his or her right to file suit in a state or federal court, as he or she will not have exhausted his or her internal administrative appeal rights (which generally is a prerequisite to bringing a suit in state or federal court). Note that under certain component benefit programs, Covered Persons may also have the right to obtain external review by an independent review organization (that is reviewed by someone not affiliated with the insurance company or HMO).

8.2 Claims Deadline

Unless specifically provided otherwise in a component benefit program or pursuant to applicable law, a claim for benefits under this Plan (including the component benefit programs) must be made within one year after the date the expense was incurred that gives rise to the claim. It is the responsibility of the Covered Person or his or her designee to make sure this requirement is met.

8.3 Limitations Period for Filing Suit

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

ARTICLE 9

GENERAL INFORMATION ABOUT THE PLAN

9.1 Plan Name

The Avnet Insured Plan.

9.2 Plan Sponsor

Avnet, Inc.
2211 S. 47th Street
Phoenix, AZ 85034-6403
888-99-HR-NOW (994-7669)

Plan Sponsor's Employer Identification Number: 11-1890605

9.3 Plan Administrator and Named Fiduciary

Avnet, Inc.
2211 S. 47th Street
Phoenix, AZ 85034-6403
888-99-HR-NOW (994-7669)
Attention: Avnet Benefits Department

9.4 Type of Plan

The Plan is a welfare plan that provides medical, vision, and EAP benefits.

9.5 Plan Year

The Plan Year is January 1 to December 31.

9.6 Plan Number

The Plan number is 702.

9.7 Effective Date

The effective date of the Plan is January 1, 2019. The Plan was originally effective January 1, 1999.

9.8 Funding Medium and Type of Plan Administration

The Plan is fully insured. As discussed in Section 5.3, the Company and the insurance companies or HMOs share responsibility for administering the insured component benefit programs under the Plan. The insurance companies or HMOs, not the Company, are responsible for paying claims with respect to the insured component benefit programs.

Insurance premiums for Employees and their eligible Dependents are paid in part by the Company out of its general assets and in part by Employees through pre-tax payroll contributions. The Plan Administrator provides a schedule of the applicable premiums during the initial and subsequent open enrollment periods and upon request for each of the component benefit programs, as applicable. Neither the Plan nor any of the component benefit programs offered through it have a trust.

9.9 Insurance Companies and HMOs

Insured benefits are provided through insurance or HMO contracts with the insurance companies or HMOs listed in Appendix B of this Plan.

9.10 Named Fiduciary (for Benefit Claims)

For each of the insured component benefit programs, the applicable insurance company or HMO is a named fiduciary with respect to decisions regarding whether a claim for benefits will be paid under the insurance or HMO contract.

9.11 Agent for Service of Legal Process

Avnet, Inc.
2211 S. 47th Street
Phoenix, AZ 85034-6403
(480) 643-2000
Attention: General Counsel

In addition, service of legal process may be made upon the Plan Administrator.

ARTICLE 10

MISCELLANEOUS

10.1 Compliance With State and Federal Mandates

The Plan, including the component benefit plans, will comply, to the extent applicable, with the requirements of all applicable state and federal laws, including but not limited to, USERRA, COBRA, HIPAA, NMHPA, WHCRA, FMLA, MHPA, MHPAEA, HITECH, GINA, and PPACA.

See Appendix C for the Plan's HIPAA Privacy Plan Amendment.

10.2 Coordination with Insurance or HMO Contract or Governing Document

To the extent an insurance contract (including the certificate of insurance or HMO booklet), plan document, or other document governing a component benefit program

contains terms or conditions that conflict or are inconsistent with this document, the terms of the insurance contract (including the certificate of insurance or HMO booklet), plan document, or other governing document shall control, rather than this document, unless such terms are prohibited by or inconsistent with applicable law. For this purpose, silence in an insurance contract (including the certificate of insurance or HMO booklet), plan document, or other governing document is not necessarily a conflict or inconsistency.

10.3 Governing Law

The Plan shall be construed and enforced according to the laws of the State of Arizona except to the extent required by federal law.

ARTICLE 11

STATEMENT OF ERISA RIGHTS

11.1 Your Rights

As a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all plan participants shall be entitled to:

11.2 Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance or HMO contracts, and a copy of the latest annual report (Form 5500 Series), if any, 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 documents governing the operation of the Plan, including insurance or HMO contracts and copies of the latest annual report (Form 5500 Series). The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual Form 5500, if any is required by ERISA to be prepared, in which case the Plan Administrator, is required by law to furnish each participant with a copy of this summary annual report.

11.3 COBRA Rights

Under ERISA, you have the right to continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Plan document and any other documents governing the Plan on the rules governing your COBRA continuation coverage rights.

11.4 Prudent Actions by Plan Fiduciaries

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

11.5 Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps that you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report (Form 5500), if any, from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator, to provide the materials and pay you up to $110 per day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored in whole or in part, and if you have exhausted the claims procedures available to you under the Plan (discussed in Article 8), you may file suit in a state or federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are 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.

11.6 Assistance with Your Questions

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

Appendix A
Component Benefit Programs

Effective January 1, 2019

Component #1: Kaiser Permanente Medical Plan

- Kaiser Permanente Deductible HMO Plan Evidence of Coverage for Avnet, Inc. – Group ID 604904
- Kaiser Permanente Deductible HMO Plan Evidence of Coverage for Avnet, Inc. – Group ID 232743

Component #2: Vision Service Plan

- Group Vision Care Policy – Certificate of Coverage

Component #3: Employee Assistance Program

- Counseling Component of the Avnet, Inc. Employee Assistance and Work/Life Program

Appendix B
Insurance Contracts

Effective January 1, 2019

Type of Insurance Benefit	Insurer Name, Address, Telephone Number	Group ID Number(s)
HMO	Kaiser Foundation Health Plan, Inc. 1950 Franklin St. Oakland, CA 94612 1-(800) 464-4000	604904 232743
Vision	Vision Service Plan Insurance Company 3333 Quality Drive Rancho Cordova, CA 95670 1-(800) 877-7195	30009825
Employee Assistance Program	LifeMatters (Empathia, Inc.) N17 W24100 Riverwood Drive Waukesha, WI 53188 1-(800) 634-6433	

Appendix C
HIPAA Privacy Plan Amendment for the Avnet Insured Plan

Avnet, Inc. ("Avnet") has adopted this Plan Document Amendment to the Avnet Insured Plan, as required by the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), to comply with 45 C.F.R. Parts 160 and 164 (the "HIPAA Privacy Rule"), and specifically 45 C.F.R. sec. 164.504(f), with respect to the portions or components of the Avnet Insured Plan that provide or pay the cost of Medical Care.

1. Definitions

The following underscored terms, when appearing herein with an initial capital will have the meanings indicated for them in this Section 1.

"Covered Plan" or "Plan" means those portions or components of the Avnet Insured Plan, which provide or pay the cost of Medical Care, including the:

- Kaiser Permanente Medical Plan,
- Vision Service Plan, and
- Employee Assistance Program/Behavioral Health.

"Plan" shall not include any portion or component of a plan that solely provides or pays the cost of Excepted Benefits.

"Designated Employees" means the following employees, classes of employees, and other persons who are designed to receive, use and disclose PHI on behalf of the Plan Sponsor:

(a) The individual employees designated in Exhibit A to the Avnet, Inc. HIPAA Privacy Policies and Procedures, to the extent they are designated therein to perform Plan Administration Functions on behalf of the Plan[1];

(b) Anyone under the immediate supervision of the individuals above;

(c) Individual employees or job categories approved by the above individuals to perform specific tasks on behalf of a Plan.

"Disclosed PHI" means PHI maintained by the Plan Sponsor, to the extent that such PHI is or has been disclosed to the Plan Sponsor by the Plan (or by an Insurer, if the Plan provides for or permits such disclosure to the Plan Sponsor), except that it does not include PHI released to the Plan Sponsor pursuant to Section 2 below.

[1] If the individuals identified in Exhibit A leaves the identified position they shall cease to be a Designated Employee and their replacement shall become a Designated Employee upon assuming the identified position.

"Enrollment Information" means information on whether an individual is participating in the Plan, or is enrolled in or has disenrolled from a health insurance issuer offered by the Plan.

"Excepted Benefits" means any one or more of the following:

(a) Coverage for accident, disability income insurance, or any combination thereof.
(b) Coverage issued as a supplement to liability insurance.
(c) Liability insurance, including general liability insurance and automobile liability insurance.
(d) Worker's compensation or similar insurance.
(e) Automobile medical payment insurance.
(f) Credit-only insurance.
(g) Coverage for on-site medical clinics.
(h) Other similar insurance coverage under which benefits for medical care are secondary or incidental to other insurance benefits.
(i) Coverage for life insurance.
(j) Dependent care reimbursement account features of a Plan.

"Insurer" means either or both of:

(a) An insurance company, insurance service, or insurance organization that is licensed to engage in the business of insurance in a state, is subject to state laws that regulate insurance, and is providing coverage under the Plan.
(b) A federally-qualified health maintenance organization, an organization recognized as a health maintenance organization under applicable state law, or a similar organization regulated for solvency under applicable state law in the same manner and to the same extent as a health maintenance organization that is providing coverage under the Plan.

"Medical Care" means the diagnosis, cure, mitigation, treatment, or prevention of disease; services and supplies applied for the purpose of affecting any structure or function of the body; transportation primarily for and essential to obtaining any of the foregoing; and insurance covering any of the foregoing.

"Operations Functions" means any of the following activities when carried out with respect to the Payment Functions of the Plan:

(a) Quality assessment and improvement activities.
(b) Population-based activities relating to improving health or reducing health care costs, protocol development, case management, disease management, care coordination, and contacting health care providers and enrollees with information about treatment alternatives and related functions.
(c) Rating provider and plan performance, including accreditation, certification, licensing, or credentialing activities.
(d) Fraud and abuse detection, and compliance activities.

(e) Underwriting, premium rating, and other activities relating to the creation, renewal, or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance). Underwriting activities shall not include the use of PHI that is genetic information. For this purpose, "genetic information" includes information about an individual's genetic tests, the manifestation of disease or a disorder in their family members, and genetic counseling and genetic education they have received.

(f) Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs.

(g) Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, and development or improvement of payment methods or coverage policies.

(h) Business management and general administrative activities, including:

- Management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements.
- Customer service, including the preparation and provision of data analyses for use of the Plan Sponsor, policy holders, or other customers.

(i) Resolution of internal grievances.

(j) Due diligence in connection with the sale or transfer of assets to a potential successor in interest if the potential successor in interest either:

- Is a covered entity for purposes of HIPAA; or
- Will become a covered entity following completion of the sale or transfer.

(k) Subject to restrictions of the Privacy Rules, creating de-identified health information, summary health information, or limited data sets.

(l) Assisting other health plans, health care providers, and health care clearinghouses with their health care operations activities that are like those listed above in this definition, but only to the extent that both the Plan and the recipient of the disclosed information have a relationship with the individual whose PHI is involved and the PHI pertains to that relationship.

"Payment Functions" means activities undertaken to obtain premium payments or to determine or fulfill the Plan's responsibility for coverage of, and provision of health benefits with respect to, an individual to whom health care is provided. Payment functions include the following:

(a) Determining individuals' eligibility for coverage under the Plan, including determinations of rights pursuant to COBRA.

(b) Obtaining reimbursement for benefits paid during a period of ineligibility.

(c) Determining whether individuals have coverage in effect under the Plan, and in what capacity.

(d) Determining whether particular expenses are covered under the Plan with respect to individuals (including, without limitation, coordination of benefits

determinations, cost sharing determinations, subrogation determinations, medical necessity determinations, and all other determinations necessary or appropriate to determine whether Plan benefits are payable for particular health benefit claims) and making claims payments based on those determinations.

(e) Coordination of benefits, including, without limitation, collecting amounts from another plan covering an individual, and determining order of benefits payment and the extent to which benefits have been paid from another plan.

(f) Activities related to rights of reimbursement the Plan may have with respect to previously-paid benefits, and subrogation activities, including asserting liens against actual or potential recoveries, exercising rights of reimbursement with respect to third parties, and making demand for repayment of Plan benefits.

(g) Determining cost-sharing amounts applicable to particular claims under the terms of the Plan, including determining whether an individual has reached applicable plan limits, satisfied Deductibles or out-of-pocket limits, or is required to make a co-payment or satisfy Coinsurance with respect to a particular claim.

(h) Adjudicating benefit claims under the Plan (including appeals and other payment disputes).

(i) Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes, and responding to enrollees' inquiries about payments.

(j) Billing and collection activities, and related data processing.

(k) Obtaining payment under a contract for reinsurance (including stop-loss and excess loss insurance), including notification to carriers issuing such insurance of diagnoses or claims that trigger reporting requirements under such policies.

(l) Review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges.

(m) Determining required employee contributions under the Plan.

(n) Risk adjusting amounts due for coverage based on enrollees' health status, claims history, and demographic characteristics, to the extent permissible under applicable law.

(o) Utilization review activities, including pre-certification and preauthorization of services, and concurrent and retrospective review of services.

(p) Disclosure to consumer reporting agencies relating to collection of premiums or reimbursement, limited to any or all of the following:

- Name and address
- Date of birth
- Social security number
- Payment history
- Account number
- Name and address of the Plan

(q) Assisting other health plans (including other health plans sponsored by the Plan Sponsor), health care providers, and health care clearinghouses with their payment activities, which include activities similar to those listed above in this definition with respect to the Plan.

"PHI" means protected health information, as defined in §160.103 of the Privacy Rules.

"Plan Administration Functions" means Payment Functions and Operations Functions.

"Plan Sponsor" means Avnet, Inc. and its related companies that sponsor one or more of the plans identified the definition of "Covered Plan" above, except that with respect to any particular Plan, "Plan Sponsor" means only the entity that sponsors that particular Plan.

"Privacy Rules" means the Standards for Privacy of Individually Identifiable Health Information promulgated by the Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act of 1996, and found at 45 CFR part 160 and part 164, subparts A and E, as amended.

"Secretary" means the Secretary of the Department of Health and Human Services or his designee.

"Summary Health Information" means summary health information as defined in §164.504(a) of the Privacy Rules to the extent disclosed to the Plan Sponsor in accordance with §164.504(f)(1)(ii) of the Privacy Rules.

2. Use and Disclosure of Certain PHI by Plan Sponsor

Except as prohibited by § 164.502(a)(5)(i) of the Privacy Rules, a plan may disclose PHI to the Plan Sponsor: (i) if such information is Summary Health Information and is requested by the Plan Sponsor in order to obtain premium bids from health plans for providing health benefits under the Plan or to modify, amend, or terminate the plan; (ii) if such information is Enrollment Information; or (iii) if such information is disclosed pursuant to an authorization under 45 C.F.R. §164.508.

3. Use and Disclosure of PHI by Plan Sponsor with Limitations

With respect to any Disclosed PHI not described in Section 2 above, the Plan Sponsor may use and disclose such Disclosed PHI only as described in this Section 3.

(a) Plan Sponsor may use and disclose Disclosed PHI:
- For purposes of performing Plan Administration Functions on behalf of the Plan.
- As required by law, as that term is defined in §164.103 of the Privacy Rules.

(b) Plan Sponsor shall not use or disclose Disclosed PHI in a manner that the Plan would not be permitted to use and disclose the Disclosed PHI under the Privacy Rules.

(c) Plan Sponsor shall not use or further disclose the Disclosed PHI other than as permitted or required by the documents setting out the terms of the Plan or as required by law.

(d) Plan Sponsor shall require its agents, including subcontractors, to whom the Plan Sponsor provides Disclosed PHI, to agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such Disclosed PHI.
(e) Plan Sponsor shall not use or disclose the Disclosed PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.
(f) Plan Sponsor shall report to the Plan any Security Incident (as that term is defined in 45 C.F.R. §164.403) or any use or disclosure of the Disclosed PHI of which the Plan Sponsor becomes aware that is inconsistent with the uses or disclosures provided for in the documents setting out the terms of the Plan.
(g) Plan Sponsor will make the Disclosed PHI available to allow participants access to their PHI in accordance with §164.524 of the Privacy Rules.
(h) Plan Sponsor will make the Disclosed PHI available for amendment, and incorporate any amendments to such Disclosed PHI, in accordance with §164.526 of the Privacy Rules.
(i) Plan Sponsor will make available, in accordance with §164.528 of the Privacy Rules, the information required to provide an accounting of disclosures of the Disclosed PHI made by the Plan Sponsor, its agents or subcontractors.
(j) Plan Sponsor will make its internal practices, books, and records relating to the use and disclosure of the Disclosed PHI available to the Secretary for purposes of determining compliance by the Plan with the Privacy Rules.
(k) If feasible, the Plan Sponsor will return to the Plan, or destroy, all Disclosed PHI maintained by the Plan Sponsor in any form, and retain no copies, when such Disclosed PHI is no longer needed for the purpose for which disclosure of it was made to the Plan Sponsor, except that, if such return or destruction is not feasible, the Plan Sponsor shall instead limit further uses and disclosures of the information by the Plan Sponsor, its agents and subcontractors to uses and disclosures required by law and those made for the purposes that make return or destruction of the Disclosed PHI infeasible.

4. Disclosure of PHI to Plan Sponsor

The Plan shall disclose PHI to the Plan Sponsor solely through the Designated Employees, and only for the purposes specified in Section 3(a) hereof.

5. Adequate Separation

(a) No one who is an employee, or is otherwise under the control, of the Plan Sponsor, other than the Designated Employees, may have access to the Disclosed PHI.
(b) The Plan Sponsor shall implement appropriate administrative, physical and technical safeguards to prohibit its employees and other persons under its control, other than the Designated Employees, from accessing the Disclosed PHI.
(c) The Designated Employees may have access to and use the Disclosed PHI only for the purposes specified in Section 3(a) hereof.
(d) The Plan Sponsor shall implement appropriate administrative, physical, and technical safeguards to prohibit and/or prevent Designated Employees from

accessing the Disclosed PHI for purposes other than those specified in Section 3(a) hereof.

(e) Any employee who intentionally accesses, uses or discloses Disclosed PHI for any purpose not specified in Section 3(a) hereof, and any Designated Employee who acts with respect to the Disclosed PHI in a manner contrary to the provisions of this Section 5 will be subject to disciplinary action at the Plan Sponsor's discretion, which may include termination of employment.

The Plan Sponsor has adopted HIPAA Privacy Policies and Procedures to implement these provisions. This Addendum supersedes any inconsistent provisions in the documents governing the Plans and replaces any prior amendments or addenda dealing with the subject matter hereof.

Exhibit A

Avnet Insured Plan Components and Designated Avnet Employees

(Revised January 1, 2019)

The portions or components of the Plans that provide or pay the cost of medical care include:

- Kaiser Permanente Medical Plan,
- Vision Service Plan, and
- Employee Assistance Program/Behavioral Health.

The following employees, classes of employees, and other persons are hereby designated to perform Plan Administration Functions on behalf of the Avnet Insured Plan:

Designated Employees (Job Title)	**Current Incumbent***
Director, Global Benefits	Anna Conti
Senior Benefits Consultant	Andrea Sherry
Rewards Advisor	Karen Hamacher
Rewards Advisor	Beth Crothers
Rewards Advisor	Alisandra Deanda

***The current incumbent is listed as of the date this Exhibit was last revised. If the incumbent subsequently changes, the new employee in the designated position will be automatically designated hereunder.*