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

Effective January 1, 2016

LifeMatters®

Accelerating Your Success™

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Use of This Booklet

This booklet is both the plan document and summary plan description for the Counseling Component of the Avnet, Inc. Employee Assistance and Work/Life Program, which is a benefit under the Avnet Insured Medical and Dental Plan.

You will find terms starting with capital letters throughout this booklet. To help you understand your benefits, many of these terms are defined in the Glossary section of this booklet. However, other terms are defined in the section of this booklet where they are primarily used.

Plan Does Not Create a Contract of Employment

Nothing contained in this booklet shall be construed as a contract of employment between Avnet, Inc. ("Avnet") (or any of its subsidiaries) and any employee or other individual. Nothing contained in this booklet shall limit Avnet's right to discipline, discharge, or take action with respect to any employee or other service provider, with or without cause, at any time, or otherwise limit the employment-at-will relationship between Avnet and an employee or other service provider.

Patient Protection and Affordable Care Act

To the extent the Counseling Component is subject to the Patient Protection and Affordable Care Act (the "Affordable Care Act"), the Counseling Component is a "grandfathered health plan" under the Affordable Care Act. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Administrator at 480-643-2000. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Employee Assistance Program

800-634-6433

Website: mylifematters.com

Password: AVNET1

LifeMatters services • Free and confidential • Available to employees and eligible dependents • Available 24/7, including holidays and weekends	**Financial consultation** • Unlimited financial consultation with certified financial representatives • Debt management, credit report reviews, budgeting, and financial planning • Online educational materials and financial calculators	**Behavioral health assessment** • Depression • Drug abuse • Anxiety • Gambling
Unlimited 24/7 telephone assessment/counseling • Up to 3 face-to-face sessions, per issue, per year with a local provider in your area • Services provided directly by LifeMatters are free; if referred to outside resources, client will be responsible for any costs • Verified referrals to services covered by insurance • Referrals to community programs and resources	**Comprehensive adoption, child/elder care, and college resources and referrals** • Telephonic and online access to work/life specialists and dependent care consultants • A minimum of 3 confirmed referrals with vacancy checks • Educational materials—tip sheets, handbooks, etc.	**Learning modules** • Emotional well-being • Relationsihps • Financial • Health • Legal • Workplace
Legal consultation • Free 30-minute initial telephonic or in-person consultation with attorneys on personal legal concerns; discount of 25% on attorney's hourly rate if the client needs continued representation • Will kits; simple wills at no or low cost • Online legal templates and forms • Six-page document review • Phone call or letter prepared by attorney to resolve simple disputes	**Telephonic convenience resources and referrals** • Home repair • Travel planning • Wellness • Entertainment services • Pet sitting • Apartment locators • Volunteer services • And more...	**Interactive e-learning sessions** • Achieving personal goals • Business writing basics • Managing change • Managing stress • And more...
	Online searches • Child and elder care • Adoption agencies • Summer camps • Schools/universities • Pet care/adoption	**Online topical videos** • Job stress • Acne treatment • Diabetes • Drugs and alcohol • And more...
Identity theft program • Identity theft guidebook • Identity theft counseling with a consumer credit counselor • Articles and tip sheets	**Physical health assessments** • Health • Cardiac risk • General health risk • Fitness • Diabetes	**Monthly webinars** • Workplace issues • Life Issues
Tobacco cessation program • Six-session telephonic model • Breaking Free workbook • Access to a personal coach	**Online relocation center** Detailed information about any neighborhood, including home sales, demographics, and schools	**Online Spanish and French articles**

Information about the Counseling Component

This booklet describes the Counseling Component of the Avnet, Inc. Employee Assistance and Work/Life Program (the "Counseling Component"). The Counseling Component provides confidential referral and counseling services for issues ranging from normal life transitions to mental health and substance abuse problems.

The Counseling Component offers assistance by telephone 24 hours a day, seven days a week, and provides face-to-face sessions and referral counseling as outlined below. The benefits are provided through a contract with LifeMatters.

Eligibility and Coverage

Eligibility for Benefits, When Coverage Begins
In general, you are eligible to participate in the Counseling Component if you are a U.S.-based employee of Avnet. Your coverage begins automatically when you start working for Avnet. If you are covered by the Counseling Component, certain family and household members will also be eligible to participate. Temporary, contract and seasonal employees, independent contractors, and leased employees are not eligible to participate in the Counseling Component; nor are employees whose contract with Avnet specifies that they are not eligible to participate in the Counseling Component.

When Coverage Ends
Your coverage under the Counseling Component will end at the earliest of the following dates:

- The date your Active Service ends, except as described below (subject to your right to continued coverage under COBRA);
- The date the Counseling Component terminates; or
- The date you stop making any required contributions.

Coverage for family and household members ends when your coverage ends.

Leave of Absence or Disability
If your Active Service ends due to leave of absence or disability (such as injury or sickness), your coverage will be continued as follows:

- **Medical Leave** – Your coverage will be continued up to a maximum of one year while you remain totally and continuously disabled as a result of injury or sickness.
- **Family and Medical Leave Act** – To the extent required by the Family and Medical Leave Act of 1993, as amended ("FMLA"), your Counseling Component coverage will continue during any leave of absence that is covered by FMLA.
- **Military Leave** – To the extent required by the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended ("USERRA"), your Counseling Component coverage will continue during any qualified military leave of 30 days or less. For qualified military leaves of 31 days or longer, you may continue coverage until the earliest of the following:
  - the second anniversary of your last day of Active Service with Avnet;
  - the deadline for returning to work with Avnet after your qualified military service is considered over under USERRA;
  - the 30th day after any payment deadline, if you fail to make a required payment;
  - the date that your coverage would otherwise terminate under the Plan (such as for submitting a fraudulent claim); or

- the date Avnet terminates all its group medical plans.

You may be charged for the cost of continuing coverage during a leave of more than 30 days. The charge may be up to 102% of the total premium cost for your coverage.

For more information, please refer to the military leave policy posted on the human resources intranet.

- **Personal Leave** – Your Counseling Component coverage will continue during any approved personal leave for the period approved by your manager, up to a maximum of one year.

Types of Benefits
The Counseling Component is designed to provide psychological assessment, short term counseling, crisis intervention, and referrals to community resource centers and healthcare providers, when needed. Assistance is available for a range of issues, including the following:

- Mental, emotional, and psychological concerns
- Family, marital, and relationship problems
- Chemical dependencies and other compulsions
- Stress and job concerns
- Legal and financial issues

You may receive short-term counseling of up to three sessions per problem per year. In addition, you have access to telephone counseling and crisis intervention 24 hours per day, seven days per week. To use the Counseling Component, call 800-634-6433 or log on to mylifematters.com. The password is AVNET1.

When you contact LifeMatters, you will be assigned to an EAP professional who will review your situation and recommend next steps.

If the telephone service and short-term counseling are not sufficient to address your concern, your EAP professional will refer you to another provider.

Claims and Appeals

Claims Procedures
In general, you may receive benefits under the Counseling Component by contacting LifeMatters directly. You are not required to file a claim for benefits.

If you are unhappy with the service that you receive or you are unable to obtain service, you should contact LifeMatters. If you are not satisfied, you may file a claim under the Counseling Component's claims procedures. If you wish, you may engage a representative to act on your behalf in the claims and appeals process.

You may not file a lawsuit against the Plan, Avnet, LifeMatters, or any of their affiliates before you have exhausted the claims and appeals procedures.

Your claim should be filed with LifeMatters at the following address:

LifeMatters (Empathia, Inc.)
N17 W24100 Riverwood Drive
Waukesha, WI 53188

LifeMatters will generally decide your claim within 30 days after it is received. LifeMatters may extend the decision period for up to 15 additional days if it determines that matters beyond its control necessitate an extension. If this happens, you should be notified in writing before the end of the initial 30-day period. If LifeMatters cannot make a decision because it needs more information, you will receive a request for more information and you will have at least 45 days to provide the information. The period for deciding your claim will be put on hold until the earlier of (a) the date the information is received or (b) the deadline for providing the information. If you do not provide the information by the deadline, your claim will be decided without the additional information.

If your claim is denied in whole or in part, a notice of denial of your claim will include the following information:

- the reason or reasons for denial of the claim;
- reference to the Plan provision upon which the denial is based;
- a description of any additional material or information necessary to perfect the claim, along with an explanation of why the material or information is necessary;
- a description of the appeal procedures and applicable time limits;
- a statement of your right to bring a civil action under ERISA if the claim is denied upon final review; and
- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making an adverse determination, a statement that a copy of the rule, guideline, protocol, or other similar criterion will be provided to you free of charge, upon written request.

If you have questions regarding a claim, please contact LifeMatters at 800-634-6433. If your claim for benefits is denied in whole or in part, you can file an appeal with LifeMatters, at the address shown above. Your appeal must be filed within 180 days after you receive a written notice of denial of the claim. With your appeal, you should submit written comments, documents, records and other information supporting your claim. Upon request and free of charge, you have a right to receive reasonable access to, and copies of, all documents, records and other information relevant to your claim.

LifeMatters will review your appeal, taking into account all comments, documents, records and other information that you submitted. LifeMatters' review will not defer to the initial adverse benefit determination.

In general, LifeMatters will deliver a written decision to you within 60 days after it receives your appeal. If your appeal is denied in whole or in part, a notice of denial of your appeal will include the following information:

- the reason or reasons for denial of the appeal;
- references to the Plan provisions upon which the denial is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim;
- a statement of your right to bring a civil action under ERISA; and
- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making an adverse determination, a statement that a copy of the rule, guideline, protocol, or other similar criterion will be provided to you free of charge, upon written request.

Whether a document, record or other information is relevant for these purposes will be determined by LifeMatters in its sole discretion, in accordance with applicable regulations.

Arbitration
To the extent permitted by law, any controversy between you and the Plan, Avnet, LifeMatters, or any of their affiliates, arising out of or in connection with the Plan, including a claim under section 502(a) of ERISA, must be submitted to arbitration upon written notice by one party to another. Such arbitration shall be governed by the provisions of the Commercial Arbitration Rules of the American Arbitration Association, to the extent that such provisions are not inconsistent with the provisions of this section.
If the parties cannot agree upon a single arbitrator within 30 days of the effective date of written notice of arbitration, each party shall choose one arbitrator within 15 working days after the expiration of such 30-day period and the two arbitrators so chosen shall choose a third arbitrator, who shall be an attorney duly licensed to practice law in the applicable state. If either party refuses or otherwise fails to choose an arbitrator within the 15-working-day-period, the arbitrator chosen shall choose a third arbitrator in accordance with these requirements.

The arbitration hearing shall be held within 30 days following appointment of the third arbitrator, unless otherwise agreed to by the parties. If either party refuses to or otherwise fails to participate in such arbitration hearing, such hearing shall proceed and shall be fully effective in accordance with this section, notwithstanding the absence of such party.

The arbitrator(s) shall render his/her (their) decision within 30 days after the termination of the arbitration hearing. To the extent permitted by law, the decision of the arbitrator, or the decision of any two arbitrators if there are three arbitrators, shall be binding upon both parties conclusive of the controversy in question, and enforceable in any court of competent jurisdiction.

Period for Bringing a Legal Action/Governing Law
No legal action (including, but not limited to, filing a lawsuit or seeking arbitration) may be brought against the Avnet, the Plan, LifeMatters, or any of their affiliates, arising out of or in connection with the Counseling Component, after the earlier of: (A) 12 months after you have exhausted the claims and appeals process described above, or (B) 24 months after you were first notified in writing that the Counseling Component will not cover all or a portion of the claimed benefits that are the subject of your legal action. If the 24-month period would otherwise expire while you are still actively seeking resolution of your claim through the claims and appeals process, it will be extended for an additional 90 days until you have exhausted the claims and appeals procedures.

Choice of Law
The Counseling Component will be interpreted in accordance with the laws of the State of Arizona (excluding any choice of law rules that would otherwise point to the law of another jurisdiction), to the extent that those laws are not superseded by ERISA or any other federal law.

Payment of Benefits and Fees

Benefits
Benefits under the Counseling Component are provided by LifeMatters. LifeMatters retains the sole and exclusive obligation to provide benefits to you.

Premiums and Fees
Currently, Avnet pays the full cost for benefits under the Counseling Component. Avnet reserves the discretion to allocate all or part of the cost to you at any time.

Unfunded Plan
Avnet's obligations under the Counseling Component are not funded through contributions to a trust or otherwise. Nothing in this booklet gives you or your dependents any right, title, or interest in any property of Avnet.

COBRA Continuation Rights under Federal Law

This section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Counseling Component. This section generally explains COBRA continuation coverage, when it may be available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). COBRA continuation coverage can become available to you when you would otherwise lose your Counseling Component coverage. It can also become available to other members of your family who are covered under the Counseling Component when they would otherwise lose their Counseling Component coverage. For additional information about your rights and obligations under the Counseling Component and under federal law, you should review this booklet or contact the Administrator listed at the end of this section.

What is COBRA Continuation Coverage?
COBRA continuation coverage is a continuation of Counseling Component coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this section. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Counseling Component is lost because of the qualifying event. Under the Counseling Component, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. In general, you will be charged 102% of the total cost for COBRA continuation coverage. As of January 1, 2016, the cost for continuing coverage is $1.45 per month; you will receive updated cost information when you have a qualifying event.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Counseling Component because either one of the following qualifying events happens:
- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Counseling Component because any of the following qualifying events happens:
- Your spouse dies,
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Counseling Component because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

When is COBRA Continuation Available?

The Counseling Component will offer COBRA continuation coverage to qualified beneficiaries only after the Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Administrator within 60 days after the qualifying event occurs. You must provide this notice to the Administrator. You should use the address or phone number provided under "Plan Contact Information" at the end of this section.

How is COBRA Coverage Provided?

Once the Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension of 18-month Period of Continuation Coverage

If you or anyone in your family covered under the Counseling Component is determined by the Social Security Administration to be disabled and you notify the Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must notify the Administrator in writing of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. Failure to provide this notice within 60 days means that you may not be offered the COBRA disability extension.

Second Qualifying Event Extension of 18-month Period of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Counseling Component. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Counseling Component as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Counseling Component had the first qualifying event not occurred.

If You Have Questions

Questions concerning the Counseling Component or your COBRA continuation coverage rights should be addressed to the Administrator listed at the end of this section. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act ("HIPAA"), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA") in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of regional and district EBSA offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Administrator.

Plan Contact Information
Administrator
Avnet, Inc.
2211 South 47th Street
Phoenix, AZ 85034
(800) 882-8638, option 4

Privacy Rights under the Health Insurance Portability and Accountability Act ("HIPAA")

The Counseling Component is required to provide you with a notice that describes your rights and the Counseling Component's obligations regarding your "protected health information." Generally, "protected health information" is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, the Counseling Component, or your employer on behalf of the Counseling Component.

You were provided with a copy of the Avnet Insured Medical and Dental Plan's Notice of Privacy Policies when you first enrolled in the Counseling Component and you will be provided with a copy following any material revisions to the Avnet Insured Medical and Dental Plan's privacy policies. You can also request a copy of the Notice of Privacy Policies at any time by contacting the Administrator.

The Avnet Insured Medical and Dental Plan's HIPAA privacy provisions are set forth in Appendix A of this booklet.

Miscellaneous

Mistake and Indemnification of Avnet
In the event of a mistake as to your or your dependents' eligibility or participation, the Administrator will make such adjustments as it, in its sole discretion, deems appropriate to correct the mistake. If the Administrator determines that coverage was incorrectly provided as a result of fraud or a material misrepresentation, your coverage will be rescinded retroactively.

If you or your dependents receive benefits under the Counseling Component and the Administrator determines that you or your dependents were not eligible to receive the benefits, you must reimburse Avnet or LifeMatters (as determined by the Administrator) for the value of the benefits provided (to the extent that the benefits exceeded the benefits for which you or your dependents were eligible).

Qualified Medical Child Support Orders
To the extent required by law, the Plan will comply with any medical child support order that the Administrator determines is a Qualified Medical Child Support Order ("QMCSO"). To obtain a free copy of the procedures governing QMCSO determinations, please contact the Administrator at 2211 S. 47th Street, Phoenix, Arizona 85034 or (480) 643-2000.

ERISA Required Information

Name of Plan	The Counseling Component is a benefit under the Avnet Insured Medical and Dental Plan, which is the Plan referred to in this document.
Plan Number	702
Type of Plan	The Plan is an employee welfare benefit plan. The Counseling Component is an employee assistance plan.
Plan Cost	The cost of the Counseling Component is currently paid for by Avnet.
Plan Sponsor	Avnet, Inc. 2211 S. 47th Street Phoenix, Arizona 85034 (480) 643-2000
Employer Identification Number	11-1890605
Plan Year	January 1 through December 31
Administrator	Avnet, Inc. 2211 S. 47th Street Phoenix, Arizona 85034 (480) 643-2000
Agent for Service of Legal Process	The Plan Sponsor named above.
Office Designated to Consider the Appeal of Denied Claims	The LifeMatters Claim Office responsible for this Plan.

Eligibility Requirements The preceding pages set forth the eligibility requirements and benefits provided for you under this Plan.

Collective Bargaining Agreements

The Counseling Component is not currently maintained pursuant to a collective bargaining agreement. For more information, please contact the Administrator.

Discretionary Authority

As a contracted service provider, LifeMatters retains discretion to interpret and construe the provisions of the Counseling Component, including the exclusive power to remedy ambiguities, inconsistencies, or omissions, and to apply the terms of the Counseling Component and to make factual determinations in connection with its review of claims under the Counseling Component. To the extent permitted by law, any interpretation of the Counseling Component by LifeMatters that is made in good faith is binding on all persons.

The Administrator retains discretion to determine eligibility of individuals who wish to obtain coverage under the Counseling Component. To the extent permitted by law, any eligibility determination that is made by the Administrator in good faith is binding on all persons.

Modification, Amendment, and Termination of the Counseling Component

Avnet reserves the right, at any time and for any reason, to change or terminate benefits under the Counseling Component, to change or terminate the eligibility of classes of employees to be covered by the Counseling Component, to amend or eliminate any other Counseling Component term or condition, and to terminate the whole Counseling Component or any part of it. The procedure by which benefits may be changed or terminated, by which the eligibility of classes of employees may be changed or terminated, and by which part or all of the Counseling Component may be terminated, is through the unilateral action of the Avnet Executive Board (AEB) or the Board of Directors of Avnet. No consent of any employee is required to terminate, modify, amend, or change the Counseling Component.

Termination of the Counseling Component will have no adverse effect on any benefits to be paid under the Counseling Component for any expense incurred or approved prior to the date the Counseling Component terminates.

Statement of Rights

As a participant in the Counseling Component you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information about the Counseling Component – ERISA Rights

- Examine, without charge, at the Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Counseling Component, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) for the Avnet Insured Medical and Dental Plan filed 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 Administrator, copies of documents governing the operation of the Counseling Component, including any insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) for the Avnet Insured Medical and Dental Plan

and updated summary plan description. The Administrator may make a reasonable charge for the copies.

- Receive a summary of the annual financial report for the Avnet Insured Medical and Dental Plan. The Administrator is required by law to furnish each person under the Avnet Insured Medical and Dental Plan with a copy of this summary annual report.

Continue Group Health Plan Coverage

- Continue coverage under the Counseling Component for yourself, spouse, or dependents if there is a loss of coverage under the Counseling Component as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

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 you can take to enforce the above rights. For instance, if you request a copy of plan documents for the Counseling Component or the latest annual report for the Avnet Insured Medical and Dental 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 Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court.

In addition, if you disagree with the Administrator's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights under the Counseling Component, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court (subject to the rules under the heading entitled "Arbitration"). 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.

Assistance with Your Questions

If you have any questions about the Counseling Component, you should contact the 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 Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or 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.

Glossary

Active Service. You will be considered in Active Service:

- on any of your employer's scheduled work days if you are performing the regular duties of your work.
- on a day that is not one of your employer's scheduled work days (*e.g.*, a weekend or holiday) if you were in Active Service on your employer's last preceding scheduled work day.

Administrator. Avnet, Inc.

Counseling Component. The Counseling Component of the Avnet, Inc. Employee Assistance and Work/Life Program, as set forth in this document and amended from time to time.

ERISA. The Employee Retirement Income Security Act of 1974, as amended.

APPENDIX A

HIPAA PRIVACY PLAN AMENDMENT
FOR THE
AVNET INSURED MEDICAL AND DENTAL PLAN

Avnet, Inc. ("Avnet") has adopted this Plan Document Amendment to the Avnet Insured Medical and Dental 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, and specifically 45 C.F.R. sec. 164.504(f) (the "HIPAA Privacy Rule") with respect to the portions or components of the Avnet Insured Medical and Dental 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 Medical and Dental Plan, which provide or pay the cost of Medical Care, including the:

- Kaiser Permanente Medical Plan,
- Avnet, Inc. Vision Service Plan,
- the Avnet, Inc. Puerto Rico Medical and Dental Plan, and
- the Counseling Component of the Avnet, Inc. Employee Assistance and Work/Life Program.

"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 written authorization of the individual that is the subject of the PHI given in accordance with and meeting the requirements of §164.508 of the Privacy Rules.

"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.

[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.

(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, such as summary health information, and 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; provided, however, that neither Summary Health Information nor Enrollment Information shall constitute PHI.

"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

(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.
- As authorized by the individual that is the subject of the PHI in accordance with the requirements of §164.508 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 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 Medical and Dental Plan Components
and
Designated Avnet Employees

(Revised January 1, 2016)

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

- Kaiser Permanente Medical Plan,
- Avnet, Inc. Vision Service Plan,
- Avnet, Inc. Puerto Rico Medical and Dental Plan, and
- Counseling Component of the Avnet, Inc. Employee Assistance and Work/Life Program.

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

Designated Employees (Job Title)	Current Incumbent*
Vice President, Compensation and Benefits	Roberta Bixhorn
Vice President, Director of Benefits	Jane Smith
Benefits Consultant	Anna Conti
Benefits Consultant	Tammy Halter
Senior Benefits Specialist	Karen Hamacher
Benefits Coordinator	Beth Crothers

*****_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._

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