



SHORT-TERM DISABILITY PLAN

Summary Plan Description

January 2024

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IMPORTANT INFORMATION

This booklet serves as both the Plan document and summary plan description for the Avnet Short-Term Disability Plan (the "Plan"). This document does not replace or affect any requirement for coverage by Workers' Compensation insurance or any state government mandated temporary Disability income benefits law. To help you understand your benefits, most of the terms are defined in the Definitions section of this document. Other terms are defined in the section of this document where they are primarily used.

Claims under the Plan are administered on behalf of this Plan by Lincoln Financial as the Claim Administrator pursuant to the terms of an administrative services agreement. Lincoln National Life Insurance Co. ("Lincoln Financial") does not insure the benefits described in this booklet.

Nothing contained in this document shall be construed as a contract of employment between Avnet (the "Company") or any of its subsidiaries and any Employee or other individual, nor as any limitation of the right of the Company (and the right of any employing subsidiary or affiliate) 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 the Company (or employing subsidiary or other entity) and you.

If you have any questions concerning the Plan, please contact Lincoln Financial at 888-408-7300 or the HR Service Center at 888-99-HR-NOW (994-7669).

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Introduction

The Plan provides Participants financial assistance when they are unable to work for a limited period of time due to Illness or Injury. This is a Non-contributory Plan. Avnet self-insures the Plan benefits with no cost to Participants for coverage.

Eligibility

You will become eligible for the Plan on the first of the month after your date of hire if you are in a class of eligible Employees and normally work at least 20 hours per week.

After meeting your initial eligibility, you remain covered by the Plan during approved leaves of absence until the end of the Maximum Benefit Period shown on the Schedule of Benefits. In order to participate in the Plan, you must be employed by a participating business unit of the Employer. Most of the Employer's business units based in the United States participate in the Plan. However, certain business units do not. For more information, please contact the HR Service Center at 888-99-HRNOW (994-7669).

Waiting Period

You are eligible for coverage on the first of the month after your date of hire. The Waiting Period applies only for new hires and people who are rehired more than six months after they last worked for the Employer. You will not be required to satisfy the Waiting Period if (a) you have not terminated employment with the Employer (e.g., you lose coverage as a result of having your hours reduced to less than 20 hours per week and later return to an eligible position without having terminated employment); or (b) you are rehired as an eligible Employee within six months after terminating your employment.

Enrollment

No enrollment is required to be a Participant in the Plan. You will automatically become a Participant on the first of the month after your date of hire if you are in Active Service on that date. Otherwise, your enrollment will take effect on the day you resume Active Service.

Schedule of Benefits

This schedule shows the benefits that are available under the Plan. You will be covered only for the benefits for which you become and remain eligible.

Short-Term Disability Benefits	
Biweekly Benefit	100 percent of your hourly rate* or target pay**, reduced as described in the Income Which Will Reduce Your Disability Benefit section
Elimination Period	7 calendar days of Disability for Illness or Injury
Maximum Benefit	12 weeks

*Hourly rate includes incentive, shift, and other differential pay.

**Target pay includes base pay and projected incentive and commission payments (excluding equity awards), as determined by the Plan Administrator. During your Disability, any guaranteed incentive or commission payments will be calculated by the business group finance department and paid on the appropriate payroll cycle.

If you work in California, Colorado, Connecticut, Hawaii, Massachusetts, New Jersey, New York, Oregon, Rhode Island, Washington, or Washington D.C., you may be eligible for state disability benefits even if you aren't eligible for benefits under this plan. For Hawaii and New York, Lincoln Financial administers the state program. For the other states, you will need to apply directly to both the applicable state and with Lincoln Financial. The chart below shows the contact information for these state-mandated plans.

Contact Information for State-Mandated Plans	
State Mandated Short-Term Disability	Contact Information
California State Disability Insurance	Website: https://edd.ca.gov/Disability/Disability_Insurance.htm Phone: (800) 480-3287
Colorado Family and Medical Leave Insurance Program (FAMLI)	Website: https://famli.colorado.gov Phone: (866) 263-2654
Connecticut Paid Family and Medical Leave Act (PFMLA)	Website: https://ctpaidleave.org/ Phone: (877) 499-8606
District of Columbia Universal Paid Leave (UPL)	Website: https://dcpaidfamilyleave.dc.gov/ Phone: (202) 899-3700
Massachusetts	Website: www.mass.gov/DFML Phone: (617) 626-6565
New Jersey Temporary Disability Insurance	Website: https://myleavebenefits.nj.gov/ Phone: (609) 292-7060
Oregon Paid Leave Oregon	Website: https://paidleave.oregon.gov/ Phone: (833) 854-0166
Rhode Island State Temporary Disability Insurance	Website: http://www.dlt.ri.gov/dti/ Phone: (401) 462-8420
Washington Paid Medical Leave	Website: https://paidleave.wa.gov/ Phone: (833) 717-2273

Claim Process

Submitting a Claim

Contact Lincoln Financial (888-408-7300) if you will be absent for more than five (5) consecutive work days due to your own Illness or Injury (including Workers' Compensation). You can file your initial claim for short-term Disability benefits over the phone or online.

Lincoln Financial will request Proof of Disability in order to review your claim. They will ask you to notify your Physician that Lincoln Financial will be contacting his/her office with regards to your Disability and that you give your permission to release medical information to Lincoln Financial. Your Physician's office may require you to sign a release before they will provide medical information to Lincoln Financial.

When you file an initial claim for short-term Disability benefits, both the notice and the required Proof should be sent to Lincoln Financial within 90 days of the date of Disability.

Alternate Claim Process

Notice of claim and Proof may also be given to Lincoln Financial by following the steps set forth below.

You may give Lincoln Financial notice by calling the toll-free number listed above or online at mylincolnportal.com (company code: AVNETINC) within 20 days of your first absence due to Illness or Injury.

- Lincoln Financial will attempt to verify your claim by phone with your physician. If unable to verify your claim, Lincoln Financial will send you a claim form and explain how to complete it.
- When you receive the claim form, fill it out as instructed and return it with the required Proof described in the claim form. If you don't receive the claim form within 15 days after giving Lincoln Financial notice of claim, documentation may be sent using any form sufficient to provide them with the required Proof.
- You must give Lincoln Financial Proof not later than 90 days after your first absence due to Illness or Injury.

If notice of claim or Proof is not given within the time limits described in this section, you will not be eligible for benefits unless you can demonstrate that notice and Proof were given as soon as was reasonably possible.

Items to be Submitted

When submitting Proof on an initial or continuing claim for Disability benefits, the following items may be required.

Documentation which must include, but is not limited to, the following information:

- the date your Disability started;
- the cause of your Disability;
- the prognosis of your Disability;
- the continuity of your Disability; and

- your application for other income, Social Security Disability benefits, Workers' Compensation benefits or benefits under a similar law (such as state-specific Disability benefits).

Written authorization for Lincoln Financial to obtain and release medical, employment and financial information and any other items they may reasonably require to document your Disability or to determine your receipt of or eligibility for other income.

Any and all medical information, including but not limited to:

- x-ray films; and
- photocopies of medical records, including histories, treatment notes and physical, mental or diagnostic examinations.

The names and addresses of all:

- physicians and medical practitioners who have provided you with diagnosis, treatment or consultation;
- hospitals and other medical facilities which have provided you with diagnosis, treatment or consultation; and
- pharmacies which have filled your prescriptions within the past three (3) years.

Initial Determination

After you submit a claim for Disability benefits to Lincoln Financial, your claim will be reviewed and Lincoln Financial will notify you of its decision to approve or deny your claim.

Such notification will be provided to you within a reasonable period, generally not to exceed 45 days after Lincoln Financial receives your claim. If Lincoln Financial needs an extension of time because of matters beyond its control, Lincoln Financial may have up to two (2) additional extensions of 30 days each to notify you of its decision. If Lincoln Financial needs an extension, it will notify you before the end of the initial 45-day period (or, in the case of a second extension, before the end of the first extension period), state the reason why the extension is needed, and state when it will make its determination.

If an extension is needed because you did not provide sufficient information or filed an incomplete claim, the time from the date of Lincoln Financial's notice requesting further information and an extension until Lincoln Financial receives the requested information (or, if earlier, the deadline for providing the information) does not count toward the time period Lincoln Financial is allowed to notify you as to its claim decision. You will have 45 days to provide the requested information from the date you receive the notice requesting further information from Lincoln Financial.

If your claim is approved, Lincoln Financial will calculate your Disability benefits and advise the Company of benefits due to you. After their initial approval, Lincoln Financial will verify that you continue to be Disabled without interruption. Lincoln Financial may periodically request that you send Proof that you continue to be Disabled. Such Proof may include physical exams, exams by independent medical examiners, in-home interviews or functional capacity exams, as needed.

If Lincoln Financial denies your claim in whole or in part, the notification of the claims decision will state the reason why your claim was denied and reference the Plan provision(s) on which the denial is based. The notification will also describe any additional material or information that is necessary to perfect the

claim, including why the additional material is necessary. In addition, if an internal rule or other criterion was relied upon in making the denial, the claims decision will indicate that such a rule or other criterion was relied upon and that you may request a copy free of charge. The notification will also include a description of the Plan's review procedures and the applicable time limits.

Appealing the Initial Determination

If Lincoln Financial denies your claim, you may appeal the decision. Upon your Written request, Lincoln Financial will provide you free of charge with copies of documents, records and other information relevant to your claim. You must submit your appeal to Lincoln Financial at the address indicated on the claim form within 180 days of receiving Lincoln Financial's decision. Appeals must be in Writing and must include at least the following information:

- name of Employee
- name of the Plan
- reference to the initial decision; and
- an explanation why you are appealing the initial decision.

As part of your appeal, you may submit any Written comments, documents, records or other information relating to your claim.

After Lincoln Financial receives your Written request appealing the initial determination, Lincoln Financial will conduct a full and fair review of your claim. Lincoln Financial will identify any medical or vocational experts whose advice was obtained in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination. Deference will not be given to the initial denial, and Lincoln Financial's review will look at the claim anew. The review on appeal will take into account all comments, documents, records and other information that you submit relating to your claim without regard to whether such information was submitted or considered in the initial determination. The person who will review your appeal will not be the same person as the person who made the initial decision to deny your claim. In addition, the person who is reviewing the appeal will not be a subordinate of the person who made the initial decision to deny your claim. If the initial denial is based in whole or in part on a medical judgment, Lincoln Financial will consult with a healthcare professional with appropriate training and experience in the field of medicine involved in the medical judgment. This healthcare professional will not have consulted on the initial determination, and will not be a subordinate of any person who was consulted on the initial determination.

Lincoln Financial will notify you in Writing of its final decision within a reasonable period of time, but no later than 45 days after Lincoln Financial's receipt of your Written request for review; under special circumstances, Lincoln Financial may have up to an additional 45 days to provide Written notification of the final decision. If such an extension is required, Lincoln Financial will notify you prior to the expiration of the initial 45-day period, and the notice will state the reason(s) why such an extension is needed and state when it will make its determination.

If an extension is needed because you did not provide sufficient information, the time period from Lincoln Financial's notice to you of the need for an extension to when Lincoln Financial receives the requested information (or, if earlier, the deadline for providing the information) does not count toward the time Lincoln Financial is allowed to notify you of its final decision. You will have 45 days to provide the requested information from the date you receive the notice from Lincoln Financial.

If Lincoln Financial denies your claim on appeal, Lincoln Financial will send you a final Written decision that states the reason(s) why the claim you appealed is being denied and references any Plan provision(s) on which the denial is based. If an internal rule or other criterion was relied upon in denying the claim on appeal, the final Written decision will indicate that such a rule or other criterion was relied upon and that you may request a copy. Upon Written request, Lincoln Financial will provide you free of charge with copies of documents, records and other information relevant to your claim.

A decision by Lincoln Financial on appeal is final and binding.

Discretionary Authority

The Plan Administrator has discretionary authority to interpret the terms of the Plan, including to resolve ambiguities and inconsistencies. The Plan Administrator has delegated to Lincoln Financial the discretionary authority to interpret and apply Plan terms and to make factual determinations in connection with its review of claims under the Plan. Such discretionary authority is intended to include the determination of whether a person is entitled to benefits under the Plan and the computation of any and all benefit payments. The Plan Administrator has delegated to Lincoln Financial the discretionary authority to perform a full and fair review of each claim denial which has been appealed by the claimant or his duly authorized representative.

Arbitration

To the extent permitted by law, any controversy between Lincoln Financial, the Employer, or the Plan, and any Participant (or any legal representative acting on behalf of a Participant under the Plan), arising out of or in connection with the Plan 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.

Exhaustion and Time Limit on Legal Action

No legal action (whether in court, arbitration, or otherwise) may be brought against the Plan, any Employer, Lincoln Financial, or any of their affiliates in connection with the Plan after the earlier of (a) 120

days after the appeal process ends or (b) the second anniversary of the first date when the Participant knew (or should have known) of the Illness or Injury that is the basis of his or her claim or assertion for Disability benefits. If a formal claim or appeal process is pending at the end of the two year period, the deadline will be extended until 90 days after the appeal process is completed.

Governing Law

This Plan shall be interpreted in accordance with the laws of the State of Arizona (disregarding any conflicting rules that might point to the laws of another jurisdiction) to the extent that those laws are not superseded by federal law.

Family and Medical Leave

The Family and Medical Leave Act (FMLA) gives employees a right to up to 12 weeks of unpaid leave during any rolling 12-month period for certain medical and family events. To be eligible for leave under the FMLA, you have to be employed by an Employer for one (1) year during which you worked 1,250 hours. Leave under the FMLA runs concurrently with Disability leave. You can apply for protection under the FMLA at the same time you apply for Disability benefits. For the complete FMLA policy, please visit [HR Now](#) on Avnet's Compass intranet.

BENEFIT PAYMENTS

Non-Exempt (Hourly) Employees

For the first week of your approved medical leave, you will not receive any benefits under the Plan. This period is known as the Elimination Period. During the Elimination Period, you will be paid from your accrued Paid Time Off (PTO) balance, to the extent available.

If Lincoln Financial approves your claim, short-term benefits will begin the day after you complete your Elimination Period. Biweekly payments will be made each regular payroll date while you remain Disabled up to a maximum of 12 weeks. For any partial week of Disability, payment will be based on the number of hours you are Disabled multiplied by your total hourly rate.

During your Disability, guaranteed incentive and commission payments, if any, will be calculated by the business group finance department and paid on the appropriate payroll cycle.

Exempt (Salaried) Employees

For the first week of your approved medical leave, you will not receive any benefits under the Plan. This period is known as the Elimination Period. During the Elimination Period, you will be paid your Flexible Time Away benefits.

If Lincoln Financial approves your claim, short-term benefits will begin as of the day after you complete your Elimination Period. Biweekly payments will be made each regular payroll date while you remain Disabled, up to a maximum of 12 weeks. Payment will be based on the number of days you are Disabled during each week. For any partial week of Disability, payment will be made at the daily rate of 1/5 of the weekly Benefit payable.

During your Disability, guaranteed incentive and commission payments, if any, will be calculated by the business group finance department and paid on the appropriate payroll cycle.

Reduction for Other Benefits

Your benefits under the Plan will be reduced by the amount of certain other benefits that you are eligible to receive, such as Workers' Compensation, state disability benefits, and other insurance. For more information, see "Income Which Will Reduce Your Disability Benefit," below.

If there is any question about a claim payment, you may request an explanation from the Plan Administrator.

Benefit Extension

If your original approved period of absence comes to an end and you are still unable to return to work, it is your responsibility to work with Lincoln Financial and your medical provider to get an extension. An approved extension is needed in order to continue Disability payments. A timely report of your continuing medical need will ensure there is no delay in receiving the Disability benefits due you. For example, let's assume your Physician provided documentation to Lincoln Financial that you would need six (6) weeks recovery time after surgery in order to return to work. However, after five (5) weeks, your recovery is slower than expected and your doctor tells you that an additional two weeks will be needed before he/she will release you to work. This information as well as medical documentation needs to be provided to Lincoln Financial for review and approval. After review, a determination will be made. If approved, Lincoln Financial will notify Avnet to continue Disability benefits for two more weeks. Your Disability benefit may not be extended beyond the Maximum Benefit Period shown on the Schedule of Benefits.

The Employer will make any Benefit payment during your lifetime to you or your legal representative. If you die before payments are completed, any unpaid amounts that were due before your death will be paid to your estate in a single sum. Any payment made in good faith will discharge the Employer from liability to the extent of such payment.

Date Benefit Payments End

Your Disability benefits will end on the earliest of:

- the end of the Maximum Benefit Period (12 weeks for non-exempt employees and 12 weeks for exempt employees);
- the date you are no longer Disabled;
- the date of your death;
- if you fail to have a medical exam when requested by the Claims Administrator, the deadline for having that exam;
- if you fail to follow Appropriate Care and Treatment; or
- if you fail to provide Proof of continuing Disability when requested by the Claims Administrator, the deadline for providing the required Proof.

While you are Disabled, the biweekly short-term Disability benefits described in this booklet will not be affected if your employment terminates.

Exclusions

The Plan will not pay benefits for any Disability caused or contributed to by elective treatment or procedures, such as:

- cosmetic surgery or treatment primarily to change appearance (unless reconstructive in nature);
- reversal of sterilization;
- liposuction;
- visual correction surgery; or
- in vitro fertilization, embryo transfer procedure, or artificial insemination. However, pregnancies and complications from any of these procedures will be treated as an Illness.

The Plan will not pay benefits for any Disability caused or contributed by:

- war, whether declared or undeclared;
- your active participation in a riot;
- intentionally self-inflicted injury;
- attempted suicide; or
- commission of or attempt to commit a felony.

Income Which Will Reduce Your Disability Benefit

Your Disability benefit will be reduced by the amount of all other income. Other income includes the following types of income:

- disability or retirement benefits under any state or public employee retirement or disability plan, or any pension or disability plan from another country;
- income for Workers' Compensation or Disability under a group insurance policy to which an Employer has made a contribution, such as benefits for loss of time from work due to Disability and installment payments for permanent total Disability;
- income for disability under a no-fault auto law for loss of income, excluding supplemental disability benefits;
- income for Workers' Compensation or disability under a government compulsory benefit plan or program which provides payment for loss of time from your job due to your Disability, whether such payment is made directly by the plan or program, or through a third party;
- income for Disability under any sick pay, vacation pay, paid time off, or other salary continuation that an Employer pays to you;
- income for disability provided under any government law or unemployment insurance program;
- income for working while Disabled including, but not limited to, salary, commissions, overtime pay, bonus pay or other extra pay arrangements from any source; and/or
- any amounts for loss of income or pain and suffering as a result of claims against a third party by judgment, settlement or otherwise, including future earnings.

If, at the time of the Disability benefit calculation, you are entitled to other income but are not receiving that other income (for example, because you have not applied to receive the other income), Lincoln Financial will estimate the amount of the other income and reduce your Disability benefit accordingly. If you later receive the other income and the amount that you receive is not the same as the estimated amount, Lincoln Financial will revise your benefit accordingly.

Single Sum Payment

If you receive other income relating to your Disability in the form of a single sum payment, you must, within 10 days after receipt of such payment, give both Lincoln Financial and the Company Written Proof satisfactory of:

- the amount of the single sum payment;
- the amount to be attributed to income replacement; and
- the time period for which the payment applies.

When Lincoln Financial receives such Proof, it will adjust the amount of your Disability benefit. Any estimated deductions already taken for other income will be credited to you.

If your Disability benefit is adjusted due to a single sum payment, the amount of the adjustment will not result in a benefit amount less than the minimum amount, except in the case of an Overpayment.

If Lincoln Financial does not receive the Written Proof described above, and it knows the amount of the single sum payment, it may reduce your Disability benefit by an amount equal to that benefit until the single sum has been exhausted.

If excess benefits were paid to you in connection with the Plan, then the Plan shall have a lien against other payments made to you in connection with your Disability and have a right to recover such payments and interest either directly from you or from a third party.

Income Which Will Not Reduce Your Disability Benefit

Your Disability benefit will not be reduced by any of the following amounts:

- cost of living adjustments that are paid under any of the above sources of other income;
- reasonable attorney fees included in any award or settlement;
- group credit insurance;
- mortgage disability insurance benefits;
- early retirement benefits that have not been voluntarily taken by you;
- any Avnet 401(k) Plan or Avnet Pension Plan benefits;
- veteran's benefits;
- individual disability income insurance policies;
- severance benefits;
- benefits received from an accelerated death benefit payment; or

- any supplemental retirement and Disability benefits paid under an Employer's supplemental life insurance plan and nonqualified retirement plans for executives.

Subrogation/Right of Reimbursement

If a Participant receives a Disability benefit for which, in the opinion of the Plan or its administrator, another party may be responsible or for which the Participant may receive payment as described above, the Plan will have subrogation and reimbursement rights as follows:

- **Subrogation:** To the extent permitted by law, the Plan will be subrogated to all rights, claims and interests that a Participant may have against the other party and will automatically have a lien upon the proceeds of any recovery that the Participant receives from the other party, up to the amount of benefits paid under the Plan. This means that the Plan will have the same rights as if it had stepped into the Participant's shoes (for example, the Plan would have the right to sue the other party to recover the amount paid by the Plan). The Participant or his/her representative must execute all documents as may be required to secure the Plan's subrogation rights.
- **Right of Reimbursement:** The Plan is also granted a right of reimbursement from the proceeds of any recovery whether by settlement, judgment, or otherwise. In other words, if a Participant recovers damages from another party, he or she must use the amount recovered to reimburse the Plan for benefits paid. This right of reimbursement is cumulative with and not exclusive of the subrogation right granted in the preceding paragraph, but only to the extent of the benefits provided by the Plan.

More information about the Plan's rights and your obligations, including the Plan's lien on any benefits you receive and your assignment to the Plan of any recovery you receive, is set forth in Appendix A of this booklet.

Alienation and Assignment of Benefits

None of your benefits under the Plan may at any time be alienated, sold, transferred, assigned, pledged, attached or encumbered in any way.

Recovery from a Disability

For purposes of this section, the term Active Work includes only those days on which you actually work.

Return to Work

In order to return to Active Work, you must provide your manager with a note from your Physician stating you are able to return to work and listing any work restrictions, limitations or accommodations required as a result of your Disability absence. Your manager will then forward this note to the [HR Service Center](#).

Elimination Period After a Return to Work

If you return to Active Work before completing your Elimination Period and then become Disabled again, you will have to complete a new Elimination Period, which could result in time off without pay for non-exempt employees if no accrued Paid Time Off is available to pay you for the absence.

If you return to Active Work after you begin receiving Disability benefits, you will be considered to have recovered from your Disability. If you become Disabled again within 30 days or less, and the Disability is due to the same or a related Illness or Injury, you will not have to complete a new Elimination Period. In this case, your Disability benefit will be based on the same pay level and the same terms, provisions and conditions that were used for the original Disability; prior Disability payments will count toward your maximum benefit period.

Transition to Long-Term Disability (LTD)

If you are unable to return to work after 13 weeks of Disability, your claim will transition into LTD. Lincoln Financial will contact you during your 9th week of absence to begin the transition process. You will be asked for details about your medical condition and contact information for your attending Physician. For information about the amount of your LTD benefit, refer to the summary plan description for the Long-Term Disability plan posted on avnet.me/spds.

Recovery of Overpayments

If for some reason (including, but not limited to, fraud) you receive a benefit under the Plan that is larger than the amount that should have been paid, the Plan Administrator has the right to recover the excess amount plus interest from the person or agency who received it. You must complete any papers that the Claims Administrator or Plan Administrator requests for the purpose of ensuring this right of recovery.

If an overpayment occurs, you must reimburse Avnet. Avnet may recover the overpayment and interest from you by:

- stopping or reducing any future benefit payments from the Plan until the overpayment has been collected;
- requiring you to reimburse the Plan in full for the overpayment (either from future Avnet wages when you return to work or in a lump sum); or
- taking legal action.

Fraudulent Claims

If you falsify any document in support of a claim for benefits or coverage under the Plan, or fail to correct information which you know or should have known to be incorrect, or fail to bring such misinformation to the attention of the Plan Administrator and/or Lincoln Financial as applicable, the Plan Administrator may, without your consent and to the fullest extent permitted by applicable law, terminate your Plan coverage, including retroactively. In addition, the Claim Administrator may refuse to honor any claim for benefits under the Plan for you related to the falsified information. You shall be responsible to provide restitution, including monetary repayment plus interest to the Plan, with respect to any overpayment or ineligible payment of benefits.

Termination of Participation

Your eligibility for benefits under the Plan will cease on the earliest date below:

- the date you cease to be in a class of eligible Employees, if you are not Disabled on that date;
- the date you cease to qualify for Plan coverage;

- the date the Plan is terminated;
- the date of your death; or
- the day your Active Service ends (such as termination of employment or retirement), except to the extent that you are already in pay status and continue to be Disabled, in which case you will receive the remainder of your Plan benefits.

It is your responsibility to provide accurate information, make accurate and truthful statements 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.

General Plan Information

The name of the Plan referred to in this booklet is:

The Avnet Short-Term Disability Plan

The name, address, ZIP code and business telephone number of the sponsor of the Plan (the Employer) is:

Avnet, Inc.
2211 South 47th St.
Phoenix, AZ, 85034
480-643-2000

Employer Identification Number (EIN):

11-1890605

Plan Number:

701

The name, address, ZIP code and business telephone number of the Plan Administrator are the same as for the Employer named above.

The name, address and ZIP code of the person designated as agent for the service of legal process are the same as for the Employer named above, attention General Counsel.

The Plan is self-insured and is funded through the Employer's general assets.

The Plan's fiscal year (also called a plan year) ends on December 31.

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

Plan Type

A self-insured group disability plan, which is exempt from Employee Retirement Income Security Act of 1974 as an unfunded, income-replacement arrangement.

Plan Modification, Amendment and Termination

The Company reserves the right, at any time, to change or terminate benefits under the Plan, to change or terminate the eligibility of classes of Employees to be covered by the Plan, to amend or eliminate any other Plan term or condition, and to terminate the whole Plan or any part of it. Any change or termination of the Plan may apply retroactively or prospectively, without regard to whether you are in pay status. 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 Plan may be terminated, is through the unilateral action of the Avnet Leadership Team (ALT) or the Board of Directors of the Company. No consent of any Participant is required to terminate, modify, amend or change the Plan.

Definitions

As used in this document, the terms listed below will have the meanings set forth below. When defined terms are used in this document, they will appear with initial capitalization. The plural use of a term defined in the singular will share the same meaning.

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 that day.
- 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.

Appropriate Care and Treatment

Care and treatment that is:

- given by a Physician whose medical training and clinical specialty are appropriate for treating Your Disability;
- consistent in type, frequency and duration of treatment with relevant guidelines of national medical research, healthcare coverage organizations and governmental agencies;
- consistent with a Physician's diagnosis of your Disability; and
- intended to maximize your medical and functional improvement.

Claim Administrator

Lincoln National Life Insurance Co. ("Lincoln Financial"), Fort Wayne, Indiana.

Company

Avnet, Inc.

Disabled or Disability

Due to an Illness or as a direct result of an Injury:

- you are receiving Appropriate Care and Treatment and complying with the requirements of such treatment; and
- you are unable to earn more than 80 percent of your Pre-disability Earnings at your Own Occupation.

For purposes of determining whether a Disability is the direct result of an Injury, the Disability must have occurred within 90 days of the Injury and resulted from such Injury independent of other causes.

If your occupation requires a license, losing your license for any reason will not, by itself, constitute Disability.

Elimination Period

The period of your Disability during which the Plan does not pay short-term Disability benefits. The Elimination Period is seven (7) consecutive calendar days. During the Elimination Period, you will be paid from your accrued Paid Time Off benefits (non-exempt employees) to the extent available or Flexible Time Away benefits (exempt employees).

Employee

A regular employee scheduled to work 20 or more hours a week for the Employer and who is currently in Active Service, except that an eligible Employee does not include any employee who:

- is temporary or classified by the Employer as a leased employee or independent contractor;
- is part-time and scheduled to work less than 20 hours a 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 Avnet, a court, or otherwise, shall not result in retroactive coverage for any individual.

Employer

Avnet, Inc. or an Avnet company that has been designated as a participating employer.

Family and Medical Leave Act

The Family and Medical Leave Act (FMLA) was passed in 1993 and has since been amended. It allows eligible Employees to take up to 12 weeks of unpaid leave a year (rolling 12-month period) to take care of a serious personal illness, care for a newborn or newly-adopted baby or new foster child or to care for a seriously ill parent, child or spouse. Eligible Employees can take up to 12 weeks to address the needs arising from a family member's call to active military duty or to care (up to 26 weeks) for a family member injured in military service. Family leave allows Employees to take time off from work to care for their families, deal with an emergency or recuperate from a serious illness with a guaranteed job when they

return. Leave under the Family and Medical Leave Act runs concurrently with Disability leave.

Flexible Time Away

If you are an exempt Employee, you have Flexible Time Away benefits available on your date of hire (time off for non-disability absences should be limited during the first 90 days of employment). You must use Flexible Time Away during your elimination period before short-term Disability benefits may be approved.

Hospital

A facility which is licensed as such in the jurisdiction in which it is located and:

- provides a broad range of medical and surgical services on a 24-hour a day basis for injured and ill persons by or under the supervision of a staff of Physicians; and
- provides a broad range of nursing care on a 24-hour a day basis by or under the direction of a registered professional nurse.

Hospitalized

Admitted for inpatient care in a Hospital or receive care at a hospice, intermediate care, or long-term care facility, or if you receive chemotherapy, radiation therapy or dialysis, regardless of where the service is performed.

Illness

A disease, sickness or pregnancy, including complications of pregnancy.

Injury

A bodily injury that is the direct result of an accident and not related to any other cause.

Non-contributory Plan

Coverage for which you are not required to pay any part of the cost of coverage.

Own Occupation

The essential functions you regularly perform that provide your primary source of earned income.

Paid Time Off

If you are a non-exempt Employee, you accrue Paid Time Off (PTO) benefits based on your years of service. PTO is available for use after 90 days of employment.

PTO can be used to cover vacation, personal illness, appointments, emergencies, or other situations that require time off from work. You may use your accrued PTO during your Elimination Period (you are required to use available PTO before going unpaid).

Participant

After you meet all points of eligibility, you are a Participant in the Plan.

Physician

A person licensed to practice medicine in the jurisdiction where such services are performed. A Physician can also be any person whose services, according to applicable law, must be treated as Physician's services for purpose of this Plan. Each such person must be licensed in the jurisdiction where he/she performs the service and must act within the scope of that license. He/she must also be certified and/or registered if required by such jurisdiction. This term does not include you, your Spouse or any member of your immediate family, including you and/or your Spouse's parents, children (natural, step or adopted), siblings, grandparents or grandchildren.

Plan

The Avnet Short-Term Disability Plan.

Plan Administrator

Avnet, Inc.

Proof

Written evidence satisfactory to Lincoln Financial and the Company that a person has satisfied the conditions and requirements for any benefit described in this document. When a claim is made for any benefit described herein, Proof must establish:

- the nature and extent of the loss or condition;
- the Plan's obligation to pay the claim; and
- the claimant's right to receive payment.

Proof must be provided at the Employee's expense, unless specifically agreed to by Lincoln Financial.

Spouse

For purposes of the Plan, a Spouse is 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.

Waiting Period

The period of employment before you are eligible to be covered under this Plan. Short-term Disability coverage will begin the first day of the month after your date of hire.

Workers' Compensation

Payments required by law to be made to an Employee who is injured or disabled in connection with work.

Written or Writing

A record which is on or transmitted by paper or electronic media which is acceptable to Lincoln Financial and the Company and consistent with applicable law.

APPENDIX A

Expenses for Which a Third Party May Be Responsible

As described in the summary plan description, the Plan has rights of subrogation and reimbursement if, in the opinion of the Plan or its administrator, another party may be responsible for Disability benefits or for which the Participant may receive payment of Disability benefits from a third party. In some cases, the Plan may advance on the Participant's behalf benefits that would have been payable by the Plan if not for payment owed by a third party. Any such advance is conditioned on the Plan's rights of subrogation and reimbursement described in the summary plan description.

Lien of the Plan

By accepting benefits under the Plan:

Each Participant grants a lien and assigns to the Plan an amount equal to the benefits paid under the Plan against any recovery made by or on behalf of the Participant. This lien and assignment are binding on the Participant and any attorney or other party who represents the Participant, whether or not an agent of the Participant or of any insurance company or other financially responsible party against whom a Participant may have a claim; provided that the attorney, insurance carrier or other party is notified by the Plan or its agents.

Each Participant agrees that this lien constitutes a charge against the proceeds of any recovery, and that the Plan is entitled to assert a security interest on those proceeds.

Each Participant agrees to hold the proceeds of any recovery in trust for the benefit of the Plan to the extent of any payment made by the Plan. In the event of a settlement or judgment, the Participant agrees to stipulate in the settlement agreement or to instruct the court to segregate the Plan's reimbursement amount before the settlement proceeds are distributed to the Participant.

Additional Terms

Each Participant must notify the Plan before starting any legal action against an alleged tortfeasor and before entering into any settlement with an alleged tortfeasor or the alleged tortfeasor's insurer. The Participant must keep the Plan informed of all material developments in any action or settlement proceeding involving the Participant and the alleged tortfeasor.

No adult Participant may assign any rights that it may have to recover damages from any third party or other person or entity to any minor dependent without the prior express written consent of the Plan. The Plan's right to recover shall apply to decedents', minors', and incompetent or disabled persons' settlements or recoveries.

No Participant shall make any settlement that reduces or excludes, or attempts to reduce or exclude, the benefits provided by the Plan.

The Plan's right of recovery is a prior lien against any proceeds recovered by the Participant. The Plan's right of recovery shall not be defeated or reduced by the application of any so-called "Make-Whole Doctrine", "Rimes Doctrine," or any attempt to defeat the Plan's recovery rights by allocating proceeds to non-Disability benefit damages.

No Participant shall incur any expenses on behalf of the Plan in pursuit of the Plan's rights; no court costs, attorneys' fees or other representatives' fees may be deducted from the Plan's recovery without the prior express written consent of the Plan. This right shall not be defeated by any so-called "Fund Doctrine", "Common Fund Doctrine", "Attorney's Fund Doctrine", or any similar doctrine. This means, for example, that the Plan can recover from proceeds that you receive even if the Plan's recovery results in your not being "made whole" for your injury.

The Plan's right to recover benefits paid will be determined without regard to any claim of fault on the part of any Participant, whether under comparative negligence or otherwise.

If a Participant fails or refuses to honor its obligations, the Plan will be entitled to recover any costs that it incurs to enforce the terms set forth above including attorney's fees, litigation, court costs, and other expenses. The Plan will also be entitled to offset the reimbursement obligation against any future Disability benefits that the Participant would otherwise be entitled to receive under the Plan until the Participant has fully complied with his reimbursement obligations, regardless of how those future Disability benefits are incurred.

No reference to state law in any other provision of this Plan will apply with respect to the Plan's subrogation and reimbursement rights.

By accepting benefits under the Plan, each Participant agrees that a breach of the Participant's obligations would cause irreparable and substantial harm and that no adequate remedy at law would exist.

The Plan is entitled to invoke all remedies as may be necessary to enforce the terms of the Plan, including specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.