Summary Plan Description

Avnet, Inc.
Flexible Benefits Plan

Effective: January 1, 2018

NOTICE TO ALL EMPLOYEES

Avnet, Inc. (the "**Company**") sponsors the Avnet Flexible Benefits Plan (the "**Plan**") for its eligible employees. The Plan allows you to pay your share of the premium for group health benefits (medical, dental and vision coverage) for you and your eligible dependents on a pre-tax basis via payroll deduction. In addition, you can set aside pre-tax dollars to pay for qualified health care, dependent care, and/or transportation expenses.

The Plan was established by the Company for the benefit of eligible employees. However, the Company reserves the right to change or discontinue the Plan at any time.

This document serves as both the plan document and summary plan description for the Plan. (The Health Care Flexible Spending Account is also a component of the Avnet Group Benefits Plan.) It describes the main provisions of the Plan as currently in effect and, among other things, explains how you become a Participant in the Plan, when you qualify for benefits under the Plan, and how the amount of your benefits is determined and paid.

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

This document is not an employment contract and shall not be construed as limiting in any way the Company's right (and the right of its subsidiaries and affiliates) to discipline, discharge, or take action with respect to any of its employees, with or without cause, at any time. All employees of the Company are "at will" employees, which means that your employment may be terminated at any time and for any reason.

If you have any questions concerning the Plan, please contact the Plan Administrator, the applicable claims administrator or HR Now. Their contact information is included in this document.

Avnet, Inc.

TABLE OF CONTENTS

SECTION 1 - INTRODUCTION

The Avnet Flexible Benefits Plan (the "**Plan**") allows you to pay your share of the cost for coverage under the Company's group health plans (medical, dental and vision) on a pre-tax basis. This benefit is referred to as a "**Contribution Benefit**."

The Plan also allows you to set aside pre-tax dollars to reimburse qualified expenses. These benefits are referred to as "**Reimbursement Benefits**."

- To reimburse qualified medical expenses, you can contribute to:
  - General Purpose Health Care Flexible Spending Account (a "**General Purpose Health FSA**"), which can be used to reimburse any qualified health expenses; or
  - Limited Purpose Health Care Flexible Spending Account (a "**Limited Purpose Health FSA**"), which can be used to reimburse only qualified dental and vision expenses; and/or
  - Health Savings Account ("**HSA**"), which can be used to reimburse any qualified health expenses.

- To reimburse qualified dependent care expenses, you can contribute to a Dependent Care Flexible Spending Account (a "**Dependent Care FSA**").

- To reimburse qualified transportation and parking benefits, you can contribute to a Commuter Benefit Account (a "**Commuter Benefit**")

The General Purpose Health FSA and the Limited Purpose Health FSA are Health Care Flexible Spending Accounts ("**Health Care FSA**"). You may contribute to either a General Purpose or a Limited Purpose Health FSA, but not both. The advantages and disadvantages of each type of account are described in this booklet.

As explained in this booklet, certain Reimbursement Benefits are subject to a "use it or lose it" rule. Accordingly, it is very important to plan carefully when you decide how much to set aside for a Reimbursement Benefit. Please refer to specific information about each account for more details.

SECTION 2 – ADVANTAGE OF PRE-TAX CONTRIBUTIONS

Your benefits under the Plan are a way to stretch your paycheck. When you participate in the Plan, you pay no federal income, Social Security, or Medicare taxes on your share of the cost for coverage or on amounts that you set aside for Reimbursement Benefits. (In most cases, your contributions will be exempt from state income tax as well.)

The following example illustrates the tax savings from setting aside money in a Health Care FSA.

FSA Annual Savings Example	With FSA	Without FSA
Annual pay	$40,000	$40,000
Pre-tax contribution to FSA account	($1,500)	$0
Taxable income	$38,500	$40,000
Approximate tax withholdings*	($7,700)	($8,000)
After-tax dollars spent on eligible expenses	$0	($1,500)
Take-home pay	$30,800	$30,500
Tax savings with the FSA	**$300**	**$0**

**Example assumes 20% tax rate and that if you do not set aside $1,500 in a Health Care FSA, you will spend the same $1,500 with after-tax dollars. Actual tax savings depends on your individual tax situation. You may wish to consult with a qualified tax advisor before electing to contribute to an FSA.*

SECTION 3 - ELIGIBILITY

Initial Eligibility

You will become eligible to participate in the Plan when you become eligible to participate in one of Avnet's group health plans. New employees are eligible on the first day of the month after your date of hire. In general, you are eligible if you are scheduled to work at least 20 hours per week.

The following categories of employees are not eligible to participate in the Plan:

- Collectively bargained employees, unless your collective bargaining agreement specifically provides for your eligibility to participate in the Plan;
- Individuals employed by a business unit or division that is not eligible to participate in the Plan;
- Temporary employees and seasonal interns;
- Leased employees;
- Independent contractors; and
- Individuals with no U.S.-source income.

For additional eligibility rules, refer to the specific section for each Reimbursement Benefit.

Eligibility upon Re-Employment

If your employment with the Company terminates and you are (i) rehired within six months of your termination date, and (ii) otherwise eligible to participate in the Plan, you will be eligible to participate in the Plan immediately upon your rehire and will be allowed to make a new election for Contribution or Reimbursement Benefits. However, if you made an election under COBRA to continue your Health Care FSA coverage at the time of your termination of employment, you generally cannot make a new Health Care FSA (General Purpose or Limited Purpose) election if your date of termination and date of rehire occur in the same year. Also, if you are rehired less than 30 days after your termination date, you may not change your Health Care FSA or Dependent Care FSA elections.

SECTION 4 - ENROLLMENT AND TERMINATION OF PARTICIPATION

Enrollment in the Plan

In order to participate in the Plan, you must enroll. If you enroll in one of the Company's group health plans, you will automatically be enrolled in the Contribution Benefits portion of the Plan and your group health plan premium will be withheld from your pay on a pre-tax basis, unless you affirmatively elect not to participate. However, you must affirmatively enroll in a Health Care FSA (General or Limited Purpose), HSA, Dependent Care FSA and/or Commuter Benefit, and specify the amount you would like to have withheld from your pay on a pre-tax basis.

You can participate in the General Purpose Health FSA and/or Dependent Care FSA even if you do not participate in the Company's group health plans. However, the HSA and Limited Purpose Health FSA are available only if you participate in Avnet's HSA 70 or HSA 80 medical plan [or another qualified high deductible health plan]. You must enroll in the HSA 70 or HSA 80 medical plan to receive Company contributions to your HSA.

You can participate in the Commuter Benefits by specifying the amount you would like to have withheld from your pay on a pre-tax basis.

When you enroll in the Plan, you will become a participant in the Plan (a "**Participant**") on your effective date.

The amounts withheld from your pay for each pay period will be shown on your paycheck stub.

Initial Enrollment for Reimbursement Benefits

You can make an initial election to participate in the Reimbursement Benefits portion of the Plan at any time during the first 30 days after you are hired into an eligible position. If you elect to participate during this initial enrollment period, your participation with respect to Reimbursement Benefits will be effective as soon as you are eligible to participate in the Plan (first of the month after your date of hire).

If you do not enroll during the 30-day initial enrollment period, you will not be allowed to enroll until the next open enrollment period unless you qualify to enroll in the Plan mid-year under the "CHANGING YOUR ELECTIONS" rules, below. Similarly, if you enroll during the 30-day initial enrollment period, you will not be allowed to change your enrollment election until the next open enrollment period, unless you qualify to make a mid-year change under the rules summarized below.

An exception to this rule applies to the HSA and the Commuter Benefit: you are allowed to enroll in or make prospective contribution changes to these accounts at any time during the Plan Year.

Open Enrollment

Each year, you will have the opportunity to change your benefit elections during the period known as "open enrollment." Open enrollment generally occurs during November of each year and any changes that you make will apply for the Plan Year beginning on the next January 1.

In general, your Contribution Benefits election will automatically carry forward from year to year, unless you affirmatively change your election for the next Plan Year. You will be notified if you are required to re-enroll prior to the open enrollment period for the next Plan Year.

In contrast, your elections for Reimbursement Benefits do not carry over from year to year. New elections must be completed before the beginning of each Plan Year.

If you do not enroll in the Plan when you are first eligible or during open enrollment, you will not be eligible for Plan benefits until the first Plan Year that starts after the next open enrollment period, unless you qualify to enroll in the Plan mid-year under the "CHANGING YOUR ELECTIONS" rules summarized below. The HSA and the Commuter Benefit is not subject to this rule: you are allowed to enroll in or make prospective contribution changes to these accounts at any time during the Plan Year as long as you meet the other eligibility requirements (see the section entitled "ELIGIBILITY").

Termination of Participation

Your participation in the Plan will cease as of the earliest of the following dates:

- the date you cease to be an eligible employee, as described under the "Initial Eligibility" section of this document;
- the last day for which you made any required contribution to the Plan;
- the date the Plan is terminated; or
- the last day of the month in which you are no longer actively employed, except as described under the "SECTION 6 - LEAVES OF ABSENCE OR DISABILITY" section of this document.

If your employment with the Company terminates and you enrolled in a Health Care FSA or Dependent Care, any remaining balance in your account may be used to provide reimbursements for expenses incurred through the last day of the month in which you terminate; expenses incurred after this date are not eligible for reimbursement. In order to be reimbursed, you must submit your reimbursement request within 90 days of the last day of your coverage. Any remaining balance will be forfeited. However, in some cases you may continue Health Care FSA coverage if you elect it through COBRA, as described under the "COBRA CONTINUATION RIGHTS UNDER FEDERAL LAW" section of this document.

When your employment with the Company terminates (for any reason), you will not forfeit any remaining HSA balance. These funds will be available for Qualified HSA Expenses for you, your Spouse or tax dependents after your coverage ends. However, discontinuing participation in the HSA 70 or HSA 80 medical plan (*e.g.*, if you leave the Company mid-year) might, in some circumstances, result in over-contributions to your HSA (unless you enroll in another qualified high-deductible health plan and otherwise remain eligible to contribute to an HSA). You should review the contribution limits before making any mid-year changes to your coverage.

If your employment with the Company terminates and you are enrolled in a Commuter Benefit account, any remaining balance in your account on your last day of employment will be forfeited. You may submit claims for eligible expensed incurred during your employment for up to 90 days after your date of termination.

SECTION 5 - CHANGING YOUR ELECTIONS

In general, your elections under the Plan may be changed only during the Plan's annual open enrollment period, with changes taking effect as of the next January 1. However, you can change an election in certain limited circumstances, as described in more detail below.

In general, unanticipated increases or decreases in your out-of-pocket health care costs are not sufficient reasons to allow you to change your annual election. Accordingly, it is very important that you accurately estimate your expenses. Subject to a limited $500 carryover rule described below, any portion of the amount you set aside in your Health Care FSA (General Purpose or Limited Purpose) that is not used during the Plan Year will be forfeited.

In contrast, HSA and Commuter Benefit changes are allowed during the Plan Year: you may prospectively start, stop, increase or decrease your contributions to these accounts at any time (Commuter Benefit changes will be effective the beginning of the next month). You will not forfeit any balance remaining in your HSA or Commuter Benefit at the end of a Plan Year.

Your HSA funds will be available for Qualified HSA Expenses for you, your Spouse or tax dependents. However, it is very important that you do not contribute more than the IRS limit, which includes the amount the Company contributes to your HSA. Contributions over the annual limit are subject to a tax penalty. As discussed above, you should keep this limit in mind if you make any mid-year changes to your benefit election (*e.g.*, stop participation in the HSA 70 or HSA 80 medical plan). Please refer to the section on HSAs for more details. You may also want to consult your tax advisor for assistance.

Any change to your elections under the Plan must be requested within 30 days after the occurrence of most special enrollment or change in status events. However, if the event is the termination of Medicaid or SCHIP coverage or the eligibility of premium assistance under Medicaid or SCHIP, you may request enrollment not later than 60 days after the special enrollment event.

The following events are change in status and approved HIPAA special enrollment events:

- **Change in Status.** If you experience one of the following change in status events, you may enroll or change your coverage under the Plan:
  - a change in legal marital status due to marriage, death of a Spouse, divorce, annulment or legal separation;
  - a change in number of dependents due to birth, adoption, placement for adoption, or death of a dependent;
  - a change in employment status of you, your Spouse or your dependent due to termination or start of employment, strike, lockout, beginning or end of unpaid leave of absence, including under the Family and Medical Leave Act (FMLA), or change in worksite;
  - a change in residence of you, your Spouse or your dependent to a location outside of the Company's network service area; or
  - a change that causes a dependent to become eligible or ineligible for coverage.
- **Loss of eligibility for other coverage, excluding COBRA continuation coverage.** If you declined coverage under one of the Company's group health plans due to coverage under another plan, loss of eligibility for the other coverage is a special enrollment event.
- **Termination of employer contributions, excluding COBRA continuation coverage.** If an employer terminates contributions toward group health coverage, other than COBRA continuation coverage, for you or a dependent, that termination of contributions is a special enrollment event. However, termination of contributions toward COBRA continuation coverage is not a special enrollment event.
- **Exhaustion of COBRA continuation coverage.** Exhaustion of COBRA continuation coverage under another employer's group health plan is a special enrollment event. In general, COBRA continuation coverage continues for a specified time period (generally 18 months). However, coverage will be exhausted earlier if: (a) the other employer fails to remit premiums on a timely basis; or (b) you no longer reside or work in the other plan's service area and there is no other COBRA continuation coverage available under the plan. A termination of your COBRA continuation coverage under another employer's group health plan because of your failure to pay required premiums is not considered exhaustion of COBRA continuation coverage and will not cause you to be eligible for special enrollment in the Plan.
- **Termination of Medicare or SCHIP Coverage.** If you or your dependents are covered under Medicaid or SCHIP and that coverage is terminated as a result of loss of eligibility for the coverage, the termination is a special enrollment event.

- **Eligibility for Premium Assistance under Medicaid or SCHIP.** If you or your dependents are not enrolled in one of the Company's group health plans and become eligible for premium assistance from Medicare or SCHIP for the purchase of coverage under one of the Company's group health plans, this eligibility is a special enrollment event.
- **Court Order.** You may enroll or change your coverage under the Plan to comply with a Qualified Medical Child Support Order, as described under the "Qualified Medical Child Support Order" section of this document.
- **Medicare or Medicaid Eligibility/Entitlement.** You may enroll, change or cancel your coverage under the Plan if you, your Spouse, or your dependent becomes entitled to or lose eligibility for Medicare or Medicaid.
- **Change in Cost of Coverage**. If the cost of benefits increases or decreases during a benefit period, the Company may automatically change your elective contribution for Contribution Benefits (but not your elective contribution under a Health Care FSA). When the change in cost is significant, you can either increase your contribution or elect less-costly coverage. When a significant overall reduction is made to the benefit option you have elected, you can elect another available benefit option. When a new benefit option is added, you can change your election to the new benefit option.
- **Change in Cost or Coverage for Dependent Care**. If the cost of providing dependent care significantly increases or decreases, you may make a corresponding increase or decrease in your Dependent Care FSA election. However, you cannot make a change if the difference in cost is imposed by a dependent care provider who is your relative by blood or marriage.
- **Changes in Coverage of Spouse or Dependent Under Another Employer's Plan.** You may make a coverage election change if the plan of your Spouse or dependent: (a) incurs a change such as adding or deleting a benefit option; (b) allows election changes due to Special Enrollment Rights under HIPAA, Change in Status, certain court orders or Medicare or Medicaid Eligibility/ Entitlement; or (c) this Plan and the other plan have different periods of coverage or open enrollment periods.
- **Reduction of Hours**. If you were expected to average at least 30 hours of service per week, you may drop group medical plan coverage midyear if your status changes so that you are expected to average less than 30 hours of service, even though the reduction of hours does not result in loss of eligibility for the plan (e.g., because the plan's eligibility provisions have been drafted to avoid penalties under health care reform's employer shared responsibility provisions). However, the change must correspond to your intended enrollment (and the intended enrollment of any related individuals whose coverage is being dropped) in other minimum essential coverage. The new coverage must be effective no later than the first day of the second month following the month in which the original medical coverage is dropped.
- **Exchange Enrollment**. If you are eligible to enroll in Exchange coverage (during an Exchange special or open enrollment period), you may drop group medical plan coverage midyear, but only if the change corresponds to your intended enrollment (and the intended enrollment of any related individuals whose coverage is being dropped) in Exchange coverage that is effective no later than the day after the last day of the original medical coverage.

The change to your election must be consistent with the special enrollment or change in status event. For example, if you gain a dependent through birth or adoption, you can change your election under the Plan to add that dependent to the Company's group health plan. However, the birth or adoption of a new dependent generally would not permit you to drop your Spouse's coverage under the Plan.

SECTION 6 - LEAVES OF ABSENCE OR DISABILITY

The impact of a leave of absence on your Plan participation depends on whether it is a paid or unpaid leave of absence.

- In the event of a paid leave of absence, there will be no change to your elected coverage unless you are otherwise eligible and make a new election under the "SECTION 5 - CHANGING YOUR ELECTIONS" section of this document. You will not be considered to have incurred a termination of employment under the Plan while on paid leave of absence.
- In the event of an unpaid leave of absence of 30 days or less, you will remain a participant in the Plan and any missed Health Care FSA (Limited Purpose or General Purpose Health FSA), HSA and/or Commuter Benefit contributions will be deducted from your pay after you return to work.
- In the event of an unpaid leave of absence longer than 30 days, the provisions described below under "Family and Medical Leave Act of 1993 (FMLA)" below will apply.

Family and Medical Leave Act of 1993 (FMLA)

In general, if you are on a leave of absence covered by the Family and Medical Leave Act of 1993 (FMLA) (or any other unpaid leave of more than 30 days), you may elect either (1) to remain covered under the Plan to the same extent as if you continued working during the leave period, or (2) to discontinue coverage during the leave and be reinstated when you return to active employment.

In general, you can choose one of three payment options: (1) the "pre-pay" option where you prepay your contributions for the rest of the Plan Year on a pre-tax basis through salary reduction contributions before starting your leave; (2) the "pay-as-you-go" option where you make periodic contributions on an after-tax basis; or (3) the "catch-up" option where you pay your contributions when you return from your leave (or, if you do not return, you pay your contributions upon your termination of employment).

If you elect to discontinue coverage, you will not be subject to any waiting periods or other qualification requirements upon your return to active employment. For more information on the impact of your leave of absence and the Company's group health plans, please refer to the summary plan description for the group health plan that covers you. Participants on FMLA leave have the right to revoke or change elections under the Plan to the same extent as other Participants who are actively employed. Also, if the Plan offers new coverage options during your FMLA leave, those options will be made available to you as well.

FSA Coverage: If you decide to continue coverage during your leave, your Health Care FSA (General or Limited Purpose) will be available to reimburse expenses incurred during your leave if you arrange to make these contributions using one of the three payment options described above.

You can also choose to continue contributions to your Dependent Care FSA during your leave of absence, using one of the three payment options described above. However, you generally will not be able to be reimbursed from your Dependent Care FSA for dependent care expenses incurred during your leave of absence. (To be eligible for reimbursement, dependent care expenses generally must be necessary so that you and your Spouse, if applicable, can work.) For this reason, you may wish to discontinue Dependent Care FSA coverage during your leave of absence, as described below.

If you decide to discontinue FSA or Commuter Benefit coverage during your leave, you will not be reimbursed for expenses incurred during the leave. If the coverage is reinstated when you return from your leave, then you can either (1) resume pre-leave coverage levels and make up the missed Health Care, Dependent Care FSA and/or Commuter Benefit contribution payments; or (2) resume coverage at a level prorated to reflect the period of your leave, but resume contributions at the level in effect before your leave. Of course, in either case, coverage would be reduced by the amount of reimbursement payments for claims incurred before the leave.

HSA: You can continue to use your HSA during any leave, or after you terminate employment; and you can change your contribution rate at any time. If you take an unpaid leave of absence and return to active employment during the same year, your contribution rate for the rest of the year will automatically increase after your return so that your total contributions for the year match your pre-leave election. If you do not want your rate to be increased, you can change it at any time. Please refer to section 9 "HEALTH SAVING ACCOUNT" for more details about changing elections and when HSA funds are available.

SECTION 7 – FEDERAL TAX DEDUCTIONS

Under federal tax laws, you can deduct medical, dental and vision care expenses that are not reimbursed by your group health plan, Health Care FSA or HSA. However, the deduction is available only after you have incurred nondeductible medical expenses equal to 10% of your adjusted gross income (7.5% if you or your Spouse is 65 or older) and only if you itemize your tax deductions (*i.e.*, you cannot take the standard deduction). If you use a Health Care FSA to pay for an expense or you reimburse yourself for an expense from your HSA, you cannot apply the same expense toward the federal tax deduction.

SECTION 8 - HEALTH CARE FLEXIBLE SPENDING ACCOUNT ("HEALTH CARE FSA")

How It Works

When you elect to contribute to a Health Care FSA (General Purpose or Limited Purpose), your pay is reduced each pay period by the amount you specify in your election and a corresponding amount is added to your Health Care FSA. Throughout the year, as you incur health care expenses, you can be paid back from your Health Care FSA. In this way, a Health Care FSA allows you to pay for covered health care expenses on a pre-tax basis. The Company does not make additional contributions to your Health Care FSA.

You can be reimbursed up to the full amount of your annual Health Care FSA election at any time during the Plan Year, even if you have not yet contributed the full amount to your FSA. For example, if you elect to contribute $1,200 to your Health Care FSA in 2018 and you incur health care expenses equal to $1,200 in January of 2018, you can receive the full $1,200 reimbursement in January, even though you have not yet contributed the full $1,200 to your Health Care FSA.

How Much Can You Set Aside?

You may elect to contribute up to the IRS limit ($2,650 for 2018) to your Health Care FSA.

Any amounts (up to $500) that are carried over from a prior year, will not count toward this limit. See discussion of the carryover rule under "Use It or Lose It," below.

The Code has certain rules so that Health Care FSAs do not discriminate in favor of highly compensated employees. If you are a highly compensated employee, as defined by the IRS, your contributions to your Health Care FSA may be further limited. You will be notified if this limitation applies to you.

When you enroll in a Health Care FSA, you should estimate your covered expenses only for the time from your enrollment date through December 31. For example, if you become a Participant in the Plan effective September 15, estimate your reimbursable expenses that will be incurred from September 15 until December 31.

General Purpose or Limited Purpose Health FSA

If you wish to participate in a Health Care FSA, you must elect either a General Purpose Health FSA or a Limited Purpose Health FSA. If you enroll in a Limited Purpose Health FSA, your balance can be used for qualified dental and vision expenses only.

If you participate in the HSA 70 or HSA 80 medical plan, you are not eligible to enroll in a General Purpose Health FSA, but may contribute to a Limited Purpose Health HSA ($2,650 for 2018)

If you or your Spouse enroll in a General Purpose Health FSA, you will not be eligible to make or receive HSA contributions during that Plan Year.

What Expenses Can be Reimbursed by your Health Care FSA?

You can pay for an expense through your Health Care FSA if:

- it is a covered medical care expense under the Code (for a General Purpose Health FSA, this includes qualified medical, dental and vision expenses); if you are enrolled in a Limited Purpose Health FSA you may be reimbursed only for qualified dental and vision expenses;
- it is an expense for you or for someone who is your dependent or Spouse, as described under the "Federal Tax Implications for Dependent Coverage" section of this document;
- the expense is not covered by a medical, dental or vision plan (and is not reimbursed by your HSA); and
- you do not deduct the expense on your federal income tax return.

See Appendix A of the Plan for examples of health care expenses that can and cannot be paid through your Health Care FSA.

Use It or Lose It and Carry Over

You may be reimbursed from your Health Care FSA only for qualified expenses that you and your dependents incur during the same Plan Year as your contributions were made to the Health Care FSA and before the end of the month in which your employment terminates. After the end of the Plan Year, you will have until March 31 to file for reimbursement of any qualified expenses incurred through December 31 of the prior Plan Year. If you terminate employment during the year, your request for reimbursement must be filed within 90 days after the last day of your coverage. In accordance with federal law, any funds left in your Health Care FSA after the claims filing deadline must be forfeited, subject to the $500 carryover rule described below.

You can carry over up to $500 of any amount remaining unused in a Health Care FSA into a Health Care FSA for the next following Plan Year. You are only permitted to carry over amounts from one Plan Year to the next Plan Year if you elect to contribute to the Health Care FSA (General Purpose or Limited Purpose) for the next Plan Year in an amount equal to at least $26 ($1 per pay period).

Subject to the following exceptions, the amount will be carried over to the same type of Health Care FSA (General or Limited Purpose):

- If you elect to participate in the HSA 70 or HSA 80 medical plan for the next following Plan Year, the amount must be carried over to a Limited Purpose Health FSA.
- If the General Purpose Health FSA is not available for the next following Plan Year (*i.e.*, the only Health FSA offered is a Limited Purpose Health FSA), the amount will be carried over to a Limited Purpose Health FSA.

If you intend to make or receive HSA contributions for the next following Plan Year, having amounts carried over to a General Purpose Health FSA will disqualify you from making or receiving those contributions. To avoid this result, you should elect to have your excess amounts carried over to a Limited Purpose Health FSA. You would need to make this election by the open enrollment deadline. Refer to the section entitled “Are You Eligible to Contribute to an HSA” for more details.

Amounts carried over from a prior Plan Year will not count toward the limit on the amount that you can contribute to your Health Care FSA for a current year. Although you can carry over up to $500 from one year to the next, you may not use the amount carried over for expenses incurred after the last day of the month in which your employment terminates. Following your termination, any balance remaining after the deadline described above will be forfeited. Also, the amount carried over from one year to the next can never exceed $500, even if you never use the balance carried over from a prior year.

Qualified Military Reservist Distribution

If you are a reservist in one of the U.S. military branches (including the National Guard) who has been called to active duty for a period of 180 days or more or for an indefinite period, you may request to receive a distribution of all or a portion of the unused balance of your Health Care FSA. For purposes of this rule, the unused balance of your account includes only the actual amount contributed to your Health Care FSA for the year minus the reimbursements already paid; the unused balance does not include amounts not yet contributed, even though amounts not yet contributed are available to reimburse qualified expenses.

Your distribution request must include a copy of the order or call to active duty and must be made by the last day of the claims filing period for the year during which you were called to active duty (currently March 31 of the following year). After you submit a distribution request, you may not seek reimbursement for covered expenses from your Health Care FSA in excess of your unused balance (*i.e.,* amounts not yet contributed will not be available for reimbursement).

Distributions will be paid within 60 days of the date of your request. The distribution will be included in your gross income and is subject to income and employment taxes.

SECTION 9 - HEALTH SAVINGS ACCOUNT ("HSA")

How It Works

You can make contributions to an HSA if you satisfy the requirements described below (in addition to the general requirements described beginning on page 1 of this document). To make HSA contributions through payroll deductions, you must be enrolled in the HSA 70 or HSA 80 medical plan.

If you enroll in the HSA 70 or HSA 80 medical plan, the Company will make a contribution to your HSA at the beginning of the year (or when you become a participant in the HSA 70 or HSA 80 medical plan, if later).

When you elect to make HSA contributions through payroll deductions, your pay is reduced each pay period by the amount you specify in your election and a corresponding amount is added to your HSA. HSA funds are deposited pre-tax and earn tax-free interest. When used to reimburse "Qualified HSA Expenses" (described below), HSA distributions are also non-taxable.

In contrast, if you withdraw money from your HSA for an expense that is not a Qualified HSA Expense, you will have to pay income tax on the withdrawal, plus an additional excise tax. (Exceptions apply after you reach age 65.)

If you don't use all the money in your HSA during the Plan Year, the balance will be carried over for reimbursement of Qualified HSA Expenses in subsequent years (*i.e.*, the "use it or lose it" rule does not apply for an HSA). In addition, contributions to your HSA can be invested (after meeting a minimum account threshold), and your HSA is portable—it goes with you even after your employment with the Company ends.

Your HSA is an individual bank account in your name. This account is not maintained, sponsored, or endorsed by the Company, nor is it subject to ERISA. The Company has contracted with HealthEquity to establish an HSA in your name and administer your account. The Company intends to pay the HealthEquity administrative fees as long as you remain enrolled in an Avnet HSA plan. However, you are free to contribute to a different HSA, or transfer amounts from your HealthEquity HSA to another HSA, provided that you pay the required account maintenance fees. For more information about the HealthEquity HSA, visit the education website at www.healthequity.com/ed/Avnet.

You are solely responsible for managing your HSA to ensure that contributions qualify for favorable tax treatment and that funds are used only for Qualified HSA Expenses. HSAs are not subject to a claims process like FSAs. As noted above, making or receiving contributions to an HSA when you are not eligible, or withdrawing HSA funds for expenses that are not qualified, will generally result in tax penalties. You should consult your tax advisor.

When Are Your Funds Available?

Unlike a Health Care FSA, HSA contributions you make through payroll deductions (or through contributions outside of the Plan) will be available only after they have been deposited into your account. For example, if you elect to contribute $100 each month to your HSA for 2018 and you incur $300 in Qualified HSA Expenses in January of 2018, you can be reimbursed for only $100 in January and must wait until you have contributed the additional $200 to your HSA before receiving reimbursement for the balance of your Qualified HSA Expenses. You can change your HSA election in Workday at any time during the year. You may also make lump sum contributions for the current tax year directly to HealthEquity until April 15 of the next year.

How Much Can You Set Aside?

The amount you can contribute to your HSA during a year is limited by the Internal Revenue Service. The limits for 2018 are:

- $3,450 if you are enrolled in Employee Only medical coverage, or
- $6,900 if you are enrolled in Employee + Dependent (Employee + Spouse, Employee + Child(ren) or Employee + Family) medical coverage.

The Company's contribution counts toward the annual limit (as shown in the chart below)*.

2018 Annual HSA Contribution Limits (for full year participation)**				
Medical Coverage	**HSA 70**		**HSA 80**	
Coverage Tier	Employee Only	Employee + One or More Dependents	Employee Only	Employee + One or More Dependents
Total Contribution*	$3,450	$6,900	$3,450	$6,900
Less Avnet Contribution**	-$250	-$500	-$500	-$1,000
Less Avnet Path to Physical Well-Being Contribution (if qualified)	-$260	-$260	-$260	-$260
Maximum Employee Contribution*	$2,940	$6,140	$2,690	$5,640

** If you are age 55 or older, you can contribute an additional $1,000 each year.*
*** For employees whose enrollment is effective July 1 or later in the year, Avnet's contribution will be one-half of the amounts shown.*

If you move to a higher coverage tier during the Plan Year (such as from Employee only coverage to Employee + Dependent coverage), the Company will contribute an additional amount to bring your annual contribution to the dollar amount corresponding to your new tier level. However, there will be no Company contribution reversal if you move to a lower coverage tier during the Plan Year (such as from Employee + Dependent coverage to Employee only coverage). You should review the applicable HSA contribution limits before making any changes to your coverage because moving to a lower tier can result in excess HSA contributions that are subject to an excise tax.

If you begin participation in the HSA 70 or HSA 80 medical plan mid-year, you may contribute a prorated amount to your HSA for the actual number of full months you are enrolled during the year. However, if you are certain you will still be enrolled in a qualified high-deductible health plan during the entire next calendar year (and are otherwise eligible to contribute to an HSA), you can contribute the entire annual HSA maximum in the current year.

As with HSA distributions, you are solely responsible for managing contributions to your HSA to ensure that you do not exceed the annual limit. If you contribute more than the maximum permitted, you will be subject to excise taxes.

What Expenses Can be Reimbursed by your HSA?

You can use your HSA to pay Qualified HSA Expenses that are incurred after the HSA was established. An expense is a Qualified HSA Expense if:

- it is a medical, dental or vision expense that qualifies for a medical expense deduction on your federal income taxes;
- it is an expense for you, your Spouse or for someone who is your tax dependent, as described under the "Federal Tax Implications for Dependent Coverage" section of this document;
- the expense is not covered by a medical, dental or vision plan (or reimbursed by your Health Care FSA); and
- you do not deduct the expense on your federal income tax return.

For example, Qualified HSA Expenses generally include coinsurance under the HSA 70 or HSA 80 medical plan, amounts that are applied to your deductible under the HSA 70 or HSA 80 medical plan, and the cost of drugs that are prescribed for you. See Appendix A of the Plan for examples of medical, dental, or vision expenses that qualify (and do not qualify) for a medical expense deduction on your federal income taxes.

Are You Eligible to Contribute to an HSA?

To make and/or receive contributions to an HSA:

- You must be enrolled in the HSA 70 or HSA 80 medical plan. If you are not enrolled in one of these plans but are enrolled in another qualified high-deductible health plan, you might still be eligible to make contributions to an HSA, but the Company will not make contributions on your behalf and you cannot make contributions through payroll deductions;
- You must not have any other medical coverage (*e.g.*, coverage under your Spouse's plan or a former employer's plan), unless that coverage also qualifies as "high deductible" coverage or the coverage is an excepted benefit under the federal tax laws. For this reason, employees enrolled in the HSA 70 or HSA 80 medical plan (or another qualified high-deductible health plan) are eligible to enroll only in a Limited Purpose Health FSA and not a General Purpose Health FSA;
- Neither you nor your Spouse may participate in a Health Care FSA if the account can reimburse expenses other than dental or vision expenses before the minimum deductible determined by the IRS is satisfied. For this reason, employees enrolled in the HSA 70 or HSA 80 medical plan (or another qualified high-deductible health plan) are eligible to enroll only in a Limited Purpose Health FSA and not a General Purpose Health FSA;
- You cannot be enrolled in Medicare, TRICARE, tribal benefits or other benefit programs. Keep in mind that some disqualifying benefit programs, such as Medicare Part A, require that you take action to avoid being covered; and
- You cannot be claimed as a dependent on someone else's tax return.

If you do not meet the above requirements, you will not be eligible to make or receive HSA contributions.

You are solely responsible for ensuring that you are eligible to contribute to an HSA. If you make or receive HSA contributions when you aren't eligible, you will be subject to excise taxes. If you enroll in the HSA 70 or HSA 80 medical plan and are not eligible to contribute to an HSA, contact the Plan Administrator at 888-99-HR NOW (994-7669) to inform the Company not to make contributions on your behalf.

If the Plan Administrator discovers that you were not eligible for HSA contributions, the Company will not make HSA contributions on your behalf, and you will be required to return prior contributions and interest.

SECTION 10 - DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT ("DEPENDENT CARE FSA")

How It Works

When you elect to contribute to a Dependent Care FSA, your pay is reduced each pay period by the amount you specify in your election and a corresponding amount is added to your Dependent Care FSA. Throughout the year, as you incur dependent care expenses for a qualifying dependent, you can be paid back from your Dependent Care FSA. In this way, a Dependent Care FSA allows you to pay for covered dependent care expenses on a pre-tax basis. The Company does not make additional contributions to your Dependent Care FSA.

Unlike a Health Care FSA, you can be reimbursed from your Dependent Care FSA only up to the amount that you have contributed to your Dependent Care FSA. For example, if you elect to contribute $100 each month to your Dependent Care FSA for 2018 and you incur $300 in qualifying dependent care expenses in January of 2018, you can be reimbursed for only $100 in January and must wait until you have contributed the additional $200 to your Dependent Care FSA before receiving reimbursement for the balance of your qualifying dependent care expense.

How Much Can You Set Aside?

You may elect to contribute up to $5,000 per family each year to your Dependent Care FSA (or $2,500 if you are married but file your taxes separately).

The Code has certain rules so that Dependent Care FSAs do not discriminate in favor of highly compensated employees. If you are a highly compensated employee, as defined by the IRS, your contributions to the Plan may be further limited. You will be notified if this limitation applies to you.

What Expenses Can Be Reimbursed by your Dependent Care FSA?

You can use your Dependent Care FSA to reimburse covered expenses incurred for your qualifying dependents, which means:

- your child under age 13 (at the time care was provided); and/or
- your Spouse or legal dependent (for federal income tax purposes) who is physically and/or mentally incapable of self-care and who lives with you for at least six months of each year.
- A dependent care expense for a qualifying dependent is a covered expense if:
- it is necessary so that you can work and, if you're married, so that your Spouse can work or look for work or be a full-time student;
- it qualifies as a dependent care expense under the Code;
- you do not claim a tax credit for it on your federal income tax return; and
- your provider gives you a federal tax identification number or a Social Security number for reporting amounts paid to the provider to the IRS.

See Appendix B of the Plan for examples of dependent care expenses that can and cannot be paid through your Dependent Care FSA.

You may be restricted from receiving reimbursements from your Dependent Care FSA while you are on a leave of absence. However, subject to the rules described under the "SECTION 5 - CHANGING YOUR ELECTIONS" section of this document, you may be allowed to modify your contribution election. Note that dependent *health care* expenses can be reimbursed from your Health Care FSA and not from your Dependent Care FSA.

Use It or Lose It

You may be reimbursed from your Dependent Care FSA only for covered dependent care expenses that you incur during the same Plan Year as your contributions were made to the Dependent Care FSA. After the end of the Plan Year, you will have until March 31 to file for reimbursement of any dependent care expenses incurred through December 31 of the prior Plan Year. If you terminate employment during the year, your request for reimbursement must be filed within 90 days after the last day of your coverage. In accordance with federal law, any funds left in your Dependent Care FSA after the claims filing deadline must be forfeited. (The $500 carryover that is described above for Health Care FSAs is not available for a Dependent Care FSA.)

When you enroll in a Dependent Care FSA, you should estimate your dependent care expenses only for the time from your enrollment date through December 31. For example, if you will become a Participant in the Plan on September 15, estimate your covered dependent care expenses to be incurred from September 15 through December 31.

Dependent Care Federal Tax Credit

Under federal tax laws, you may be eligible to receive a tax credit for certain dependent care expenses. However, dependent care expenses that are reimbursed from your Dependent Care FSA are not eligible for the dependent care federal tax credit. For some employees, the dependent care tax credit might be more favorable than a Dependent Care FSA. The determination of which is more favorable depends on a number of factors such as your tax filing status (*e.g.*, married, single, head of household) and your number of dependents. You might wish to consult a qualified tax advisor to determine whether the tax credit or the Dependent Care FSA is better for you.

SECTION 11 – COMMUTER BENEFIT ACCOUNT ("COMMUTER BENEFITS")

How It Works

The Commuter Benefit allows you to pay for qualified transit and parking expenses on a pre-tax basis. When you elect to contribute to a Commuter Benefit account, your pay is reduced 2 times per month by the amount you specify in your election and a corresponding amount is added to your Commuter Benefit account. Please note there will only be two Commuter Benefit deductions per month; if there are three pay periods in a given month, there will be no deduction on the third paycheck. The Company does not make additional contributions to your Commuter Benefit account.

Throughout the year, as you incur qualified transit and parking expenses, you can be paid back from your Commuter Benefit account. The Commuter Benefit reimburses only up to the amount that you have accumulated in your Commuter Benefit account. For example, if you elect to contribute $100 each month to your Commuter Benefit account for 2018 and you incur $300 in qualified transit expenses in January of 2018, you can be reimbursed for only $100 in January and must wait until you have contributed the additional $200 to your Commuter Benefit account before receiving reimbursement for the balance of your qualified transit expense.

How Much Can You Set Aside?

You may elect to contribute up to $260 per month for transit and/or $260 per month for parking to your Commuter Benefit account.

What Expenses Can Be Reimbursed by your Commuter Benefit Account?

You can use your Commuter Benefit to reimburse eligible transportation expenses for your commute to and from work.

- qualified transportation fringe benefits allowed under section 132(f) include reimbursement for the cost of transportation in commuter highway vehicles (vanpooling), transit passes, and qualified commuter parking expenses,
- you do not deduct the expense on your federal income tax return, and
- qualified parking does not include any parking on or near your residential property.

See Appendix C of the Plan for examples of commuter expenses that can and cannot be paid through your Commuter Benefit account.

Use It or Lose It

The amount you contribute to your Commuter Benefit account will be rolled over from month to month and year to year, as long as you are eligible to participate. However, you would forfeit funds if you terminate employment with Avnet and there are unused funds remaining in your account.

SECTION 12 – APPLYING FOR GENERAL PURPOSE OR LIMITED PURPOSE FSA REIMBURSEMENTS AND APPEALING DENIED CLAIMS

Submitting a FSA Claim for Reimbursement

There are two ways to submit claims for reimbursement from your General Purpose Health FSA or Limited Purpose Health FSA: (1) debit card payment and (2) manual claims submission.

First, payments for covered expenses in the General Purpose Health FSA (medical, Rx, dental, vision, etc.) or the Limited Purpose Health FSA (dental and vision only) will occur automatically if you pay your provider using the debit card provided by the FSA's third-party vendor, HealthEquity.

Second, you can choose to manually submit claims for reimbursement for covered expenses that are not paid using the debit card. In the case of a manual submission, you are responsible for paying the provider and filing for a reimbursement from your General Purpose Health FSA or Limited Purpose Health FSA. The reimbursement will be paid directly to you, unless you request that it be paid directly to the provider.

You can file a manual claim for reimbursement by following these steps:

- Submit your request online at myhealthequity.com, OR
- Fill out the claim form (posted on HR Now) completely, sign and date it.
- If you want your reimbursement via check (Option 1), please allow 7-10 business days. A $2 fee will be deducted from your account (there is no fee if the payment is made directly to the provider).
- If you want your reimbursement via electronic funds transfer (EFT) to an account already tied to HealthEquity, you can choose Option 2. Please note if there is not an EFT on file, you will be sent a check and charged a $2 fee.
- If you want your reimbursement to be deposited to another bank account, choose Option 3 and send a copy of a voided or actual check along with the completed form.
- Attach a copy of your Explanation of Benefits (EOB) or detailed receipt. Documentation must include the actual date the expense was incurred, the name of the person for whom the service was provided, the provider's name, description of service and cost. Orthodontic contracts are required with first submission of orthodontic claims.
- Fax all necessary documentation to HealthEquity at 801-999-7829 or mail to:

HealthEquity
Attention: Reimbursement Accounts
15 W. Scenic Pointe Dr., Suite 100
Draper, UT 84020

You will receive periodic statements showing your annual election and your reimbursements. If you have any questions about the status of your claim, please call HealthEquity, the FSA's third-party administrator, at 866-382-3511.

All claims must be submitted by March 31 following the end of the Plan Year in which the claim was incurred, or within 90 days after the last day of your coverage, whichever is earlier. Up to $500 of any amount remaining unused in a Health Care FSA can be carried over into a Health Care FSA for the next following Plan Year (provided that you are still employed by the Company). Any unused amounts remaining in your Health Care FSA after the deadline will be forfeited, except to the extent that the $500 carryover is available.

Claim Determination

The claims administrator will notify you of its decision in writing. In general, you should receive this notice within 30 days after you file a request for reimbursement. If more time is needed to make a determination, the claims administrator will notify you or your representative within 30 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the request. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed and you or your representative must provide the

specified information within 45 days after receiving the notice. The determination period will be suspended when the claims administrator sends such a notice of missing information and resume when you or your representative responds to the notice.

Notice of Adverse Determination

Every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific Plan provisions on which the determination is based; (3) a description of any additional material or information necessary to perfect the claim and an explanation of why the additional material or information is necessary; (4) a description of the Plan's review procedures and the applicable time limits, including a statement of a claimant's rights to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on appeal; and (5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit.

Appealing a Denied Claim

If you question a denial, you may try to resolve the claim dispute with the claims administrator through its established informal issue resolution process. If attempts are unsuccessful, you should request assistance from the Company-contracted health advocate or HR Now. If the claim continues to be unresolved, you may request a formal review of the denied claim. Your request for formal review must be submitted within 180 days after you receive the claim denial: the 180-day deadline will not be suspended if you try to resolve the claim through the claims administrator's informal appeal process.

A formal request for review must be submitted in writing to Avnet Benefits at 2211 South 47th Street, Phoenix, AZ 85034. Upon receipt of your written request, a rewards advisor will contact you to acknowledge receipt of the claim and request additional information, if necessary. The claim will be presented to the Sr. Benefits Manager for review. The Sr. Benefits Manager will approve or deny the claim. You will be notified in writing if the claim has been approved or denied. The notice will include specific reasons for the decision and references to the pertinent Plan provision(s) on which the decision is based, a statement that you can obtain relevant documents and information related to your claim, and a statement regarding your right to bring a lawsuit against the Plan. The review process should take no longer than 60 days from the date the claim is received by Avnet Benefits. The decision by the Sr. Benefits Manager will be final and binding.

For purposes of the General Purpose Health FSA and Limited Purpose Health FSA, the claims administrator is HealthEquity.

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 Plan, the Company, or HealthEquity, or any of their affiliates in connection with the Plan after the earlier of (i) 12 months after the claimant has completed his or her last appeal under the Plan, or (ii) 24 months after the claimant was first notified in writing that the Plan will not cover all or a portion of the claimed benefits that are the subject to the claimant's legal action. If the 24-month period would otherwise expire while a claimant is still actively seeking resolution of his or her claim through the Plan's appeal process, it will be extended for an additional 90 days after the claimant's final appeal process has been completed. If you miss the Plan's deadline for filing any required claim or appeal, you will forfeit your right to legal action.

The Plan is governed by the laws of the State of Arizona (disregarding any conflicting rules that might point to the laws of another jurisdiction) except to the extent superseded by federal law. In general, ERISA preempts state laws that relate to the Plan.

SECTION 13 - APPLYING FOR HSA REIMBURSEMENTS

Submitting an HSA Claim for Reimbursement

Your HSA is an individual account. This means that you do not have to request approval from the Plan, Avnet or a claims administrator to receive a distribution; and there is no claims procedure under the Plan for your HSA. You are responsible for determining whether expenses reimbursed by your HSA are Qualified HSA Expenses, and for any adverse tax consequences from a non-qualified withdrawal.

There are two ways to submit claims for reimbursement from your HSA: (1) debit card payment and (2) manual claims submission.

First, payments for certain healthcare expenses will occur automatically if you pay your provider using the debit card provided by the HSA's third-party vendor, HealthEquity.

Second, you can choose to manually submit claims for reimbursement for expenses incurred with providers. In the case of a manual submission, you are responsible for paying the provider and filing for a reimbursement from your HSA; the reimbursement will be paid directly to you. Or, you can request the reimbursement be paid directly to the provider.

You can file a manual claim for reimbursement by following these steps:

- Submit your request online at myhealthequity.com, OR
- Fill out the claim form (posted on HR Now) completely, sign and date it.
- If you want your reimbursement via check (Option 1), please allow 7-10 business days. A $2 fee will be deducted from your account (there is no fee if the payment is going directly to the provider).
- If you want your reimbursement via electronic funds transfer (EFT) to an account already tied to HealthEquity, you can choose Option 2. Please note if there is not an EFT on file, you will be sent a check and charged a $2 fee.
- If you want your reimbursement to be deposited to another bank account, choose Option 3 and send a copy of a voided or actual check along with the completed form.
- Fax your request form to HealthEquity at 801-727-1005 or mail to:

HealthEquity
Attention: Member Services
15 W. Scenic Pointe Dr., Suite 400
Draper, UT 84020

You will receive periodic statements showing your account balance. If you have any question about the status of your account or a reimbursement, please call HealthEquity, the HSA's third-party administrator, at 866-346-5800.

Beneficiary

If you die, your beneficiaries or your estate may submit claims for Qualified HSA Expenses for the portion of the Plan Year preceding the date of your death. You may designate a specific beneficiary for this purpose. If you do not name a beneficiary, HealthEquity may pay any amount to your Spouse, one or more of your dependents, or a representative of your estate.

SECTION 14 - APPLYING FOR DEPENDENT CARE FSA REIMBURSEMENTS AND APPEALING DENIED CLAIMS

Submitting a Dependent Care FSA Claim for Reimbursement

In order to be reimbursed from your Dependent Care FSA, you must obtain a receipt or other proof of payment that includes the provider's federal tax identification number or Social Security number.

You can file a claim for reimbursement by following these steps.

- Fill out the claim form (posted on HR Now) completely, sign and date it. You will be required to select either the annual reimbursement option to receive automatic payments throughout the year or the pay as-you-go option requesting a one-time reimbursement.
- If you want your reimbursement via check (Option 1), please allow 7-10 business days. A $2 fee will be deducted from your account.
- If you want your reimbursement via electronic funds transfer (EFT) to an account already tied to HealthEquity, you can choose Option 2. Please note if there is not an EFT on file, you will be sent a check and charged a $2 fee.
- If you want your reimbursement to be deposited to another bank account, choose Option 3 and send a copy of a voided or actual check along with the completed form.
- Attach a copy of your receipt or other proof of payment or have your dependent care provider complete the reimbursement form if you don't want to provide receipts.
- Fax all necessary documentation to HealthEquity at 801-999-7829 or mail to:

HealthEquity
Attention: Member Services
15 W. Scenic Pointe Dr., Suite 400
Draper, UT 84020

You can be reimbursed only up to the amount currently deposited into your Dependent Care FSA at the time you file your claim for reimbursement.

You will be able to access periodic statements showing your account balance. If you have any questions about the status of your account or a reimbursement, please call HealthEquity at 866-382-3511.

All claims must be submitted by March 31 following the end of the Plan Year in which the claim was incurred, or within 90 days after the last day of your coverage if you terminate employment with the Company, whichever is earlier. Any amounts remaining in your Dependent Care FSA after the deadline will be forfeited. (There is no carryover.)

Claims and Appeals

Claims and Appeals for a Dependent Care FSA are subject to the same procedures that apply for the General Purpose Health FSA or Limited Purpose Health FSA (see "APPLYING FOR GENERAL PURPOSE HEALTH FSA OR LIMITED PURPOSE HEALTH FSA REIMBURSEMENTS AND APPEALING DENIED CLAIMS," above).

Period for Bringing a Legal Action/Governing Law

The deadlines described above for bringing a legal action with respect to a General Purpose Health FSA or Limited Purpose Health FSA (see "Period for Bringing a Legal Action/Governing Law") also apply for the Dependent Care FSA.

SECTION 15 – SUBMITTING A COMMUTER BENEFIT CLAIM FOR REIMBURSEMENT

There are two ways to submit claims for reimbursement from your Commuter Benefit account: (1) debit card payment and (2) online claims submission.

First, payments for certain transit expenses will occur automatically if you pay your expense using the debit card provided by the Commuter Benefit third-party vendor, Discovery Benefits.

Second, you can choose to submit claims online for reimbursement for expenses incurred. In the case of an online submission, you are responsible for paying the expense and filing for a reimbursement from your Commuter Benefit account; the reimbursement will be paid directly to you.

- Submit your claim online at discoverybenefits.com or
- Download the Discovery Benefits app on your mobile device.

Claim Determination

The claims administrator will notify you of its decision in writing. In general, you should receive this notice within 30 days after you file a request for reimbursement. If more time is needed to make a determination, the claims administrator will notify you or your representative within 30 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the request. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed and you or your representative must provide the specified information within 45 days after receiving the notice. The determination period will be suspended when the claims administrator sends such a notice of missing information and resume when you or your representative responds to the notice.

Appealing a Denied Claim

If you question a denial, you may try to resolve the claim dispute with the claims administrator through its established informal issue resolution process. If attempts are unsuccessful, you should request assistance from HR Now. If the claim continues to be unresolved, you may request a formal review of the denied claim. Your request for formal review must be submitted within 180 days after you receive the claim denial: the 180-day deadline will not be suspended if you try to resolve the claim through the claims administrator's informal appeal process.

A formal request for review must be submitted in writing to Avnet Benefits at 2211 South 47th Street, Phoenix, AZ 85034. Upon receipt of your written request, a rewards advisor will contact you to acknowledge receipt of the claim and request additional information, if necessary. The claim will be presented to the Sr. Benefits Manager for review. The Sr. Benefits Manager will approve or deny the claim. You will be notified in writing if the claim has been approved or denied. The notice will include specific reasons for the decision and references to the pertinent Plan provision(s) on which the decision is based, a statement that you can obtain relevant documents and information related to your claim, and a statement regarding your right to bring a lawsuit against the Plan. The review process should take no longer than 60 days from the date the claim is received by Avnet Benefits. The decision by the Sr. Benefits Manager will be final and binding.

For purposes of the Commuter Benefit, the claims administrator is Discovery Benefits.

SECTION 16 - 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 Health Care FSA portion of the Plan. This section explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.

COBRA continuation coverage is limited to participation in a Health Care FSA (General Purpose or Limited Purpose). For more information on COBRA continuation coverage of your medical, dental and vision benefits, please refer to the summary plan description for the applicable group health plan.

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 and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review this summary plan description or contact the Plan Administrator listed at the end of this section.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called 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 Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. You will receive more information about premiums after you experience a qualifying event. In general, you will be charged 102% of the total cost for COBRA continuation coverage.

If you are an Employee, you will become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- 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 Plan because of the following qualifying events:

- 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 Plan because of the following qualifying events:

- 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."

For this Plan, COBRA continuation coverage applies only to a Health Care FSA (only in limited circumstances). At the time of the qualifying event, you must have a positive balance in your Health Care FSA (*i.e.*, the amount contributed to your Health Care FSA at the time of your termination of employment must exceed the amount that has been paid to you as reimbursement for qualified health care expenses). You will be eligible to make a COBRA election only for the remainder of the year in which the qualifying event occurs.

These special COBRA rules do not impact your rights to make an election to receive full COBRA coverage under the Company's general group health plan covering you at the time of a COBRA qualifying event.

When is COBRA Continuation Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- 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).

For all 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 Plan Administrator (Avnet) within 60 days after the qualifying event occurs. 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 Plan 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.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the Plan Administrator listed at the end of this section. For more information about your rights under ERISA, including COBRA, the Patient Protection and Affordable Care Act, 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 Plan 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 Plan Administrator.

Plan Contact Information

Plan Administrator
Avnet, Inc.
2211 South 47th Street
Phoenix, AZ 85034
888-99-HR Now (994-7669)

SECTION 17 - OTHER FEDERAL AND STATE LEGAL REQUIREMENTS

Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA)

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) has requirements for continuation of health coverage and re-employment if an employee is on a qualified military leave of absence. These requirements apply only to medical, dental, and vision coverage for you and your dependents and to coverage under the Health Care FSA (General or Limited Purpose).

For more information about whether a leave will be treated as a "qualified military leave" or about your rights under USERRA, please refer to the military leave policy posted on HR Now.

For leaves of 30 days or less, coverage will continue as if you remained actively employed on short-term unpaid leave. Thus, you will have to pay for your share of the premium for any Plan coverage and can elect whether to continue or discontinue coverage under the Health Care FSA.

For qualified military leaves of more than 30 days, you may continue coverage for yourself and your dependents by paying the required premium (generally the same as the COBRA premium) to the Company, until the earliest of the following:

- 24 months from the last day of your active employment with the Company;
- the day after you fail to return to work with the Company after your qualified military service is considered over under USERRA and after any applicable grace period provided by the Company's military leave policy;
- the first day of the month for which your Plan coverage payment is late by more than 30 days;
- the date your coverage would otherwise terminate under the Plan (such as for submitting a fraudulent claim); or
- the date the Company terminates all of its group medical plans.

The Company may charge you and your dependents up to 102% of the total premium under USERRA, similar to the COBRA continuation coverage rules described above.

Reinstatement of Benefits

If your coverage ends during the leave of absence because you do not elect USERRA or an available conversion plan at the expiration of USERRA and you are reemployed by the Company, coverage for you and your dependents may be reinstated if (a) you gave the Company advance written or verbal notice of your qualified military service leave, (b) the duration of all qualified military leaves while you are employed with the Company does not exceed 5 years, and (c) you return to work with the Company before your USERRA rights expire.

If your coverage under this Plan terminates as a result of your eligibility for military medical and dental coverage and your order to active duty is canceled before your active duty service commences, these reinstatement rights still apply.

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

The Plan is required to provide you with a notice that describes your rights and the Plan's obligations regarding your "protected health information." In general, "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 Plan, or your employer on behalf of the Plan.

You were provided with a copy of the Plan's Notice of Privacy Policies when you first enrolled in the Plan, and you will be provided with a copy following any material revisions to the Plan's privacy policies. You can also request a copy of the Notice of Privacy Policies at any time by contacting the Plan Administrator listed below. The Group Benefits Plan amendment relating to disclosure of individually identifiable information to a Plan Sponsor is set forth in Appendix D of this booklet.

Federal Tax Implications for Dependent Coverage

Contribution benefits for dependent health coverage are usually exempt from federal income tax if you can claim the individual as a dependent for purposes of federal income tax or the individual is your Spouse.

When parents are divorced or legally separated, either parent may claim a child as a dependent for purposes of group health benefits, including the Health Care FSA (General Purpose or Limited Purpose Health FSA). However, the child must reside with a parent for at least six months of each year in order for covered dependent care expenses to be reimbursable from the employee's Dependent Care FSA.

Effect on Social Security Benefits

If your annual pay is less than the Social Security taxable wage base (which may change from year to year), salary reductions made on your behalf in connection with the Plan will reduce the Social Security taxes you pay. While such a reduction will provide you with current tax savings, it may also result in a reduction in the Social Security benefits you eventually receive upon your retirement.

SECTION 18 - GENERAL INFORMATION ABOUT THE PLAN

Discretionary Authority

The Plan Administrator has discretionary authority to interpret the terms of the Plan, including to resolve ambiguities and inconsistencies. The Plan Administrator delegates to UnitedHealthcare (with respect to Contribution Benefits), HealthEquity (with respect to General Purpose Health, Limited Purpose Health, and Dependent Care FSA claims), Discovery Benefits (with respect to Commuter Benefits) and the Sr. Benefits Manager 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, but is not limited to, the determination of the eligibility of persons desiring to enroll in or claim benefits under the Plan, the determination of whether a Participant is entitled to benefits under the Plan, and the computation of any and all benefit payments.

Plan Modification, Amendment and Termination

The Company, as Plan sponsor, 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. 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 Executive Board (AEB) or the Board of Directors of the Company. No consent of any Participant is required to terminate, modify, amend or change the Plan.

Termination of the Plan will have no adverse effect on any benefits to be paid under the Plan for eligible expenses incurred or approved before the date the Plan terminates.

Forfeitures

As discussed above under the heading “Use It or Lose It” in the “HEALTH CARE FLEXIBLE SPENDING ACCOUNT” and “DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT” sections, you may be reimbursed only for qualified expenses during the same Plan Year as your contributions were made to the FSA (subject to the carryover rule if the FSA is a Health Care FSA) and before the last day of the month in which your employment terminates. In accordance with federal law, any funds left in your FSA after the claims filing deadline described in the applicable “Use It or Lose It and Carry Over” section, must be forfeited.

In general, forfeitures will be used to pay plan expenses. Forfeitures for Health Care FSAs (General Purpose and Limited Purpose) may be used to pay any expenses related to medical benefits under the Avnet Group Benefits Plan. Forfeitures for Dependent Care FSAs will be treated like Company assets and may be used to pay any Company expenses.

Alienation and Assignment of Benefits

Except as described under the “Recovery of Excess Payment ” section of this document, none of your benefits under the Plan may at any time be alienated, sold, transferred, assigned, pledged, attached or encumbered in any way.

Qualified Medical Child Support Order

If the Plan receives a medical child support order that the administrator determines is a Qualified Medical Child Support Order (QMCSO), the child covered by the QMCSO will be eligible for the coverage required by the order.

A QMCSO is a judgment, decree or order (including approval of a settlement agreement) or administrative notice issued pursuant to a state domestic relations law (including a community property law), or an administrative process that provides for child support or provides for health benefit coverage to such child, and satisfies all of the following requirements:

- the order recognizes or creates a child’s right to receive group health benefits for which an employee is eligible;
- the order specifies your name and last known address, and the child’s name and last known address, except that the name and address of an official of a state or political subdivision may be substituted for the child’s mailing address;

- the order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;
- the order states the period to which it applies; and
- if the order is a National Medical Support Notice completed in accordance with the Child Support Performance and Incentive Act of 1998, the notice must also meet the requirements described above.

In general, a QMCSO may not require the Plan to provide coverage for any type or form of benefit or option not otherwise provided under the Plan, except that an order may require a plan to comply with State laws regarding health care coverage for the child.

Any payment of benefits or reimbursement for covered expenses paid by the child, or the child's custodial parent or legal guardian, shall be made to the child, the child's custodial parent or legal guardian, or a state official whose name and address have been substituted for the name and address of the child.

Recovery of Excess Payment

If for some reason a benefit is paid that is larger than the amount allowed under the Plan, the Plan Administrator has the right to recover the excess amount from the person or agency who received it. A Participant receiving benefits must complete any papers requested by the Plan Administrator needed to ensure this right of recovery.

If an overpayment is made to you or your dependent, the Plan Administrator may withhold future benefit payments from the Plan until the overpayment has been collected or, instead, you may be required to reimburse the Plan Administrator in full for the overpayment.

Privilege

The Company and the Plan Administrator may engage attorneys, accountants, actuaries, consultants and others to advise them on issues related to the Plan. When they do so, the advisor's client is the Company or the Plan Administrator, as applicable, and not any Participant, employee, dependent or other individual. Communications between an attorney and a client are "privileged," which means that they may not be disclosed to third parties unless the client waives the privilege. The Company and the Plan Administrator intend and expect to preserve this attorney-client privilege, and all other rights to maintain confidentiality, to the full extent permitted by law. No Participant, employee, dependent or other individual will be permitted to review any communications between the Company or the Plan Administrator (including any of their representatives, agents or delegates) and any of their attorneys or other advisors with respect to whom a privilege applies, unless mandated by a court.

SECTION 19 - ERISA REQUIRED INFORMATION

The Health Care FSA portion of the Plan is a component of the Avnet Group Benefits Plan and is subject to the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). The Dependent Care FSA and Commuter Benefit portion of the Plan is not subject to ERISA. The HSA is not sponsored by the Company and also is not subject to ERISA.

Plan Sponsor and Administrator

Avnet, Inc. is the Plan Sponsor and Plan Administrator of the Avnet Group Benefits Plan and has the discretionary authority to interpret the Plan. You may contact the Plan Administrator at:

Plan Sponsor and Administrator

Avnet, Inc.
2211 S 47th St.
Phoenix, AZ 85034
888-99HR NOW (994-7663)

Type of Administration

The Plan is a self-funded welfare Plan and the administration is provided through one or more third party administrators.

Plan Name	Avnet Group Benefits Plan
Plan Number	510
Employer ID	11-1890605
Play Type	General and Limited Purpose FSA
Plan Year	January 1 – December 31
Plan Administration	Self-Insured
Source of Plan Contributions	Employee and Company
Source of Benefits	General assets of the Company

Collective Bargaining Agreements

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

SECTION 20 - STATEMENT OF ERISA RIGHTS

As a Participant in the plan you are entitled to certain rights and protections under ERISA. ERISA provides that all Participants in a Health Care FSA (General Purpose and Limited Purpose Health FSAs) shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Health Care FSA, including insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) filed by the Plan for the Health Care FSA with the U.S. Department of Labor and available at the Public Disclosure room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the Health Care FSA, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the Health Care FSA's annual financial report. The Plan Administrator is required by law to furnish each person who participates in a Health Care FSA with a copy of this summary annual report.

Continue Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Health Care FSA Participants, ERISA imposes duties upon the people responsible for the operation of the Health Care FSA. The people who operate your Health Care FSA, called "fiduciaries," have a duty to do so prudently and in the interest of you and other Health Care FSA 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 reimbursement from your Health Care FSA 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 Health Care FSA plan documents or the latest annual report from the Health Care FSA and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 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 reimbursement 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 Plan'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, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or 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. You can also 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.)

DEFINITIONS

COBRA - Continuation health coverage as provided under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Code - Internal Revenue Code of 1986, as amended.

Company - Avnet, Inc.

Commuter Benefit – An account in which a Participant sets aside pre-tax dollars to reimburse qualified transit and parking expenses.

Contribution Benefits - The portion of the Plan that permits a Participant to pay his or her share of the cost of coverage under the Company's group health plans on a pre-tax basis

Dependent Care Flexible Spending Account or Dependent Care FSA - A Flexible Spending Account in which a Participant sets aside pre-tax dollars to reimburse qualified dependent care expenses.

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

Flexible Spending Account or FSA - A book-entry account in which a Participant can set aside pre-tax dollars to reimburse qualified health care (a Health Care FSA) and/or dependent care (a Dependent Care FSA) expenses.

FMLA - The Family and Medical Leave Act of 1992, as amended.

General Purpose Health FSA - A Health Care FSA in which a Participant sets aside pre-tax dollars to reimburse any qualified medical care expenses.

Health Care Flexible Spending Account or Health Care FSA - A Flexible Spending Account in which a Participant sets aside pre-tax dollars to reimburse qualified medical care expenses. A Health Care FSA may be either a General Purpose Health FSA or a Limited Purpose Health FSA.

Health Savings Account or HSA - An account in which a Participant enrolls in a qualified high deductible health plan and then sets aside pre-tax dollars to reimburse Qualified HSA Expenses for eligible tax dependents.

HIPAA - The Health Insurance Portability and Accountability Act, as amended.

Limited Purpose Health FSA - A Health Care FSA in which a Participant sets aside pre-tax dollars to reimburse any qualified dental and vision expenses. (Other medical expenses may not be reimbursed by a Limited Purpose Health FSA.)

Participant - An individual who is enrolled in the Plan.

Plan - The Avnet Flexible Benefits Plan, as set forth in this document and amended from time to time.

QMSCO - A qualified medical child support order.

Qualified HSA Expenses - Expenses eligible for reimbursement from an HSA as defined under the "What Expenses Can be Reimbursed by your HSA?" section of this document.

Reimbursement Benefits - The portion of the Plan that permits a Participant to set aside pre-tax dollars in an FSA or HSA to reimburse qualified healthcare, dependent care expenses, and/or commuter expenses.

Spouse - A Spouse, for purposes of the Plan, 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.

USERRA - The Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

APPENDIX A - HEALTH CARE FSA COVERED EXPENSES

Below are some of the health care expenses the IRS considers deductible for income tax purposes, and therefore, generally eligible for reimbursement from your Health Care FSA. Expenses eligible for reimbursement from your Limited Purpose Health FSA include only dental and vision expenses.

Examples of covered expenses include, but are not limited to:

- acupuncture;
- charges for amounts over group health plan maximums or expenses over the usual and customary fee allowed by the plan;
- chiropractic services;
- copayments, deductibles and coinsurance;
- dental and orthodontic services;
- durable medical equipment;
- hearing aids and hearing aid batteries;
- insulin;
- over-the-counter medications used for the treatment of illness or injury, if prescribed by a doctor;
- prescription drugs;
- smoking cessation products, if prescribed by a doctor; and
- vision care, including eye exams, eyeglasses, and contact lenses.

Examples of excluded items that cannot be reimbursed through your Health Care FSA include, but are not limited to:

- premiums for a group health plan, including COBRA coverage (whether the Company's plan or that of another employer) or other health insurance;
- cosmetic surgery (with certain limited exceptions based on medical conditions);
- electrolysis or laser hair removal;
- expenses reimbursed through any health insurance policy or plan, such as the Company's or another employer's group health plan or Medicare;
- hair transplant;
- health club membership;
- massage therapy;
- over-the-counter medications, in the absence of a prescription;
- teeth whitening; and
- vitamins and supplements.

For additional information about covered expenses, see IRS Publication 502 or consult a qualified tax advisor.

APPENDIX B - DEPENDENT CARE FSA COVERED EXPENSES

Below are some of the dependent care expenses the IRS generally considers eligible for reimbursement from your Dependent Care FSA.

Examples of approved items include, but are not limited to:

- care in your home, someone else's home or in a child care or adult care center;
- care provided by someone other than your Spouse, your child under age 19, the parent of your qualifying dependent who is a child under age 13, or any other person who is a dependent for federal income tax purposes (e.g., your mother-in-law who lives with you);
- education expenses for a child not yet in kindergarten, such as a preschool, if the amount you pay for education cannot be separated from the cost of care;
- wages paid to a housekeeper whose duties include providing care for a qualifying dependent; and
- preschool, after-school or summer day camp programs.

Examples of items that are not eligible for reimbursement include, but are not limited to:

- care for a child over age 13;
- kindergarten expenses;
- food and clothing;
- overnight camps;
- babysitting for an evening out; and
- education expenses for the first grade and higher grades.

For additional information about covered expenses, see IRS Publication 503 or consult a qualified tax advisor.

APPENDIX C - COMMUTER BENEFIT COVERED EXPENSES

Below are some of the commuter expenses the IRS generally considers eligible for reimbursement from your Commuter Benefits:

- Eligible transit expenses include a metro or transit pass, token fare card, or voucher for transportation via:
  - Bus
  - Train
  - Subway
  - Ferry
  - Light rail
  - Vanpool costs – a van is usually considered a commuter vehicle if:
    - It seats at least 6 adults (not including the driver),
    - At least 80 percent of the vehicle's mileage is used to transport employees to and from their place of employment, and
    - At least half of the adults are employees going to and from work.

- Eligible parking expenses include:
  - Parking expenses at or near your worksite
  - Parking expenses at a location where you commute to work, either by mass transit, qualifying commercial or noncommercial highway vehicle, or car pool
  - Vendor parking lots
  - Garages

Examples of items that are not eligible for reimbursement include, but are not limited to:

- Airfare
- Business meeting parking, tolls or driving-related costs
- Gas
- Tunnel, bridge or highway tolls
- Parking on or near your residential property

Expenses for anyone other than the employee

For additional information about covered expenses, see IRS Publication 5137 or consult a qualified tax advisor.

APPENDIX D - HIPAA PRIVACY PLAN AMENDMENT

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

- HSA 70 Medical Plan,
- HSA 80 Medical Plan,
- Classic 70 Medical Plan,
- Out-of-Area Medical Plan,
- Kaiser Permanente Medical Plan,
- Hawaii Medical Plan,
- Employee Assistance Program/Behavioral Health,
- Vision Service Plan,
- PPO Dental,
- Copay Dental, and
- Flexible Spending Account.

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

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

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

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

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

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

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

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

a) Coverage for accident, disability income insurance, or any combination thereof.

b) Coverage issued as a supplement to liability insurance.

c) Liability insurance, including general liability insurance and automobile liability insurance.

d) Worker's compensation or similar insurance.

e) Automobile medical payment insurance.

f) Credit-only insurance.

g) Coverage for on-site medical clinics.

h) Other similar insurance coverage under which benefits for medical care are secondary or incidental to other insurance benefits.

[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.

i) Coverage for life insurance.

j) Dependent care reimbursement account features of a Plan.

"Insurer" means either or both of:

a) An insurance company, insurance service, or insurance organization that is licensed to engage in the business of insurance in a state, is subject to state laws that regulate insurance, and is providing coverage under the Plan.

b) A federally-qualified health maintenance organization, an organization recognized as a health maintenance organization under applicable state law, or a similar organization regulated for solvency under applicable state law in the same manner and to the same extent as a health maintenance organization that is providing coverage under the Plan.

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

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

a) Quality assessment and improvement activities.

b) Population-based activities relating to improving health or reducing health care costs, protocol development, case management, disease management, care coordination, and contacting health care providers and enrollees with information about treatment alternatives and related functions.

c) Rating provider and plan performance, including accreditation, certification, licensing, or credentialing activities.

d) Fraud and abuse detection, and compliance activities.

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

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

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

h) Business management and general administrative activities, including:

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

i) Resolution of internal grievances.

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

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

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

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

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

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

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

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

d) Determining whether particular expenses are covered under the Plan with respect to individuals (including, without limitation, coordination of benefits determinations, cost sharing determinations, subrogation determinations, medical necessity determinations, and all other determinations necessary or appropriate to determine whether Plan benefits are payable for particular health benefit claims) and making claims payments based on those determinations.

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

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

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

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

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

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

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

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

m) Determining required employee contributions under the Plan.

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

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

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

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

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

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

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

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

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

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

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

2. Use and Disclosure of Certain PHI by Plan Sponsor

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

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

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

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

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

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

d) Plan Sponsor shall require its agents, including subcontractors, to whom the Plan Sponsor provides Disclosed PHI, to agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such Disclosed PHI.

e) Plan Sponsor shall not use or disclose the Disclosed PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

f) Plan Sponsor shall report to the Plan any Security Incident (as that term is defined in 45 C.F.R. §164.403) or any use or disclosure of the Disclosed PHI of which the Plan Sponsor becomes aware that is inconsistent with the uses or disclosures provided for in the documents setting out the terms of the Plan.

g) Plan Sponsor will make the Disclosed PHI available to allow participants access to their PHI in accordance with §164.524 of the Privacy Rules.

h) Plan Sponsor will make the Disclosed PHI available for amendment, and incorporate any amendments to such Disclosed PHI, in accordance with §164.526 of the Privacy Rules.

i) Plan Sponsor will make available, in accordance with §164.528 of the Privacy Rules, the information required to provide an accounting of disclosures of the Disclosed PHI made by the Plan Sponsor, its agents or subcontractors.

j) Plan Sponsor will make its internal practices, books, and records relating to the use and disclosure of the Disclosed PHI available to the Secretary for purposes of determining compliance by the Plan with the Privacy Rules.

k) If feasible, the Plan Sponsor will return to the Plan, or destroy, all Disclosed PHI maintained by the Plan Sponsor in any form, and retain no copies, when such Disclosed PHI is no longer needed for the purpose for which disclosure of it was made to the Plan Sponsor, except that, if such return or destruction is not feasible, the Plan Sponsor shall instead limit further uses and disclosures of the information by the Plan Sponsor, its agents and subcontractors to uses and disclosures required by law and those made for the purposes that make return or destruction of the Disclosed PHI infeasible.

4. Disclosure of PHI to Plan Sponsor

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

5. Adequate Separation

a) No one who is an employee, or is otherwise under the control, of the Plan Sponsor, other than the Designated Employees, may have access to the Disclosed PHI.

b) The Plan Sponsor shall implement appropriate administrative, physical and technical safeguards to prohibit its employees and other persons under its control, other than the Designated Employees, from accessing the Disclosed PHI.

c) The Designated Employees may have access to and use the Disclosed PHI only for the purposes specified in Section 3(a) hereof.

d) The Plan Sponsor shall implement appropriate administrative, physical, and technical safeguards to prohibit and/or prevent Designated Employees from accessing the Disclosed PHI for purposes other than those specified in Section 3(a) hereof.

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

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

APPENDIX E – AVNET GROUP BENEFITS PLAN AND AVNET INSURED PLAN COMPONENTS AND DESIGNATED EMPLOYEES

(Revised January 1, 2018)

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

- HSA 70 Medical Plan,
- HSA 80 Medical Plan,
- Classic 70 Medical Plan,
- Out-of-Area Medical Plan,
- Kaiser Permanente Medical Plan,
- Hawaii Medical Plan,
- Employee Assistance Program,
- Vision Service Plan,
- PPO Dental,
- Copay Dental,
- Health Care Flexible Spending Account,

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

Designated Employees (Job Title)	Current Incumbent*
Vice President, Global Total Rewards	Roberta Bixhorn
Senior Benefits Manager	Anna Conti
Rewards Advisor	Karen Hamacher
Rewards Advisor	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.*

Rev. 4/18