EXECUTION COPY

Autodesk, Inc.

Group Welfare Plan

and

Summary Plan Description

As Amended and Restated Effective January 1, 2025

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DEFINED TERMS

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INTRODUCTION

Autodesk, Inc. (the "Company") established the Autodesk, Inc., Group Welfare Plan, ("the Plan"), effective January 1, 1995, primarily for the benefit of its Eligible Employees. The Plan is an "employee welfare benefit plan" under ERISA Section 3(l). It is the intent of the Company to maintain the Plan for the exclusive benefit of the Eligible Employees of the Company and its participating affiliates. The Plan is hereby amended and restated to read as set forth herein effective January 1, 2025. The Plan was previously amended and restated effective January 1, 2012, January 1, 2013, and January 2015, and amended effective January 1, 2016, January 1, 2017, and January 1, 2023. The Plan provides the following coverage and/or benefits (referred to in this document as a "**Coverage**").

- Health Benefits. The Plan provides self-funded and insured medical, dental, vision, employee assistance program ("**EAP**"), and wellness program benefits.

- Welfare Benefits. The plan provides insured basic life, voluntary (or supplemental) life, voluntary dependent life, employee assistance, long-term disability ("**LTD**"), accidental death and dismemberment ("**AD&D**") insurance, legal and travel accident.

The insurance carriers and third party administrators prepare booklets to describe the coverage and benefits available under the Coverage(s) they insure or administer. Those booklets, referred to throughout this SPD as "**Evidences of Coverage**" or "**Benefit Booklets**" contain important information about the Coverages. The terms of the Evidences of Coverage or Benefit Booklets are hereby incorporated by reference. This Plan and Summary Plan Description document and its Appendices, along with the Insurance Policies, Evidences of Coverage, Benefit Booklets and other documents described in Appendix 1 and Appendix 2, any other documents (such as an insurance or health maintenance organization contract) pursuant to which benefits are provided hereunder and any that apply to the Coverage(s) in which a Participant is enrolled, and any Summaries of Material Modifications ("**SMMs**") thereto, constitute the official Plan document and Summary Plan Description (as that term is defined by ERISA) for the Autodesk, Inc., Group Welfare Plan. You should read and keep these documents together.

The Plan is designed to be an "employee welfare benefit plan," as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974, as amended ("**ERISA**") and, accordingly, the Plan is governed by ERISA.

This Plan and Summary Plan Description document ("SPD") is generally the official document that legally governs the operation of the Plan. However, if the terms of this Plan and SPD document conflict with the terms of the insurance contracts, policies or Evidence of Coverage booklets provided by an Insurance Company, then the Plan will be interpreted to give effect to those insurance contracts and policies and Evidence of Coverage booklets.

All references to "**Forms**," in this document include any interface approved by the Plan Sponsor and/or Plan Administrator by which you may submit or update information with the Plan, insurance carrier, or third party administrator. This may include, but is not limited to, paper Forms, online Forms, and telephonic data entry processes. Forms also include the online enrollment system used by employees to enter their benefit elections. Employee elections are captured in the online enrollment system and sent to the applicable insurance carriers or third party administrators and the Autodesk payroll system.

The laws relating to employee benefit plans frequently change. In any case in which a Plan provision is inconsistent with any new law, regulation or ruling, the Plan may be administered, at the sole and absolute discretion, of the Plan Administrator, in accordance with the new law, regulation or ruling, regardless of the terms and conditions of the Plan or this Summary Plan Description.

This Plan and Summary Plan Description contains a summary in English of an Eligible Employee's Plan rights, coverage and benefits under the Autodesk, Inc., Group Welfare Plan, Plan No. 505. If you have difficulty understanding any part of this booklet, for assistance please contact **Sr. Manager, AMER Benefits, One Market Street, Suite 400, San Francisco, CA 94105**, via telephone at (**415) 507-5000** or via e-mail at **hr.benefits.us@autodesk.com**. Office hours are generally from **8:00am to 5:00pm PT Monday through Friday**. If there is any conflict or inconsistency between these materials, it is the Plan Administrator's responsibility to interpret the conflicting provisions and determine what Coverage and benefits will be provided under the Plan.

Other Plan materials provided by the Insurance Companies (such as Evidence of Coverage booklets) may contain more detailed provisions. You and your eligible dependents may obtain copies of the Plan and its related documents or examine these documents by contacting the Plan Administrator.

ARTICLE I

ELIGIBILITY AND PARTICIPATION

1.1 Participant Eligibility

Each benefit provided by this Plan has its own eligibility requirement. You are eligible under this Plan if you are eligible for any of these Coverages and you are an "**Eligible Employee**."

(a) An "**Eligible Employee"** includes a regular Autodesk employee on the U.S. payroll regularly scheduled to work at least 20 hours a week. Whether you are regularly scheduled to work 20 hours a week is determined by the Company. Autodesk intends to determine eligibility in accordance with the full-time employee determination rules set forth in Internal Revenue Code Section 4980H for the employer shared responsibility provisions. An employee who was an Eligible Employee but who remains on the Autodesk U.S. payroll pursuant to the terms of a separation agreement authorized by the Autodesk human resources and legal departments shall continue to be considered an Eligible Employee for a period not to exceed 60 days. An employee is on payroll if Autodesk withholds employment taxes from the employee's compensation.

An Eligible Employee does not include (and has not at any time included) any individual during any period he or she is not classified as a common-law employee by Autodesk, without regard to whether such an individual is subsequently determined to have been a common-law employee of Autodesk by any agency, court, or any other entity, during such period. For example, an Eligible Employee does not include any contingent worker whether classified as a temporary worker, an outside service provider, an independent contractor, a consultant, or in some other way.

(b) Not all Eligible Employees are Plan Participants. Some Eligible Employees may be extended the opportunity of participating in this Plan, but may (as determined by the Company) have declined participation (orally, in writing, or otherwise), which means that these persons are not Participants. You may be excluded from the Plan by any other Plan provision. You may be an Eligible Employee under the Plan, but not eligible to participate in all of the Coverages offered under the Plan. Specific eligibility rules may apply to eligibility for a particular Coverage and a person has no right to a particular Coverage unless he or she meets those specific eligibility rules. Your eligibility and the eligibility of your dependents for specific Coverages, as well as the amount, type, and duration of Coverage are determined in accordance with the terms of the applicable insurance contracts or policies, if applicable, and the terms of enrollment of the particular Coverage.

1.2 Dependent Eligibility

(a) For purposes of the Plan, a "**Dependent**" is any individual who qualifies to receive benefits under a Coverage because of that individual's relationship with an Eligible Employee who elects or has elected to become a Participant. **Dependent** means one of the following individuals:

(i) The Eligible Employee's legal Spouse who qualifies as the Eligible Employee's dependent under the provisions of Section 152 of the Code or Domestic Partner.

Domestic Partner as the term is used above, includes Registered Domestic Partners (as described below) and Non-Registered Domestic Partners:

(1) Registered Domestic Partners

(a) Domestic Partners – same-sex and opposite-sex couples who have registered with any state or local government domestic partnership registry; or

(b) State Registered Domestic Partners – two individuals who are Registered Domestic Partners with the state, in a state in which they reside pursuant to a domestic partner registration law; or

(c) Civil Union Partners – two individuals who are in a legally recognized Civil Union with the state, in a state in which they reside pursuant to a civil union law.

(2) Non-Registered Domestic Partners

Partners not registered or recognized by any legal entity, but who meet the Autodesk domestic partner requirements.

(ii) The Eligible Employee's or Registered Domestic Partner's son, daughter, stepson, stepdaughter, or eligible foster child under the provisions of Section 152(f) of the Code who has not yet attained the age of 26.

(1) Except for the CIGNA Travel Medical plan which covers the Eligible Employee's son, daughter, stepson, stepdaughter, or eligible foster child under the provisions of Section 152(f) of the Code who has not yet attained the age of 21 or, if a regular student, who has not yet attained the age of 25.

(iii) The Eligible Employee's or Registered Domestic Partner's son, daughter, stepson, stepdaughter, or eligible foster child under the provisions of Section 152(f) of the Code who has attained the age of 26 and is disabled.

(iv) A child for whom the Eligible Employee or Registered Domestic Partner has a Qualified Medical Child Support Order ("QMCSO") as defined in Section 609 of ERISA.

(v) Any other children the Eligible Employee financially supports who live with the Eligible Employee in a parent-child relationship and whom the Eligible Employee claims as dependents on the Eligible Employee's federal income tax return.

(b) To enroll a Non-Registered Domestic Partner, you and your partner must be:

(i) Each other's sole partner and intend to remain so indefinitely;

(ii) Engaged in a committed relationship of mutual caring and support;

(iii) Jointly responsible for each other's common welfare and financial obligations;

(iv) Both at least 18 years of age and mentally competent to consent to a contract;

(v) Not related by blood to a degree that could prohibit legal marriage in the state in which you legally reside;

(vi) Maintaining the same residence(s) and intend to do so indefinitely; and

(vii) Not married to or legally separated from anyone else.

1.3 When Participation Begins

(a) You will become a "**Participant**" in a specific benefit after you have elected that particular Coverage as described in Article II. The amount, if any, that you are required to contribute in order to receive a specific Coverage will be described at initial eligibility and during any open enrollment. You may pay for some Coverages with pre-tax dollars under the Cafeteria Plan with Flexible Spending Arrangement.

Health Coverages (including medical, dental, and vision) will become effective on your date of hire provided that you enroll by the later of the date you became eligible or the thirtieth (30th) day after you began employment with the Company. Other Coverages will become effective as described in the applicable Benefit Booklet or Evidence of Coverage.

1.4 When Participation Ends

You will cease to be a Participant in the Plan as of the earliest of:

(a) the date on which the Plan terminates; or

(b) the date on which the Coverage terminates; or

(c) the date on which you elect to terminate Coverage;

(d) the earlier of (i) the date you cease to be an Eligible Employee if the specific Coverage's Benefit Booklet or Evidence of Coverage limits coverage to Eligible Employees (and their Dependents) without extending coverage through the end of the month, or (ii) the end of the month during which you cease to be an Eligible Employee, or

(e) the end of the period for which you last made a required contribution for the cost of the Coverage; or

(f) the date you revoke your election to participate or fail to timely make the required premium payments;

(g) the loss of eligibility for the Plan or a Coverage; or

(h) The date Coverage is terminated pursuant to Section 6.2 of this Plan and SPD.

1.5 FMLA Leave

If you go on a qualifying unpaid leave under the Family and Medical Leave Act of 1993, as amended (the "**FMLA**"), to the extent required by the FMLA, you will continue to be treated as an Eligible Employee and a Participant, and the Company will continue to maintain your health benefits on the same terms and conditions as if you were still an active Eligible Employee, generally for the period of the FMLA leave. If you continue health coverage during FMLA leave, you will pay monthly with after-tax dollars directly to the Benefits Department while on unpaid leave.

If your health coverage ceases while on FMLA leave for failure to pay your share of premium cost, then you will be permitted to re-enter the Plan upon return from such FMLA leave on the same basis with respect to health benefit coverage as if you were participating in the Plan prior to the FMLA leave, or as otherwise required by the FMLA.

If you commence an FMLA leave, then your entitlement to non-health benefits during the FMLA leave shall be determined by the Plan Administrator's policy for providing such Coverages when the Participant is on a leave that is not a FMLA leave, as described in Section 1.7.

1.6 USERRA

Leave. If you are absent from employment with the Company because you are in "uniformed service," as that term is defined by the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended ("**USERRA**"), you may elect to continue participation in the Plan, as required by USERRA. The coverage period shall continue until the earliest of (a) the completion of the period required by USERRA; (b) the date you fail to pay required premiums (unless timely payment is impossible, unreasonable, or prevented by military necessity); (c) the date the Company terminates all group health plan coverage; or (d) the date you fail to apply for reinstatement or to return to employment with the Company within the period required by USERRA. You are responsible for making the required premium payments and contributions under the Plan during the period that you are in uniformed service. The manner in which such premium payments and contributions are made shall be determined by the Plan Administrator, in a manner similar to Section 1.5 (regarding the payment of premiums and contributions during FMLA leave) during the first thirty (30) days of uniformed service, and in a manner similar to COBRA (including the determination of the applicable premium) for uniformed service of thirty-one (31) days or more. This continuation coverage will run concurrently with any other applicable continuation coverage period (e.g., under FMLA and COBRA), to the extent allowed by law. If your coverage under the Plan is terminated on account of your being in uniformed service, and you are later reinstated, you shall not be subject to a new exclusion or waiting period requirement imposed by the Plan; provided however, that such requirements would not have been imposed if coverage had not been terminated as a result of the uniformed service, unless otherwise permitted by law. If you have any questions about USERRA continuation coverage, please contact the Plan Administrator. You may also contact the Department of Labor or visit the Department of Labor's Veterans' Employment and Training Service (VETS) website at www.dol.gov/vets. (Addresses and phone numbers for the Department of Labor are available on the VETS website.)

If you commence an USERRA leave, then your entitlement to non-health benefits during the leave shall be determined by the Plan Administrator's policy for providing such Coverages when the Participant is on a leave that is not an USERRA leave, as described in Section 1.7. When returning from an USERRA leave, you shall be eligible to re-enroll in any Coverages offered under the Plan in accordance with the requirements of USERRA, as applicable, or as otherwise required by applicable law, and in addition, as otherwise permitted under the terms of the applicable Coverage.

1.7 Leave Other Than FMLA or USERRA Leave

(a) Personal Leave. If you commence an unpaid personal leave, you may continue to be treated as an Eligible Employee and a Participant in health (medical, dental and vision) and non-health benefits. You may choose to continue any of your current Coverages, but you will be responsible for the employee and employer portion. If you continue coverage, you will pay monthly with after-tax dollars directly to the Benefits Department while on unpaid leave.

If your health coverage ceases while on leave for failure to pay your share of premium cost, then you will be permitted to re-enter the Plan upon return from such leave on the same basis with respect to health benefit coverage as if you were participating in the Plan prior to the leave.

(b) Other Leave. If you commence an unpaid leave other than an FMLA or an USERRA or a Personal leave then you will continue to be treated as an Eligible Employee and a Participant in health (medical, dental and vision) and non-health benefits. The Company will continue to maintain your health benefits on the same terms and conditions as if you were still an active Eligible Employee, generally for the period of the leave. If you continue health benefits you will pay monthly with after-tax dollars directly to the Benefits Department while on unpaid leave.

If your health coverage ceases while on leave for failure to pay your share of premium cost, then you will be permitted to re-enter the Plan upon return from such leave on the same basis with respect to health benefit coverage as if you were participating in the Plan prior to the leave.

ARTICLE II

ELECTIONS

2.1 Initial Participation

As a condition of participation, each Eligible Employee shall enroll using the online benefits enrollment system. It is by this election that the Eligible Employee applies to participate in the Plan, allocates his employer contributions, designates the required portion of his Compensation for that Plan Year as Salary Reduction Contributions under the Autodesk, Inc. Cafeteria Plan with Flexible Spending Arrangement, makes a benefit election, and supplies any other pertinent information that the Plan Administrator reasonably requires. The application and any required supporting documents shall be delivered to the Plan Administrator prior to the first day of an Eligible Employee's participation. Notwithstanding the forgoing, with respect to a newly hired Eligible Employee the application and any required supporting documents shall be delivered to the Plan Administrator within 30 calendar days after the Eligible Employee's date of hire.

If you terminate employment and are rehired within thirty (30) days of your termination, you will not be treated as a new Participant and you will automatically be reinstated in your prior elections.

2.2 Annual Election Procedure/Open Enrollment

Generally, prior to the beginning of each Plan Year, the Plan Sponsor will provide the opportunity to make an election through the online enrollment system and specify a period of time (which is commonly referred to as "**Open Enrollment**") to elect benefits. At the beginning of the period, the Plan Sponsor will provide notice of available benefits. Each election must be properly completed within the time specified in the enrollment system (but not later than the beginning of the Plan Year for which Coverage is elected). Unless you are notified otherwise, the Coverages elected will remain in effect during subsequent Plan Years unless you complete a new election. Any changes will take effect at the beginning of the next Plan Year.

2.3 Default Coverages

If you fail to make an active election under this Plan during Open Enrollment with respect to the next Plan Year you shall be deemed to have elected (as applicable): employee-only high deductible medical, PPO Dental and Basic Vision, or the same Coverages under which you were covered (including the same coverage you elected for your Spouse or Domestic Partner and Dependents) in the preceding Plan Year except for any benefits that require affirmative elections, or, in the event that the same Coverages are no longer offered under the Plan, Coverages that are substantially the same as the Coverages elected in the preceding Plan Year except for any benefits that require affirmative elections. In certain circumstances in which a significant change has been made to one or more Coverages, you will be required to make an affirmative election instead of being deemed to have elected the same Coverages.

2.4 Changes in Elections

Any election for Plan pre-tax Coverages may not be changed during the Plan Year, except as provided in the Autodesk, Inc. Cafeteria Plan with Flexible Spending Arrangement. Any election for Plan taxable Coverages may be revoked or changed only to the extent permitted under the applicable insurance contract or policy as described in the insurance carrier's or third party administrator's Evidence of Coverage or Benefit Booklet.

2.5 HIPAA Special Enrollment

The Health Insurance Portability and Accountability Act of 1996, as amended (**"HIPAA**"), provides that if you are eligible for HIPAA Special Enrollment, you, along with certain of your Dependents, may enroll (within a certain number of days following the occurrence of an event as described below) in a Coverage (including medical, dental, or vision coverage) under the Plan before the next Open Enrollment period.

HIPAA Special Enrollment is permitted within thirty (30) days if:

(a) you previously declined coverage for yourself, your Spouse Domestic Partner**,** or your Dependents under the Plan on account of coverage you, your Spouse or Domestic Partner**,** or your Dependents had under other outside health plan coverage, and

(b) that other coverage is lost for reasons of termination of employment, reduction in hours, exhaustion of maximum COBRA coverage, a termination of employer contributions for non-COBRA coverage, or because of death, legal separation, or divorce.

HIPAA Special Enrollment is also permitted within 30 days if you acquire new dependents due to marriage (or becoming eligible as a Domestic Partner as determined by the Plan Administrator), by completing a new election Form within thirty (30) days of the marriage or domestic partnership.

Lastly, HIPAA Special Enrollment is permitted within sixty (60) days as follows:

(a) you acquire a new dependent on account of birth, adoption or placement for adoption;

(b) Changes Due to a Change in Medicaid or State CHIP Coverage. Eligible Employees and/or their Dependents who are eligible but not enrolled in medical benefits are entitled to enroll under the following circumstances:

(i) The Eligible Employee's or Dependent's Medicaid or State CHIP coverage has terminated as a result of loss of eligibility and the Eligible Employee requests coverage under the Plan within 60 calendar days after the termination; or

(ii) The Eligible Employee or Dependent becomes eligible for a premium assistance subsidy under Medicaid or a State CHIP, and the Eligible Employee requests coverage under the Plan within 60 calendar days after eligibility is determined.

Coverage due to a HIPAA Special Enrollment generally becomes effective for the next payroll period after your new election Form is processed. However, actual enrollment for Coverage will not occur until the Coverage contract administrator or HMO provider accepts your application. HIPAA Special Enrollment coverage for Dependents newly acquired on account of birth, adoption, or placement for adoption may become retroactively effective as of the date of birth, adoption, or placement for adoption, up to a maximum of sixty (60) days before the actual enrollment date, if enrollment is made after the date of birth, adoption or placement for adoption. If HIPAA Special Enrollment coverage is requested for a Dependent within sixty (60) days prior to that Dependent's birth, adoption, or placement for adoption, coverage for that Dependent will become effective as of the date of the Dependent's actual birth, adoption or placement for adoption.

If you enroll yourself, your Spouse or Domestic Partner, or your Dependents due to a HIPAA Special Enrollment event, you will be permitted to change your prior elections for health care coverage. For example, you may add other previously eligible dependents that you did not initially enroll in the Plan.

Your payroll deductions under the Coverage will change based on any change you make in your health care coverage under the Plan due to a permitted HIPAA Special Enrollment.

2.6 Election Mistakes and Legal Compliance

If the Plan Administrator or Plan Sponsor, as applicable, determines, based on clear and convincing evidence, that an election was a mistake, the Plan Administrator or Plan Sponsor, as applicable, may correct the mistake. The Plan is intended to qualify for tax-favored treatment under Code Sections 79, 105, 125, 129. In some circumstances, a Benefit otherwise payable to a highly compensated individual or key employee or other prohibited group identified in the Code may not be payable without violating the applicable Code Section. The Plan Administrator or Plan Sponsor as applicable, may treat the election associated with the Benefit as a mistake and correct it.

ARTICLE III

BENEFITS

3.1 Self-Funded Health Plan Coverages

The benefits under the Plan's self-funded health Coverages are described in the applicable Summary Plan Descriptions or Benefit Booklets. The self-funded benefits are listed in Appendix 1. The Company shall have the right from time to time to change the Coverages or third party administrators of any one or more self-funded health Coverages.

3.2 Insured Welfare Benefit Plan Coverages

The benefits under the Plan's insured Coverages are described in the applicable Evidences of Coverage or Benefit Booklets. The insurance benefits are listed in Appendix 2. To the extent that insurance or prepaid benefit coverage is procured to provide any of the benefits under this Plan, an Employee's right to such benefits shall be limited to the amounts payable by such insurance, or available under the prepaid program, and the receipt thereof shall be subject to satisfaction of all of the terms, covenants, conditions, rules and regulations of the insurer or prepaid program. The Company shall not have any independent obligation or duty to provide benefits to participants to the extent that such benefits are to be provided by the insurance or prepaid program. The Company shall have the right from time to time to change the Coverages or insurance carriers of any one or more insurance policies.

ARTICLE IV

ELIGIBILITY CLAIMS AND REVIEW PROCEDURES

Any person who has a question regarding eligibility to participate in the Plan should contact the Plan Administrator. If the person is not satisfied with the outcome, they can file a claim by following the procedures set forth below.

4.1 Claims Procedure

If a person has been denied participation in the Plan when they believe they should be eligible, the person can file a written claim with the Plan Administrator. The writing should include the grounds on which the claim is based and any documents, records, written comments or other information that will support the claim. The Plan Administrator will make a determination on the claim within 60 calendar days after the claim is received. However, if there are special circumstances that require additional time, the Plan Administrator will provide written notice of the extension prior to the termination of the initial 60 calendar day period. In such case, the Plan Administrator will make a determination within 120 calendar days after the claim is received. If the Plan Administrator denies the claim for participation in the Plan, in whole or in part, the Plan Administrator will send a written notice explaining the reason(s) for the denial, including references to the specific Plan provision(s) or Company policy upon which the denial was based. If the claim was denied because the claimant did not furnish complete information or documentation, the notice will specify the additional materials or information needed to support the claim and an explanation of why such information or materials are necessary. The notice will also state how and when to request a review of the denied claim and will include a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following denial of the claim on appeal.

4.2 Right of Appeal

If a person's claim for eligibility to participate in the Plan is denied, in whole or in part, may appeal such denial by submitting to the Director, Global Benefits a written request for review of the claim within 60 calendar days after receiving written notice of such denial from the Plan Administrator. The request for review must be in writing and shall set forth all of the grounds upon which it is based, all facts in support thereof and any other matters that the claimant deems pertinent. The claimant shall have the opportunity to submit written comments, documents, records, and other information relating to the claim. Upon request, and free of charge, the claimant will be provided reasonable access to and copies of, all documents, records, and other information Relevant to the claimant's claim that is not privileged or protected.

The Director, Global Benefits will act on each request for a review within 60 calendar days after receipt thereof. However, if there are special circumstances that require additional time, the Director, Global Benefits will provide written notice of the extension prior to the termination of the initial 60 calendar day period. In such case, the Director, Global Benefits will make a determination within 120 calendar days after the appeal is received.

The Director, Global Benefits will either reverse the earlier decision and permit participation in the Plan or deny the appeal. In the event that the Director, Global Benefits confirms the denial of the claim, in whole or in part, the Director, Global Benefits will give written notice of its decision to the claimant. The notice will set forth, in a manner calculated to be understood by the claimant, the following information:

(1) The specific reasons for the denial and the specific Plan provision(s) or Company policy on which the denial is based; and

(2) A statement that, upon request, and free of charge, the claimant will be provided reasonable access to and copies of, all documents, records, and other information Relevant to the claimant's claim that is not privileged or protected; and

(3) A statement of the claimant's right to bring a civil action under Section 502(a) of ERISA.

The Director, Global Benefits may require the claimant to submit (at the claimant's expense) additional information, documents or other material that may be necessary for the review.

ARTICLE V

CLAIMS FOR BENEFITS

In order for you or your beneficiary to claim benefits under the Plan, you or beneficiary must use the Plan's claims procedures, as set forth in Appendix 3. The claims procedures for coverage or benefits under insured Coverages are generally as described in the claims procedures of the applicable Evidences of Coverage or Benefit Booklets. Please note that in all cases, *you or your beneficiary must generally exhaust the Plan's claims procedures prior to bringing any legal action to obtain Plan Coverage or benefits.*

ARTICLE VI

CIRCUMSTANCES THAT MAY LIMIT, TERMINATE, OR REDUCE BENEFITS

6.1 In General

Participation in the Plan will terminate upon the occurrence of any of the events listed in Section 1.4, and as otherwise described in the applicable Evidences of Coverage or Benefit Booklets. Other circumstances may result in the termination, reduction, loss, offset, or denial of benefits including (but not limited to), exclusions for certain medical procedures, limitations on preventive care, limitations of coverage for new drugs, termination of coverage for false representations (as described in Section 6.2), and rights of recovery or reimbursement (as described in Article VII). Benefits under a particular Coverage may also be subject to coordination of benefits if you or your beneficiary has coverage under another plan. Benefits under certain Coverages may be subject to utilization review or similar policies that may limit benefits. Some income replacement benefits will be reduced by income that you receive from other sources. Refer to the applicable Evidences of Coverage or Benefit Booklets for more information about the circumstances which may affect benefits under particular Coverages. The Plan is intended to qualify for tax favored treatment under Code Sections 105 and 79. In some circumstances, a Benefit otherwise payable to a highly compensated individual or key employee or other prohibited group identified in the Code may not be payable without violating the applicable Code Section. Such a Benefit may be reduced or eliminated as necessary to avoid violating the Code requirements. The Plan Administrator has discretion to reduce or eliminate benefits prospectively to comply with such requirements or may correct retroactively treating the benefit as a mistake.

6.2 Termination of Coverage for Fraud or Making an Intentional Misrepresentation of Material Fact

If any individual commits fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the Plan, the Plan Administrator has the right to permanently terminate coverage for the individual and his or her dependents. Fraud includes (but is not limited to) submitting falsified claims. An intentional misrepresentation of material fact includes (but is not limited to) covering an individual who is not eligible to participate in the Plan (for example, adding a Spouse before the date of marriage or continuing to cover a former Spouse after a divorce, or adding a child who does not meet the Plan's definition of an eligible dependent). The Plan Administrator may also seek reimbursement for all claims or expenses paid by the Plan as a result of the fraud or intentional misrepresentation of material fact, and may reduce future benefits as an offset for amounts that should be reimbursed or pursue legal action against the individual.

Thirty days written notice will be provided in the event of termination of coverage for fraud or making an intentional misrepresentation of material fact.

6.3 Coordination of Benefits

(a) Except as otherwise described in an applicable Evidence of Coverage or Benefits Booklet, in the event that a Participant is entitled to benefits from another plan or policy or medical benefits under workers compensation, benefits under this Plan may be reduced to an amount, which together with all other amounts paid under any other plan or policy, will not exceed the benefits that would in fact be eligible for reimbursement under this Plan.

(b) Medicare benefits will be secondary with respect to covered individuals who receive Plan Coverage by virtue of current employment status during a mandatory Medicare secondary period. In all other circumstances, Medicare benefits will generally be primary and the Plan will coordinate with Medicare to the extent permitted under applicable law.

(c) The Plan will not provide any incentive for TRICARE-eligible employees not to enroll under any group health Coverage that would be primary and no TRICARE-eligible employees will be deprived of the opportunity to participate in a group health Coverage and to receive primary coverage in the same manner and to the same extent as similarly situated employees who are not TRICARE eligible.

ARTICLE VII

SUBROGATION OF CLAIMS AND REIMBURSEMENT

If benefits are paid or payable to you or your Spouse or Domestic Partner (**"Covered Individual"** for purposes of this Article VII) from this Plan or a benefit option, and there is a third party, insurer or guarantor, or any other alternate source that is or may be liable or legally responsible to pay the Covered Individual on account of the illness, disease, injury or condition that resulted in the payment of benefits (a **"Responsible Person"**), then as a condition of participating in the Plan and accepting such benefits, each Covered Individual agrees to the following:

(a) The Plan shall automatically have a first lien upon any recovery that the Covered Individual may receive, may be entitled to receive, or may have paid on his or her account, from a Responsible Person, directly or indirectly, whether by litigation, settlement, or otherwise (a **"Recovery"**). The lien shall be in the amount of benefits paid for the treatment of any illness, disease, injury or condition with respect to which the Responsible Person may be liable to the Covered Individual. The Covered Individual consents to this lien and agrees to cooperate with the Plan or its agents or assignees to enforce any rights that the Plan may have with respect to any Recovery. The Covered Individual's failure to acknowledge the Plan's lien shall be grounds for termination of future benefit payments from a benefit option and the Plan and, accordingly, such Covered Individual may be denied future coverage under such benefit option and the Plan.

(b) The Plan shall have a specific and first right of reimbursement, up to the amount of the Plan's lien, out of the proceeds of any Recovery that a Covered Individual may receive or may be entitled to receive. The Covered Individual shall reimburse the Plan, in full and as a first priority, for benefits provided or to be provided by the benefit option, immediately upon collecting any Recovery from a Responsible Person or receiving the benefit of such Recovery. If the Covered Individual is a minor, then any amount recovered by the minor or the minor's representative shall also be subject to the subrogation and reimbursement provisions in this Section 6.20, regardless of state law and regardless of whether the minor's representative has access or control of any covered funds. In the event that any dispute exists over entitlement to the Recovery, the Covered Individual agrees to segregate any Recovery (up to the amount of the Plan's lien) in a separate account, and shall preserve such Recovery so that the Plan can enforce its lien and so that any disputes as to entitlement can be resolved.

(c) The Plan shall be entitled to equitable relief, including without limitation the imposition of a constructive trust or an injunction, to the extent necessary to enforce the Plan's lien and/or to obtain (or preclude the transfer, dissipation or disbursement of) such portion of any Recovery in which the Plan may have a right or interest. The Plan shall be entitled to enforce its lien even if the Recovery is less than the actual loss suffered by the Covered Individual.

(d) A Covered Individual shall not, without the Plan's written consent, assign any right, claim or cause of action against a Responsible Person to recover for any illness, disease, injury or condition on account of which benefits were paid by the Plan.

(e) If a claim is asserted against any Responsible Person by or on behalf of a Covered Individual, the Covered Individual must advise the Plan in writing of that fact within sixty (60) days of the date when the Covered Individual (or his or her authorized representative) first acts to assert a claim against the Responsible Person (for example, by sending notice of the claim or by submitting or filing a claim). The Plan shall be entitled to intervene and participate in such action, and to record a notice of payment of

benefits, which shall constitute a lien on any judgment recovered less a pro-rata share of court costs (but not attorneys' fees).

(f) If a Covered Individual (or the estate of a Covered Individual) fails, refuses or is unable to institute legal action against a Responsible Person, then the Plan shall have the right, in its sole and absolute discretion and at its option, to become subrogated to, and thereby assume and prosecute, the Covered Individual's claim (or the claim of the Covered Individual's estate) against any Responsible Person in order to secure the Plan's right of recovery of its payments and expenses regarding services provided under a benefit option. The Plan shall be entitled to prosecute such a claim in the name of the Covered Individual (or the Covered Individual's estate), with or without specific consent. The Plan shall be entitled to retain from any judgment or settlement with a Responsible Person the amount of benefits paid or to be paid to the Covered Individual (or the Covered Individual's estate), together with all court costs and attorneys' fees.

(g) The Covered Individual shall furnish such information and assistance, execute and deliver such instruments and papers, and take such other actions as the Plan or its agents or assignees may require to secure the rights of the Plan under this Section 6.20 and/or facilitate the enforcement of the Plan's rights or interests. The Covered Individual shall not, without the prior written consent of the Plan or its agents or assignees (as may be applicable), take any action that may prejudice the Plan's rights or interests respecting subrogation or reimbursement, including without limitation disbursing or dissipating any Recovery, or releasing or compromising any claim against a Responsible Person as to which the Plan may have an interest. Failing to advise the Plan of the assertion of a claim against a Responsible Person, failing to cooperate with the Plan or its agents or assignees, disbursing, transferring or dissipating any Recovery to which the Plan has a claim or upon which the Plan has a lien, or taking any action that prejudices the Plan's rights or interests relating to subrogation or reimbursement, would be a material breach of the Plan and shall result in the Covered Individual's being personally responsible for compensating the Plan for any losses that may result from such acts or omissions.

(h) Each Covered Individual shall fully cooperate with and abide by the terms of the benefit option and this Plan, including the provisions of this Section 6.20. The Plan shall have the right to withhold payment of claims and/or benefits pending the resolution of disputes relating to subrogation or reimbursement.

(i) The Plan's rights of subrogation and reimbursement shall have first priority and shall not be reduced for any reason, including the make-whole doctrine; comparative or contributory fault; the common fund doctrine; because another party is liable only in part; because the other party's resources or insurance may be limited; or to share in a pro rata allocation of a Covered Individual's fees and costs (including attorneys' fees) incurred in pursuit of a claim. The Plan is entitled to recover from the Covered Individual the value of all services provided and paid for by or on behalf of the Plan, when the Covered Individual is reimbursed or paid for the cost of care by a Responsible Person. The Plan will not apportion recoveries and shall remain entitled to one hundred percent (100%) reimbursement, from any Recovery, for all benefits provided to the Covered Individual, regardless of whether the Covered Individual obtains a full or partial recovery (i.e., is "made whole"), regardless of whether the Recovery is a settlement or award, and regardless of the attorneys' fees and costs incurred by the Covered Individual in seeking the Recovery from the Responsible Person. Any Recovery received by or on behalf of a Covered Individual shall first be used to reimburse the expenses paid by the Plan (including attorneys' fees and court costs, in the event the Plan brings suit in the name of the Covered Individual).

(j) A Covered Individual might receive payments through the Plan that exceed the payments to which the Covered Individual is legally entitled under the Plan. Such payments, to the

extent that they exceed the amount to which the Covered Individual is legally entitled under the Plan, are hereinafter referred to as **"Overpayments"**. In the event that a Covered Individual receives an Overpayment, (i) the Overpayment shall belong to the Plan; (ii) the Covered Individual shall not have any right to retain the Overpayment; (iii) the Covered Individual shall segregate and shall not disburse or dissipate the Overpayment, so that the Overpayment can be returned to the Plan and any dispute over entitlement to the Overpayment can be resolved; (iv) the Covered Individual shall be required to return the Overpayment to the Plan; (v) the Covered Individual shall cooperate fully with efforts to recover the Overpayment; (vi) the Plan shall automatically have a lien upon any monies paid to the Covered Individual by the Plan in the amount of the Overpayment; and (vii) the Plan shall be entitled, at its option and in its sole and absolute discretion, to recoupment by withholding and retaining any monies payable to the Covered Individual, up to the amount of the Overpayment.

(k) To the extent that any portion of this Section 6.20 of the Plan and SPD is inconsistent with applicable law in whole or in part, the inconsistent provision shall be construed so that it is given effect to the maximum extent permitted by applicable law, and all other provisions of this Section 6.20 shall remain in full force and effect. Thus, for example, if an applicable law were to limit the amount of the lien provided for in the first bullet above in this Section 6.20, then the lien shall be enforceable in the greatest amount allowable consistent with such law.

(l) The Covered Individual acknowledges and agrees that this Section 6.20, and any action taken pursuant to its provisions, is intended to restore and preserve the status quo ante and to avoid duplicative or undeserved recovery by the Covered Individual.

(m) For purposes of this Subrogation of Claims and Reimbursement provision, any action, right, or entitlement of the Plan may be taken, asserted, or enforced by the Plan's fiduciary.

PLEASE REFER TO THE EVIDENCE OF COVERAGE DOCUMENTS AND BENEFIT BOOKLETS PROVIDED BY EACH INSURANCE COMPANY OR CONTRACT ADMINISTRATOR FOR MORE INFORMATION ON SUBROGATION AND REIMBURSEMENT.

ARTICLE VIII

FACILITY OF PAYMENT

If any benefits of this Plan are payable to the estate of a Participant or to a Dependent who is a minor or otherwise not competent to give a valid release, the Plan may pay such benefits to any relative or other person or persons whom the Plan determines to have accepted competent responsibility for the care of such Participant or Dependent or the administration of the Participant's estate. Any payment made by the Plan in good faith pursuant to this provision shall fully discharge the Plan and the Company to the extent of such payment.

ARTICLE IX

AMENDMENTS AND TERMINATION

9.1 Amendments

The Company reserves the right to amend the Plan, in whole or in part, at any time, for any reason, without notice and even if currently payable benefits are reduced or eliminated. No person has any vested right to benefits under this Plan.

9.2 Benefits Provided Through Third Parties

In the case of any benefit provided pursuant to any insurance policy or other contract with a third party, the Company may amend the Plan by changing insurers, third party administrators, policies, or contracts without changing the language of this Plan document, provided that copies of the contracts or policies are filed with the Plan documents and the Participants are reasonably informed (to the extent required by law) as to the effects of any such changes. If there is any perceived conflict or inconsistency at any given point in time among the description of benefits contained in the contract or policy and the other Plan documents, the terms of the contract or policy shall control.

9.3 Termination

The Company reserves the right to terminate the Plan, in whole or in part, at any time. In the event of a Plan termination, Salary Reduction Contributions and Company Contributions will cease. Thereafter neither the Company nor any of its Eligible Employees shall have any further financial obligations under the Plan except such that have accrued up to the date of termination and have not been satisfied.

ARTICLE X

GENERAL PLAN INFORMATION

10.1 Information to Be Furnished

You must provide the Company and the Plan Administrator or Plan Sponsor with any information and evidence and must sign any documents that the Plan Administrator or Plan Sponsor may reasonably request for the administration of the Plan.

10.2 Address and Notice

You, as a Participant in the Plan or Spouse or Domestic Partner of an Eligible Employee, must provide the Plan Administrator and the Company your mailing address when requested to do so. A communication, statement, or notice addressed to you at your last known address as filed with the Plan Administrator and/or Company will be binding on you for all purposes under the Program, and neither the Company, nor the Plan Administrator shall be obligated to conduct any further search to determine how you may be contacted.

10.3 Plan Records

The records of the Company with respect to any person's employment, employment history, absences, illnesses, and all other relevant matters are conclusive for purposes of the administration of the Plan.

10.4 Plan Representations

Except as otherwise provided in the Plan, no one, including a Participant, may rely on any statement or representation or opinion of any Company official or other person that alters, modifies, amends, or is inconsistent with the written terms of the official plan documents of the Plan. This is true regardless of whether the statement or representation is oral, written, electronic, or otherwise.

10.5 Indemnification of Company by Participants and Beneficiaries

If you receive one or more payments or reimbursements in connection with a plan or program offered under the Plan that appeared to be, but are not, reimbursable under the Plan, you indemnify or hold harmless and reimburse the Company for any liability the Company incurs for failure to withhold income or Social Security tax from those payments or reimbursements. However, any such indemnification and reimbursement will not be greater than the following: the additional income tax that you would have owed if the payments or reimbursements had been made to you as regular cash compensation, plus your share of any Social Security tax that would have been paid on that compensation, less any such additional income and Social Security tax actually paid by you.

10.6 No Guarantee of Outcomes

The Plan does not provide health-related diagnoses, treatments, or services, although it pays for them if its requirements are met, subject to the limitations it imposes. Neither the Company, the Plan Sponsor, the Plan Administrator, nor any of their delegates, agents, or affiliates guarantees any medical results or outcomes or is responsible for them or makes any express or implied warranties concerning the outcome of any covered services or supplies.

10.7 Limitation of Rights

Neither the establishment nor any amendment of the Plan, nor the payment of any benefits under the Plan, will be construed as giving to you or any other person any legal or equitable right against the Company, Plan Sponsor or the Plan Administrator, except as provided in the official plan documents of the Plan.

10.8 Communications

All communications (including, without limitation, all notices, consents, requests, elections and online enrollment elections) claiming rights, coverage or benefits under this Plan must contain the content, be delivered within the deadlines, be given by the means and manner, satisfy all requirements, and will become effective following receipt, in each case as prescribed by the Company, the Plan Sponsor, the Plan Administrator, the Claims Administrator, the Appeals Administrator or their authorized delegates, as applicable (or, to the extent not prescribed, as may be acceptable to them). The Company, the Plan Sponsor, the Plan Administrator, the Claims Administrator, the Appeals Administrator or their authorized delegates, without liability, may disregard any communication made otherwise. Every reference in this Plan to "written" communications shall also be deemed to be a reference to written substitutes (e.g., e-mail or other electronic communications) acceptable to the Company, the Plan Sponsor, the Plan Administrator, the Claims Administrator, the Appeals Administrator or their authorized delegates, as applicable, for the type of communication involved.

10.9 Plan Administrator

Within the meaning of ERISA, the Plan Administrator is the Company. The name, business address, and business telephone number are provided in Article XII. The Plan Administrator is the Plan's "named fiduciary" within the meaning of ERISA Section 402(a)(2), except that the Claims Administrator and Appeals Administrator, in each case if different from the Plan Administrator, shall be the named fiduciary with respect to claims for benefits and review of denied claims to the extent responsibility for such claims and appeals has been assumed by the Claims Administrator and Appeals Administrator. In general, the Plan Administrator is the sole judge of the application and interpretation of the Plan, and has the full discretionary authority to administer and interpret the Plan, to resolve disputed issues of fact, and to make determinations regarding eligibility for coverage and benefits under the Plan. The Plan Administrator has the authority to delegate certain of its powers and duties to a third party. A delegation under this Section 11.9 shall be accomplished by a written instrument executed by the Plan Administrator, specifying responsibilities delegated and the fiduciary responsibilities allocated to such delegate. The delegation of such responsibilities shall be effective upon the date specified in the delegation, subject to written acceptance by the delegate. The Plan Administrator has delegated certain administrative functions under the Plan to various service providers. As the Plan Administrator's delegate, these service providers have the authority to make decisions under the Plan relating to benefit claims, including determinations as to the medical necessity of any service or supply. Any determination by the Plan Administrator or its authorized delegate in all matters relating to the Plan (including, but not limited to, eligibility for benefits, Plan interpretations, and disputed issues of fact) are final and binding on all persons and entities and generally will not be overturned by a court of law.

10.10 Plan Sponsor

Within the meaning of ERISA, the Plan Sponsor is the Company. As the Plan Sponsor, the Company has full discretionary authority to administer and interpret the Plan. Any authorized delegate acting on behalf of the Plan Sponsor shall have full discretionary authority to carry out the Plan Sponsor's duties. Any determination by the Plan Sponsor or its authorized delegate in all matters relating to the Plan (including, but not limited to, eligibility for benefits, Plan interpretations, and disputed issues of fact) are final and binding on all persons and entities.

10.11 No Right to Employment

Nothing contained in the Plan documents shall give any employee the right to be retained in the service of the Company or to interfere with or restrict the right of the Company to terminate your employment at any time for any reason, which right is hereby expressly reserved.

10.12 Administration

Benefits under the Plan are administered in accordance with contracts the Company has entered into with various Third Party Administrators and Insurance Companies as listed in Appendix 1 and Appendix 2.

10.13 Contributions to and Funding of the Plan

Participants shall make contributions to the Plan in the amounts communicated to them from time to time by the Plan Sponsor. The Company shall bear the balance of the cost of the Plan, provided that Plan contributions may be used to pay Plan expenses to the full extent permitted under law, as determined by the Plan Administrator in its sole discretion.

10.14 General Assets

Plan benefits for the self-funded health Coverages are paid for out of the Company's general assets. Plan benefits for the insured Coverages are paid for through insurance contracts and policies purchased from various insurance companies. With respect to the insured Coverages, the insurance carriers (and not the Company) are financially responsible for the payment of claims under those Coverages. Premiums for those insurance contracts and policies are paid from the general assets of the Company, and benefits are administered and paid by the insurance carriers pursuant to the insurance contracts and policies

10.15 No Guarantee of Tax Consequences

All coverage and benefits hereunder are not intended to be subject to taxation**;** provided, however, taxable income shall be imputed for benefits provided to Domestic Partners who do not otherwise constitute the eligible Employee's tax dependents under Code Section 152. Notwithstanding the foregoing, no guarantee of the tax consequences of such coverage or benefits is provided herein and any failure by the Plan to meet any discrimination standards under the Code may result in taxable income to Plan Participants. In addition, benefits provided to a child may be taxable as state income under applicable state law.

10.16 Assignability

Except as provided in the last paragraph of this section 10.16, the interest of any Participant in the Coverages and benefits described in this Plan may not be sold, assigned, transferred or otherwise disposed of in any way, and any attempted sale, assignment, transfer or other disposition shall be null and void. If a Participant attempts to sell, assign, transfer or otherwise encumber his or her rights or interest under the Plan, then such act will be treated as an election by the Participant not to participate in the Plan.

The payment of benefits directly to a health care provider, if any, shall be done as a convenience to the covered person and will not constitute an assignment of benefits under the Plan. Subject to any written direction of a Participant, all or a portion of any benefits provided by any plan or program contained in this Plan, may, at the option of such plan or program and unless the Participant requests otherwise in writing, be paid directly to the person rendering the service. Any payment made by a plan or program in good faith pursuant to this provision shall fully discharge the Plan and the Company to the extent of such payment.

Benefits may be assigned to an alternate recipient pursuant to a Qualified Medical Child Support Order ("QMCSO") or a National Medical Support Notice which is deemed to be a QMCSO.

10.17 Separate Plans

To the extent required to satisfy applicable law, including, but not limited to, the nondiscrimination provisions of Internal Revenue Code Section 105(h), each coverage level, each group of Employees covered by the Plan, and each class of benefits provided under the Plan will constitute a separate "plan."

10.18 Controlling Law and Severability

The Plan shall be governed by, and construed in accordance with, ERISA and, to the extent not preempted by ERISA, the laws of the State of California (other than the choice of law principles). If any provision of this Plan or application thereof to any individual or circumstance, is deemed invalid or unenforceable by a court of competent jurisdiction, then the remainder of the Plan or the application of such term or provision to individuals or circumstances shall be valid and enforceable to the fullest extent permitted by law. If any provision of the Plan or the application of the Plan to any person or circumstance is held invalid, the invalidity will not affect other provisions of the Plan, which can be given effect without the invalid provisions or application. To this end, the provisions of the Plan are severable.

Notwithstanding the forgoing, to the extent provided in an applicable insurance contract or, Evidence of Coverage booklet, the laws of a state other than the State of California may control to the extent that such laws are not preempted by ERISA or any other applicable federal law.

10.19 No Third Party Beneficiaries

No right hereunder shall inure to any third party beneficiary.

10.20 Plan Year

The Plan's records are maintained on a Plan Year basis.

10.21 Uncashed Benefit Payments and Missing Participants

If within one year after any amount becomes payable hereunder to a Participant and such amount has not been claimed, provided due and proper care was made by the Claims Administrator to attempt to make such payment by providing notice at the Participant's last known address, the amount thereof shall be forfeited and shall cease to be a liability of the Plan or the Employer.

10.22 Construction

The article and section headings in this Plan and Summary Plan Description document are included solely for convenience of reference. If there is any conflict between the headings and the text of the Plan, or between the Plan and any descriptive material (other than SPDs) distributed to Participants, the Plan will control. A precondition to the entitlement to any protection or benefits under this Plan is a covered person's acceptance that the doctrine of contra proferentum shall not apply to this Plan and his or her agreement that all ambiguities shall be construed against the payment of Plan benefits.

10.23 Qualified Medical Child Support Orders and National Medical Support Notices

As required by applicable law, the Plan shall honor medical child support orders that the Plan Administrator determines are "qualified." The Plan Administrator is hereby authorized to adopt, maintain and amend procedures for determining whether medical child support orders are "qualified" under applicable law and for handling such orders. Such procedures are available from the Plan Administrator.

10.24 Patient Protection Disclosures

Kaiser Permanente HMO California, Kaiser Permanente High Deductible HMO California, and Kaiser Permanente HMO Oregon generally require the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Kaiser Permanente will designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the plan administrator at the number on the back of your ID card.

For children, you may designate a pediatrician as the primary care provider.

For plans and issuers that provide coverage for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider, you do not need prior authorization from Kaiser Permanente HMO California, Kaiser Permanente High Deductible HMO California, and Kaiser Permanente HMO Oregon or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the plan at the number on the back of your ID card.

ARTICLE XI

YOUR RIGHTS UNDER ERISA

As a Participant in the Autodesk, Inc., Group Welfare Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants will be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated SPD. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, Domestic Partner, Spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan Documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court after you have exhausted the Plan's claims and appeals procedures. 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.

ARTICLE XII

REQUIRED LEGAL INFORMATION

Plan Name	**Autodesk, Inc., Group Welfare Plan**
Plan Number	**505**
Type of Plan	A "welfare benefit plan" under the Employee Retirement Income Security Act of 1974 (ERISA)
Plan Sponsor	Autodesk, Inc. One Market Street, Suite 400 San Francisco, CA 94105 (415) 507-5000
Company Identification Number	94-2819853
Plan Administrator	Autodesk, Inc. One Market Street, Suite 400 San Francisco, CA 94105 (415) 507-5000
Agent For Service of Legal Process	Service of legal process may be made upon the General Counsel at Autodesk, Inc. One Market Street, Suite 400 San Francisco, CA 94105
Plan Year	**The calendar year, that is, January 1 through December 31**
Type of Payments	Contributions toward the cost of Coverages under the Plan are paid for partially by Company and by the Eligible Employee through his/her premium contributions. Self-funded benefits are paid from the Company's general assets. Insured benefits are paid for by the insurance companies.
Plan Expenses	**Most Plan expenses are paid for by the Plan. However, certain expenses, such as legal fees, are paid by the Plan Sponsor.**

The **Company** has caused this amendment and restatement of the Autodesk, Inc. Group Welfare Plan document to be executed by its authorized representative effective on January 1, 2025.

Company

By: *Tony Phelan*_____

Title: Senior Director Total Rewards – Enablement and Operations_____

APPENDIX 1

SELF-FUNDED HEALTH BENEFIT PROVIDERS, CLAIMS ADMINISTRATORS AND APPEALS ADMINISTRATORS

The Contact Information below lists the Third Party Administrator or Claims Administrator for each self-funded Plan Coverage. Summary Plan Descriptions, Benefit Booklets, Evidence of Coverage and Summary of Coverage documents for the following Coverages are hereby incorporated into this SPD by reference:

Program/Provider	Contract Number or Document	Type of Benefit	Contact Information
UnitedHealthcare (UHC) Choice Plus PPO, UnitedHealthcare Choice Plus Out-of-Area PPO, UnitedHealthcare Choice EPO, and UHC Choice Plus High Deductible PPO	Policy # 169460	Medical and Prescription Drug	P.O. Box 30555 Salt Lake City, UT 84130-0555 866-747-1018 (United States and Canada) 336-540-6107 (outside United States and Canada) www.uhc.com www.myuhc.com (for enrolled employees)
Vision Service Plan	Policy # 12026932	Vision	P.O. Box 997105 Sacramento, CA 95899-7105 800-877-7195 www.vsp.com
Aetna	Policy # 878966	Dental	P.O. Box 14094 Lexington, KY 40512-4094 877-238-6200 www.aetna.com
Lyra Health (Program is terminated effective May 31, 2025)		Employee Assistance Program (EAP) - Work/Life Resource and Referral	1-844-937-6404 https://autodesk.lyrahealth.com/
Modern Health (Available as of February 18, 2025)		Employee Assistance Program (EAP) - Work/Life Resource and Referral	1-866-535-6463 https://www.modernhealth.com/
Included Health		Employee Assistance Program (EAP) - Medical Second Opinion Benefit	360 3rd Street San Francisco, CA 94107 800-929-0926 www.includedhealth.com

APPENDIX 2

INSURANCE CARRIERS

The Contact Information below lists the insurance carriers for each Plan Coverage. Certificate of Coverages, Insurance Schedules, Schedule of Benefits, and Description of Coverages for the following Coverages are hereby incorporated into this SPD by reference:

Program/Provider	Contract Number or Document	Type of Benefit	Contact Information
UnitedHealthcare PPO Hawaii	Policy# 169460	Medical and Prescription	866-633-2446 P.O. Box 30555 Salt Lake City, UT 84130-0555 866-747-1018 (United States and Canada) 336-540-6107 (outside United States and Canada) www.uhc.com www.myuhc.com (for enrolled employees)
Kaiser Permanente HMO California	Policy # 23941-0000	Medical and Prescription	800-464-4000 www.kaiserpermanente.orghttp://my.kp.org/ca/autodesk (for enrolled employees) Kaiser Permanente HMO
Kaiser Permanente High Deductible HMO California (available only to employees subject to the SFHCAO)	Policy # 23941-0001	Medical and Prescription	800-464-4000 www.kaiserpermanente.orghttp://my.kp.org/ca/autodesk (for enrolled employees) Kaiser Permanente HMO
Kaiser Permanente HMO Oregon	Policy # 4367-001	Medical and Prescription	800-813-2000 www.kaiserpermanente.org
Prudential (Life and AD&D)	Policy # 50178	Life Insurance – Basic and Supplemental Accidental Death and Dismemberment Insurance– Basic and Supplemental	The Prudential Insurance Company of America Group Life Claim Division P.O. Box 8517 Philadelphia, PA 19176 800-524-0542
Prudential (Long-Term Disability)	Policy # 50178	Long-Term Disability	The Prudential Insurance Company of America Disability Management Services P.O. Box 13480 Philadelphia, PA 19176 800-842-1718
ARAG	Policy # 10428	Group Legal	P.O. Box 93180 Des Moines, IA 50393-3180 800-247-4184
Chubb – ACE American Insurance Company	Policy #: ADD N19016869	Business Travel Accident and Business Travel Medical	https://www.chubbclaims.com/ace/us-en/welcome.aspx 1-800-336-0627 (United States) 1-302-476-6194 (outside United States)

Program/Provider	Contract Number or Document	Type of Benefit	Contact Information
Connecticut General Life Insurance Company	Policy # 03742B	Medical, Dental and Prescription Drug	CIGNA International www.cignaenvoy.com 302-797-3100 (collect calls are accepted) 800.441-2668 (U.S. & Canada) 800-243-6998 (toll free fax) ATT Access Code + 800-243-6998 (international fax) 302-797-3150 (fax)

APPENDIX 3

CLAIMS PROCEDURES

The insurance contracts, Evidences of Coverage or Benefit Booklets and other materials that describe a particular coverage and benefit under Appendix 1 of the Plan generally will contain a specific set of claims and appeals procedures that you must follow to make a claim to receive that particular coverage or benefit and/or to appeal a denied claim for that particular coverage or benefit. Although these separate claims and appeals procedures will be similar in most respects, there may be important differences. As such, you should follow the specific claims and appeals procedures for a particular Coverage carefully. If the booklets and other materials that describe a particular benefit do not contain a specific set of claims and appeals procedures, the Plan's default procedures as described below will apply. If you have any questions about which set of claims and appeals procedures to follow or any other questions about making a claim, you should contact the Plan Administrator immediately.

For purposes of this Section of the SPD describing the Plan's default claims and appeals procedures, the Plan Administrator (or any third party to whom the Plan Administrator has delegated the discretionary authority to review and evaluate claims, such as a third party administrator or an insurance company) shall be referred to as the "Claims Administrator" at the initial claim level and the "Appeals Administrator" at the appeal level. With respect to a group health plan that provides for external appeals, the Independent Review Organization ("IRO") shall have the discretionary authority to review, evaluate, and make final binding determinations with respect to an external appeal.

A request for benefits is a "claim" subject to these procedures only if you or your authorized representative file it in accordance with the Plan's claim filing guidelines. In general, claims must be filed in writing (except urgent care claims, which may be made orally) with the applicable provider identified in Appendix 1. Any claim that does not relate to a specific benefit under the Plan (for example, a general eligibility claim) must be filed with the Plan Administrator at the address set forth in Article VIII, "Required Legal Information" above. An initial request for prior approval of a benefit or service where prior approval is not required under the Plan is not a "claim" under these rules. Similarly, a casual inquiry about coverage or benefits or the circumstances under which benefits might be paid under the Plan is not a "claim" under these rules, unless it is determined that your inquiry is an attempt to file a claim.

If you want to bring a claim for coverage or benefits under the Plan, you may designate an authorized representative to act on your behalf so long as you provide written notice of such designation to the Claims Administrator and/or the Appeals Administrator identifying such authorized representative. In the case of a claim for medical benefits involving urgent care, a health care professional who has knowledge of your medical condition may act as your authorized representative with or without prior notice. If you (or your beneficiary) appoint a representative to act on your behalf, then the Claims and Appeals Administrators will communicate all matters to your authorized representative.

If you or your Spouse or Domestic Partner have questions about, or have been denied eligibility or benefits under, the Plan, you may contact Sr. Manager, AMER Benefits, One Market Street, Suite 400, San Francisco, CA 94105; email: hr.benefits.us@autodesk.com. You may also file a formal claim for eligibility or benefits by following the procedures described in this Appendix 3.

CLAIMS UNDER THE PLAN

Delegation of Claims Administration. The Plan Administrator has delegated responsibility for claims administration for: (1) all claims for benefits under an Insurance Coverage to the applicable contract administrator or insurance provider, and (2) for payment of claims under the self-funded benefits **to the third party administrator for these benefits**. Accordingly, you must submit: (a) a benefit claim under an Insurance Coverage to the applicable contract administrator or insurance provider, who will resolve the claim according to procedures stated in the administrative or insurance contract, or other document governing that benefit program (see Appendix 1); (b) claims for reimbursement from either the Health Care and Dependent Flexible Spending Accounts **to the third party administrator for each program**

(see Appendix 1). Each of these claims administrators has the discretion and authority to interpret the terms of the benefits they respectively administer, including, but not limited to whether, a limit or exclusion applies and whether a service or supply that is provided to an employee or dependent is an "essential health benefit" or a "non-essential health benefit" within the meanings of the Patient Protection and Affordable Care Act, as amended, and the regulations and other guidance issued thereunder. As such, for purposes of the scope of services and limits for the self-funded medical plans, the term "essential health benefits" is defined by reference to the benchmark plan selected by the State of Utah in accordance with the Patient Protection and Affordable Care Act of 2010 and the "Frequently Asked Questions on Essential Health Benefits Bulletin" issued by the Department of Health and Human Services Centers for Medicare and Medicaid Services and the "Essential Health Benefits Bulletin" issued by the Department of Health and Human Services Center for Consumer Information and Insurance Oversight on December 16, 2011. With respect to those self-funded health plan benefits that the Plan must provide pursuant to the Patient Protection and Affordable Care Act and for which guidance issued thereunder permits a good faith and/or reasonable interpretation of the Patient Protection and Affordable Care Act's requirements with regard to the provision of such benefit or the use of reasonable medical management techniques to determine any coverage limitation (including, but not limited to preventive care and routine patient costs for services and supplies furnished in connection with participation in an approved clinical trial), the claims administrators for the respective benefits they administer, shall have the sole and complete discretion to make such good faith and/or reasonable determinations regarding the extent to which a charge(s) incurred by a covered employee or dependent is covered by the Plan. Such contract administrators are the named fiduciaries of the respective benefit options that they administer on behalf of Autodesk.

Such claims also must be made according to the applicable time and notice requirements described in the Claims Review Chart below. If you do not file a claim under these benefit programs within the time limits specified, then you may lose benefits under the Plan.

See the specific Coverage's Evidence of Coverage, Benefit Booklet or other document listed in Appendix 1 for more information about how to file a claim, and for details regarding the claims and appeals procedures for that contract administrator.

Claims Appeals under ERISA. Under ERISA, you have the right to appeal a denied claim. If your claim is denied, in whole or in part, by a contract administrator as Claims Administrator, then you may appeal to that contract administrator (acting as Appeals Administrator) for a review of the denied claim according to the appeals procedures stated in the applicable administrative contract or other document governing that particular Coverage (see Appendix 1). Those claims procedures may require you to complete, sign, and submit a written claim within certain timeframes.

If you do not timely appeal, then you will generally lose your right to file suit in a state or federal court, as you will not have exhausted your internal administrative appeal rights.

Content of Notice of Denial of a Claim. If a benefits claim you file with a contract administrator (as Appeals Administrator) is denied, you will be furnished with a notice of the denial within the time periods described in the Claims Review Chart. If your benefits claim is wholly or partially denied, the notice will include:

(i) the specific reason(s) for the denial;

(ii) reference to the specific Plan provision(s) on which the denial is based;

(iii) a description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary;

(iv) a description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of your rights to bring a civil action under Section 502(a) of ERISA, following the denial of a claim on review; and

(v) if the Appeals Administrator relied on an internal rule, guideline, protocol, or other criterion (other than that which is legally privileged) to deny your claim, then you will be furnished with either a copy of the specific rule, guideline, protocol, or other similar criterion, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in denying your claim and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request.

If the denial is based on medical necessity or experimental treatment, then the denial notice will also provide an explanation of the scientific or clinical judgment for the determination, applying Plan terms to your medical condition.

If the denial is for an urgent care claim, then the denial notice will include a description of the expedited review process applicable to such claims. This denial may be conveyed to you orally, provided that a written or electronic notice is furnished to you no later than three (3) days after the oral notice.

Procedures for Appealing a Denied Claim. If you apply for medical or disability benefits from the Plan and your application is denied by the Claims Administrator for that specific Coverage (see Appendix 1), then you have the right to appeal the denial within 180 days after receiving the claim denial. You must submit your appeal in writing in accordance with the claims appeal procedures stated in the applicable administrative contract. You also have the right to appeal a rescission of non-grandfathered medical benefit coverage.

Your request for an appeal of a denied claim, or a rescission of non-grandfathered medical benefit coverage, should describe all of the grounds upon which it is based, all facts in support of your request and any other matters that you consider pertinent to your appeal. If you appeal, you have the right to review pertinent documents (other than legally or medically privileged documents) and to submit issues and comments in writing.

The appeals administrator may also require you to submit such additional facts, documents or other material, as it considers necessary or appropriate in making its decision. The review of the claim denial will take into account all new information, whether or not that information was presented or available for your initial claim, and will not be influenced by the decision on your initial claim.

If your claim appeal involves urgent care, then you may submit a request for an expedited appeal orally or in writing and all necessary information will be transmitted between the Plan and you by telephone, fax, or other similar method.

The applicable Claims Administrator has been delegated the discretionary authority to administer and interpret the Plan and to determine benefit claims and appeals under the Plan. Accordingly, the final decision on your appeal will include the following:

(i) the specific reasons for the decision and reference to the Plan provision(s) or other governing Plan Documents on which the decision is based;

(ii) a statement indicating that you are entitled to receive upon request, and without charge, reasonable access to or copies of all documents, records, or other information (other than legally privileged documents) relevant to the determination;

(iii) a statement describing any voluntary appeal procedures offered by the Plan and your right to obtain information about these procedures;

(iv) a statement of your rights to bring a civil action under Section 502(a) of ERISA, following the denial of a claim on review after completion of all levels of review; and

(v) a statement disclosing any internal rule, guideline, protocol, or other similar criterion (other than legally privileged information) relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request).

If the denial on appeal is based on medical necessity or experimental treatment, then the final decision will include an explanation of the scientific or clinical judgment for the determination, applying Plan terms to your medical condition will be included (or state such information will be provided free of charge upon request).

The appeal determination notice may be provided in written or electronic form.

SPECIAL CLAIMS RULES FOR NON-GRANDFATHERED GROUP HEALTH PLANS

For all non-grandfathered medical claims, the Plan will provide participants, free of charge, with new or additional evidence considered, relied upon or generated by the Plan, and any new or additional rationale for the denial, as well as a reasonable opportunity for the participant to respond, and will prohibit conflicts of interest, such as making compensation, promotion, or other employment decisions about a claims adjudicator, medical expert, or other employee based on the likelihood that the individual will support a denial of benefits. Individuals also have the right to appeal a rescission of non-grandfathered medical coverage.

The following external claims review procedure will apply to all claims related to "medical care" (as defined in Section 733 of ERISA) benefits under a non-grandfathered self-insured group health plan that is not subject to or voluntarily complying with a State external review process and is, therefore, subject to the Federal external review process. Refer to the applicable Evidence of Coverage or Benefits Booklet for non-grandfathered health plans to determine the specific external review process that applies to the coverage. If no state based external review is used, the following federal external review process will be applied (subject to any subsequent changes in procedures mandated by Federal law)

External Review

Request for external review. External review is available for claims that involve a medical judgment, recissions of coverage, or denials that involve consideration of whether the group health plan is complying with the surprise billing and cost-sharing protections set forth in ERISA section 716 and 717. A group health plan must allow a claimant to file a request for an external review with the Plan if the request is filed within four months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

Preliminary review. Within five business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether:

(i) The claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;

(ii) The adverse benefit determination or the final adverse benefit determination does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the group health plan (e.g., worker classification or similar determination);

(iii) The claimant has exhausted the Plan's internal appeal process unless the claimant is not required to exhaust the internal appeals process under the interim final regulations; and

(iv) The claimant has provided all the information and forms required to process an external review.

Within one business day after completion of the preliminary review, the Plan must issue a notification in writing to the claimant. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification will describe the information or materials needed to make the request complete and the Plan will allow a claimant to perfect the request for external review within the four-month filing period or within the 48-hour period following the receipt of the notification, whichever is later.

Referral to Independent Review Organization. The contract administrator or claims administrator, as applicable, on behalf of the Plan will assign an independent review organization ("IRO") that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the external review. The Plan will contract with at least three (3) IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection).

(i) Within five business days after the date of assignment of the IRO, the Plan will provide to the assigned IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. If the Plan fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the adverse benefit determination or final internal adverse benefit determination. Within one business day after making the decision, the IRO must notify the claimant and the Plan.

(ii) The assigned IRO will timely notify the claimant in writing of the request's eligibility and acceptance for external review. This notice will include a statement that the claimant may submit in writing to the assigned IRO within ten business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after ten business days.

(iii) Upon receipt of any information submitted by the claimant, the assigned IRO will within one business day forward the information to the Plan. Upon receipt of any such information, the Plan may reconsider its adverse benefit determination or final internal adverse benefit determination that is the subject of the external review. Reconsideration by the Plan will not delay the external review. The external review may be terminated as a result of the reconsideration only if the Plan decides, upon completion of its reconsideration, to reverse its adverse benefit determination or final internal adverse benefit determination and provide coverage or payment. Within one business day after making such a decision, the Plan will provide written notice of its decision to the claimant and the assigned IRO. The assigned IRO will terminate the external review upon receipt of the notice from the Plan.

(iv) The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

(a) The claimant's medical records;

(b) The attending health care professional's recommendation;

(c) Reports from appropriate health care professionals and other documents submitted by the Plan or issuer, claimant, or the claimant's treating provider;

(d) The terms of the Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;

(e) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;

(f) Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and

(g) The opinion of the IRO's clinical reviewer or reviewers after considering the information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

(v) The assigned IRO will provide written notice of the final external review decision within 45 days after the IRO receives the request for the external review. The IRO will deliver the notice of final external review decision to the claimant and the Plan.

Notice. The assigned IRO's decision notice will contain:

(i) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);

(ii) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

(iii) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

(iv) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

(v) A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the group health plan or to the claimant;

(vi) A statement that judicial review may be available to the claimant; and

(vii) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793. In California, claimants may contact:

California Department of Managed Health Care Help Center
980 9th Street, Suite 500
Sacramento, CA 95814
(888) 466-2219
http://www.healthhelp.ca.gov

helpline@dmhc.ca.gov

Reversal of Plan's decision. Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, the Plan will provide coverage or payment (including authorizing or paying benefits) for the claim.

Expedited External Review For Self-Insured Group Health Plans

Request for expedited external review. The claimant may request an expedited external review with the Plan at the time the claimant receives:

(i) An adverse benefit determination if the adverse benefit determination involves a medical condition of the claimant for which the standard time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an expedited internal appeal; or

(ii) A final internal adverse benefit determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

Preliminary review. Upon receipt of the request for expedited external review, the Plan will determine whether the request meets the reviewability requirements set forth in paragraph A.2 above for standard external review. The Plan will send a notice that meets the requirements set forth in paragraph A.2 above for standard external review to the claimant of its eligibility determination.

Referral to Independent Review Organization. Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO pursuant to the requirements set forth above for standard review. The Plan will provide all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

Notice of final external review decision. The IRO will provide notice of the final external review decision, in accordance with the requirements set forth in above, as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO will provide written confirmation of the decision to the claimant and the Plan.

Reversal of Plan's decision. Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, the Plan will provide coverage or payment (including authorizing or paying benefits) for the claim.

EXHAUSTION OF REMEDIES

No legal action against or relating to this Plan may be brought more than four (4) years after the facts giving rise to the claim or allegations occurred. No legal action against or relating to this Plan may be brought until the claimant:

(i) has submitted a written claim in accordance with the procedures described herein;

(ii) has been notified by the Claims Administrator that such claim is denied;

(iii) has filed a written request for review of the claim;

(iv) has been notified by the Appeals Administrator that it has affirmed the denial of the claim on review;

(v) If the Plan or program provides for two levels of review, has filed a written request for a second review of the claim; and

(vi) If the Plan or program provides for two levels of review, has been notified by the Appeals Administrator that it has affirmed the denial of the claim on second review.

Some plans or programs may provide for an additional voluntary level of review and/or external review. You should refer to the applicable Evidence of Coverage or Benefit Booklet to determine whether such provisions apply to a particular plan or program.

TIME LIMITS FOR SUBMITTING BENEFIT CLAIMS

Self-funded Coverages

Insurance Coverages. You must submit a benefits claim under an Insurance Coverage within the time limits stated in the documents governing each Insurance Coverage (see Appendix 1). If no time limit is set by the applicable the booklet or insurance contract, then you must submit your benefits claim within one year after you have knowledge (or should have knowledge) of the facts giving rise to the claim.

Claims Review Time Limits. The following chart sets forth the time limits that will apply for initial review and appeal of claims under the Plan, unless a shorter period is prescribed by the applicable administrative contract.

Claims Review Time Limits		
Type of Claim	**Time Limits**	
URGENT HEALTH CARE CLAIM		
Claims for conditions that could jeopardize life, health, or ability to regain maximum function, or would subject you to severe pain. The reasonable layperson standard is used for these claims, except that if a physician determines the condition is urgent, the Plan must accept the physician's determination.	YOUR INITIAL CLAIM	
	Step 1:	The Plan has 72 hours after receiving your initial claim to approve or deny the claim.
	IF YOUR CLAIM IS IMPROPER OR INCOMPLETE	
	Step 1:	The Plan has 24 hours after receiving your initial claim to notify you that your claim is improper or incomplete.
	Step 2:	You have 48 hours after receiving notice from the Plan to correct or complete your claim.
	Step 3:	The Plan has 48 hours to notify you if your claim is approved or denied. The Plan must do so within the earlier of 48 hours of: The Plan's receipt of your completed claim, or Your deadline to complete the claim.
	APPEAL OF A DENIED CLAIM	
	Step 1:	If denied, you have 180 days after receiving the claim denial to appeal the Plan's decision.
	Step 2:	The Plan has 72 hours after receiving your appeal to notify you of its appeal decision.
PRE-SERVICE HEALTH CLAIM		
Group health claims where treatment must be pre-certified before it is performed.	YOUR INITIAL CLAIM	
	Step 1:	The Plan has 15 days after receiving your initial claim to notify you if your claim is approved or denied.
	IF YOUR CLAIM IS IMPROPER OR INCOMPLETE	
	Step 1:	The Plan has 5 days after receiving your initial claim to notify you that your claim is an improper claim.
	Step 2:	If the Plan needs more information and provides an extension notice during the initial 15-day period, the Plan has 30 days after receiving the claim to notify you of its decision.
	Step 3:	You have 45 days after receiving the extension notice to provide additional information or complete the claim. (The time the Plan waits for claimant information is not counted in totals.)
	APPEAL OF A DENIED CLAIM	
	Step 1:	If your claim is denied, you have 180 days after receiving the claim denial to appeal the Plan's decision.

Claims Review Time Limits		
Type of Claim	**Time Limits**	
	Step 2:	The Plan has 30 days after receiving your appeal to notify you of the appeal decision.
POST-SERVICE HEALTH CLAIM		
Health claims where you request reimbursement after treatment has been performed.	YOUR INITIAL CLAIM	
	Step 1:	The Plan has 30 days after receiving your initial claim to notify you if your claim is denied.
	IF THE PLAN NEEDS FURTHER INFORMATION OR AN EXTENSION	
	Step 1:	The Plan has 30 days after receiving the initial claim to notify you if your claim is denied. If the Plan Administrator determines that an extension is necessary due to matters beyond the control of the Plan and provides an extension notice during the initial 30-day period, the Plan has 45 days after receiving the claim to notify you if your claim is denied.
	Step 2:	You have 45 days after receiving the extension notice to provide additional information or complete your claim. (The time the Plan waits for claimant information is not counted in totals).

Claims Review Time Limits		
Type of Claim	**Time Limits**	
	APPEAL OF A DENIED CLAIM	
	Step 1:	If your claim is denied, you have 180 days after receiving the claim denial to appeal the Plan's decision.
	Step 2:	The Plan has 60 days after receiving your appeal to notify you of the appeal decision.
DISABILITY BENEFITS CLAIM		
	YOUR INITIAL CLAIM	
	Step 1:	The Plan has 45 days after receiving your initial claim to notify you if your claim is denied.
	IF THE PLAN NEEDS FURTHER INFORMATION OR AN EXTENSION	
	Step 1:	The Plan may notify you within the initial 45 days after receiving the initial claim of the need for an extension of up to 30 days to review your claim and render a decision, and why the extension is needed, and may notify you within that extension period of the need for an additional extension of up to another 30 days, and the reason why.
	Step 2:	If the Plan needs more information, then you will be notified of the specific information needed and you will have 45 days to provide the specified information. Any decision period or extension period will be tolled from the date of notice to you that more information is needed to the date you supply the information.
	APPEAL OF A DENIED CLAIM	
	Step 1:	If your claim is denied, then you have 180 days after receiving the claim denial to appeal the Plan's decision.

APPENDIX 4

HIPAA AMENDMENT

A. Introduction

Autodesk, Inc. (the "Plan Sponsor") sponsors the Autodesk Group Welfare Plan (the "Plan"). In certain circumstances as described below, the Plan will disclose to the Plan Sponsor Protected Health Information of Plan participants and other persons covered by the Plan (the "Covered Individual").

The Health Insurance Portability and Accountability Act of 1996, and the privacy regulations thereunder found at 45 C.F.R. Parts 160 and 164, as amended from time to time require the Plan to restrict the Plan Sponsor's ability to Use and Disclose Protected Health Information that is received from the Plan. One of the requirements is that the Plan Sponsor will amend the Plan as set forth in 45 C.F.R. § 164.504(f)(2) and 45 C.F.R. § 164.314(b)(2). In accordance with such requirements, the Plan was amended as set forth below to comply with 45 C.F.R. § 164.504(f)(2) and with 45 C.F.R. § 164.314(b)(2) with respect to the to the components of the Plan that provide self-funded health care benefits.

The Plan will not Use or Disclose PHI to the Plan Sponsor in circumstances in which the HIPAA Privacy Rule or the HIPAA Security Rule would prohibit such Use or Disclosure.

B. Definitions

1. Business Associate. The term "Business Associate" has the meaning set forth in 45 C.F.R. § 160.103.

2. Disclose or Disclosure. The term "Disclose" or "Disclosure" means the release or transfer of, provision of access to, or divulging in any other manner individually identifiable health information to persons outside the Plan Sponsor.

3. Electronic Protected Health Information. The term "Electronic Protected Health Information" will have the meaning set forth in 45 C.F.R. § 160.103.

4. HIPAA Privacy Rule. The term "HIPAA Privacy Rule" means the applicable requirements of the privacy rules of Health Insurance Portability and Accountability Act of 1996 and related regulations, Title 45 Parts 160 and 164 of the Code of Federal Regulations, as amended from time to time.

5. HIPAA Security Rule. The term "HIPAA Security Rule" will mean the Standards for Security of Electronic Protected Health Information at 45 C.F.R. parts 160 and 164, subparts A and C.

6. Plan Administration Functions. The term "Plan Administration Functions" means administrative functions performed by the Plan Sponsor on behalf of the Plan and excludes functions performed by the Plan Sponsor in connection with any other benefit or benefit plan of the Plan Sponsor.

7. Privacy Official. The term "Privacy Official" means the person who is responsible for the development and implementation of the HIPAA Privacy Rule policies and procedures of the Plan.

8. Protected Health Information. The term "Protected Health Information" or "PHI" will have the meaning set forth in 45 C.F.R. § 164.501.

9. Use. The term "Use" means the sharing, employment, application, utilization, examination, or analysis of individually identifiable information by the Plan Sponsor or any Business Associate of the Plan.

C. Permitted Uses and Disclosures of PHI by the Plan Sponsor

1. General. The Plan will Disclose PHI to the Plan Sponsor only to enable the Plan Sponsor to carry out Plan Administration Functions described in Section C.2 below, and such Disclosures will be consistent with the requirements of the HIPAA Privacy Rule. The Plan will not Disclose PHI to the Plan Sponsor unless the Disclosures are explained in a Notice of Privacy Practices that is distributed to Covered Individuals.

2. Description of Uses of PHI by the Plan Sponsor. The Plan may disclose PHI to specified employees or specified classes of employees of Autodesk, Inc. solely for purposes of performing Plan Administration Functions, and only to the extent necessary for such purposes. Such Plan Administration Functions may include, but are not limited to, the design, administration, financial operations, or legal defense of the Plan. Plan Administration Functions may also include the review of denied claims under the Plan or claim advocacy on behalf of Plan participants. The Plan Sponsor will not Use or further Disclose the PHI other than as permitted or required in accordance with this stated purpose or as required by applicable law.

D. Agents

The Plan Sponsor will ensure that any agents (including any subcontractors) to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to the PHI.

E. Employment Actions

The Plan Sponsor will not Use or Disclose PHI for employment related actions and decisions or in connection with any other benefit or employee benefit plan that is sponsored by the Plan Sponsor, except to the extent that such employee benefit plan is part of an Organized Health Care Arrangement (as defined in 45 C.F.R. § 164.501).

F. Reporting

The Plan Sponsor will report to the Privacy Official of the Plan any Use or Disclosure of PHI that is inconsistent with the purposes set forth in Section C. above, including any breach within the meaning of 45 C.F.R. section 164.402.

G. Access to PHI

The Plan Sponsor will make PHI available to Covered Individuals for inspection and copying in accordance with 45 C.F.R. § 164.524.

H. Amendment of PHI

The Plan Sponsor will make PHI available to Covered Individuals for amendment and incorporate any amendments to PHI in accordance with 45 C.F.R. § 164.526.

I. Accounting of Disclosures of PHI

The Plan Sponsor will make available the PHI required for the Plan to provide an accounting of Disclosures to Covered Individuals in accordance with 45 C.F.R. § 164.528.

J. Information Available to the Secretary of Health and Human Services

The Plan Sponsor will make its internal practices, books, and records relating to the Use and Disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining the Plan's compliance with the HIPAA Privacy Rule.

K. Return or Destroy PHI

If feasible, the Plan Sponsor will return or destroy all PHI received from the Plan that it maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which the Disclosure was made, except that, if such return or destruction is not feasible, the Plan Sponsor will limit further Uses and Disclosures to those purposes that make the return or destruction of the information infeasible.

L. Adequate Separation

1. General. The Plan Sponsor will ensure that there is adequate separation between the Plan and the Plan Sponsor as required by the HIPAA Privacy Rule.

2. Employees with Access to PHI. The following is a description of the employees or classes of employees or other persons under the control of the Plan Sponsor that will be given access to PHI: Autodesk, Inc. Benefits Department personnel, Autodesk, Inc. Finance, Accounting and Internal Audit personnel, in-house legal counsel and paralegals.

3. Restriction of Access and Use. The access to and Use by the persons described in Section L.2 above will be restricted to the Plan Administration Functions that the Plan Sponsor performs for the Plan.

4. Resolving Issues of Noncompliance. In the event there are any issues of noncompliance by the persons described in Section L.2, the Plan Sponsor will take all necessary and appropriate action that is consistent with its disciplinary policy.

M. Certification by the Plan Sponsor

The Plan will not Disclose PHI to the Plan Sponsor unless the Plan Sponsor certifies that the Plan has been amended as required by the HIPAA Privacy Rule.

N. HIPAA Security Rule Requirements

The Plan Sponsor will reasonably and appropriately safeguard Electronic Protected Health Information that it creates, receives, maintains or transmits on behalf of the Plan, other than Electronic Protected Health Information that is summary health information disclosed pursuant to 45 C.F.R. Section 164.504(f)(1)(ii), enrollment or disenrollment information disclosed pursuant to 45 C.F.R. Section 164.504(f)(1)(iii), or information disclosed pursuant to an authorization under 45 C.F.R. Section 164.508 In implementing such safeguards, the Plan Sponsor is required to do the following:

1. Safeguards. The Plan Sponsor will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic Protected Health Information that it creates, receives, maintains or transmits on behalf of the Plan.

2. Adequate Separation. The Plan Sponsor will ensure that the adequate separation between the Plan and the Plan Sponsor as required by Section 164.504(f)(2)(iii) of the HIPAA Security Rule is supported by reasonable and appropriate security measures.

3. Agents. The Plan Sponsor will ensure that any agents (including any subcontractors) to whom it provides Electronic Protected Health Information received from the Plan agrees to implement reasonable and appropriate security measures to the Electronic Protected Health Information.

4. Reporting Obligation. The Plan Sponsor will report to the Plan any security incident (as defined by 45 C.F.R. Section 164.304) of which it becomes aware.

O. Miscellaneous

1. Rights. This Appendix shall not be construed to establish requirements or obligations beyond those required by the HIPAA Privacy Rule. Any portion of this Appendix that appears to grant any additional rights not required by the HIPAA Privacy Rule or HIPAA Privacy Rule shall not be binding upon the Plan Sponsor.

2. Amendment. The Plan Sponsor reserves the right to amend or terminate any and all provisions set forth in this Appendix at any time to the extent permitted under the HIPAA Privacy Rule or HIPAA Security Rule.

3. Document Retention. If a communication under this Appendix is required by the HIPAA Privacy Rule to be in writing, the Plan Sponsor will maintain such writing, or electronic copy, as documentation. If an action, activity, or designation is required by the HIPAA Privacy Rule to be documented, the Plan Sponsor will maintain a written or electronic record of such action, activity or designation. The Plan Sponsor will retain the required documentation for six years from the date of its creation or the date when it last was in effect, whichever is later.

4. Construction. The terms of this Appendix shall be construed in accordance with the requirements of the HIPAA Privacy Rule and HIPAA Security Rule and in accordance with any applicable guidance on the HIPAA Privacy Rule and HIPAA Security Rule issued by the Department of Health and Human Services.