Autodesk, Inc.

CAFETERIA PLAN

with

FLEXIBLE SPENDING ARRANGEMENT

(As Amended and Restated Effective as of January 1, 2022)

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ARTICLE 1. INTRODUCTION AND PURPOSE

1.1 Introduction and Purpose. Unless otherwise stated herein, the Autodesk, Inc. Cafeteria Plan with Flexible Spending Arrangement (the "Plan") is hereby amended and restated in its entirety effective January 1, 2022. The Plan was previously amended and restated effective January 1, 2011, effective January 1, 2014, effective January 1, 2015, effective January 1, 2016, effective January 1, 2020, effective June 1, 2020, and effective January 1, 2021. The purpose of the Plan is to provide Eligible Employees who may participate in the Plan the choice among different combinations of health, dependent care, health savings account and other benefits as permitted under Section 125 of the Internal Revenue Code and as specified in the Plan.

1.2 Qualified Status. The Plan is intended to meet the requirements of Section 125 of the Internal Revenue Code and shall be interpreted and administered in accordance with the requirements of that section.

ARTICLE 2. DEFINITIONS

2.1 Definitions. Whenever used in the Plan, the following words and phrases shall have the meanings set forth below unless the context plainly requires a different meaning.

(a) Administrator means the individual or committee appointed by the Employer to supervise the administration of the Plan, in accordance with the provisions of Article 14.

(b) Affiliate means any entity (other than the Employer) that is part of a group of entities that includes the Employer and that constitutes: (i) a controlled group of corporations (as defined in section 414(b) of the Code); (ii) a group of trades or businesses, whether or not incorporated, under common control (as defined in section 414(c) of the Code); or (iii) an affiliated service group (within the meaning of section 414(m) of the Code), and that adopts the Plan with the Employer's consent.

(c) Change in Status means a Change in Status, as defined in Section 4.3(c)(2) of this Plan.

(d) COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1986, as amended.

(e) Code means the Internal Revenue Code of 1986, as amended.

(f) Compensation of a Participant means the amounts paid to a Participant by the Employer and reported on the Participant's Federal Income Tax Withholding Statement (Form W-2), but excluding all fringe benefits.

(g) Contract Administrator means an administrator that has contracted with the Employer to provide administrative services under the Plan. This term is not the same and is not intended to have the same meaning as the term defined in section 3(16) of ERISA.

(h) Default Coverage means the medical, dental, vision, employee life insurance, employee accidental death and dismemberment insurance and long-term disability insurance that all Participants will be enrolled in as determined each Plan Year by the Administrator.

(i) Dependent means one of the following individuals:

(1) An individual who qualifies as the Eligible Employee's dependent under the provisions of Section 152 of the Code; or

(2) 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 26; or

(3) For all purposes of the Plan other than Dependent Care FSA, the term "Dependent" includes a child who is otherwise a Dependent under this section and who is entitled to coverage under a qualified medical child support order or otherwise in accordance with the provisions of section 609 of ERISA.

(j) Effective Date means January 1, 2022, the date on which the Plan is hereby amended and restated.

(k) Eligible Employee

(1) includes a regular Autodesk employee on the U.S. payroll regularly scheduled to work at least 20 hours a week. Whether an individual is regularly scheduled to work 20 hours per week is determined by the Employer, in its sole discretion, in accordance with the full-time employee determination rules set forth in Section 4980H of the Code for the employer shared responsibility provisions. An individual 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.

(A) Notwithstanding the foregoing, an otherwise Eligible Employee who was formerly employed by Innovyze, Inc. as of April 30, 2021, shall be considered an Eligible Employee and eligible to participate in this Plan effective as of May 1, 2021;

(2) An Eligible Employee for purposes of eligibility to participate in this Plan, 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.

(3) Notwithstanding the foregoing, for purposes of the FSA Dependent Care Plan, an employee who elects to participate in the FSA Dependent Care Plan for a Plan Year or Period of Coverage and whose employment is terminated during the same Plan Year or Period of Coverage, shall remain an Eligible Employee for the remainder of the Plan Year for purposes of receiving reimbursements from his FSA Dependent Care only. Such employee shall be permitted to receive reimbursements of Employment-Related Dependent Care Expenses that are incurred through the last day of the Plan Year from the balance of his FSA Dependent Care remaining as of the later of the date of his termination or the last day of the period that the employee remains on the Autodesk U.S. payroll. Such employee shall cease to make contributions towards the FSA Dependent Care upon the later of the date of his termination or the last day of the period that the employee remains on the Autodesk U.S. payroll.

(4) 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.

(l) Employee Benefit Election means the election made in the form and manner required by the Administrator as described in Section 3.2.

(m) Employment-Related Dependent Care Expense means an amount paid by a Participant for household services or for the care of a Qualifying Individual, to the extent that such expense is incurred to enable the Participant to be gainfully

employed for any period for which there are one or more Qualifying Individuals with respect to the Participant. However, (1) if such amounts are paid for expenses incurred outside the Participant's household, they shall constitute Employment-Related Dependent Care Expenses only if incurred for a Qualifying Individual who is a Dependent under the age of 13 or for a Qualifying Individual who regularly spends at least eight hours per day in the Participant's household; (2) if the expense is incurred outside the Participant's home at a facility that provides care for more than six individuals who do not regularly reside at the facility, the facility must comply with all applicable licensing requirements, if any; and (3) Employment-Related Dependent Care Expenses of a Participant shall not include expenses paid or incurred for services provided by (i) a child of such Participant who is under the age of 19 or (ii) an individual who is a Dependent of such Participant or such Participant's Spouse.

(n) Employer means Autodesk, Inc. or its successor(s). However, where appropriate, the term Employer shall also mean an Affiliate that is the employer of a particular Participant.

(o) Employer Contributions means the contribution to the Plan made by the Employer. To the extent that less expensive benefits are chosen by a Participant, the Participant shall receive such excess as additional cash compensation on a pro rata basis per payroll period.

(p) Dependent Care Flexible Spending Account (FSA) Dependent Care means the account established under Section 7.1 for each Participant, as increased under Section 7.2 by allocated Salary Reduction Contributions and/or Employer Contributions and as decreased under Section 7.3 by benefit payments made to the Participant.

(q) Health Care Flexible Spending Account (FSA) General Purpose or Limited Purpose means the account established under Section 6.1 for each Participant, as increased under Section 6.2 by allocated Salary Reduction Contributions and as decreased under Section 6.3 by benefit payments made to the Participant.

(r) Health Savings Account or HSA means the tax-favored trust account as described in Section 223 of the Code that is established under Section 8.1 by an HSA-eligible individual who is an Employee covered by a high-deductible HSA-compatible health plan option offered under the Health and Welfare Plan, with the entity with whom the Employer has contracted for the purpose of depositing eligible HSA-contributions from the Employer and/or the Employee, as applicable.

(s) HSA Benefits means the benefits described in Article 8 hereof.

(t) FMLA Leave means a leave of absence provided to an Employee of the Employer under the Family and Medical Leave Act of 1993, as amended.

(u) Health and Welfare Plan means the self-funded and insured plan(s) maintained by the Employer to provide medical, dental, vision, life, AD&D (accidental death and dismemberment, and disability benefits to Employer's Eligible Employees.

(v) Health Care Expense means, with respect to the General Purpose Health Care Flexible Spending Account (FSA), an expense related to the diagnosis, cure, mitigation, treatment, or prevention of disease consisting of expenses for medical care within the meaning of Section 213 of the Code, including, but not limited to, payments for the purpose of affecting any structure or function of the body, or for any hospital or nursing charges, optometrical, ophthalmological or auditory care, routine physical examinations, well-baby care, dental and orthodontic care, psychiatric care, prescription drugs, insulin, eyeglasses or contact lenses, hearing-aid appliances, similar prosthetic devices, medical-related transportation or medical, dental, or vision insurance out-of-pocket expenses. Effective January 1, 2020, over-the-counter drugs and medicines and menstrual products within the meaning of the CARES Act of 2020 and its implementing guidance (i.e., tampon, pads, liners, cups, sponges, or similar products used by individuals with respect to menstruation or other genital-tract secretions).

(w) Highly Compensated Employee means a highly compensated individual or participant as defined in Code Section 125(e); a highly compensated employee as defined in Code Section 129(d)(2); or a highly compensated individual as defined in Code Section 105(h)(5).

(x) HIPAA means the Health Insurance Portability and Accountability Act of 1996, and the regulations issued thereunder, as amended from time to time.

(y) Key Employee means a key employee as defined in Code Section 416(i)(1).

(z) Minimum Coverage means the minimum medical, dental, vision, employee life, employee AD&D, and long-term disability insurance plan or coverage as determined each Plan Year by the Administrator.

(aa) Participant means a person who is an Eligible Employee on or after the Effective Date, who applies to participate in the Plan, and who satisfies the participation conditions of Article 3.

(bb) Period of Coverage, with respect to any Plan Year, means that Plan Year. However, for any Employee:

(1) Who becomes a Participant after the start of a Plan Year, the Period of Coverage means the period commencing on the effective date of the Participant's participation and extending through the remainder of the Plan Year, or

(2) Who ceases being a Participant after the start of a Plan Year, the Period of Coverage means the period commencing on the first day of the Plan Year and extending through the last day of the Participant's participation.

(cc) Plan means the Autodesk, Inc. Cafeteria Plan with Flexible Spending Arrangement as amended or restated from time to time.

(dd) Plan Year means each twelve-month period ending December 31.

(ee) Premium Only Option means the option to pay insurance plan premiums on a pre-tax basis through the Plan.

(ff) Protected Health Information or "PHI" means protected health information as defined under HIPAA.

(gg) Qualifying Individual means (i) a Dependent of a Participant who is under the age of 13 who is a qualifying child as defined in Code Section 152; and (ii) a Dependent or Spouse of a Participant who is a qualifying relative as defined by Code Section 152 who is physically or mentally incapable of caring for himself and who has the same principal place of abode as the Participant for more than half the year, without regard to the income limitation set forth in Section 151(d) of the Code.

(hh) Relevant means a document, record, or other information regarding a claimant's claim for a Plan benefit if such document, record, or other information:

(1) Was relied upon in making the benefit determination; or

(2) Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; or

(3) Demonstrates compliance with the administrative processes and safeguards required pursuant to the ERISA claims regulations; or

(4) Constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

(ii) Salary Reduction Contributions means the contributions of a Participant made by salary reduction agreement in accordance with Section 4.2.

(jj) Spouse means the person to whom the Participant is lawfully married under any state law, including individuals married to a person of the same sex who were legally married in a state that recognizes such marriages, but who are domiciled in a state that does not recognize such marriages. For purposes of this definition, "state" means any state of the United States, the District of Columbia, Puerto Rico,

the Virgin Islands, American Samoa, Guam, Wake Island, the Northern Mariana Islands, any other territory or possession of the United States, and any foreign jurisdiction having the legal authority to sanction marriages.

2.2 Gender and Number. Except as otherwise indicated by context, masculine terminology also includes the feminine, and vice versa, and terms used in the singular may also include the plural.

ARTICLE 3. PARTICIPATION

3.1 Participation Conditions. As a condition of participation and receipt of benefits under this Plan, each Participant shall be required to:

(a) Enroll using the online enrollment system and provide any required documentation to the Administrator;

(b) Designate and apply a portion of his or her Compensation as Salary Reduction Contributions and/or Employer Contributions;

(c) Observe all Plan requirements, rules and regulations; and

(d) Submit to the Administrator or the Contractor Administrator all reports, bills and other information that the Administrator or the Contractor Administrator may reasonably require to verify eligibility under the Plan or to process a claim for reimbursement under the Plan.

3.2 Application to Participate. 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, makes a benefit election, and supplies any other pertinent information that the Administrator reasonably requires. The application and any required supporting documents shall be delivered to the Administrator prior to the first day of an 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 Administrator within 30 calendar days after the Eligible Employee's date of hire.

3.3 Commencement of Participation. After an Eligible Employee satisfies the participation requirements of this Article 3, the Eligible Employee may become a Participant the latter of:

(a) The date of hire provided the Administrator receives the Participant's election in the form and manner required by the Administrator within 30 calendar days of the date of hire; or

(b) The first day of the calendar year following an open enrollment period provided that the Administrator timely receives the Participant's election in the form and manner required by the Administrator.

3.4 Cessation of Participation. Participation in the Plan will end at the time that an individual ceases to be a Participant. With respect to periods following the date participation otherwise ends, Salary Reduction Contributions and Employer Contributions will cease but coverage may continue for the remainder of the Period of Coverage with respect to which the required premium has been paid.

ARTICLE 4. CONTRIBUTIONS AND BENEFIT ELECTIONS

4.1 Employer Contributions. The maximum amount of the Employer Contribution provided with respect to any Plan Year shall be an amount communicated to each Participant by the Administrator prior to the beginning of each Plan Year. If the cost of the benefits selected or deemed selected by a Participant for a Plan Year is less than the Participant's Employer Contributions for such Plan Year, the Participant shall receive such excess as additional cash compensation on a pro rata basis per payroll period.

4.2 Salary Reduction Contributions. Each Participant shall designate a portion of his or her Compensation for each Plan year to be applied as Salary Reduction Contributions. The portion shall be specified by the Participant at the time that a benefit election is made pursuant to Section 4.3. If the Participant does not make an election under this Plan the Participant shall be deemed to have elected Default Coverage.

The Employer may, if necessary, adjust the rate to account for benefit election adjustments prescribed by Article 5. Except as otherwise provided by the Employer, Salary Reduction Contributions shall reduce the Participant's Compensation ratably on each pay day beginning on or after the first day of the Participant's participation, and shall continue in effect until changed in accordance with Section 4.3.

4.3 Benefit Elections.

(a) Each Participant shall make a benefit election, in the manner provided in the Plan, to apply his Salary Reduction Contributions and Employer Contributions during each Plan Year, in such proportions as he chooses, to the following:

(1) To pay the Participant's premiums for Employer-sponsored health care insurance and other insured Employer-sponsored plans, as set forth in Article 5.

(2) To apply to the Participant's General Purpose Health Care FSA or the Participant's Limited Purpose Health Care FSA, as applicable, for that Plan Year in accordance with Article 6.

(3) To apply to the Participant's Dependent Care FSA for that Plan Year in accordance with Article 7.

(4) To apply to the Participant's HSA for that Plan Year in accordance with Article 8.

A Participant's initial benefit election shall be made as part of his application to participate under Section 3.2 and the election shall remain in effect until changed in accordance with this Section. A Participant may change his benefit election for a subsequent Plan Year by enrolling during annual open enrollment as announced by the Administrator.

(b) A Participant's benefit election for any Plan Year shall be irrevocable during the Plan Year, except that the Employer may limit a Participant's contributions in accordance with Section 14.2.

(c) Salary Reduction Contributions to HSA

(1) Notwithstanding the foregoing, to make a Salary Reduction Contributions towards HSA Benefits, a Participant must: (i) be enrolled in the high-deductible health plan HSA-compatible health plan option offered under the Health and Welfare Plan, (ii) be an individual who is eligible to contribute to an HSA as provided in Section 223 of the Code; (iii) not be enrolled in any disqualifying health plan coverage offered by the Employer, including but not limited to the General Purpose Health Care FSA (a Participant may not make a Salary Reduction Contributions towards HSA Benefits for the first three calendar months of a Period of Coverage if such Participant has an election in effect under the General Purpose Health Care FSA on the last day of the immediately preceding Period of Coverage, unless the balance in that Participant's General Purpose Health Care FSA is $0 on the last day of that immediately preceding Period of Coverage (as determined on a cash basis without taking into account expenses that have not been reimbursed as of that date); (iv) has opened a valid HSA with the trustee/custodian selected by the Employer; and (v) reside or work in a state in which contributions to a health savings account may be made on a pre-tax basis. Once an Employee meets the Plan's eligibility requirements, the Employee may elect coverage effective the first day of the next calendar month, or for any subsequent Period of Coverage, in accordance with the procedures in Article 4.

(2) For purposes of the General Purpose Health Care FSA, an Employee who enrolls in the high-deductible health plan HSA-compatible option offered under the Health and Welfare Plan and who elects to contribute to HSA Benefits in the same Period of Coverage shall not be eligible to elect or participate in the General Purpose Health Care FSA. Such Employee is eligible to enroll in Limited Purpose Health Care FSA only and may elect coverage thereunder. If an Employee makes an election under the General

Purpose Health Care FSA for a given Period of Coverage and later enrolls in or is otherwise covered by a high-deductible health plan HSA-compatible option offered under the Health and Welfare Plan and elects to contribute towards HSA Benefits, such Employee's election under the General Purpose Health Care FSA shall automatically and immediately be converted as of the date such Employee commences coverage under the high-deductible health plan HSA-compatible option offered under the Health and Welfare Plan, for the remainder of such Period of Coverage to a Limited Purpose Health Care FSA.

(3) For purposes of the General Purpose Health Care FSA, an Employee who does not enroll in a high-deductible health plan HSA-compatible option offered under the Health and Welfare Plan in the same Period of Coverage shall be eligible to elect or participate in the General Purpose Health Care FSA only and shall not be eligible to enroll in Limited Purpose Health Care FSA unless the Employee certifies in writing that the Employee is covered under another high-deductible health plan HSA-compatible offered outside the Employer (for example, such a plan sponsored by the Employee's Spouse) in which case such Employee may enroll in the Limited Purpose Health Care FSA.

(4) If an Employee who is enrolled in the high-deductible health plan HSA-compatible option offered under the Health and Welfare Plan and makes an election under the Limited Purpose Health Care FSA for the same Period of Coverage and later enrolls in a medical plan other than high-deductible health plan HSA-compatible option offered under the Health and Welfare Plan in the same Period of Coverage, such Employee's election and balance under the Limited Purpose Health Care FSA will be automatically converted at that time to the same election and balance under the General Purpose Health Care FSA. The Employee's new election and balance under the General Purpose Health Care FSA will apply for the remainder of the Period of Coverage and the Employee will no longer be permitted to contribute to the HSA Benefits component of the Plan for that period, subject to the rules set forth in this Plan.

(5) If an Employee who is enrolled in the high-deductible health plan HSA-compatible option offered under the Health and Welfare Plan, makes an election under the Limited Purpose Health Care FSA for the same Period of Coverage and within the same Period of Coverage minimum satisfies the annual "high deductible health plan" deductible under Code §223(c)(2)(A)(i), such Employee's election and balance under the Limited Purpose Health Care FSA will be automatically converted at the time such minimum deductible is met to the same election and balance under the General Purpose Health Care FSA. The Employee's new election and balance under the General Purpose Health Care FSA will apply for the remainder of the Period of Coverage and the Employee will be permitted to

contribute to the HSA Benefits component of the Plan for that period, subject to the rules set forth in this Plan.

(6) Once a Salary Reduction Contribution is deposited in an HSA, contributions are governed by the trustee/custodian per the agreement between the Employee and trustee/custodian when the HSA was opened, including the requirements relating to contributions that exceed the applicable statutory maximum.

(d) Change in Status for All Benefits Other Than HSA Benefits.

(1) Except with respect to HSA Benefits, if the Participant has a Change in Status (as defined in Section 4.3(c)(2) below), he shall be entitled to revoke or modify his benefit election in a manner that is consistent with such Change in Status, by providing written notice to the Administrator within 30 calendar days of the status change. An authorized change in the Participant's benefit election due to a Change in Status shall be effective at the time determined by the Administrator in accordance with the Internal Revenue Code and applicable Treasury Regulations.

(2) A Change in Status is an event that falls into one of the following categories:

(A) Legal Marital Status Changes: including marriage, death of Spouse, divorce, legal separation and annulment.

(B) Changes in Number of Dependents: including birth, death, adoption and placement for adoption (note: to the extent enrollment is subject to Section 4.3(e) below, the enrollment provisions of Section 4.3(e) will control).

(C) Employment Status Changes of the Participant or the Participant's Spouse or Dependents:

(i) Termination or commencement of employment, strike or lockout, commencement or return from unpaid leave of absence, change of work-site or change in employment status.

(ii) Notwithstanding the foregoing, an election of coverage under a group health plan that provides "minimum essential coverage" as defined in Internal Revenue Code Section 5000A(f)(1) (hereinafter for purposes of this election change event, "MEC") and contributions towards such coverage under Article V, may be revoked in the following circumstances, in accordance with IRS Notice 2014-55:

1. When a Participant who was in an employment status under which he was reasonably expected to average at least 30 hours of service per week at the time he elected MEC under Article V, shall be permitted to revoke such election of such coverage if:

    a. The Participant's employment status changes so that he is reasonably expected to average less than 30 hours of service per week after the change, even if that reduction does result in the Participant ceasing to be eligible for such MEC; and

    b. The Participant represents to the Plan that such Participant intends to enroll (or has enrolled) himself and his Dependents who will lose coverage because of the revocation in another plan that provides "minimum essential coverage" that will become effective no later than the first day of the second month following the month in which the Participant's election will be revoked; or

2. When a Participant becomes eligible for a special enrollment period under Internal Revenue Code Section 9801(f) and represents to the Plan that such Participant intends to enroll (or has enrolled) himself and his Dependents who will lose coverage because of the revocation in a "qualified health plan" through a competitive marketplace established under Section 1311 of the Patient Protection and Affordable Care Act and that such coverage will become effective no later than the day immediately following the last day of the Participant's MEC under Article V.

(D) Dependent Satisfies or Ceases to Satisfy the Requirements for Unmarried Dependents: change in student status or dependent no longer qualifies because of age.

(E) Change in Residence: change in place of residence of the employee, Spouse or Dependent that affects eligibility for benefits.

(3) For accident or health coverage and group term life, the election change is consistent with the Change in Status only if the election change is on

account of and corresponds with a Change in Status that affects eligibility for coverage under the Employer's Plan or if it is made pursuant to IRS Notice 2014-55.

For other qualified benefits, the election change is consistent with the Change in Status only if it meets one of the following conditions:

(A) The election change is on account of and corresponds with a change in status that affects eligibility for coverage under the Employer's Plan.

(B) The election change is on account of and corresponds with a change in status that affects expenses described in IRC Section 129 with respect to the Dependent Care FSA.

The consistency rule of this Subsection shall be interpreted in accordance with the special consistency rules of applicable law.

(e) Judgments or Orders.

A Participant may revoke or modify his benefit election during the current Plan Year if the revocation or modification is on account of a Qualified Medical Child Support Order (QMCSO) or other Judgments or Orders under 29 USC Section 1169(a);

(f) Special Enrollment.

A Participant may revoke or modify an election with respect to coverage under the Autodesk, Inc. Group Welfare Plan on account of the special enrollment rights of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

(1) HIPAA Special Enrollment is permitted if the Participant provides written notice to the Administrator within thirty (30) days if

(A) The Participant previously declined group health plan coverage under the Autodesk, Inc. Group Welfare Plan for himself, his Spouse, Domestic Partner, or Dependents on account of coverage 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.

(2) HIPAA Special Enrollment is permitted if the Participant acquires a new dependent(s) due to marriage (or becoming eligible as a Domestic Partner as determined by the Plan Administrator), provided the Participant provides

written notice to the Administrator within thirty (30) days of the marriage or domestic partnership.

(3) HIPAA Special Enrollment is permitted if the Participant acquires a new dependent on account of birth, adoption or placement for adoption, provided the Participant provides written notice to the Administrator within sixty (60) days of the dependent's birth, adoption or placement for adoption;

(4) Coverage due to a HIPAA Special Enrollment generally becomes effective for the next payroll period after the new election change is processed. However, actual enrollment for coverage under the Autodesk, Inc. Group Welfare Plan will not occur until the applicable contract administrator or HMO provider under such plan accepts the applicable application for enrollment. 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.

(5) If coverage is made due this Section 4.3(e), the Participant will be permitted to change his prior elections for health care coverage. For example, other previously eligible Dependents who were not initially enrolled in the Autodesk, Inc. Group Welfare Plan may be enrolled.

(g) Medicare or Medicaid Entitlement.

On account of an employee, Spouse or Dependent becomes entitled to coverage under Part A or Part B of Medicare or Medicaid for purposes of health coverage under the Health and Welfare Plan. Any change under this Section 4.3(f) may be effectuated if written notice of the change is provided to the Administrator within 30 days of enrollment in Medicare or Medicaid.

(h) COBRA Entitlement.

If a Participant, or the Participant's Spouse or Dependent becomes entitled under Code Section 4980B, or any similar state law, for continuation coverage, a Participant may decrease his or her salary reduction contributions. Alternatively, a Participant may increase his or salary reduction contributions to pay for such continuation coverage. Any change under this Section 4.3(g) may be effectuated if written notice of the change is provided to the Administrator within 30 days of enrollment in continuation coverage.

(i) Cost and Coverage Changes. This section does not apply to the General Purpose Health Care FSA or the Limited Purpose Health Care FSA or HSA Benefits.

(1) Cost Changes.

(A) The Employer may modify a Participant's contribution in accordance with the automatic adjustment in Section 5.2.

(B) If the cost of coverage of an Employer-sponsored Plan described in Section 5.1 significantly increases or significantly decreases, a Participant who is covered under that Employer-sponsored Plan may choose to pay the increased or decreased premium or revoke coverage under the Plan for which the premiums are being increased and elect coverage under a Plan providing similar coverage, if available.

If the cost of coverage of an Employer-sponsored Plan described in Section 5.1 significantly decreases, an Eligible Employee who is not a Participant may choose to commence participation in the Plan with the decrease in cost.

(C) With respect to a Dependent Care FSA Plan under Article 7, a Participant may modify a benefit election if the cost for service provided by a dependent care provider, who is not a relative of the Participant, increases or decreases.

(D) Cost changes covered by this Section 4.3(h)(1) include but are not limited to, cost changes initiated by the Eligible Employee or the Employer.

(E) The changes described in Section 4.3(h)(1)(B) through (D) may be effectuated if written notice is furnished to the Administrator within 30 calendar days of the cost change. An authorized change in the Participant's benefit election shall be effective at the time determined by the Administrator in accordance with the Internal Revenue Code and applicable Treasury Regulations.

(2) Coverage Changes.

(A) If coverage provided under a plan described in Section 5.1 or Article 7 is significantly curtailed that is not a loss of coverage, a Participant who is covered under that plan shall be entitled to change his benefit election by revoking coverage under the plan being curtailed but must elect coverage under a plan providing similar coverage, if available.

(B) If coverage provided under a plan described in Section 5.1 or Article 7 is significantly curtailed that is a loss of coverage, a Participant who is covered under that plan shall be entitled to change his benefit election by revoking coverage under the plan being curtailed and elect coverage under a plan providing similar coverage, if available.

(C) If during a period of coverage, a new benefit plan is added or an existing benefit option is significantly improved, an Eligible Employee may elect the new benefit plan or improved benefit plan and make a corresponding election change with respect to other plans providing similar coverage.

(D) A Participant may make a change in such Participant's benefit election if such change is on account of and corresponds with a change made under another employer plan if (a) such change is permitted under the other employer's cafeteria plan (or qualified benefit plan) and Code requirements applicable to such change; or (b) this Plan permits participants to make an election for a period of coverage which is different from the period of coverage under the other cafeteria plan (or qualified benefit plan).

(E) The changes described in Section 4.3(h)(2)(A) through (D) may be effectuated if written notice is furnished to the Administrator within 30 calendar days of the cost change. An authorized change in the Participant's benefit election shall be effective at the time determined by the Administrator in accordance with the Internal Revenue Code and applicable Treasury Regulations.

(j) Election Changes for HSA Benefits.

(1) A Participant may change his or her Salary Reduction Contribution for HSA Benefits at any time. Changes will be calculated based on remaining pay periods in the calendar year. This includes making a new election, revoking a previous election, and increasing or decreasing the amount of the current election. All HSA Salary Reduction Election changes will be effective on a prospective basis. This paragraph shall apply only to elections of HSA Benefits. Any change in election of HSA Benefits that decreases the amount of the contribution to the HSA, either through a decrease or a revocation, will result in the Participant's receipt of that amount as taxable income.

(2) Furthermore, the Company may, at any time, amend the amount of any election for HSA Benefits if it determines that such action is necessary or advisable, including but not limited to, satisfying the requirements of Section 223 of the Code or the nondiscrimination requirements of the Code.

(k) Special Rule for Rehires.

(1) A Participant who separates from the service of the Employer during a Period of Coverage may revoke existing benefit elections and terminate the receipt of benefits for the remaining portion of the Period of Coverage. If the Employee should return to service within 30 calendar days for the Employer during the same Plan Year, the Employee shall reenroll with the same benefit elections prior to termination for the remaining portion of the Period of Coverage. If the Employee should return to service of the Employer after 30 calendar days, but during the same Plan Year, the Employee may enroll with a new Benefit Election for the remaining portion of the Period of Coverage.

(2) Notwithstanding the foregoing or anything else in this Plan to the contrary, an individual who returns from an FMLA leave of absence shall be entitled to reinstatement in this Plan as may otherwise be required under the Family and Medical Leave Act or other applicable law.

(l) Medicaid or State Child Health Insurance Plan (CHIP).

(1) 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:

(A) 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

(B) 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.

(m) Special Requirements for FMLA Leave.

(1) A Participant taking an FMLA Leave may revoke an existing election of group health plan coverage under a plan to which this Plan applies and may make such other election for the remaining portion of the Plan Year for which an election under this Plan applies as may be provided for under the FMLA, and under applicable guidance issued under Section 125 of the Code pertaining to FMLA leaves, as it may be amended from time to time.

(2) When the Participant returns from taking leave under FMLA after having revoked his benefit elections on account of taking FMLA Leave, the Participant may have his benefit elections reinstated in the manner provided by Treasury Regulations section 1.125-3.

ARTICLE 5. INSURANCE PREMIUMS

5.1 Coverages. To the extent a Participant so elects, a portion of the Participant's Salary Reduction Contributions and/or Employer Contributions shall be used to pay the Participant's share of the cost of medical, dental and vision coverage (employee only, employee plus Spouse, employee plus one child, employee plus two children, employee plus three children, employee plus Spouse plus one child, employee plus Spouse plus two children, or employee plus Spouse plus three children coverage, whichever applies) under the Autodesk, Inc. Group Welfare Plan.

The maximum annual contribution per Participant to pay for insurance premiums under Article 5 shall be the actual cost of such premium payments. The benefit description in each of those plans is incorporated by reference into this Plan. The terms and conditions of each of those plans shall govern the provision of benefits under each plan.

5.2 Automatic Adjustments. If during the Plan Year the cost of Employer-sponsored Plans described in Section 5.1 which is selected by a Participant change and the change is not significant, the Participant's benefit election shall, with respect to premium payments for that health plan, automatically be adjusted to reflect such change. A Participant shall not be permitted to change coverage during a Plan Year because of change in the cost of coverage, except as otherwise provided in Article 4.

ARTICLE 6. GENERAL PURPOSE HEALTH CARE FSA AND LIMITED PURPOSE HEALTH FSA CARE PLANS

6.1 General Purpose Health Care FSA and Limited Purpose Health Care FSA. The Administrator shall establish for each Participant who elects one of the benefit options under this Article 6 either a General Purpose Health Care FSA or a Limited Purpose Health Care FSA for each Plan Year. To the extent a Participant so elects, a portion of the Participant's Salary Reduction Contributions shall be used to fund a General Purpose Health Care FSA or a Limited Purpose Health Care FSA, as applicable. The Employer may establish the annual minimum and maximum General Purpose Health Care FSA and Limited Purpose Health Care FSA contribution amounts. The maximum annual contribution per Participant to the General Purpose Health Care FSA or the Limited Purpose Health Care FSA shall be $2,850.00 for the 2022 Plan Year, and the minimum is $25.00. The $2,850.00 limitation set forth in this Section 6.1 shall be adjusted each Plan Year for cost of living increases as set forth in Section 125(i)(2) of the Code as determined by the Internal Revenue Service, and as communicated to Participants by the Employer. Each General Purpose Health Care FSA or Limited Purpose Health Care FSA shall contain zero dollars ($0.00) initially and at the commencement of each Plan Year, subject to any amount carried over as permitted by the Plan and applicable law.

A Participant may enroll in either the General Purpose Health Care FSA or the Limited Purpose Health Care FSA — a Participant may not enroll in both. Furthermore, a participant may not move from General to Limited or Limited to General during a Plan Year. The General Purpose Health Care FSA may reimburse eligible medical, dental,

vision and other eligible Health Care Expenses. The Limited Purpose Health Care FSA only reimburses eligible dental and vision care expenses—it does not reimburse medical care expenses. The Limited Purpose Health Care FSA is available to Eligible Employees who are enrolled in the UHC Choice Plus High Deductible PPO, which is a Health Savings Account compatible medical plan and employees who are covered by a Health Savings Account compatible-high deductible health plan sponsored by his Spouse's employer.

6.2 Increases in General Purpose Health Care FSA or Limited Purpose Health Care FSA. A Participant's General Purpose Health Care FSA or Limited Purpose Health Care FSA for a Plan Year shall be increased by the portion of the Participant's Salary Reduction Contributions for that Plan Year that he has elected to apply toward his General Purpose Health Care FSA or Limited Purpose Health Care FSA in accordance with Section 4.3.

6.3 Decreases in General Purpose Health Care FSA or Limited Purpose Health Care FSA. The balance in a Participant's Health Care FSA or Limited Purpose Health Care FSA for a Plan Year shall be reduced by the amount of any benefits paid to a Participant under Section 6.4.

6.4 Health Care Benefits. Subject to limitations contained in other provisions of this Plan, a Participant who elects the General Purpose Health Care FSA benefit option under this Article 6 and who incurs Health Care Expenses attributable to himself, his Spouse or his dependents during his Period of Coverage for a Plan Year shall be entitled to receive from the Plan full reimbursement for the entire amount of such Health Care Expenses to the extent of the amount of the Participant's benefit election for the General Purpose Health Care FSA for that Plan Year less prior reimbursements. Subject to limitations contained in other provisions of this Plan, a Participant who elects the Limited Purpose Health Care FSA benefit option under this Article 6 and who incurs eligible dental and vision care expenses attributable to himself, his Spouse or his dependents during his Period of Coverage for a Plan Year shall be entitled to receive from the Plan full reimbursement for the entire amount of such dental and vision care expenses to the extent of the amount of the Participant's benefit election for the Limited Purpose Health Care FSA for that Plan Year less prior reimbursements, subject to any amount carried over as permitted by the Plan and applicable law.

6.5 Reimbursement Procedures. In order to receive reimbursement for Health Care Expenses under the General Purpose Health Care FSA or reimbursement for eligible dental and vision care expenses under the Limited Purpose Health Care FSA of this Article 6:

(a) The Participant must complete a claim form, attach (i) an itemized billing statement from the health care provider, (ii) an explanation of benefits from the Participant's insurer or (iii) other satisfactory proof of claim, and forward the documents to the Contract Administrator. The Participant must provide additional information reasonably requested by the Contract Administrator.

(b) A request for reimbursement must relate to Health Care Expenses incurred during the Participant's Period of Coverage. For this purpose, the term "incurred" refers to when the health care services were provided.

(c) A request for reimbursement for Health Care Expenses incurred during a Plan Year must be received by the Contract Administrator either during the Period of Coverage or on or before 90 calendar days following the Period of Coverage ("run-out period").

(d) Reimbursement, if made, shall be made by the Contract Administrator directly to the Participant, upon which the Employer, the Plan, the Administrator and the Contract Administrator shall be relieved of all responsibility with respect to the Health Care Expenses reimbursed.

Upon presentation of a claim, a Participant shall expressly represent that the item for which a claim is made is not subject to reimbursement under any policy described in Article 5 or from any other source or that such item will not be used as a deduction under Section 213 of the Code.

(e) The Employer may establish a minimum reimbursement amount.

6.6 Limitations on Health Care Benefits. Despite the provisions of this Article 6, no benefits shall be paid under this Article:

(a) If and to the extent that such reimbursement or payment is made under any insurance policy or policies, whether paid for by the Employer or the Participant, or under any other health and accident plan by whoever maintained.

(b) To the extent that an expense has been submitted for reimbursement from a Participant's Dependent Care FSA.

(c) For any expenses incurred for medical insurance premiums.

6.7 Continuation of General Purpose Health Care FSA Plan and Limited Purpose Health Care FSA Plan Coverage. If you have a COBRA qualifying event, and you are "underspent" in your Health Care FSA Plan or your Limited Purpose Health Care FSA Plan, as applicable, you may continue to contribute to your General Purpose Health Care FSA Plan or your Limited Purpose Health Care FSA Plan under COBRA on a post-tax basis until the end of the calendar year in which the COBRA qualifying event occurs. This enables you to submit eligible expenses incurred after your termination or status change date for reimbursement. If you elect COBRA coverage, it will be retroactive to your termination date. If you do not elect to continue coverage through COBRA, you can only submit claims for reimbursement for services incurred through your termination date or status change date. For more information about COBRA continuation rights and coverage, see the Employer's COBRA Notice.

6.8 Additional Requirements for Group Health Plans. The General Purpose Health Care FSA Plan and the Limited Purpose Health Care FSA Plan shall be interpreted and administered so as to provide coverage, under written procedures established by the Administrator, with respect to individuals for whom coverage is required by the applicable provisions of ERISA section 609 and any regulations under those provisions.

6.9 Separate Written Plan. For purposes of the Code, this Article shall constitute a separate written plan providing for the reimbursement of Health Care Expenses. To the extent necessary, other provisions of the Plan are deemed incorporated by reference in this Article 6.

6.10 Certain Election Changes Not Permitted. Section 4.3(e) does not apply to an election change with respect to the General Purpose Health Care FSA Plan or the Limited Purpose Health Care FSA Plan described in this Article 6.

6.11 Application of HIPAA Privacy and Security Rules. The General Purpose Health Care FSA Plan and the Limited Purpose Health Care FSA Plan are each intended to qualify as a group health plan and are subject to Article 9.

6.12 Erroneous Reimbursements or Payments. In the event of an erroneous reimbursement or payment under this Article 6, the Employer may take such steps as are consistent with applicable law to recoup such monies for the benefit of the Plan, or to impute such amounts as income to affected Participants.

6.13 Disposition of Unclaimed General Purpose Health Care FSA and Limited Purpose Health Care FSA Reimbursement Checks. In the event a Participant fails to cash a Health Care FSA or a Limited Purpose Health Care FSA reimbursement check within one year of the date of its issuance (a "Stale Check"), such monies shall be automatically forfeited by the Participant. A Participant shall have no right to request or receive a reissued Stale Check.

ARTICLE 7. DEPENDENT CARE FSA PLAN

7.1 Dependent Care FSA. The Administrator shall establish for each Participant who elects the benefit option under this Article 7, a Dependent Care FSA for each Plan Year. To the extent a Participant so elects, a portion of the Participant's Salary Reduction Contributions and/or Employer Contributions shall be used to fund a Dependent Care FSA. The maximum annual contribution per Participant to his Dependent Care FSA under Section 7.1 shall be the lesser of: (i) $5,000.00 (with respect to a calendar year), or, instead, $2,500.00 (with respect to a calendar year) if a Participant is married and files a separate Federal income tax return for that year; (ii) the Participant's earned income or (iii) the Spouse's earned income, if applicable.

(a) The maximum annual contribution shall not be affected by any amount carried over from the prior Plan Year to the current Plan Year in accordance with Section 10.2 as permitted by the Consolidated Appropriations Act, 2021 and IRS Notice 2021-15.

(b) If the Spouse is a full-time student or is disabled, the Spouse is deemed to have an income of $250 per month for one dependent, or $500 per month for two or more dependents. The Employer will establish the annual minimum Dependent Care FSA contribution amount. The annual maximum Dependent Care FSA contribution amount is established by the IRS. The minimum annual contribution amount is $25.00. Each Dependent Care FSA shall contain zero dollars ($0.00) initially and at the commencement of each Plan Year.

7.2 Increases in Dependent Care FSA. A Participant's Dependent Care FSA for a Plan Year shall be increased each payroll period by the portion of the Participant's Salary Reduction Contributions and/or Employer Contributions for that Plan Year that he has elected to apply toward his Dependent Care FSA in accordance with Section 4.3.

7.3 Decreases in Dependent Care FSA. The balance in a Participant's Dependent Care FSA for a Plan Year shall be reduced by the amount of any benefit paid to or on behalf of a Participant under Section 7.4.

7.4 Dependent Care Benefits. Subject to limitations contained in other provisions of this Plan, a Participant who elects the benefit option under this Article 7 and incurs Employment-Related Dependent Care Expenses during his Period of Coverage for a Plan Year shall be entitled to receive from the Plan full reimbursement for the entire amount of such expenses to the extent of the amount contained in the Participant's Dependent Care FSA for that Plan Year. However, no reimbursement shall be paid pursuant to this Article to the extent that an expense has been submitted and reimbursed from a Participant's General Purpose Health Care FSA or from a Participant's Limited Purpose Health Care FSA.

7.5 Reimbursement Procedures. In order to receive reimbursement for dependent care expenses under this Article 7:

(a) The Participant must complete a claim form, attach a statement of service from the dependent care provider or other proof of claim, and forward the documents to the Contract Administrator. The Participant must provide additional information reasonably requested by the Contract Administrator.

(b) A request for reimbursement that exceeds the balance in the Participant's Dependent Care FSA (including any amount carried over as permitted by the Plan and applicable law) shall be processed only to the extent of the amount of the account balance. The excess shall be carried over to a subsequent reimbursement period to the extent of the amount of the available balance and processed at that time. However, after the Participant's Dependent Care FSA has been exhausted, claims remaining unpaid at the end of the Plan Year shall be canceled. In no event may these claims be resubmitted during the following Plan Year, nor shall any unpaid claims be the liability of the Plan, the Employer, the Administrator or the Contract Administrator.

(c) A request for reimbursement must relate to Employment-Related Dependent Care Expenses incurred during the Participant's Period of Coverage. For this purpose, the term "incurred" refers to when the dependent care services were provided.

(d) A request for reimbursement for Dependent Care Expenses incurred during a Plan Year must be received by the Contract Administrator either during the Period of Coverage or on or before 90 calendar days following the Period of Coverage.

(e) Reimbursement, if made, shall be made by the Contract Administrator directly to the Participant, which shall cause the Employer, the Plan, and the Administrator to be relieved of all responsibility with respect to the Employment-Related Dependent Care Expenses reimbursed.

(f) The Employer may establish a minimum reimbursement amount.

7.6 Separate Written Plan. For purposes of the Code, this Article shall constitute a separate written plan providing a program for the reimbursement of Employment-Related Dependent Care Expenses. To the extent necessary, other provisions of the Plan are deemed incorporated by reference in this Article 7.

7.7 Erroneous Reimbursements or Payments. In the event of an erroneous reimbursement or payment under this Article 7, the Employer may take such steps as are consistent with applicable law to recoup such monies for the benefit of the Plan, or to impute such amounts as income to affected Participants.

7.8 Disposition of Unclaimed Dependent Care FSA Reimbursement Checks. In the event a Participant fails to cash a Dependent Care FSA reimbursement check within one year of the date of its issuance (a "Stale Check"), such monies shall be forfeited by the Participant. A Participant shall have no right to request or receive a reissued Stale Check.

ARTICLE 8. HEALTH SAVINGS ACCOUNT

8.1 Benefits . An eligible Employee can elect to participate in the HSA Benefits component of this Plan by electing to make contributions to the HSA established by the Employee with the trustee/custodian to whom the Employer has agreed to forward contributions for deposit. As described in Article 4, such election can be increased, decreased or revoked prospectively at any time during the Period of Coverage, effective no later than the first day of the next calendar month following the date that the election change was filed.

8.2 Contributions for Cost of Coverage for HSA. The annual contribution for a Participant's HSA Benefits is equal to the following: (1) the annual benefit amount elected by the Participant, provided such Participant elected coverage under a high-deductible health plan HSA-compatible option offered under the Health and Welfare Plan, or (2) the annual benefit amount elected by the Participant and any Employer contribution made on the Participant's behalf, provided such Participant elected coverage under a high-deductible health plan HSA-compatible option offered under the Health and Welfare Plan. In no event

shall the amount contributed by the Participant and the Employer, as applicable, exceed the statutory maximum amount for HSA contributions applicable to the high-deductible health plan HSA-compatible option offered under the Health and Welfare Plan for the calendar year in which the contribution is made.

(a) An additional catch-up contribution of $1,000 may be made for Participants who are age 55 or older.

(b) In addition, the maximum annual contribution shall be:

(1) reduced by any matching (or other) Employer contribution made on the Participant's behalf if such Participant, if any; and

(2) prorated for the number of months in which the Participant is an eligible to contribute to an HSA as provided in Section 223 of the Code.

8.3 Recording Contributions for HSA. The HSA is not an employer-sponsored employee benefit plan-it is an individual trust or custodial account separately established and maintained outside the Plan by the trustee/custodian. The HSA trustee/custodian, not the Employer, establishes the HSA at the direction of the Participant and maintains the HSA. The HSA trustee/custodian, however, to which pre-tax Contributions may be made under this Plan is chosen by the Employer. The Employer will forward contributions that the Employee makes to the HSA established by the HSA trustee/custodian at the direction of the Participant. No Contributions will be forwarded on behalf of a Participant unless the Participant has established a valid HSA with the trustee/custodian selected by the Employer. The Employer will not create a separate fund or otherwise segregate assets for this purpose. The Employer has no authority or control over any funds deposited in any HSA.

8.4 Tax Treatment of HSA Contributions and Distributions. The federal income tax treatment of the HSA (including contributions and distributions) is governed by Code § 223. The taxation of contributions may be further governed by applicable state law.

8.5 HSA Not Intended to Be an ERISA Plan. HSA Benefits under this Plan only consist of the ability to make contributions to the HSA on a pre-tax compensation reduction basis. Terms and conditions of coverage and benefits (e.g., distributions, claims procedures, etc.) will be provided by and are set forth in the HSA trust or custodial agreement provided by the applicable trustee/custodian to each electing Participant and are not a part of this Plan.

8.6 The HSA is not an employer-sponsored employee benefits plan. It is a savings account that is established and maintained by an HSA trustee/custodian outside this Plan for the purpose of reimbursing "qualified eligible medical expenses" as set forth in Code § 223(d)(2).

ARTICLE 9. APPLICATION OF HIPAA PRIVACY AND SECURITY RULES

9.1 HIPAA Privacy and Security Rules. To the extent and effective when required by HIPAA, the Employer agrees that it shall take the following actions with respect to the General Purpose Health Care FSA Plan and the Limited Purpose Health Care FSA Plan:

(a) use and disclose Protected Health Information ("PHI") only for payment and health care operations under the General Purpose Health Care FSA Plan and the Limited Purpose Health Care FSA Plan and not use or further disclose PHI other than as required by law;

(b) ensure that any agents or subcontractors to which it provides PHI received from the General Purpose Health Care FSA Plan and the Limited Purpose Health Care FSA Plan agree to same restrictions and conditions that apply to the Plan Sponsor;

(c) not use or disclose PHI for employment-related actions or in connection with any other employee benefit plan;

(d) report to the General Purpose Health Care FSA Plan or the Limited Purpose Health Care FSA Plan, as applicable, any use or disclosure of information that is inconsistent with the permitted uses or disclosures described herein;

(e) make PHI available to plan participants, consider their amendments and, upon request, provide them with an accounting of PHI disclosures;

(f) make its internal practices and records relating to the use and disclosure of PHI received from the General Purpose Health Care FSA Plan and the Limited Purpose Health Care FSA Plan available to the United States Department of Health and Human Services;

(g) if commercially reasonable, return or destroy all PHI received from the General Purpose Health Care FSA Plan and the Limited Purpose Health Care FSA Plan and maintained in any form, retaining no copies of such information when no longer needed for the purpose for which the disclosure was made, except that, if such return or destruction is not commercially reasonable, limit further uses and disclosures to the purposes that make the return or destruction infeasible;

(h) permit only those employees of an Employer who are responsible for payment and health care operations under the General Purpose Health Care FSA Plan and the Limited Purpose Health Care FSA Plan to receive PHI;

(i) restrict access to and use of PHI by the employees described in Subsection (h) above to the General Purpose Health Care FSA Plan and the Limited Purpose Health Care FSA Plan administrative functions that the Employer performs for the Health Care FSA Plan and the Limited Purpose Health Care FSA Plan, except as otherwise allowed by HIPAA

(j) resolve any issues of noncompliance with HIPAA through intervention by an appropriate officer of the Employer;

(k) ensure the adequate separation between the General Purpose Health Care FSA Plan and the Limited Purpose Health Care FSA Plan and the plan sponsor required in HIPAA as set forth in 45 CFR § 164.504(f)(2)(iii);

(l) ensure that any agent, including any subcontractor, to which it provides electronic Protected Health Information ("ePHI"), as defined in HIPAA, agrees to the restrictions, conditions, and security measures of the Plan with respect to Participants' ePHI;

(m) implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of Participants' ePHI that Employer creates, receives, maintains, or transmits on Plan's behalf;

(n) report to the Plan and affected Participant(s), upon the Plan's request, any attempted or successful (i) unauthorized access, use, disclosure, modification, or destruction of Participants' ePHI or (ii) interference with Employer's system operations in Employer's information systems, of which Employer becomes aware, except any such security incident that results in disclosure of Participants' ePHI not permitted by the Plan must be reported to Plan as soon as reasonably possible; and

(o) support the adequate separation between Employer and the Plan with reasonable and appropriate security measures.

ARTICLE 10. FORFEITURES AND LIMITATIONS

10.1 Health Care FSA Account Forfeitures.

(a) Carryover Amount. The Plan shall provide for a carryover of up to 20 percent of the maximum Salary Reduction Contribution permitted under Internal Revenue Code Section 125(i) for that Plan Year of any amount remaining unused in a General Purpose Health Care FSA or Limited Purpose Health Care FSA as of the end of the Plan Year for use in the immediately following Plan Year. Such carryover amount may be used to pay or reimburse eligible expenses under the General Purpose Health Care FSA or Limited Purpose Health Care FSA as applicable that are incurred in the Plan Year to which the amount was carried over. Eligible expenses incurred during a current Plan Year will be reimbursed first from the available balance for the current Plan Year, if any, and then from amounts that are carried over from the preceding Plan Year. Any available balance up to up to 20 percent of the maximum Salary Redirection permitted under Internal Revenue Code Section 125(i) for that Plan Year will be carried over from each Plan Year regardless of which Plan Year it was initially deducted from pay. Notwithstanding the foregoing, in response to the continuing COVID-19 pandemic and in accordance with the Consolidated Appropriations Act, 2021 and IRS Notice 2021-

15, any balance in a Participant's Health Care FSA as of December 31, 2021, shall be carried over to the 2022 Period of Coverage and allow such Participant to receive reimbursement for eligible expenses incurred during the 2022 Period of Coverage and submitted for reimbursement no later than March 31, 2022 (or, if the Participant's participation in the Plan terminates prior to December 31, 2022, the run-out period applicable to terminated Participants) from his General Purpose Health Care FSA or Limited Purpose Health Care FSA as applicable. Such reimbursements shall be made from the balance carried over from the 2021 Period of Coverage and/or any Salary Reduction amount elected by the Participant for the 2022 Period of Coverage to the General Purpose Health Care FSA or Limited Purpose Health Care FSA as applicable.

(1) Carryovers that are used to reimburse prior Plan Year expenses: (1) will reduce the amounts available to pay prior Plan Year expenses during the prior Plan Year's run-out period; (2) will be counted against the permitted carryover amount; and (3) will not exceed the permitted carryover amount.

(2) Carryover amounts may not be cashed out or converted to any other taxable or nontaxable benefit and will not affect the maximum amount of salary reduction contributions that the participant is permitted to make under §125(i) of the Code.

(b) Participant Opt Out. Notwithstanding the foregoing, any Plan participant shall have the right to opt out of the carryover if such participant has already enrolled in a health care savings account for the following Plan year or to have his carryover contributed to a Limited Purpose Health Care FSA.

10.2 Dependent Care FSA Account Forfeitures . Any amounts contributed to a Participant's Dependent Care FSA which have not been used to pay claims for benefits incurred by the end of each Period of Coverage after the period for filing claims has expired shall be forfeited by a participant.

(a) Notwithstanding, the foregoing, in response to the continuing COVID-19 pandemic and in accordance with the Consolidated Appropriations Act, 2021 and IRS Notice 2021-15, if a Participant has a balance in his or her Dependent Care FSA as of December 31, 2020, such balance shall be carried over to the 2021 Period of Coverage. Such Participant may receive reimbursement for Employment-Related Dependent Care Expenses incurred during the 2021 Period of Coverage and submitted for reimbursement no later than April 15, 2022 (or, if the Participant's participation in the Plan terminates prior to December 31, 2021, the run-out period applicable to terminated Participants) from the balance carried over from the 2020 Period of Coverage. If such a Participant has one or more children who attains the age of 13 either (i) during the 2020 Period of Coverage, or (ii) the 2021 Period of Coverage, for any Child that attained age 13 in the 2020 Period of Coverage or in the 2021 Period of Coverage, the Participant may receive reimbursement for Employment-Related Dependent Care Expenses incurred during the 2021 Plan

Year and submitted for reimbursement no later than March 31, 2022 (or, if the Participant's participation in the Plan terminates prior to December 31, 2021, the run-out period applicable to terminated Participants) from the balance carried over from the 2020 Plan Year for such Child that attained age 13 in the 2020 Plan Year or in the 2021 Plan Year only and not from any Dependent Care FSA election for the 2021 Plan Year.

(1) Further notwithstanding the foregoing, in accordance with the Consolidated Appropriations Act, 2021 and IRS Notice 2021-15, if a Participant has a balance in his or her Dependent Care FSA as of December 31, 2021, such balance shall be carried over to the 2022 Period of Coverage. Such Participant may receive reimbursement for Employment-Related Dependent Care Expenses incurred during the 2022 Period of Coverage and submitted for reimbursement no later than March 31, 2023 (or, if the Participant's participation in the Plan terminates prior to December 31, 2022, the run-out period applicable to terminated Participants) from the balance carried over from the 2022 Period of Coverage.

10.3 Uncashed Benefit Payments and Missing Participants. If within two years 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.

10.4 Limitation on Contributions and Benefits for Certain Participants. The Administrator shall determine whether the Plan fails to satisfy for the Plan Year any nondiscrimination requirement imposed by the Code, or any limitation on benefits provided to Eligible Employees who are considered Highly Compensated Employees, Key Employees and/or 5% owners under applicable Code provisions. The Administrator shall take action that it deems appropriate, under rules uniformly applied to similarly situated Participants, to assure compliance with such requirements or limitations. Such action may include, without limitation, a modification of elections by Highly Compensated Employees, Key Employees and/or 5% owners with or without the consent of such Eligible Employees.

ARTICLE 11. ARTICELIGIBILITY CLAIMS REVIEW PROCEDURES

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

11.1 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 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 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 Administrator will provide written notice of the extension prior to the termination of the initial 60 calendar day period. In such case, the Administrator will make a determination within 120 calendar days after the claim is received. If the Administrator denies the claim for participation in the Plan, in whole or in part, the Administrator will send a written notice explaining the reason(s) for the denial, including references to the specific Plan provision(s) or Employer 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.

11.2 Right of Appeal. If a person's claim for eligibility to participate in the Plan is denied, in whole or in part, they may appeal such denial by submitting to the Director of Global Benefits a written request for review of the claim within 60 calendar days after receiving written notice of such denial from the 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 of 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 of 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 of Global Benefits will make a determination within 120 calendar days after the appeal is received.

The Director of Global Benefits will either reverse the earlier decision and permit participation in the Plan or deny the appeal. In the event that the Director of Global Benefits confirms the denial of the claim, in whole or in part, the Director of 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:

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

(b) 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

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

The Director of 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 12. DEPENDENT CARE FSA CLAIMS REVIEW PROCEDURES

12.1 Determinations. The Contract Administrator shall notify a Participant in writing within 30 calendar days of his written application for benefits of his eligibility or non-eligibility for benefits under the Plan unless special circumstances require an extension of time for perfecting the claim. Notice must be given to the claimant of the extension within 30 calendar days of his submission of the claim. The notice must specify the reason for the extension of the date with which a decision is expected to be rendered.

12.2 Notice. If the Contract Administrator determines that a Participant is not eligible for all or part of the benefits, the notice shall set forth (a) the specific reasons for such denial, (b) a specific reference to the provision of the Plan on which the denial is based, (c) a description of any additional information or material necessary for the claimant to validate his claim and a description of why it is needed, and (d) an explanation of the Plan's claims review procedure and other appropriate information as to the steps to be taken in the event the participant wishes to submit the denied claim for review.

12.3 Review. If a Participant is determined to be ineligible for benefits, or if the Participant believes that he is entitled to greater or different benefits, he shall have the opportunity to have his denied claim reviewed by the Administrator by filing a petition for review with the Administrator within 180 calendar days after he received the claim denial notice. The petition shall state the specific reasons, which the Participant believes, entitle him to benefits or to greater or different benefits. Within 60 calendar days after the Administrator receives the petition for review, the Administrator shall afford the Participant (and his counsel, if any) an opportunity to present his position to the Administrator orally or in writing, and the Participant (or his counsel) shall have the right to review the pertinent documents.

12.4 Decision. The Administrator shall notify the Participant of its final decision in writing within the 60 calendar day period after receiving the request for review stating specifically in writing the basis of the decision in a manner calculated to be understood by the Participant and the specific provisions of the Plan on which the decision is based.

ARTICLE 13. GENERAL PURPOSE HEALTH CARE FSA AND LIMITED PURPOSE HEALTH CARE FSA CLAIMS REVIEW PROCEDURES

13.1 Named Fiduciary. The Administrator is the named fiduciary which has the authority to act with respect to any appeal from a denial of benefits.

13.2 Right to Appeal. Any person whose claim for reimbursement is denied, in whole or in part, or such person's authorized representative, may appeal the denial by submitting a written request for a review of the claim to the Administrator within 180 calendar days after

receiving written notice of the denial from the Contract Administrator. A 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.

13.3 Procedures on Review. If the claimant (or the claimant's authorized representative) requests a review of a denied claim, the following procedures shall apply:

(a) The claimant (or the claimant's authorized representative) shall have the opportunity to submit written comments, documents, records, and other information relating to the claim; and

(b) The claimant (or the claimant's authorized representative) shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information Relevant to the claimant's claim (other than legally or medically privileged documents); and

(c) The review shall take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such comments, documents, records, and other information were submitted or considered in the initial benefit determination; and

(d) The review shall not afford deference to the initial claim denial and shall be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the review, nor the subordinate of that individual; and

(e) In deciding an appeal that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and such health care professional shall not be the individual who was consulted in connection with the adverse benefit determination that is the subject of the review (nor the subordinate of such individual); and

(f) The Administrator shall, upon request, provide for the identification of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

13.4 Decision on Review. The Administrator shall act upon each request for a review within 60 calendar days after receipt thereof and shall give written notice of its decision to the claimant. In the event that the Administrator determines on review that benefits are payable under the Plan, the Administrator will direct the Contract Administrator to promptly send a check to the Participant. In the event that the Administrator confirms the denial of the claim, in whole or in part, the Administrator shall notify the claimant of such denial in

writing. Such written notice shall set forth, in a manner calculated to be understood by the claimant, the following information:

(a) The specific reason(s) for the denial; and

(b) Reference to the specific Plan provision(s) on which the denial is based; and

(c) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information Relevant to the claimant's claim for reimbursement; and

(d) A statement of the claimant's right to bring an action under Section 502(a) of ERISA; and

(e) If an internal rule, guideline, protocol, or other similar criterion was relied upon in denying the claim, either the specific rule, guideline, protocol, or other similar criterion, or a statement that such rule, guideline, protocol or other similar criterion was relied upon in denying the claim, and that a copy of such rule, guideline, protocol, or other similar criterion will be provided to the claimant free of charge upon request; and

(f) If the denial is based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided to the claimant free of charge upon request.

13.5 Rules and Procedures. The Administrator shall establish such rules and procedures as it deems necessary or appropriate in carrying out its responsibilities under this Section 13. The Administrator may require the claimant to submit (at the expense of the claimant) such additional facts, documents or other material as it may deem necessary or appropriate in making its review.

13.6 Exhaustion of Remedies. No action at law or in equity shall be brought to recover benefits under this Plan unless the action is commenced within two years after the occurrence of the loss for which a claim is made. No action at law or in equity shall be brought to recover a benefit under this Plan unless and until the claimant has:

(a) Submitted a written claim for benefits; and

(b) Been notified by the Contract Administrator that the claim is denied; and

(c) Timely filed a written request for a review of the claim with the Administrator; and

(d) Been notified in writing by the Administrator that the denial of the claim has been affirmed on review.

ARTICLE 14. ADMINISTRATION AND FINANCES

14.1 Administration. The Plan shall be administered by the Administrator. With respect to the General Purpose Health Care FSA and the Limited Purpose Health Care FSA, the Administrator shall be the named fiduciary (as described in Section 402 of ERISA) and the plan administrator (as described in Section 3(16)(A) of ERISA) under the Plan. Neither the Dependent Care FSA nor HSA Benefit is subject to ERISA.

14.2 Powers of Administrator. The Administrator shall have the following powers, rights and duties in addition to those vested in it elsewhere in the Plan:

(a) To adopt rules of procedures and regulations it determines may be necessary for the proper and efficient administration of the Plan, consistent with the provisions of the Plan.

(b) To enforce the Plan in accordance with its terms and with rules and regulations adopted by the Administrator.

(c) To determine all questions arising under the Plan, including claims for benefits, interpret the Plan, and to remedy ambiguities, inconsistencies or omissions.

(d) To maintain adequate records concerning the Plan and its administration.

(e) To furnish the Employer with such information with respect to the Plan as it may require for tax or other purposes.

14.3 Delegation by the Administrator. The Administrator may employ agents and counsel (who may also be employed by or represent the Employer) and delegate to them such nondiscretionary powers as the Administrator deems desirable. Any such delegations shall be in writing and shall describe the advice to be rendered or the functions and duties to be performed by the delegate.

14.4 Uniform Rules. The Administrator shall uniformly apply rules and regulations adopted by it to all persons similarly situated.

14.5 Information to be Furnished to Administrator. The Employer and Participants shall furnish the Administrator such information as may be required by the Administrator. The records of the Employer as to an Employee's or Participant's period of employment, termination of employment, and compensation will be conclusive on all persons unless determined by the Administrator to be incorrect. Participants and other persons entitled to benefits under the Plan shall furnish to the Administrator such evidence or information as it considers desirable to carry out the Plan.

14.6 Administrator Decisions Final. To the extent permitted by law, any interpretation of the Plan and any decision on any matter within the discretion of the Administrator made by it in good faith are binding on all persons. A misstatement or other mistake of fact shall be corrected when it becomes known, and the Administrator shall make such adjustment on

account thereof as it considers equitable and practicable and in accordance with the Autodesk, Inc. Mistaken Election Procedures.

14.7 Plan Expenses. Any forfeitures shall be used to pay the reasonable expenses of administering the Plan. Any costs of the Plan remaining after the application of any forfeitures shall be borne by the Employer. Notwithstanding the foregoing, the Participant shall be individually responsible for any fees charged by the trustee/custodian with respect to such Participant's HSA. The Employer may pay monthly administrative fees, but is not responsible for paying any such HSA-related fee.

ARTICLE 15. AMENDMENTS AND TERMINATION

15.1 Amendments. The Employer reserves the right to amend the Plan, in whole or in part, at any time.

15.2 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 Employer may amend the Plan by changing insurers, 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.

15.3 Termination. The Employer 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 Employer Contributions will cease. Thereafter neither the Employer 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 16. MISCELLANEOUS

16.1 No Guarantee of Employment. The adoption and maintenance of the Plan shall not be deemed to be a contract of employment between the Employer and any Eligible Employee. Nothing contained in the Plan shall give any Employee the right to be retained in the employ of the Employer or to interfere with the right of the Employer to discharge any Eligible Employee at any time, nor shall it give the Employer the right to require any Eligible Employee to remain in its employ or to interfere with the Employee's right to terminate his employment at any time.

16.2 Limitation on Liability. The Employer does not guarantee benefits payable under any insurance policy or other similar contracts described or referred to in the Plan, and any benefits thereunder shall be the exclusive responsibility of the insurer or other entity that is required to provide such benefits under the policy or contract.

16.3 Non-Alienation. No benefit payable at any time under this Plan shall be subject in any manner to alienation, sale, transfer, assignment, pledge, attachment, or encumbrance of any kind.

16.4 Exclusive Benefit. The Plan shall be maintained for the exclusive benefit of Eligible Employees. Benefits shall be paid only in accordance with the Plan's terms. Reasonable expenses of administering the Plan may be paid in accordance with the Plan's terms.

16.5 Applicable Law. The Plan and all rights under the Plan shall be governed by and construed according to the laws of the State of California, except to the extent preempted by Federal Law.

IN WITNESS WHEREOF, the Employer has caused this amendment and restatement of the Plan to be executed on this ____29th_____ day of ___November_____, 2022.

Autodesk, Inc.
San Francisco, CA

By: Lori Wong
(signature)

Name: Lori Wong

Title: Director, Global Benefits

Date: 11/29/2022