Synopsys, Inc. Bridge to Medicare Plan

Plan Document and Summary Plan Description (SPD)

Amended and Restated Effective as of January 1, 2023

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1. Definitions

Capitalized terms used in this document have the following meanings:

COBRA "COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Code "Code" means the Internal Revenue Code of 1986, as amended.

Company "Company" means Synopsys, Inc.

Dependent "Dependent" means the eligible Retiree's Spouse or Domestic Partner.

Domestic Partner "Domestic partner" means the eligible Retiree's same or opposite sex domestic partner, registered domestic partner, or civil union partner.

Employee "Employee" means any common-law employee of the Company, except employees classified or treated by the Company as independent contractors or as employees of an employment agency.

ERISA "ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

NMHPA "NMHPA" means the Newborns' and Mothers' Health Protection Act of 1996, as amended.

Plan "Plan" means the Synopsys, Inc. Bridge to Medicare Plan

Plan Administrator "Plan Administrator" means the Company.

Retiree For purposes of this Plan, "Retiree" means a former Employee who meets the following requirements:

(1) the former Employee was covered under one of the self-funded medical plan options offered under the Synopsys, Inc. Welfare Plan on the day before his or her Retirement Date; and

(2) the former Employee attained the age of 59.5 on or before his or her Retirement Date with at least 10 years of Synopsys service. Notwithstanding the foregoing, if a former Employee terminates employment with Synopsys on or after December 1, 2021, they must have attained the age of 59.5 on or before their Retirement Date with at least 7 years of Synopsys service. Please reference the Synopsys service date in Employee Central for more information on your applicable years of service; and

(3) the former Employee is under the age of 65; and

(4) the former Employee is not eligible for Medicare.

Retirement Date "Retirement Date" means the date that the former Employee terminates employment from the Company.

Spouse "Spouse" means the person who is recognized as the Retiree's spouse in accordance with the laws of the state, the District of Columbia, a United States territory or a foreign jurisdiction where the marriage took place.

WHCRA "WHCRA" means the Women's Health and Cancer Rights Act of 1998, as amended.

2. Introduction

The Company maintains the Plan for the exclusive benefit of its eligible Retirees and their eligible Dependents. The Plan provides self-funded medical benefits as listed in Section 11.

This document coupled with the underlying self-funded medical plan booklets constitutes the ERISA Plan Document and Summary Plan Description ("SPD") for the Plan.

This Plan is meant to be exempt from the market reform rules of the Patient Protection and Affordable Care Act (the "Affordable Care Act") as a retiree-only program. The Company maintains this Plan exclusively for the benefit of certain Retirees and their eligible dependents. The preamble to "The Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan under the Patient Protection and Affordable Care Act" (the "Grandfathered Regulations") provides that plans with less than two participants who are current Employees (commonly referred to as "retiree-only health plans") are exempt from the group market reform requirements of the Affordable Care Act. The preamble to the Grandfathered Regulations states, in relevant part, "Accordingly, the exceptions of ERISA section 732 and Code section 9831 for very small plans and certain retiree-only health plans, and for excepted benefits, remain in effect and, this ERISA section 715 and Code section 9815, as added by the Affordable Care Act, do not apply to such plans or excepted benefits." This Plan is intended to qualify as a "retiree-only health plan" under Section 9831 of the Internal Revenue Code.

The Company may amend, modify, suspend, or terminate this Plan (in whole or in part) at any time in its sole discretion. This includes, but is not limited to, changing future eligibility for coverage or increasing or reducing benefits. A change can apply to those who retired in the past, as well as to those who retire in the future. No statement in this or any other document, nor any oral representation, should be construed as a waiver of this right.

NOTICE REGARDING CERTAIN EXTENDED PLAN DEADLINES DUE TO THE COVID-19 PANDEMIC

In accordance with the Department of Labor's guidance, jointly issued with the Department of the Treasury and Internal Revenue Service, the Plan shall disregard any days within the "Outbreak Period"[1] when determining certain Plan periods and deadlines, for all Plan participants and claimants. Accordingly, the deadlines to submit ERISA benefit claims and appeals under the Plan has been temporarily extended due to the COVID-19 pandemic.

These temporarily extended Plan deadlines shall prevail in case of any conflict with the Plan terms. Unless otherwise specified herein, all other provisions of the Plan continue to apply.

[1] The Outbreak Period is the period from March 1, 2020 until 60 days after the end of the National Emergency period (or other date announced by the Department of Labor, Department of the Treasury, the Internal Revenue Service, or Plan Administrator in the future). As of the time of the restatement of this Plan, the National Emergency Period ended on May 11, 2023, and it is anticipated that the Outbreak Period will end on July 10, 2023.

3. General Information About the Plan

Plan Name:	The Synopsys, Inc. Bridge to Medicare Plan.
Type of Plan:	The Synopsys, Inc. Bridge to Medicare Plan is a group health plan under ERISA, providing group medical benefits.
Plan Year:	January 1 to December 31.
Plan Number:	505
Effective Date:	This Plan was established effective March 1, 2019, and amended on December 1, 2021. The Plan is hereby amended and restated effective as of January 1, 2023. .
Funding Medium and Type of Plan Administration:	Benefits under this Plan are self-funded and paid from Company general assets.
Plan Sponsor:	The Company is the Plan Sponsor. Synopsys, Inc. 675 Almanor Avenue Sunnyvale, CA 94085 (650) 584-5000
Plan Sponsor's Employer Identification Number:	56-1546236
Plan Administrator:	Synopsys, Inc. 675 Almanor Avenue Sunnyvale, CA 94085(650) 584-5000
Agent for Service of Legal Process:	The Plan Administrator Synopsys, Inc. 675 Almanor Avenue Sunnyvale, CA 94085 (650) 584-5000 Service for legal process may also be made on the Plan Administrator.

4. Eligibility and Participation Requirements

Eligibility and Participation

Retirees (as defined in Section 1 above) are eligible to participate in the Plan.

Your eligible Dependent may also participate in this Plan if you are an eligible Retiree. An eligible Dependent includes your Spouse or Domestic Partner who is not entitled to Medicare and who is under the age of 65. However, if a Retiree's Spouse or Domestic Partner is not covered by a medical plan option under the Synopsys, Inc. Welfare Benefit Plan on the Retiree's Retirement Date, such Spouse or Domestic Partner is not eligible to participate in this Plan. For example, if the Retiree re-marries or has a newborn child after his or her retirement from the Company, these newly acquired dependents are not eligible for coverage under the Plan.

If a former employee is Medicare eligible at the time of his or her retirement from the Company, the former employee's eligible Spouse or Domestic Partner is eligible for coverage under this Plan for up to three years (following exhaustion of his or her COBRA continuation coverage period). However, the former employee (who is Medicare eligible at the time of his or her retirement from the Company) is not eligible for coverage under this Plan. Further, if a Retiree did not elect and exhaust COBRA continuation coverage upon terminating employment with the Company, then their Spouse or Domestic Partner (as applicable) is not eligible for coverage under this Plan.

When Participation Begins

To begin participation in the Plan you must (1) meet the Plan's definition of Retiree (see Section 1), (2) terminate employment with the Company, (3) elect COBRA continuation coverage upon termination of employment with the Company and exhaust your maximum COBRA coverage period; and then (3) properly elect retiree coverage under this Plan. You must submit a completed Plan enrollment form within 30 days of the date you exhaust your maximum COBRA continuation coverage period in order for you or your eligible Dependents to participate in the Plan. If an individual become Medicare eligible before exhausting his or her applicable period of COBRA continuation coverage, such individual is not eligible for coverage under this Plan.

If you do not timely elect benefits under this Plan, you will forfeit the right to benefits under this Plan.

Termination of Participation

Your participation in the Plan will end at the end of the month upon the earliest of any of the following events:

- The date you are no longer eligible to participate in any of the Plan's self-funded medical plans;
- The date you turn age 65;
- The date you become entitled to Medicare;
- The date you die;

- The date this Plan ends or is amended; or
- The first of the month for which a contribution is not received.

Coverage for your covered Dependent will end on the earliest of:

- The date your dependent becomes entitled to Medicare;
- The date your dependent is no longer eligible to participate in any of the Plan's self-funded medical plans as an eligible Dependent;
- The first of the month for which a contribution is not received;
- The date this Plan ends or is amended; or
- The first of the month for which a contribution is not received.

Note: If a Retiree becomes eligible for Medicare, his or her eligible Spouse or Domestic Partner (as applicable) may continue to receive coverage under this Plan for up to three years from the first day of the month following the Retiree's Medicare eligibility date.

Note: If the Retiree dies prior to reaching age 65 or becoming eligible for Medicare, his or her Spouse or Domestic Partner (as applicable) may continue to receive coverage under this Plan for up to three years from the first day of the month following the date of the Retiree's death.

Note: If the Retiree and his Spouse or Domestic Partner get legally separated or divorced prior to the Retiree attaining age 65 or becoming eligible for Medicare, his or her Spouse or Domestic Partner may continue coverage under this Plan for up to three years from the first day of the month following the legal separation, judgment of divorce, or dissolution of domestic partnership.

You should consult the applicable self-funded medical benefits booklet for specific termination events and information.

5. Summary of Plan Benefits

Benefits and Contributions

The Plan provides the Retiree and the Retiree's eligible Dependents with the medical plan coverage listed in Section 11. A summary of the applicable medical plan is provided in the applicable self-funded medical plan booklet. The Company reserves the right to make changes in the benefit programs and premiums at any time and for any reason.

All Retirees and eligible Dependents (as applicable) are required to pay premiums for coverage under the Plan. The Company will determine such premiums and communicate these amounts to Plan participants.

Note: Once coverage has terminated for non-payment of premiums or Plan dis-enrollment, there is no reinstatement available (i.e., you cannot later re-enroll in the Plan).

Medical benefits under this Plan may be subject to cost-sharing provisions, premiums, deductibles, co-insurance, copayment amounts, pre-authorization requirements, or utilization review. There may also be limitations on the selection of primary care or network providers, limits on emergency medical care, drugs, medical tests, medical devices, or medical procedures. These limitations are set forth and explained in the underlying self-funded medical plan booklets.

Special Rights on Childbirth

As provided under NMHPA, group health plans and health insurance issuers offering group insurance coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than the above periods. In any case, such plans and issuers may not, under federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of the above periods.

Coverage for Reconstructive Surgery Following Mastectomy

To the extent required by the WHCRA, the Plan provides benefits for breast reconstruction in connection with a mastectomy, as follows:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of complications of the mastectomy, including lymphedema.

6. How the Plan Is Administered

Plan Administration

The Company is responsible for reporting and disclosure requirements under ERISA. The Company also has the discretion and authority to change Plan eligibility requirements, and the amount of any Plan contributions.

Questions

If you have any question regarding your eligibility for, or the amount of, any benefit payable under the Plan contact Benefits@synopsys.com.

7. Amendment or Termination of the Plan

The Synopsys, Inc. Bridge to Medicare Plan may be amended or terminated at any time for any reason, at the sole and absolute discretion of the Company as Plan Sponsor. The Company's authority to amend the Plan includes the right to modify any term of the Plan, including but not limited to medical services and supplies covered by the Plan, benefits paid under the Plan, persons eligible for coverage, and rates charged for coverage. The Company's authority to terminate the Plan includes the right to terminate all or part of the Plan at any time. No

participant (including a Retiree) shall have a right to continuing benefits once the Plan is terminated or amended, except to the extent required by law.

The Company may amend, modify, suspend, or terminate this Plan (in whole or in part) at any time in its sole discretion. This includes, but is not limited to, changing future eligibility for coverage or increasing or reducing benefits. A change can apply to those who retired in the past, as well as to those who retire in the future. No statement in this or any other document, nor any oral representation, should be construed as a waiver of this right.

8. Claims Procedures

In general, claims for benefits will be classified in one of the following three categories:

- Urgent Care Claim
- Pre-Service Claim
- Post-Service Claim

Urgent Care Claims

An urgent care claim is any claim for a benefit for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations either:

- Could seriously jeopardize your life or health or your ability to regain maximum function.
- Would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim, in the opinion of a physician with knowledge of your medical condition.

Pre-Service Claims

A pre-service claim is any claim for a benefit with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on advance approval of the benefit.

Post-Service Claims

A post-service claim is any claim for a benefit that is neither a pre-service nor an urgent care claim.

Time Limits for Processing Claims

The Plan will follow the time limits described in the following table in providing notices of decisions, notices of extensions and notices of the need for additional information to you. The time limits that you are required to follow regarding providing additional information to complete your claim, or to correct your claim, are also described in the following table.

Type of Notice	Type of Claim

or Claim Event	Urgent Care Claim	Pre-Service Claim	Post-Service Claim
Notice of failure to follow the proper procedure for filing a claim	Not later than 24 hours after receiving the improper claim.	Not later than 5 days after receiving the improper claim.	Not later than 15 days after receiving the improper claim.
Your deadline to provide additional information required by the Plan to decide your claim	48 hours after receiving notice that additional information is required.	45 days after receiving notice that additional information is required.	45 days after receiving notice that additional information is required.

Type of Notice or Claim Event	Type of Claim		
	Urgent Care Claim	**Pre-Service Claim**	**Post-Service Claim**
Notice of Initial Claim Decision	1. Not later than 72 hours after receipt of the initial claim if the claim was proper and complete. 2. Not later than 48 hours after receipt of the requested information or, within 48 hours after the expiration of the 48-hour claimant deadline, whichever is earlier if additional information is needed to decide your claim.	1. Not later than 15 days after receipt of the initial claim, unless an extension of up to 15 days is necessary due to matters beyond the control of the Plan. You will be notified within the initial 15 days if an extension is needed. The notice shall state the reason for the extension and the date by which the Plan expects to render its decision. 2. Not later than 15 days after receipt of the additional information or within 15 days after the expiration of the 45-day claimant deadline, whichever is earlier, if additional information is needed to decide your claim. Notice of the need for additional information will be provided during the initial 15-day period.	1. Not later than 30 days after receipt of the initial claim, unless an extension of up to 15 days is necessary due to matters beyond the control of the Plan. You will be notified within the initial 30 days if an extension is needed. The notice shall state the reason for the extension and the date by which the Plan expects to render its decision. 2. Not later than 15 days after receipt of the additional information or within 15 days after the expiration of the 45-day claimant deadline, whichever is earlier, if additional information is needed to decide your claim. Notice of the need for additional information will be provided during the initial 30-day period.

If Your Claim is Denied

If all or part of your claim is denied, you will receive a written notice in a culturally and linguistically appropriate manner that explains:

- The specific reason(s) for the adverse benefit determination;
- References to the specific plan and/or SPD provisions on which the benefit determination is based;

- A description of any additional material or information needed to process the claim and an explanation of why that material or information is necessary;
- A description of the Plan's internal appeal and external review procedures that may be available to you and the time limits applicable to those procedures, including a statement of your right to bring a civil action under ERISA after an appeal of an adverse benefit determination;
- Any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse benefit determination, or a statement that a copy of this information will be provided free of charge to you upon request;
- If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;
- If the adverse benefit determination concerns a claim involving urgent care, a description of the expedited review process applicable to the claim; and
- Sufficient information to identify the claim, including the date of service, the provider, the claim amount (if applicable), the diagnosis, treatment and denial codes and their meanings, and the standard, if any, used for deciding the claim.

Your Right to Appeal

If the Plan denies your request for benefits, you or your authorized representative may appeal the denial. To begin the appeal process, you must file a written notice of the appeal with United Healthcare within 180 days of your receipt of a denial. In your appeal request, you should state why you believe your claim should be paid.

You may submit written comments, documents, records and other information relating to your claim in connection with your appeal. If your appeal involves an urgent care claim, information may be provided by phone or fax. You may also request to receive, free of charge, reasonable access to, or copies of, all documents, records and other information relevant to your claim for benefits and review your claim file.

Time Limits for Appeal

The time limits described in the following table describe the time by which the Plan is required to provide you with notice of its determinations of appeal. If more time or information is needed to make the determination, the United Healthcare will notify you in writing to request an extension of time and to specify any additional information needed to complete the review.

Time Limits	Type of Claim		
	Urgent Care Claim	Pre-Service Claim	Post-Service Claim
Plan notice of appeal decision	Not later than 72 hours after receipt of an appeal	Not later than 30 days after receipt of an appeal	Not later than 60 days after receipt of an appeal

Procedure on Appeal

As part of your appeal, you have the right to:

- Submit written comments, documents, records, testimony and other information relating to the claim for benefits whether or not submitted in connection with your initial claim.
- Request, free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim for benefits. For this purpose, a document, record, or other information is treated as "relevant" to your claim if it:
    - Was relied upon in making the benefit determination;
    - Was submitted, considered or generated in the course of making the benefit determination, regardless of whether such document, record or other information was relied upon in making the benefit determination;
    - Demonstrates compliance with the administrative processes and safeguards required in making the benefit determination;
    - Constitutes a statement of policy or guidance with respect to the plan concerning the denied benefit for your diagnosis, regardless of whether such statement was relied upon in making the benefit determination.
- A review that takes into account all comments, documents, records and other information submitted by you related to the claim, regardless of whether the information was submitted or considered in the initial benefit determination.
- A review that does not defer to the initial adverse benefit determination and that is conducted neither by the individual who made the adverse determination nor by that person's subordinate.
- A review in which the named fiduciary consults with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the initial adverse benefit determination, nor the subordinate of any such individual. This applies only if the appeal involves an adverse benefit determination based in whole or in part on a medical judgment (including whether a particular treatment, drug or other item is experimental).
- The identification of medical or vocational experts whose advice was obtained in connection with the adverse benefit determination, regardless of whether the advice was relied upon in making the decision.

- In the case of a claim for urgent care, an expedited review process in which:
    - You may submit a request (orally or in writing) for an expedited appeal of an adverse benefit determination.
    - All necessary information, including the plan's benefit determination on review, will be transmitted between the plan and you by telephone, facsimile or other available similarly prompt method.

You will also be provided, free of charge, any new or additional evidence considered or rationale, relied upon or generated by the plan or at the Plan's direction in connection with your claim. This material, if any, will be provided to you as soon as possible and sufficiently in advance of the deadline for the determination of the appeal to give you an opportunity to respond prior to the deadline.

Notice of Determination on Appeal

If all or part of your claim is denied, you will receive a written notice in a culturally and linguistically appropriate manner that explains:

- The specific reason(s) for the adverse benefit determination;
- References to the specific plan and/or SPD provisions on which the benefit determination is based;
- Your right to receive reasonable access to and copies of all documents, records and other information relevant to your claim, free to you upon your request;
- A description of the Plan's internal appeal and external review procedures that may be available to you and the time limits applicable to those procedures, including a statement of your right to bring a civil action under ERISA after an appeal of an adverse benefit determination;
- Any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse benefit determination, or a statement that a copy of this information will be provided free of charge to you upon request;
- If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;
- If the adverse benefit determination concerns a claim involving urgent care, a description of the expedited review process applicable to the claim; and
- Sufficient information to identify the claim, including the date of service, the provider, the claim amount (if applicable), the diagnosis, treatment and denial codes and their meanings, and the standard, if any, used for deciding the claim.

Eligibility Claims and Appeals

If you have a question solely relating to eligibility under the Plan that is not connected to a claim for benefits under the Plan, you must file a written inquiry with the Company within sixty (60) days of the event that gives rise to the question. The Company will make a determination on your eligibility within ninety (90) days after your written request is received.

If a claim relating solely to eligibility is denied, you may appeal such a denial by submitting to the Company a written request for review within ninety (90) days after receiving notice of the denial. You will be notified by the Company of its decision on review within sixty (60) day from receipt of the written request.

9. Statement of ERISA Rights

Your Rights

As a participant in an ERISA Plan you are entitled to certain rights and protections under ERISA. ERISA provides that, as a participant, you are entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, the Plan documents, including insurance contracts, and copies of all documents filed by the Plan with the U.S. Department of Labor (if any) such as annual reports and Plan descriptions;
- Obtain copies of the benefit program documents and other program information on written request to the Plan Administrator (the Plan Administrator may make a reasonable charge for the copies); and
- Receive a summary of the Plan's annual financial report, if any (the Plan Administrator is required by law to furnish each participant with a copy of this summary annual report).

Fiduciary Obligations

In addition to creating rights for participants, ERISA imposes duties on the people who are responsible for the operation of the benefit program. These people, called "fiduciaries" of the program, have a duty to operate the program prudently and in the interest of you and other program participants. Fiduciaries who violate ERISA may be removed and may be required to make good any losses they have caused the program.

Enforce Your Rights

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You may have a right to have the insurance company review and reconsider your claim.

See the appropriate certificate of insurance booklet for details.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in the appropriate 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 that is denied or ignored, in whole or in part, you may file suit in the appropriate a state or federal court.

If it should happen that benefit program 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 the appropriate 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 (for example, if the court finds your claim is frivolous), the court may order you to pay these costs and fees.

Questions

If you have any questions about this statement or your rights under ERISA, 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.

10. Miscellaneous

Taxation

The Company intends that all benefits provided under the Plan will not be taxable to you under federal tax law. However, the Company does not represent or guarantee that any particular federal, state or local income, payroll, personal property or other tax consequence will result from participation in this Plan. You should consult with your professional tax advisor to determine the tax consequences of your participation in this Plan.

11. Plan Provider Information

LISTING OF PLAN PROVIDERS AS OF JANUARY 1, 2023

PROVIDER	PLAN	WHEN PARTICIPATION BEGINS	TO FILE A CLAIM, CONTACT:
United Healthcare	The Synopsys Health Savings (HS) Basic Plan	First of the month following the eligible individual's exhaustion of COBRA continuation coverage.	United Healthcare P O Box 30555 Salt Lake City, Utah, 84130-0555

EXECUTION

IN WITNESS WHEREOF, Synopsys, Inc. has caused this document to be executed by its duly authorized officer, as of the date set forth below.

SYNOPSYS, INC.

Signed: DocuSigned by: Bridgette Deloach 405BCE2E4A20414...

Name: Bridgette Deloach

Title: Benefits-Dir

Date: July 10, 2023 | 11:29:03 AM PDT