EXECUTION COPY

SYNOPSYS, INC.

SECTION 125 PLAN

Amended and Restated Effective January 1, 2024

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SYNOPSYS, INC.
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ARTICLE I.

INTRODUCTION

This Plan has been established by Synopsys, Inc. ("Employer") for the benefit of Eligible Employees of the Employer. It is the intention of the Employer that the Plan qualify as a cafeteria plan within the meaning of Section 125 of the Code, a general purpose medical expense reimbursement plan and a limited purpose medical expense reimbursement plan under Section 105(h) of the Code, and a dependent care assistance plan under Section 129 of the Code. The Plan also allows the Employer and Eligible Employees to make pre-tax contributions to health savings accounts pursuant to Section 223 of the Code. The purpose of the Plan is to provide Participants with a choice between cash compensation and nontaxable fringe benefits to be made available under separate health and welfare benefit plans maintained by the Employer. The Plan is amended and restated in its entirety effective January 1, 2024.

ARTICLE II.

DEFINITIONS

The following words and phrases, when used in this Plan, shall have the following meanings.

2.1 "Administrator" shall mean the Employer, which shall discharge its responsibilities as Administrator through any individual, committee, or other entity on whom the Employer has delegated responsibilities to either directly or indirectly.

2.2 "Benefit Plans" shall mean any of the health care benefit plans or welfare benefit plans sponsored by the Employer for the benefit of its Employees and listed on Exhibit A attached hereto.

2.3 "Code" shall mean the Internal Revenue Code of 1986, as amended from time to time.

2.4 "Dependent" shall mean for the programs of this Plan other than the Dependent Care Reimbursement Account, the Eligible Employee's child as defined in Code section 152(f)(1) who is under age 26 and the Eligible Employees spouse and any other dependents as defined in Code section 152.

For purposes of the Dependent Care Reimbursement Account, "Dependent" means a Qualifying Dependent as defined in Section 2.32 of this Plan.

2.5 "Dependent Care Expenses" shall mean the amounts paid for expenses incurred by a Qualifying Dependent by a Participant for those services, which if paid by the Participant would be considered employment related expenses under Section 21(b)(2) of the Code. Dependent Care Expenses of a Participant shall not include amounts paid for services provided by a child of such Participant who is under the age of 19 at the close of the Participant's tax year pursuant to Section 129(c) of the Code or by an individual who is a dependent of such Participant or such Participant's spouse.

2.6 "Dependent Care Reimbursement Account" shall mean the account described in Article VII.

2.7 "Dependent Care Reimbursement Program" shall mean the program described in Article VII.

2.8 "Earned Income" shall mean earned income as defined under Section 32(c)(2) of the Code, but excluding such amounts paid or incurred by the Employer for dependent care reimbursement to the Participant.

2.9 "Effective Date" of this restatement of the Plan shall mean January 1, 2024.

2.10 "Election Form" shall mean the form which an Eligible Employee shall complete in order to select the Benefit Plans offered under the Plan and to authorize Employee Contributions. The Election Form is an agreement between the Eligible Employee and the Employer under which the Eligible Employee agrees to reduce his compensation or to forego all or part of the increases in such compensation and to have such amounts contributed by the Employer to the Plan on the Participant's behalf. The Election Form shall apply only to compensation that has not been actually or constructively received by the Participant as of the date of the agreement (after taking this Plan and Code Section 125 into account) and, subsequently does not become currently available to the Participant.

2.11 "Eligible Employee" means a person who is an Employee of Synopsys, Inc. or Synopsys International, Inc. who is on a U.S. payroll and customarily works 20 hours per week or more.

2.12 "Employee" shall mean any person employed by the Employer as a common law employee.

2.13 "Employee Contribution" shall mean the contribution that a Participant elects to make as a reduction in compensation to pay for benefits under one or more Benefit Plans he or she has chosen under the Plan, as set forth in Section 4.2. Employee Contributions are made on a pre-tax basis by payroll deduction.

2.14 "Employer" shall mean Synopsys, Inc. and any successor to all or a major portion of its assets or business, which shall by appropriate action adopt this Plan.

2.15 "ERISA" shall mean the Employee Retirement Income Security Act of 1974, as amended from time to time.

2.16 "FMLA" shall mean the Family and Medical Leave Act.

2.1 "Grace Period" shall mean with respect to any Plan Year, the time period ending on the last day of the second calendar month after the end of such Plan Year, during which Medical Expenses and/or Dependent Care Expenses (as applicable) incurred by a Participant will be deemed to have been incurred during such Plan Year. This Grace Period is subject to the following conditions:

(a) In order for an individual to be reimbursed for Medical Expenses and/or Dependent Care Expenses (as applicable) during a Grace Period from amounts remaining in his or her Health Care Reimbursement Account, Limited Purpose Health Care Reimbursement Account, or Dependent Care Reimbursement Account (as applicable) at the end of the Plan Year to which that Grace Period relates, he or she must be either (1) A Participant with Health Care Reimbursement Account, Limited Purpose Health Care Reimbursement Account and/or Dependent Care Reimbursement Account coverage (as applicable) that is in effect on the last day of that Plan Year, or (2) a qualified beneficiary (as defined under COBRA) who has COBRA coverage under the Health Care Reimbursement Account or Limited Purpose Health Care Reimbursement Account (as applicable) on the last day of the Plan Year;

(b) During the Grace Period, unused benefits or contributions may be paid or reimbursed only for a particular qualified benefit (i.e., Medical Expenses or Dependent Care Expenses, as applicable) for which the contribution was made, and may not be cashed out or converted to any other taxable or non-taxable benefit available under the Plan; and

(c) Medical Expenses and Dependent Care Expenses (as applicable) incurred during a Grace Period and approved for reimbursement in accordance with the Plan's claims procedures will be reimbursed and charged first against any amounts that are available to reimburse expenses that are incurred during the current Plan Year, and then against any amounts that are available to reimburse expenses that are incurred during the prior Plan Year. All claims for reimbursement under the Health Care Reimbursement Account, Limited Purpose Health Care Reimbursement Account, and Dependent Care Reimbursement Account will be paid in the order in which they are approved.

2.2 "Health Care Reimbursement Account" shall mean the account described in Article VIII.

2.3 "Health Care Reimbursement Account Program" shall mean the program described in Article VIII.

2.4 "Health Savings Account" or "HSA" shall mean a tax-favored trust account as described in Section 223 of the Code that may be established by an HSA-eligible individual who is a Participant in the United Healthcare Health Savings Plan.

2.5 "Highly Compensated Employee" shall mean an Employee described in Section 414(q) of the Code and the Regulations thereunder.

2.6 "Highly Compensated Individual" shall mean an (a) for purposes of the Plan, an Employee who is (i) an officer; (ii) a shareholder owning more than five percent (5%) of the

voting power or value of all classes of stock of any Employer; (iii) highly compensated; or (iv) a spouse or dependent of an Employee described in clause (i), (ii) or (iii) and (b) for purposes of Articles VIII and IX regarding the Health Care Reimbursement Account Program and the Limited Purpose Health Care Reimbursement Account Program, an Employee who is (i) one of the five (5) highest paid officers, (ii) a shareholder owning more than ten percent (10%) in value of the stock of any Employer or (iii) one of the highest paid twenty-five percent (25%) of all Employees.

2.7 "Highly Compensated Participant" shall mean a Participant who is a Highly Compensated Individual.

2.8 "Key Employee" shall mean any individual who is a key employee pursuant to the criteria set forth in Section 416(i) of the Code and the Regulations issued thereunder.

2.9 "Limited Purpose Health Care Reimbursement Account" shall mean the account described in Article IX.

2.10 "Limited Purpose Health Care Reimbursement Account Program" shall mean the program described in Article IX.

2.11 "Medical Expense" means any expense for medical care within the meaning of the term "medical care" or "medical expense" as defined in Section 213(d) of the Code and the rulings and Regulations thereunder, and not otherwise reimbursed or reimbursable by insurance or other sources and not used by the Participant as a tax deduction. Notwithstanding the foregoing, medicines or drugs that are sold lawfully without a prescription need not be prescribed to qualify as Medical Expenses that are reimbursable under the Health Care Reimbursement Account Program or Limited Purpose Health Care Reimbursement Account Program if the expenses for these items are incurred on or after January 1, 2020. Furthermore, expenses for menstrual care products incurred by a Participant or Dependent on or after January 1, 2020 also shall qualify as Medical Expenses that are reimbursable under the Health Care Reimbursement Account Program. For this purpose, "menstrual care product" shall mean a tampon, pad, liner, cup, sponge or similar product as defined in Code Section 223(d)(2)(D).

Notwithstanding the foregoing, for purposes of the Limited Purpose Health Care Reimbursement Account, Medical Expenses shall be further limited to eligible dental and vision expenses only, as provided by applicable Code provisions or regulations or guidance issued by the United States Treasury Department, including the Internal Revenue Service.

2.12 "Non-highly Compensated Employee" shall mean an Employee who is not a Highly Compensated Employee.

2.13 "Open Enrollment Period" shall mean the period selected by the Administrator during which Eligible Employees may elect benefits for the following Plan Year.

2.14 "Participant" shall mean each Eligible Employee who participates in the Plan in accordance with the provisions of Article III.

2.15 "Plan" shall mean the Synopsys, Inc. Section 125 Plan, as set forth in this Plan document and as amended from time to time.

2.16 "Plan Year" shall mean the calendar year.

2.17 "Qualifying Dependent" means, for Dependent Care Reimbursement Program purposes, a "Qualifying Individual" as defined in Section 21(b) of the Code. This includes:

(a) A child, brother, sister, stepbrother or stepsister (or a descendent of any of these) of the Participant under the age of 13 who has the same principal place of abode as the Participant for more than half of the taxable year and who has not provided over one-half of his or her own support for the calendar year; or

(b) Any of the following, who is physically or mentally incapable of caring for himself or herself as defined in Treasury Regulations § 1.21-1(b)(4), and who has the same principal place of abode as the Participant for more than half of the taxable year:

(1) The Participant's child, brother, sister, stepbrother or stepsister (or a descendent of any of these) who is under the age of 19, a full-time student under the age of 24, or who is permanently and totally disabled (as defined in Code Section 22(e)(3)), and who has not provided over one-half of his or her own support for the calendar year; or

(2) The Participant's child (or a descendent of the child), brother, sister, stepbrother, stepsister, parent, grandparent, stepparent, niece, nephew, aunt, uncle, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law, who depends on the Participant for at least half of his or her financial support, and who is not a qualifying child (as defined by Code Section 152(c)) of the Participant or any other person; or

(3) Any person (other than the Participant's Spouse) who depends on the Participant for at least half of his or her financial support, who is not the qualifying child (as defined by Code Section 152(c)) of the Participant or any other person, and for the taxable year, has the same principal place of abode as the Participant and is a member of the Participant's household; or

(4) The Participant's Spouse who is physically or mentally incapable of caring for himself or herself, and who has the same principal place of abode as the Participant for more than half of the taxable year.

For purposes of this Section 2.31, the term "child" includes a stepchild, eligible foster child, legally adopted child, or a child placed with the Participant for legal adoption by the Participant. An individual's status as a "Dependent" for purposes of the Dependent Care Reimbursement Program, shall be determined on a daily basis. An individual shall not be considered a "Dependent" on the day this status terminates.

2.18 "Regulations" shall mean the Treasury Regulations issued from time to time under the Code.

2.19 "Reimbursement Accounts" shall mean the Dependent Care Reimbursement Account, the Health Care Reimbursement Account, and the Limited Purpose Health Care Reimbursement Account.

ARTICLE III.

ELIGIBILITY AND PARTICIPATION

3.1 Commencement of Participation. Every Eligible Employee who is a Participant in the Plan on the Effective Date shall continue to be a Participant in the Plan and each other Employee shall become a Participant in the Plan as of the date that the Employee becomes an Eligible Employee in accordance with Article IV, and properly enrolls in the Plan in accordance with Article V. Notwithstanding the foregoing, an intern who is an Eligible Employee is not eligible to participate in the Dependent Care Reimbursement Account Program, the Health Care Reimbursement Account Program, or the Limited Purpose Health Care Reimbursement Account Program.

3.2 Termination of Participation.

(a) A Participant will cease to be a Participant in the Plan as of the earliest of (i) the date on which the Plan terminates, (ii) the date on which the Participant ceases to be an Eligible Employee, or (iii) the date on which the Participant's benefit election pursuant to Article V expires or terminates in accordance with this Article III or Section 5.6. However, benefits under the Benefit Plans elected when participation ceases shall continue to the extent specified in such Benefit Plans.

(b) In the event that a Participant is no longer an Eligible Employee during a Plan Year, Employee Contributions shall cease and the Participant will be entitled to receive the benefits under the Benefit Plans for which Employee Contributions have been made in accordance with the provisions of such Benefit Plans.

3.3 Resumption of Participation.

A former Participant who once again becomes an Eligible Employee may enroll in the Plan in accordance with Article V. Further, a former Participant who at all times remains an Eligible Employee may enroll in the Plan in accordance with Sections 5.3 and 5.5.

3.4 Discrimination Limitations. The Plan, the Health Care Reimbursement Account Program, the Limited Purpose Health Care Reimbursement Account Program, and the Dependent Care Reimbursement Account Program are intended not to discriminate in favor of highly compensated individuals or highly compensated employees as to eligibility to participate, contributions and/or benefits, and to comply in this respect with the requirements of the Code. If the Administrator determines, before or during any Plan Year, that the Plan, the Health Care Reimbursement Account Program, the Limited Purpose Health Care Reimbursement Account Program, or the Dependent Care Reimbursement Account Program may fail to satisfy for such

Plan Year any nondiscrimination requirement imposed by the Code or any limitation on benefits provided to Key Employees, the Administrator shall take such action as the Administrator deems appropriate, to assure compliance with such requirement or limitation. Such action may include, without limitation, a modification of elections by Highly Compensated Employees, Highly Compensated Individuals or Key Employees with or without the consent of such Employees.

ARTICLE IV.

BENEFITS

4.1 Benefit Plans. When first eligible or during an Open Enrollment Period, a Participant may select among the Benefit Plans set forth in Exhibit A and such other Benefit Plans as the Administrator may designate from time to time for the Plan Year. The Benefit Plans to be offered under the Plan shall be selected at the discretion of the Administrator and may be prospectively changed at any time.

4.2 Benefit Plan Selection. A Participant shall designate on the Election Form those Benefit Plans which he or she selects. The Participant shall also designate the amount of Employee Contributions, if any, to be allocated to each Benefit Plan which he or she has selected. Such amounts shall be contributed from pay periods during the Plan Year. Benefit Plan selection shall be made in the time and manner designated by the Employer.

Any election shall be determined prior to the beginning of a Plan Year (subject to initial elections pursuant to Section 5.2) and prior to the end of the election period designated by the Employer and shall be irrevocable for such Plan Year. However, a Participant may revoke a Benefit election after the Plan Year has commenced and make a new election with respect to the remainder of the Plan Year, if both the revocation and the new election are on account of and consistent with a change in status and such other permitted events as determined under Section 5.5 of the Plan and consistent with the rules and regulations of the Department of the Treasury. All individual Election Forms are deemed to be part of this Plan and incorporated by reference hereunder.

4.3 Description of Benefits Other than Cash. While the election to receive benefits under one or more of the Benefit Plans shall be made under this Plan, the benefits will be provided not by this Plan but by the particular Benefit Plan. The types and amounts of benefits available under each option Benefit Plan, the requirements for participating in such Benefit Plans, and the other terms and conditions of coverage and benefits under such Benefit Plans, are as set forth from time to time in the documents that constitute (or are incorporated by reference in) such Benefit Plans. The Benefit Plans are hereby incorporated by reference into the Plan. Any amendments to such Benefit Plans are also to be incorporated by reference into the Plan.

ARTICLE V.

ENROLLMENT

5.1 Enrollment of Eligible Employees. An Employee who first becomes eligible to participate in the Plan mid-year may elect to participate in the Premium Payment Program and/or

the Reimbursement Programs provided in Exhibit A on the first day the eligibility requirements have been satisfied. The Eligible Employee must submit an Election Form to the Plan Administrator before the first day in which participation will commence. An Employee who does not elect benefits when first eligible may not enroll until the next Open Enrollment Period, unless an event occurs that would justify a mid-year election change, as described in Exhibit C. Notwithstanding the foregoing, a Participant may change his or her HSA contribution election on a monthly basis, as described in Exhibit C.

Any Eligible Employee's existing election under the Premium Payment Program shall remain effective for subsequent Plan Years, unless the Eligible Employee elects otherwise. If any Eligible Employee wishes to participate in the Dependent Care Reimbursement Account Program, the Health Care Reimbursement Account Program, or the Limited Purpose Health Care Reimbursement Account Program, such Eligible Employee shall complete and return the Election Form to the Administrator prior to the beginning of the Plan Year. Such election shall not renew for subsequent Plan Years. Eligible Employees who wish to continue to participate in the Dependent Care Reimbursement Account Program, the Health Care Reimbursement Account Program, and/or the Limited Purpose Health Care Reimbursement Account Program must make a new election to participate in such Reimbursement Program prior the beginning of the applicable Plan Year.

5.2 Enrollment of Newly Eligible Employees. Each newly Eligible Employee shall complete and return the Election Form to the Administrator within thirty (30) days after he or she becomes an Eligible Employee. The elections made or deemed to be made by the newly Eligible Employee shall, subject to Section 5.3 and 5.4, be effective for the period beginning on the date the Employee becomes an Eligible Employee and ending on the last day of the Plan Year.

5.3 Open Enrollment Period.

(a) Each Participant may complete and return a new Election Form to the Administrator during the Open Enrollment Period. The elections made or deemed to be made by the Participant during an Open Enrollment Period shall be effective, subject to Section 5.5, for the next Plan Year. A Participant may not change his or her election, subject to Section 5.6, after the Plan Year has begun.

(b) A Participant's election with respect to a Benefit Plan other than the Reimbursement Accounts shall be automatically effective, subject to Section 5.5, for the next Plan Year, unless the Participant affirmatively elects otherwise. The Participant's Employee Contribution shall be adjusted automatically in the event of a change in the cost of such coverage.

5.4 Special Enrollment Period. An Eligible Employee who acquires a new dependent via marriage, birth, adoption or placement for adoption may complete and return the Election Form to the Administrator within thirty-one (31) days after he or she acquires such new dependent to enroll in the Health Care Reimbursement Account Program or the Limited Purpose Health Care Reimbursement Account Program, or to change his or her election to increase his or her contribution to the Health Care Reimbursement Account Program, or the Limited Purpose Health Care Reimbursement Account Program.

5.5 Irrevocability of Election by the Participant During the Plan Year. Elections made or deemed to be made under the Plan for any Plan Year may not be changed or revoked after the first Payroll period to which they apply, except upon the occurrence of any of the events specified in the Treasury Regulations or other applicable guidance issued under Code Section 125. A Participant may modify a benefit election for the balance of a Plan Year and file a new election only if both the modification and the new election are in response to and consistent with the applicable event as defined by Treasury Regulations or other applicable guidance issued under Code Section 125. Exhibit C of this Plan sets forth these events.

5.6 Changing Elections. A Participant may, during the Open Enrollment Period, revoke or change his or her election or deemed election effective as of the beginning of the next Plan Year in accordance with Section 5.3.

ARTICLE VI.

PREMIUM PAYMENT PROGRAM

6.1 Benefits. The Premium Payment Program offers medical, dental, and vision benefits through the Synopsys, Inc. Welfare Plan (see Exhibit A). An Eligible Employee may elect benefits under the Premium Payment Program by electing to pay for his share of the Employee Contributions for medical, dental, and vision benefits through the Synopsys, Inc. Welfare Plan on a pre-tax on his Election Form. A Participant's Employee Contributions under the Premium Payment Program shall be applied by the Employer to pay for his share of the cost of coverage for the medical, dental, and vision benefits he elected for the Plan Year.

The medical, dental, and vision benefits are subject to the terms of the conditions of the Synopsys, Inc. Welfare Plan and any insurance policies or contracts for any insured benefits provided thereunder. No election changes with respect to such benefits (e.g., mid-year election changes as described in Exhibit C) can be made under this Plan if such changes are not permitted under the applicable underlying Benefit Plan. All claims to receive benefits under such Benefit Plans shall be subject to and governed by the terms and conditions of the applicable Benefit Plan and the rules, regulations, policies, and procedures adopted in accordance therewith, as may be amended from time to time.

6.2 Cost of Coverage. The annual contribution for a Participant's premium payments for the Benefit Plans elected by the Participant is equal to the amount as set by the Employer.

ARTICLE VII.

DEPENDENT CARE REIMBURSEMENT ACCOUNT PROGRAM

7.1 Establishment of Accounts. The Administrator shall establish a Dependent Care Reimbursement Account for each Participant who elects to receive reimbursement of Dependent Care Expenses for the applicable calendar year. The Dependent Care Reimbursement Account is a bookkeeping entry only and no assets will be segregated, earmarked or dedicated to pay Plan benefits. All benefits will be paid out of the Employer's general assets and no Participant will

obtain any right to any Employer assets because of establishment of the Dependent Care Reimbursement Account.

7.2 Crediting of Accounts. A Participant's Dependent Care Reimbursement Account shall be increased each pay period by the portion of the Employee Contributions that the Participant has elected to apply toward his or her Dependent Care Reimbursement Account pursuant to elections made under Articles III, IV and V hereof.

7.3 Debiting of Accounts. A Participant's Dependent Care Reimbursement Account shall be reduced by the amount of any Dependent Care Expense reimbursements paid to or on behalf of a Participant pursuant to Section 7.7 for Dependent Care Expenses incurred during such calendar year and/or its associated Grace Period.

7.4 Allowable Dependent Care Reimbursement. Subject to limitations contained in Section 7.6 of this Plan, and to the extent of the amount contained in the Participant's Dependent Care Reimbursement Account, a Participant who incurs Dependent Care Expenses for a Qualifying Dependent shall be entitled to receive full reimbursement for the entire amount of such expenses incurred during the calendar year and its associated Grace Period except as otherwise provided herein; no reimbursement shall exceed the amount in the Participant's Dependent Care Reimbursement Account at the time of the reimbursement. For purposes of this rule, Dependent Care Expenses shall be deemed to have been incurred at the time the services which generated the Dependent Care Expenses were provided.

7.5 Forfeitures. The amount in a Participant's Dependent Care Reimbursement Account as of the end of any Plan Year and its associated Grace Period (and after the processing of all claims for such Plan Year pursuant to Section 7.7 hereof) shall be forfeited to the Employer's general assets and shall be used in any manner deemed appropriate by the Employer.

7.6 Limitation On Payments. Notwithstanding any provision contained in this Article to the contrary, amounts paid from a Participant's Dependent Care Reimbursement Account in or on account of any taxable year of the Participant shall not exceed the lesser of the Earned Income limitation described in Section 129(b) of the Code or $5,000 ($2,500 if a separate tax return is filed by a Participant who is married as determined under the rules of paragraphs (3) and (4) of Section 2 1(e) of the Code).

7.7 Dependent Care Reimbursement Account Program Claims. The claims administrator shall direct the payment of all such claims for Dependent Care Expenses to the Participant upon the presentation to the claims administrator of documentation of such expenses in a form satisfactory to the claims administrator. In its discretion in administering the Plan, the claims administrator may utilize forms and require documentation as may be necessary to verify that the claims submitted are for Dependent Care Expenses. If a Participant fails to submit a claim by the 90th day following the end of the applicable Plan Year, the claim shall not be considered for reimbursement by the claims administrator.

Furthermore, the minimum amount for submission of a reimbursement request is $100 (this may be more than one claim combined).

7.8 Termination of Participation. In the event that a Participant ceases participation in the Plan in accordance with Section 3.2 of the Plan, no further Employee Contributions shall be allocated to such Participant's Dependent Care Reimbursement Account. The former Participant (or his or her estate) shall be entitled to reimbursement for Dependent Care Expenses incurred prior to the date of termination of participation within the same Plan Year in which participation in the Plan is terminated provided that the former Participant (or his or her estate) applies for such reimbursement in accordance with Section 7.7. Notwithstanding the forgoing, if a Participant ceases to be an Eligible Employee, the former Participant shall be entitled to reimbursement for Dependent Care Expenses incurred prior to the end of the Plan Year in which the former Participant loses eligibility. No such reimbursement shall exceed the remaining balance, if any, in the former Participant's Dependent Care Reimbursement Account for the Plan Year in which the expenses were incurred.

7.9 Discrimination Limitations.

(a) It is the intent of this Dependent Care Reimbursement Account Program not to discriminate in favor of Highly Compensated Employees in violation of Code Section 129(d)(2) and the Treasury regulations thereunder.

(b) If the Administrator determines, before or during any Plan Year, that the Plan may fail to satisfy any nondiscrimination requirements of Code Section 129(d)(2) for such Plan Year, the Administrator shall take such action as the Administrator deems appropriate. Such action may include, without limitation, a discontinuation or the modification of elections by Highly Compensated Employees. Any such discontinuation or modification of elections may be applied selectively to individual Participants or to particular classes of Participants, as the Employer may determine.

ARTICLE VIII.

HEALTH CARE REIMBURSEMENT ACCOUNT PROGRAM

8.1 Establishment of Accounts. The Administrator shall establish a Health Care Reimbursement Account for each Plan Year with respect to each Participant who has elected to receive reimbursement of Medical Expenses for the Plan Year. The Health Care Reimbursement Account is a bookkeeping entry only and no assets will be segregated, earmarked or dedicated to pay Plan benefits. All benefits will be paid out of the Employer's general assets and no Participant will obtain any right to any Employer assets because of establishment of the Health Care Reimbursement Account.

Any Employee who elects to participate in the Health Care Reimbursement Account Program will not be eligible to make or receive Health Savings Account contributions.

8.2 Crediting of Accounts. As of the first day of each Plan Year, each Participant's Health Care Reimbursement Account shall be credited with an amount equal to Employee Contributions which the Participant has elected to apply towards his or her Health Care Reimbursement Account pursuant to elections made under Articles III, IV and V hereof.

8.3 Debiting of Accounts. A Participant's Health Care Reimbursement Account for each Plan Year shall be debited from time to time in the amount of any reimbursement made pursuant to Section 8.6 to or for the benefit of the Participant for Medical Expenses incurred during such Plan Year and/or its associated Grace Period.

8.4 Forfeitures. Amounts remaining in Participants' Health Care Reimbursement Accounts after the processing of all claims for any Plan Year and its associated Grace Period pursuant to Section 8.6 hereof, shall be forfeited to the Employer's general assets and shall be used to pay Plan administrative expenses, and in any other manner deemed appropriate by the Employer.

8.5 Limitation of Allocations. Notwithstanding any provision contained in this Article VIII to the contrary, the maximum amount that a Participant may receive in reimbursements under the Health Care Reimbursement Account Program is determined by the limitations set forth in Section 125(i)(2) of the Code, which may be adjusted each year for cost of living increases.

8.6 Health Care Reimbursement Account Claims.

(a) To be eligible for reimbursement, Medical Expenses must be incurred by a Participant while covered under the Plan and during the Plan Year and/or its associated Grace Period. For purposes of this rule, Medical Expenses shall be deemed to have been incurred at the time the medical care which generated the Medical Expenses was provided. Medical Expenses incurred during the Plan Year or its associated Grace Period shall be reimbursed if the submission of the claim occurs no later than the 90th day following the end of the applicable Plan Year.

(b) The claims administrator shall direct the reimbursement to each eligible Participant for all allowable Medical Expenses which have been incurred by the Participant and/or his or her spouse or other Dependents, in excess of any payments or other reimbursements under any health care plan which may be sponsored by the Employer, any governmental agency or any other plan covering a Participant and/or his or her spouse or other Dependents, up to the balance in the Participant's Health Care Reimbursement Account at the time of reimbursement.

(c) Payments under this Plan may be made directly to the Participant. Payment requires adequate substantiation and shall be made to the claims administrator in a form acceptable to the claims administrator within a reasonable time but in no event later than the 90th day following the end of the applicable Plan Year. In its discretion in administering the Plan, the claims administrator may utilize forms and require documentation as may be necessary to verify that the claims submitted are for Medical Expenses.

(d) Claims for the reimbursement of Medical Expenses incurred in any Plan Year or its associated Grace Period shall be paid as soon after a claim has been filed as is administratively practicable; provided however, that if a Participant fails to submit a claim by the 90th day following the end of the Plan Year, those Medical Expense claims shall not be considered for reimbursement by the claims administrator.

8.7 Termination of Participation. Subject to the Participant's election of COBRA as provided in Section 8.9, in the event that a Participant ceases participation in the Plan in accordance with Section 3.2 of the Plan, the former Participant (or his or her estate) shall be entitled to reimbursement for Medical Expenses incurred through the date that such Participant's participation in the Plan is terminated provided that the former Participant (or his or her estate) applies for such reimbursement in accordance with Section 8.6. No such reimbursement shall exceed the remaining balance, if any, in the former Participant's Health Care Reimbursement Account for the Plan Year in which the expenses were incurred.

8.8 Discrimination Limitations. If the Administrator determines, before or during any Plan Year, that the Plan may fail to satisfy any nondiscrimination requirements of the Code (including, without limitation, sections 105(h) and 125) for such Plan Year, or that a Participant's participation in the Plan would cause the Participant to fail to satisfy section 415 of the Code, the Administrator shall take such action as the Administrator deems appropriate. Such action may include, without limitation, a discontinuation or reduction in the rate of Salary Redirection. Any such discontinuation or reduction may be applied selectively to individual Participants or to particular classes of Participants, as the Employer may determine.

8.9 Continuation of Coverage Under COBRA. Notwithstanding anything in the Plan to the contrary, to the extent required by Section 4980B of the Code and the Regulations thereunder (COBRA), a qualified beneficiary (as defined in Section 4980B(g)(1) of the Code) who would lose coverage under the Health Care Reimbursement Account Program upon the occurrence of a qualifying event (as defined in Section 4980B(f)(3) of the Code) shall be permitted to continue coverage under the Health Care Reimbursement Account Program as long as there is a positive balance in his or her Health Care Reimbursement Account as of the date of the qualifying event by electing to make the applicable contributions, on an after-tax basis, in accordance with procedures established by the Administrator that are consistent with COBRA. The Employer or its delegate shall provide notice to each covered Employee and his or her spouse of their rights under COBRA accordance with applicable law.

ARTICLE IX.

LIMITED PURPOSE HEALTH CARE REIMBURSEMENT ACCOUNT PROGRAM

9.1 Establishment of Accounts. The Administrator shall establish a Limited Purpose Health Care Reimbursement Account for each Plan Year with respect to each Participant who has elected to receive reimbursement of Medical Expenses for the Plan Year. The Limited Purpose Health Care Reimbursement Account is a bookkeeping entry only and no assets will be segregated, earmarked or dedicated to pay Plan benefits. All benefits will be paid out of the Employer's general assets and no Participant will obtain any right to any Employer assets because of establishment of the Limited Purpose Health Care Reimbursement Account.

The Limited Purpose Health Care Reimbursement Account shall reimburse Medical Expenses that are limited to eligible dental and vision expenses only, as provided by the applicable Code provisions or regulations or guidance issued by the United States Treasury Department, including the Internal Revenue Service.

9.2 Crediting of Accounts. As of the first day of each Plan Year, each Participant's Limited Purpose Health Care Reimbursement Account shall be credited with an amount equal to Employee Contributions which the Participant has elected to apply towards his or her Limited Purpose Health Care Reimbursement Account pursuant to elections made under Articles III, IV and V hereof.

9.3 Debiting of Accounts. A Participant's Limited Purpose Health Care Reimbursement Account for each Plan Year shall be debited from time to time in the amount of any reimbursement made pursuant to Section 9.6 to or for the benefit of the Participant for Medical Expenses incurred during such Plan Year and/or its associated Grace Period.

9.4 Forfeitures. Amounts remaining in Participants' Limited Purpose Health Care Reimbursement Accounts after the processing of all claims for any Plan Year or its associated Grace Period pursuant to Section 8.6 hereof, shall be forfeited to the Employer's general assets and shall be used to pay Plan administrative expenses, and in any other manner deemed appropriate by the Employer.

9.5 Limitation of Allocations. Notwithstanding any provision contained in this Article IX to the contrary, the maximum amount that a Participant may receive in reimbursements under the Limited Purpose Health Care Reimbursement Account Program is determined by the limitations set forth in Section 125(i)(2) of the Code, which may be adjusted each year for cost of living increases. Further, for purposes of the Limited Purpose Health Care Reimbursement Account, Medical Expenses shall be limited to eligible dental and vision expenses only, as provided by the applicable Code provisions or regulations or guidance issued by the United States Treasury Department, including the Internal Revenue Service.

9.6 Limited Purpose Health Care Reimbursement Account Claims.

(a) To be eligible for reimbursement, Medical Expenses must be incurred by a Participant while covered under the Plan and during the Plan Year or its associated Grace Period. For purposes of this rule, Medical Expenses shall be deemed to have been incurred at the time the medical care which generated the Medical Expenses was provided. Medical Expenses incurred during the Plan Year or its associated Grace Period shall be reimbursed if the submission of the claim occurs no later than the 90th day following the end of the applicable Plan Year.

(b) The claims administrator shall direct the reimbursement to each eligible Participant for all allowable Medical Expenses which have been incurred by the Participant and/or his or her spouse or other Dependents, in excess of any payments or other reimbursements under any health care plan which may be sponsored by the Employer, any governmental agency or any other plan covering a Participant and/or his or her spouse or other Dependents, up to the balance in the Participant's Limited Purpose Health Care Reimbursement Account at the time of reimbursement.

(c) Payments under this Plan may be made directly to the Participant. Payment requires adequate substantiation and shall be made to the claims administrator in a form acceptable to the claims administrator within a reasonable time but in no event later the 90th day

following the end of the applicable Plan Year. In its discretion in administering the Plan, the claims administrator may utilize forms and require documentation as may be necessary to verify that the claims submitted are for Medical Expenses.

(d) Claims for the reimbursement of Medical Expenses incurred in any Plan Year or its associated Grace Period shall be paid as soon after a claim has been filed as is administratively practicable; provided however, that if a Participant fails to submit a claim by the 90th day following the end of the Plan Year, those Medical Expense claims shall not be considered for reimbursement by the claims administrator.

9.7 Termination of Participation. Subject to the Participant's election of COBRA as provided in Section 9.9, in the event that a Participant ceases participation in the Plan in accordance with Section 3.2 of the Plan, the former Participant (or his or her estate) shall be entitled to reimbursement for Medical Expenses incurred through the date that such Participant's participation in the Plan is terminated provided that the former Participant (or his or her estate) applies for such reimbursement in accordance with Section 9.6. No such reimbursement shall exceed the remaining balance, if any, in the former Participant's Limited Purpose Health Care Reimbursement Account for the Plan Year in which the expenses were incurred.

9.8 Discrimination Limitations. If the Administrator determines, before or during any Plan Year, that the Plan may fail to satisfy any nondiscrimination requirements of the Code (including, without limitation, sections 105(h) and 125) for such Plan Year, or that a Participant's participation in the Plan would cause the Participant to fail to satisfy section 415 of the Code, the Administrator shall take such action as the Administrator deems appropriate. Such action may include, without limitation, a discontinuation or reduction in the rate of Salary Redirection. Any such discontinuation or reduction may be applied selectively to individual Participants or to particular classes of Participants, as the Employer may determine.

9.9 Continuation of Coverage Under COBRA. Notwithstanding anything in the Plan to the contrary, to the extent required by Section 4980B of the Code and the Regulations thereunder (COBRA), a qualified beneficiary (as defined in Section 4980B(g)(1) of the Code) who would lose coverage under the Limited Purpose Health Care Reimbursement Program upon the occurrence of a qualifying event (as defined in Section 4980B(f)(3) of the Code) shall be permitted to continue coverage under the Limited Purpose Health Care Reimbursement Account Program as long as there is a positive balance in his or her Limited Purpose Health Care Reimbursement Account as of the date of the qualifying event by electing to make the applicable contributions, on an after-tax basis, in accordance with procedures established by the Administrator that are consistent with COBRA. The Employer or its delegate shall provide notice to each covered Employee and his or her spouse of their rights under COBRA accordance with applicable law.

ARTICLE X.

HEALTH SAVINGS ACCOUNTS

10.1 Eligibility for Health Savings Account Contributions. A Participant is eligible to make pre-tax deferrals under the Health Savings Account if he or she (a) is a participant in an

Employer sponsored High Deductible Health Plan (as defined in Section 223(c)(2) of the Code), (b) is not a participant in any health plan which is not a High Deductible Health Plan, (c) is not enrolled in Medicare, (d) cannot be claimed as a dependent on another taxpayer's tax return, (e) is not a Participant in the Health Care Reimbursement Account Program, and (f) has established a Health Savings Account in accordance with the rules established by the Plan Administrator with the Health Savings Account custodian specified by the Plan Administrator.

10.2 Elections. An eligible Participant who wishes to make pre-tax deferrals to be credited to his or her Health Savings Account during the Plan Year must make an affirmative deferral election during the period established by the Plan Administrator. Each eligible Participant who elects to make pre-tax deferrals to his or her Health Savings Account may increase or decrease his or her deferral level, or may suspend or restart his or her deferrals during the Plan Year in accordance with the rules established by the Plan Administrator, which shall, at a minimum allow changes to be made prospectively on a monthly basis.

10.3 Participant Pre-Tax Deferrals

(a) The maximum amount that an eligible Participant may elect to defer to his or her Health Savings Account is subject to the limitations set forth in Code Section 223(g). Further, the maximum amount an eligible Participant may elect to defer to their Health Savings Account shall be reduced by the maximum amount, if any, that the Employer has pledged to contribute to the Participant's Health Savings Account for the applicable Plan year pursuant to Section 10.4.

(b) The limitations set forth in this Section 10.3 shall be adjusted for cost of living increases as set forth in section 223(g) of the Code.

10.4 Employer Contributions.

(a) The Employer may, but is not required to, make a contribution to an eligible Participant's Health Savings Account on account of the Participant. Any such contribution shall result in a reduction in the amount that the Participant may defer under Section 10.3. If a Participant does not establish a Health Savings Account in accordance with the rules established by the Plan Administrator, the Employer will not make a contribution to the Participant's Health Savings Account.

(b) Employer contributions, if any, will be made in accordance with the rules established by the Plan Administrator.

10.5 Catch-Up Deferrals. An eligible Participant who has attained age 55 before the end of the Plan Year (and who is not otherwise enrolled in Medicare) may defer an additional amount in accordance with section 223(b)(3) of the Code.

ARTICLE XI.

CONTRIBUTIONS

11.1 Leave of Absence.

(a) Paid. A Participant's coverage under the Benefit Plans the Participant has selected shall continue to be paid only for family or medical leaves of absence and the Participant shall continue to pay his or her Employee Contribution in accordance with Section 11.1. Notwithstanding the foregoing, any salary continuation payments received by a Participant shall be considered "pay" for purposes of determining whether a Participant is on a paid or unpaid leave of absence

(b) Unpaid. A Participant's coverage under the Benefit Plans the Participant has selected shall not continue during an unpaid leave of absence unless the underlying Benefit Plan provides for extended coverage or coverage during the applicable leave of absence. A Participant on a leave of absence may make a new election for the following Plan Year in accordance with Section 5.6 following his return from leave. Such new election shall take effect when the Participant becomes covered under the Benefit Plans. Upon returning from an unpaid leave within the same Plan Year, the elections for the Plan Year will be automatically reinstated, but may be changed by a Participant that experiences a change in status event as described in Section 5.6. Additionally, a Participant who returns from FMLA leave may elect to reduce the amount that the Participant elected to have reimbursed through Reimbursement Accounts so that the salary reduction for the Reimbursement Account benefits is the same before the leave as after the leave or make a new election altogether for the remainder of the year.

11.2 Allocation of Contributions. Except as otherwise provided in the Health Care Reimbursement Account Program or the Limited Purpose Health Care Reimbursement Account Program portions of the Plan, as of each date an amount equal to the Participant's Employee Contribution is withheld from the Participant's Compensation, such amount shall be credited to provide benefits under the appropriate Benefit Plans consistent with the Participant's election under the Plan.

ARTICLE XII.

BENEFIT CLAIMS

12.1 Claim for Benefits. Any claim for Benefits under a Benefit Plan shall be made pursuant to provisions set forth in the documents governing that Benefit Plan. A claim may be filed under the Plan to the extent that such claim relates to the terms of this Plan. Claims under the Plan (other than the Health Care Reimbursement Account Program and the Limited Purpose Health Care Reimbursement Account Program) shall be administered as provided in this Section 12.1. If the claims administrator denies a claim, the claims administrator may provide notice to the Participant or beneficiary, in writing, within 90 days after the claim is filed unless special circumstances require an extension of time for processing the claim. The notice of a denial of a claim shall be written in a manner calculated to be understood by the claimant and shall set forth:

(a) specific references to the pertinent Plan provisions on which the denial is based;

(b) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation as to why such information is necessary; and

(c) an explanation of the Plan's claim procedure.

12.2 Right to Appeal. Within 60 days after receipt of the above material, the claimant shall have a reasonable opportunity to appeal the claim denial to the claims administrator for a full and fair review. The claimant or his duly authorized representative may:

(a) request a review upon written notice to the claims administrator;

(b) review pertinent documents; and

(c) submit issues and comments in writing.

A decision on the review by the claims administrator will be made not later than 60 days after receipt of a request for review, unless special circumstances require an extension of time for processing (such as the need to hold a hearing), in which event a decision should be rendered as soon as possible, but in no event later than 120 days after such receipt. The decision of the claims administrator shall be written and shall include specific reasons for the decision, written in a manner calculated to be understood by the claimant, with specific references to the pertinent Plan provisions on which the decision is based.

12.3 Health Care Reimbursement Account Program and Limited Purpose Health Care Reimbursement Account Program Claims Procedure. Notwithstanding the foregoing, in the case of a claim for medical expenses under the Health Care Reimbursement Account Program and the Limited Purpose Health Care Reimbursement Account Program (hereinafter, for this Section 12.3, collectively "Program") the following timetable applies:

Notification of whether claim is accepted or denied	within 30 days of the receipt of the claim
Extension due to matters beyond the control of the Program	an additional 15 days (so long as prior to the expiration of the initial 30-day period, the Program notifies the claimant of the circumstances requiring an extension of time and the date by which the Program expects to render a decision)

Failure of the Claimant to Provide the Information Necessary to decide the Claim:

Notification by the Program	30 days of the receipt of the claim
Response due by Participant	45 days from the notification
Benefit determination	15 days after receiving the information or 15 days after the end of the 45-day

Failure of the Claimant to Provide the Information Necessary to decide the Claim:

deadline, whichever is sooner

Review on appeal of denied claim 60 days after receipt of the appeal

(a) The claims administrator will provide written or electronic notification of an initial claim denial. The notice will state:

(1) The specific reason or reasons for the denial.

(2) Reference to the specific Program provisions on which the denial was based.

(3) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary.

(4) A description of the Program's review procedures and the time limits applicable to such procedures. This will include a statement of the right to bring a civil action under section 502 of ERISA following a denial on review.

(5) If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to the claimant upon request.

(6) If the denial is based on a 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 Program to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge to the claimant upon request.

(b) When the Participant receives a denial of a Program claim, the Participant or his authorized representative shall have 180 days following receipt of the notification in which to appeal the decision. The Participant may submit written comments, documents, records, and other information relating to the Claim. If the Participant requests, the Participant shall be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information Relevant to the Claim.

(1) The period of time within which a denial on review is required to be made will begin at the time an appeal is filed in accordance with the procedures of the Program. This timing is without regard to whether all the necessary information accompanies the filing.

(2) A document, record, or other information shall be considered relevant to a Claim if it: (i) was relied upon in making the claim determination; (ii) was

submitted, considered, or generated in the course of making the claim determination, without regard to whether it was relied upon in making the claim determination; (iii) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that claim determinations are made in accordance with Program documents and Program provisions have been applied consistently with respect to all claimants; or (iv) constituted a statement of policy or guidance with respect to the Program concerning the denied claim.

(3) The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial claim determination. The review will not afford deference to the initial denial and will be conducted by a named fiduciary of the Program who is neither the individual who made the adverse determination nor a subordinate of that individual.

(4) If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental and/or investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who was not involved in the original benefit determination (nor the subordinate of that individual). This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, upon request by the claimant, medical or vocational experts whose advice was obtained on behalf of the Program in connection with the adverse benefit determination will be identified.

(c) The claims administrator will provide written notification of any claim that is denied on appeal under the Program. The notice will state:

(1) The specific reason or reasons for the denial.

(2) Reference to the specific Program provisions on which the denial was based.

(3) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all document, records, and other information Relevant to the claimant's claim for benefits.

(4) A statement describing any voluntary appeal procedures offered by the Program and the claimant's right to obtain the information about such procedures, and a statement of the claimant's right to bring an action under section 502(a) of ERISA.

(5) If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. Alternatively, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to the claimant upon request.

(6) If the denial is based on a 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 Program to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge to the claimant upon request.

12.4 Amounts Under The Plan.

(a) In no event shall such amounts be carried over to reimburse a Participant for expenses incurred during a subsequent Plan Year (excluding amounts incurred during the Grace Period) for the same or any other Benefit available under the Plan; nor shall amounts forfeited by a particular Participant be made available to such Participant in any other form or manner, except as permitted by Treasury regulations.

(b) Any balance remaining in the Participants' Health Care Reimbursement Account, Limited Purpose Health Care Reimbursement Account, or Dependent Care Reimbursement Account as of the end of each Plan Year and its associated Grace Period shall be forfeited unless the Participant had made a claim in writing for such Plan Year within the required time periods, which has been denied or is pending; in which event the amount of the claim shall be held in his account until the claim appeal procedures set forth above have been satisfied or the claim is paid. If any such claim is denied on appeal, the amount held beyond the end of the Plan Year shall be forfeited.

(c) Amounts forfeited shall be retained by the Employer.

12.5 Named Fiduciary For The Health Care Reimbursement Account Program and the Limited Purpose Health Care Reimbursement Account Program. For the purposes of the Health Care Reimbursement Account Program and the Limited Purpose Health Care Reimbursement Account Program, the Administrator shall be the named fiduciary pursuant to ERISA Section 402 and shall be responsible for the management and control of the operation and administration of the Plan.

12.6 General Fiduciary Responsibilities Under The Health Care Reimbursement Account Program and the Limited Purpose Health Care Reimbursement Account Program. For the purposes of the Health Care Reimbursement Account Program and the Limited Purpose Health Care Reimbursement Account Program, the Administrator and any other fiduciary under ERISA shall discharge their duties with respect to the Health Care Reimbursement Account Program and the Limited Purpose Health Care Reimbursement Account Program solely in the interest of the Participants and their beneficiaries and

(a) for the exclusive purpose of providing Benefits to Participants and their beneficiaries and defraying reasonable expenses of administering the Health Care Reimbursement Account Program and Limited Purpose Health Care Reimbursement Account Program;

(b) with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent man acting in like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims; and

(c) in accordance with the documents and instruments governing the Health Care Reimbursement Account Program and the Limited Purpose Health Care Reimbursement Account Program insofar as such documents and instruments are consistent with ERISA.

12.7 Non-Assignability of Rights. The right of any Participant to receive any reimbursement under the Plan shall not be alienable by the Participant by assignment or any other method, and shall not be subject to the rights of creditors, and any attempt to cause such right to be so subjected shall not be recognized, except to such extent as may be required by law.

ARTICLE XIII.

FUNDING

The Employer shall contribute from time to time the amount determined by the Administrator as necessary to provide the coverages elected by the Eligible Employees. Such contributions shall be made out of the general assets of the Employer as benefits become payable under the Benefit Plans, and no trust fund, escrow account or other segregated fund is to be maintained for the purpose of pre-funding any benefits payable hereunder.

ARTICLE XIV.

AMENDMENT AND TERMINATION

14.1 Amendment. The Employer reserves the power at any time or times to amend the provisions of the Plan to any extent and in any manner it shall deem advisable, by a written instrument signed by a duly authorized officer of the Employer. Any amendment shall become effective in accordance with its terms as to all Participants and all other persons having or claiming any interests under the Plan. The Employer may delegate to any Employee all or a portion of the authority to amend the Plan or any of the documents or welfare benefits described in Exhibit A by signed written instrument, but the delegate's authority will terminate if the delegation is revoked by a written instrument signed by the a duly authorized officer of the Employer or if the employee's employment terminates.

14.2 Termination. The Employer has established the Plan with a bona fide intention and expectation that it will be continued indefinitely, but the Employer will have no obligation whatsoever to maintain the Plan for any given length of time and may discontinue or terminate the Plan at any time without liability, by a written instrument signed by an appropriate officer or individual delegated with the authority to act on behalf of the Employer.

ARTICLE XV.

ADMINISTRATION

15.1 Administrator. The Employer shall be the "administrator" of the Plan and "named fiduciary" within the meaning of those terms under ERISA for purposes of the Health Care Reimbursement Account Program and the Limited Purpose Health Care Reimbursement

Account Program. The Administrator shall have exclusive authority and responsibility for all matters in connection with the operation and administration of the Plan. Specifically, the Administrator shall: (i) be responsible for the compilation and maintenance of all records necessary in connection with the Plan; (ii) compute and authorize the payment of all benefits as they become payable under the Plan; (iii) decide questions relating to the eligibility of Employees to become Participants; (iv) engage such legal, actuarial, accounting and other professional and clerical services as may be necessary or proper; and (v) interpret this instrument and make and publish such uniform and nondiscriminatory rules for administration of the Plan as are not inconsistent with the provisions of this instrument.

The Employer also has the full authority to administer the provisions of the Plan which are not subject to ERISA or its fiduciary requirements.

15.2 Delegation of Duties. The Administrator may, from time to time, delegate any of the rights, powers, and duties of the Administrator (including fiduciary responsibilities) with respect to the operation and administration of the Plan to one or more committees, individuals or entities. If the Administrator delegates any rights, powers or duties to any person, such person may from time to time further delegate such rights, powers and duties to any other person. If any right, power or duty is delegated to more than one person, such persons may from time to time allocate among themselves any such right, power or duty. Any allocation or delegation of fiduciary responsibilities under the Plan shall be terminable upon such notice as the Administrator, in its sole discretion, deems reasonable and prudent.

15.3 Administrative Procedures.

(a) The Administrator shall keep records of its actions. No delegate of the administrator shall act as a delegate of the Administrator on any matter relating solely to the delegates own interests in the Plan.

(b) All written instruments and notices required to be filed with the Administrator shall be deemed to be filed upon delivery to the Administrator or its designate, provided the instrument or notice is in the form prescribed by the Administrator.

(c) Any person serving as the delegate of the Administrator may resign by filing a written resignation with the Employer. While any vacancy exists, the remaining person or persons serving as delegates of the Administrator may perform any act that the Administrator has delegated to be performed.

15.4 Expenses. All necessary and proper expenses incurred in the administration of the Plan shall be paid for by the Employer.

15.5 Fiduciary Responsibilities. The Administrator and each person performing fiduciary duties of the Administrator pursuant to delegation under Section 15.2 shall discharge his/her duties and responsibilities with respect to the Plan:

(a) solely in the interest of the Participants; and

(b) for the exclusive purpose of providing benefits to Participants and defraying reasonable expenses of administering the Plan.

15.6 Indemnification. To the extent permitted by law, the Employer shall indemnify and hold harmless any person to whom any fiduciary duty with respect to the Plan is delegated pursuant to Section 15.2 and all employees of the Employer and all members of the Employer's board of directors who may be deemed fiduciaries of the Plan, from and against any and all liabilities, claims, demands, costs and expenses (including attorneys' fees) arising out of an alleged breach in the performance of its fiduciary duties under the Plan, other than such liabilities, claims, demands, costs and expenses as may result from the gross negligence or willful misconduct of such person. The Employer shall have the right, but not the obligation, to conduct the defense of such person in any proceeding to which this Section 15.6 applies. The Employer may satisfy its obligations under this Section 15.6 in whole or in part through the purchase of a policy or policies of insurance providing equivalent protection.

15.7 Discretionary Authority. When exercising its authority and responsibility under all of the provisions of the Plan, including but not limited to the provisions of Article XIII of the Plan, the Administrator will have full discretionary authority to administer and interpret the Plan, including discretionary authority to determine eligibility for participation and for benefits under the terms of the Plan. Benefits under the Plan will be paid only if the Administrator decides in its discretion that a Participant is entitled to them. The Administrator may delegate such discretionary authority and such duties and responsibilities (e.g., claims administration) as it deems appropriate to facilitate the day-to-day administration of the Plan. Unless otherwise noted, delegation includes delegation of discretion. Any determination by the Administrator or its delegate will be final and conclusive upon all persons.

ARTICLE XVI.

MISCELLANEOUS

16.1 Construction. The headings and subheadings of this instrument are inserted for convenience of reference only and are not to be considered in the construction or interpretation of this Plan.

16.2 Applicable Law. The Plan shall be construed, administered and governed in all respects in accordance with the Internal Revenue Code and other pertinent federal laws and in accordance with the laws of the State of California to the extent not preempted by ERISA. Notwithstanding the foregoing, the Health Care Reimbursement Account Program and the Limited Purpose Health Care Reimbursement Account Program components of the Plan shall be construed, administered and governed in all respects in accordance with ERISA and other pertinent federal laws and in accordance with the laws of the State of California to the extent not preempted by ERISA. If any provision of this Plan shall be held by a court of competent jurisdiction to be invalid or unenforceable, the remaining provisions of the Plan shall continue to be fully effective.

16.3 Gender and Number. Whenever used in this Plan, the masculine gender will include the feminine gender and the singular will include the plural, unless the context indicates otherwise.

16.4 Contract of Employment. Nothing contained in this Plan shall be deemed to give any Participant the right to be retained in the employ of the Employer or to interfere with the right of the Employer to discharge any Participant at any time, with or without cause, regardless of the effect which such discharge shall have upon such individual as a Participant in this Plan.

16.5 Nonassignability of Rights. Neither the Employer nor the Administrator shall recognize any transfer, mortgage, pledge, hypothecation, order or assignment by any Participant or beneficiary of all or any part of his or her interest under the Plan. Any attempt by a Participant or beneficiary to assign, alienate, sell, transfer, pledge or encumber his or her benefits shall be void. A Participant's or beneficiary's interests shall not be subject in any manner to transfer by operation of law, and shall be exempt from the claims of creditors or other claimants (including but not limited to debts, contracts, liabilities, or torts) from all orders, decrees, levees, garnishments, and/or executions and other legal or equitable process or proceedings against such Participant or beneficiary to the full extent which may be permitted by law.

16.6 Benefits Provided Through Third Parties. In the case of any benefit provided pursuant to an 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 the Plan document. In the case of any benefit provided through a third party, such as an insurance company, pursuant to a contract or policy with such third party, if, with respect to the obligations of the third party to pay or provide benefits, there is any conflict or inconsistency between the description of benefits contained in this Plan and such contract or policy, the terms of such contract or policy shall control except to the extent that such contract or policy is inconsistent with the requirements of Section 125 of the Code or ERISA.

16.7 Payments. Any Benefit payable under the Plan after the death of the Participant is to be paid to his/her surviving spouse, if any, and otherwise to the Participant's estate. Furthermore, if the Administrator or its delegate determines that any person who is entitled to payments under the Plan is incompetent by reason of physical or mental disability or other incapacity, the Administrator may cause all payments thereafter becoming due to the person to be made to any other person for his/her benefit, without responsibility to follow the application of amounts so paid. Payments made pursuant to this Section 16.7 shall completely discharge the Administrator and the Employer from further liability hereunder. In addition, any expense reimbursements remaining unclaimed (e.g., unclaimed Health Reimbursement Account Program checks) after the end of the Plan Year in which the expense was incurred (and applicable run-out period) will be forfeited. Any such forfeited amounts will be used to pay the applicable reasonable expenses of maintaining and administering the Plan (e.g., unclaimed Health Reimbursement Account Program checks will be used towards the reasonable expense of maintaining and administering the Health Reimbursement Account Plan). If a Participant subsequently requests payment with respect to an unclaimed check, the Administrator in its discretion, shall make such payment under the terms and provisions of the Plan as in effect when the claim was originally processed.

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

16.9 No Guarantee of Tax Consequences. Neither the Participating Companies nor the Administrator makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under the Plan will be excludable from the Participant's gross income for federal or state income tax purposes, or that any other federal or state tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each payment under the Plan is excludable from the Participant's gross income for federal and state income tax purposes, and to notify the Employer if the Participant has reason to believe that such payment is not so excludable.

16.10 Indemnification of Employer by Participants. If any Participant receives one or more reimbursements under the Plan that are not for Medical Expenses or Dependent Care Expenses or that are includable in the Participant's gross income for any reason, upon the request of the Employer, such Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold federal or state income tax or social security tax from such reimbursements. However, such indemnification and reimbursement shall not exceed the amount of additional federal and state income tax that the Participant would have owed if the reimbursements had been made to the Participant as regular cash compensation, plus the Participant's share of any social security tax that would have been paid on such compensation, including any interest and penalties attributable thereto, less any additional income and social security tax actually paid by the Participant.

In Witness Whereof, to record the amendment and restatement of the Plan as set forth herein, effective as of January 1, 2024, the Employer has caused this Plan to be executed by its duly authorized representative on _____.

SYNOPSYS, INC.

By: _____

Printed Name: _____

Title: _____

EXHIBIT A

BENEFIT PLANS

Medical, dental, and vision Components provided under the Synopsys, Inc. Welfare Plan.

Reimbursement Accounts under this Plan.

EXHIBIT B

HIPAA PRIVACY AND SECURITY PROVISIONS

This Exhibit B is being added to amend the Synopsys, Inc. Section 125 Plan (the "Plan") to reflect the privacy and security provisions of the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("HIPAA"). HIPAA and its implementing regulations restrict group health plans (among other covered entities) from using and disclosing protected health information ("PHI"), as such term is defined in 45 CFR Section 160.103. The following provisions regarding the use and disclosure of PHI are intended to meet the applicable provisions of HIPAA.

A.1 Definitions. The following words and phrases shall have the following meanings (terms used but not otherwise defined, shall have the same meaning as those terms in 45 CFR Sections 160.103 and 164.501):

(a) Group Health Benefits. Group Health Benefits means the Health Care Reimbursement Account Program and the Limited Purpose Health Care Reimbursement Account Program components of the Synopsys, Inc. Section 125 Plan.

(b) Group Health Plan. Group Health Plan means the Group Health Benefit components of the Plan.

A.2 Designation of Hybrid Entity under HIPAA. The Plan is a "hybrid entity" as defined in 45 CFR Section 164.103. In accordance with 45 CFR Section 164.105(a)(2)(iii)(C), the Plan designates the Health Care Reimbursement Account Program and the Limited Purpose Health Care Reimbursement Account Program components of the Plan ("Group Health Plan") as the health care components of the Plan that is subject to the security and privacy provisions of Part 164 of HIPAA.

A.3 Use and Disclosure of PHI. The Group Health Plan will use and disclose PHI to the full extent permitted or required by HIPAA, including (without limitation): (i) for treatment, payment and health care operations; (ii) as required by law; (iii) to the individual; (iv) to the Secretary of Health and Human Services; (v) for legal and public policy purposes; (vi) to business associates; (vii) pursuant to a valid authorization; and (viii) to the Plan Sponsor as described below. The Group Health Plan's use and disclosure of PHI shall be in accordance with, and comply with, HIPAA and the Plan's Privacy Policy and accompanying Use and Disclosure Procedures (as amended from time to time).

A.4 Disclosure to Plan Sponsor. Pursuant to 45 CFR Section 164.504(f), the Group Health Plan is permitted to disclose PHI to the Plan Sponsor to carry out its plan administrative functions. In accordance with 45 CFR Section 164.504(f), the Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the Plan has been amended to incorporate the provisions set forth in 45 CFR Section 164.504(f)(2). The Plan Sponsor agrees to:

- Not use or further disclose PHI other than as permitted or required by the Plan document or as required by law;

- Ensure that any agents or subcontractors to whom it provides PHI received from the Group Health Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;

- Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by the individual;

- Report to the Group Health Plan any use or disclosure of PHI that is inconsistent with the uses or disclosures provided for of which it becomes aware;

- Make PHI available based on HIPAA's access requirements in accordance with 45 CFR Section 164.524;

- Make PHI available for amendment and incorporate any amendments to PHI based on HIPAA's amendment requirements in accordance with 45 CFR Section 164.526;

- Make available the information required to provide an accounting of disclosures in accordance with 45 CFR Section 164.528;

- Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Group Health Plan available to the Secretary of Health and Human Services for purposes of determining the Plan's compliance with certain provisions of HIPAA;

- If feasible, return or destroy all PHI received from the Group Health Plan that the Plan Sponsor still maintains in any form and retain 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 feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

- Ensure that adequate separation between the Group Health Plan and the Plan Sponsor is established as required by 45 CFR Section 164.504(f)(2)(iii).

- Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic Protected Health Information (as that term is defined at 45 C.F.R. Section 160.103) that it creates, receives, maintains or transmits on behalf of the Plan other than Electronic Protected Health Information that is summary health information disclosed pursuant to 45 C.F.R. Section 164.504(f)(1)(ii), enrollment or disenrollment information disclosed pursuant to 45 C.F.R. Section 154.504(f)(1)(iii), or information disclosed pursuant to an authorization under 45 C.F.R. Section 164.508.

- Ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

- Report to the Group Health Plan any security incident (as defined by 45 C.F.R. § 164.304) of which it becomes aware.

A.5 Adequate Separation between the Group Health Plan and the Plan Sponsor. In accordance with HIPAA, only the following employees or classes of employees of the Plan Sponsor shall be given access to the PHI disclosed by the Group Health Plan: Human Resources personnel. Access shall be restricted to use by such employees described above for purposes of the Group Health Plan administration functions that Plan Sponsor performs for the Group Health Plan. If the persons described above do not comply with these provisions, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

EXHIBIT C

EVENTS WHICH MAY PERMIT AN EMPLOYEE TO CHANGE HIS/HER ELECTION MID-YEAR

Any Participant may change a benefit election after the Plan Year (to which such election relates) has commenced and make new elections with respect to the remainder of such Plan Year if, under the facts and circumstances, the changes are necessitated by and are consistent with a change in status which is acceptable under rules and regulations adopted by the Department of the Treasury, the provisions of which are incorporated by reference. Notwithstanding anything herein to the contrary, if the rules and regulations conflict, then such rules and regulations shall control.

In general, a change in election is not consistent if the change in status is the Participant's divorce, annulment or legal separation from a Spouse, the death of a Spouse or Dependent, or a Dependent ceasing to satisfy the eligibility requirements for coverage, and the Participant's election under the Plan is to cancel accident or health insurance coverage for any individual other than the one involved in such event. In addition, if the Participant, Spouse or Dependent gains or loses eligibility for coverage, then a Participant's election under the Plan to cease or decrease coverage for that individual under the Plan corresponds with that change in status only if coverage for that individual becomes applicable or is increased under the family member plan.

Regardless of the consistency requirement, if the individual, the individual's Spouse, or Dependent becomes eligible for continuation coverage under the Employer's group health plan as provided in Code Section 4980B or any similar state law, then the individual may elect to increase payments under this Plan in order to pay for the continuation coverage. However, this does not apply for COBRA eligibility due to divorce, annulment or legal separation.

Any new election must be submitted within 31 days of the event and shall be effective at such time as the Administrator shall prescribe, but not earlier than the first pay period beginning after the election is submitted unless otherwise required by law. For the purposes of this subsection, a change in status shall only include the following events or other events permitted by Treasury regulations:

(a) Special Enrollment Rights. Any event specified in Code Section 9801(f) that entitles a Participant to special enrollment rights under a group health plan to which this Plan applies.

(b) Change in Status Events.

(1) Legal Marital Status. Any event that changes a Participant's legal marital status, including marriage, death of a Spouse, divorce, legal separation and annulment.

(2) Number of Dependents. Any event that changes a Participant's number of Dependents, including birth, death, adoption and placement for adoption.

(3) Employment Status. Any of the following events that change the employment status of a Participant, or of a Participant's Spouse or Dependent: a termination or commencement of or a return from an unpaid leave of absence and a change in worksite. In addition, if eligibility for the Plan, any plan to which this Plan applies, or a cafeteria plan or qualified employee benefit plan of the employer of the Participant's Spouse or Dependent, is conditioned on employment status and there is a change in the employment status of a Participant or a Participant's Spouse or Dependent with the consequence that such individual becomes (or ceases to be) eligible under such plan, then that change constitutes a change in employment status for purposes of this Plan.

(4) Dependent Satisfies or Ceases to Satisfy Eligibility Requirements. Any event that causes a Participant's Dependent to satisfy, or to cease to satisfy, the eligibility requirements for coverage under a plan to which this Plan applies on account of attainment of age, student status or any similar circumstance.

(5) Residence. A change in residence of a Participant or the Participant's Spouse or Dependent; provided, however, that this shall not apply to the Health Care Reimbursement Account Program or the Limited Purpose Health Care Reimbursement Account Program.

(c) COBRA Eligibility. If a Participant, or the Participant's Spouse or Dependent, becomes eligible under Code Section 4980B, or any similar state law, for continuation coverage in a group health plan offered by the Employer, a Participant may decrease his or her election under the Plan. Alternatively, a Participant may increase his or her election under the Plan to pay for such continuation coverage.

(d) Judgment, Decree, or Order. A judgment, decree, or order resulting from a divorce, legal separation, annulment or change in legal custody (including a Qualified Medical Child Support Order as defined in Section 609 of ERISA) that either:

(1) Requires a Participant to provide accident or health coverage under a plan to which this Plan applies for a Participant's child or for a foster child who is a dependent (as defined in Code Section 152 and any applicable Treasury Regulations thereunder, as modified by Code Section 105(b)) of the Participant; or

(2) Requires the Participant's Spouse, former Spouse or another individual to provide accident or health coverage for such child; provided, however, that this Subsection (2) shall only apply if the Participant's Spouse, former Spouse or another individual actually provides such accident or health coverage.

(e) Entitlement or Loss of Entitlement to Medicare or Medicaid. If a Participant or the Participant's Spouse or Dependent who is enrolled in an accident or health plan to which this Plan applies becomes enrolled under Medicare Part A or Part B, or in Medicaid, the Participant may make a prospective election change to cancel or reduce coverage for the

individual who becomes enrolled in Medicare or Medicaid. If a Participant or the Participant's Spouse or Dependent who has been enrolled in Medicare or Medicaid loses eligibility for such coverage, a Participant may make a prospective election to commence or increase coverage under an accident or health plan to which this Plan applies for the individual who lost coverage under Medicare or Medicaid.

(f) Changes in Cost. This Subsection (f) shall not apply to the Health Care Reimbursement Account Program or the Limited Purpose Health Care Reimbursement Account Program.

(1) Automatic Changes. If the cost of a plan to which this Plan applies increases (or decreases) during a Plan Year and, under the terms of such plan, Participants are required to make a corresponding change in their contributions, the Administrator may, on a reasonable and consistent basis, automatically make a prospective increase (or decrease) in an affected Participant's election under the Plan.

(2) Significant Cost Increases. If the cost charged to a Participant for a plan to which this Plan applies significantly increases or significantly decreases during a Plan Year and, under the terms of such plan, Participants are required to make a corresponding change in their contributions, in the case of an increase in cost an affected Participant may either:

(i) Revoke his or her election for that coverage and prospectively elect coverage under another plan to which this Plan applies, if any, that provides similar coverage; or

(ii) Drop coverage if no other plan providing similar coverage is available.

In the case of a decrease in cost, a Participant may commence participation in the plan with a decrease in cost.

Notwithstanding the foregoing, for purposes of Dependent Care Expenses, this subparagraph (2) shall only apply if the cost change is imposed by a dependent care provider who is not a Relative of the Participant. For this purpose, a Relative means an individual who is related to the Participant as described in Code Section 152(a)(1) through (8) and incorporating the rules of Code Section 152(b)(1) and (2).

(g) Changes in Coverage. This Subsection (g) shall not apply to the Health Care Reimbursement Account Program or the Limited Purpose Health Care Reimbursement Account Program.

(1) Significant Curtailment Without Loss of Coverage. If, during a Plan Year, a Participant or the Participant's Spouse or Dependent has a significant curtailment of coverage under a plan to which this Plan applies, that is not a loss of coverage as defined by Treasury Regulations or other applicable guidance issued under Code Section 125, such affected Participant may revoke his or her election under the Plan for that coverage, and may prospectively make a new election for coverage under another

plan to which this Plan applies, if any, that provides similar coverage. Coverage is significantly curtailed only if there is an overall reduction in coverage provided to Participants so as to constitute reduced coverage generally.

(2) Significant Curtailment With Loss of Coverage. If, during a Plan Year, a Participant or the Participant's Spouse or Dependent has a significant curtailment of coverage under a plan to which this Plan applies, that is a loss of coverage as defined by Treasury Regulations or other applicable guidance issued under Code Section 125, or as determined by the Administrator, in its sole discretion, consistent with such Treasury Regulations or other applicable guidance, such affected Participant may elect to either:

(i) Revoke his or her election under the Plan and prospectively make a new election for coverage under another plan to which this Plan applies, if any, that provides similar coverage; or

(ii) Drop coverage if no other plan providing similar coverage is available.

For purposes of this Subsection (2), a loss of coverage means a complete loss of coverage under the benefit package option (including the elimination of a benefits package option, an HMO ceasing to be available in the area where the individual resides, or the individual losing all coverage under the benefits package option by reason of an overall lifetime or annual limitation). In addition, the Administrator may, in its sole discretion, treat the following as a loss of coverage: (A) A substantial decrease in the medical care providers available under the benefits package option; or (B) A reduction in the benefits for a specific type of medical condition or treatment with respect to which a Participant or the Participant's Spouse or Dependent is currently in a course of treatment; or (C) Any other similar fundamental loss of coverage.

(h) Addition Or Improvement of Plan to Which this Plan Applies. If, during a Plan Year, the Employer adds a new plan, or significantly improves the coverage provided under an existing plan to which this Plan applies, an Eligible Employee (including those who are not Participants in the Plan) or a Participant may revoke his or her election under the Plan and may prospectively make a new election under the Plan for coverage in the new plan.

(i) Change in Coverage Under Another Employer Plan. A Participant may make a prospective election change under this Plan that is on account of and corresponds with a change made under another employer cafeteria plan or a qualified benefits plan if:

The other cafeteria plan or qualified benefits plan permits participants to make an election change that would be permitted under Treasury Regulation Section 1.125-4 Par. 2 paragraphs (b) through (g); or

This Plan permits Participants to make an election for a Period of Coverage that is different from the period of coverage under the other cafeteria plan or qualified benefits plan.

(j) Loss of Other Group Health Coverage. If, during a Plan Year, a Participant or the Participant's Spouse or Dependent loses coverage under any group health

coverage sponsored by a governmental or educational institution, the Participant may prospectively elect coverage under a health plan to which this Plan applies.

(k) Special Requirements For Family And Medical Leave. A Participant taking leave under the Family and Medical Leave Act (FMLA) 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.

(l) Revocation Due to Reduction in Hours of Service Without Loss of Plan Eligibility (This Subsection (l) shall not apply to the Health Care Reimbursement Account Program or the Limited Purpose Health Care Reimbursement Account Program). An Eligible Employee may revoke an existing election of group health plan coverage under a plan to which this Plan applies provided the requirements described in subsections (1) and (2) below are satisfied.

(1) The Eligible Employee has been in an employment status under which the Eligible Employee was reasonably expected to average at least 30 hours of service per week for the Employer, and there is a change in that Eligible Employee's status so that the Eligible Employee will reasonably be expected to average less than 30 hours of service per week after the change in employment status, even if that reduction in hours does not result in the Eligible Employee ceasing to be eligible under the applicable health plan; and

(2) The Eligible Employee represents to the Plan that such revocation of his or her election for health plan coverage corresponds to the intended enrollment of the Eligible Employee and any of his or her Dependents who will cease coverage due to the revocation, in another plan that provides Minimum Essential Coverage (as defined under Code section 5000A(f)), with the new plan coverage effective no later than the first day of the second month following the month that includes the date that the Eligible Employee revoked his or her applicable health plan coverage.

(m) Revocation Due to Enrollment in a Qualified Health Plan (This Subsection (m) shall not apply to the Health Care Reimbursement Account Program or the Limited Purpose Health Care Reimbursement Account Program). An Eligible Employee may revoke an existing election of group health plan coverage under a plan to which this Plan applies provided the requirements described in subsections (1) and (2) below are satisfied.

(1) The Eligible Employee is eligible to enroll in a Qualified Health Plan through a Marketplace (as defined under section 1311 of the Patient Protection and Affordable Care Act) during either (i) a Marketplace Special Enrollment Period (as defined under 45 CFR section 155.420), or (ii) a Marketplace annual open enrollment period; and

(2) The Eligible Employee represents to the Plan that such revocation of coverage under the applicable health plan corresponds to the intended enrollment of

the Eligible Employee and any of his or her Dependents who will cease coverage because of the revocation, in a Qualified Health Plan through a Marketplace for new coverage that is effective beginning no later than the day immediately following the last day of the health plan coverage that is revoked.

(n) Revocation of Dependent group health plan coverage Due to Enrollment in a Qualified Health Plan (This Subsection (n) shall not apply to the Health Care Reimbursement Account Program or the Limited Purpose Health Care Reimbursement Account Program). An Eligible Employee may revoke an existing election of group health plan coverage for their Dependent under a plan to which this Plan applies, provided the requirements described in subsections (1) and (2) below are satisfied.

1. The Eligible Employee's Dependent(s) are eligible to enroll in a Qualified Health Plan through a Marketplace (as defined under section 1311 of the Patient Protection and Affordable Care Act) during either (i) a Marketplace Special Enrollment Period (as defined under 45 CFR section 155.420), or (ii) a Marketplace annual open enrollment period; and

2. The Eligible Employee represents to the Plan that such revocation of Dependent coverage under the applicable group health plan corresponds to the intended enrollment of the Dependent(s) who will cease coverage because of the revocation, in a Qualified Health Plan through a Marketplace for new coverage that is effective beginning no later than the day immediately following the last day of the group health plan coverage that is revoked.

(o) Other Circumstances. Any other circumstances approved by the Administrator in a non-discriminatory manner which are consistent with regulations or other guidance issued by the Secretary of the Treasury.

Any modification and/or new election made shall conform to the requirements of the Synopsys, Inc. Welfare Plan, the Health Care Reimbursement Account Program, the Limited Purpose Health Care Reimbursement Account Program, and/or the Dependent Care Reimbursement Program, as applicable. Any modification and/or new election shall be effective at such time as the Administrator shall prescribe, but not earlier than the first pay period beginning after the election is made and provided to the Administrator.