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SYNOPSYS, INC. WELFARE PLAN AND SUMMARY PLAN DESCRIPTION

As Amended and Restated Effective January 1, 2025

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INTRODUCTION

This Plan document and Summary Plan Description ("SPD") summarizes certain health and welfare benefits provided by the Synopsys, Inc. Welfare Plan (the "Plan") to Eligible Employees of Synopsys, Inc. (the "Employer") and their Eligible Dependents. The health and welfare benefits provided in this Plan document and SPD are provided by a program of insured and self-funded medical, dental, vision, employee assistance program, group term life insurance, accidental death and dismemberment, health flexible spending account, long term disability, business travel accident, wellness program, and legal service benefits ("Benefits").

This Plan document and SPD, together with the applicable self-funded and insured summaries, constitutes the written plan document required by section 402 of the Employee Retirement Income Security Act of 1974 ("ERISA") and the summary plan description required by section 102 of ERISA for the Synopsys, Inc. Welfare Plan.

Synopsys, Inc. adopted the Plan originally effective on January 1, 1990 and has subsequently amended the Plan from time to time. The Plan was last amended and restated effective January 1, 2024. The Plan is hereby amended and restated effective January 1, 2025.

This Plan relates to various group benefit programs identified through descriptions of self-funded benefits found in summary plan descriptions, evidences of coverage, and other written materials ("Benefit Section") and in insurance contracts with various insurance companies including Health Maintenance Organizations ("Insurers"), which provide Insured Benefits ("Policy or Policies"). The Plan Sponsor may add or delete Benefits and may change the Policies and Benefit Sections to reflect any changes in Plan Benefits without a formal Plan amendment. The Plan's Benefits are listed in Appendix A. By reference, this document incorporates materials summarizing the Benefits listed in Appendix A.

The Plan Sponsor intends the Plan to be an "employee welfare benefit plan" as defined in ERISA, and to comply with all applicable federal laws including but not limited to ERISA, the Newborns' and Mothers' Health Protection Act of 1996 (the "Newborns' Act"), the Family and Medical Leave Act of 1993, as amended ("FMLA"), the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), the Women's Health and Cancer Rights Act of 1998 ("WHCRA"), the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the Patient Protection and Affordable Care Act ("PPACA"), and all applicable requirements under Sections 9801 and 9802 of the Internal Revenue Code of 1986, as amended (the "Code").

ELIGIBILITY AND PARTICIPATION

1. Who receives benefits under this Plan?

Each Benefit provided by this Plan has its own eligibility requirements.

An "Eligible Employee" for Benefits is generally any regular common-law employee of Synopsys, Inc. or its Affiliate (as designated in Appendix F) who is residing in the United States ("US"), on the Employer's US payroll, and customarily working 20 hours per week or more, except the following individuals:

(a) employees that the Employer categorizes as leased employees;

(b) employees working under a collective bargaining agreement that does not explicitly provide for participation in the Plan;

(c) employees whose contract of employment excludes them from participation in Employer employee benefit plans; or

(d) employees classified or treated by the Employer during such period as independent contractors or as employees of an employment agency (even if subsequently determined to have been common law employees of the Employer during such period).

Note: An "Affiliate" includes a wholly owned subsidiary of Synopsys, Inc., and who is described in Appendix F of this Plan.

The following special eligibility rules apply only with respect to the specified group or benefit option:

(a) Enrollment in HMO benefits is limited to Eligible Employees residing in the particular HMO's service area.

(b) Any Eligible Employee traveling on Employer business is covered by the business travel accident component of the Plan.

(c) A foreign national employee of a foreign affiliate of the Employer who is not on the Employer's US payroll but who is transferred to the United States for an assignment with the Employer that is expected to last more than 60 days will only be eligible for business travel accident benefits and employee assistance program benefits. Such individual's Spouse, Domestic Partner, Children or other Eligible Dependents also are eligible for coverage under the business travel accident component of the Plan.

(d) If an employee is no longer eligible for coverage under this Plan because the employee has, at the request of the Employer, accepted an assignment with a non-United States division of the Employer, that employee's covered dependents, including Spouse or Domestic Partner, Children or other Eligible Dependents,

may receive COBRA-like continuation coverage subject to the Employer's discretion, and provided that the employee's covered dependents remain in the United States and subject to all other requirements of this Plan

(e) An intern who qualifies as an Eligible Employee is eligible to elect coverage under the HS Basic Plan. If such an intern elects coverage under the HS Basic Plan within his or her required enrollment election deadline, he or she also will be eligible for coverage under the Company's Employee Assistance Program, Teladoc Health, and Crossover Health benefits. Further, provided the intern is HSA-eligible (as defined under applicable IRS rules), he or she also will be eligible to make and receive HSA contributions. Dependents of eligible interns are also eligible for the same Plan benefits.

(f) An "Eligible Dependent" is an individual who qualifies to receive Plan benefits as described in a Benefit Section or Policy. Generally, the Plan provides benefits to a Participant's Spouse or Domestic Partner, and a Participant's Child who has not attained the age of 26.

(g) Notwithstanding the foregoing, Defined Term Employees also are eligible for Plan coverage. For purposes of this subsection (g), a Defined Term Employee is an individual who is employed by the Employer for a defined duration, regardless of the hours worked. The duration of the individual's temporary assignment with the Employer shall not exceed a period of 12 months. For example, an individual who is hired by the Employer as part of an acquisition and who has been given a defined end date in their assignment letter is considered an eligible Defined Term Employee.

A Participant's "Child" generally will include the Participant's natural child, step-child, adopted child, foster child, a tax-qualified child under the Participant's guardianship, a child placed with the Participant for adoption, and a Domestic Partner's child who is covered under a Benefit Section or Policy. Notwithstanding the foregoing, if there is any conflict between the terms of this Plan (e.g., the Plan's eligibility provisions), and the terms of the underlying Benefit Sections or Policies, the terms of the underlying Benefit Sections or Policies will prevail.

For purposes of life insurance and accidental death and dismemberment benefits provided under this Plan, a Participant's "Child" will include the Employee's unmarried natural child, adopted child, step-child who is dependent on the Employee for support and maintenance and living with the Employee in a regular parent-child relationship, and child who is on and after the date on which insurance would otherwise end because of the child's age, is continuously disabled (as defined in the underlying Policy).

Note: If an Employee and his or her Spouse/Domestic Partner are (i) both employed by the Employer, and (ii) have a Child together – the Child may only be covered under the Plan by the Employee, or the Spouse/Domestic Partner. The Child may not be covered under the Plan by both the Employee and his or her Spouse/Domestic Partner.

Note: If an Employee and his or her Spouse/Domestic Partner are both employed by the Employer, such individuals cannot receive coverage under the Plan as both an "Employee" and a "Dependent".

Note: If an Employee and his or her Child are both employed by the Employer, such individuals cannot receive coverage under the Plan as both an "Employee" and a "Dependent".

A "Domestic Partner" of a Participant shall be an "Eligible Dependent" for purposes of Plan coverage if the Domestic Partner is a state-registered domestic partner or meets the definition of Domestic Partner in the Synopsys Domestic Partnership Policy and is covered by a Benefit Section or Policy. A Participant may only cover one individual as a "Domestic Partner" and the Participant cannot cover both a Domestic Partner and a Spouse.

A "Spouse" means the person who is recognized as the Participant's spouse in accordance with the laws of the state, the District of Columbia, a United States territory or a foreign jurisdiction where the marriage took place. Unless a Plan provision provides for separate treatment, the Participant's Spouse will be an Eligible Dependent.

Medical coverage that is administered through United Healthcare has special coverage available for an unmarried dependent Child who is not able support his or herself because of mental incapacity or physical handicap. If such a Child is supported by the Participant, the Child's coverage will not end during the Child's incapacity on account of age. Proof of incapacity and dependency is required within 31 days of the time that coverage would otherwise end due to age and the Plan may request this information annually during the period of incapacity. New hires must provide proof of their Child's incapacity within 30 days of their new hire date.

Medical coverage that is administered through Kaiser Permanente also has special coverage available for an unmarried dependent Child who is not able support his or herself because of mental incapacity or physical handicap. For further information regarding medical plan eligibility under the Kaiser Permanente plan for disabled dependents, please consult the applicable Kaiser Permanente Evidence of Coverage ("EOC").

The Plan Administrator, in its sole discretion, reserves the right to determine Plan eligibility, and audit employees and dependents to ensure that all Participants meet the eligibility rules of the Plan. In addition, the Plan Administrator reserves the right, in its sole discretion, to (a) remove dependents from coverage if such dependents are found to be ineligible during an audit, or if the dependent does not comply with audit requests for information or verification request; (b) seek re-payment of claims incurred by ineligible or noncompliant dependents; (c) terminate the coverage of any employee in cases of benefit eligibility fraud; and (d) not offer COBRA coverage to dependents who lose coverage because the dependent is found to be ineligible or non-compliant during the audit.

2. What Enrollment Periods are available?

An Eligible Employee may elect to participate in the Plan by enrolling when first eligible, or when eligible for a HIPAA special enrollment period, or when eligible for a mid-year election change under the Synopsys, Inc. Section 125 Plan, or during the Plan's annual open enrollment period (which will be announced from time to time by the Plan Administrator).

3. When will coverage begin?

Except as otherwise provided for in a specific Benefit Section or Policy, you will begin coverage on your date of hire assuming you properly complete and submit your election form. Further, if you are an Eligible Employee who has transferred to the United States from another country, you will begin coverage on the date of your transfer, provided you properly complete and timely submit any required election forms. The amount, if any, that you are required to contribute in order to receive a specific coverage will be described at initial eligibility and will be deducted on the first day of the payroll period after you submit an election form. You may pay for some coverages pre-tax through the Synopsys, Inc. Section 125 Plan. The Plan Administrator will require that you complete an agreement to reduce your compensation by a specified amount to cover your share in the cost for Benefits. This salary reduction agreement/election may occur during the on-line enrollment process.

Your enrolled Eligible Dependents' coverage will begin on the same date that your coverage begins. Other coverages not payable on a pre-tax basis will become effective as described in the applicable Benefit Booklet or Evidence of Coverage.

At the time of your enrollment in Plan coverage, you will need to complete and submit a Salary Deduction Agreement. Once you are enrolled in the Plan, you are a Plan "Participant".

4. When will HIPAA special enrollment be allowed?

(a) *General Rule*. If you are declining enrollment for yourself or your Eligible Dependents (including your Spouse) because of other health insurance or group health plan coverage you may in the future be able to enroll yourself or your Eligible Dependents in health coverage provided under this Plan if you or your Eligible Dependents' other coverage is terminated because either (a) the coverage was provided under COBRA, and the entire COBRA coverage period was exhausted, or (b) eligibility for the other coverage was lost (for reasons other than the individual's failure to pay premiums or for cause), or employer contributions toward the cost of the coverage terminated. You must request enrollment in the Plan within 31 days after your or your Eligible Dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you acquire a new Eligible Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your

Eligible Dependents. However, you must properly elect coverage under the Plan within 31 days after the marriage, birth, adoption, or placement for adoption.

(b) *Medicaid and Children's Health Insurance Program ("CHIP") Rule*

(i) *Loss of eligibility under Medicaid or CHIP*. If you or your Eligible Dependents are eligible for coverage under the group health plan components under the Plan, but are not currently enrolled, you may enroll in coverage if you or your Eligible Dependents are covered by Medicaid or CHIP and such coverage is terminated as a result of a loss of eligibility; provided that you must request coverage under the Plan's group health plan components within sixty (60) days after losing Medicaid or CHIP coverage.

(ii) *Eligibility for Premium Assistance under Medicaid or CHIP*. If you or your Eligible Dependents are eligible for coverage under the group health plan components under the Plan, but are not currently enrolled, you may enroll in coverage if you or your Eligible Dependents become eligible for a premium assistance subsidy under Medicaid or CHIP; provided that you must request coverage under the Plan's group health plan components within sixty (60) days after becoming eligible for a premium assistance subsidy under Medicaid or CHIP. The Employer will opt out of receiving direct payment of your premium assistance subsidy from Medicaid or CHIP and instead, the premium assistance subsidy under Medicaid or CHIP will be provided directly to you or your Eligible Dependents. For additional information see Appendix F.

To request special enrollment or obtain more information, contact the Plan Administrator.

5. When will coverage end?

Except as otherwise provided in a Benefit Section or Policy, your participation will terminate on the date you cease to be an Eligible Employee. Your Eligible Dependent's participation will terminate when he or she ceases to be an Eligible Dependent or when Eligible Employee coverage ceases, except as described below.

Coverage for an Eligible Dependent or Spouse of a Participant who dies during a period of Plan coverage will terminate at the end of the month of the Participant's death. Upon termination, the Eligible Dependent of the deceased Participant may elect continuation coverage under COBRA by enrolling in the manner prescribed by the Company. The Employer will subsidize the first six (6) months of this COBRA continuation coverage. See below for more details about the requirements of COBRA continuation coverage.

Sometimes a Policy will allow coverage to continue until the end of the month (or such later period of time as may be provided to Eligible Dependents of deceased Participants), but if a specific Policy or Benefit Section does not provide this continuation, coverage will end immediately. The Plan's Policies and Benefit Sections describe terms and conditions of any conversion.

Coverage under the Plan may also terminate due to fraud or an intentional misrepresentation of material fact, or because you (or your Eligible Dependent) knowingly provided the Plan Administrator or other provider with false information, including but not limited to information relating to another person's eligibility for coverage or status as a dependent. Upon 30 days written notice, the Employer has the right to rescind coverage back to the effective date of coverage and to seek reimbursement of all expenses paid by the Plan, provided such coverage is group health plan coverage subject to the requirements of the Patient Protection and Affordable Care Act.

CONTINUATION COVERAGE

1. When will continuation coverage under COBRA apply?

Under Federal law, if you, your Spouse, and/or covered Eligible Dependents lose coverage under the Plan's medical, dental, vision, health flexible spending account, and/or employee assistance program benefit options, then you, your Spouse, and/or your covered Eligible Dependents may be entitled to elect continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1986, as amended, and its implementing regulations ("COBRA").

COBRA provides for continued health coverage if a COBRA Qualified Beneficiary experiences a COBRA Qualifying Event and properly elects COBRA (as described below). Unless otherwise specified and to the extent allowed by law, COBRA continuation coverage shall run concurrent to any other continuation coverage (e.g., USERRA continuation coverage).

Under COBRA, if an Eligible Employee, his or her Spouse, or dependent Child ("Qualified Beneficiaries") loses group health plan coverage under the Plan due to an event described in ERISA § 603 ("Qualifying Event"), the Qualified Beneficiary can elect continuation coverage. Note: During the COBRA election period and during any payment grace period, an individual's coverage may be terminated; if so, it will be reinstated retroactively if a COBRA election and applicable payments are made during the required time periods.

Your COBRA rights are described more fully in Appendix C. As described in the "Eligibility and Participation" section above, an Eligible Dependent of the deceased Participant may elect continuation coverage under COBRA by enrolling in the manner prescribed by the Company. If such Eligible Dependent properly elects COBRA continuation coverage, he or she is eligible to receive COBRA continuation coverage for the maximum COBRA continuation coverage period (i.e., 36 months). Note, the Employer will subsidize the Eligible Dependent's COBRA continuation coverage for the first six (6) months of this COBRA continuation coverage period.

Note: There may be other coverage options for you and your family. You may also be eligible to purchase coverage on the Health Insurance Marketplace (the "Marketplace"). In the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

2. Who may become a Qualified Beneficiary?

Only a Participant, his or her Spouse, and his or her dependent children who were covered under the Plan prior to a Qualifying Event can become a Qualified Beneficiary.

A Domestic Partner and any children of the Domestic Partner cannot become a Qualified Beneficiary under Federal law.

3. What type of coverage does COBRA provide?

COBRA coverage provided to Qualified Beneficiaries will ordinarily be the same coverage that the Qualified Beneficiary had on the day before the Qualifying Event. Each COBRA Qualified Beneficiary has an independent right to elect COBRA. During the COBRA election period and during any payment grace period, the individual's coverage may be terminated; if so, it will be reinstated retroactively if a COBRA election and applicable payments are made during the required time periods.

4. Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

5. Non-COBRA Continuation Coverage

(a) *Participant Transfers to Non-US Payroll*. If an Eligible Employee is transferred to non-US payroll in the course of employment for the Employer, and therefore loses coverage under this Plan, his or her covered Eligible Dependents may become eligible to continue coverage under the Plan while they are separated from the employee. This coverage is not mandated by COBRA (because no COBRA qualifying event has occurred to entitle dependents to receive coverage

mandated by COBRA). The coverage outlined here does not run concurrent with COBRA Coverage.

(b) *Domestic Partner Continuation Coverage*. If your Eligible Dependent who is your Domestic Partner or your Domestic Partner's Child and who is covered under a Benefit Section or Policy, loses coverage under our medical, vision, dental, or the employee assistance program, then your Domestic Partner, and/or your covered Domestic Partner's Child(ren) may be entitled to continuation of the health care coverage by electing COBRA-like continuation coverage with similar terms as set forth in the Plan's general Notice of COBRA Rights and Responsibilities in Appendix C.

(c) *Limitations*. The limitations and requirements for receiving this coverage are as follows:

- All Eligible Dependents receiving benefits must live in a service area in which they are eligible to receive benefits (if limited by an HMO). If they do not, they may switch to coverage under another provider offered by the Plan;
- Eligible Dependents may not be covered by any other plan while receiving this coverage. If coverage by another plan commences, the Plan must be notified within the timeframes outlined in the COBRA Notice of Rights and Responsibilities;
- Coverage is limited to a maximum of 36 months following the date the Eligible Employee or Eligible Dependent who is your Domestic Partner or your Domestic Partner's Child ceases to be covered under the Plan;
- Coverage is limited to medical, vision, dental, health flexible spending accounts, and employee assistance program coverage;
- Coverage is administered using COBRA administration procedures. Please refer to the COBRA Notice of Rights and Responsibilities to determine how to maintain your coverage. This coverage will cease and may not be reinstated if you do not follow the procedures as outlined in that notice; and
- If a COBRA Qualifying Event occurs during the time dependents are covered under this non-COBRA continuation of coverage, the Plan must be informed of the COBRA event.

6. Will coverage continue during FMLA or military leave?

You may maintain health plan coverage during a FMLA leave of absence or during an absence from work for duty in the "Uniformed Services" (as that term is defined by USERRA), but to do so, you must make required contributions.

Subject to certain conditions, you will be permitted to continue group health plan coverage for a period of up to 12 weeks during any 12-month period while on a leave of absence under FMLA for any of the following reasons:

(a) to care for your Child up to the first year after birth or placement for adoption or foster care;

(b) to care for your FMLA Spouse, son or daughter under the age of 18 (or age 18 or older if the son or daughter is incapable of self-care because of a mental or physical disability) or parent who has a serious health condition;

(c) for a serious health condition that makes you unable to perform your job; or

(d) any "qualifying exigency" due to your FMLA Spouse, son, daughter or parent being on active duty (or being notified of an impending call or order to active duty) in the United States armed forces (including the National Guard or Reserves) in support of a contingency operation. A "qualifying exigency" is defined as (1) short-notice deployment, (2) military events and related activities, (3) childcare and school activities, (4) financial and legal arrangements, (5) counseling, (6) rest and recuperation, (7) post-deployment activities, and (8) additional activities where your Employer and you agree to the leave.

Note: An "FMLA Spouse" means a husband or wife as defined or recognized under state law for purposes of marriage in the state where the Eligible Employee resides.

Further, subject to certain conditions, you will be permitted to continue group health plan coverage for up to 26 weeks during any 12-month period while on a leave of absence under FMLA to care for an injured or ill service member who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness suffered while on active-duty for the United States armed forces (including the National Guard or Reserves) and who is your FMLA Spouse, son, daughter, parent, or "next of kin," as required by FMLA. This special leave to care for an injured or ill service member is combined with any 12-week leave period under the standard FMLA leave rules (as described above).

For FMLA purposes, FMLA leave is a period that is an approved absence from service that is not treated as a termination of employment in accordance with the Employer's employment policies, as may be amended at the discretion of the Employer. The coverage period for FMLA leave is limited to the FMLA leave. FMLA leave includes an absence under FMLA or to perform Uniformed Service protected under USERRA (which is described below).

The coverage period under USERRA ends after 24 months or when you fail to apply for reinstatement or to return to employment with your Employer within the period prescribed by USERRA, as described in the USERRA Notice found at Appendix D of this document.

You may pay your Employer during each month that the payment would have been deducted from your paycheck if leave had not been taken or may pay under another arrangement agreed upon in writing by you and the Plan Administrator. Required contributions during FMLA leave and for the first 180 days of USERRA coverage are equal to the contributions required for an active Eligible Employee. Otherwise, required contributions are equal to COBRA premiums.

7. Will coverage continue during other employer approved leave of absence?

If you are on one of the following types of employer approved leaves of absence, you may continue regular health plan (i.e., medical, dental, vision and employee assistance program) coverage for the time period specified below as long as you remain an employee of Synopsys, Inc. At the end of such time period, you may be eligible for an additional period of continued coverage in accordance with COBRA or USERRA.

Type of Leave of Absence	Time Coverage Will Be Continued
Medical Disability	Up to one year of continuous leave
Family Care after the birth, adoption or foster care placement of a child, or for the serious health condition of certain family members	Up to one year of continuous leave
Pregnancy Disability	Up to one year of continuous leave
Family Care and Bonding Leave (i.e., employees providing family care after the birth, adoption or foster care placement of a child; to certain family members with serious health conditions; to themselves when suffering serious health conditions).	Up to 12 weeks
Jury/Witness	Benefits continue throughout length of legal service
Military	Up to one year of military leave
Personal	Up to the duration of the personal leave
Bereavement Leave	Up to 10 days
Voting Leave	Up to 2 hours

Please refer to the Synopsys Leave of Absence Chart for more details Leaves of Absence | Synopsys Benefits Center

If you are covered during one of the above types of Employer approved leaves of absence you must make required contributions by:

- Paying the Employer each month an amount equal to the amount of Eligible Employee contributions that would have been deducted from your paycheck if leave had not been taken, provided that any delinquent payments must be made within 30 days of their due date; or

- Other arrangements agreed upon between you and the Plan Administrator (e.g. the Plan Administrator may fund coverage during the leave and withhold amounts upon your return).

PLAN BENEFITS

1. What type of Benefits does the Plan provide?

Your Employer will arrange for welfare benefit coverage for you and your Eligible Dependents. Benefits may be self-funded benefits or insured benefits as determined by the Employer, in its sole discretion.

2. What happens if Benefits are payable under more than one Plan?

The Plan will not pay any amount which, when added to the Benefits payable by another plan or plans, will equal more than 100% of allowable expenses. The coordination of benefits provisions contained in the Benefit Sections and Policies will determine which plan pays benefits first.

If there is no applicable Benefit Section or Policy, or if the applicable Benefit Section or Policy does not have its own coordination of benefits provisions, then the following rules apply:

If:	Then:
a) one plan has a coordination of benefits (COB) provision, and the other plan does not,	… the plan without a COB provision determines its benefits before the plan that has such a provision.
b) one plan covers the person as a dependent, and the other plan covers the person as an employee,	… the plan that covers a person as an employee, participant, member or subscriber determines its benefits before the plan that covers the person as a dependent.
c) the person is eligible for Medicare and is actively working,	… the Medicare Secondary Payer rules will apply. Under the Medicare Secondary Payer rules, the order of benefits will be determined as follows: • the plan that covers the person will pay first; and • Medicare will pay second.
d) the person is eligible for Medicare and is <u>not</u> actively working,	… the Medicare Secondary Payer rules will apply. Under the Medicare Secondary Payer rules, the order of benefits will be determined as follows: • the plan that covers the person as a dependent of a working spouse will pay first; • Medicare will pay second; and • the plan that covers the person as a retired employee will pay third.

If:	Then:
e) a child's parents are not divorced or separated,	… the plan of the parent whose birthday occurs earlier in the calendar year pays the child's expenses first. When both parents' birthdays occur on the same day, the plan that has covered the parent the longest pays first. If the other plan does not have the parent birthday rule, the other plan's COB rule applies.
f) a child's parents are separated or divorced,	… and there is a Qualified Medical Child Support Order or a court decree that states that the parents will share joint custody of a dependent child, without stating that one of the parents is responsible for the health care expenses of the child, the parent birthday rule, above, applies. … and there is a Qualified Medical Child Support Order or a court decree gives financial responsibility for the child's medical, dental or other health care expenses to one of the parents, the plan covering the child as that parent's dependent determines its benefits before any other plan that covers the child as a dependent. … and there is no such court decree, the order of benefits will be determined as follows: • the plan of the natural parent with whom the child resides, • the plan of the stepparent with whom the child resides, • the plan of the natural parent with whom the child does not reside, or • the plan of the stepparent with whom the child does not reside. If the primary plan cannot be determined by using the guidelines above, then the plan covering the child the longest is primary.
g) a person has coverage as an active employee or as the dependent of an active employee, and also has coverage as a retired or laid-off employee,	… the plan that covers the person as an active employee or as the dependent of an active employee is primary. If the other plan does not have this rule and if as a result, the plans do not agree on the order of benefits, this rule will not apply.

If:	Then:
h) a person is covered under a federal or state right of continuation law (such as COBRA),	… the benefits of a plan that covers a person under a right of continuation under federal or state laws will be determined after the benefits of any other plan that is not a mandated continuation plan.
i) the above rules do not establish an order of payment,	… the plan that has covered the employee, participant, member or subscriber for the longest time will pay benefits first.

When the federal law states that Medicare is the primary payor, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts.

3. <u>Does Federal law protect hospital stays after childbirth under the Plan?</u>

Group health plans and health insurers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and insurers may not, under Federal law, require that a provider obtain authorization from the plan or the insurer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

FUNDING

1. How are Benefits funded?

The Plan has both self-funded benefits and insured benefits. The Employer pays for self-funded benefits through its general assets and/or Participant contributions. The Employer and/or Participants pay premiums for insured benefits, which are funded solely by the Insurer.

Your Employer will announce the amount of contributions and premiums at least annually. The amount you pay may depend on the type of coverage elected, the number of covered Eligible Dependents, the age of the Participant, your employee classification and the location of your employment. In addition, the amount of employer contributions you may receive for benefits may vary depending on whether you are a full-time or part-time Participant. Your Employer may change the level of Participant contributions for any Benefit, at any time, in its sole discretion.

Benefits under the Legal Services Plan are paid by the Legal Services Provider, listed in Appendix A to this SPD.

2. How can I pay for Plan Benefits pre-tax?

The Plan Administrator will provide you a description of the Benefits provided under the Plan which can be funded through pre-tax contributions, an explanation of the effect of paying the Benefit contributions with pre-tax premium contributions on the Eligible Employee's federal income taxes, and any other material deemed to be necessary by the Plan Administrator to provide you with complete information about the Benefit.

PLAN ADMINISTRATION

1. Who are the Plan's named fiduciaries?

The Plan Administrator is a named fiduciary within the meaning of ERISA § 402 and has full discretionary authority to administer the Plan, to interpret the Plan, and to determine eligibility for participation and for Benefits under the terms of the Plan. However, Insurers and parties that have entered into administrative service agreements with the Plan ("Third Party Administrators" or "TPAs") assume sole responsibility for their performance under applicable Policies or administrative services agreements and, under ERISA, are named fiduciaries with respect to their performance. To the fullest extent permitted by law, the Plan Administrator, and any of the fiduciaries with respect to the plans to the extent that such individual or entity is acting in its fiduciary capacity, shall have full and sole discretionary authority to interpret all Plan documents and to make all interpretive and factual determinations as to whether any individuals are entitled to receive any benefit under the terms of the Plan, and to determine all questions arising in connection with the administration, interpretation, and application of the Plan, including the eligibility and coverage of individuals and the authorization or denial of payment or reimbursement of benefits. Any final determination by a named fiduciary or its delegate is binding and conclusive upon all persons.

2. What authority does the Plan Administrator have?

The Plan Administrator has complete discretion to construe and interpret this Plan, to decide all questions of fact and issues relating to eligibility, participation and Benefits and to make and publish appropriate rules for administration of the Plan.

The Plan Administrator's officers, directors and employees can carry out the Plan Administrator's duties on behalf of and in the name of the Plan Administrator and not as individual fiduciaries. The Plan Administrator may also engage individuals or entities to perform legal, actuarial, accounting and other professional and clerical services for the Plan.

The Plan Administrator will compile and maintain records necessary for proper administration of the Plan and will supply, as required, information and reports to the Internal Revenue Service, Department of Labor, and Participants, including annual reports, Summary Plan Description, and any required certificates of Creditable Coverage (unless prepared by Insurers for distribution to Participants pursuant to written agreements). The Plan Administrator will review the performance of all persons who have been delegated or allocated duties pursuant to the Plan.

3. What authority do Insurers have?

Insurers have sole discretion regarding payment of Insured Benefits and may make any other determinations set forth in the Policy issued by that Insurer. The Plan Administrator has no liability or responsibility for any Insured Benefits except authority granted by an Insurer to perform limited administrative functions. The Employer is not responsible for Insured Benefits in excess of the amount paid by Insurers.

4. What authority do TPAs have?

TPAs have initial discretion to determine eligibility to participate, to determine whether Benefits are provided by the Plan, to authorize payment of Benefits and to make any other determinations set forth under the applicable administrative services agreement.

5. Can this Plan be amended or terminated?

The Plan Sponsor reserves the power at any time or times to amend or terminate the provisions of the Plan (and the underlying Policies and administrative services agreements) to any extent and in any manner that it deems advisable, by a written instrument signed by a duly authorized officer of the Employer. The Plan Sponsor may delegate to any Employee all or a portion of the authority to amend the Plan (or any of the underlying Policies and administrative services agreements) by signed written instrument, but the delegate's authority will terminate if the delegation is revoked by a written instrument signed by the duly authorized officer of the Employer, or if the employee's employment terminates.

CLAIMS PROCEDURES

1. What procedures are used to claim Plan Benefits?

This Section addresses all claims for self-funded benefits. Claims for insured benefits are handled by the applicable Insurer as outlined in the applicable Policy or Benefit Section. The Legal Services Plan is treated as an Insured Benefit for claims purposes. More information about Insured Benefit claims is included in Section 9, below. The Claims Administrator for medical claims is United Healthcare, which is a claims fiduciary entitled to interpret the benefit provisions of the Plan with regard to the claims and appeals it administers on behalf of the Plan. The Claims Administrator for dental claims and appeals is Delta Dental. The Claims Administrator for vision claims and appeals is VSP. For all other self-funded benefits, claims are determined by the designated Claims Administrator, while appeals are determined by the Plan Administrator. In pursuing a claim under this section, an individual may act through an authorized representative so long as the Claims Administrator receives documentation demonstrating that the representative is in fact authorized to act on behalf of the claimant. Any "**Extensions**" of the determination deadlines must be required by matters beyond the control of the Plan and the Claims Administrator must, before the original determination deadline, provide notice to you stating the matter beyond the control of the Plan and the date by which a determination is expected.

2. How do I make a claim for Self-Funded Benefits?

To make a claim for self-funded benefits, except for Urgent Care Claims, you must complete and file an application for Benefits with the Claims Administrator. The Claims Administrator will review all applications for Benefits and will notify you in writing of its decision within a reasonable period appropriate for the circumstances that shall not exceed the deadlines set forth below:

Type of Claim	Determination Deadline
Group Health Plan Urgent Care Claim	As soon as possible within 72 hours of the claim
Group Health Plan Pre-Service Claim	Within 15 days of the claim (with a 15 day Extension)
Group Health Plan Post–Service	Within 30 days of the claim (with a 15 day Extension)
Group Health Plan Concurrent Care	In time to permit appeal and determination before treatment ends or is reduced. If a claimant is requesting to extend a concurrent care course of treatment, and urgent care is involved, the extension request must be decided as soon as possible, with notification to the claimant to be

Type of Claim	Determination Deadline
	provided within 24 hours after receipt of the claim. However, the claimant's extension request must be made at least 24 hours before the prescribed period of time expires or number of treatment ends. For any urgent care requests made later than this cutoff, the normal period for urgent care claims would apply (i.e., the normal decision periods otherwise applicable for pre and post-service claims).
Disability Claim	Within 45 days of the claim (with two 30 day Extensions)
Other Claims	Within 90 days of the claim (with a 90 day Extension)

The period for making the claims decision is tolled (will not run) for up to 60 days while the claimant completes the claim.

3. <u>What happens if my claim for Self-Funded Benefits is denied?</u>

The Claims Administrator will forward any denial of a claim for Benefits to you in writing in a manner and in a language calculated to be understood by you clearly stating:

(a) The reason(s) for the denial, including references to specific Plan provision(s) upon which the denial was based;

(b) The additional materials or information needed to support your claim and why such information or materials are necessary if the claim was denied because you did not furnish complete information or documentation;

(c) A statement that you will be provided, upon request, reasonable access to, and free of charge, copies of all documents, records and other information relevant to your claim;

(d) For group health plan claims, information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), and a statement regarding the right to obtain the diagnosis code and treatment code and their corresponding meanings upon written request;

(e) An explanation of the steps you must take if you disagree with the denial and wish to have your benefit application reviewed again;

(f) Any available internal and external appeal procedures and the applicable time limits (including the expedited review process applicable for urgent health care claims);

(g) A statement regarding your right to bring an action under Section 502(a) of ERISA if your claim is denied at each required level of appeal; and

(h) For group health plan claims, the denial will also include (as applicable):

(i) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, either the specific rule, guideline, protocol, or other similar criterion; or a statement that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request; or

(ii) 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 Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

(i) For disability claims, the denial will also include (as applicable) a discussion of the denial, including an explanation of the basis for the Plan's disagreeing with or not following:

(i) Views timely provided by you to the Claims Administrator of health care professionals who treated you, or vocational professionals who evaluated you;

(ii) A disability determination regarding you that was made by the Social Security Administration and timely provided by you to the Plan; and

(iii) Views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your claim denial.

(j) For disability claims, the denial will also include (as applicable):

(i) If your claim for benefits is denied based on an internal rule, guideline, protocol, standard, or other similar criterion, the notice will either state the specific rule, guideline, protocol, standard, or other similar criterion; or alternatively, include a statement that such rule, guideline, protocol, standard, or other criterion will be provided to you free of charge upon request does not exist; or

(ii) If your claim is denied based on medical necessity, experimental treatment, or similar exclusion or limitation, an explanation of the scientific or clinical judgment applied in the benefit determination, or a

notice of where and a statement that such explanation will be provided to you free of charge and upon request.

4. How is a Self-Funded Benefits claim denial appealed?

You may appeal a denial within 60 days (180 days for disability claims or group health plan claims) after receipt of written notice of the denial by submitting in writing to the Claims Administrator a request for review of the denial of claim. As part of the appeal process, you may submit comments, documents, records, testimony, and other information concerning the claim and may upon request review (free of charge) documents, records, testimony and other information relevant to the claim, including any new or additional documents, records or other relevant information considered, relied upon, or generated by the Plan and relevant to the claim. The Claims Administrator will provide these documents to you at a convenient location during regular business hours within 30 days of your request. In addition, you may submit written comments, documents, records and other information relating to the claim, without regard to whether such information was submitted or considered in the initial application for Benefits.

On appeal, the Claims Administrator will take into account all of the comments, documents, records, testimony and other information you submit. The individual deciding the appeal will not be the same individual or a subordinate of the individual who decided the initial claim. If a final decision is based on a new or additional rationale, the Claims Administrator shall provide the rationale to you, free of charge, within a time period sufficiently in advance of the due date of the final determination (as set forth below) so that you have a reasonable opportunity to respond prior to the due date. The Claims Administrator will transmit a final written decision setting forth specific reasons for any denial (as well as any other information required by current Department of Labor regulations, as described in Section 3 above) within a reasonable period under the circumstances that shall not exceed the deadlines set forth below:

Type of Claim	**Determination Deadline**
Group Health Plan Urgent Care Claim	As soon as possible within 72 hours
Group Health Plan Pre-Service Claim	Within 30 days
Group Health Plan Post-Service Claim	Within 60 days
Group Health Plan Concurrent Care Decision	Before treatment ends or is reduced
Disability Claim	Within 45 days (with a 45 day Extension)
Other Claims	Within 60 days (with a 60 day Extension)

5. What are the procedures for External Review?

A claimant must exhaust the internal claims and appeals process before he or she can request an external review or bring any litigation regarding his or her adverse benefit determination, except in the case of "deemed exhaustion." If the Plan fails to adhere to the internal claims and appeals process above, the claimant will be deemed to have exhausted the internal claims and appeals process and may initiate an external review (as described below), or pursue available remedies under ERISA.

Note: The internal claims and appeals process will not be "deemed exhausted" based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the claimant so long as the Plan demonstrates that (a) the violation was for due cause or due to matters beyond the control of the Plan and that (b) the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and the claimant.

Non-Expedited Requests for External Review

If you have exhausted (or have been deemed to have exhausted) the internal claims and appeals process, you may file a written request for an external review with the applicable Claims Administrator, provided the request is filed within four months after the date of receipt of the denial notice. External review is available for any claim that involves a medical judgment as provided in the amended interim final rules implementing PPACA; for rescissions of coverage; and denials that involve a consideration of whether the Plan is complying with the surprise billing and cost-sharing protections set forth in ERISA sections 716 and 717. External review is not available for any claim that is denied because the claimant fails to meet the eligibility requirements for coverage under the terms of the Plan. For example, external review is available for a claim that is denied on the basis of medical necessity or because the treatment, service or supply is experimental or investigational.

Within 5 business days of the Claims Administrator's receipt for the request for external review, a preliminary review will be conducted to determine whether the request is suitable for external review. Within one business day after completion of the preliminary review, a written notification will be provided to you or your authorized representative as to whether your request is eligible for external review. If the request is complete but not eligible for external review, the notification will include the reason(s) for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, the notification will describe the information or materials needed to make the request complete. The required information must be provided no later than the last day of the four month period after the date of the denial notice (for example, not later than March 1, 2025 for a denial notice dated October 30, 2024) or 48 hours after receipt of the preliminary review notification, whichever is later.

Requests that are eligible for external review will be reviewed by an accredited independent review organization ("IRO"). The IRO will not provide any deference to

any prior determination and will not be bound to any decisions or conclusions that were reached by the applicable Claims Administrator. The assigned IRO will provide you or your authorized representative with a notice inviting you to submit any additional information that you wish the IRO to consider within 10 business days after the date of the notice. Any additional information that the IRO receives from you or your authorized representative will be provided to the applicable Claims Administrator. The applicable Claims Administrator may reconsider its prior denial on the basis of such information. If the denial is reversed and coverage or payment is provided, you or your authorized representative will be notified in writing and the external review will be terminated.

The IRO will review any timely received additional information you or your authorized representative provides and the documents and information that the applicable Claims Administrator reviewed in connection with its denial (for example, your medical records, the terms of the plan, etc.). The IRO will provide you or your authorized representative and the plan with its final external review decision in writing within 45 days after the IRO's receipt of the request for external review. The IRO's final external review decision is binding. If the IRO's decision reverses the applicable Claims Administrator's adverse benefit determination or final adverse benefit determination, the plan will provide the coverage or payment for the claim.

Expedited Requests for External Review

If the adverse benefit determination involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, you (or your authorized representative) may file a request for an expedited external review of your claim by an IRO, provided you (or your authorized representative) files a request for an internal appeal of the denied claim with the applicable Administrator at the same time.

You (or your authorized representative) may also file a request for an expedited external review by an IRO if your final level of appeal has been denied and the appeal involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function or concerns an admission, availability of care, continued stay or health care item or service for which the claimant received emergency services and you have not been discharged from a facility.

The standards and processes described above regarding the preliminary review for eligibility and review by the IRO also apply to expedited requests except that the IRO will provide you (or your authorized representative) and the Plan with its final external review decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the assigned IRO's receipt of the request for external review. If the notice is not in writing, the IRO will provide written confirmation of its decision within 48 hours after the date it provided you (or your authorized representative) with oral notice of its decision.

6. When must my claim for Self-Funded Benefits be filed?

Except as otherwise provided in a Benefit Section, you waive any claim for self-funded benefits not filed within two years after the earlier of the date the expense was incurred or the date the service was rendered.

7. Are there special rules for medical and disability claims?

The following additional procedural rules apply to disability claims and to medical claims:

(a) *Tolling.* Both the decision on appeal and an initial decision will be tolled (will not run) while you complete an incomplete claim.

(b) *Notice of Incorrect Filing.* If you incorrectly file a Pre-Service Claim, the Claims Administrator will provide notice to you that the claim was incorrectly filed within 5 days (24 hours for Urgent Care Claims).

(c) *Claim Denial*. Any claim denial will include a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, will be provided free of charge upon request if the adverse benefit determination is based on medical necessity, experimental judgment, or a similar exclusion or limit.

(d) *Medical or Vocational Experts.* If the denial is a denial on appeal, any medical or vocational expert that was consulted will be identified and the notice will contain the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office or your State insurance regulatory agency."

(e) *Medical Judgment.* If the appeal of the adverse determination is based in whole or in part on a medical judgment, the Claims Administrator will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not consulted and is not a subordinate of a person consulted in connection with the adverse benefit determination that is the subject of the appeal.

(f) *Access to Statements of Policy*. The claimant may, upon request, free of charge, be given access to any statement of policy or guidance with respect to the Plan concerning denied treatment options or Benefit for the claimant's diagnosis.

8. How do I determine what type of claim for Medical Benefits I am making?

(a) *Urgent Care Claims.* An "Urgent Care Claim" is a claim for medical care or treatment if the time period for making non-urgent care determinations could seriously jeopardize your life, health or ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition, would

subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

(b) *Pre-Service Claims.* A "Pre-Service Claim" is a claim for benefits under a group health plan that is conditioned, in whole or in part, on approval of the benefit in advance of obtaining medical care.

(c) *Post-Service Claims*. A "Post-Service Claim" is a claim for benefits under a group health plan that is not a Pre-Service Claim.

(d) *Concurrent Care Decisions.* A "Concurrent Care Decision" is a decision related to an early reduction or termination by the Plan in the course of an approved ongoing course of medical treatment to be provided over a period of time or for a specified number of treatments.

9. <u>What procedures do I follow to make a claim for Insured Benefits?</u>

You must submit any claim for Insured Benefits to the Insurer that issued the Policy providing the benefit and must follow the claims procedures described in the appropriate Policy. Any claims denied by the Insurer may be appealed to the Insurer in accordance with appeal procedures described in the applicable Policy. The Insurer will transmit its final decision to you, setting forth the specific reasons for any denial. You waive all claims not filed within the time limits specified in the appropriate Policy.

If an Insurer denies a claim (in whole or in part) because you are not eligible for Benefits under the insurance Policy due to an administrative function of the Plan Administrator, such as determining eligibility for participation and enrolling eligible individuals, you may appeal the denial to the Plan Administrator. The Plan Administrator will review the claim using the procedures for self-funded benefits, but the review will be limited to review of the Plan Administrator's function. If the Plan Administrator determines that you met eligibility and enrollment requirements, the Plan Administrator will forward the claim and an explanation directly to the Insurer who will complete the review according to the Policy's claims procedures.

10. <u>What other obligations do I have under the Plan's claims procedures?</u>

The Claims Administrator and any person or entity designated as a named fiduciary who has the discretionary authority to approve or deny all or any portion of a claim for Benefits may retain the services of a third party to perform pre-certification, utilization review, cost containment, and quality assurance services in accordance with an agreement and procedures approved by the Claims Administrator. By receiving Benefits under this Plan, you agree to cooperate with such organizations. Failure to cooperate may result in adjustments to Benefit payments.

You must exhaust these claims procedures prior to pursuing any other remedy. Further, no action at law or in equity in any court or agency may be brought at all unless it is brought within one year after the date the Plan Administrator or Claims Administrator (as applicable) renders its

final decision upon appeal, unless specifically provided otherwise in the applicable Benefit Section.

ADDITIONAL RIGHTS, OBLIGATIONS AND RESTRICTIONS

1. Does this Plan give me any employment rights?

This Plan is not intended and should not be construed to give you any right to continued employment with the Employer.

2. What agreements and cooperation are required to receive Benefits?

(a) *Proof of Marriage, Domestic Partnership, Age and Dependent Status.*

You may be required to furnish satisfactory proof of eligibility such as age, marital/domestic partnership or dependent status as a condition to maintaining coverage or receiving benefits under the Plan.

(b) *Acts of Third Parties.*

(i) Plan's First Rights of Subrogation and Reimbursement. As a condition of receiving Plan benefits, Eligible Employees and/or Eligible Dependents grant specific and first rights of subrogation, reimbursement, and restitution to the Plan with respect to benefits they receive from the Plan that either relate to an injury, illness or condition which results from the act or omission of a third party or are, otherwise, subject to any reimbursement provision of a no fault automobile insurance policy. Such rights shall come first and shall not be adversely impacted in any way by:

(1) The "make whole doctrine" (i.e., the Participant's or covered Eligible Dependent's recovery of his full damages or attorney's fees), contributory or comparative negligence, the common fund doctrine, or any other defense or doctrine which may limit the Plan's rights (equitable or otherwise); or

(2) The manner in which any recovery by a Participant or covered Eligible Dependent is characterized or structured (e.g., as lost wages, damages, attorney's fees rather than as for medical expenses).

(ii) The Plan's rights of subrogation, reimbursement, and restitution shall extend to any property (including money), without regard to the type of property or the source of the recovery, including any recovery from the payment or compromise of a claim (including an insurance claim), a judgment or settlement of a lawsuit, resolution through any alternative dispute resolution process (including arbitration), or any insurance (including insurance on the Participant and/or covered Eligible Dependent, no-fault coverage, uninsured and/or underinsured motorist coverage).

(iii) Lien and Creation of Constructive Trust. At the time the Plan pays benefits which may be subject to the Plan's right of reimbursement,

subrogation, or restitution, the Participant and/or covered Eligible Dependent shall at that time grant to the Plan (as a condition of such payment) a lien (including, but not limited to an equitable lien by contract) on any property described in subsection (b), without regard to the identity of the property's source or holder at any particular time; or whether property at the time the property exists, is segregated, or whether the Participant and/or covered Eligible Dependent has any rights to it. Until the time such lien is completely satisfied, the Participant and/or covered Eligible Dependent or other holder of the property that is subject to such equitable lien by contract (e.g., an account or trust established for the benefit of the Participant or covered Eligible Dependent, an Insurer, etc.) shall hold such property as the Plan's constructive trustee. Such constructive trustee shall immediately deliver such property to the Plan upon the direction of the Plan to satisfy the lien.

(iv) Obligations of the Participant and/or covered Eligible Dependent. The Participant and/or covered Eligible Dependent shall:

(1) Not assign any rights or causes of action he or she may have against others (including under insurance policies) which may implicate the Plan's right to reimbursement, subrogation or restitution without the express written consent of the Plan;

(2) Cooperate with the Plan and take any action that may be necessary to protect the Plan's interests;

(3) Immediately take or regain possession of any property subject to the Plan's lien in his or her own name, place it in a segregated account within his or her control at least in the amount of the lien, and not alienate it or otherwise take any action so that such property is not in his or her possession prior to the satisfaction of such lien by contract; and

(4) Promptly notify the Plan of the possibility that the circumstances regarding the payment of benefits by the Plan may be subject to the Plan's right of reimbursement, subrogation or restitution, or of the submission any claim or demand letter, the filing of any legal action or request for any alternative dispute resolution process, or of the commencement of any trial or alternative dispute resolution process (at least 30 days prior notice), or of any agreement (relating to any claim, legal action or alternative dispute resolution), that relates to any property that may be subject to the Plan's rights of subrogation, reimbursement, restitution, to a lien, or as beneficiary of a constructive trust.

(v) No Duty to Independently Sue or Intervene. While the Plan's right of subrogation includes the right to file an independent legal action or alternative dispute resolution proceeding against such third party (or to intervene in one brought by or on behalf of the Participant and/or covered Eligible Dependent), it has no obligation to do so.

(vi) Recovery of Overpayments.

(1) General. To the extent that the Plan makes a payment to any Participant or covered Eligible Dependent in excess of the amount payable under the terms of the Plan, the Plan shall have a first right of reimbursement and restitution with a lien (including, but not limited to an equitable lien by contract) in the amount of such overpayment. The holder of any such overpayment shall hold such property as the Plan's constructive trustee. The Plan's rights of reimbursement and restitution shall in no way be affected, reduced, compromised, or eliminated by any doctrines limiting its rights (equitable or otherwise) such as the make-whole doctrine, contributory or comparative negligence, the common fund doctrine, or any other defense. The Plan's rights against the Participant and/or covered Eligible Dependent and the Participant's or covered Eligible Dependent's obligation to the Plan shall also not be affected if the overpayment was made to another person or entity on behalf of the Participant.

(2) Obligations of the Participant. If any Participant or covered Eligible Dependent has cause to reasonably believe that an overpayment may have been made, the person shall promptly notify the Plan Administrator of the relevant facts, shall not alienate any property that may be subject to the Plan's right of reimbursement or restitution, and shall cooperate with the Plan and take any action that may be necessary to protect the Plan's interests. If the Plan Administrator determines (on the basis of any relevant facts) that an overpayment was made to any Participant (or any other person), any amounts subsequently payable as benefits under this Plan with respect to the Participant may be reduced by the amount of the outstanding overpayment or the Plan Administrator may recover such overpayment by any other appropriate method that the Plan Administrator shall determine.

3. Will the Plan follow a Qualified Medical Support Order?

The Plan will provide Benefits in accordance with the applicable requirements of any qualified medical child support order as described in ERISA § 609(a). You may obtain a copy of the Plan's qualified medical child support order procedures from the Plan Administrator free of charge.

4. How does Medicaid eligibility impact Plan Benefits?

In accordance with ERISA § 609(b): (a) payment for Benefits with respect to a Participant under the Plan will be made in accordance with any assignment of rights made by or on behalf of such Participant or a beneficiary of the Participant as required under Medicaid, (b) the fact that an individual is eligible for Medicaid will not be taken into account, and (c) if the Plan is liable to provide Benefits but Medicaid provides them instead, Benefits will be provided in accordance with state law to the state as if the state were a participant.

5. Is the Plan subject to HIPAA?

The Plan is a hybrid plan, so that the medical privacy and security rules of Title II of HIPAA apply to any Benefit of the Plan that provides Group Health Plan benefits. The HIPAA privacy and security rules do not apply to any non-Group Health Plan components of the Plan (e.g., disability, life insurance, etc.). See the Plan's HIPAA Privacy Policy and Procedures for further information.

6. What happens if I make a false statement to the Plan?

If any individual makes a false representation to the Plan, the Plan Administrator has the right to permanently terminate coverage for the individual and his or her dependents. False representation includes (but is not limited to) submitting falsified claims, falsified dependent audit verification requests or covering an individual who is not eligible to participate in the Plan (for example, adding a Spouse before the date of marriage or after a divorce, or adding or keeping a child who does not meet the Plan's definition of an Eligible Dependent). The Plan Administrator may also seek reimbursement for all premiums, claims or expenses paid by the Plan as a result of the false representation, and may reduce future benefits as an offset for amounts that should be reimbursed or pursue legal action against the individual.

7. Will the Plan comply with the Women's Health and Cancer Rights Act?

To the extent required by the Women's Health and Cancer Rights Act of 1998 ("WHCRA"), any Benefit that is subject to WHCRA requires that the following procedures be covered for a person who receives group health plan benefits for a mastectomy and decides to have breast reconstructive surgery in connection with the mastectomy: all stages of reconstruction of the breast on which a mastectomy has been performed; surgery and reconstruction of the other breast to create a symmetrical appearance; prostheses; and treatment of physical complications of all stages of mastectomy, including lymphedemas. This coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same annual deductibles and coinsurance provisions that apply to the mastectomy.

8. What procedures are available for wellness reward programs?

The Plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under a wellness program offered by this Plan, you might qualify for an opportunity to earn the same reward by different means. Contact us by submitting a Benefits Question through My Synopsys and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

9. What rights do I have as a patient under PPACA?

Selection of a Primary Care Provider: Your group benefit program may require or allow the designation of a primary care provider. You have the right to designate any primary care provider who participates in your group benefit program's network and who is available to accept you or your Eligible Dependents. If your group benefit program requires designation of a primary care provider, your group benefit program may designate one for you until you make this designation. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your group benefit program using the telephone number listed on the back of your medical identification card.

For children enrolled in a group benefit program, you may designate a pediatrician as the primary care provider.

Direct Access to Obstetricians and Gynecologists: You do not need prior authorization from your group benefit program or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in your group benefit program's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your group benefit program using the telephone number listed on the back of your medical identification card.

10. Does the Plan cover Preventive Care Services?

To the extent required by PPACA, the Plan covers certain preventive care services without any cost-sharing (e.g., deductibles, co-insurance, or co-payments). Such preventive care services include (but are not limited to) blood pressure screening in adults, diabetes screening, obesity screening, and certain women's preventive health care services.

11. How does the Plan handle unclaimed self-funded Plan funds?

In the event a benefits check issued by the Plan for a self-funded Plan benefit is not cashed within eighteen (18) months of the date of issue, the check will be voided and the

funds will be returned to the Plan and applied to the payment of applicable Plan administrative fees. If a benefits check is not cashed within the eighteen month period, the amount will be forfeited, and the Plan will not re-issue the check. Unclaimed self-funded Plan amounts may be applied only to the payment of benefits (including administrative fees) under the Plan pursuant to ERISA.

STATEMENT OF ERISA RIGHTS

1. What are my rights under ERISA?

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

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

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

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

COBRA Rights

You may have a right to continue health care coverage for yourself, your covered Spouse or covered Child(ren) if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your covered Spouse/Children may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Action by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report (if any) from the Plan and do not receive them

within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied and you have been through the Plan's claims and appeal procedures or you have a claim for benefits that is ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a Medical Child Support Order, you may file suit in Federal court.

If it should happen that Plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you lose, for example, if it finds your claim frivolous, the court may order you to pay these costs and fees.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA or HIPAA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

ADDITIONAL PLAN INFORMATION

1. **Type of Plan.** This Plan is a health and welfare plan comprised of insured and self-funded medical, dental, vision, employee assistance program, group term life insurance, accidental death and dismemberment, long term disability, business travel accident, wellness program, legal service, and health flexible spending account benefits.

2. **Plan Sponsor.** The name, address and telephone number of the Plan Sponsor are: 675 Almanor Avenue, Sunnyvale, CA 94085, (650) 584-5000.

3. **Plan Administrator.** The name, address, and telephone number of the Plan Administrator are: 675 Almanor Avenue, Sunnyvale, CA 94085, (650) 584-5000.

4. **Name of Plan.** The Synopsys, Inc. Welfare Plan.

5. **Agent for Service of Process.** For disputes arising under the Plan, service of legal process may be made upon the Plan Administrator at the following address: Synopsys, Inc: 675 Almanor Avenue, Sunnyvale, CA 94085, (650) 584-5000.

6. **Identification Numbers.** The Employer Identification Number (EIN) assigned by the Internal Revenue Service to Synopsys, Inc. is 56-1546236. The Plan Number is: Plan #501.

7. **Plan Year.** The Plan Year is January 1st through December 31st.

EXECUTION

In Witness Whereof, to record the amendment and restatement of the Plan as set forth herein, effective as of January 1, 2025, the Employer has caused this Plan to be executed by its duly authorized representative.

SYNOPSYS, INC.

DocuSigned by:
Bridgette Deloach
By: 405BCF2F4A20414

Printed Name: Bridgette Deloach

Title: Benefits-Senior Director

APPENDIX A

Program or Policy Name	**Type of Welfare Benefit**	**Name and Address of Insurer** (or Third Party Administrator)
Health Plan Medical Plan Options: • Health Savings Basic Plan – HDHP • Health Savings Premium Plan – HDHP • PPO Plan	Medical Benefits	Benefits paid out of Employer's general assets. Administered by United Healthcare Insurance Co. United HealthCare Services, Inc. 9900 Bren Road East Minnetonka, MN 55343
Kaiser Foundation Health Plan of the Northwest HMO	Medical Benefits	Kaiser Foundation Health Plan of the Northwest Kaiser Permanente Building 500 NE Multnomah St., Suite 100 Portland, OR 97232
Kaiser Foundation Health Plan of Northern California HMO	Medical Benefits	Kaiser Foundation Health Plan of Northern California PO Box 12923 Oakland, CA 94604-2923
Kaiser Foundation Health Plan of Southern California HMO	Medical Benefits	Kaiser Foundation Health Plan of Southern California P.O. Box 7004 Downey, CA 90242-70004
Hawaii Medical Service Association HMO/PPO	Medical Benefits	Hawaii Medical Service Association (Blue Cross Blue Shield of Hawaii) 818 Keeaumoku Street Honolulu, HI 96814
Employee Assistance Program	Employee Assistance	Benefits paid out of Employer's general assets. Administered by Lyra Health. 287 Lorton Avenue Burlingame, CA 94010
Wellness Program	Wellness Program	Benefits paid out of Employer's general assets. Administered by Limeade. 10885 NE 4th ST #400 Bellevue, WA 98004
ReThink	Employee Assistance	ReThink 49 West 27th Street, 8th Floor New York, NY 10001
Group Life Insurance Policy	Group Term Life Insurance	Lincoln Financial Group Co. 175 Berkeley Street Boston, MA 02117
Group Accidental Death & Dismemberment Policy	Group Accidental Death & Dismemberment Policy	Lincoln Financial Group Co. 175 Berkeley Street Boston, MA 02117

Program or Policy Name	**Type of Welfare Benefit**	**Name and Address of Insurer** (or Third Party Administrator)
Group Disability Income Policy	Long Term Disability	Lincoln Financial Group Group Protection Claims P.O. Box 7207 London, KY 40742-7207
Dental Plan	Dental Benefits	Benefits paid out of Employer's general assets. Administered by Delta Dental of California. P.O. Box 997330 Sacramento, CA 95899-7330
Group Vision Care Plan	Vision	Benefits paid out of Employer's general assets. Administered by Vision Service Plan. 3333 Quality Drive Rancho Cordova, CA 95670
Synopsys Tuition Reimbursement Plan * This benefit is not subject to ERISA	Tuition Reimbursement	Benefits paid out of Employer's general assets. Administered by Edcor Data Services. 3310 W Big Beaver Rd, #305Troy, MI 48084
Travel Accident Plan	Business Travel Accident Insurance	Chubb North American Claims P.O. Box 5124 Scranton, PA 18505
MetLife Legal Plan Legal Plan Options: • MetLife Legal Plan • MetLife Legal Buy Up Plan	Legal Services Plan	Access to coverage is gained through a payment on behalf of each Participant, which is paid out of the Employer's general assets. Benefits are paid by: MetLife Legal Plans 1111 Superior Avenue Cleveland, OH 44114-2407
Rocket Lawyer	Legal Services Plan	2261 Market Street STE 10647 San Francisco, CA 94114
Long Term Care *This benefit is not subject to ERISA	Voluntary Long Term Care Insurance Program	Combine Insurance Company of America 17 Church Street Keene, NH 03431
Health Flexible Spending Account	Health Reimbursement Account Component under the Synopsys Section 125 Plan	Health Equity 121 W. Scenic Pointe Drive Draper, UT 84020
TelaDoc*	Medical (Second Opinion Service)	1945 Lakepointe Dr Lewisville, TX 75057

Program or Policy Name	**Type of Welfare Benefit**	**Name and Address of Insurer** (or Third Party Administrator)
*This benefit will terminate effective April 1, 2025.		
HealthJoy	Medical (Health Care Navigation Services)	215 W Superior Street 5th Floor Chicago, IL 60654
Wondr	Medical (Weight Management)	12790 Merit Dr Suite 700 Dallas, TX 75251
Accident Protection Plan * This benefit is not subject to ERISA	Accident	UnitedHealthcare Insurance Company PO Box 31328 Salt Lake City, UT 84131-0321
Critical Illness Protection Plan * This benefit is not subject to ERISA	Critical Illness	UnitedHealthcare Insurance Company PO Box 31328 Salt Lake City, UT 84131-0321
Hospital Indemnity Protection Plan * This benefit is not subject to ERISA	Hospital Indemnity	UnitedHealthcare Insurance Company PO Box 31328 Salt Lake City, UT 84131-0321

APPENDIX B

SYNOPSYS, INC. WELFARE PLAN

NOTICE OF COBRA RIGHTS AND RESPONSIBILITIES

[SEE COBRA LETTERS]

APPENDIX C

USERRA NOTICE

(To Accompany Notice of COBRA Rights and Responsibilities)

Background

The Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") established requirements that employers must meet for certain employees who are involved in the uniformed services (defined below). In addition to the rights that you have under COBRA (described in the attached Notice of COBRA Rights and Responsibilities), you (the Eligible Employee) are entitled under USERRA to continue the coverage that you (and your Eligible Dependents, if any) had under the Plan.

You Have Rights Under Both COBRA and USERRA

Your rights under COBRA and USERRA are similar but not identical. Any election that you make pursuant to COBRA will also be an election under USERRA, and COBRA and USERRA will both apply with respect to the continuation coverage elected. If COBRA and USERRA give you different rights or protections, the law that provides the greater benefit will apply. The administrative policies and procedures described in the attached Notice of COBRA Rights and Responsibilities (for example, the procedures for how to elect COBRA Coverage and for paying for premiums for COBRA Coverage) also apply to coverage under USERRA, unless compliance with the procedures is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances.

Definitions

"Uniformed services" means the Armed Forces, Army National Guard, and the Air National Guard when an individual is engaged in active duty for training, inactive duty training, or full-time National Guard duty (i.e. pursuant to orders issued under federal law), the commissioned corps of the Public Health Service, and any other category of person designated by the President in time of war or national emergency.

"Service in the uniformed services" or "service" means the performance of duty on a voluntary or involuntary basis in the uniformed services under competent authority, including active duty, active and inactive duty for training, full time National Guard duty under federal statute, a period for which a person is absent from employment for an examination to determine his or her fitness to perform any of these duties, and a period for which a person is absent from employment to perform certain funeral honors duty. It also includes certain service by intermittent disaster response appointees of the National Disaster Medical System (NDMS).

Duration of USERRA Coverage

General Rule: 24-Month Maximum. If you take a leave for service in the uniformed services, USERRA coverage for you (and your Eligible Dependents for whom you elect

coverage) can continue until up to 24 months from the date on which your leave began. However, USERRA coverage will end earlier if one of the following events takes place:

- A premium is not paid within the required time;
- You fail to report back to work or apply for reemployment within the time required under USERRA (see below) following completion of your service in the uniformed services; or
- You lose your rights under USERRA as a result of a dishonorable discharge or other conduct specified in USERRA.

Reporting to Work/Applying for Reemployment. Your right to continue coverage under USERRA will end if you do not notify us of your intent to return to work within the time required under USERRA following the completion of your service in the uniformed services by either reporting to work (if your uniformed service was for less than 31 days) or applying for reemployment (if your uniformed service was for more than 30 days). The time for returning to work depends on the period of uniformed service, as follows:

Period of Uniformed Service	**Report-to-Work/Apply for Reemployment Requirement**
Less than 31 days	The beginning of the first regularly scheduled work period on the day following the completion of your service, after allowing for safe travel home and an eight-hour rest period, or if that is unreasonable or impossible through no fault of your own, as soon as possible.
More than 30 days but less than 181 days	Submit an application for reemployment within 14 days after completion of your service or, if that is unreasonable or impossible through no fault of your own, the first full day on which it is possible to do so.
More than 180 days	Submit an application within 90 days after completion of your service.
Any period if for purposes of an examination for fitness to perform uniformed service	Report by the beginning of your first regularly scheduled work period on the day following the completion of your service, after allowing for safe travel home and an eight-hour rest period, or if that is unreasonable or impossible through no fault of your own, as soon as possible.
Any period if you were hospitalized for or are convalescing from an injury or illness incurred or aggravated as a result of your service.	Report or submit an application for reemployment as above (depending on length of service period) except that time periods begin when you have recovered from your injuries or illness rather than upon completion of your service. Maximum period for recovering is limited to two years from completion of service but may be extended if circumstances beyond your control make it impossible or unreasonable for you to report to work within the above time periods.

COBRA and USERRA Coverages Are Concurrent. This means that COBRA Coverage and USERRA coverage begin at the same time. However, COBRA Coverage can continue for up to 18 months (it may continue for a longer period and is subject to early termination, as described in the attached Notice of COBRA Rights and Responsibilities. In contrast, USERRA coverage can continue for up to 24 months, as described above.

Premium Payments for Continuation Coverage Under USERRA

If you elect to continue health coverage pursuant to USERRA, you will be required to pay 102% of the full premium for the coverage elected (the same rate as COBRA), at the times and using the procedures specified in the attached Notice of COBRA Rights and Responsibilities. However, if your uniformed service period is less than 180 days, you are not required to pay more than the amount that you pay as an active employee for that coverage.

APPENDIX D

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP	RHODE ISLAND – Medicaid and CHIP
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

APPENDIX E

HIPAA APPENDIX

A. Introduction

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

The Health Insurance Portability and Accountability Act of 1996, and both the privacy and security regulations thereunder found at 45 C.F.R. Parts 160 and 164, as amended from time to time require the Plan to restrict the Plan Sponsor's ability to Use and Disclose Protected Health Information that is received from the Plan and to implement reasonable and appropriate security measures to the ePHI required by the Plan and to implement reasonable and appropriate security measures to the ePHI maintained and used by the Plan. One of the requirements is that the Plan Sponsor will amend the Plan as set forth in 45 C.F.R. § 164.504(f)(2) (for privacy) and 45 C.F.R. §164.314(b)(2) (for security).

B. Hybrid Entity Designation

The HIPAA Privacy Rule (as defined below) and the HIPAA Security Rule (as defined below) only apply to the components of the Plan that provide health care benefits, including medical, dental, vision, employee assistance program, health flexible spending account, and wellness benefits (the "healthcare components"). Neither Rule shall apply to any other components of the Plan, including short term disability benefits, long term disability benefits, life insurance benefits and accidental death and dismemberment benefits, and group legal benefits (the "non-healthcare components").

C. Definitions

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

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

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

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

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

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

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

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

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

D. HIPAA Privacy Rule Requirements

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

2. Description of Uses of PHI by the Plan Sponsor. The Plan Sponsor will Use or Disclose PHI as set forth in the Plan's Notice of Privacy Practices. The Plan Sponsor will not Use or further Disclose the PHI other than as permitted or required in accordance with this stated purpose or as required by applicable law.

3. Employment Actions. The Plan Sponsor will not Use or Disclose PHI for employment related actions and decisions or in connection with any other benefit or employee benefit plan that is sponsored by the Plan Sponsor, except to the extent that such employee benefit plan is part of an Organized Health Care Arrangement (as defined in 45 C.F.R. § 160.103).

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

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

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

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

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

9. Adequate Separation.

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

(b) Employees with Access to PHI. The employees or classes of employees or other persons under the control of the Plan Sponsor that will be given access to PHI shall be set forth in the Plan Sponsor's HIPAA policies and procedures and that portion of the HIPAA policies and procedures shall be incorporated into this Section 9(b) by reference.

(c) Restriction of Access and Use. The access to and Use by the persons described in Section D.9(b) above will be restricted to the Plan Administration Functions that the Plan Sponsor performs for the Plan.

(d) Resolving Issues of Noncompliance. In the event there are any issues of noncompliance by the persons described in Section D.9(b), the Plan Sponsor will take all necessary and appropriate action that is consistent with its disciplinary policy.

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

E. HIPAA Security Rule Requirements

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

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

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

F. Agents

The Plan Sponsor will ensure that any agents (including any subcontractors) to whom it provides (1) PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to the PHI, and (2) ePHI received from the Plan agrees to implement reasonable and appropriate security measures to the ePHI .

G. Reporting

1. The Plan Sponsor will report to the Privacy Official any Use or Disclosure of the information that is inconsistent with the purposes set forth in Section D above.

2. The Plan Sponsor will report to the Plan Privacy Officer any security incident (as defined by 45 C.F.R. § 164.304) of which it becomes aware.

H. Miscellaneous

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

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

3. Delegation. The Plan Sponsor may delegate or allocate any authority or responsibility with respect to this Appendix. The Plan Sponsor (or its delegate) has discretion to construe and interpret the terms, provisions and requirements of this Appendix. All decisions of the Plan Sponsor (or its delegate) with respect to this Appendix will be given the maximum deference permitted by law.

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

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

APPENDIX F

Participating Affiliates

FirstPass Engineering PC