THIS IS A SUMMARY PLAN DESCRIPTION FOR THE SYNOPSYS, INC. SHORT TERM DISABILITY PLAN. UNLESS OTHERWISE STATED, THE PROVISIONS OF THIS SUMMARY APPLY TO DISABILITIES AND PAID FAMILY LEAVES BEGINNING ON OR AFTER JANUARY 1, 2024.

INTRODUCTION

The purpose of the Synopsys, Inc. Short Term Disability (STD) Benefit Plan ("Plan") is to assist you in meeting your reasonable income needs in the event you suffer a short-term disability and are unable to work, you need to care for a sick or injured family member, you wish to bond with a new minor child, or need to participate in a Qualifying Exigency.

What follows is a Summary Plan Description (SPD) that is required by the Employee Retirement Income Security Act (ERISA). (Read your ERISA rights at the end of this Summary.) Because this summary has been written to conform to Department of Labor (DOL) regulations, it does not contain a complete explanation of each and every provision and term contained in the more comprehensive Plan Document. If your particular circumstances are not described within this summary or if you do not understand something described in this summary, a copy of the entire Plan Document is available for your review at the Benefits Department.

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Synopsys, Inc. (the Company) has contracted with The Larkin Company (the Claims Administrator) to process claims and review adverse claim determinations, when applicable, in accordance with the Plan Document. The Claims Administrator has been given the ultimate and final authority to determine whether or not you are entitled to Plan benefits.

The Company reserves the right to amend or terminate the Plan at any time. If the Plan is terminated and you meet or continue to meet the requirements of the Plan, benefits will continue to be paid for any disability that began before the termination date.

Certain capitalized terms used in this summary have the meanings set forth on page 5.

PARTICIPATION

Who may participate? You, provided you are a regular Synopsys, Inc. employee who is on the U.S. Payroll and working 20 or more hours per week at a Company location outside of California but within the United States. The officers of the Company may authorize employees of any wholly owned subsidiary of Synopsys to participate if they meet the above criteria.

You are not eligible to participate if you work at Synopsys through an employment or leasing agency, are working as an independent contractor or consultant, or you are classified as an Intern. Your status as an employee will be determined by the Company, and such determination will be conclusive and binding on all persons.

How do I enroll? You aren't required to. When you satisfy the eligibility requirements (20 or more hours per week, etc.), you are automatically enrolled as of that date. You must be at work on the day that your participation in the Plan begins. If you are not at work on that day, your participation will be delayed until you are back at work.

You will be given an opportunity to opt-out of the Plan when you first become eligible. If you opt-out of the Plan, your decision to opt-out will remain in effect until you notify the Synopsys, Inc. Benefits Department that you wish to opt back into the Plan.

If you have rejected coverage or withdrawn from the Plan, you may opt-in to the Plan by notifying the Synopsys, Inc. Benefits Department. Your participation in the Plan will begin on January 1 of the year following your request to opt-in to the Plan, regardless of when you submitted your request.

When does my participation in the Plan end? As of midnight (at the beginning of the day) when any of the following occurs:

- you cease to be an eligible employee. For example, your scheduled work week is reduced to fewer than 20 hours per week.
- you are laid off. (A temporary shutdown initiated by the Company is not a layoff for the purposes of this Plan.)
- on the date you begin an unpaid leave of absence (unless you are on an approved leave under FMLA or similar state or local law);
- you withdraw from the Plan by submitting an opt-out form;
- the Plan terminates; or
- you fail to make the required Plan contributions.

What is it going to cost me? Effective January 1, 2024, your cost is 0.4% of the first $168,600 of your Earnings. Your maximum cost in 2024 is $674.40.

DISABILITY

What is a disability? For the purposes of the Plan, any of the following:

- you suffer an injury or illness (physical, mental) that prevents you from performing the material duties of your occupation (or any reasonably related occupation);
- your pregnancy prevents you from performing the material duties of your occupation (or any reasonably related occupation);
- you contract or are exposed to a communicable disease (e.g., TB, chickenpox), and your doctor (or a bona fide health official) states, in writing, that you must stay away from work; or
- you are under treatment for alcohol or drug abuse. To qualify for benefits you must participate in an accredited residential program or an approved outpatient program that requires your attendance for a minimum of 5 days per week for a minimum of 6 hours per day. Benefits for alcohol and drug abuse treatment are limited to a maximum of 90 calendar days.

You will not be considered disabled if you are doing work of any kind for pay or profit without first obtaining approval from the Plan Administrator. You will not be considered disabled if you turn down alternative employment offered by the Company that is within your capabilities and is comparable in status and pay to your regular job.

Who determines when I am disabled? The Claims Administrator, based on a certificate from your Physician or Practitioner, objective medical evidence, and any other information that the Claims Administrator considers to be relevant. (For additional detail see "What must I provide to have a valid disability claim?" on page 4.)

PAID FAMILY LEAVE (PFL)

When am I eligible for PFL? When you are unable to work because you must provide care to a sick or injured Family Member, wish to Bond with a new, minor Child, or need to participate in a Qualifying Exigency. A leave for the purpose of Bonding with a new, minor Child is limited to the first year after the birth, adoption, or foster care placement of that Child.

What documentation do I need to care for a sick or injured Family Member? You must provide a certificate from a Physician or Practitioner that supports the Care Recipient's Serious Health Condition.

The certificate must include a diagnosis or diagnostic code prescribed in the International Classification of Diseases. If no diagnosis has been made, a statement of symptoms, and the date, if known, on which the condition commenced must be included. All of the above must be based on a physical examination and a documented medical history. It must also include the issuer's opinion as to the probable duration of the Care Recipient's Serious Health Condition. Additionally, the Physician or Practitioner must provide an estimated amount of time (days and hours per day) that you are needed to provide care and a statement that the Serious Health Condition warrants your participation to provide care.

What must I provide to have a valid claim for bonding? For the purpose of Bonding with a new, minor Child you must submit a claim and supporting documentation that provides sufficient evidence of (i) your relationship with the child, and (ii) the birth, adoption or foster care placement of the child. The supporting documentation must contain but is not limited to the child's full name, date of birth, gender, and, if applicable, date of foster care placement or adoption.

What must I provide to have a valid claim for Qualifying Exigency? For the purpose of leave because of a Qualifying Exigency you must submit a claim and supporting documentation including but not limited to: a statement or description of appropriate facts regarding the Qualifying Exigency; start and end dates of the requested leave period (including frequency and duration for intermittent leave); if meeting with a third party, contact information for the individual or entity; and, a copy of the rest and recuperation orders, if applicable.

If you have any questions as to whether or not the supporting documentation you are submitting is acceptable, please call The Larkin Company (Synopsys' authorized claims & leave administrator). You can reach The Larkin Company toll-free at (866) 330-1975 or by emailing synopsysleaves@thelarkincompany.com.

BENEFITS

When will my disability benefits begin? Your benefits begin on the 1st day of your disability provided (i) you are disabled for at least 8 consecutive, calendar days, and (ii) you have been treated by a Physician or Practitioner during that 8-day period. A disability is deemed continuous (i.e., you do not need to serve another 7-day waiting period) if you return or are able to return to work for 60 or fewer days and then become disabled again due to the same or related cause or condition.

When will my PFL benefits begin? Your PFL benefits begin on the 1st day that you are on a leave to care for a Family Member with a Serious Health Condition, to Bond with a new, minor Child, or have a Qualifying Exigency. A PFL is deemed continuous if you must provide care to the same Care Recipient, if you take leave to bond with a new, minor Child within a Twelve-month period, or participate in a Qualifying Exigency for the same Family Member.

How much will I receive? If you are disabled, you will be paid 75% of your weekly Earnings to a maximum weekly benefit of $3,000. If you are entitled to PFL benefits you will be paid 75% of your weekly Earnings to a maximum of $3,000. Partial weeks are paid at a daily rate that is 1/7th of your weekly benefit.

Will I still be eligible for benefits if I work while claiming benefits? If you return to work on a part-time basis while eligible for disability benefits, your weekly benefit will be reduced by 80% of the income you earn from part-time employment.

If you work intermittently or on a reduced schedule while eligible for PFL benefits, you will receive 75% of the difference between your Earnings (defined below) and the amount you are receiving while working intermittently or on a reduced schedule) but never more than $3,000 per week.

While eligible for benefits you must obtain the approval from the Plan Administrator before engaging in employment.

How are benefits determined? Benefits are based on your earnings. "Earnings" means your base pay and, if applicable, your target commissions, in effect on the date immediately prior to the start of your disability. "Earnings" does not include bonuses, differentials, overtime or any other type of compensation.

If your disability begins while you are on an approved unpaid leave of absence, "Earnings" means your base pay and, if applicable, your target commissions in effect on the date immediately prior to the start date of your leave. "Earnings" does not include bonuses, differentials, overtime or any other type of compensation.

An increase in your Earnings during a period of disability will not increase your benefit amount.

What is deducted from my benefit? Any of the following for which you and, if applicable, your spouse or children are eligible: (i) temporary or permanent disability payments (whether total or partial) and vocational rehabilitation payments under workers' compensation or similar occupational disease law; (ii) benefits under a state disability or PFL plan or a Company plan providing disability or PFL benefits established in place of a state plan, or (iii) benefits under any plan or fund (by whatever name known) providing disability or PFL benefits pursuant to any benefit act or law. If you apply for these for these benefits, you will receive full Plan benefits while waiting to receive them (provided you sign an agreement to repay the Plan up to the amount of payments made, immediately upon receipt of such benefits).

What if someone else injures me? If your disability is the result of injury or illness caused by someone else, you will receive Plan benefits only if you agree to reimburse the Plan from the proceeds of any award you receive in relation to that injury or illness. Any portion of the award remaining after you have reimbursed the Plan for prior benefits will reduce future Plan benefits.

Can benefits be suspended? Yes. The Claims Administrator may request that a Physician or Practitioner examine you or the Care Recipient at the Company's expense. Your benefits will be suspended as of the date of the examination. However, if the examination establishes that you are still disabled, your benefits will resume retroactive to the examination date. If you fail to furnish information about your disability within 30 days following a written request by the Claims Administrator, your benefits will be suspended. Finally, if you leave your Physician's or Practitioner's care, or you reject the treatment plan recommended by your Physician or Practitioner, unless you dispute such treatment plan in good faith and on the advice of another Physician or Practitioner, your benefits will be suspended. Benefits will resume once you comply with these requirements. In no event will you be paid benefits for the period when you were out of compliance with the Plan.

When do disability benefits end? Benefits are not payable beyond your 180th day of disability. However, if your disability ends before then (or in the event of your death), your benefits will end as of that day.

When do PFL benefits end? Benefits are payable for a maximum of 56 calendar days or until you have received 8 times your weekly benefit, whichever occurs first. However, if the Care Recipient dies or ceases to have a Serious Health Condition or your need to provide care ends before then, your benefit will end as of that date. You cannot be paid a PFL benefit for more than 56 calendar days or 8 times your weekly benefit in any Twelvemonth Period.

With respect to a disability or PFL that commenced while you were covered under this Plan, benefits will not terminate solely because you cease to be an employee of Synopsys.

EXCLUSIONS

Are there conditions under which I will not be eligible for benefits? You will not receive benefits if:

- you were not a Plan participant when your disability or PFL began;
- for a PFL claim, if you are receiving or entitled to receive disability benefits under this Plan or under any state act or a Company plan established in lieu of;
- for a PFL claim, if you are entitled to receive workers' compensation temporary disability payments or vocational rehabilitation payments;
- your illness or injury was self-inflicted;
- you became disabled because of your commission or your attempted commission of a felony or your engagement in an illegal occupation;
- you are incarcerated (in jail or any other facility) as a result of a criminal conviction;
- you are injured due to a war or any act of war, declared or undeclared (as a civilian or soldier), riot, insurrection, or

rebellion; or service in the armed forces of any country or international authority;

- you are no longer under the regular and continuous care of a Physician or Practitioner unless the Claim Administrator determines that your disability does not warrant such attention;
- your disability stems from dipsomania, drug addiction, or sexual psychopathy; provided however, that this exclusion will apply only to periods during which you are confined by court order or certification as a result of such condition or conditions;
- another Family Member is ready, willing, able, and available to provide care to the Care Recipient for the same period of time on a day that you are claiming PFL benefits and providing the required care to that Care Recipient;
- you are receiving unemployment compensation under any federal or state program;
- you receive Company-paid sick leave, PTO used as sick leave pay or salary continuation pay during your period of disability, unless the combination of sick leave pay, PTO or salary continuation and your benefits does not exceed your regular weekly Earnings; or
- you are receiving in-lieu-of-notice pay.

CLAIMS

How do I file a claim? Notify Synopsys' Leave and Claims Administrator, The Larkin Company, toll-free at (866) 330-1975 or by emailing synopsysleaves@thelarkincompany.com as soon as reasonably possible following the commencement of a disability or your need to take PFL. The Larkin Company will send you an information packet including claim forms. Fill out the forms and return them to The Larkin Company. (See Claims Administrator information on page 7.) To avoid losing some or all of your benefits, your claim for benefits must be filed not later than 45 calendar days after the date you would have been eligible to receive benefits (unless you can show it was not reasonably possible for you to comply with this requirement); otherwise, you may lose some or all of your benefits. No claim will be accepted if filed more than 6 months after benefits were payable. **Note:** due to the COVID-19 pandemic, the deadline for submitting claims has been extended. If you have any questions regarding these extended claims deadlines, please refer to the attached "Addendum" or contact your Larkin administrator at (866) 923-3336.

What must I provide to have a valid disability claim? You must submit a claim that includes a certificate from your Physician or Practitioner. The certificate must include the medical facts of your disability, including his or her opinion as to the probable duration of your disability. The certificate must include a diagnosis or diagnostic code prescribed in the International Classification of Diseases. If no diagnosis has been made, a statement of symptoms must be included. All of the above must be based on a physical examination and documented medical history.

In order to qualify for benefits, the Claims Administrator may require that you submit other information relevant to your claim.

Time limit for a claim decision The Claims Administrator will make a determination no later than 45 calendar days after receipt of your claim. If a decision cannot be made in that period, the Claims Administrator may extend that period up to 60 calendar days (in 30 calendar day increments) provided you are notified, in writing, prior to the expiration of the deadline(s), of the cause of the delay, of the standards on which entitlement is based, of any unresolved issues or additional information needed to resolve those issues, and the date that a decision is expected. If additional information is needed, you will have 45 calendar days in which to provide it. **Note:** due to the COVID-19 pandemic, the deadline for submitting claims has been extended. If you have any questions regarding these extended claims deadlines, please refer to the attached "Addendum" or contact your Larkin administrator at (866) 923-3336.

When can I expect payment? After you have submitted all of the required information, your claim will be evaluated. If it is approved, the amount of your benefit will be calculated, and The Larkin Company will notify you of the amount approved. Payments will be directly deposited to your bank account if you have selected that option. If not, a check will be sent to you by The Larkin Company. Subsequent payments will be made every two weeks.

Overpayments In the event you are paid benefits by the Plan in excess of those to which you are entitled, the Plan has a right to recover the overpayment. The Plan Administrator will make reasonable arrangements for you to repay the Plan. In no event will you be required to repay more than the amount of benefits paid to you.

Disputing a denied claim If your claim is denied, you will receive written notification of the determination. The notification will be written in a culturally and linguistically appropriate manner and will set forth the following: (i) the specific reason for the denial; (ii) references to the specific Plan provisions on which the denial is based; (iii) a description of any additional material necessary to perfect your claim and an explanation of why such material or information is necessary; (iv) a description of the Plan's claim review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review; (v) if applicable, the rule (or similar criterion) on which the denial was based or, if the denial was not based on a rule (or similar criterion), a statement that these were not used; (vi) if applicable, an explanation of the scientific or clinical judgment used in making the determination and a statement that such an explanation is available, on request, free of charge; and

(vii) an explanation as to why the Plan disagreed with the views of your treating Physician or Practitioner, medical or vocational experts, or the Social Security Administration, if applicable.

If you receive notice that your claim has been denied, you have 180 calendar days following receipt of the denial to file a written request for a review. You may submit any documentation you feel will support your claim including any comments that you feel are relevant to your claim. You are entitled to a copy of the Plan Document and other documents relevant to your claim. Send your written request for a claim review to: Synopsys Claims Administrator, Short Term Disability Benefit Plan, The Larkin Company, 2350 Mission College Blvd., Suite 390, Santa Clara, CA 95054. **Note:** due to the COVID-19 pandemic, the deadline for submitting claims has been extended. If you have any questions regarding these extended claims deadlines, please refer to the attached "Addendum" or contact your Larkin administrator at (866) 923-3336.

Claim review time limit and notification requirements The Claims Administrator will render a written decision within 45 calendar days of receipt of your request. The review of your claim will: (i) give no weight to the initial denial; (ii) be of your entire file including any new material and arguments you submit; (iii) provide you, free of charge, with any new or additional evidence considered as soon as possible and sufficiently in advance of the end of the 45-day period; (iv) be done by an individual or individuals who neither made the initial denial nor is a subordinate of that individual; and (v) be made with the consultation of a health care professional (with the appropriate training and experience) who was not the health care professional consulted on the initial denial nor a subordinate of that health care professional, if the initial denial was made in consultation with a health care professional or was based in whole or in part on a medical judgment. If new or additional evidence is received and relied upon while your claim is being reviewed, you will be provided with that evidence as soon as possible and sufficiently in advance of the date on which the review of the adverse determination is due and you will be afforded the opportunity to respond.

If a decision cannot be reached within 45 calendar days, you will be notified, in writing, prior to the expiration of that deadline. The notice will include the reason for the delay and the date a decision is expected. In no event will the decision process take more than 90 calendar days from the date your request for review was received.

If, on review, your claim is denied, you will receive a written notification of the determination. The notification will be written in a culturally and linguistically appropriate manner and will set forth the following (i) the specific reason(s) for the denial; (ii) reference(s) to the specific Plan provision(s) on which the denial is based; (iii) a statement that you are entitled to receive, free of charge upon request, reasonable access to, and copies of, all documents relevant to your claim; (iv) a statement that you have the right to file a civil suit under Section 502(a) of ERISA no later than 6 months after the date of the final determination, including the calendar date of when the 6-month period will end; (v) if applicable, the rule (or similar criterion) on which the denial was based, or, if not applicable, a statement that these were not used; (vi) if applicable, an explanation of the scientific or clinical judgment used in making the determination and a statement that such explanation is available on request, free of charge; (vii) if applicable, the identity of any medical or vocational experts whose advice was obtained during the decision process, and (viii) a discussion of the decision, including an explanation of the basis for disagreeing with or not following the views presented by the Participant's Physician(s), Practitioner(s) or vocational experts, the views of the medical or vocational experts whose advice was obtained on behalf of the plan, and the disability determination presented by him or her to the Plan made by the Social Security Administration.

ERISA INFORMATION

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 Plan participants are entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office, all documents governing the Plan, including a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. If you wish to examine any of these documents, contact the Synopsys Benefits Department in Mountain View, CA.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan 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. The Plan Administrator is required by law to furnish each participant with a copy of the summary annual financial report.

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 Plan 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 this 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 the Plan documents or the latest annual report from the Plan Administrator and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.
- If you receive this document through electronic means, you have the right to request, free of charge, a paper copy of this document.

Assistance with Your Questions

If you have any questions about the Plan, contact the Plan Administrator. If you have any questions about this statement or your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you may contact the nearest office (listed in your telephone directory) of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor. EBSA also has a national toll-free number: 1-866-444-EBSA. You may also contact EBSA by writing to the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, DC 20230.

DEFINITIONS FOR KEY TERMS

"**Bond or Bonding**" means to develop a psychological and emotional attachment between yourself and the new minor Child. Bonding involves being in one another's presence.

"Care Provider" means either (i) the Family Member who is providing the required care for a Serious Health Condition, (ii) the Family Member who is Bonding with the New Child, or (iii) the Participant who is participating in a Qualifying Exigency.

"**Care Recipient**" means either (i) the Family Member who is receiving care for a Serious Health Condition, or (ii) the New Child with whom you are Bonding. For the purposes of a Qualifying Exigency, care recipient is limited to the individual's Spouse, Domestic Partner, Child or Parent in the Armed Forces of the United States.

"**Child**" means a biological, adopted or foster child, a stepchild, a legal ward, a son or daughter of a Domestic Partner, or a child for whom you stand "in loco parentis."

"**Domestic Partner**" means your registered domestic partner if the domestic partnership meets the Synopsys group health plan requirements for domestic partnership.

"**Family Member**" means Child, Parent, Parent-in-law, Grandparent, Grandchild, Sibling, Spouse, or Domestic Partner as defined in this section. For Qualifying Exigency, "Family Member" means a Spouse, Domestic Partner, Child, or Parent who is a member of the regular Armed Forces of the United States.

"**Grandchild**" means a Child of one of your children.

"**Grandparent**" means a Parent of one of your Parents or Parents-in-law.

"Intern" means an individual, participating in an established intern program at the Company, performing work for a specified period of time.

"New Child" means a minor child for whom leave is taken for the purposes of bonding within one year of the child's birth or placement with the Participant or the Participant's Spouse or Domestic Partner.

"Parent" means a biological, foster or adoptive parent, a stepparent, a legal guardian, or other person who stood "in loco parentis" to you when you were a child.

"**Parent-in-law**" means the Parent to your Spouse or Domestic Partner.

"Physician" means a physician or surgeon holding an MD or DO degree, Psychologist, optometrist, dentist, podiatrist, or chiropractic practitioner, who is licensed and acting within the scope of his or her practice. "Psychologist" means a licensed psychologist with a doctoral degree in psychology and who either (i) has at least two years of clinical experience in a recognized health setting, or (ii) has met the standards of the National Register of Health Service Providers in Psychology.

"**Practitioner**" means a Nurse Practitioner or physician assistant (provided the physician assistant has performed a physical examination and collaborated with a Physician or surgeon) duly licensed or certified by the state or foreign country in which he or she practices and acting within the scope of his or her license or certification. With regard to Disability resulting from normal pregnancy or childbirth, Practitioner will also include a midwife or nurse midwife, or nurse practitioner. "Nurse Practitioner" means a licensed nurse practitioner who has completed a transition to practice in their licensed state of a minimum of three (3) full-time equivalent years of practice or 4,600 hours.

"Qualifying Exigency" means time off to assist a Family Member deployed to a foreign country on active military service for reasons including, but not limited to, the following: short-notice deployment; attendance in an official ceremony; attendance in a family support program sponsored by the military; arranging or providing childcare; transferring a Child to a new school; making or updating financial or legal arrangements; attending counseling; accompanying the Family Member while he or she is on short-term rest and recuperation leave; or, attending arrival ceremonies.

"**Serious Health Condition**" means an illness, injury, impairment, or physical or mental condition that involves inpatient care in a hospital, hospice, or residential health care facility, or continuing supervision by a health care provider, as defined in Section 825.113 of the Family and Medical Leave Act (FMLA).

"Sibling" means a person related to you by blood, adoption, or affinity through a common legal or biological Parent.

"**Spouse**" means a partner to a lawful marriage.

"**Twelve-month Period**" means the 365 consecutive days that begins with the first day you first establish a valid claim for PFL.

MISCELLANEOUS

Synopsys' Short Term Disability Benefit Plan does not provide job protection or return to work rights. You may have job protection rights if you are eligible for a leave under the federal Family and Medical Leave Act (FMLA) and/or any other applicable state or local mandated leave law that provides for such protections. These protections (if eligible) may run concurrently with any approved disability and/or PFL benefits.

PLAN INFORMATION

Type of Plan
Welfare benefit plan providing temporary disability benefits.

Plan Administrator and Agent for Service of Legal Process
Synopsys, Inc.
690 East Middlefield Road
Mountain View, CA 94043 (650) 962-5000

Claims Administrator
The Larkin Company
PO Box 910
Roseville, CA 95661
www.thelarkincompany.com
Toll Free 866 330-1975
Local 650 938-0933
Fax 650 938-0943 or 916 594-0131

Funding
All Plan contributions are deposited to a trust and are used for the exclusive purpose of paying Plan benefits and operating expenses.

Trustee(s)
Director of Compensation, Benefits and HRIS
Senior Benefits Manager

Employer ID Number
56-1546236

Plan Number
526

Plan Year End
December 31st