THIS IS A SUMMARY PLAN DESCRIPTION FOR THE PIXAR SHORT-TERM INCOME PROTECTION PLAN. UNLESS OTHERWISE STATED, THE PROVISIONS OF THIS SUMMARY APPLY TO DISABILITIES AND PAID FAMILY LEAVES BEGINNING ON OR AFTER JANUARY 1, 2026. THIS PLAN IS PART OF THE PIXAR GROUP HEALTH AND WELFARE PLAN.

PIXAR ANIMATION STUDIOS

INTRODUCTION

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The purpose of the Pixar Short Term Income Protection (STIP) Plan is to assist you in meeting your reasonable income needs in the event you suffer a short-term disability or need to care for a sick or injured Family Member or Bond with a new, minor Child, or have a Qualifying Exigency and are unable to work.

What follows is a Summary Plan Description that is required by the Employee Retirement Income Security Act (ERISA). (Read your ERISA rights on page 4 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 your HR/Benefits Department.

Pixar (the Company) has contracted with The Larkin Company (the Claims Administrator) to administer claims in accordance with the Plan Document. However, the Company, in its capacity as Plan Administrator, has the ultimate authority and discretion to determine whether or not you are entitled to Plan benefits.

The Company intends to continue the Plan indefinitely but reserves the right to change or terminate the Plan at any time. If the Plan is terminated, benefits will continue to be payable for any covered disability which 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, Pixar employee or an intern who works at a Company location in the United States of America or its territories but outside the state of California. Individuals performing services for the Company as independent contractors or through an employment or leasing agency are not eligible to participate.

How do I enroll? You don't need to; Pixar employees are automatically enrolled. 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.

When does my participation in the Plan end? When either of the following occurs:

- you cease to be an eligible employee (for example, if you are laid off or furloughed including temporary layoff or furlough);
- you are no longer employed by the Company; or
- the Plan terminates.

What is it going to cost me? Nothing. The Company pays for all Plan costs.

DISABILITY

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

- you suffer an injury or illness (physical and/or mental) which prevents you from performing your regular and customary occupation (or any reasonably related occupation);
- your pregnancy prevents you from performing your regular and customary occupation (or any reasonably related occupation);
- you contract or are exposed to a communicable disease (e.g., TB, chickenpox), and your Physician or Practitioner (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 8 hours per day. Benefits for alcohol or drug abuse treatment are limited to a maximum of 90 days.

You will not be considered disabled if you are doing work of any kind for the Company or any other employer (including self-employment) 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 based on Objective Medical Evidence, and any other information that the Claims Administrator considers to be relevant.

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 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 (Pixar's authorized claims administrator).

You can reach The Larkin Company at (650) 938-0933 or toll-free at (866) 923-3336, or by emailing pixarleaves@thelarkincompany.com.

BENEFITS

When will my benefits begin? Your benefits begin on the 8th consecutive day of your disability (provided you have been treated by a Physician or Practitioner during that 8-day period); 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 participate in a Qualifying Exigency.

A disability is considered to be 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 days or less and become disabled again due to the same or related cause or condition. 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, or participate in Qualifying Exigency for the same Family Member within a Twelve-month Period.

How are benefits determined? Benefits are based on your earnings with the Company. "Earnings" mean your gross base pay in effect on the date immediately prior to the start of your disability or PFL. "Earnings" do not include bonuses, differentials, overtime, or any other type of additional compensation.

If your disability or PFL begins while you are on an approved unpaid leave of absence, "Earnings" means your gross base pay in effect on the date immediately prior to the start of your leave.

How much will I receive? If you are disabled, you will be paid 70% of your weekly Earnings to a maximum of $4,600 per week. If you are entitled to PFL benefits you will be paid 70% of your weekly Earnings to a maximum of $1,765. 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 return to work on a part-time basis? If you are disabled or on a PFL and return to work for fewer hours than you are regularly scheduled to work for the Company, your weekly benefit (as described above) will be reduced by 80% of the income you earn from part-time employment.

You may not engage in work of any kind for pay or profit without first obtaining approval from the Plan Administrator.

What is deducted from my benefit? Any of the following for which you are eligible: (i) temporary or permanent disability payments (whether total or partial), vocational rehabilitation payments and any other amounts awarded or allocated under workers' compensation or similar occupational disease law; (ii) benefits under a state disability plan or Paid Family Leave plan, or a Company plan providing disability benefits in place of a state plan; (iii) benefits under any other plan, fund, or arrangement, by whatever name known, providing disability benefits pursuant to a compulsory act or law of any government; and (iv) to the extent that the amount of sick leave or salary continuation, when combined with the benefit payable under this Plan, exceeds your "Earnings." If you are (or might be) entitled to these benefits but do not apply for them, your benefits from this Plan will be reduced by the amount the Claims Administrator believes you would have been entitled to receive. If you have applied but not yet received these other benefits, you will be required to sign an agreement to reimburse this Plan before benefits may be issued.

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 (or the Care Recipient has a Serious Health Condition that requires your care), 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 or the Care Recipient leaves a Physician's or Practitioner's care, or you or the Care Recipient rejects the treatment plan recommended by the Physician or Practitioner, your benefits will be suspended. Benefits will resume once you or the Care Recipient complies with these requirements. In no event will you be paid benefits for the period when you or the Care Recipient was out of compliance with the Plan.

When do disability benefits end? Benefits are not payable beyond your 90th 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.

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

When do PFL benefits end? Benefits are payable for a maximum of 56 calendar days. 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 in any Twelve-month Period.

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;
- your illness or injury was self-inflicted unless your underlying injury or illness is otherwise covered by the plan and results from a documented medical condition, i.e., depression or mental illness;
- you became disabled because of your commission or your attempted commission of a felony or other illegal occupation;
- you are incarcerated (in jail or any other facility) as a result of a criminal conviction;
- you are injured in a war (as a civilian or soldier), riot, insurrection, or rebellion (this provision does not apply if you are conducting business, on a temporary basis, at the request of the Company in a foreign country);
- you are no longer under the Regular and Continuous Care of a Physician or Practitioner, unless the Claims Administrator determines that your disability does not warrant such attention;
- you are claiming PFL benefits and are receiving or are entitled to received temporary disability benefits (whether total or partial) or vocational rehabilitation payments under any workers' compensation law, occupational disease law, or any other legislation or law of similar purpose;
- you are receiving unemployment compensation under any federal or state program;
- 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 receive Company-paid sick leave, PTO used as sick leave, or salary continuation pay during your period of disability or PFL, unless the combination of sick leave pay or salary continuation and your benefit does not exceed your regular weekly Earnings;
- their disability is caused by or results from gainful self-employment or employment elsewhere;

- you made false, fraudulent, or misleading statements related to your Disability claim, or submitted false or fraudulent information or documentation regarding your claim; or
- you are receiving pay under the Worker Adjustment and Retraining Notification (WARN) Act or in-lieu-of notice pay.

CLAIMS

How do I file a claim? Obtain a claim form from the HR/Benefits Department or by emailing pixarleaves@thelarkincompany.com. After you and your Physician or Practitioner have completed and signed the required sections of the form, it should be sent to The Larkin Company. (See Claims Administrator information on page 6.) 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). No claim will be accepted if filed more than 6 months after the first day on which benefits may have been payable.

What must I provide to have a valid 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 must make a determination no later than 45 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 days (in 30-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 days in which to provide it.

How and When will I be paid? After you have submitted all the needed information, your claim will be evaluated. If it is approved, the amount of your benefit will be calculated, and The Larkin Company will issue you a voucher. The voucher will show you the period covered and the amount of your benefit. Pixar payroll will also be notified of the period covered and the benefit amount and your benefits will be included in the check(s) you receive from Pixar on or near your next regularly scheduled payroll date(s).

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 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: Plan Administrator Short Term Disability Benefit Plan, Pixar, 1200 Park Avenue, Emeryville, CA 94608.

Claim review time limit and notification requirements The Plan 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 days, you will be notified, in writing, prior to the expiration of that deadline. The notice must include the reason for the delay and the date a decision is expected. In no event will the decision process take more than 90 days from the date your request for review was received.

If, on review, 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(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; (v) the calendar date on which the 6 month deadline will expire; (vi) if applicable, the rule (or similar criterion) on which the denial was based, or, if not applicable, a statement that these were not used; (vii) 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; (viii) if applicable, the identity of any medical or vocational experts whose advice was obtained during the decision process, and (ix) 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

Do I have rights as an employee? As a Plan participant, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants will be 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 Pixar Benefits Department in Emeryville, 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 20210.

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 employee 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 minor 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 domestic partner if the domestic partnership meets the Pixar 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.

"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.

"Objective Medical Evidence" means a measurable abnormality which is evidenced by one or more standard medical diagnostic procedures including laboratory tests, physical examination findings, X-rays, MRIs, EEGs, ECGs, CAT scans or similar tests that support the presence of a Disability or indicate a functional limitation. Objective Medical Evidence does not include Physician's or Practitioner's opinions based solely on the acceptance of subjective complaints (e.g. headache, fatigue, pain, and nausea), age transportation, local labor market and other non-medical factors. To be considered an abnormality, the test result must be clearly recognizable as out of the range of normal for a healthy population; the significance of the abnormality must be understood and accepted in the medical community.

"**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.

"**Physician**" means a physician or surgeon holding an MD or DO degree, Psychologist, optometrist, dentist, podiatrist, or chiropractic practitioner, who is duly licensed or certified in the state or foreign country in which they practice and is acting within the scope of their practice. "Psychologist" means a licensed psychologist with a doctoral degree in psychology and who either (i) has at least two (2) years of clinical experience in a recognized health setting, or (ii) has met the standards of the National Register of the Health Service Providers in Psychology. "Physician" does not include you or your child (biological, adopted, foster child, stepchild, legal ward, or child of a domestic partner), domestic partner, grandchild, grandparent, parent, parent-in-law, sibling, or spouse.

"**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 they practice and acting within the scope of their license or certification. With regard to Disability resulting from pregnancy, childbirth, or postpartum conditions, Practitioner will also include a midwife, Nurse Practitioner, or nurse midwife acting within the scope of their license. "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. “Practitioner” does not include you or your child (biological, adopted, foster child, stepchild, legal ward, or child of a domestic partner), domestic partner, grandchild, grandparent, parent, parent-in-law, sibling, or spouse.

“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.

“Regular and Continuous Care” means that you personally consult with a Physician or Practitioner at a frequency that is medically necessary to effectively manage and treat your disabling condition(s), in accordance with generally accepted medical standards; and receive appropriate treatment from a Physician and/or Practitioner whose specialty or experience is suited to your disabling condition(s), with such care conforming to generally accepted medical standards.

"**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 federal Family and Medical Leave Act.

“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

The Pixar 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 leave under the federal Family and Medical Leave Act (FMLA) and/or any other applicable state leave law that provides for such protections. These protections (if eligible) will run concurrently with any approved disability benefits.

PLAN INFORMATION

Plan Name
Pixar
Short Term Income Protection Plan
(Part of the Group Health and Welfare Plan)

Type of Plan
Welfare benefit plan providing temporary disability and family care benefits.

Funding
Benefits and costs are paid by Pixar

Plan Administrator and Agent for Service of Legal Process
Pixar
1200 Park Avenue
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510 922-3433

Employer ID Number
68-0086179

Plan Number
501

Plan Fiscal Year End
July 31

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