Pixar Group Health and Welfare Plan

Master Summary Plan Description

Restated Effective August 1, 2022

This document, together with the additional documents provided along with it, constitute the written plan document required by ERISA § 402 and the Summary Plan Description required by ERISA § 102.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see the notice reproduced in Appendix B for more details.

This Wrap Summary Plan Document (SPD) has been formally modified through the Summary of Material Modification document(s) attached at the back of this document.

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1. Definitions

Capitalized terms used in this document have the following meanings:

"AD&D" means accidental death and dismemberment insurance.

“Affordable Care Act” means the Patient Protection and Affordable Care Act, as amended.

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

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

"Company" means Pixar (“Pixar”) or any successor thereto, and any affiliated entity within the same controlled group, as that term is defined under section 414(b) of the Internal Revenue Code, that participates in the plan.

"DCAP" means a dependent care assistance program that may be established by the Company under a separate document. The DCAP is a benefit program under the Plan. It may allow you to use pre-tax dollars to pay for the care of your eligible dependents while you are at work. It is not subject to ERISA.

"Employee" means any common-law employee of the Company who satisfies the eligibility provisions of in this document and is not excluded from participation by the terms of an applicable benefit program, except individuals classified or treated by the Company as independent contractors (regardless of any subsequent reclassification), or as an employee of an employment agency.

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

"Health FSA" means a health flexible spending account plan that may be established by the Company under a separate document. The health FSA is a benefit program under the Plan. It allows you to use before-tax dollars to pay for most medical and dental expenses not reimbursed under other programs.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.

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

"Plan" means the Pixar Group Health and Welfare Plan and includes this document, written amendments and updates to this document, and the terms of all policies and component benefit programs listed in Section 15.

"Plan Administrator" means the Company.

"SPD" means the Summary Plan Description required by ERISA § 102 summarizing this Plan and includes this document, information booklets supplied by insurance carriers, and other benefits descriptions provided to participants with this document or at any other period as appropriate to provide updates to the document, such as during open enrollment.

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

2. Introduction

The Company maintains the Plan for the exclusive benefit of eligible Employees and eligible family members or “dependents.” It is important that you share this document and the materials referenced herein with your covered dependents. The Plan provides health and welfare benefits through the benefit programs listed in Section 15. See Section 15. for a listing of benefit programs and the entities that help administer the programs.

Each of these benefit programs is summarized in a certificate of insurance booklet issued by an insurance company, a summary plan description or another document (a "Benefit Description"). A Benefit Description will be available from the insurer (if the benefit is fully-insured) or Plan Administrator (if the benefit is self-funded). Whether a benefit program is fully-insured or self-funded is noted in Section 15.

This document and its attachments constitute the plan document required by ERISA § 402. This document and its attachments, coupled with the information booklets and other descriptive materials provided for benefits as described in Section 15. constitutes the wrap Summary Plan Description as required by ERISA § 102.

3. General Information about the Plan

Plan Name:	Pixar Group Health and Welfare Plan.
Type of Plan:	Welfare plan providing coverages listed in Section 15. The Plan also includes funding through a cafeteria plan under Code § 125.
Plan Year:	August 1 to July 31.
Plan Number:	501
Effective Date:	May 1, 1987. The Plan has been amended several times since its original effective date, most recently as of August 1, 2022.
Funding Medium and Type of Plan Administration:	Some benefits under the Plan are self-funded, and some are fully-insured. See Section 15 for a description of the benefit programs and whether they are self-funded or fully-insured. For benefit programs which are fully-insured, benefits are insured under a group contract entered into between the Company and insurance companies or HMO. The insurance companies and/or HMO, not the Company, are responsible for paying claims with respect to these programs. The Company shares responsibility with the insurance companies and/or HMO for administering these program benefits, as described below. For benefit programs which are self-funded, the Company is responsible for processing and paying appropriate claims. The

	Company may hire a third-party administrator (a "TPA") to process claims. Premiums for Employees and their eligible family members may be paid in part by the Company out of its general assets and in part by Employees' pre-tax and/or post-tax payroll deductions. The Plan Administrator provides a schedule of the applicable premiums during the initial and subsequent open enrollment periods and on request for each of the benefit programs, as applicable. The Company provides Employees the opportunity to pay for benefits on a pre-tax basis through a cafeteria plan. Appendix C provides information with regard to such a plan.
Plan Sponsor:	The Company is the Plan Sponsor. Pixar 1200 Park Avenue, Emeryville, CA 94608 (510) 922-3000
Plan Sponsor's Employer Identification Number:	68-0086179
Insurance Companies/HMO:	See a complete list under the heading Plan Provider Information later in this document.
Plan Administrator:	Attention: Benefits Department Pixar 1200 Park Avenue Emeryville, CA 94608 (510) 922-3000
Named Fiduciary:	Pixar 1200 Park Avenue Emeryville, CA 94608 (510) 922-3000
Agent for Service of Legal Process:	Attention: Legal Department Pixar 1200 Park Avenue Emeryville, CA 94608 (510) 922-3000 Service for legal process may also be made on the Plan Administrator.

Language assistance is available. If you have difficulty understanding any part of this Summary Plan Description contact the Plan Administrator.

Benefits hereunder may be provided pursuant to an insurance contract or pursuant to a governing document adopted by the Company. If so, these contracts are made a part of this Plan document, and the contracts and Plan document should be construed as consistent, if possible. If the terms of this Plan document conflict with the terms of such insurance contract or other governing document, then the terms of the insurance contract or governing document will control, with the exception of defining eligible employees and dependents, which is determined by the Company, unless otherwise required by law.

4. Eligibility and Participation Requirements

Eligibility and Participation

An eligible Employee with respect to the Plan will be an Employee who is eligible to participate in and receive benefits under one or more of the benefit programs. To determine whether you or your family members are eligible to participate in a benefit program, please see Section 15. Reclassification from non-employee to employee status by a court or any agency or by the Company will not create any retroactive right to coverage.

Certain benefit programs require that you make an annual election to enroll for coverage. ***Generally, you cannot enroll, drop coverage, or change your or your dependents coverage under the plan except during annual Open Enrollment.*** However, you may be able to add or drop coverage for yourself or a dependent during the plan year if you experience an event that triggers a HIPAA Special Enrollment Right (see section below) or if you have a Status Change Event (see Appendix C for an explanation of Status Change Events). Please review the rules for changing your benefits elections described in Appendix C very carefully as the rules regarding making benefits changes mid-year must be strictly enforced.

Information about enrollment procedures is provided by the Company. Information about when your participation begins in various benefit programs is found under Section 15. You must follow any required enrollment procedures. ***Always make sure the Company has your current home address and other contact information for you and your covered dependent to correctly administer your benefits and to send you important benefits information.***

Eligible Dependent Status

Consult your plans carrier documentation for details as to whether your child can participate in a particular benefit program and any limits on such participation. For example, children covered under the Medical benefit program generally can be covered until the end of the month during which they reach age 26. However, coverage may end earlier for other benefits (or may not be available at all).

You cannot be covered both as an employee and as a dependent under the plan.

Full Time Status and the ACA

Under the ACA, employers are required to report specific benefits information to IRS on “full-time” employees as defined by the ACA. A “full-time” employee is generally an employee who works on average 30 hours per week or 130 hours per month. Employers may also face penalties if they do not offer major medical coverage to substantially all full-time employees or if the coverage they offer is unaffordable or does not meet a minimum value standard. The Company determines full-time status using the Look-back method. ACA full-time status is not a guarantee of major medical benefits eligibility. Benefits eligibility is described in Section 15.

Special Enrollment Provisions under HIPAA

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a special enrollment period for the Medical benefit program (or similar benefit programs providing medical benefits) may be available, usually if you lose medical coverage under certain conditions or when you acquire a new dependent by marriage, birth, or adoption.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this Plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you acquire a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

In addition, if you declined enrollment in the Plan for yourself or your dependents (including a spouse) because of coverage under Medicaid or a State Children's Health Insurance Program, there may be a right to enroll in this Plan if there is a loss of eligibility for the government-provided coverage. However, a request for enrollment must be made within 60 days after the government-provided coverage ends.

Finally, if you declined enrollment in the Plan for yourself or your dependents (including a spouse), and you or a dependent later becomes eligible for state “premium assistance” through Medicaid or a State Children's Health Insurance Program which provides help with paying for Plan coverage, then there may be a right to enroll in this Plan. However, a request for enrollment must be made within 60 days after the determination of eligibility for the state assistance. ***Medicaid and State Children's Health Insurance Program premium assistance are not available with respect to coverage under a health FSA or a high-deductible health plan. Thus, this special enrollment event will not apply to such plans.***

Coverage during Certain Leaves of Absence

Certain Federal (and State) statutes like the Family and Medical Leave Act (FMLA) require that eligibility for medical benefits continue for employees on those protected leaves of absence under the same terms as active employees. When wages continue during such a leave, your contributions will be deducted from those wages on a pre-tax basis. When such a leave is unpaid, you are still required to pay your portion of the premium.

You may also generally discontinue coverage when coverage is exhausted while on LOA and re-enroll for the remainder of the coverage period or plan year when you return.

Human Resources must determine whether or not you are eligible for a statutory or other leave of absence.

Terms of Participation

Your participation and the participation of your spouse and dependents in a benefit program will terminate according to the terms of the specific benefit program. Generally, coverage for most benefit programs terminates on the last day of the month in which you terminate employment, but certain benefit programs may provide coverage only through the date your employment terminates. Please see Section 15 for further information on the date participation in a specific benefit program will terminate.

Coverage may also terminate if you fail to pay your share of an applicable premium, if your hours drop below the required hourly threshold for the particular benefit, if you engage in fraud or make an intentional misrepresentation of a material fact, or for any other reason as set forth in the attached documents. You should consult Section 15 for a general summary and the attached documents for specific termination events and information.

Coverage may be terminated retroactively in the normal course of business due to a participant's termination of employment, nonpayment of premiums, loss of dependent eligibility or other, similar factors. When you or a dependent lose eligibility for benefits, regardless of whether or not you timely report that loss of eligibility, a change to any existing salary reduction election will be made automatically. To the extent that the coverage at issue does not allow for retroactive termination of that coverage and election to the date of the loss of eligibility, such changes will be prospective. If coverage can be terminated retroactively to the date of the loss of eligibility, or sometime thereafter, excess salary reduction contributions will be refunded on a post-tax basis to the date the termination of coverage can be made effective.

Any person claiming benefits under the Plan shall furnish the Company, any insurance company or other entity working on behalf of the Plan or a benefit program with such information and documentation as may be necessary to verify eligibility for and/or entitlement to benefits under the Plan or a benefit program. This may include but is not limited to providing social security numbers, birth certificates, marriage certificates, or proof of dependent eligibility. Failure to cooperate and provide such information will lead to a loss of eligibility for benefits.

Knowingly enrolling an ineligible dependent in plan benefits constitutes fraud and is considered a material misrepresentation that will result in termination of coverage as well as other disciplinary action up to and including termination of employment. Eligibility for benefits is described in Section 15. If you have questions about whether a dependent is eligible you must contact Human Resources before enrolling that dependent.

COBRA Rights

You may be eligible for COBRA continuation coverage or conversion policies when your coverage for a medical benefit program under this Plan terminates. Information about continuation coverage or conversion is contained in Appendix A. If you have questions about this law or these rights, please contact the Plan Administrator (for benefit programs that are self-funded) or the insurance carrier (if the benefit is fully-insured). You can determine whether a benefit program is self-funded or fully-insured by consulting Section 15

For the Health FSA benefit program, COBRA continuation coverage is available if your account is underspent (if the COBRA premium for the account (the monthly salary reduction election + 2%) for the remainder of the coverage period is less than the account's balance) but generally cannot extend beyond the end of the Plan Year (including any 2½ month grace period). COBRA continuation coverage will not be offered with respect to the Health FSA benefit program if your Health FSA is overspent, unless otherwise required by applicable law.

5. Summary of Plan Benefits

Benefits and Contribution

The Plan provides you and your eligible spouse and dependents with the benefit programs listed in Section 15. A summary of each benefit program provided under the Plan may be provided in the attached documents (such as a certificate of insurance booklet, summary plan description for a specific benefit program or other governing document). **Note that some of the attached documents may be labeled as a "summary plan description." If so, that document will only be a summary of the specific benefit program to which it relates. Notwithstanding any of the terms of such a document, that document is not the formal, single "Summary Plan Description" for this Plan. Rather, this document constitutes the formal, single "Summary Plan Description."**

The cost of the benefits provided through the benefit programs may be funded in part by Company contributions and in part by pre-tax and/or post-tax employee contributions. The Company will determine and periodically communicate your share of the cost, if any, of the benefit programs. The Company reserves the right to change that determination.

The Company will make its contributions, if any, in an amount that (in the Company's sole discretion) is at least sufficient to fund the benefits or a portion of the benefits that are not otherwise funded by your contributions. The Company will pay its contribution and your contributions to any insurance carrier or, with respect to benefits that are self-insured, will use these contributions to pay benefits directly to, or on behalf of, you or your eligible family members from the Company's general assets. Your contributions toward the cost of a particular benefit program will be used in their entirety prior to using Company contributions to pay for the cost of such benefit program.

Medical benefits under this Plan may be subject to cost-sharing provisions, premiums, deductibles, co-insurance, copayment amounts, annual or lifetime limits, pre-authorization requirements or utilization review. There may also be limitations on the selection of primary care or network providers, limits on emergency medical care, or limited coverage for preventive services, drugs, medical tests, medical devices or medical procedures. These limitations are set forth in the attached documents.

Certain prescription drug benefits are considered “Creditable Coverage” under Medicare Part D. The attached documents provide details regarding this coverage and an annual notice (attached and incorporated by reference in Appendix B) explains how this creditable coverage works for these prescription drug benefit programs.

The Plan will provide benefits in accordance with the requirements of all applicable Federal laws regulating group health plans, such as COBRA, HIPAA, NMHPA, WHCRA and the Affordable Care Act. A brief summary of some of these laws is below.

Newborns' and Mothers' Health Protection Act (NMHPA) of 1996

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a 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 issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act (WHCRA) of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this Plan.

Qualified Medical Child Support Orders

Group health plans and health insurance issuers generally must provide benefits as required by any qualified medical child support order, or "QMCSO." The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. Participants and beneficiaries can obtain, without charge, a copy of such procedures from the Plan Administrator.

Lifetime and Annual Limits

Lifetime or annual limit on the dollar value of "essential health benefits" are no longer permitted under the major medical plans offered by the Plan. For more information on "essential health benefits" refer to the terms of policies and benefit program materials listed in Section 15. These documents are provided to you during enrollment and are available from Human Resources, the insurer (if the benefit is fully-insured), or Plan Administrator (if the benefit is self-funded).

6. Grandfathered Status under the Affordable Care Act

Non-Grandfathered Benefit Programs under the Affordable Care Act

The following benefit programs that provide health benefits are not “grandfathered health plans” under the Affordable Care Act:

- Kaiser HMO
- Cigna OAP
- Cigna CDHP

These benefit programs must, under the Affordable Care Act, provide additional protections. The protections provided by the Affordable Care Act include the following:

Preventive Services covered at 100%

In-network preventive care services will be covered at 100% with no cost sharing (e.g., copayment, coinsurance percentage, deductible, etc.). Preventive services include those services outlined in the US Preventive Services Taskforce recommendations (services rated “A” or “B”). Please see the attached documents for the preventive services included at no cost share.

Non-Network Emergency Services covered as In-Network

Emergency services must be covered without the need for prior authorization, regardless of the participating status of the provider or facility, and at the in-network cost sharing level.

Access to Primary Care Physicians

The Affordable Care Act generally allows participants the right to designate any primary care provider who participates in the network and who is available to accept the participant and his or her family members. If the benefit program requires that a primary care provider be designated, but one is not designated, the benefit program or a health insurance issuer will designate one until the participant or family member makes such a designation.

- For children, you may designate a pediatrician as the primary care provider.
- You do not need prior authorization from the Plan 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 our 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.

7. How the Plan Is Administered

Plan Administration

The administration of the Plan is under the supervision of the Plan Administrator. 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 (Third Party Service Providers or TPAs) assume sole responsibility for their performance under applicable policies or administrative services agreements and, under ERISA, may be fiduciaries with respect to their performance.

The principal duty of the Plan Administrator is to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan. The administrative duties of the Plan Administrator include, but are not limited to, interpreting the Plan, prescribing applicable procedures, determining eligibility for and the amount of benefits, and authorizing benefit payments and gathering information necessary for administering the Plan. (However, as noted below, one or more insurance companies may have these responsibilities with respect to fully-insured benefits.)

The Plan Administrator may delegate any of these administrative duties among one or more persons or entities, provided that such delegation is in writing, expressly identifies the delegate(s) and expressly describes the nature and scope of the delegated responsibility. The Plan Administrator has the discretionary authority to interpret the Plan in order to make eligibility and benefit determinations as it may determine in its sole discretion. The Plan Administrator also has the discretionary authority to make factual determinations as to whether any individual is entitled to receive any benefits under the Plan.

Power and Authority of Insurance Company

As detailed in Section 15, certain benefits under the Plan may be fully insured. The insurance companies are responsible for: (1) determining eligibility for and the amount of any benefits payable under their respective benefit programs, and (2) prescribing claims procedures to be followed and the claims forms to be used by employees pursuant to their respective benefit programs.

Questions

If you have any general questions regarding the Plan, or your eligibility for or the amount of any benefit payable under any benefit program, please contact the Plan Administrator or the appropriate insurance company as applicable.

8. Circumstances Which May Affect Benefits

Denial or Loss of Benefits

Your benefits (and the benefits of your eligible spouse and dependents) will cease when your participation in the Plan terminates. See Section 15. Your benefits will also cease on termination of the Plan.

Right to Recover Benefit Overpayments and Other Erroneous Payments

The Plan and its benefit programs (including any insurance company on behalf of a benefit program) have all necessary or helpful rights to subrogation or reimbursement of benefits. If, for any reason, any benefit under the Plan is erroneously paid or exceeds the amount appropriately payable under the Plan, the recipient of such benefit (the "Recipient") shall be responsible for

refunding the overpayment to the Plan or insurance company to the fullest extent permitted by law. In addition, if the Plan or insurance company makes any payment that, according to the terms of the Plan, policy or contract should not have been made, the insurance company, the Plan Administrator, or the Plan Sponsor (or designee) may, to the fullest extent permitted by law, recover that incorrect payment, whether or not it was made due to the insurance company's or Plan Administrator's (or its designee's) own error, from the person to whom it was made or from any other appropriate party.

As may be permitted in the sole discretion of the Plan Administrator or insurance company, the refund or repayment may be made in one or a combination of the following methods: (a) as a single lump-sum payment, (b) as a reduction of the amount of future benefits otherwise payable under the Plan, (c) as automatic deductions from pay, or (d) any other method as may be required or permitted in the sole discretion of the Plan Administrator or the insurance company. The Plan may also seek recovery of the erroneous payment or benefit overpayment from any other appropriate party.

Any benefit payments or reimbursements made by check must be cashed or deposited within one year after the check is issued. If any check or other payment for a benefit is not cashed or deposited within one year of the date of issue, the Plan will have no liability for the benefit payment and the amount of the check will be deemed a forfeiture. No funds will escheat to any state.

9. Amendment or Termination of the Plan

Amendment or Termination

The Plan and any benefit program under the Plan may be amended or terminated at any time, in the sole discretion of the Company as Plan sponsor, by a written instrument signed by an authorized individual. Some benefit programs may also be amended or terminated by an insurance carrier, as more fully described in any attached documents from an insurance carrier. The policies and agreements may also be amended or terminated at any time in accordance with their terms. No individual (including a retired employee) shall have a right to continuing benefits except to the extent required by law.

10. No Contract of Employment

The Plan is not intended to be, and may not be construed as, constituting a contract or other arrangement between you and the Company to the effect that you will be employed for any specific period of time.

11. No Assignment

Except as may otherwise be specifically provided in this Plan, the benefit programs, or applicable law, an individual's rights, interests or benefits under this Plan or the benefit

programs shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution or levy of any kind, either voluntary or involuntary, prior to being received by the persons entitled thereto under the terms of the benefit programs, and any such attempt shall be void.

Specifically, participants and beneficiaries covered under this plan cannot assign their rights to medical providers to pursue direct payment of claims either as the participant or beneficiaries' agent or under power of attorney. Under the terms of this plan, medical providers cannot take action enforcing a patient's right to recover benefits under ERISA or assert any claims under ERISA on behalf of patients, even where the patient(s) have assigned their rights to their medical providers.

12. Claims Procedure

Claims for Fully-Insured Benefits

For purposes of determining of the amount of, and entitlement to, benefits of the benefit programs provided under insurance contracts or policies, the respective insurer is the named fiduciary under the Plan, with the full power to interpret and apply the terms of the Plan as they relate to benefits.

To obtain benefits from the insurer of a benefit program, you must follow the claims procedures under the applicable insurance contract, which may require you to complete, sign and submit a written claim on the insurer's form.

The insurance company will decide your claim in accordance with its reasonable claims procedures as required by ERISA.

See the appropriate certificate of insurance or booklet for details regarding the insurance company's claims procedures. You must fully follow and exhaust these claims procedures before you can file a lawsuit in state or federal court. You may have a right to seek external review of your claims, if so noted in the applicable insurance contract or policy.

Claims for Self-Funded Benefits

For purposes of determining the amount of, and entitlement to, benefits under the benefit programs which are self-funded, the Plan Administrator is the named fiduciary under the Plan, with the full power to make factual determinations and to interpret and apply the terms of the Plan.

To obtain benefits from a benefit program which is self-funded you must complete, execute, and submit to the Plan Administrator a written claim on the form available from the Plan Administrator. The Plan Administrator has the right to secure independent medical advice and to require such other evidence, as it deems necessary to decide your claim.

The Plan Administrator will decide your claim in accordance with reasonable claims procedures, as required by ERISA. You may have a right to seek external review of your claims, if so noted in the applicable attached document for the self-funded benefit program.

See the appropriate benefits description for information about how to file a claim and for details regarding the claims procedures applicable to your claim. You must fully follow and exhaust these claims procedures before you can file a lawsuit in court.

The Role of Authorized Representatives

Under ERISA and the ACA participants and beneficiaries have the right to designate an Authorized Representative for certain purposes. These purposes are generally limited to requesting documents or other information on behalf of a participant or beneficiary or acting on their behalf during claims and appeals procedures that can follow an adverse benefits determination. In any situation that does not constitute an urgent care claim, to designate any third party as an Authorized Representative a participant or beneficiary must use the signed statement included as an appendix of this document with the required witness signature. A medical provider will not become a participant or beneficiary's Authorized Representative as a result of an attempt to secure an assignment of benefits. The Plan does not guarantee that any purported assignment will be valid under the terms of the Plan.

13. Statement of ERISA Rights

This Statement of ERISA Rights applies to those benefit programs which are subject to ERISA. Not all benefit programs which are part of this Plan will be subject to ERISA. The following benefit programs are not subject to ERISA: Cafeteria Plan, Dependent Care FSA.

Your Rights

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

- examine, without charge, at the Plan Administrator's office and at other specified locations, the Plan documents, including insurance contracts, and copies of all documents filed by the Plan with the U.S. Department of Labor (if any) such as annual reports and Plan descriptions;
- obtain copies of the benefit program documents and other program information on written request to the Plan Administrator (the Plan Administrator may make a reasonable charge for the copies);
- 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);
- continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents 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.

Fiduciary Obligations

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

No Discrimination

No one, including the Company or any other person, may fire you or discriminate against you in any way with the purpose of preventing you from obtaining welfare benefits or exercising your rights under ERISA.

Right to Review

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

Filing Suit

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

Any lawsuit must be filed within 36 months of the final decision on the claim. Exhaustion of the internal claims and appeals procedure is required prior to filing suit.

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

Questions

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

14. General Information

COBRA

Benefit programs which provide health benefits generally are subject to the federal law known as COBRA. COBRA generally allows covered participants and beneficiaries to continue in the benefit program, even after a "qualifying event" occurs. For more information about COBRA please see Appendix A. You may also have state law continuation or conversion rights.

Subrogation and Reimbursement

If an individual has a claim for benefits under this Plan or any benefit program, and that individual acquires any right or action against a third party for the person's injury, sickness or other illness which is so covered, then: (a) the Plan shall be entitled to reimbursement for such benefits from such third party up to 100% of the benefits paid by the Plan; and (b) the Plan is automatically subrogated to all such rights or claims of the covered person. The covered person shall cooperate fully with the Plan in the enforcement of the Plan's subrogation and reimbursement rights. In addition, the person shall permit suit to be brought in the person's name under the direction of and at the expense of the Company if the Company so chooses. The Plan shall not be liable for such a person's attorney's fees absent prior written approval from the Plan. The Plan Administrator may require the receipt of a signed and dated subrogation and reimbursement agreement from the person before advancing any monies.

The failure or refusal of a covered person to fully cooperate with the Plan in the enforcement of the Plan's subrogation and reimbursement rights shall result in a forfeiture of all benefits payable to that person, even if such benefits have already been paid, in which event the Company shall retain a right to recover paid benefits which are forfeited in such a manner.

The Company, on behalf of this Plan, shall have a first priority right to recover from and a lien against any payment, whether designated as a payment for medical benefits or any other type of damages, from the proceeds of any recovery, including but not limited to any settlement, award or judgment which results from a claim or lawsuit by or on behalf of a covered person who received benefits under this Plan (even if such covered person is not made whole). The plan is not required to contribute to any expenses or fees (including attorney's fees or costs) incurred in obtaining the funds. The plan's recovery will not be limited or reduced by doctrines (equitable or other) including but not limited to, the make-whole doctrine, contributory or comparative negligence, or the common fund doctrine. The plan's right to full recovery is not reduced if settlement funds or other payments to you are spent or no longer in an individual's possession or control. Notice of the Plan's claim shall be sufficient to establish this Plan's lien against the third party or insurance carrier. The Company shall be entitled to deduct the amount of the lien from any future claims payable to or on behalf of the covered person or payee if the covered person or payee fails to promptly notify the Plan Administrator of a payment received from a third party or insurance carrier that is subject to this Plan's subrogation and reimbursement rights.

In the event that the Plan obtains a recovery against a third party in excess of payments made to or on behalf of the covered person and reasonable out of pocket expenses of the recovery, then the Plan shall pay to the covered person that excess amount recovered by the Plan.

In the event of any direct conflict between this Section 14 and the subrogation and reimbursement provisions in any benefit program, the subrogation and reimbursement provisions in the benefit program shall control. Otherwise, the provisions of this Section 14 shall apply and may supplement those contained in any benefit program.

The above provisions of this "Subrogation and Reimbursement" section apply with respect to a benefit program that is self-funded and does not, in its governing documents (but excluding this Plan document) have a subrogation and reimbursement section. If the benefit program does have such a section that section shall control. With respect to a fully-insured benefit program, the contract or policy from the insurer shall control with respect to subrogation and reimbursement matters.

No Vesting of Benefits

Nothing in the Plan, nor anything in any benefit program, shall be construed as creating any vested rights to benefits in favor of any employee, former employee or covered person.

Waiver and Estoppel

No term, condition, or provision of this Plan or any benefit program shall be deemed to be waived, and there shall be no estoppel against enforcing any provision of the Plan or benefit program, except through a writing of the party to be charged by the waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless explicitly made so, and shall operate only with regard to the specific term or condition waived, and shall not be deemed to waive such term or condition in the future, or as to any act other than as specifically waived. No covered person other than as named or described by class in the waiver shall be entitled to rely on the waiver for any purposes.

Effect on Other Benefit Plans

Amounts credited or paid under this Plan or any benefit program shall not be considered to be compensation for purposes of any benefit program hereunder or any qualified or nonqualified pension plan maintained by the Company unless expressly provided in such benefit program or qualified or nonqualified pension plan, as applicable, or if required by applicable law. The treatment of amounts paid under this Plan or any benefit program for purposes of any other employee benefit plan maintained by the Company shall be determined under the provisions of the applicable employee benefit plan.

Severability

If any provision of this Plan or any benefit program is held by a court of competent jurisdiction to be invalid or unenforceable, the remaining provisions hereof shall continue to be fully effective.

Rebates

In some situations, a rebate may be paid by an insurance company which provides coverage under the Plan. For example, a rebate may be provided under the Medical Loss Ratio ("MLR") rules, which are part of the Affordable Care Act. Except as specifically and unambiguously provided in a Benefit Description, or as otherwise required by applicable law, any rebate from any source will be:

☐ Considered an asset of the Company, not the Plan. The Company does not need to use such a rebate to benefit Employees, participants or beneficiaries. The Company can use such a rebate for the Company's own purposes

☒ An asset of the Plan in proportion to how much of the rebate relates to Employee, participant, or beneficiary contributions. The portion relating to Company contributions shall not be considered a Plan asset. The Company will have the ability to make certain assumptions or minor changes (such as rounding to the nearest $1 or $10) when determining the amount which is considered a plan asset. The Company shall have discretion to determine how to use all amounts. Amounts which are plan assets will be used to benefit individuals selected by the Company. This group of individuals may not be identical to the group which relates to the rebate. In addition, certain individuals can receive the rebate (or the benefit of the rebate) even if the rebate related to a different benefit, to the extent allowed by applicable law.

☐ The entire amount shall be an asset of the Plan, to be used for the benefit of individuals covered by the Plan.

In all situations where ERISA applies the use of any ERISA-covered plan assets will be governed by applicable law, including but not limited to U.S. Department of Labor Technical Release 2011-04.

Controlling Law

This Plan shall be administered, construed, and enforced according to the federal law and the laws of the State of California, to the extent not preempted by federal law. However, with respect to a fully-insured benefit program, the applicable insurance policy or contract will control with respect to which state's laws apply.

15. Benefit Program Information

Summary of Eligibility and Participation Provisions

Note: If you have any questions about eligibility or participation, contact the Plan Administrator

Benefit Program[3]	Fully-insured or self-funded? if fully-insured, carrier name	Policy or Group #, if fully-insured	Who is eligible[2]	When Participation begins	When Participation Ends[1]	To File a Claim, Contact:
Medical OAP and CDHP	Self-Funded / Cigna	3337061	Full time employees working 30+ hours per week. Spouses and children generally are covered.	Immediately upon hire.	At the end of the month in which coverage is dropped or employment is terminated. Continuation coverage usually is available.	PO Box 182223 Chattanooga, TN 37422 (800) 244-6224
Medical HMO	Fully-Insured / Kaiser	603351	Full time employees working 30+ hours per week. Spouses and children generally are covered.	Immediately upon hire.	At the end of the month in which coverage is dropped or employment is terminated. Continuation coverage usually is available.	PO Box 12923 Oakland, CA 94604 (800) 390-3510
Family Planning Health Reimbursement Arrangement	Self-Funded / Kindbody	N/A	Full time employees working 30+ hours per week. Spouses and children generally are covered.	Immediately upon hire.	At the end of the month in which coverage is dropped or employment is terminated. Continuation coverage usually is available.	(800) 310-6301
Dental PPO	Self-Funded / Cigna	3337061	Full time employees working 30+ hours per	Immediately upon hire.	At the end of the month in which	PO Box 188037 Chattanooga, TN 37422

[1] Other Events (such as fraud or intentional misrepresentation of a material fact) can also terminate coverage -- see the benefit program details.
[2] Please consult carrier documentation for further details regarding which family members are eligible to participate in each of the above coverages. For more information on eligibility and hours calculation please contact the Plan Administrator or Human Resources.
[3] The health flexible spending account and DCAP provisions in the Section 125 plan are NOT part of this welfare benefit plan or summary plan description.

Benefit Program[3]	Fully-insured or self-funded? if fully-insured, carrier name	Policy or Group #, if fully-insured	Who is eligible[2]	When Participation begins	When Participation Ends[1]	To File a Claim, Contact:
			week. Spouses and children generally are covered.		coverage is dropped or employment is terminated. Continuation coverage usually is available.	(859) 410-2422
Vision	Self-Funded / Vision Service Plan (VSP)	30026566	Full time employees working 30+ hours per week. Spouses and children generally are covered.	Immediately upon hire.	At the end of the month in which coverage is dropped or employment is terminated. Continuation coverage usually is available.	PO Box 385018 Birmingham, AL 35238 (800) 877-7195
Mental Health Counseling and Therapy and Employee Assistance Program	Fully-Insured / Modern Health and Workplace Options	N/A	Full-time employees working 30+ hours per week.	Immediately upon hire.	At the end of the month in which coverage is dropped or employment is terminated. Continuation coverage usually is available.	576 Sacramento St. San Francisco, CA 94111 help@modernhealth.com
Life and Accidental Death and Dismemberment	Fully-Insured / New York Life	FLX967393; OK968911	Full-time employees working 30+ hours per week.	Immediately upon hire.	Date of termination.	PO Box 22328, Pittsburgh, PA 15222 (877) 300-6770
Long-Term Disability	Fully-Insured / New York Life	LK965073	Full-time employees working 30+ hours per week.	Immediately upon hire.	Date of termination.	PO Box 709015, Dallas, TX 75370 (800) 238-2125
Legal	Fully-Insured / MetLife	9903737	Full-time employees working 30+ hours per week.	Immediately upon hire.	End of the month following date of termination.	1111 Superior Avenue Cleveland, Ohio 44114 (800) 821-6400

Additional Information on ACA FT Status Determination

Under the ACA, employers are required to report specific benefits information to IRS on "full-time" employees as defined by the ACA. A "full-time" employee is generally an employee who works on average 130 hours per month. ACA full-time status can affect or determine major medical benefits eligibility but is not a guarantee of benefits eligibility.

New employees hired to work full-time. If you are hired as a new full-time employee (work on average 130 or more hours a month), you and your dependents are generally eligible for group health plan coverage as of your date of hire.

New employees hired to work a part-time, variable hour or seasonal schedule. If you are hired into a part-time position, a position where your hours vary and Pixar is unable to determine — as of your date of hire — whether you will be a full-time employee (work on average 130 or more hours a month), or you are hired as a seasonal employee who will work for six (6) consecutive months or less (regardless of monthly hours worked), you will be placed in an initial measurement period (IMP) of 12 months to determine whether you are a full-time employee. Your 12-month IMP will begin on the first of the month following your date of hire and will last for 12 months. If, during your IMP, you average 130 or more hours a month over that 12-month period, you will be full time and, if otherwise eligible for benefits, you will be offered coverage by the first of the second month after your IMP ends. Your full-time status will remain in effect during an associated stability period that will last 12 months from the date that status is determined. If your employment is terminated during that stability period, and you were enrolled in benefits, you will be offered coverage under COBRA.

Ongoing employees. Pixar uses the look-back measurement method to determine [group health /medical/health] plan eligibility for ongoing employees. An ongoing employee is an individual who has been employed for an entire standard measurement period. A standard measurement period is the 12-month period of time over which [Employer/plan sponsor name] counts employee hours to determine which employees work full-time. An employee is deemed full-time if he or she averages 130 or more hours a month over the 12-month standard measurement period. Those employees who average 130 or more hours a month over the 12-month standard measurement period will be full time and, if otherwise eligible for benefits, offered coverage as of the first day of the stability period associated with the standard measurement period. Full-time status will be in effect for a 12-month stability period. If your employment is terminated during a stability period, and you were enrolled in benefits, you will be offered continued coverage under COBRA.

Pixar uses the standard measurement period and associated stability period annual cycle set forth below.

PLAN YEAR	MEASUREMENT PERIOD	ADMIN PERIOD	STABILITY PERIOD
Aug 1	Jun 1 – May 31	Jun 1 – Jul 31	Aug 1 – Jul 31

Appendix A: COBRA Continuation

Sample Employee
123 Main St.
Anywhere, GA 12345

Re: Important General Notice of COBRA Continuation Coverage Rights Pixar-101309

To: Sample Employee and Eligible Covered Dependents (if applicable)

This Notice is provided for your information only. You are receiving this notice because you recently gained coverage through the group health plan benefits sponsored by Pixar (the "Plan(s)"). Pixar has retained WageWorks, Inc. to assist with its COBRA administration. The following information about your rights and obligations under a federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA) is very important. While no action or response is required unless you or your eligible dependent(s) experience a loss of coverage under the Plan(s), both you and your covered spouse (if applicable) should read this summary of rights very carefully, retain it with other Plan(s) documents, and refer to it in the event that any action is required on your part.

COBRA requires that most employers providing group health plans offer participants and/or their covered family members the opportunity for a temporary extension of group health plan coverage ("COBRA coverage") at group rates under certain circumstances when coverage under the Plan(s) would otherwise end. COBRA (and the description of COBRA coverage contained in this notice) generally applies only to the group health plan benefits offered under the Plan(s) - such as any major medical, dental, vision, health flexible spending account ("Health FSA"), or any other employer-sponsored Plan(s) component which provides medical care - and not to any other benefits offered under the Plan(s) or by Pixar (e.g., life insurance).

This notice generally explains COBRA coverage, when it may become available to you and/or your family, and what you need to do to protect your right to receive it. This notice does not fully describe COBRA coverage or other rights under the Plan(s). You will find a more detailed summary of your rights and obligations under COBRA in the applicable group health plan Summary Plan Description(s) (SPD) and from the Plan Administrator. For additional information about your rights and obligations under the Plan(s) and under federal law, you should review the Plan(s) SPD, contact the Plan Administrator identified in that SPD, or you can contact WageWorks, Inc.

You may have other options available to you when you lose group health plan coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace ("Marketplace"). By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. You can learn more about many of these options at www.HealthCare.gov. In addition, 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 does not accept late enrollees.

What is COBRA Coverage?
COBRA coverage is continuation of coverage under the Plan(s) by qualified beneficiaries who lose coverage as a result of certain qualifying events (described below). After a qualifying event occurs and any required notice of that event is properly provided to the Plan Administrator, COBRA coverage must be offered to individuals who lose coverage under the Plan(s) and are qualified beneficiaries.

A qualified beneficiary is any of the following who are covered under the Plan(s) on the day before a qualifying event (1) the employee (including retired employee), (2) the employee's spouse (including the spouse of a retired employee), and/or (3) a dependent child (as defined by the Plan(s)) (including the dependent child of a retired employee). Also, a child who is born to, adopted by, or placed for adoption with a covered employee during a COBRA coverage period is considered a qualified beneficiary if enrolled in accordance with the terms of the Plan(s).

A child of the covered employee receiving benefits pursuant to a qualified medical child support order (QMCSO), if enrolled in accordance with the terms of the Plan(s), is entitled to the same rights to elect COBRA coverage as any other covered dependent child.

You do not have to show that you are insurable to elect COBRA coverage. Under the Plan(s), however, qualified beneficiaries who elect COBRA coverage must pay for COBRA coverage. Generally, a qualified beneficiary will have to pay 102 percent of the "applicable premium" (as defined in COBRA) for your COBRA coverage (and possibly up to 150 percent of the "applicable premium" during the 11-month disability extension [see "Disability Extension of an 18-Month COBRA Coverage Period," below]). The "applicable premium" is the total cost of coverage to the Plan(s), as determined in accordance with COBRA. The first COBRA premium is due 45 days after the date you make your COBRA coverage election. All subsequent premiums are typically due the first day of each month with a 30-day grace period by which a complete premium must be made.

The law also requires that, at the end of the 18-, 29-, or 36-month COBRA coverage period, you must be allowed to enroll in an individual conversion health plan provided under the current group health plan, if the plan provides a conversion privilege.

What is a Qualifying Event?

If you are a covered employee, you may elect COBRA coverage if you lose coverage under the Plan(s) because of either one of the following qualifying events: (1) your hours of employment are reduced; or (2) your employment ends for any reason (other than gross misconduct on your part).

If you are the covered spouse of a covered employee (including the spouse of a retired employee), you may elect COBRA coverage if you lose coverage under the Plan(s) because of any of the following qualifying events: (1) the covered employee dies; (2) the covered employee's hours of employment are reduced; (3) the covered employee's employment ends (for reasons other than gross misconduct); (4) the covered employee becomes entitled to Medicare under Part A, Part B, or both (typically, this will not be a qualifying event for spouses of active employees due to the Medicare Secondary Payer rules); or (5) you and the covered employee divorce or legally separate. Also, if the covered spouse's coverage is reduced or dropped by the covered employee in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for the spouse even though the coverage was canceled or reduced before the divorce or legal separation. If the ex-spouse notifies the Plan Administrator within 60 days after the divorce or legal separation and the Plan Administrator determines, at its sole discretion based on the applicable facts and circumstances, that the coverage was dropped in anticipation of the divorce or legal separation, then COBRA coverage may be available beginning with the date of the divorce or legal separation (if properly elected).

For a covered dependent child of the covered employee (including the dependent child of a retired employee), you may elect COBRA coverage if you lose coverage under the Plan(s) because of any of the following qualifying events: (1) the covered employee dies; (2) the covered employee's hours of employment are reduced; (3) the covered employee's employment ends (for reasons other than gross misconduct); (4) the covered employee becomes entitled to Medicare under Part A, Part B, or both (typically, this will not be a qualifying event for dependent children of active employees due to the Medicare Secondary Payer rules); (5) the covered employee and his/her spouse divorce or legally separate; or (6) you cease to be eligible for coverage under the Plan(s) as a "dependent child."

Covered retired employees, covered spouses of retired employees, surviving spouses of retired employees, and covered dependent children of retired employees also have a right to elect COBRA coverage if coverage is lost within one year before or after the commencement of proceedings under Title 11 (bankruptcy), United States Code.

How is COBRA Coverage Provided?

Pixar is obligated to notify the Plan Administrator of the occurrence of these qualifying events: (1) the reduction in hours of an employee's employment; (2) the termination of the employee's employment (for reasons other than his or her gross misconduct); (3) the death of the employee; (4) the commencement proceedings under Title 11 (bankruptcy), United States Code with respect to the employer (in the case of retiree coverage only); or (5) the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

You must give notice of some qualifying events. For the other qualifying events (i.e., divorce or legal separation of the employee and a covered dependent child losing eligibility for coverage under the Plan(s) as a "dependent child"), a COBRA election will be available to you only if you notify the Plan Administrator in accordance with the notice procedures described in the section of this notice titled "Notice Procedures for All Required Notices from

Qualified Beneficiaries," unless other procedures are specified in the most recent SPD. Contact Pixar, to request a copy of your SPD. Such notice must be provided no later than 60 days after the date of the qualifying event or the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan(s) as a result of the qualifying event, whichever is later. If you fail to provide a timely qualifying event notice in accordance with the notice procedures specified in this notice (or the procedures specified in the most recent SPD, if those are different), the qualified beneficiaries will lose their right to a COBRA election. If any claims are mistakenly paid for expenses incurred after the qualifying event, then you and your eligible dependent(s) will be required to reimburse the Plan(s) for any claims so paid.

How do Qualified Beneficiaries Elect COBRA Coverage?
When the Plan Administrator is notified that one of these events has happened, notice of your right to elect COBRA will be provided.

Each qualified beneficiary has an independent right to make a COBRA election. Covered employees and covered spouses (if the spouse is a qualified beneficiary) may elect COBRA coverage on behalf of all the qualified beneficiaries, and parents or legal guardians (whether qualified beneficiaries or not) may elect COBRA coverage on behalf of their covered minor children who are qualified beneficiaries. However, a qualified beneficiary employee or spouse may not decline COBRA coverage on behalf of his or her covered spouse or an adult covered dependent child (if the spouse or adult covered dependent child is a qualified beneficiary).

Under the law, you will have 60 days from the later of the date you would lose coverage under the Plan(s) or the date the COBRA Election Notice is provided. Any qualified beneficiary for whom COBRA coverage is not timely elected, will lose COBRA coverage election rights.

How Long Does COBRA Coverage Last?
Unless specifically stated otherwise in the applicable SPD, COBRA coverage is measured from the date of the qualifying event, even if coverage is not immediately lost.

In the case of a loss of coverage due to the covered employee's termination of employment or reduction in hours of the covered employee's employment, COBRA coverage may generally last for up to 18 months.

In the case of all other qualifying events (except the commencement of proceedings under Title 11 (bankruptcy), United States Code), COBRA coverage may last for up to 36 months.

If retiree coverage is lost within one year before or after the commencement of proceedings under Title 11 (bankruptcy), United State Code, COBRA coverage may last for the retired employee for life; COBRA coverage may last for the covered spouse and dependent children of the retired employee's for the life of the retiree (and if they survive the retired employee, for 36 months after the retired employee's death); and, if the retired employee is not living when the qualifying event occurs, but the retired employee's surviving spouse is covered by the Plan(s), then COBRA coverage may last for the surviving spouse for life.

If the covered employee becomes entitled to Medicare benefits (under Part A, Part B, or both) less than 18 months before a termination or reduction in hours of employment, COBRA coverage for qualified beneficiaries (other than the employee) who lose coverage as a result of the qualifying event can last up to 36 months from the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which her employment ends, COBRA coverage for her spouse and children who lost coverage as a result of the qualifying event can last up to 36 months from the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

COBRA coverage under a Health FSA may only last through the end of the plan year in which the qualifying event occurs, except for a grace period or carryover applicable to the plan year (unless stated otherwise in the group health plan SPD). In addition, you may not be able to elect COBRA coverage if the reimbursement available at the time of the qualifying event is less than the COBRA premium required to continue coverage through the end of the plan year.

The COBRA periods described above are maximum coverage periods. The law provides that COBRA coverage may be terminated prior to the end of the maximum coverage periods described in this notice for several reasons (please consult the Plan(s) applicable SPD for more information).

There are two ways in which the 18-month COBRA period of coverage resulting from a covered employee's termination of employment or reduction in hours of employment may be extended. (NOTE: The period of COBRA coverage under a Health FSA generally cannot be extended beyond the end of the plan year.)

Disability Extension of an 18-Month COBRA Coverage Period

If a qualified beneficiary is determined by the Social Security Administration ("SSA") to have been disabled under Title II or XVI of the Social Security Act, all of the covered qualified beneficiaries may be entitled to receive an additional 11 months of COBRA coverage, for a maximum of 29 months. This extension is only available for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the covered employee's termination of employment or reduction of hours. This disability must have started prior to or within the first 60 days of the COBRA period and must last at least until the end of the period of COBRA coverage that would otherwise be available without the disability extension (generally 18 months, as described above). The disability extension is only available if you notify WageWorks, Inc. in a timely fashion (described in the next paragraph). All qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the covered employee's termination of employment or reduction in hours may be eligible to receive up to an additional 11 months of COBRA coverage (for a total of 29 months).

The disability extension is available only if you notify WageWorks, Inc. of the SSA's determination of disability within 60 days after the latest of (1) the date of the determination of disability by the SSA; (2) the date of the covered employee's termination or reduction in hours of the covered employee's employment; (3) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the plan as a result of the covered employee's termination or reduction in hours of the covered employee's employment; or (4) the date that you receive this notice or the SPD. Notwithstanding the 60-day period, you must provide notice of the SSA's determination of disability prior to the end of the 18-month continuation period (irrespective of when the 60-day period would otherwise end).

To provide notice of the SSA's determination of disability, you must mail the SSA determination document to WageWorks, Inc. The SSA determination document must include the date you became disabled. If the date is not on your documentation, you must contact your local SSA office to obtain this information to send to WageWorks, Inc. in order to apply for the 11-month extension.

The Plan(s) can charge up to 150 percent of the applicable premium during the 11-month extension in most circumstances. The disabled individual must notify the employer within 30 days of any final determination that he or she is no longer disabled. If COBRA coverage is extended to a total of 29 months, extended COBRA coverage will cease on the first day of the month that begins more than 30 days after the SSA's notice that the qualified beneficiary is no longer disabled.

Second Qualifying Event Extension of COBRA Coverage

If a qualified beneficiary who is a covered spouse or covered dependent child experiences another qualifying event during the first 18 months of COBRA coverage (because of the covered employee's termination of employment or reduction in hours) or during an 11-month disability extension period (see "Disability Extension of an 18-Month COBRA Coverage Period," above), this qualified beneficiary receiving COBRA coverage may receive up to 18 additional months of COBRA coverage (for a total of 36 months from the original qualifying event), if notice of the second qualifying event is provided in accordance with applicable notice procedures.

This extension may be available to the covered spouse and any covered dependent children receiving COBRA coverage if the employee/former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the covered dependent child stops being eligible under the Plan(s) as a "dependent child," but only if the event would have caused the spouse or dependent child to lose coverage under the Plan(s) had the first qualifying event not occurred.

Notice Procedures for all Required Notices from Qualified Beneficiaries

As described earlier in this notice, you must provide notice of certain qualifying events. Notices of these qualifying events must be sent to the Plan Administrator in writing to Pixar, 1200 Park Ave., Emeryville, CA 94608.

In addition, as described earlier in this notice, you must provide notice of the SSA's determination of disability and certain second qualifying events. These notices must generally be sent to WageWorks, Inc. in writing (by mail or electronic transmittal [e.g. facsimile]) to WageWorks, Inc., P.O. Box 223684, Dallas, TX 75222-3684; or Fax#: 866-450-5634.

If a different address and/or procedures for providing notices to the Plan(s) appear in the most recent SPD, you must follow those notice procedures or deliver your notice to that address.

Oral notice (including notice by telephone) is not acceptable.

Any notice you provide to WageWorks, Inc. must contain the name of the Plan(s) (the group health plan benefits sponsored by Pixar); the name, WageWorks, Inc. account number or Social Security number, and address of the employee/former employee who is or was covered under the Plan(s); the name(s) and address(es) of all qualified beneficiaries who lost or will lose coverage as a result of the qualifying event (if applicable); the qualifying event (e.g. divorce or legal separation, child's loss of dependent status, death of the covered employee) (if applicable) and the certification, signature, name, address, and telephone number of the person providing the notice.

Any notice you provide to the Plan Administrator must also contain the information indicated directly above, unless other procedures are specified in the most recent SPD. Contact Pixar to request a copy of your SPD.

The employee/former employee who is or was covered under the Plan(s), a qualified beneficiary who lost coverage due to the qualifying event described in the notice, or a representative acting on behalf of either may provide the notices. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who lost coverage due to the qualifying event described in the notice.

Special Rules for Leaves of Absence Due to Services in the Uniformed Services

If a covered employee takes a leave of absence to perform services in the Uniformed Services (as addressed in the Uniformed Services Employment and Reemployment Act [USERRA]) that is expected to last 31 days or more, the covered employee may be able to continue health coverage for the employee and any covered dependents until the earlier of 24 months from the date the leave began or the date the employee fails to return to or apply for work as required under USERRA. The cost to continue this coverage for periods lasting 31 days or more is 102 percent of the applicable premium. The USERRA continuation period will run concurrent with the COBRA period described herein. Notwithstanding anything to the contrary in this notice, the rights described in this notice apply only to the COBRA continuation period. Continuation of coverage following a military leave of absence covered under USERRA will be administered in accordance with the requirements of USERRA.

Are There Other Coverage Options Besides COBRA Coverage?

Yes. Instead of enrolling in COBRA Coverage, there may be other coverage options for you and your family through the Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA Coverage. You can learn about many of these options at www.HealthCare.gov.

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 initial enrollment period for Medicare Part A or B, you have an 8-month special enrollment period[1] to sign up, beginning or the earlier of

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

If you don't enroll in Medicare Part Band 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 then enroll in Medicare Part A or B before the COBRA continuation coverage

1 These rules are different for people with End Stage Renal Disease (ESRD). Please visit https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods for more information.

ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date on 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 will pay second. Certain COBRA continuation coverage 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.

Keep the Plan(s) Informed of Address Changes

To protect your family's rights, it is important that you keep the Plan Administrator informed of any changes in your or your family members' addresses. In such an event, please notify Pixar, 1200 Park Ave. Emeryville, CA 94608. You should also keep a copy, for your records, of any notices you send to the Plan Administrator and/or WageWorks, Inc.

If You Have Questions

Questions concerning the Plan(s) should be addressed to Pixar, 1200 Park Ave. Emeryville, CA 94608. For additional information about your COBRA rights and obligations under federal law, please review the Plan(s) SPD, contact the Plan Administrator identified in the SPD, or you can contact WageWorks, Inc. at 888-678-4881 or you can go to mybenefits.wageworks.com.

In addition, you may obtain more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), the Patient Protection and Affordable Care Act, and other laws affecting group health plans, by contacting the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. Addresses and phone numbers of Regional and District EBSA offices are available through the EBSA website. For more information about the Marketplace, visit www.HealthCare.gov.

Appendix B: Medicare Part D

Medicare Part D Notice

Important Notice from Pixar About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Pixar and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Pixar has determined that the prescription drug coverage offered by the Pixar Group Health and Welfare Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your Pixar coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Since the existing prescription drug coverage under Pixar Group Health and Welfare Plan is creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your Pixar prescription drug coverage, be aware that you and your dependents can only get this coverage back at open enrollment or if you experience an event that gives rise to a HIPAA Special Enrollment Right.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Pixar and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Pixar changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call 800-MEDICARE (800-633-4227). TTY users should call 877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at socialsecurity.gov, or call them at 800-772-1213 (TTY 800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	August 1, 2022
Name of Entity/Sender:	Pixar
Contact-Position/Office:	Benefits Department
Address:	1200 Park Ave., Emeryville, CA 94608
Phone Number:	(510) 922-4065

Appendix C: Cafeteria Plan and FSA Provisions

During the Election Period prior to each Plan Year, each Participant shall be given the opportunity to elect which Benefit options he or she wishes to participate in. Those elections are irrevocable for the Plan Year, except as provided below and subject to Internal Revenue Code Consistency Rule requirements. You can change your elections only if you come forward within 30 days of an event described below (note the 60 day exception under item (b)). An Employee who elects not to participate for the Plan Year following the Election Period will generally have to wait until the next Election Period before again electing to participate in the Plan, except as provided below in item (b) and, subject to applicable facts and circumstances, items (e), (g), and (j) .

(a) **Changes in Status.** You are permitted to change elections if you have a "change in status" and you make an election change that is consistent with the change in status. Currently, Federal law considers the following events to be a change in status

(1) Legal Marital Status: events that change a Participant's legal marital status, including marriage, divorce, death of a Spouse, legal separation or annulment;

(2) Number of Dependents: Events that change a Participant's number of Dependents, including birth, adoption, placement for adoption, or death of a Dependent;

(3) Employment Status: Any of the following events that change the employment status of the Participant, Spouse, or Dependent: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, or a change in worksite. In addition, if the eligibility conditions of this Plan or other employee benefit plan of the Employer of the Participant, Spouse, or Dependent depend on the employment status of that individual and there is a change in that individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under the plan, then that change constitutes a change in employment under this subsection;

(4) Dependent satisfies or ceases to satisfy the eligibility requirements: An event that causes the Participant's Dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age or any similar circumstance; and

(5) Residency: A change in the place of residence of the Participant, Spouse or Dependent, that would lead to a change in status (such as a loss of HMO coverage).

For the Dependent Care Flexible Spending Account, a Dependent becoming or ceasing to be a "Qualifying Dependent" as defined under Code Section 21(b) shall also qualify as a change in status.

(b) **HIPAA Special enrollment rights.** Participants may change an election for major medical coverage (and any other non-excepted benefit) during a Plan Year and make a new election that corresponds with the special enrollment rights provided for under HIPAA including:

(1) Loss of health coverage.

(2) Acquisition of new dependent by marriage, birth, adoption, or placement for adoption.

(3) Loss of coverage due to loss of eligibility for Medicaid or CHIP.

(4) Eligibility for premium assistance under Medicaid or CHIP.

For items (3) and (4) individuals must request enrollment not later than 60 days after the loss of eligibility for Medicaid or CHIP or determination of eligibility for premium assistance.

(c) **Qualified Medical Support Order**. In the event of a judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order defined in ERISA) which requires accident or health coverage for a Participant's child (including a foster child who is a Dependent of the Participant):

(1) The Plan may change an election to provide coverage for the child if the order requires coverage under the Participant's plan; or

(2) The Participant shall be permitted to change an election to cancel coverage for the child if the order requires the former Spouse to provide coverage for such child, under that individual's plan and such coverage is actually provided.

(d) **Medicare or Medicaid**. A Participant may change elections to cancel accident or health coverage for the Participant or the Participant's Spouse or Dependent if the Participant or the Participant's Spouse or Dependent is enrolled in the accident or health coverage of the Employer and becomes entitled to coverage (i.e., enrolled) in Medicare or Medicaid, other than coverage consisting solely of the distribution of pediatric vaccines. If the Participant or the Participant's Spouse or Dependent who has been entitled to Medicaid or Medicare coverage loses eligibility, that individual may prospectively elect coverage under the Plan.

(e) **Cost increase or decrease.** If the cost of a Benefit provided under the Plan increases or decreases during a Plan Year, then the Plan shall automatically increase or decrease, as the case may be, the Salary Redirections of all affected Participants for such Benefit. Alternatively, if the cost of a benefit package option increases significantly, the Administrator shall permit the affected Participants to either make corresponding changes in their payments or revoke their elections and, in lieu thereof, receive on a prospective basis coverage under another benefit package option with similar coverage, or drop coverage prospectively if there is no benefit package option with similar coverage.

A cost increase or decrease refers to an increase or decrease in the amount of elective contributions under the Plan, whether resulting from an action taken by the Participants or an action taken by the Employer.

(f) **Significant Coverage Curtailment.** If the coverage under a Benefit is significantly curtailed or ceases during a Plan Year, affected Participants may revoke their elections of such Benefit and, in lieu thereof, elect to receive on a prospective basis coverage under another plan with similar coverage, or drop coverage prospectively if no similar coverage is offered.

(g) **Addition or Significant Improvement of Benefit Package Option.** If, during the period of coverage, a new benefit package option or other coverage option is added, an existing benefit package option is significantly improved, or an existing benefit package option or other coverage option is eliminated, then the affected Participants may elect the newly-added option, or elect another option if an option has been eliminated prospectively and make corresponding election changes with respect to other benefit package options providing similar coverage. In addition, those Eligible Employees who are not participating in the Plan may opt to become Participants and elect the new or newly improved benefit package option.

(h) **Loss of coverage under certain other plans.** A Participant may make a prospective election change to add group health coverage for the Participant, the Participant's Spouse or Dependent if such individual loses group health coverage sponsored by a governmental or educational institution, including a state children's health insurance program under the Social Security Act, the Indian Health Service or a health program offered by an Indian tribal government, a state health benefits risk pool, or a foreign government group health plan.

(i) **Change of coverage due to change under certain other plans.** A Participant may make a prospective election change that is on account of and corresponds with a change made under the plan of a Spouse's, former Spouse's or Dependent's employer if (1) the cafeteria plan or other benefits plan of the Spouse's, former Spouse's or Dependent's employer permits its participants to make a change; or (2) the cafeteria plan permits participants to make an election for a period of coverage that is different from the period of coverage under the cafeteria plan of a Spouse's, former Spouse's or Dependent's employer.

(j) **Change in dependent care provider.** A Participant may make a prospective election change that is on account of and corresponds with a change by the Participant in the dependent care provider. The availability of dependent care services from a new childcare provider is similar to a new benefit package option becoming available. A cost change is allowable in the Dependent Care Flexible Spending Account only if the cost change is imposed by a dependent care provider who is not related to the Participant.

(k) **Health FSA election cannot change due to a cost or coverage change.** A Participant shall not be permitted to change an election to the Health Flexible Spending Account as a result of a cost or coverage change under any health insurance benefits as described above in items (e), (f), and (g).

(l) **Changes due to reduction in hours or enrollment in an Exchange Plan.** A Participant may prospectively revoke coverage under the group health plan (that is not a health Flexible Spending Account) which provides minimum essential coverage provided the following conditions are met:

Conditions for revocation due to reduction in hours of service:

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

(2) The revocation of coverage under the group health plan corresponds to the intended enrollment of the Participant, and any related individuals who cease coverage due to the revocation, in another plan that provides minimum essential coverage with the new coverage effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

The Administrator may rely on the reasonable representation of the Participant who is reasonably expected to have an average of less than 30 hours of service per week for future periods that the Participant and related individuals have enrolled or intend to enroll in another plan that provides minimum essential coverage for new coverage that is effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

Conditions for revocation due to enrollment in a Qualified Health Plan:

(1) The Participant is eligible for a Special Enrollment Period to enroll in a Qualified Health Plan through a Marketplace (federal or state exchange) pursuant to guidance issued by the Department of Health and Human Services and any other applicable guidance, or the Participant seeks to enroll in a Qualified Health Plan through a Marketplace during the Marketplace's annual open enrollment period; and

(2) The revocation of the election of coverage under the group health plan corresponds to the intended enrollment of the Participant and any related individuals who cease coverage due to the revocation in a Qualified Health Plan through a Marketplace for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

The Administrator may rely on the reasonable representation of a Participant who has an enrollment opportunity for a Qualified Health Plan through a Marketplace that the Participant and related individuals have enrolled or intend to enroll in a Qualified Health Plan for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

Appendix D: Summary of Material Modifications

This memo constitutes a Summary of Material Modifications (SMM) to the Pixar Group Health and Welfare Plan. It is meant to supplement and/or replace certain information in the SPD, so retain it for future reference along with your SPD. Please share these materials with your covered family members.

The Pixar Group Health and Welfare Plan sponsored by Pixar has been revised as follows:

Effective August 1, 2022

1. The Cigna medical HDHP 1 and HDHP 2 plans will cover eligible transportation and lodging expenses after the annual plan deductible if you need to travel to seek covered medical care because access is limited when you live. A lifetime dollar maximum of $10,000 per member applies to travel reimbursement except as otherwise outlined in the Cigna plan documents. This benefit is subject to the limitations outlined below.

   What is covered?

   - The Cigna travel benefit program helps you pay for eligible transportation and lodging expenses for any covered medical service under the Cigna plan in which access to a provider is limited. Travel is covered for:
     - Consultation and diagnostic tests provided at the approved facility or provider prior to the procedure or treatment.
     - The procedure or treatment.
     - Follow-up care as medically appropriate.
     - Eligible travel expenses such as gas, car rental, tolls, taxi/Uber, air travel, and hotels.
   - Travel is covered for you and, depending on the nature of the services, for your companion/caregiver. It will be covered until you reach the maximum benefit amount (specified in your plan document) or you are no longer eligible for coverage.

Availability

- Covers travel to in-network participating providers when you cannot find an available in-network provider within 100 miles of your primary home residence

How does it work?

- Contact Cigna to review coverage before you travel. After traveling, simply complete and submit an expense form with the original itemized receipts from travel and lodging expenses incurred for medical procedures and/or treatments where travel was required.

Except as outlined above, your benefits remain unchanged.

Effective May 11, 2023

Both the National Emergency and Public Health Emergency will end on May 11, 2023, impacting the expiration of many rules stemming from the COVID-19 federal emergency declarations. Information below summarizes the timing of when important rules will be phased out.

- On April 28, 2020, Multi-Agency guidance extended certain deadlines that apply to group health plans that fall within the COVID-19 outbreak period beginning **March 1, 2020**. Those deadlines included and were limited to the following:

    - The 30-day period to request special enrollment under HIPAA (or 60-day period as applicable to CHIP enrollment requests);
        - employees, spouses, and new dependents are allowed to enroll upon marriage, birth, adoption, or placement for adoption;
        - employees and dependents are allowed to enroll if they had declined coverage due to other health coverage and then lose eligibility or lose all employer contributions towards active coverage;
        - employees and their dependents are allowed to enroll upon loss of coverage under a state Children's Health Insurance Program (CHIP) or Medicaid or who are eligible to receive premium assistance under those programs;
    - The 60-day election period for COBRA continuation coverage;
    - The deadline for making COBRA premium payments;
    - The 60-day deadline for individuals to notify a plan of a COBRA qualifying event or determination of disability;
    - The deadline for individuals to file an ERISA benefit claim under the plan's claims procedure (including a H-FSA run out period deadline that ends during the outbreak period); or
    - The deadline for claimants to file an appeal of an adverse benefit determination, a request for an external review, and to file information related to a request for external review for an ERISA plan.

The period that these deadlines can be tolled was limited to the earlier of one year from the date an individual was first eligible for relief, or 60 days after the announced end of the National Emergency. Therefore, all deadline tolling ends 60 days after May 11, 2023 or July 10, 2023.

Examples and Explanations:

If a qualified beneficiary would have been required to make their COBRA election (generally 60 days after the loss of coverage) by March 1, 2022, the Outbreak Period delays that election requirement until the earlier of 1 year from that date (March 1, 2023) or the end of the Outbreak Period, plus an additional 60-day extension. With the May 11, 2023 end date of the Outbreak Period and 60-day extension (July 10, 2023), the applicable deadline would be March 1, 2023.

If a qualified beneficiary would have been required to make their COBRA election (generally 60 days after the loss of coverage) by August 1, 2022, the Outbreak Period delays that election requirement until the earlier of 1 year from that date (August 1, 2023) or the end of the Outbreak Period, plus an additional 60-day extension. With the May 11, 2023 end date of the Outbreak Period and 60-day extension (July 10, 2023), the applicable deadline would be July 10, 2023.

If an individual experienced the birth of a child in February 2023, and with Outbreak Period over May 11, 2023, the employee would have 60 days from the end of Outbreak Period (July 10, 2023) plus the 30-days allowed under HIPAA to give notice of the birth to request enrollment from the plan, which is August 9, 2023.

On March 18, 2020, the Families First Coronavirus Response Act (FFCRA) was signed into law and required all employer-sponsored health plans to provide coverage for testing and other services related to COVID-19 without cost sharing. The Coronavirus Aid, Relief, and Economic Security Act (CARES Act) expanded coverage of COVID-19 testing and effective January 15, 2022, Multi-Agency guidance included OTC COVID-19 tests to be covered by all group health plans without cost sharing.

This requirement was effective for the duration of the Public Health Emergency and will end May 11, 2023. Below you will find helpful information as it relates to your medical plan.

Cigna Participants:
Coverage for COVID-19 testing/treatment will be subject to the plan's standard cost-sharing effective May 12, 2023. OTC COVID-19 tests will no longer be covered under the plans, although will remain eligible for FSA/HSA reimbursement.

Kaiser California Participants:
California state mandate requires that cost-share waivers for COVID-19 testing continue until the California Public Health Emergency expires, currently anticipated to be November 11, 2023.

If you have any questions regarding these changes to the Plan or your specific circumstances, please contact the Benefits Department if you have questions regarding the information in this SMM at (510) 922-4065.

FILING INSTRUCTIONS
Please keep this memorandum with your copy of the Plan's Summary Plan Description (SPD), as it explains important changes that may affect your benefits (please contact me if you need another copy of the SPD).

ERISA INFORMATION
Plan Sponsor: Pixar
Sponsor's EIN#: 68-0086179
Plan Name: Pixar Group Health and Welfare Plan
Plan Number: 501
Plan Year: 2022-23