DGA-PRODUCER PENSION AND HEALTH PLANS

spotlight on benefits

Volume 22, Number 1 | Spring 2014

In Memoriam: Abby Singer

Legendary Assistant Director, Unit Production Manager and DGA–Producer Pension and Health Plans Trustee Abby Singer passed away on March 13, 2014 at the age of 96.

Abby joined the Board of Trustees in 1980, serving these Plans for over 33 years. He was a member of the Board's Administrative Committee, where he contributed his industry-renowned expertise in managing production budgets to overseeing the Plans' operations.

Mr. Singer's entertainment career began in 1945 working for the head of production at Columbia Pictures. He soon after joined the (then) Screen Directors Guild in 1949. During his career he oversaw the budgets and crews for some of TV's most enduring hit shows, including Rhoda, The Bob Newhart Show, WKRP in Cincinnati, and Hill Street Blues. His work in the Directors Guild of America earned him the Frank Capra Achievement Award in 1985.

But Singer won most of his international notoriety for his namesake shot. "The Abby Singer," as it came to be known, is the second-to-last shot of the workday. Usually signaled on set by someone calling out "We're on the Abby Singer" or "This shot and one more," it warns the crew to prepare to move locations after the next shot. The technique saved valuable production time, earning directors up to an additional hour of shooting, time that was usually spent moving equipment from place to place.

Mr. Singer said about the DGA and the Plans: "The Guild is the best thing that ever happened to me…And the health and welfare have been incredible; it really watches out for its members."

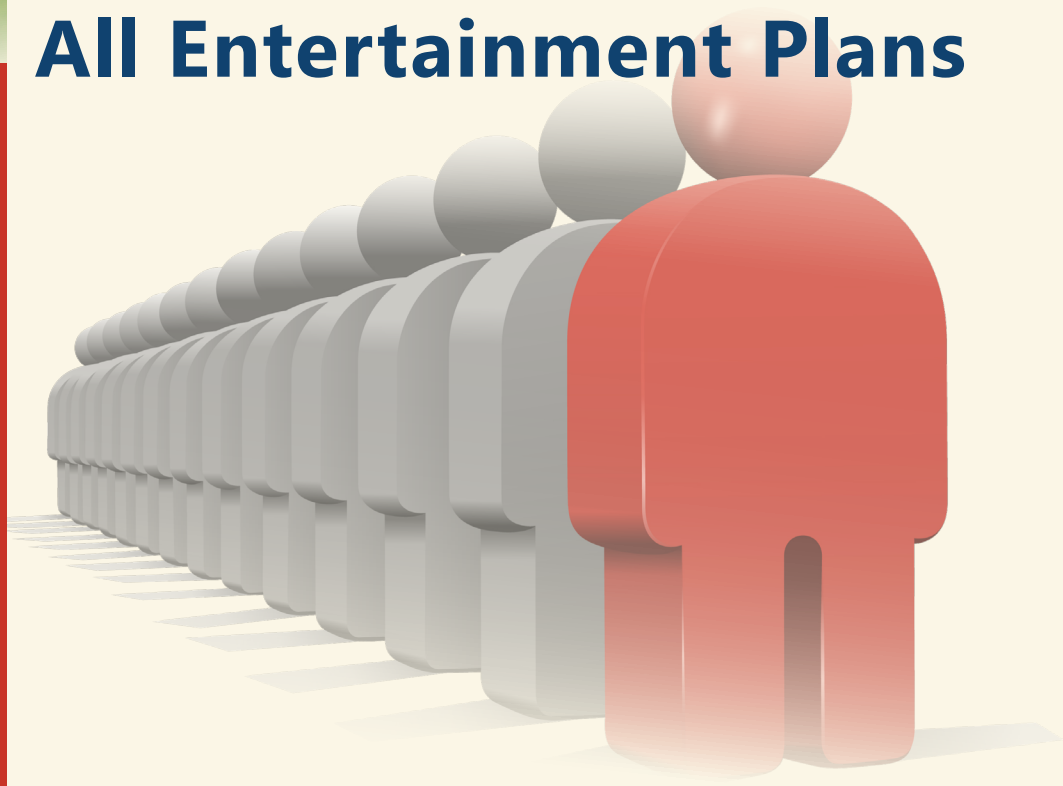
"Abby will be fondly remembered by the Plans' Board and its staff as a devoted Trustee, a legendary Guild member, a good friend and a loyal family man. We extend our condolences to Mr. Singer's wife, Lotte, and his daughters, Jo Ann, Laura and Erica," said Jay Roth, Chair of the Plan's Board of Trustees and DGA National Executive Director.

Mr. Singer served these Plans with the same dedication, wisdom, enthusiasm and generosity that were the hallmarks of his nearly half-century career in Hollywood. He will be greatly missed. PH

Clarification of Coordination of Benefits Rules Page 2

Inside Spotlight

Coordination of Benefits Rule Clarified to Include All Entertainment Plans



When you are covered by multiple health plans, the Health Plan's coordination of benefits rules are used to determine which of your health plans is primary, or in first position, to pay a claim. After the primary plan has paid its portion of a claim, the claim is passed on to the secondary plan for processing.

Our coordination of benefits rules state that if you or your dependents are eligible for earned active primary coverage with another entertainment industry health plan that requires a premium, and you fail to pay or decline to pay the premium in that plan, the DGA–Producer Health Plan will maintain its secondary position on your claims. In other words, you will be responsible for all medical expenses your primary plan would have paid if you had paid that plan's premium.

This rule, as it is written in the January 2010 Health Plan Booklet, mentions some of the other entertainment industry health plans that this rule applies to (the AFTRA Health Fund, the Motion Picture Industry Health Plan, Screen Actors Guild Producers Health Plan, and the Writers' Guild Industry Health Fund).

The Health Plan's Board of Trustees recently voted to remove the phrase that includes the five plans listed above. This change simply clarifies that the Health Plan will coordinate benefits with all entertainment industry plans. For more details regarding coordination of benefits, please refer to the Coordination of Benefits section (beginning on Page 57) of the January 2010 Health Plan Booklet and Health Plan Booklet Updates. **PH**

Two Pension Plans: Basic and Supplemental

When you worked on your first DGA project, you were automatically enrolled into **two** pension plans—the Basic and Supplemental Plans. With every DGA job, you build the benefits you can receive from these plans. The following is a brief overview of how each plan works.

The Basic Plan

The Basic Plan is a defined benefit plan. As a defined benefit plan, your benefit is based on a formula that includes your DGA-covered earnings and the number of Credited Service Months (CSMs) you earn while working on DGA-covered projects.

CSMs are based on your DGA-covered earnings during the year. Currently, you receive 1 CSM for every $3,000 in earnings, up to a maximum of 12. The amount to earn 1 CSM is periodically adjusted by the Board of Trustees.

When you retire, your Career Average Earnings and total CSMs will be used to calculate your benefit.

Your benefit is not affected by the performance of the Plans' investments. The Plan, not you, the participant, bears the risk of ensuring that adequate funds are available to meet all pension obligations. These obligations are taken very seriously by the Plans' Board of Trustees. Their efforts have helped to make the Basic Plan one of the best funded defined benefit plans in existence. Currently the Plan is 102% funded.

The Basic Plan is funded by DGA-signatory producers. When you work in a DGA capacity, your employer makes a total pension contribution equal to 5.5% of your eligible compensation: 3.3% to the Basic Plan; and 2.2% to the Supplemental Plan, up to $150,000 in compensation. Producers also make residual contributions to the Basic Plan when DGA-covered film and television projects are sold in supplemental markets. These residual contributions, which are based on work performed by film and television directors, make up over 70% of the Plan's funding and benefit all participants.

Contributions received by the Plan are invested at the direction of the Board of Trustees' Finance Committee.

The Supplemental Plan

The Supplemental Plan is more like a 401(k) or an IRA, and is known as a defined contribution plan.

As stated above, your employer makes a 5.5% pension contribution, with 2.2% going into your Supplemental Plan account. On compensation over $150,000, the entire 5.5% employer contribution goes to your Supplemental Plan account, subject to IRS limits.

You also contribute 2.5% of your reportable earnings to your Supplemental Plan account. Employers typically withhold and submit this contribution. If they don't, we'll notify you of the amount due, so you can receive your maximum benefit.

Your account balance is affected by contributions and the performance of the Plan's investments, which are under the supervision of the Finance Committee. Investment gains and losses, and administrative expenses are shared by all participants in proportion to their account.

When you retire, you have full access to your account. You can take ad hoc payments, or you can set up convenient monthly, quarterly, semi-annual or annual payments. You can also take the entire balance, or purchase an annuity.

You also have the ability to roll funds from a qualified retirement account into your Supplemental Plan account.

The different portions of your account—the employer and employee portions—are taxed differently. The employer portion is received before taxes; so it is taxed when paid to you. Employee contributions are received after taxes, so, in most cases, that portion can be paid to you without additional tax withholding.

For a full description of the Supplemental Plan, refer to pages 29–44 of the November 2009 Pension Plans Booklet and its updates.

The information included here provides only a brief overview of the Plans. You should always refer to the November 2009 Pension Plans Booklet and its updates for complete descriptions. PH

QUESTIONS ABOUT THE LUMP SUM

You may have noticed on your 2013 Pension Statement that your Lump Sum benefit decreased from 2012.

For an explanation of how the Lump Sum benefit is calculated, go to **dgaplans.org/lumpsum**.

How to Be a Prudent Health Care Consumer

There's nothing worse than coming back from an outpatient surgery and getting hit with a bill much higher than you expected. In this article, you'll find out how excessive charges from a non-network provider could land you with an astronomically high bill and what you can do to avoid the financial pitfalls that come with non-network providers.

Non-Network Providers Could Cost You Big Time

Not only does the Health Plan pay a lower percentage on non-network charges, but the amount covered is limited to the reasonable and customary (R&C) rates. All amounts in excess of the R&C rate are your responsibility.

The R&C rate is an established rate that is equal to or less than the rate charged by 80% of the physicians performing similar services in a given geographical area. Schedules of maximum R&C rates are adjusted periodically to reflect changes in physicians' rates.

If a non-network provider wants to charge you $10,000 for a procedure that has an R&C rate of $1,000, you will end up paying the entire $9,000 difference, plus your share of the $1,000 that was covered.

Talk Money. Get Estimates.

Price shopping can help when you are in need of non-urgent care. If the specialist you want to see isn't in our network, you can request an estimated charge. If you think the doctor's estimate is too high, our office can provide the R&C rate for your area.

Call our office with the following information:

- The procedure codes a non-network doctor tells you they intend to bill;
- A breakdown of the fee for each procedure code; and
- The zip code of where the service will be performed.

Once you have our R&C rate and your doctor's estimate, you'll be able to make an informed financial decision. One call could save you hundreds or thousands of dollars.

This advice not only applies to doctors and facilities (like hospitals or outpatient surgery centers), but also when you are in need of durable medical equipment. If you or a dependent need to rent equipment like a wheel chair or hospital-type bed, call a few services, get estimates, and choose the most cost-effective one. You could even negotiate a lower rate.

In this article, you'll find out how excessive charges from a non-network provider could land you with an astronomically high bill and what you can do to avoid the pitfalls that come with non-network providers.

Use the Network. Save $$$.

For California participants who are not enrolled in the HealthNet HMO, our provider network is provided by Anthem Blue Cross of California. For non-California participants, the provider network is Anthem Blue Cross' BlueCard Network. Overseas, you have access to BlueCard Worldwide. These networks are diverse, and it's easy to find a doctor, specialist, or hospital.

Simply go to our website, **dgaplans.org**, and click on the **Find a Network Provider** link, located under the **Quick Links** section of the home page. This will take you to the Anthem Blue Cross website. Enter the prefix "DGA" in the member ID field. You can search for a specific doctor or specialty and even filter your results.

We're Here to Help

Any time you go out of network and are concerned about cost, please call us. We want to provide you with the information you need to make an informed decision about your medical expenses. You can reach us Monday-Friday, 8:30 AM to 5:00 PM Pacific Time at (877) 866-2200, Option 2. **PH**

Pay Premiums On Time to Make Sure Your Benefits Are Available

The Health Plan offers a 30-day grace period on premium payments (45 days for your initial COBRA premium), but that doesn't mean you should wait to pay your premium. There are downsides to not paying your premium in a timely manner.

If you are in your grace period and have not paid your self-pay or dependent premium, then you will not be able to get coverage for yourself or your dependents. This means you will pay the full price when you seek medical services or try to fill a prescription. Of course, once you pay your premium, you can submit the claim to us for reimbursement.

For example, if you haven't paid your January premium and visit a doctor on January 10, you will pay for the visit in full. If you pay your premium on January 15, you can submit the claim to us. But you may not receive full reimbursement, as the Plan will not reimburse you for the difference between full price and the discounted price the Plan would have paid.

What if I miss my grace period?

If you are on earned coverage and do not pay your dependent premium within the 30-day grace period, your dependents will not be eligible for coverage until the beginning of your next benefit period.

If you are on self-pay coverage, your self-pay coverage will be terminated.

Don't let an oversight be the reason you or your dependents lose Health Plan coverage. Pay your premium in a timely manner, or set up an automatic recurring payment through E-Bill Express, the Health Plan's online payment service (go to dgaplans.org/onlinebillpay.htm for more information).

For more information on grace periods, please see **Premium Payments** on pages 22-23 and **Dependent Premiums** on pages 37-38 in the January 2010 Health Plan Booklet and corresponding Health Plan Booklet Updates. They can be found on our website at dgaplans.org/forms.htm. **PH**

Spotlight on Benefits

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The Pension and Health Plans were created as a result of the Directors Guild of America's collective bargaining agreements with producer associations representing the motion picture, television and commercial production industries.

The DGA-Producer Pension and Health Plans are separate entities from the DGA and are administered by a Board of Trustees made up of DGA representatives and Producers' representatives.

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Help the Plans Stay Green

Beginning next year, the Plans will be publishing new booklets for the Pension and Health Plans.

Help us save a tree by registering for e-delivery of these documents using the postcard included with this newsletter.

Thank you.