

SPRING 2018

## Board of Trustees Continues Efforts to Further Strengthen Basic Pension Plan



### HOW YOUR HEALTH PLAN WORKS:

Knowing what counts as medically necessary helps avoid unforeseen costs.

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Beginning July 1, an additional 0.5% will be diverted to the Basic Plan, helping to secure benefits for future generations.

Last year, the Board of Trustees of the Directors Guild of America–Producer Pension and Health Plans took a number of steps to ensure the continued strength of the Basic Pension Plan and protect its financial status for future generations of participants and their beneficiaries.

Those actions included allocating the entire 0.5% increase in employer pension contributions from 5.5% to 6% of compensation to the Basic Plan. This increase was negotiated as part of the 2017 Basic, FLTTA, Commercial and Networks' Collective Bargaining Agreements. These Agreements also allow the Directors Guild of America (DGA) the option to allocate up to 0.5% of the negotiated increases in minimum salary rates in each of the second and third years of the agreements. Accordingly, to further ensure the Basic Plan's ability to pay promised benefits, the DGA exercised the option to divert the entire 0.5% in the second year of these agreements and increased the Employer pension contribution rate from 6% to 6.5% of compensation, effective July 1, 2018 for the Basic, FLTTA and Network Agreements, and effective December 1, 2018 for the Commercial Agreement.

The resulting allocations between the Basic and Supplemental Plans will change to the following:

- ▶ 6.5% of the first \$20,000 in compensation (changed from 6.0%) to the Basic Plan;
- ▶ 4.3% of compensation (changed from 3.8%) exceeding \$20,000 up to a maximum of \$150,000 to the Basic Plan;
- ▶ 2.2% of compensation exceeding \$20,000 up to a maximum of \$150,000 to the Supplemental Plan (unchanged); and
- ▶ 6.5% of compensation (changed from 6.0%) in excess of \$150,000 to the Supplemental Plan.

For more information on this change, refer to the March 2015 Pension Plans Summary Plan Description and its updates available at [www.dgaplans.org/forms/pension](http://www.dgaplans.org/forms/pension).

For details on the past changes made to the Basic Plan, refer to the Summer 2017 and Winter 2017 *Spotlight on Benefits* newsletters available at [www.dgaplans.org/newsletters](http://www.dgaplans.org/newsletters). PH

2017 Annual  
Funding  
Notice  
Enclosed

# Spotlight

ON BENEFITS

VOLUME 26, NUMBER 1  
SPRING 2018

## DGA-PRODUCER PENSION & HEALTH

Directors Guild of America-Producer  
Pension and Health Plans

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### ABOUT THE PLANS

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 Directors Guild of America and are administered by a Board of Trustees made up of DGA representatives and Producers' representatives.

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# New Coordination of Benefits Policy Ensures Health Plan Dollars Spent Appropriately

The Health Plan provides one of the finest benefits packages in the industry. In order to preserve these benefits for current and future generations of participants and their families, the Health Plan continuously works to ensure its dollars are spent appropriately. Part of its ongoing efforts include coordinating your benefits with other plans so that claim costs are properly apportioned among your insurers.

So that the Health Plan maintains your most up-to-date coverage information, the Board of Trustees is updating its policy regarding the submission of Coordination of Benefits (COB) forms. Under the revised policy all participants are required to submit an updated COB form at least once per year, regardless of whether the information has changed from the previous year. If your other health coverage changes during the year, you must also submit an updated COB form notifying the Health Plan.

The COB form is included in all Health Plan open enrollment packets and is also available for download at [dgaplans.org/forms](http://dgaplans.org/forms). The COB form is an important tool used by the Health Plan when determining its share of claims costs for participants covered under multiple plans.

To help prevent any delays in processing your claims and avoid having to reimburse the Health Plan for any overpayments, it's important to promptly return the COB form you receive during your open enrollment period. In addition, an updated COB form is required outside of your Health Plan open enrollment period whenever coverage status changes for you or your covered dependents, such as when obtaining or losing coverage with



another plan or becoming eligible for additional earned coverage with another industry plan, even if you choose not to accept that coverage. If your updated COB form indicates a loss of coverage, you must also include the termination notice for the other carrier that indicates the date coverage ended.

In cases when you or your covered dependent(s) become eligible for primary, active coverage with another entertainment industry health plan, whether or not you choose to pay any premiums applicable for that coverage, the Health Plan will maintain its coordination of benefits position as if you had accepted the additional coverage and calculate your benefits accordingly. When the Health Plan is the secondary insurer, it will pay claims at up to 20% of the allowable charges. This rule ensures that the plan you've had longest with no break in coverage maintains its position as the primary insurer.

The new coordination of benefits policy ensures that Health Plan dollars are spent appropriately. Help us preserve your benefits by keeping your COB status updated with the Health Plan.

For more details regarding coordination of benefits, refer to the March 2015 Health Plan Summary Plan Description and its updates. **PH**

# Changes to Disability Claims and Appeals Procedure to Further Protect Your Rights



The claims notices for the Health and Supplemental Plans have been updated to comply with recent regulations from the Department of Labor that require additional information to be disclosed to disability claimants whose disability status is not based solely on a determination by the Social Security Administration (SSA). These changes allow greater insight into disability decisions. Since the Basic Plan follows the disability determinations of the SSA, only the Supplemental and Health Plans are subject to the revised federal regulations. The following changes are effective for claims filed initially or on appeal as of April 1, 2018.

## CHANGES TO THE HEALTH PLAN'S CLAIMS AND APPEALS PROCEDURES

The Health Plan's procedures have been revised with respect to claims and appeals involving coverage for disabled adult dependents and continuation of such coverage for periods of disability in situations when adult dependents cannot meet the residency or resource requirements for an SSA determination of disability.

As many of the new federal guidelines mirror those the Health Plan must meet as part of the Affordable Care Act, the only change to the Health Plan's existing claims and appeals procedures is as follows:

- ▶ All adverse benefit determinations must include a full discussion of the Health Plan's disability decision, including the reason for disagreeing with any health care professional or SSA determination.

## CHANGES TO THE SUPPLEMENTAL PLAN'S CLAIMS AND APPEALS PROCEDURES

The Supplemental Plan's procedures have been revised with respect to claims and appeals involving disability pension benefits and the granting of vesting credit for periods of disability in situations when a participant cannot meet the residency or resource requirements for an SSA determination of disability. In such cases, the Plan's Board of Trustees may determine disabled status based on medical evidence.

The Supplemental Plan's claims and appeals procedures as related to such determinations have been updated to

include the following provisions:

- ▶ Any denial of benefits must include a full discussion of the Supplemental Plan's disability decision, including the reason for disagreeing with any health care professional or SSA determination.
- ▶ Any denial of benefits must provide the claimant with any new evidence or rationale considered on review and afford the claimant sufficient time to respond to the new information before the final adverse benefit determination.
- ▶ Any denial of benefits must be provided in a culturally and linguistically appropriate manner (CLAS) as defined by the Department of Health and Human Services National CLAS Standards.

In addition, any denial of benefits must adhere strictly to the Plan's claims and appeals procedures.

Both the Pension Plans and Health Plan Summary Plan Descriptions have been updated to reflect the revised procedures. For details, download the applicable Summary Plan Description updates at [dgaplans.org/forms](http://dgaplans.org/forms). **PH**

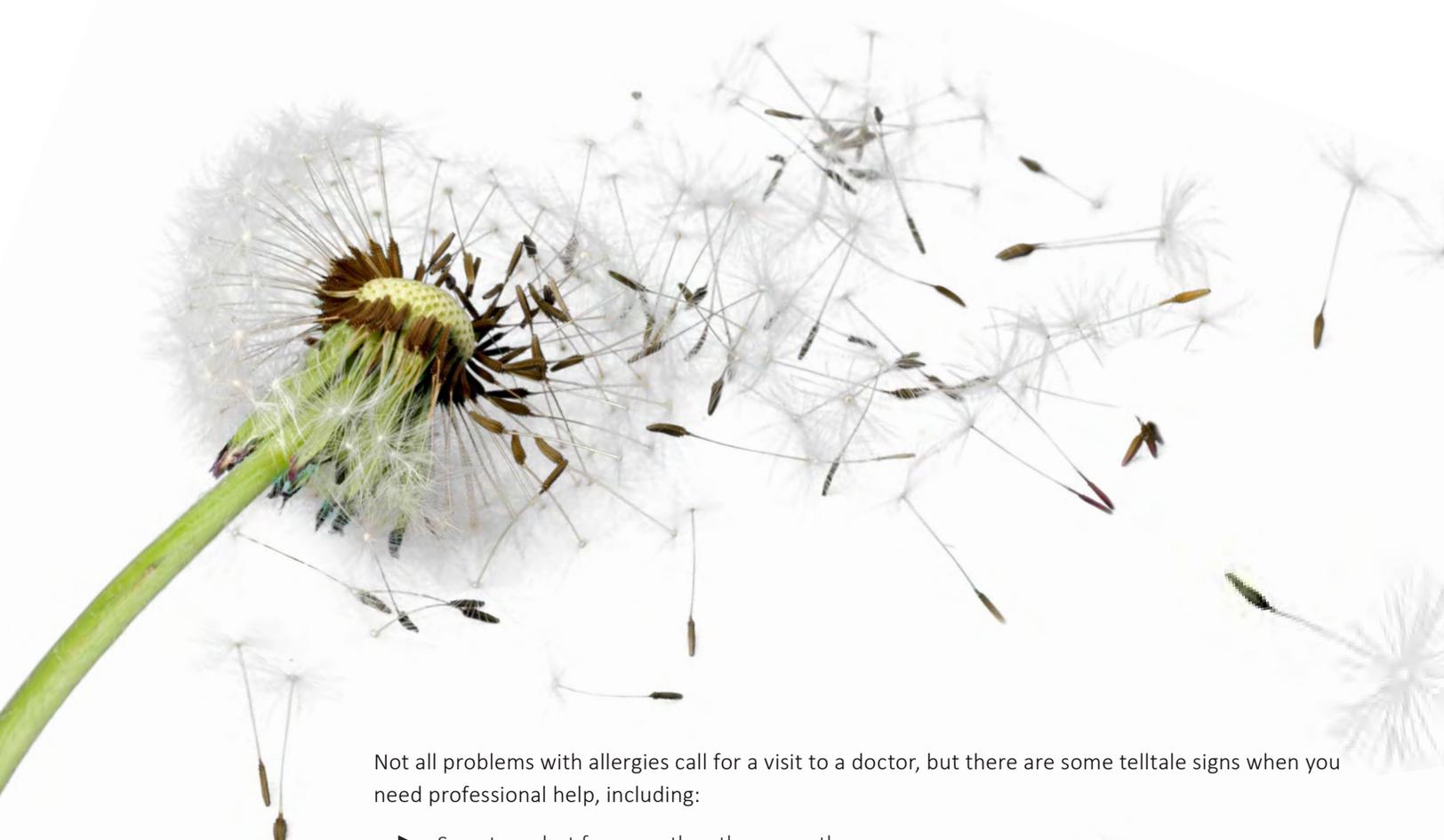
# MANAGING Seasonal Allergies

Springtime brings warmer weather, blooming flowers, and lush, green landscapes. But for those who suffer from seasonal allergies, springtime also brings endless sneezing, runny noses, and itchy eyes.

Allergic rhinitis, or hay fever, affects millions of people and can cause significant discomfort, as well as a disruption in sleep and productivity. As winter fades and plants begin to bloom, trees and grasses release pollens and particles that cause the immune systems of those affected to go into overdrive. The histamines released by the body to fight the allergens are what trigger the familiar allergy symptoms.

While there is no cure for hay fever, there are many steps you can take to alleviate your stuffy nose and watery eyes. Look for weather forecasts that include daily pollen count reports, so you can avoid being outside when counts are at their highest. Windy days tend to be the worst, and rainy days are usually best, as the pollen gets washed away. The time of day also matters – in the spring, pollen counts are highest usually between 10 a.m. and 4 p.m.

See the opposite page for more advice on managing hay fever symptoms.



Not all problems with allergies call for a visit to a doctor, but there are some telltale signs when you need professional help, including:

- ▶ Symptoms last for more than three months.
- ▶ Your symptoms make it hard to work, sleep or participate in activities you enjoy.
- ▶ Over-the-counter medications don't provide enough relief.
- ▶ You frequently have sinus and ear infections, headaches or a stuffy nose.

It might take some work and persistence, but keeping irritating symptoms at bay will allow you to better enjoy the beauties of spring. **PH**

# Tips to alleviate seasonal allergy symptoms:

- ▶ Shut the windows (of both your car and home) on dry and windy days.
- ▶ When you return home after being outside for long periods of time, change your clothing and shower (to remove pollen from your hair and body). Wearing sunglasses can block particles from getting in your eyes.
- ▶ If you must participate in an activity where you are exposed, such as mowing the lawn, wear a NIOSH-rated mask. NIOSH ratings test the filtration of particles – the higher the rating, the better the filtration. Look for a baseline of N95.
- ▶ Use an air purifier in your home, particularly in the bedroom. HEPA filters are considered the gold standard when it comes to air filtration – choose one with a MERV rating of 10 or higher.
- ▶ Over-the-counter medications, such as antihistamines, nasal sprays, eye drops, and decongestants can bring relief. Begin antihistamines several weeks before symptoms appear: typically, early February if you're allergic to trees, early June if you're allergic to grasses, and early August if you're allergic to ragweed. (Timing can vary, depending on your geographic region.) Note that over-the-counter medications are not safe for everyone and it is best to consult with your doctor if you have certain conditions (i.e. heart disease, diabetes, thyroid disease, kidney disease, liver disease, high blood pressure, enlarged prostate and/or glaucoma).
- ▶ Natural remedies may help, like nasal irrigation with a neti pot. Rinsing out sinuses clears away trapped pollens and opens passages. Be sure to use a sterile saline solution and carefully follow instructions.



# How Your Health Plan Works:

## Knowing what counts as medically necessary helps avoid unforeseen costs

The DGA-Producer Health Plan covers medically necessary doctor visits, treatments, and procedures for covered participants and dependents. This means, after you've met your deductible, you can anticipate that claims for most routine doctor visits and preventive care will be processed with no need for additional evaluation and no unexpected costs to you. However, in other situations that may not be as simple, it pays to understand how your Health Plan works so that you know what to expect and can manage your medical costs accordingly.

The Health Plan follows a specific set of standards in evaluating medical necessity before making payment on claims. Maintaining these standards ensures that the Health Plan's resources are used to maximize your benefits. As defined in the Health Plan Summary Plan Description, a treatment, service, or supply is considered medically necessary when it is:

- ▶ Consistent with accepted medical practice within the medical community for your diagnosis or direct care of symptoms, sickness or injury, or routine screening exams under wellness benefits;
- ▶ Ordered by your attending licensed physician and not solely for you or your health care provider's convenience;
- ▶ Consistent with professionally recognized standards of care in the medical community with respect to quality, frequency and duration; and
- ▶ The most appropriate and cost-efficient treatment, service, or supply that can be safely provided.



If a treatment or service is not recognized by an established medical society in the United States, then it will not be considered medically necessary.

While the majority of claims meet these four criteria, others are not as clear-cut, particularly those that require ongoing, regular visits. If you ever have questions about a procedure or treatment your doctor has requested for you, call the Health Plan's Participant Services Department at (877) 866-2200 ext. 401 for guidance.

When the Health Plan requires more information before a claim can be processed, you or your doctor may be asked to provide documentation that speaks to the necessity or continued medical necessity of a service or treatment. As reported previously in the *Spotlight on Benefits*, mental health and physical therapy often fall into this category, as these services typically involve multiple appointments. Unlimited visits for these categories are covered when considered medically necessary, but determination of continued coverage of these types of claims takes place at set intervals throughout ongoing treatment. The first determination is made after 30 visits.

After the 30th visit, your doctor must submit records to demonstrate continued medical necessity. For mental health treatment, your doctor may schedule a peer-to-peer review in addition to, or in lieu of, submitting medical records.

This type of evaluation may also be required for other types of treatments and are performed on a case-by-case basis.

This is why timely filing of claims is very important. While the Health Plan allows up to one year from the date of service to file non-network claims, submitting claims as they are incurred ensures you are aware as soon as possible if a particular service will not be covered going forward.

To avoid unexpected out-of-pocket expenses, it's helpful to be aware of the Plan's medically necessary standard and the types of services that require review. When in doubt, the Health Plan's Participant Services Department is available Monday through Friday, 8:30 a.m. to 5:00 p.m. to assist you. A quick call, as well as prompt filing of your claims as they are incurred, may help you avoid unforeseen costs. **PH**

# For the Aging, MPTF Offers Services Nationwide

**W**ith 1 in 7 Americans caring for an aging relative either now or in the past and people generally living longer, odds are good that at some point in your lifetime you might require some type of assistance. This may range from help proofing your home for safety hazards, transportation to and from appointments, or a simple phone call to break up an otherwise lonesome day. Regardless of the need, MPTF (Motion Picture & Television Fund) can be your one-stop resource when and if these needs arise.

MPTF offers a wide range of programs and services that support the entertainment industry in “living and aging well with dignity and purpose,” both locally in the Los Angeles area and beyond. Entertainment industry members and their families nationwide can benefit from MPTF through either its direct services or its connections to locally-based resources wherever you or your loved ones might live.

## OUTSIDE LOS ANGELES

Though headquartered in the Los Angeles area, MPTF and its staff of experienced social workers can put entertainment industry members in touch with resources wherever you or your loved one might require them.

MPTF’s Elder Connection Program is a free service of its Community Social Services Department and provides assistance for older adults, their loved ones and their caregivers. The services offered include assessment of care needs via phone, supportive counseling and help for caregivers, and referrals to community resources for more specialized needs like housing alternatives,

home care agencies, support groups, meal delivery services and more.

In addition to its Elder Connection services, MPTF also offers nationwide telephone outreach through its “Daily Call Sheet” program, which links friendly volunteers with industry members and/or their aging loved ones who are looking for social connection. With funding from the AARP Foundation, the Daily Call Sheet volunteers have made hundreds of phone calls to ease the loneliness and isolation that more heavily affect older adults, sufferers of chronic illnesses and people with disabilities. If other needs surface during these phone calls, volunteers can then refer to MPTF social workers.

And while those living outside of Southern California may not be able to attend MPTF’s local classes and presentations, MPTF has partnered with Mather Lifeways to offer “Telephone Topics,” which allow anyone with a telephone to participate in an expansive selection of courses, all from the comfort of home – wherever that may be.

## IN THE LOS ANGELES AREA

In addition to the services detailed above, eligible industry members and their families have access to MPTF’s Wasserman Campus which houses their residential community offering retirement living at all levels of care (independent living, assisted living, skilled nursing and Alzheimer’s/dementia care), as well as the Saban Center for Health and Wellness.

Industry members and their families also have access to the five UCLA-MPTF Health Centers located throughout the

Los Angeles area providing medical care and palliative care services.

L.A. residents may also utilize the comprehensive Age Well Program, which provides assessments and interventions for age-related medical and emotional concerns, as well as cognitive and functional evaluations. For those older adults living at home, MPTF’s Home Safe Home Program sends volunteers to conduct free home safety checks and even make small home modifications, such as installing grab bars and tub rails. Staying on top of health issues and ensuring safe living environments allows older people to maintain their independence, enabling them to live at home longer.

As social connections are critical but often difficult to sustain as we age, MPTF has created an array of opportunities for seniors to stay engaged with fellow members of the industry. Volunteer engagement at MPTF provides purposeful opportunities for volunteers that benefit industry members with meaningful programs, classes, and workshops. These peer-to-peer and intergenerational connections are enriching for everyone and help to reduce boredom, loneliness and isolation.

MPTF is committed to caring for the nationwide entertainment community over the spans of their lifetimes, and a large part of its resources is geared towards the aging. Whether you are concerned about yourself, an elderly friend, or a loved one, chances are MPTF can provide assistance.

For more information about MPTF’s programs or to confirm eligibility, please visit [www.mptf.com](http://www.mptf.com) or contact the MPTF Social Services Intake Line at (323) 634-3888. **PH**

# DGA-PRODUCER PENSION & HEALTH

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## MOVING? LET US KNOW.

It's important to keep your contact information current with the DGA-Producer Pension and Health Plans office to ensure you are reachable should you become eligible for health or pension benefits.

If you've recently moved, had a change in mailing address, or have a new phone number, it's quick and simple to submit these updates to the Plans' Address Change Department. You can conveniently make changes by downloading the Change of Address Form available at [dgaplans.org/forms](http://dgaplans.org/forms). Once completed, return the form by email to [addresschange@dgaplans.org](mailto:addresschange@dgaplans.org), by fax to (323) 866-2389, or mail it to the Plans office.

If you prefer to submit updates by phone, Address Change Representatives are available Monday through Friday, 8:30 a.m. to 5:00 p.m. Pacific Time. Call (323) 866-2200 ext. 407 to reach a representative or to leave a voicemail outside of normal business hours.

Keep in mind you must separately notify the Directors Guild of America of any changes in your information, as it is a separate entity. You can reach the DGA Membership Department at (310) 289-2000. **PH**



## Annual Funding Notice for the Directors Guild of America—Producer Pension Plan Basic Benefit Plan

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### Introduction

This notice includes important information about the funding status of your multiemployer pension plan (“the Plan”) and general information about the benefit payments guaranteed by the Pension Benefit Guaranty Corporation (“PBGC”), a federal insurance agency. All traditional pension plans (called “defined benefit pension plans”) must provide this notice every year regardless of their funding status. This notice does not mean that the Plan is terminating. It is provided for informational purposes and you are not required to respond in any way. This notice is for the plan year beginning January 1, 2017 and ending December 31, 2017 (“Plan Year”).

### How Well Funded Is Your Plan

Under federal law, the Plan must report how well it is funded by using a measure called the “funded percentage.” This percentage is obtained by dividing the Plan’s assets by its liabilities on the Valuation Date for the Plan Year. In general, the higher the percentage, the better funded the plan. Your Plan’s funded percentage for the Plan Year and each of the two preceding Plan Years is set forth in the chart below, along with a statement of the value of the Plan’s assets and liabilities for the same period.

	2017 Plan year	2016 Plan Year	2015 Plan Year
<b>Valuation Date</b>	January 1, 2017	January 1, 2016	January 1, 2015
<b>Funded Percentage</b>	92.7%	95.43%	100.90%
<b>Value of Assets</b>	\$1,623,455,984	\$1,567,501,737	\$1,535,087,542
<b>Value of Liabilities</b>	\$1,751,029,113	\$1,642,523,540	\$1,521,466,562

### Year-End Fair Market Value of Assets

The asset values in the chart above are measured as of the Valuation Date for the Plan Year and are actuarial values. Because market values can fluctuate daily based on factors in the marketplace, such as changes in the stock market, applicable federal law allows plans to use actuarial values that are designed to smooth out those fluctuations for funding purposes. The asset values below are market values and are measured as of the last day of the Plan Year, rather than as of the Valuation Date. Substituting the market value of assets for the actuarial value used in the above chart would show a clearer picture of a plan’s funded status as of the Valuation Date. The fair market value of the Plan’s assets as of the last day of the Plan Year and each of the two preceding Plan Years is shown in the following table:

	December 31, 2017	December 31, 2016	December 31, 2015
<b>Fair Market Value of Assets</b>	\$1,670,133,011	\$1,504,821,858	\$1,404,686,177

### Endangered, Critical, or Critical and Declining Status

Under applicable federal law, a plan generally will be considered to be in “endangered” status if, at the beginning of the plan year, the funded percentage of the plan is less than 80 percent, or in “critical” status if the percentage is less than 65 percent (other factors may also apply). A plan is in “critical and declining” status if it is in critical status and is projected to become insolvent (run out of money to pay benefits) within 15 years (or within 20 years if a special rule applies). If a pension plan enters endangered status, the trustees of the plan are required to adopt a funding improvement plan. Similarly, if a pension plan enters critical status or critical and declining status, the trustees of the plan are required to adopt a rehabilitation plan. Rehabilitation and funding improvement plans establish steps and benchmarks for pension plans to improve their funding status over a specified period of time. The plan sponsor of a plan in critical and declining status may apply for approval to amend the plan to reduce current and future payment obligations to participants and beneficiaries.

The Plan was not in endangered, critical, or critical and declining status in the Plan Year.

### Participant Information

The total number of participants and beneficiaries covered by the Plan as of the Plan’s Valuation Date was 12,775. Of this number, 7,719 were active participants, 2,840 were retired or separated from service and receiving benefits, and 2,216 were retired or separated from service and entitled to future benefits.

## Funding & Investment Policies

Every pension plan must have a procedure for establishing a funding policy to carry out plan objectives. A funding policy relates to the level of assets needed to pay for benefits promised under the plan currently and over the years. The funding policy of the Plan is as follows:

The applicable collective bargaining agreements stipulate the contribution rates for determining contributions to fund the Plan’s benefits. Actual contributions are thus a function of these negotiated contribution rates and the covered earnings of participants. Additionally, the Plan receives contributions based on residuals, which are not related to participants’ current covered earnings. It is intended that the actual contributions will be sufficient to fund each year’s benefit accrual and also amortize any unfunded liabilities over 15 years measured from each January 1 valuation date.

Once money is contributed to the Plan, the money is invested by Plan officials called fiduciaries, who make specific investments in accordance with the Plan’s investment policy. Generally speaking, an investment policy is a written statement that provides the fiduciaries who are responsible for plan investments with guidelines or general instructions concerning investment management decisions. The investment policy of the Plan is to achieve a positive rate of return for the Plan over the long term that significantly contributes to meeting the Plan’s obligations, including actuarial interest and benefit payment obligations.

Under the Plan’s investment policy, the Plan’s assets were allocated among the following categories of investments, as of the end of the Plan Year. These allocations are percentages of total assets:

Asset Allocations	Percentage
Interest-bearing cash	1.6
U.S. Government securities	5.5
Corporate debt instruments (other than employer securities):	
Preferred	1.5
All Other	3.7
Corporate stocks (other than employer securities):	
Preferred	0.0
Common	1.8
Partnership/joint venture interests	14.2
Real estate (other than employer real property)	0.0
Loans (other than to participants)	0.0
Participant loans	0.0
Value of interest in common/collective trusts	29.6
Value of interest in pooled separate accounts	0.0
Value of interest in master trust investment accounts	0.0
Value of interest in 103-12 investment entities	21.8
Value of interest in registered investment companies (e.g. mutual funds)	19.5
Value of funds held in insurance co. general account (unallocated contracts)	0.0
Employer-related investments:	
Employer Securities	0.0
Employer Real Property	0.0
Buildings and other property used in Plan operation	0.0
Other	0.8

For information about the Plan’s investment in any of the following types of investments as described in the chart above – common/collective trusts, pooled separate accounts, master trust investment accounts, or 103-12 investment entities – contact Jean Sommerville, CFO, at (323) 866-2224.

## Right to Request a Copy of the Annual Report

A pension plan is required to file with the U.S. Department of Labor an annual report called the Form 5500 that contains financial and other information about the plan. Copies of the Plan’s annual report are available from the U.S. Department of Labor, Employee Benefits Security Administration’s Public Disclosure Room at 200 Constitution Avenue, NW, Room N-1513, Washington, DC 20210, or by calling (202) 693-8673. For 2009 and subsequent Plan Years, you may obtain an electronic copy of the Plan’s annual report by going to [www.efast.dol.gov](http://www.efast.dol.gov) and using the Form 5500 search function. Or you may obtain a copy of the Plan’s annual report by making a written request to the Plan administrator. Individual information, such as the amount of your accrued benefit

under the Plan, is not contained in the annual report. If you are seeking information regarding your benefits under the Plan, contact the Plan administrator identified below under “Where to Get More Information.”

### **Summary of Rules Governing Insolvent Plans**

Federal law has a number of special rules that apply to financially troubled multiemployer plans that become insolvent, either as ongoing plans or plans terminated by mass withdrawal. The plan administrator is required by law to include a summary of these rules in the annual funding notice. A plan is insolvent for a plan year if its available financial resources are not sufficient to pay benefits when due for that plan year. An insolvent plan must reduce benefit payments to the highest level that can be paid from the plan’s available resources. If such resources are not enough to pay benefits at a level specified by law (see Benefit Payments Guaranteed by the PBGC, below), the plan must apply to the PBGC for financial assistance. The PBGC will loan the plan the amount necessary to pay benefits at the guaranteed level. Reduced benefits may be restored if the plan’s financial condition improves.

A plan that becomes insolvent must provide prompt notice of its status to participants and beneficiaries, contributing employers, labor unions representing participants, and PBGC. In addition, participants and beneficiaries also must receive information regarding whether, and how, their benefits will be reduced or affected, including loss of a lump sum option. This information will be provided for each year the plan is insolvent.

### **Benefit Payments Guaranteed by the PBGC**

The maximum benefit that the PBGC guarantees is set by law. Only benefits that you have earned a right to receive and that cannot be forfeited (called vested benefits) are guaranteed. There are separate insurance programs with different benefit guarantees and other provisions for single-employer plans and multiemployer plans. Your Plan is covered by PBGC’s multiemployer program. Specifically, the PBGC guarantees a monthly benefit payment equal to 100 percent of the first \$11 of the Plan’s monthly benefit accrual rate, plus 75 percent of the next \$33 of the accrual rate, times each year of credited service. The PBGC’s maximum guarantee, therefore, is \$35.75 per month times a participant’s years of credited service.

*Example 1:* If a participant with 10 years of credited service has an accrued monthly benefit of \$600, the accrual rate for purposes of determining the PBGC guarantee would be determined by dividing the monthly benefit by the participant’s years of service ( $\$600/10$ ), which equals \$60. The guaranteed amount for a \$60 monthly accrual rate is equal to the sum of \$11 plus  $\$24.75$  ( $.75 \times \$33$ ), or \$35.75. Thus, the participant’s guaranteed monthly benefit is \$357.50 ( $\$35.75 \times 10$ ).

*Example 2:* If the participant in Example 1 has an accrued monthly benefit of \$200, the accrual rate for purposes of determining the guarantee would be \$20 (or  $\$200/10$ ). The guaranteed amount for a \$20 monthly accrual rate is equal to the sum of \$11 plus  $\$6.75$  ( $.75 \times \$9$ ), or \$17.75. Thus, the participant’s guaranteed monthly benefit would be \$177.50 ( $\$17.75 \times 10$ ).

The PBGC guarantees pension benefits payable at normal retirement age and some early retirement benefits. In addition, the PBGC guarantees qualified preretirement survivor benefits (which are preretirement death benefits payable to the surviving spouse of a participant who dies before starting to receive benefit payments). In calculating a person’s monthly payment, the PBGC will disregard any benefit increases that were made under the plan within 60 months before the earlier of the plan’s termination or insolvency (or benefits that were in effect for less than 60 months at the time of termination or insolvency). Similarly, the PBGC does not guarantee pre-retirement death benefits to a spouse or beneficiary (e.g. a qualified pre-retirement survivor annuity) if the participant dies after the plan terminates, benefits above the normal retirement benefit, disability benefits not in pay status, or non-pension benefits, such as health insurance, life insurance, death benefits, vacation pay, or severance pay.

For more information about the PBGC and the pension insurance program guarantees, go to the Multiemployer Page on PBGC’s website at [www.pbgc.gov/multiemployer](http://www.pbgc.gov/multiemployer). Please contact your employer or Plan administrator for specific information about your Plan or pension benefits. PBGC does not have that information. See “Where to get More Information” below.”

### **Where to Get More Information**

For more information about this notice, you may contact Ed Bohm, Manager, Pension Department, at the Directors Guild of America—Producer Pension Plans, 5055 Wilshire Blvd, Suite 600, Los Angeles, CA 90036, (323) 866-2200. For identification purposes, the official Plan number is 001 and the Plan Sponsor’s name and employer identification number or “EIN” are the Board of Trustees, Directors Guild of America—Producer Pension Plan Basic Benefit Plan, and 95-2892780, respectively.