DGA-PRODUCER PENSION & HEALTH

Spotlight ON BENEFITS

Spring 2019

Inside this issue...

New, Easier Access to Diabetic Supplies at No Cost

Previously, diabetic supplies like needles, syringes and test strips needed to be ordered in combination with your insulin prescription to avoid paying a separate co-payment. You will now be able to order your insulin and diabetic supplies separately, but without an increase in your total co-payment as the co-payment for supplies is now $0.

Thousands of individual items qualify for the $0 co-payment for diabetic supplies, including insulin needles, test strips, swabs, lancets, monitors and sensors. The $0 co-payment applies to any diabetic supply item, regardless of whether you are pre-diabetic or have Type 1 or Type 2 diabetes. For more information, please call Participant Services at (323) 866-2200, Ext. 401. **PH**

Basic Plan Remains Well-Funded: 2018 Basic Pension Plan Annual Funding Notice Enclosed

Spotlight
ON BENEFITS
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DGA-PRODUCER
PENSION & HEALTH

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

The Opioid Crisis: What You Should Know

Dozens of articles have appeared in the press describing the tragic consequences of opioid abuse in the United States and throughout much of the world. Many individuals are uncertain regarding the specifics of the problem and what they can do to help themselves and others. The following are some common questions and answers regarding this important issue:

WHAT ARE OPIOIDS?

Opioids are a class of drugs that include the illegal drug heroin, synthetic opioids such as fentanyl, and pain relievers available legally by prescription, such as oxycodone (Oxycontin®), hydrocodone (Vicodin®), codeine, morphine and many others.

WHAT DO OPIOIDS DO?

All opioids are chemically related and interact with specific opioid receptors in the brain. Opioid pain relievers are generally safe when taken for a short time and as prescribed by a doctor, but because they produce euphoria in addition to pain relief, they can be misused. Regular use can lead to dependence, addiction, overdoses and deaths.

HOW DID THIS EPIDEMIC START?

In 1991, deaths involving opioids began to rise following a sharp increase in the prescription of opioid medications. In 2010, as the problem was recognized, early efforts to decrease opioid prescriptions began to take effect, making prescription opioids harder to obtain. Around this time, more individuals who were addicted to prescription opioids then turned to heroin, a potent illegal opioid, as a cheap and widely available substitute. Deaths due to heroin-related overdoses increased by 286% from 2002 to 2013; approximately 80% of heroin users admitted to misusing prescription opioids before turning to heroin. In 2013, deaths related to synthetic opioids such as fentanyl began to rise, as these drugs were much less expensive and easier to obtain.

HOW BIG OF A PROBLEM IS THIS?

More than 130 people in the United States die every day after overdosing on opioids. Deaths attributed to opioids now exceed the combined number of deaths from auto accidents and firearms.

WHAT CAN I DO?

People who take opioids quickly develop tolerance and dependence on this class of drug. Many adults who are prescribed opioids by doctors subsequently become addicted or move from pills to heroin or fentanyl. Seventy

percent of people who have abused prescription painkillers reported initially getting them from friends or relatives and are unaware that sharing opioids is a felony.

The US Centers for Disease Control and Prevention (CDC) issued comprehensive guidelines for prescribing opioids. These prescribing recommendations state that non-opioid treatments are the preferred first step for treatment of chronic pain. Opioid medications should only be added after careful assessment of pain control and followed by regular evaulations of their continued need.

If your physician prescribes opioids, you should inquire about the alternatives that can be tried first. Often, other approaches such as non-opioid medications, psychological, physical rehabilitative therapy or approved medical devices can be quite effective. If opioids are needed

despite these interventions, you should use the lowest effective dose of medication for the shortest possible time. Full disclosure to your physician of all other medications and supplements taken is also important to avoid problems. Opioids require prior authorization from Express Scripts in order to be covered under the prescription benefit. Your provider should call (800) 417-1764 to obtain such an approval.

WHERE CAN I GET HELP IF I NEED IT?

The Health Plan covers both inpatient and outpatient chemical dependency treatment under its medical benefit when medically necessary (See sidebar on page 5: *How does the Health Plan determine medical necessity?*). Coverage for intensive outpatient services, partial hospitalization, residential treatment and inpatient hospitalization requires pre-authorization from Anthem Blue Cross. Prior to admission, ask your provider to call (800) 274-7767 for a coverage review.

HOW CAN I HELP OTHERS?

If a friend or relative is taking opioids, it is important to make them aware of the concerns and dangers noted above. Referral to a physician specializing in pain management or opioid use disorder may help those who have refractory pain, and addiction specialists are available if needed. If you need help finding a provider, visit dgaplans.org/networkproviders, or call the Participant Services Department at (877) 866-2200, Ext. 401. PH

The UCLA/EIMG Jack H. Skirball Health Center Has Moved

Effective earlier this month, the UCLA/EIMG Jack H. Skirball Health Center, formerly located in Woodland Hills, California, moved to a new location in Calabasas, California and was renamed the UCLA/EIMG Calabasas Health Center. The location and phone number of the center are below:

UCLA/EIMG Calabasas Health Center
26585 W. Agoura Road, Suite 330
Calabasas, CA 91302
(818) 876-1050

Patients of the former Woodland Hills location can see the same doctors and receive the same services at the new Calabasas location. Office hours remain the same: 8:00 a.m. to 5:00 p.m. Monday through Friday, and 8:00 a.m. to 4:00 p.m. on Saturdays. The Calabasas location can easily be accessed from the 101 freeway and has free parking. PH

Planning a Nasal Surgery? Request a Predetermination to Estimate Coverage

Before you have nasal surgery, requesting a voluntary predetermination could help anticipate out-of-pocket costs.

The Health Plan covers medically necessary visits, treatments and procedures for covered participants and their dependents. One of the Health Plan's criteria for determining medical necessity includes whether the procedure or service is consistent with generally accepted medical guidelines and practices, which may require that certain treatment options be administered prior to or instead of others (See sidebar on page 5: *How does the Health Plan determine medical necessity?*). When standard medical practice is not followed, a treatment will be deemed not medically necessary and, therefore, will not be covered under the Health Plan.

With regard to nasal conditions such as a deviated septum or chronic sinusitis, doctors sometimes recommend immediate surgery, even though standard medical practice suggests utilizing *non*-surgical treatments prior to considering surgical intervention. While you might assume that whatever treatment plan your doctor recommends is considered medically necessary under the Health Plan, this may not be the case if the treatment plan is not consistent with standard medical practices. If surgery is done and is later determined not to have been medically necessary, you may be held responsible for the full cost of the procedure, leaving you with significant unanticipated expenses.

For complex procedures—like nasal surgery—and for procedures that include both reconstructive and cosmetic components, determining medical necessity is not straightforward.

WHAT *IS* STANDARD MEDICAL PROCEDURE FOR NASAL DIAGNOSES?

Nasal Septum Deviation and Chronic Sinusitis are common nasal conditions for which doctors might recommend surgery as a first course of treatment. Surgery as a first response, however, is *not* standard medical practice in treating these conditions and, therefore, will not be considered medically necessary by the Health Plan.

According to standard medical practices, before advancing to nasal surgery, you should have first tried the following with no success:

- Decongestants,
- Nasal steroid sprays,
- Antihistamines for Nasal Septum Deviation,
- Saline nasal irrigation for Chronic Sinusitis (ex: Neti Pot), and
- Antibiotics.

Be aware, however, that even if you have followed standard medical procedure, given the complex nature of nasal surgery, some features of a surgery may be considered medically necessary while others may not. Rhinoplasty, for example, will likely be considered not medically necessary, as will any other cosmetic procedure.

Although a surgery might seem like a single procedure, in reality, it might include several procedures, each of which must be evaluated for coverage by the Health Plan. When in doubt, review each of the planned procedures with your doctor so you have a full understanding of your surgery and its costs.

If you are uncertain about whether a treatment or procedure is medically necessary, you should request a **voluntary predetermination** from the Health Plan before receiving the service. A predetermination will help you evaluate ahead of time whether the treatment is considered medically necessary and whether it will be covered.

WHAT IS A PREDETERMINATION?

A predetermination is a written analysis, provided by the Health Plan upon request, which evaluates the medical necessity of a particular procedure or treatment before

you receive it. A predetermination will provide you with information on how the Health Plan might apply benefits for the service in question; however, it does not guarantee coverage. A final determination of coverage can be made only after the procedure has been performed, upon processing the claim and reviewing additional information and records submitted.

A "predetermination" is not the same as a "pre-authorization." Predetermination is a *voluntary* request for information from the Health Plan. Pre-authorization, on the other hand, is a *required* step your provider must take to confirm Health Plan coverage for certain services, including inpatient hospital stays, mental health and substance abuse intensive outpatient treatment, certain prescription drugs, partial hospitalization and residential care. In contrast to predetermination, pre-authorization guarantees that the authorized procedures will be covered.

HOW DO I SUBMIT A PREDETERMINATION REQUEST?

To start the predetermination process, you or your provider should submit your medical records and a letter of medical necessity, including diagnoses and procedure codes for the services being considered. The request should be sent to the Health Plan Claims Department via fax at (323) 866-2351 or via email at hpclaims@dgaplans.org. Depending on the type of service in question, your predetermination may be sent to a third-party to conduct an independent medical review.

Within 10 business days following receipt of the request, the Health Plan will send you or your provider a written response outlining the results of the predetermination of medical necessity for each procedure code. The predetermination will indicate whether a particular procedure code reflects medical necessity; it is not a guarantee of coverage for the procedure.

Please note that your predetermination applies only to the procedure codes submitted with your request. For example, if you receive a predetermination of medical necessity for procedure codes 1, 2, and 3, and the actual claim submitted by your provider includes codes 1, 2, 3, 4 and 5, codes 4 and 5 may not be medically necessary, leaving you responsible for the costs of the procedures.

For any questions concerning predetermination, please call the Health Plan at (877) 866-2200, Ext. 401. PH

How does the Health Plan Determine Medical Necessity?

Medical necessity is determined on a case-by-case basis. The Health Plan considers a treatment, service or supply medically necessary when the treatment meets all of the following requirements:

- Consistent with generally accepted medical practice within the medical community for the diagnosis or direct care of symptoms, sickness or injury of the patient, or for routine screening examination under wellness benefits, where and at the time the treatment, service or supply is rendered. The determination of "generally accepted medical practice" is the prerogative of the Health Plan through consultation with appropriate authoritative medical, surgical, or dental practitioners;
- Ordered by the attending licensed physician (or, in the case of dental services, ordered by the dentist), and not solely for the convenience of the participant or the participant's physician, hospital or other health care provider;
- 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, at the most cost-efficient and medically appropriate site and level of service.

Common examples of procedures or services for which medical necessity might not be clear include genetic testing, drug testing, nasal surgery and breast surgeries unrelated to cancer. For these procedures, a voluntary predetermination from the Health Plan is recommended. (See previous page). PH

Mental Health Benefits: Understanding Coverage for Therapy Treatment

Included in the wide range of benefits provided by the Health Plan is coverage for mental health services, including individual therapy. Individual therapy is covered when medically necessary. However, family therapy is not covered by the Health Plan. Knowing the differences between individual and family therapy can help you anticipate which services will be covered by the Health Plan.

Family and Relationship Therapy

The Health Plan considers a therapy session to be "family therapy" when another family member is present during a session. For example, if a child is receiving therapy and the child's parents and/or siblings are included in a therapy session, that session is considered family therapy, and will not be covered.

Relationship, marriage counseling and couples therapy are also not covered by the Health Plan. If the Health Plan receives records indicating the presence of multiple parties in one therapy session, those sessions will not be covered, even if they were billed as individual therapy.

Individual Therapy

As noted above, individual therapy is covered by the Health Plan when treatment is medically necessary (See sidebar on page 5: *How does the Health Plan determine medical necessity?*). Medically necessary individual therapy sessions are subject to the same deductible and co-insurance as other covered medical services.

If you are in doubt as to whether a mental health therapy service will be covered under the Health Plan, contact Participant Services at (877) 866-2200, Ext. 401. **PH**

HAVE NEW CONTACT INFORMATION? TELL US.

Keep your information with the Plans up to date so you don't miss out on important benefits and communications. If you've recently moved, had a change of 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:

- **Download a Change of Address Form from dgaplans.org/forms**. Once completed, return the form by email to addresschange@dgaplans.org, by fax to (323) 866-2389 or mail it to the Plans' office.
- **Call an Address Change representative** Monday-Friday, 8:30 a.m-5:00 p.m Pacific Time at (323) 866-2200, ext. 407.

Keep in mind you must separately notify the Directors Guild of America of any changes in your information, as it is a separate entity. **PH**

Health Plan Updates

R_X Programs Update: Health Plan Will Not Participate in the Medicare Part B Program

The Health Plan will *not* participate in Express Scripts' Medicare Part B program, as previously reported in the Special R_X Edition of *Spotlight on Benefits* in November 2018.

The Medicare Part B Program would have affected Medicare-eligible participants receiving supplies covered by both Medicare Part B and the Health Plan's prescription drug benefit. The aim of the program was to coordinate payment of claims for Part B-eligible supplies between the two insurers. Upon further review, the Health Plan determined the program would cause confusion and restrict participants' ability to continue to obtain certain supplies via mail order. **PH**

Health Plan Booklet Language Changes: Preventive Care

The Preventive Care section of the March 2015 Health Plan Summary Plan Description has been amended to update outdated website references and language in reference to current Health Plan policies. The amendments, which make no other substantive changes to the Plan, are as follows:

- The address of the Affordable Care Act's preventive care services site was updated to https://www.healthcare.gov/coverage/preventive-care-benefits/.
- Smoking cessation and weight loss prescription drugs were removed from the description of preventive care prescription drugs covered at 100%, as they are no longer on the federal government's list of preventive services. These are now subject to the Health Plan's prescription benefits.

Please refer to the March 2015 Health Plan Summary Plan Description and its updates, available at dgaplans.org/forms/health, for more details. **PH**

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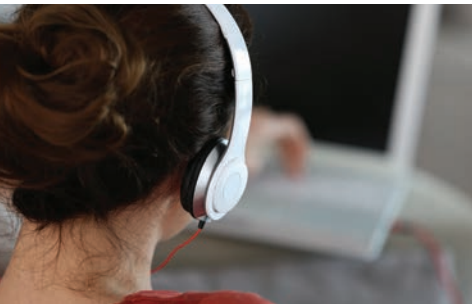

SKYPE MEETINGS

WE'RE HERE FOR YOU

As a Pension and Health Plans' participant, you have access to a diverse set of retirement and health benefits.

In addition to meeting with Pension and Health Plans' staff in our office or periodically scheduled meetings at various locations, you can meet "face to face" with Plans's staff online.

GOT SKYPE?

If you have a Skype-enabled computer or tablet, you can meet with us from the comfort of your home during our normal business hours: M-F, 8:30 a.m. to 5:00 p.m., Pacific Time.

To schedule an online meeting, call (877) 866-2200 and dial "0". Tell the Plans' representative that you are calling to schedule a Skype meeting. **PH**

TO SCHEDULE A SKYPE MEETING WITH A PLANS' REPRESENTATIVE, CALL:

(877) 866-2200

DIAL "0" FOR THE OPERATOR

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

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, 2018 and ending December 31, 2018 ("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.

	2018 Plan year	2017 Plan Year	2016 Plan Year
Valuation Date	January 1, 2018	January 1, 2017	January 1, 2016
Funded Percentage	92.4%	92.7%	95.43%
Value of Assets	$1,691,869,004	$1,623,455,984	$1,567,501,737
Value of Liabilities	$1,830,229,017	$1,751,029,113	$1,642,523,540

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, 2018	December 31, 2017	December 31, 2016
Fair Market Value of Assets	$1,622,185,407	$1,705,241,948	$1,504,821,858

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 13,191. Of this number, 7,945 were active participants, 3,009 were retired or separated from service and receiving benefits, and 2,237 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	1.5
U.S. Government securities	4.7
Corporate debt instruments (other than employer securities):	
Preferred	1.6
All Other	5.0
Corporate stocks (other than employer securities):	
Preferred	0.0
Common	1.5
Partnership/joint venture interests	20.7
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	27.2
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	20.4
Value of interest in registered investment companies (*e.g.* mutual funds)	16.3
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	1.1

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 Samantha Petersen, Controller, at (323) 866-2272.

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** 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 PBGS'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 x $33), or $35.75. Thus, the participant's guaranteed monthly benefit is $357.50 ($35.75 x 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 x $9), or $17.75. Thus, the participant's guaranteed monthly benefit would be $177.50 ($17.75 x 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. 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.