DGA-PRODUCER PENSION & HEALTH

Spotlight ON BENEFITS

WINTER 2019

Board of Trustees Announces Improved Vision Benefits and Other Changes to the Pension and Health Plans, Effective January 1, 2020

This year-end issue of the *Spotlight on Benefits* newsletter announces several changes to the Pension and Health Plans, effective January 1, 2020, including vision benefit improvements to reduce the amount you pay out of pocket for common network services like contacts, lenses and frames. Also included are adjustments to the minimum earnings threshold for Health Plan coverage, the addition of a new premium tier for retiree spouses under 60, and changes to the pension benefit accrual rate for new (Basic) Pension Plan participants.

Also, be sure not to miss the back cover announcing the Plans' new online benefits portal, myPHP, available now to all participants and dependents age 18 and over. MyPHP provides 24/7 access to your contributions, estimated pension benefits, Health Plan eligibility status, medical claims, annual and quarterly statements, and more. PH

What is the Summary Annual Report?

The enclosed Summary Annual Report is a government mandated document distributed by the Plans Office each year to qualified participants and beneficiaries. Like the Annual Funding Notice for the Basic Pension Plan (distributed each spring), the Summary Annual Report provides summarized financial information for the Supplemental Pension Plan and the Health Plan, including assets, expenses, and investment gains and losses as of December 31, 2018.

2018 Summary Annual Report Enclosed

Spotlight
ON BENEFITS
Volume 27 | Number 4 | Winter 2019
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.

Board of Trustees Announces Improved Vision Benefits

Beginning January 1, 2020, Health Plan participants with vision coverage will enjoy improved vision benefits that will lower the amount you pay out of pocket for common network services like contacts, lenses and frames.

The improved vision benefits include the following:

- increased network allowances on frames and elective contact lenses,
- the elimination of the co-payment for standard progressive lenses, and
- a limit on the amount you pay for contact lens fitting and evaluation.

With these enhancements you will enjoy lower out-of-pocket costs when you visit a network vision provider.

The chart below summarizes the improvements to covered network services.

Service	Current Network Coverage	Changes Effective 1/1/2020
Standard Progressive Lenses	Covered with $50 co-payment	**Covered (no co-payment)**
Frame	$120 allowance with $30 co-payment	**$220 allowance with $30 co-payment**
Elective Contacts	$120 allowance with $30 co-payment	**$200 allowance with $30 co-payment**
Contact Lens Fitting and Evaluation	15% savings	**$200 allowance with co-payment not to exceed $60**

In addition, there are extra savings to take advantage of with your VSP coverage. Go to vsp.com/offers for details. **PH**

Board of Trustees Approve Health Plan Eligibility Changes, Effective January 1, 2020

The Board of Trustees recently approved the following Health Plan eligibility changes, aligning the benefits with wage increases in the Collective Bargaining Agreements:

1. Minimum earnings threshold for Health Plan coverage increasing for both the Premier Choice and Choice Plans

   Effective with earnings periods beginning on or after January 1, 2020, the minimum earnings threshold for coverage under the Choice and Premier Choice Plans will increase to the following:

   - $35,875 for Choice coverage
   - $116,000 for Premier Choice coverage

2. Carry-over threshold and maximum carry-over bank amount increasing

   Effective with benefit periods beginning on or after January 1, 2020, both the threshold at which you begin to accumulate carry-over credit and the amount of carry-over credit necessary for one year of Health Plan coverage will increase from $135,000 to $140,000. In order to accommodate the increased carry-over threshold amounts, the carry-over bank maximum has likewise been increased from $465,000 to $480,000, effective with benefit periods beginning on or after October 1, 2019.

   Under these new carry-over amounts, you will be able to bank covered earnings in excess of $140,000 (up to a maximum of $480,000) for use during periods in which you do not meet the minimum earnings threshold for earned coverage. During such periods, $140,000 in carry-over credit is needed to grant one year of Health Plan coverage.

If you have questions regarding any of the Health Plan changes, contact Participant Services at (323) 866-2200, Ext. 401 or toll-free at (877) 866-2200, Ext. 401. PH

New Premium Tier for Retiree Spouses Under Age 60

In order to preserve the generous benefits currently extended to qualified retirees and their spouses, the Board of Trustees announces a new premium tier for spouses under age 60 who are covered under Certified Retiree coverage and Retiree Carry-Over coverage.

Currently, premiums for Certified Retiree and/or Retiree Carry-Over spousal coverage are based on two tiers: (1) Medicare-eligible spouses age 65 and older and (2) spouses under the age of 65. Beginning January 1, 2020, the Health Plan is adding a third tier of premiums for spouses under age 60. PH

Clarification on Interest Paid on Pension Benefits Underpayments

The Board of Trustees has added language to the *March 2015 Pension Plans Summary Plan Description*, clarifying that the Basic and Supplemental Pension Plans will apply a 5% per annum interest rate to any underpayments owed to participants.

For more information on these changes, refer to the *March 2015 Pension Plans Summary Plan Description* and its updates available on dgaplans.org/forms. PH

Board of Trustees Continues Its Efforts to Further Strengthen the Basic Plan

Changes Announced to Basic Plan Accrual Rates for New Participants

Over the past several years, the Board of Trustees has made incremental changes to ensure the continued strength of the Basic Plan and its ability to pay promised benefits well into the future, including diverting previously negotiated pension contribution increases to the Basic Plan. To further ensure the strength of the Basic Plan, the Trustees recently approved a change to the Basic Plan benefit accrual rate for participants who begin participating in the Pension Plans on or after January 1, 2020.

If you are a new participant commencing participation in the Basic Plan on or after January 1, 2020 and become vested under the 5-year vesting rule, your benefits will accrue at 93% of the accrual rate that was in effect prior to January 1, 2020. Once you reach 10-year vesting, accruals for all years will phase-in over the following 5 years, reaching 100% of the previous rates after 15 years. The accrual rate will increase in accordance with the total number of Credited Service Months (CSMs) earned, as described in the following chart:

Total Number of Credited Service Months	Benefit Accrual Rate
Less than or equal to 131 CSMs	93.0% of old rate
132 – 143 CSMs	94.4% of old rate
144 – 155 CSMs	95.8% of old rate
156 – 167 CSMs	97.2% of old rate
168 – 179 CSMs	98.6% of old rate
180 or more CSMs	100% of old rate

Under the schedule shown above, you will accrue pension benefits at 93% of the old accrual rate until you earn 132 CSMs, at which point your accrual rate will increase by 1.4% for each additional 12 CSMs earned until eventually reaching 100% of the old accrual rate after earning 180 CSMs.

If you commenced participation before January 1, 2020, your benefits will remain unchanged. You will continue to accrue Basic Plan benefits at the accrual rate in effect prior to the change. **PH**

Express Scripts Updates Its List of Covered Medications

Express Scripts, the Health Plan's prescription drug benefit manager, periodically reviews its list of covered medications, called the National Preferred Formulary, to ensure access to safe, effective treatments in all drug classes. As new medications enter the market, they are reviewed in consultation with an independent group of physicians to determine which medications provide significant health benefits beyond other available options. Certain medications may be excluded from the formulary when clinically equivalent alternatives are available and offer significant cost savings. Changes to the formulary affect which medications will be covered by the Health Plan and how much you pay out of pocket for prescriptions.

Effective January 1, 2020, Express Scripts will revise its list of covered medications. If you are currently taking a medication that will be excluded from the revised formulary, Express Scripts should have already notified you via mail with information on alternatives. If you are taking a maintenance medication, be sure to review the new list in case the status of your medication has changed.

The complete 2020 list of excluded medications along with preferred alternatives is available at www.express-scripts.com/art/pdf/Preferred_Drug_List_Exclusions2020.pdf. For information on whether this change will affect your current prescriptions, log on to your Express Scripts account at expressscripts.com/covered. If you have any questions, please call Express Scripts at (800) 987-7828. **PH**

How Coordination of Benefits Works

When you have other medical coverage in addition to the DGA-Producer Health Plan, the Health Plan's coordination of benefits rules establish which of your plans should pay your claims first, or is your primary plan. This process is important not only for dividing responsibility for payment of your claims but also in determining the order in which your claims should be submitted. For example, after your primary plan processes your claim, the claim should go to your secondary plan, then your tertiary plan, etc.

Each year you have Health Plan coverage, you are required to complete a Coordination of Benefits form, notifying the Health Plan of any additional coverage, even if the information has not changed since the prior year. Outdated coordination of benefits information will result in denial of your claims until an updated form is received. For more information on the COB form, read ***Coordination of Benefits Form is Required When You are Covered by the Health Plan*** on page 7.

The following sections provide important information on how to apply the coordination of benefits rules to establish which of your plans is primary and, once the COB order is established, how your claims should be submitted.

The types of plans with which benefits are coordinated

The Health Plan coordinates benefits with the following types of plans:

- Group insurance coverage;
- Private (individual, non-group) insurance coverage;
- Government-provided programs (e.g., Medicare);
- Coverage provided by statute;
- Employer-sponsored coverage; and
- Any coverage under labor-management trusteed plans.

How to determine your primary plan

Your primary plan is the plan that should process your claims first. The first of the following rules that applies to your specific situation determines which plan is primary, secondary, tertiary, etc.:

- The plan without a coordination of benefits provision is always primary.
- The plan covering you as a participant is primary to the plan covering you as a dependent, with one exception. When you are covered as a dependent by a working spouse, have inactive coverage (not based on current compensation) and are covered by Medicare, your spouse's plan is primary, Medicare is secondary, and your inactive plan is tertiary.
- The plan covering you as an active employee is primary to any plan covering you as an inactive, self-pay or retired employee.
- If you have the same type of coverage with more than one plan, the plan with the longest continuous eligibility* as a participant is your primary plan and pays benefits first. If you have the same effective date in both plans, each plan is responsible for 50% of the allowable covered charges.

*If you are eligible for group health benefits and are required to pay a premium but decline to pay the premium, and then at a later date begin to pay the premium, the period during which the premium was unpaid does not constitute a break in eligibility for the purpose of determining the plan that you have with the longest continuous eligibility.

Coordination of Benefits with Other Entertainment Industry Health Plans

If you or your dependents are eligible for earned active primary coverage with

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How Coordination of Benefits Works

another entertainment industry health plan that requires a premium and you or your dependent fails to pay or declines to pay the premium in that plan, the Health Plan will maintain its secondary position. This means that for hospital and major medical benefits, the Health Plan will calculate the benefit payable at 20% of the allowable charge, subject to deductibles and co-payments, if any.

How to submit your claims for coordinating benefits

If you use a network provider, your network doctor, hospital or other provider will submit your claim on your behalf. They will automatically accept assignment of benefits and bill directly to Anthem Blue Cross (for claims incurred in CA) or the appropriate Blue Cross Blue Shield office (for claims incurred outside of CA). Your claims will be coordinated automatically with all your coverage plans. All you have to do is pay the appropriate co-insurance and deductible, if applicable, which will be billed to you from your network provider once coordination of the benefits is completed.

However, if you use a non-network provider, take the following steps to ensure your claims are coordinated properly:

If you are covered by another insurance plan and that plan is your primary plan:

1. File your claim with that plan first.
2. Once the primary plan has processed your claim, send a copy of the itemized bill and the Explanation of Benefits to Anthem Blue Cross. Visit www.dgaplans.org/filing-a-claim for more information on steps to take to file a claim.

   The Health Plan will process your claim by first determining how much it would have paid had there been no other group coverage. Next, the Health Plan will use the Explanation of Benefits you submitted to determine what your primary plan paid and make a payment for the difference, if any, between the greater of the allowable amount and the amount paid by the primary plan—not to exceed the amount the Health Plan would have paid if it had been the primary plan.

If you are covered by another insurance plan and that plan is your secondary plan:

1. File your claim with Anthem Blue Cross first.

   The Health Plan will process your claim with no consideration of what the secondary plan may or may not pay.

2. Send a copy of the itemized bill and EOB to your secondary plan.

Refer to the *March 2015 Health Plan Summary Plan Description* and its updates for more information on how coordination of benefits works, including coordination of benefits for dependent children at www.dgaplans.org/Health-Plan-Booklet.pdf. If you have additional questions, contact Participant Services at (323) 866-2200, Ext. 401. **PH**

All-Inclusive Out-of-Pocket Limits Increase, Effective January 1, 2020 as Established Under the Affordable Care Act

The All-Inclusive Network Out-of-Pocket Limit sets a maximum on the amount you pay out of pocket per calendar year for network benefits, including deductibles, co-insurance and co-payments (such as prescription drug co-payments, the $50 emergency room co-payment and the $10 co-payment for visits to the UCLA/MPTF health centers). The Health Plan indexes this limit annually, in line with the amount established each year under the Affordable Care Act.

Accordingly, beginning January 1, 2020, the Health Plan's All-Inclusive Network Out-of-Pocket Limit will increase from $7,900 individual/$15,800 family to $8,150 individual/$16,300 family for all coverage plans. If you reach the limit, the Health Plan will pay 100% of covered network expenses. **PH**

Coordination of Benefits Form Is Required When You Are Covered By the Health Plan

Claims submitted to the Health Plan will be denied if a current Coordination of Benefits form is not on file.

For each year you have Health Plan coverage, you must submit a new Coordination of Benefits ("COB") form, verifying whether or not you and/or any of your dependents are eligible for coverage from another insurer. This form is included in the open enrollment packet you receive at the beginning of each benefit period and should be completed and returned even if the information has not changed. **Without a current COB form on file, your claims and those of your dependents will be denied until a new form is submitted.**

Below is a list of frequently asked questions regarding the COB form:

1. **Where can I get a COB form?**

   The COB form is included in your open enrollment package. It is also available on the Plans' website: www.dgaplans.org under Documents and Forms.

2. **Should I include my DGA Health Plan information on the COB form?**

   No. Only outside insurance information, such as coverage from other entertainment industry health plans, coverage provided by your spouse's employer, or private plans should be included on the COB form.

3. **Should I include Medicare information on the COB form?**

   You do not need to include Medicare information on the form.

4. **Do I need to submit a COB form for each dependent?**

   No. Only one COB form is required for you and your dependents unless you need additional space to add more information.

5. **What happens if I am late submitting my COB form?**

   If a current COB form is not on file, the Health Plan will deny your claims until a new COB form is submitted.

6. **Where can I send the COB form?**

   A completed COB form can be emailed to eligibility@dgaplans.org, mailed to the address on the form, or faxed to (323) 866-2399.

7. **Should I submit a COB form each year, even though there is no change?**

   Yes. A new COB form is required each year.

8. **Can I use a copy of last year's COB form for the following year if the information is the same?**

   No. The Health Plan requires a new COB form every year regardless of whether the information on the form has changed.

9. **My COB form was received. How long will it take for my denied claim(s) to be reprocessed?**

   Once the COB form is processed, it takes up to 10 business days for your denied claim(s) to be reprocessed.

10. **Do I need a new COB form for each claim denied?**

    No. Only one COB form for that period is required for each benefit period. **PH**

Women's Health and Cancer Rights

Women who have had a mastectomy or expect to have one may be entitled to special benefits under the Women's Health and Cancer Rights Act of 1998. The Health Plan provides several important benefits to help women fighting breast cancer.

The following notice is made on an annual basis:

> *The Health Plan provides medical and surgical benefits for certain types of reconstructive surgery in connection with a mastectomy. This covers reconstruction of the breast on which the mastectomy was performed, surgery on the other breast to produce a symmetrical appearance, and prostheses and physical complications of all stages of mastectomy, including lymphedemas.*

If you have questions, please contact the Participant Services Department toll-free at (877) 866-2200, Ext. 401. **PH**

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Introducing
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the NEW online benefits portal for participants
in the DGA–Pension and Health Plans

The myPHP online benefits portal is open to all DGA Plans Participants and their dependents age 18 and over. Register today to put your benefits information in your hands wherever you have an internet connection.

To register, have your Plan ID number ready, go to **www.dgaplans.org/myPHP** and click Register.

- **Check your estimated pension benefits**
- **Check your Health Plan eligibility status**
- **Verify your health and pension contributions**
- **Update your Plans mailing address electronically with NO FORM NEEDED**
- **View, print, or download your claims, pension and contributions statments**

...and MORE!

REGISTER TODAY at www.dgaplans.org/myPHP

For myPHP support, email **myphp-support@dgaplans.org** or call **(323) 866-2200, Ext. 409**
Monday–Friday, 8:30 a.m.–5:00 p.m. Pacific Time

DGA-PRODUCER PENSION PLANS

Summary Annual Report for the:

Directors Guild of America–Producer Pension Plan Supplemental Benefit Plan

This is a summary of the annual report for the Directors Guild of America - Producer Pension Plan Supplemental Benefit Plan, E.I.N. 95-6027308, Plan No. 002, for the year ended December 31, 2018. The annual report has been filed with the Employee Benefits Security Administration, U.S. Department of Labor, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Basic Financial Statement

Benefits under the plan are provided through a trust fund or arrangements providing benefits partially through annuity contracts. Plan expenses were $104,345,016. These expenses included $10,862,877 in administrative expenses and $93,482,139 in benefits paid to or for participants and beneficiaries. A total of 23,628 persons were participants in or beneficiaries of the plan at the end of the plan year, although not all of these persons had yet earned the right to receive benefits.

The value of plan assets, after subtracting liabilities of the plan, was $1,710,212,092 as of December 31, 2018, compared to $1,797,133,439 as of January 1, 2018. During the plan year, the plan experienced a decrease in its net assets of $86,921,347. This decrease includes unrealized appreciation or depreciation in the value of plan assets; that is, the difference between the value of the plan's assets at the end of the year and the value of the assets at the beginning of the year, or the cost of assets acquired during the year. The plan had total income of $17,423,669 including employer contributions of $38,554,625, participant contributions of $27,567,330, rollovers of $14,954,142, losses of $2,890,356 from the sale of assets, losses from investments of $60,911,394 and other income of $149,322.

Your Rights to Additional Information

You have the right to receive copies of the full annual report, or any part thereof, on request. The items listed below are included in that report:

1. an independent auditor's report;
2. financial information and information on payments to service providers;
3. assets held for investment;
4. transactions in excess of 5% of the plan assets;
5. fiduciary information, including non-exempt transactions between the plan and parties-in-interest (that is persons who have certain relationships with the plan); and
6. information regarding any common or collective trusts, pooled separate accounts, master trusts or 103-12 investment entities in which the plan participates.

To obtain copies of the full annual report, or any part thereof, write or call the office of the Directors Guild of America - Producer Pension and Health Plans, 5055 Wilshire Boulevard, Suite 600, Los Angeles, California 90036, or call (323) 866-2200. The charge to cover copying costs will be $.25 per page for any parts thereof.

You also have the right to receive from the plan administrator, on request and at no charge, a statement of the assets and liabilities of the plan and accompanying notes, or statement of income and expenses of the plan and accompanying notes, or both. If you request a copy of the full annual report from the plan administrator, these statements and accompanying notes will be included as part of that report. The charges to cover copying costs given above do not include charges for the copying of these portions of the reports because these portions are furnished without charge.

You also have the legally protected right to examine the annual reports at the main office of the plan (5055 Wilshire Boulevard, Suite 600, Los Angeles, California 90036) and at the U.S. Department of Labor in Washington, D.C., or to obtain copies from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

DGA-PRODUCER HEALTH PLAN

Summary Annual Report for the:

Directors Guild of America–Producer Health Plan

This is a summary of the annual report of the Directors Guild of America - Producer Health Plan, E.I.N. 23-7067289, Plan No. 501, for the year ended December 31, 2018. The annual report has been filed with the Employee Benefits Security Administration, U.S. Department of Labor, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Basic Financial Statement

The value of Plan assets, after subtracting liabilities of the Plan, was $87,092,057 as of December 31, 2018, compared to $87,429,900 as of January 1, 2018. During the Plan year, the Plan experienced a decrease in its net assets of $337,843. This decrease includes unrealized appreciation and depreciation in the value of Plan assets; that is, the difference between the value of the Plan's assets at the end of the year and the value of the assets at the beginning of the year or the cost of assets acquired during the year. During the Plan year, the Plan had total income of $142,869,620 including employer contributions of $137,464,338, participant contributions of $11,306,754, gains of $826,703 from the sale of assets, losses from investments of $6,803,745 and other income of $75,570.

Plan expenses were $143,207,463. These expenses included $5,624,950 in administrative expenses and $137,582,513 in benefits paid to or for participants and beneficiaries.

Your Rights to Additional Information

You have the right to receive copies of the full annual report, or any part thereof, on request. The items listed below are included in that report:

1. an independent auditor's report;
2. financial information and information on payments to service providers;
3. assets held for investment;
4. transactions in excess of 5% of the plan assets; and
5. information regarding any common or collective trusts, pooled separate accounts, master trusts or 103-12 investment entities in which the plan participates.

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