DGA-PRODUCER PENSION & HEALTH

Spotlight ON BENEFITS

SPRING 2020

Board of Trustees approves temporary Health Plan coverage changes in response to COVID-19

Subject to Health Plan rules and requirements below, all patient cost sharing (*i.e.*, co-pays, co-insurance and deductibles) will be waived for COVID-19 related testing, and telemedicine/telepsychology visits will be covered until further notice.

During this challenging and unprecedented time caused by the coronavirus outbreak, the Board of Trustees has decided that certain temporary changes to your health benefits are warranted for the protection and safety of all Plan participants. Further details are provided below but, effective immediately, all patient cost sharing (*i.e.,* co-pays, co-insurance and deductibles) will be temporarily waived for all COVID-19 related testing and physician advice. In addition, many physicians' offices and therapists' offices are no longer seeing patients in-person to prevent further spread of the virus. As a result, the Board of Trustees has approved telemedicine and telepsychology visits on a temporary basis. These changes take into account the importance of COVID-19 testing and related treatment, as well as the need for limiting in-person interactions and social gatherings to the extent possible, as recommended by health authorities.

Telemedicine and telepsychology visits (network and non-network) covered until further notice

The Health Plan's Board of Trustees has unanimously approved a Plan amendment that will temporarily provide coverage for both network and non-network telemedicine and telepsychology services. This means that, effective March 16, 2020, and until further notice, the Health Plan will cover office visits that can properly be conducted online with a licensed provider, as long as those visits and services would otherwise be covered under the terms of the Health Plan.

You may visit your network or non-network provider online or use Anthem's LiveHealth Online network providers, subject to the Health Plan's applicable deductibles and co-insurance rules. For further information regarding Anthem's telemedicine and telepsychology program, please visit www.livehealthonline.com, call 1-888-LiveHealth (548-3432) or email to help@livehealthonline.com. When emailing, make sure to include your name, email address and phone number where you can be reached.

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Spotlight
ON BENEFITS
Volume 28 | Number 1 | Spring 2020
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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.

CONTINUED FROM FRONT COVER

Board of Trustees approves temporary Health Plan coverage changes in response to COVID-19

Except as provided below for COVID-19 testing, all other Health Plan rules remain in effect, including but not limited to the exclusion of services that are not medically necessary, the exclusion of marriage, family or relationship counseling and/or therapy, and the exclusion for charges in excess of the Allowable Charge limit (meaning you will be responsible for any out-of-network charges above the Allowable Charge or Reasonable and Customary Charge limit).

Because this change is temporary, you will be notified when this special telemedicine benefit ends.

For more information about Anthem's LiveHealth Online, go to the Plans' website at www.dgaplans.org.

Cost Sharing waived for COVID-19 related testing

Effective immediately and continuing until further notice, all patient cost sharing (*i.e.*, deductibles, co-pays, co-insurance and prior-authorizations) will be waived for all testing for the detection and diagnosis of the COVID-19 virus. This means you will not have any cost-sharing for these services, regardless of whether they are in-person or via telemedicine/telepsychology and regardless of whether they are in-network or non-network.

The Plan's waiver of cost sharing will apply to testing-related office visits, telemedicine visits, urgent care centers, and hospital emergency room visits for the purpose of COVID-19 testing. There are two important things to keep in mind about these new changes regarding cost-sharing. First, the waiver of cost sharing only applies to items and services related to testing for the virus or the evaluation of the individual to determine if he or she needs testing. Second, the waiver of cost-sharing does not apply to medical treatments following a diagnosis of COVID-19. Those treatments are subject to all other Health Plan rules.

These new rules are intended to comply, and will be administered and applied in accordance with the requirements of the new Families First Coronavirus Response Act, which was signed in to law on March 18.

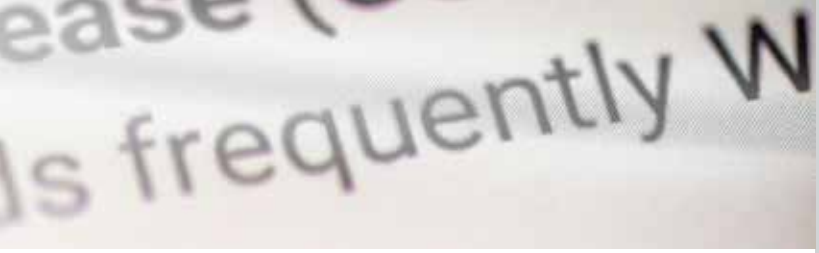
If you have already incurred a claim

If you have already incurred a claim for services affected by the aforementioned Health Plan coverage changes, you may be eligible for reimbursement. We recommend that you reach out to the provider you received services from and ask that they submit a claim to Anthem on your behalf (or directly to the Plan in the case of non-network providers). If they are unable to do so, you will need to submit a claim form and copy of the itemized bill to Anthem (or to the Plan). For more information on how to submit a claim, please go to our website: www.dgaplans.org/the-dga-producer-health-plan/filing-a-claim/medical-claims/.

If you have questions, please reach out to the Participant Services Department at (323) 866-2200, Ext. 401.

How to protect yourself and others

It is important to take appropriate preventive measures to ensure the health and safety of yourself, your loved ones and those around you. To that end, the Centers for Disease Control and Prevention (CDC) offer the following recommendations:



- Stay home when you are sick from any illness.
- If you have personally suffered symptoms of acute respiratory illness, stay home until you are free of fever (100.4° F or greater using an oral thermometer), signs of a fever, and any other symptoms for at least 24 hours, without the use of fever-reducing or other symptom-altering medicines (*e.g.*, cough suppressants).
- Avoid close contact with people who are sick.
- Avoid touching your eyes, nose, and mouth with unwashed hands.
- Wash your hands often with soap and water for at least 20 seconds. Regularly use an alcohol-based hand sanitizer that contains at least 60% alcohol if soap and water are not available.
- Cover your cough or sneeze with a tissue, then throw the tissue in the trash. While sneezing in your elbow is certainly preferable to sneezing in your hand, the clothing on your elbow can contain infectious viruses that can be passed on for up to a week or more. Clean and disinfect frequently touched objects and surfaces. All surfaces where infectious droplets land can remain infectious for about a week, on average.
- To the extent possible, use knuckles to touch light switches, elevator buttons, etc., and please avoid handshaking and other physical contact.

Where to find updated information

For updates on the coronavirus, the CDC and the World Health Organization have created special websites with a wealth of information regarding what the coronavirus is, how it is contracted, what countries are under a travel advisory, etc. This information is updated regularly as the situation evolves and can be found on the following websites:

- **www.cdc.gov/coronavirus/2019-ncov/summary.html**
- **www.who.int/emergencies/diseases/novel-coronavirus-2019**

Call your doctor if you develop a fever, have a cough, or have difficulty breathing. Let your doctor know if you have been in close contact with a person known to have COVID-19, or if you live in or have recently traveled to an area where the virus has spread. PH

Updated Pension and Health Summary Plan Descriptions Now Available Online and on myPHP

Keep on the look out in the mail for your new Summary Plan Descriptions! These documents describe the benefits offered by the Pension and Health Plans, as amended through March 2020.

The updated Summary Plan Descriptions are available now at www.dgaplans.org/forms and on the myPHP online benefits portal for registered portal users. PH

Health Plan Summary Plan Description Corrections

On page 23, Article III, Section 4(d)(1)(D) and Article III, Section 4(d)(2)(D), the All-Inclusive Network Out-of-Pocket Limit for the DGA Gold Plan and DGA Silver Plan should be $8,150 individual / $16,300 family.

On page 23, Article III, Section 4(d)(3)(C), the network Out-of-Pocket Maximum for the DGA Bronze Plan should be $8,150 individual / $16,300 family (includes Deductible, Co-Payments, and Co-Insurance for medical claims and prescription drugs).

On page 54, Article IV, Section 8, pre-authorization 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 prescriptions drugs, partial hospitalization and residential care. PH

IMPORTANT: How Health Plan Eligibility Works

During these unprecedented times, we understand you may be concerned about qualifying for Health Plan coverage.

To qualify for Health Plan coverage, you must first meet the minimum earnings threshold during a 12-month period called an earnings period. You must earn $35,875 for earnings periods beginning in 2020 to qualify for Health Plan benefits. This amount was $35,000 for earnings periods starting in 2019.

For the benefit period beginning on April 1st, the earnings period was January through December 2019. If you made $35,000 in 2019, you will continue to have coverage through March 31, 2021, - even if you had no earnings in the first quarter of 2020.

Similarly, if your 12-month earnings period ends in March or June 2020, and you make $35,000 during that time, you will have another year of coverage beginning on July 1, or October 1.

If you did not earn at least $35,000 during the 12-month earnings period that ended December 2019, you will not qualify for benefits beginning April 1, 2020. Similarly, if you do not earn at least $35,000 for the 12-month earnings periods ending March 2020 or June 2020, you will not qualify for benefits beginning July 1 or October 1, 2020, respectively.

The Plans' myPHP online benefits portal provides you with up to date information regarding your eligibility and reported earnings. Please see below for more information on registering for the myPHP online benefits portal.

For more information about qualifying for coverage under the Health Plan, you can also contact the Eligibility Department at (323) 866-2200, Ext. 402. PH

Register online for 24/7 access to your pension and health benefits information

myPHP

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

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

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.

myPHP users enjoy up-to-date information about their pension and health benefits in an easy-to-use format viewable on any screen. To create your account: ❶ Get your Plan ID number ready ❷ Go to **www.dgaplans.org/myPHP** and ❸ Click *Register.*

Register at www.dgaplans.org/myPHP

For technical assistance with registering for your myPHP account, call (323) 866-2200, Ext. 409, Monday—Friday, 8:30 a.m. to 5:00 p.m. (Pacific Time). For all other benefits-related questions, call Participant Services at (323) 866-2200, Ext. 401.

Non-Network Claims Can Now Be Submitted Online at Anthem.com

For Health Plan participants, one of the benefits of using an Anthem Blue Cross network provider is not having to submit claims yourself, as Anthem providers electronically submit your claims for you. Using a non-network provider, on the other hand, normally requires that you submit your claims yourself—previously, only via fax or mail. Now you may also submit non-network claims online.

To use the online claims submission option, you must first be a registered user of the Anthem online portal. If you currently have Health Plan coverage, you may register at Anthem.com. Be sure to have your Health Plan ID number ready. Once registered, follow these steps to submit your non-network claims online:

1. Log onto www.Anthem.com.
2. Under the *My Plan* tab, click *Claims*.
3. On the *Claims* page, click *Submit a Claim*.
4. On the *Submit a Claim* page, complete the requested information, attach copies of your itemized bills, and click *Next*.
5. Complete your contact information and click *Next*.
6. Check the box attesting to the accuracy of your claim information and click *Submit*. You will receive onscreen confirmation when your claim has been submitted.

For technical assistance with the online claims submission process, contact Anthem Blue Cross at (866) 755-2680. **PH**

Where to Submit Your Non-Network Claims	 Domestic	 International
	Customer Service: (877) 866-2200 ext. 401	**Customer Service: (800) 810-2583**
ONLINE	www.Anthem.com (You must be a registered user)	www.bcbsglobalcore.com
FAX	(866) 896-1393 (866) 896-6531 (866) 896-6629 (866) 896-6532 If you have Caller ID Block installed on your phone line, you will need to temporarily disable the feature by dialing *82 before faxing your claim to Blue Cross.	**Not available**
MAIL	Anthem Blue Cross PO Box 60007 Los Angeles, CA 90060-0007	BlueCross BlueShield Global Core Service Center PO Box 2048 Southeastern, PA 19399
EMAIL	**Not available**	claims@bcbsglobalcore.com
OTHER	**Not available**	BlueCross BlueShield Global mobile app (for Android, iPhone and iPod touch)

If Orthopedic Surgery Is Your First Course of Treatment, Request a Predetermination of Medical Necessity to Avoid Unexpected Costs

The Health Plan covers medically necessary orthopedic surgeries (*i.e.*, shoulder, knee, back, etc.) 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. When standard medical practice is not followed, treatment may sometimes be deemed not medically necessary and, therefore, will not be covered under the Health Plan.

With regard to orthopedic surgeries, doctors sometimes recommend immediate surgery without attempting non-surgical treatments prior to surgical intervention. While your doctor may believe that immediate surgery is necessary, it may not be medically necessary under the terms of the Health Plan if there is no documentation of attempted non-surgical treatments. If surgery is done and is later determined to be not medically necessary, you may be held responsible for the full cost of the procedure, leaving you with significant unanticipated expenses.

WHAT IS STANDARD MEDICAL PROCEDURE FOR ORTHOPEDIC SURGERIES?

Orthopedic surgeries might be recommended by doctors as a first course of treatment. Surgery as a first response, however, is generally not standard medical practice in treating orthopedic conditions and may not be considered medically necessary by the Health Plan. If your doctor is advising that your condition does not require standard medical care prior to surgery, the rationale for this decision needs to be clearly documented in your medical records.

According to standard medical practice, before advancing to orthopedic surgery, you should have first tried the following modalities/studies:

- Nonsteroidal anti-inflammatory drug
- Physical therapy
- Home exercise program
- Cortisone injections
- Medications
- Diagnostic imaging confirming diagnosis

Although a surgery might seem like a single procedure, in reality, it might include several related 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 as to whether or not your orthopedic surgery 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. For more information regarding how to submit a predetermination, go to www.dgaplans.org/predeterminations. **PH**

Important Considerations While Reviewing Your Pension Plans Annual Statement

By now, you should have received your Pension Plans annual statement. Y ou can also view your annual statement (and obtain other pension and health benefits information) from your myPHP portal account by logging in to www.dgaplans.org/myPHP.

Your annual statement details your vested status in both the Basic and Supplemental Benefit Plans, and includes an estimate of your Basic Plan benefits upon retirement, and your Supplemental Plan account balance as of the last day of the preceding calendar year. Your annual statement can be an important tool for planning your financial future.

When using your annual statement to anticipate future benefits, however, keep in mind that the benefit amounts shown on your statement may differ from the actual amounts available to you upon retirement, due to a variety of factors, including additional work in covered service, the date your benefits commence, any Qualified Domestic Relations Orders (QDROs) in effect, adjustments due to audits of employer contributions, and any legal requirements that must be satisfied. These factors may cause increases or reductions to your benefits that would not be reflected in your annual statement.

Benefit Commencement Date

For participants in the Basic Plan, the estimated benefit amounts shown on your annual statement may differ from the amounts you actually receive when you retire. That is because the estimated benefit amounts shown on your annual statement are based on your current age relative to Normal Retirement Age (usually 65) and any work reported through 2019. At the time you retire, however, your actual benefit amount will be calculated based on the date that benefits commence and any work reported through that date. Any variation between the two dates will likely result in an adjustment to your Basic Plan benefit amount that may or may not be reflected in your annual statement, depending on the following circumstances:

- If you are Ten-Year vested and plan to commence your benefit before you reach Normal Retirement Age, an estimate of the reduced benefit amount resulting from an early retirement will be shown on your annual statement.
- If you have surpassed Normal Retirement Age and have not yet taken a benefit, the increased benefit amount resulting from deferring your benefit commencement date beyond Normal Retirement Age will not be reflected on your annual statement.
- If you take a Basic Plan benefit but continue to work after your benefit commencement date, any additional benefit resulting from your additional earnings will not be reflected on your annual statement. After you take a Basic Plan benefit, subsequent annual statements will no longer show the estimated Basic Plan benefit amounts.

QDROs

A Qualified Domestic Relations Order is a type of court order that assigns a portion of the participant's pension benefits to a spouse, former spouse, child or other dependent of the participant. Your annual statement may not reflect changes to your pension benefit due to any applicable QDRO's.

Employer Audits

If it has been determined that unacceptable contributions have been made to the Pension Plans on a participant's behalf, the Plans may recover any overpaid pension benefits based on such contributions. When there is an adjustment that reduces the amount of acceptable contributions made on your behalf—for example, as a result of an employer audit —the estimated benefit shown on your annual statement will likely differ from your actual benefit.

Other Legal Requirements

Certain legal requirements may affect the estimated benefit shown on your annual statement. For example, if your benefits are subject to an IRS tax levy (a legal seizure of property to satisfy a tax debt), the Plans are required to withhold a certain amount from your benefits.

Participants should look over their annual statements carefully and contact the Plans as soon as possible if there is a discrepancy. If you have questions about your annual statement, please contact a Pension Department representative by phone at (323) 866-2200, Ext. 404, or email pension@dgaplans.org. PH

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your benefits information • at your fingertips • wherever you are

myPHP Online Benefits Portal

www.dgaplans.org/myPHP

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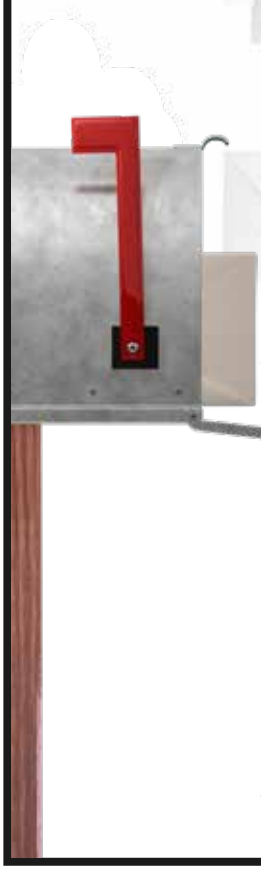

HAVE NEW CONTACT INFORMATION? TELL US.

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:

- **Create a myPHP online benefits portal account.** You may submit an address change electronically (no form needed) through the myPHP benefits portal. To create a myPHP account, go to **www.dgaplans.org/myPHP**. Then go to *My Profile* to submit your address change.
- **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

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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, 2019 and ending December 31, 2019 ("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.

	2019 Plan year	2018 Plan Year	2017 Plan Year
Valuation Date	January 1, 2019	January 1, 2018	January 1, 2017
Funded Percentage	88%	92.4%	92.7%
Value of Assets	$1,755,235,398	$1,691,869,004	$1,623,455,984
Value of Liabilities	$1,994,078,508	$1,830,229,017	$1,751,029,113

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, 2019	December 31, 2018	December 31, 2017
Fair Market Value of Assets	$1,846,803,010	$1,622,185,407	$1,705,241,948

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 13,659. Of this number, 8,199 were active participants, 3,185 were retired or separated from service and receiving benefits, and 2,275 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	2.0
U.S. Government securities	4.9
Corporate debt instruments (other than employer securities):	
Preferred	2.5
All Other	4.5
Corporate stocks (other than employer securities):	
Preferred	0.0
Common	1.5
Partnership/joint venture interests	23.7
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	35.7
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	10.4
Value of interest in registered investment companies (*e.g.* mutual funds)	13.5
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	1.3

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, Manager, Accounting Department 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 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 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 Plan Sponsor's name, employer identification number or "EIN", and official Plan number are the Board of Trustees, Directors Guild of America–Producer Pension Plan Basic Benefit Plan, 95-2892780, and 001 respectively.