DGA-PRODUCER PENSION & HEALTH

Spotlight ON BENEFITS

WINTER 2020

New Premium-Free Benefit Created for Eligible Participants

For those who lost Earned Active Coverage on June 30th, September 30th or December 31st, 2020, the Board of Trustees has created the *Bronze Plus Plan* as an alternative to COBRA Continuation Coverage.

Recognizing the pandemic's continued impact on production, the Board of Trustees has created a new limited benefit plan in order to continue to be able to provide premium-free health benefits for eligible participants who lost Earned Active Coverage in 2020. The premium-free coverage is called the *Bronze Plus Plan* and includes the same level of coverage as the DGA Bronze Plan COBRA benefit, except it also provides prescription drug benefits.

The new Bronze Plus Plan will provide coverage for the period January 1, 2021 to March 31, 2021 only, as an alternative to COBRA Continuation Coverage. It is only available to those participants for whom the DGA-Producer Health Plan is their primary coverage, and who lost their Earned Active Coverage on June 30th, September 30th, or December 31st, 2020.

Qualifying participants will have the choice of choosing either the: (1) premium-free Bronze Plus Plan or (2) COBRA Continuation Coverage by paying the applicable premium amount.

Who qualifies for the premium-free Bronze Plus Plan option?

To qualify for the premium-free Bronze Plus Plan, you must meet the following criteria:

Any one of the following:

- ❑ You had Earned Active Coverage that terminated June 30, 2020.*
- ❑ You had Earned Active Coverage that terminated September 30, 2020.*
- ❑ You have Earned Active Coverage that terminates on December 31, 2020.

*Regardless of any periods of premium-free COBRA Continuation Coverage offered after Earned Active Coverage terminated.

AND:

- ❑ The DGA-Producer Health Plan is your primary coverage.

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Spotlight ON BENEFITS
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DGA-PRODUCER PENSION PLANS

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ABOUT THE PLANS
The Pension and Health Plans were created as a result of the Directors Guild of America's collective bargaining agreements with producer associations representing the motion picture, television and commercial production industries. The DGA-Producer Pension and Health Plans are separate from the Directors Guild of America and are administered by a Board of Trustees made up of DGA representatives and Producers' representatives.

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How is the Bronze Plus Plan different from COBRA Continuation Coverage?

The premium-free Bronze Plus Plan is different from COBRA Continuation Coverage in several key ways.

	Premium-Free Bronze Plus Plan	COBRA Continuation Coverage
Premium Amount	None.	You must pay the premium amount applicable for the level of coverage you elected.
Choice of Plans	None. Your coverage will be set at the DGA Bronze Plan level and includes prescription drug coverage. Refer to the table at the bottom for details about the Bronze Plus Plan option.	You are given a choice of Self-Pay plans at or below the coverage level you had at the time your Earned Coverage terminated.
Duration	Effective January 1, 2021 through March 31, 2021, and will not run concurrent with your COBRA Continuation Coverage eligibility. This means you will be eligible to elect or resume COBRA Continuation Coverage at the applicable premium after your premium-free Bronze Plus Plan terminates on March 31, 2021. For example, participants who lost Earned Active Coverage on June 30, 2020 will have had 6 months of premium-free COBRA Continuation Coverage when the Bronze Plus Plan is offered. If you elect the premium-free Bronze Plus Plan, you will still have 12 months of self-pay COBRA Continuation Coverage remaining when the premium-free coverage terminates.	Generally, a total of 18 months, including any periods of premium-free COBRA Continuation Coverage approved by the Health Plan's Board of Trustees.
Dependents	Eligible spouse and dependent child(ren) are covered provided the Health Plan is their primary plan.	Eligible spouse and dependent child(ren) are covered provided the applicable premium for the level of coverage elected is remitted.

What is covered under the premium-free Bronze Plus Plan?

Like the current DGA Bronze Plan, the premium-free Bronze Plus Plan will have higher cost-sharing amounts (co-insurance, deductible and out-of-pocket limits) compared to the other Self-Pay plans. Unlike the current DGA Bronze Plan, however, this premium-free coverage will also include prescription drug coverage. The premium-free Bronze Plus Plan is summarized below:

MEDICAL COVERAGE

	Network Provider	Non-Network Provider
Calendar Year Deductible	$750 per person $2,250 per family	$750 per person $2,250 per family

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MEDICAL COVERAGE (continued)

	Network Provider	Non-Network Provider
Percentage Payable	70% of Covered Expenses *Essential health benefits listed under the Patient Protection and Affordable Care Act are covered at 100%	50% of Reasonable and Customary Charges
Calendar Year Out-of-Pocket Maximum	$8,550 per person $17,100 per family	$12,500 per person
What's Not Included with this Coverage	· Vision; · Dental; and · Special arrangements with UCLA Health/EIMG	

PRESCRIPTION COVERAGE

Co-Payments for	Up to 30-day supplies from Participating Retail Pharmacies	Up to 90-day supplies from the Express Scripts Pharmacy or Walgreens[1]
Generic Drugs	$10	$25
Brand Name Drugs	$24	$60
Lifestyle Drugs[2]	Greater of $40 or 50% of the cost of the medication	Greater of $60 or 50% of the cost of the medication

[1]The Plan participates in a Smart90 Walgreens program with Express Scripts. Smart90 Walgreens allows patients to obtain up to two 30-day fills of their maintenance medication at any participating retail pharmacy. After these two fills are exhausted, patients must pay the full cost for their prescription unless they transition their maintenance medication to Walgreens or the Express Scripts Pharmacy for a 90-day supply. Acute medications may be filled at any participating retail pharmacy.

[2]Erectile dysfunction drugs, proton pump inhibitors, and sleep aids are covered under the Lifestyle Drug tier; in certain cases, these drugs require a coverage review.

How do I elect the premium-free Bronze Plus Plan?

The procedures for electing the premium-free Bronze Plus Plan option will depend on when your Earned Active Coverage terminated as follows:

- **If your Earned Active Coverage terminated June 30 or September 30, 2020:** When your period of premium-free COBRA Continuation Coverage ends on December 31, 2020, you will be offered the option to either: (1) elect the premium-free Bronze Plus Plan, or (2) elect to continue your COBRA Continuation Coverage at the applicable premium for the level of coverage you choose. If you enroll in the premium-free Bronze Plus Plan, you will have the option to resume your remaining paid COBRA Continuation Coverage once the premium-free coverage terminates on March 31, 2021.
- **If your Earned Active Coverage terminates December 31, 2020:** Your Open Enrollment materials will offer the option of electing either: (1) the premium-free Bronze Plus Plan, or (2) COBRA Continuation Coverage at the applicable premium for the level of coverage you choose. If you enroll in the premium-free Bronze Plus Plan, you will have the option to start your COBRA Continuation Coverage once the premium-free coverage terminates on March 31, 2021.

For more information, contact the Eligibility Department at (323) 866-2200, Ext. 502 or eligibility@dgaplans.org. **PH**

COVID-19 Vaccine Availability and Distribution: What We Know So Far

It is anticipated that the Food and Drug Administration will soon approve a COVID-19 vaccine. Nationwide distribution is expected to begin in mid-December to prioritized communities. While details about this process are not yet finalized, here is what we know so far:

- It is anticipated the following communities will be prioritized for initial vaccinations:
  - ◊ Healthcare personnel;
  - ◊ Non-healthcare essential workers;
  - ◊ Adults with high-risk medical conditions and risk factors for severe COVID-19 illness; and
  - ◊ People aged 65 years and older (including those living in long-term care facilities).
- Children are unlikely to have a vaccine available until later in 2021.
- Most health plans will be required to cover vaccination and related administration costs without cost sharing (i.e., deductibles, co-pays, co-insurance and prior authorizations), regardless of whether administered by a network or non-network provider.

As more details about vaccine distribution and how the vaccine will be covered by insurers become available, it will be posted on our website at www.dgaplans.org/coronavirus-resources-and-updates. **PH**

Incremental Increases to Earnings Threshold for Pension Plans' Credited Service Months (CSMs)

Credited Service Months (CSMs) reflect your DGA-covered service in the Pension Plans and are used in both the Basic and Supplemental Pension Plans to determine vesting status. For the Basic Pension Plan, CSMs are also used along with your earnings to determine the amount of your monthly benefit. You earn CSMs based on your reportable earnings during a calendar year and can earn a maximum of 12 CSMs in any year.

Currently, for the 2020 Plan Year, a participant will accrue one CSM per $3,600 in reportable earnings. Beginning January 1, 2021 and continuing through January 1, 2023, the earnings threshold required to earn one CSM will increase as follows:

New Credited Service Months Earnings Requirements

Time Period	Requirement to Earn One Credited Service Month
2021	$3,700
2022	$3,800
2023	$3,900

Please note these changes are based on the recently negotiated increases to the minimum earnings requirements under the applicable Collective Bargaining Agreements. For more information, please refer to the enclosed notice to Plan participants and Alternate Payees.

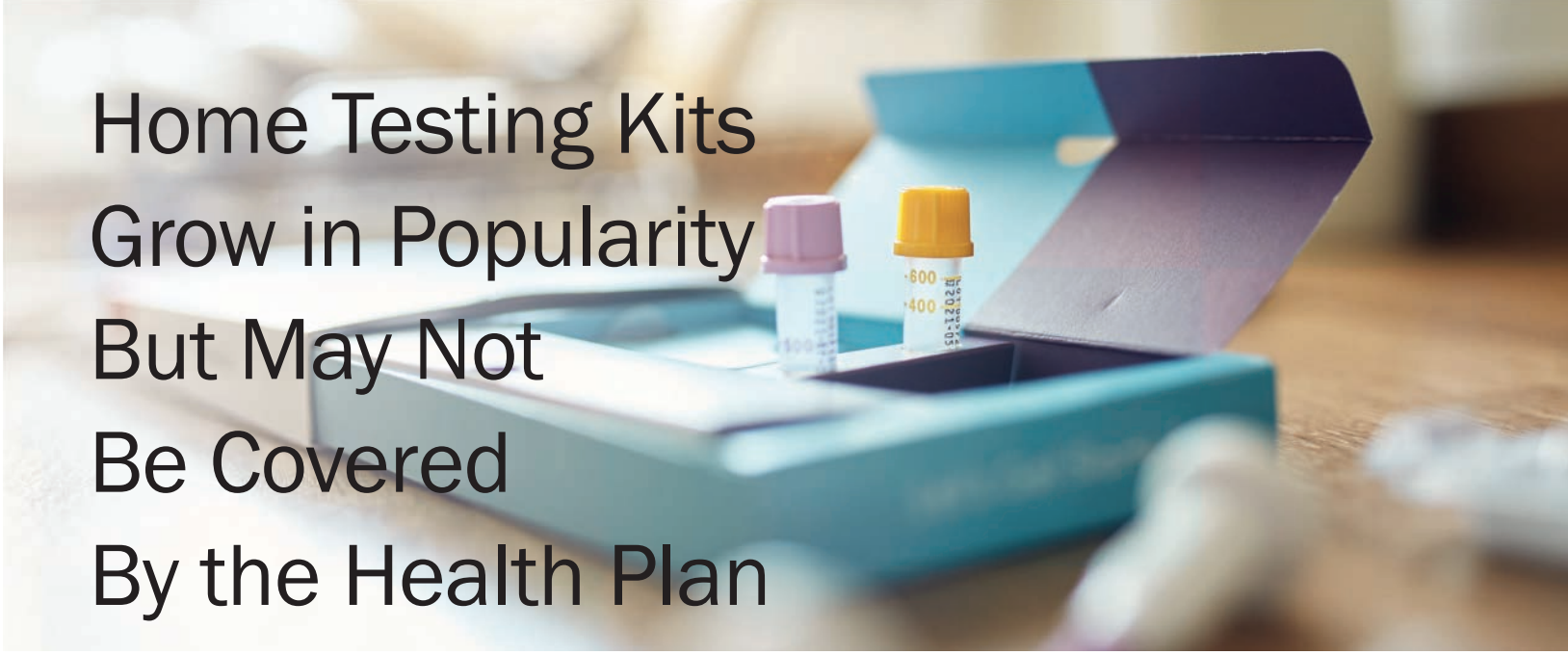
For more information on how CSMs affect your pension, refer to the March 2020 Pension Plans Summary Plan Description available at dgaplans.org /Pension-Plans-SPD. **PH**

Express Scripts' Changes to List of Covered Medications Taking Effect January 1, 2021

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 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 DGA Producer-Health Plan and how much you pay out of pocket for prescriptions.

Effective January 1, 2021, Express Scripts is revising 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 2021 list of excluded medications along with preferred alternatives is available at https://www.express-scripts.com/art/open_enrollment/DrugListExclusionsAndAlternatives.pdf. For information on whether this change will affect your current prescriptions, log on to your Express Scripts account at expressscripts.com. If you have any questions, please call Express Scripts at (800) 987-7828. **PH**



Home Testing Kits Grow in Popularity But May Not Be Covered By the Health Plan

Home testing kits have grown in popularity in recent years, beginning with widely used genetics services like *23andMe* and *Ancestry.com*. As interest in home testing kits has grown, the market has exploded accordingly, with companies now offering home testing kits for a host of medical conditions like STDs, vitamin deficiencies, HIV, pregnancy, cholesterol, thyroid function and most recently, COVID-19.

As the public continues to embrace this technology, the accuracy, appropriateness and costs of these tests have come under increased scrutiny from both government agencies and private insurers. While the Health Plan takes no position regarding the validity of specific home testing kits, Health Plan participants should know the circumstances under which these tests might be covered under the Health Plan.

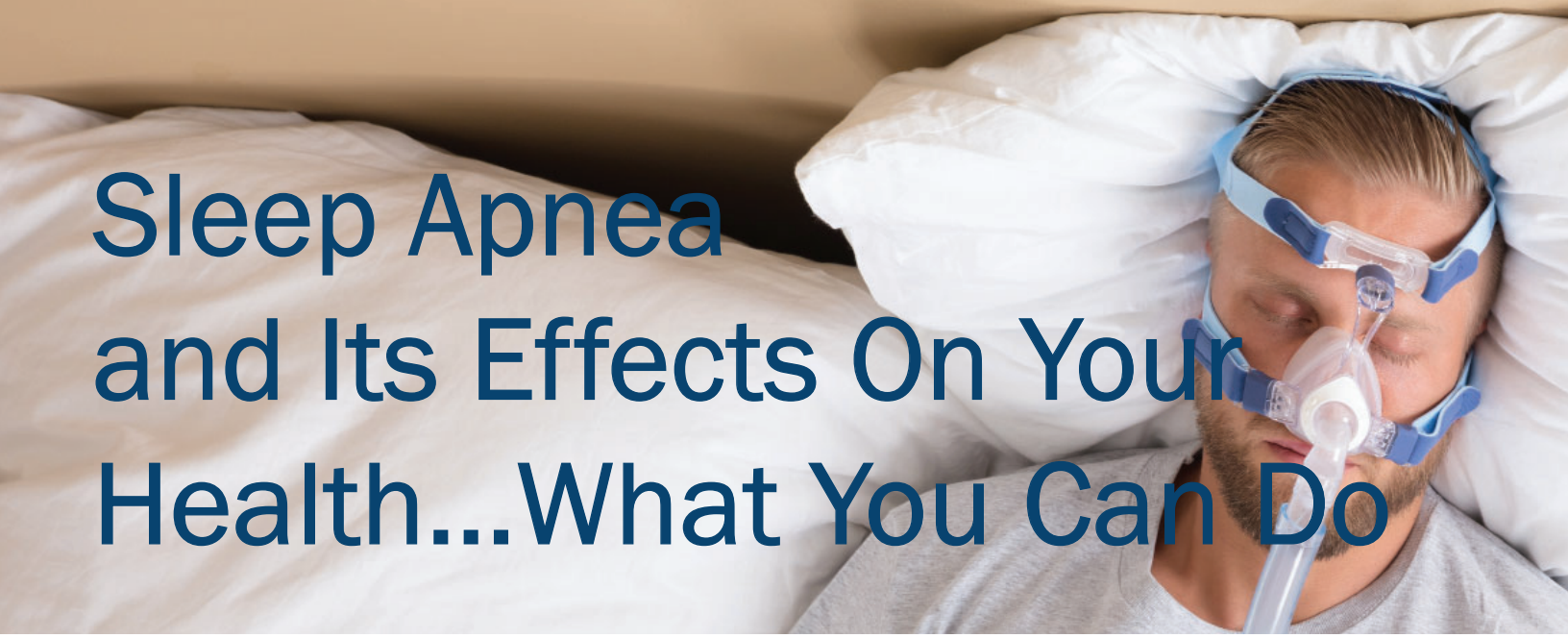
Please remember that the Health Plan covers Medically Necessary visits, treatments and procedures for you and your eligible dependents, including laboratory and diagnostic tests and services ordered by a physician to treat sickness or injury. All care must be considered Medically Necessary, excluding covered preventive care services, to be covered under the Health Plan.

When it comes to home testing kits, like all other testing—including testing for COVID-19—one important metric for determining whether it may be covered under the Health Plan, is whether the test has been ordered by an attending licensed physician or healthcare provider, and it was not ordered solely to satisfy the curiosity of the participant or the participant's physician, hospital, or other health care provider. The Health Plan considers a treatment, service or supply Medically Necessary when the treatment:

- ❑ Is 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.

It is important to understand the definition of medical necessity before you purchase and use a home testing kit. Understanding this standard will help you avoid surprise costs for tests that are not covered. Unless the test meets all four of the aforementioned requirements, it will likely not be covered, leaving you to pay the cost out of pocket.

For details about the medical necessity standard, refer to the 2020 Health Plan Summary Plan Description, pages 114-115, and its updates or speak to a Participant Services Representative at toll-free at (323) 866-2200, Ext. 401 or (877) 866-2200, Ext. 401. **PH**



Sleep Apnea and Its Effects On Your Health...What You Can Do

It's amazing what a good night's sleep can do for the body and alarming how troublesome a chronic lack of sleep can be. Getting adequate sleep helps reduce stress, increase alertness, and preserve memory, while sleep deprivation has been linked to lost productivity, higher overall health costs, and a host of serious health conditions, including depression, anxiety, heart failure, and stroke.

When most people think of good sleep, they tend to focus on the total number of hours of sleep that they get in a day. Just as important, however, is the quality of sleep one experiences. While the amount of sleep that most of us get is manageable, for 10%-17% of the U.S. population, poor quality sleep is a much more serious issue; it is a matter of health.

Sleep apnea is a disorder in which breathing is repeatedly interrupted during sleep, most commonly because of an obstructed upper airway (obstructive sleep apnea), though it can also result from the brain's failure to properly signal the muscles that control breathing (central sleep apnea). Though symptoms of sleep apnea—which include loud snoring, excessive sleepiness during the day, and poor concentration—can be highly detrimental to one's quality of life, most cases of sleep apnea go undiagnosed and untreated.

Diagnosing Sleep Apnea

Most people might not recognize waking up tired, falling asleep during the day, or the occasional complaint from their partner that they snore loudly as causes for concern, but when incidents like these are recurrent, it might be time to see a doctor and take a closer look. All of these things could be symptoms of sleep apnea.

Sleep apnea is a treatable medical condition that must be diagnosed by your doctor. It is estimated that 22 million Americans suffer from sleep apnea, although the condition is more prevalent among adult males aged 40 to 70, individuals who are obese, and individuals with other health conditions, such as heart failure or stroke.

Generally, sleep apnea is diagnosed through a questionnaire followed by a sleep study (either in a sleep lab or at home using a portable device). The "gold standard" for sleep apnea testing and diagnosis is the attended sleep study, or polysomnography (PSG) testing, in which attendants continuously monitor the patient overnight in a hospital or in a sleep lab. PSG testing involves recording a patient's brain activity, eye movement, heartbeat, muscle movements, oxygen saturation, respiratory effort, and airflow, in order to obtain a comprehensive assessment of how the patient's body changes as they sleep. Non-PSG sleep monitoring is usually conducted with portable devices in a home setting and without an attendant present. Non-PSG testing typically only includes some of the measurements recorded during PSG testing, but they are often sufficient to make a diagnosis.

If a patient is diagnosed with sleep apnea, the severity of their condition is determined by an analysis of the average number of times per hour their breathing briefly stops (apneic episodes) and any corresponding reduction of the volume of air moving in and out of their lungs (hypopneic episodes). From this data, your doctor can prescribe a suitable course of treatment.

The Health Plan covers both attended sleep studies (PSG testing) and at-home sleep studies with portable monitoring devices (non-PSG testing), as long as such treatment is recommended by your treating physician for the analysis of suspected sleep apnea and considered medically necessary under the terms of the Health Plan. Please note the Health Plan does not cover related services performed in conjunction with sleep studies for sleep disorders. The Health Plan's medical necessity standard is set forth in the Glossary of the DGA-Producer Health

Plan Summary Plan Description ("SPD"). The Health Plan SPD and all updates are available online at www.dgaplans.org. If you would like a hard copy, please let us know and we will mail you one at no cost.

Treating Sleep Apnea

PAP Therapy

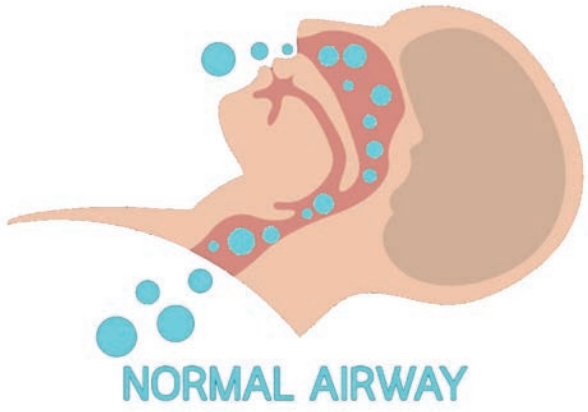
Positive airway pressure, or PAP, is the most common treatment for severe sleep apnea. Positional therapy, non-surgical weight loss or bariatric surgery might also be used for patients who cannot tolerate or have been deemed non-responsive to other therapies.

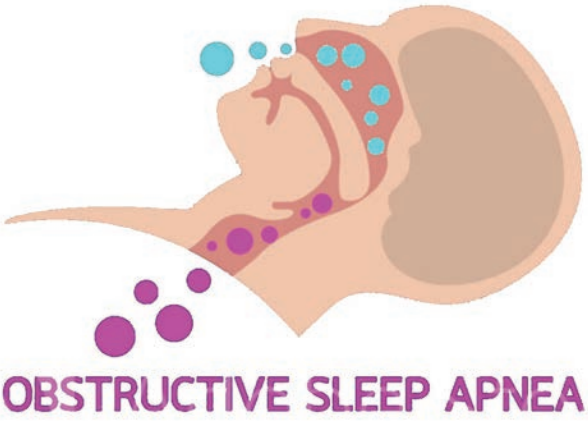
PAP works by providing positive pressure into the patient's airways through a mask or nosepiece, so that they remain open throughout sleep. There are three types of PAP therapies, named according to the way air pressure is regulated:

- ***CPAP***, or continuous positive airway pressure, is the most common type of PAP therapy, and it delivers air at a continuous pressure;
- ***APAP***, or auto-titrating positive airway pressure, automatically raises or lowers air pressure as needed throughout the night; and
- ***BPAP***, or bi-level positive airway pressure, alternates the air pressure depending on whether the user is exhaling or inhaling.

Your doctor may prescribe any of these PAP therapies, taking into account your previous PAP experience and any other underlying conditions you may have. Regardless of the type prescribed, however, PAP therapy has been found to be highly effective when adhered to consistently.

The Health Plan covers PAP machines when they are prescribed by your doctor, considered medically necessary under the terms of the Plan, and satisfy the Plan's coverage requirements for durable medical equipment. In the case of rented PAP machines, the Health Plan will request a copy of your doctor's prescription to confirm these conditions have been satisfied, which must include the frequency and duration that the machine is to be used.





Custom Sleep Appliances

For patients who are diagnosed with mild obstructive sleep apnea or who are PAP intolerant, the doctor may prescribe a custom oral sleep appliance in lieu of PAP therapy. Custom sleep devices adjust your mouth and tongue in a manner that prevents upper airway collapse and have been found to be effective in many cases of obstructive sleep apnea. If your doctor prescribes a custom sleep device, it is recommended that you request a predetermination of coverage from the Health Plan before filling your prescription.

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; though 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.

When requesting a predetermination for a custom sleep device, the Health Plan will request the sleep study results confirming your sleep apnea diagnosis and the specific product description of the custom oral appliance your doctor has prescribed. Within 10 business days following receipt of your predetermination request, the Health Plan will send you or your provider a written response outlining the results of the predetermination. The predetermination will indicate whether the specified procedure codes included in your request reflect medical necessity.

Undiagnosed sleep apnea has been proven to lead to increased doctor visits, more frequent and longer hospital stays and greater health care costs. If you or a loved one is experiencing chronic unexplained sleepiness during waking hours, snoring, fatigue, insomnia or unrefreshing sleep, it may be time to see your doctor for further evaluation. PH

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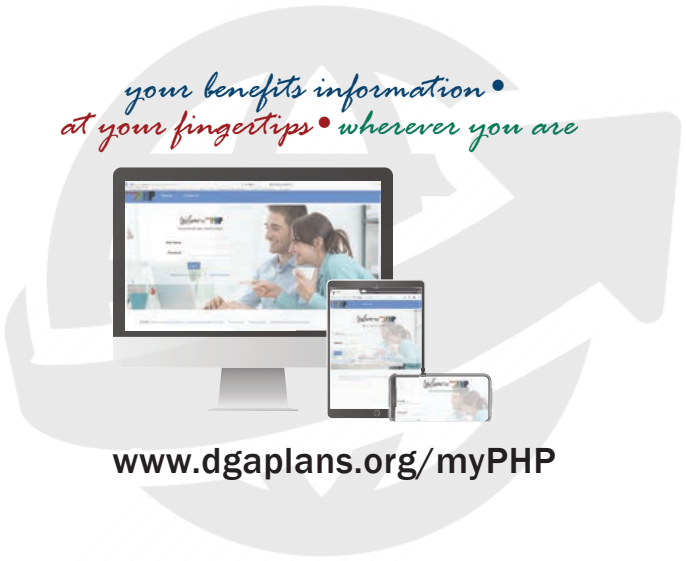

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All-Inclusive Out-of-Pocket Limits Increase, Effective January 1, 2021 as Established Under the Affordable Care Act

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, 2021, the Health Plan's All-Inclusive Network Out-of-Pocket Limit will increase from $8,150 individual/$16,300 family to $8,550 individual/$17,100 family for all coverage plans. If you reach the limit, the Health Plan will pay 100% of covered network expenses. **PH**