

Board of Trustees Approves 13th Check for Basic Plan Retirees and Beneficiaries in Pay Status as of December 2020

The Board of Trustees is pleased to announce the payment of a 13th check to eligible participants in the Basic Plan. The payment was made possible by the Basic Plan's strong investment performance in 2020. (For details, refer to *Pension Plans' Investments Perform Well in 2020 Despite Market Turmoil* below.) Retirees and beneficiaries who were eligible for a monthly benefit from the Basic Plan as of December 2020 will receive an additional payment equal to the amount of their regular monthly benefit. Payments will be processed in early April 2021. This additional benefit reflects the continued financial strength of the Basic Plan, which remains well funded and in "Green Zone" status, as measured by the Pension Protection Act.

It is important to note that this additional payment is being made on a one-time, non-precedential basis and is based entirely on the Trustees' judgment and discretion about the financial condition of the Basic Plan. There is no right (vested, accrued or otherwise) to any additional or similar payment in future months or years.

For more information, contact the Pension Department at pension@dgaplans.org or (323) 866-2200, Ext. 404. **PH**

Pension Plans' Investments Perform Well in 2020 Despite Market Turmoil

Investment returns are an important part of the ability of pension plans, including the Directors Guild of America-Producer Basic and Supplemental Pension Plans, to pay promised benefits. Surprisingly, and contrary to early and mid-year forecasts, the Plans' investments ended 2020 very well, despite the COVID-19 pandemic—enough for the Board of Trustees to approve a 13th check for retirees and beneficiaries in the Basic Plan.

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Pension Plans' Investments Perform Well in 2020

During the first months of 2020, as the world became increasingly aware of COVID-19, investment returns across all asset classes predictably reflected the economic stress of worldwide business lockdowns and rapid job losses. As Congress and the Federal Reserve began providing fiscal and monetary support, asset prices began to stabilize, and bonds began to recover.

During the last quarter of 2020, increased economic activity, the prospect of an effective vaccine program and government stimulus brought significant asset price recovery. The result: Significant 4th quarter price appreciation across several asset classes, resulting in total year-end returns of 12.4% for the Basic Plan, and 11.5% for the Supplemental Plan, which has a lower risk profile due to its shorter investment horizon as compared to the Basic Plan.

The Basic and Supplemental Plans' investment strategies are designed for longevity and stability, so that the Plans are better positioned to persevere extreme market changes like those experienced in 2020. While this does not guarantee future performance, the Basic and Supplemental Plans' ability to withstand 2020's volatility is attributable in part to the continued oversight and thoughtful planning by the Finance Committee of the Board of Trustees, pension consultants and investment managers.

To learn more about the Plans' Investment Program, including monthly investment return updates, visit the Pension Plans' Investment Program pages at www.dgaplans.org/pension. **PH**

CVS Caremark to Replace Express Scripts as Pharmacy Benefit Manager, Effective July 1, 2021



The Directors Guild of America - Producer Health Plan is pleased to announce the selection of CVS Caremark as its new pharmacy benefit manager, effective July 1, 2021. CVS Caremark will replace Express Scripts.

In reaching this decision, the Board of Trustees considered several candidates to determine which would best serve the needs of Health Plan participants and ensure the best use of Health Plan resources. The Health Plan looks forward to partnering with CVS Caremark and its network of more than 68,000 retail pharmacies to ensure your continued access to affordable medication.

The transition to CVS Caremark may bring changes in how prescriptions are filled and to which medications are covered. Please note the Health Plan is working with CVS Caremark to minimize disruptions as much as possible, and the information here will help you prepare for the transition. Any medications currently covered under Express Scripts, but excluded by CVS Caremark, will be grandfathered for 90 days so that you can receive one additional fill of your old medication through CVS Caremark after the July 1st transition date. This will allow you ample time to have your doctor select an equivalent medication that is covered under CVS Caremark. If you are taking such a medication, you will be contacted directly with further instructions.

Until June 30, 2021, please continue to contact Express Scripts at (800) 987-7828 or the Health Plan at (877) 866-2200, ext. 401 with your prescription benefit questions. As the July 1 transition date draws near, you will receive detailed instructions on the next steps you will need to take.

A timeline of what to expect over the next several months as we move toward the July 1st transition to CVS Caremark is included on the next page. We will keep you informed of updates and next steps by mail, email and on our website at www.dgaplans.org. **PH**



APRIL
2021

Timeline of the Transition to CVS caremark®

- Start reviewing CVS Caremark pharmacy locations and learn more about CVS Caremark and its offerings. Visit www.caremark.com for more information.



MAY/JUNE
2021

- If you are currently participating in any specialized programs with Express Scripts, you will receive a personalized welcome letter from CVS Caremark to help ensure a smooth transition to similar programs. The following Express Scripts programs will be transitioned:
 - Maintenance medication mail service program with open refills; and
 - Prior authorization for select medications.
- CVS Caremark customer care phone lines will open mid-May 2021.

JUNE
2021

- Receive your ID Cards and welcome kit (mid-to late June).
- Register at www.caremark.com to review your plan and cost information, plus access tools to help you stay on track with your medications.
- Review medications with your provider, and if you have any prior authorizations, have your provider renew them with CVS Caremark.
- Fill any maintenance prescriptions running out before the end of the month with Express Scripts. That way, you'll have enough medication to last into the summer and can refill with CVS Caremark at the next refill.

JULY
2021

Effective July 1, 2021,



will become the Health Plan's pharmacy benefit manager.



Women's Health and Cancer Rights Notice



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 lymphedema.

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

Employer Pension Contributions Increase from 8% to 8.5% of Compensation, with the Additional 0.5% Allocated to the Basic Plan Effective July 1, 2021

As a result of the three-year collective bargaining agreement negotiated between the Directors Guild of America, the Alliance of Motion Picture and Television Producers and the Networks (ABC, CBS and NBC), pension contributions for signatories covered under the Basic, FLTTA and the Networks' Collective Bargaining Agreements will increase by 0.5%, effective July 1, 2021. This change will bring the Pension Plans' employer contribution rate to 8.5% of compensation.

This new 0.5% contribution increase will be allocated entirely to the Basic Plan for the first \$150,000 in compensation. The increased Employer contributions will further support funding of the Basic Plan and better position the Plan to continue paying promised benefits.

The allocation between the Basic and Supplemental Plans will change to the following, effective July 1, 2021:

- ▶ 8.5% of the first \$20,000 in compensation to the Basic Plan (previously 8.0%)

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UPDATE: COVID-19 Vaccine Rollout and Distribution

On December 11, 2020, the Food and Drug Administration granted emergency authorization for two COVID-19 vaccines—from Pfizer and Moderna; a third vaccine, from Johnson & Johnson, was recently approved as well. Though phased rollout of the vaccines is currently underway, limited supply and shifting distribution continue to present challenges. In response, vaccine manufacturers are working to increase production so that additional vaccine can be expected by spring or early summer to fully meet demand. Distribution is expected to improve with the increased supply.

Each state has been tasked with developing its own vaccine distribution protocols, leading to a patchwork of procedures that vary widely depending on location. However, with the forthcoming increase in vaccine supply, it is expected that the U.S. will begin vaccinating the general public beginning in May 2021, with the

goal of inoculating most Americans by June or July.

To ensure nationwide accessibility to vaccination sites, the government has partnered with several national pharmacy chains to launch the Federal Retail Pharmacy Program. Under the program, select retail pharmacies are serving as vaccination sites for eligible individuals in their areas. Pharmacy participation varies by state and includes a number of national networks including CVS, Walgreen's, WalMart, Publix, Rite Aid, Albertsons and many others. For a list of participating pharmacies in your state, refer to the Resources listing at the bottom of this page.

It is important to continue following CDC guidelines for protecting yourself and slowing the spread of COVID-19: Wear a mask to protect yourself and others; wash your hands frequently; stay at least 6 feet (about 2 arm lengths) from others who don't live with you, and avoid crowds.

The DGA-Producer Health Plan continues to monitor the situation and will provide updates on www.dgaplans.org and in future Spotlight on Benefits newsletters as new information becomes available. You are also encouraged to consult your state or county department of public health for the most up-to-date information in your area. Refer to the list of resources below for links to vaccine-related information. **PH**

RESOURCES

- ▶ **Pharmacies Participating in the Federal Retail Pharmacy Program:**
<https://www.cdc.gov/vaccines/covid-19/retail-pharmacy-program/participating-pharmacies.html>
- ▶ **State or County Department of Public Health:**
<https://www.usa.gov/state-health>
- ▶ **Things to Know about the COVID-19 Pandemic:**
<https://www.cdc.gov/coronavirus/2019-ncov/your-health/need-to-know.html>



New Federal Law Provides 100% COBRA Premium Subsidy to Eligible Individuals, Beginning April 1, 2021



On March 11, 2021, President Biden signed into law the American Rescue Plan Act, a sweeping \$1.9 trillion relief bill aimed at hastening the U.S. recovery from the COVID-19 pandemic and its economic fallout. Included in the package is the provision of a COBRA premium subsidy that will pay 100% of the COBRA premium for eligible participants and dependents from April 1, 2021 to September 30, 2021. Though the Health Plan is currently awaiting detailed guidance on who will be eligible for the subsidy and the timing of its application, here is what we know so far.

Who will be eligible for the COBRA premium subsidy?

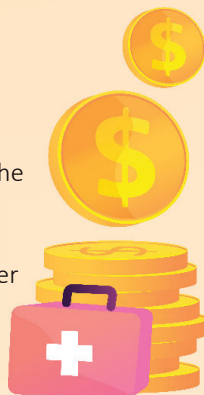
Currently, assistance-eligible participants are defined as those who have lost Health Plan coverage owing to involuntary termination of employment or to an involuntary reduction of hours. The subsidy is available to any such participant or dependent who:

- ▶ Is currently enrolled in COBRA or becomes eligible for COBRA between April 1, 2021 and September 30, 2021; or
- ▶ Became eligible for COBRA prior to April 1, 2021 and the period of COBRA coverage for which they are eligible includes any month between April 1, 2021 and September 30, 2021—even if they previously declined that COBRA coverage or decided to discontinue it before April 1, 2021.

Who will NOT be eligible for the COBRA premium subsidy?

The following groups will not be eligible for the COBRA premium subsidy:

- ▶ Anyone who has coverage under another insurance carrier;
- ▶ Anyone who is on Medicare; or
- ▶ Anyone who lost coverage due to voluntary termination of their employment, a divorce, aging out of coverage, or any other qualifying event other than an involuntary termination.



How long will the COBRA premium subsidy be available?

Currently, the maximum subsidy period is six months—from April 1, 2021 to September 30, 2021; however, an individual's subsidy period would end earlier if the individual's maximum period of COBRA coverage (generally, 18 months) ends earlier than September 30, 2021. An individual's subsidy period will also end earlier if the individual becomes eligible for coverage under another group health plan or Medicare. Individuals are required to notify their group health plan if they become eligible for such coverage and will be subject to penalty if they fail to do so.

What will the COBRA premium subsidy provide?

The COBRA premium subsidy will cover 100% of the COBRA premium amounts for eligible participants and dependents from April 1, 2021 to September 30, 2021. The Health Plan will waive the participant premium obligation, and the government will refund the plan. The participant will not be required to remit a COBRA premium payment during the subsidy period.

If I previously chose not to elect COBRA coverage, will I be eligible for the subsidy?

If you (1) previously qualified for COBRA as a result of involuntary termination or a reduction in hours; (2) do not have coverage under another group health plan or Medicare; **and** (3) have a COBRA coverage period that includes any months between April 2021 and September 2021, you will be eligible only for those months.

What happens next?

As the government releases additional guidance on how the COBRA premium subsidy is to be administered, the Health Plan will notify assistance-eligible participants and dependents. Included in those notifications will be detailed information on the steps you will need to take to claim the subsidy.

The Health Plan will also post updates on www.dgaplans.org as new information becomes available. For additional assistance, you can speak to a Participant Services representative at (323) 866-2200, Ext. 502 or toll free at (877) 866-2200, Ext. 502. **PH**

How to Read Your Explanation of Benefits

The statement you receive from the Health Plan after each visit to your doctor is the be

After you go to the doctor, the Health Plan will send you a statement of how your benefits were applied to that visit, including the amount charged by your doctor, the amount paid by the Health Plan and the amount you can expect your doctor to bill you. This statement is called the Explanation of Benefits, or "EOB." The EOB provides important information you can use to guard against billing errors and medical fraud, as well as track your medical spending. Understanding your EOBs is an essential part of staying informed about your healthcare.

EOBs are not bills. The EOB's Patient Responsibility section, however, indicates the amount you can expect to be charged by your provider. If there is an amount indicated in the Patient Responsibility section, wait until your doctor's office sends you an invoice before submitting payment.

HOW TO READ YOUR EOBs

The sample above notes the most important sections of your EOB.

1 PATIENT RESPONSIBILITY: This amount represents what may be your out-of-pocket responsibility to the provider of service (hospital/doctor). In the sample above, the patient, under normal circumstances, could expect a bill from the provider in the amount of \$10.32, matching the amount listed in the Patient Responsibility section.

In certain instances, however, a \$0 Patient Responsibility will not necessarily mean no out-of-pocket costs related to the services listed. If additional information is needed before your claim can be fully processed, your EOB may show a \$0

Patient Responsibility until the requested information is received and processed by the Health Plan. For this reason, it is very important to always check your EOB's Claim Messages (explained in item #3 below) to ensure they do not indicate an issue with the claim that might affect the amount listed in the Patient Responsibility section, such as more information being needed before the claim can be fully processed.

Otherwise, if the amount on your EOB does not match the bill from your provider or if you get the bill from the provider before you receive your EOB, call the Health Plan at (877) 866-2200, ext. 401 and one of our Participant Services representatives will assist you.

2 CLAIM/BENEFITS INFORMATION: This section provides the following information about your claim and how your benefits were applied:

- ▶ **Service:** a brief description of the service you received
- ▶ **From/To:** the dates the services were provided
- ▶ **Billed:** the amount billed by the provider
- ▶ **Non-Covered:** the amount of the billed charges that is not covered by the Health Plan, such as any amount over the Health Plan's allowed amount for that service

**DGA-PRODUCER
HEALTH PLAN**

**Directors Guild of America
Producer Pension & Health Plans**
5055 Wilshire Blvd. Suite 600
Los Angeles, CA 90036

THIS IS NOT A

**Findley Smith
123 MAIN STREET
ANYWHERE, CA 000000**

Patient: Findley Smith

2

| | Service | From | To | Billed |
|---------------|---------------|------------|------------|------------|
| 1 | Office Visits | 01/23/2021 | 01/23/2021 | 200 |
| Totals | | | | 200 |

3

Line Item Reference

For Item: 1

Provider is in the Blue Cross Network resu

- ▶ **Discount:** the applicable Anthem Blue Cross negotiated network discount
- ▶ **Deduct/Copay:** the portion of the allowed amount you are responsible for either as your deductible or co-pay
- ▶ **Balance:** the remaining allowable charges after all deductions (Billed - Non-Covered - Discount - Deduct/Copay = Balance)
- ▶ **Ben%:** the percentage covered by the Health Plan. This percentage varies by type of service, your coverage plan and whether you have reached your annual out-of-pocket maximum

Best way to ensure you pay only what you should.



Retain for your records along with any provider bills
Questions? Contact us: (323) 866-2200
Outside of the Los Angeles Area: (877) 866-2200

| Participant Information | |
|-------------------------|---------------|
| Participant | Findley Smith |
| ID Number | 12345678 |
| Date | 02/20/2021 |

Patient Responsibility: 10.32

1

Claim #: 21001E8035
Provider: JONES, JANE

| Eligible | Non-Covered | Discount | Deduct/Copay | Balance | Ben % | Benefit |
|----------|-------------|----------|--------------|---------|--------|---------|
| 100.00 | 0.00 | 96.80 | 0.00 | 103.20 | 90.00% | 92.88 |
| 100.00 | 0.00 | 96.80 | 0.00 | 103.20 | | 92.88 |

DGA Net Benefit: 92.88

Payment to
JANE JONES, MD Amount
92.88

4

Claim Messages

resulting in a savings, as detailed in the Discount column.

- **Benefit:** the dollar amount covered by the Health Plan (Balance x Ben% = Benefit)

3

CLAIM MESSAGES: This section lists special messages from the Health Plan. Each message will reference a specific line or lines of the EOB. These messages could include information about discounts applied (as in the sample), requests for additional information, explanations for why an item was not covered, etc.

If a Claim Message indicates that additional information is requested, it is important that the information is provided to the Health Plan in a timely manner. Any requested information submitted to the Health Plan more

than 180 days from the date of the EOB will not be accepted and the claim will be denied per Health Plan rules. If you are unsure what information is required, contact the Health Plan's Participant Services Department at (877) 866-2200, ext. 401 for further assistance.

4

TOTAL BENEFIT/PAYMENT INFORMATION:

This section indicates the dollar amount the Health Plan paid and where payment was sent. If your provider billed the Health Plan directly for services, the Health Plan will make a payment to the provider, the amount of which will be indicated on your EOB (as in the sample).

If you paid the provider in full at the time of service, a check payable from the Health Plan to you will be attached to your EOB.

HOW TO USE YOUR EOBs

You can use your EOBs for a number of purposes:

Anticipate your bill and verify its accuracy. The bill you receive from your doctor should not be higher than the Patient Responsibility amount on your EOB, provided all information required to process the claim has been submitted.

If your claim has been denied for any reason (refer to the Claims Messages section for this information), your provider may bill you for the services. Make sure you provide the Health Plan with all requested information so that your claim can be fully processed.

As you compare your EOB to the bill from your provider, some questions you should ask include:

- Is the service described accurately? For example, you should not be charged for X-rays when your office visit did not include X-rays.
- Is the Health Plan sending payment to the correct party? Most claims are paid to the provider, but if you paid the provider in full at the time of service, payment will most likely be made directly to you.

Keep in mind that, for certain services or procedures, such as labs or treatments performed in a hospital setting, you may not recognize the providers listed on your EOB, as you may not have directly interacted with them. For example, surgeries typically involve not only the surgeon, but an anesthesiologist, a lab technician and other personnel whose charges may appear on your EOB. If you have any questions about the parties receiving payment from the Health Plan, please call Participant Services.

Track your medical spending. EOBs are an easy way to track the status of your annual deductible or to keep track of your out-of-pocket costs for the year. If you receive services through the Health Plan's PPO network, Anthem Blue Cross, you may also track your medical spending

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DGA-PRODUCER PENSION & HEALTH

5055 WILSHIRE BLVD, SUITE 600
LOS ANGELES, CALIFORNIA 90036
ADDRESS SERVICE REQUESTED

Presorted First Class
U.S. POSTAGE
PAID
LOS ANGELES, CA
PERMIT NO. 31327

*your benefits information •
at your fingertips • wherever you are*



www.dgaplans.org/myPHP



Visit Us Online
www.dgaplans.org

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How to Read Your Explanation of Benefits

DGA-PRODUCER HEALTH PLAN
Directors Guild of America
Producer Pension & Health Plans
5055 Wilshire Blvd., Suite 600
Los Angeles, CA 90036

THIS IS NOT A BILL

Finley Smith
123 MAIN STREET
ANYWHERE, CA 90000

Retain for your records along with any provider bills.
Questions? Contact us: (323) 866-2200
Outside of the Los Angeles Area: (877) 866-2200

| Participant Information | | | | | | | | | |
|-------------------------------|--|--|--|--|--|--|--|--|--|
| Participant: Finley Smith | | | | | | | | | |
| ID Number: 12345678 | | | | | | | | | |
| Plan: Q2202021 | | | | | | | | | |
| Patient Responsibility: 10.32 | | | | | | | | | |

| Patient: Finley Smith | | | | | | | | | | Claim #: 100012345 | | | | | | | | | |
|-----------------------|------------|------------|---------|--------------|----------|-------------|---------|---------|---------|-----------------------|--|--|--|--|--|--|--|--|--|
| | | | | | | | | | | Provider: JONES, JANE | | | | | | | | | |
| Service | From | To | Initial | Rev. Granted | Discount | Direct Cost | Balance | Net % | Benefit | | | | | | | | | | |
| 1 Office Visit | 01/15/2021 | 01/15/2021 | | | 0.00 | 95.00 | 0.00 | 100.00% | 92.88 | | | | | | | | | | |
| | | | | | 0.00 | 90.00 | 0.00 | 100.00% | 92.88 | | | | | | | | | | |
| Total: | | | | | 0.00 | 90.00 | 0.00 | 100.00% | 92.88 | | | | | | | | | | |

| DGA Net Results | |
|-----------------|-------|
| Amount | 92.88 |
| Payment to | 90.00 |
| Amount | 90.00 |

Line Item Reference
For Item: 1

Claim Message
Provider is in the Blue Cross Network resulting in a savings, as detailed in the Discount column.

through the Plans' myPHP portal at www.myphp.dgaplans.org, Anthem's portal at www.anthem.com, or the Sydney Health phone app. These tools will allow you to easily view your claims and progress toward meeting your deductible.

Careful reading of your EOBs is a key part of staying informed of your healthcare expenses. To be sure you are not being overcharged, match your EOB with your bill BEFORE submitting payment to your provider. This can help you catch any errors before you send payment. For questions about an EOB, contact Participant Services at (877) 866-2200, ext. 401. **PH**

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Employer Pension Contributions Rate Increase

- ▶ 6.3% of compensation exceeding \$20,000 and up to \$150,000 to the Basic Plan (previously 5.8%)
- ▶ 2.2% of compensation exceeding \$20,000 and up to \$150,000 in compensation to the Supplemental Plan (no change)
- ▶ 8.5 % of compensation in excess of \$150,000 to the Supplemental Plan (previously 8.0%)

The new collective bargaining agreements grant the DGA the right to allocate up to 0.5% of negotiated salary increases in the second and third years to either the Pension Plans or the Health Plan, providing additional support and the flexibility to direct those resources as needed. For more information on these changes, refer to the March 2020 Pension Plans Summary Plan Description and its updates available at www.dgaplans.org/forms/pension. **PH**

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, 2020 and ending December 31, 2020 (“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.

| | 2020 Plan year | 2019 Plan Year | 2018 Plan Year |
|-----------------------------|-----------------|-----------------|-----------------|
| Valuation Date | January 1, 2020 | January 1, 2019 | January 1, 2018 |
| Funded Percentage | 88.6% | 88.0% | 92.4% |
| Value of Assets | \$1,867,951,607 | \$1,755,235,398 | \$1,691,869,004 |
| Value of Liabilities | \$2,109,368,228 | \$1,994,078,508 | \$1,830,229,017 |

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, 2020 | December 31, 2019 | December 31, 2018 |
|------------------------------------|-------------------|-------------------|-------------------|
| Fair Market Value of Assets | \$2,073,692,403 | \$1,846,803,010 | \$1,622,185,407 |

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 14,083. Of this number, 8,390 were active participants, 3,393 were retired or separated from service and receiving benefits, and 2,300 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 | 2.2 |
| U.S. Government securities | 4.5 |
| Corporate debt instruments (other than employer securities): | |
| Preferred | 2.7 |
| All Other | 4.7 |
| Corporate stocks (other than employer securities): | |
| Preferred | 0.0 |
| Common | 1.6 |
| Partnership/joint venture interests | 38.1 |
| 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 | 34.8 |
| 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 | 2.6 |
| Value of interest in registered investment companies (e.g. mutual funds) | 7.6 |
| 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 | 1.2 |

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 $\$24.75 (.75 \times \$33)$, or \$35.75. Thus, the participant’s guaranteed monthly benefit is \$357.50 ($\35.75×10).

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

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.