DGA-PRODUCER PENSION & HEALTH

Spotlight ON BENEFITS

FALL 2021

No Surprises Act: New Law Protects You From Certain Surprise Medical Bills and Improves Price Transparency

Under the following three circumstances, you are protected from excessive out-of-pocket costs from non-network providers or facilities:

1. **Emergency services provided at a non-network facility,**
2. **Services/items provided by a non-network provider at a network facility, or**
3. **Non-network emergency air ambulance services.**

The No Surprises Act of 2020 provides you with significant protections from surprise billings charged by non-network providers in the three situations listed in the graphic on the left. It also provides pricing transparency that will make it easier for you to comparison shop for medical services. These and other components of the law take effect January 1, 2022.

Refer to page 3 for more details.

Minimum Earnings Threshold for Health Plan Coverage Adjusted

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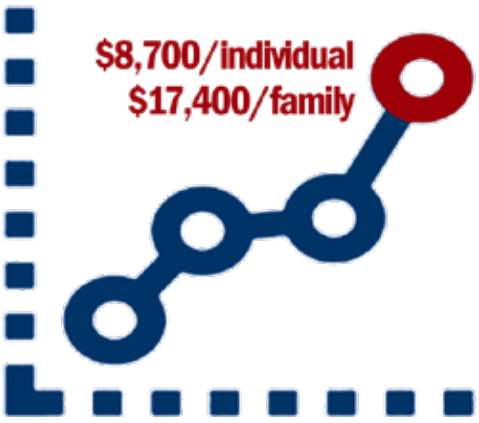
ABOUT THE PLANS
The Pension and Health Plans were created as a result of the Directors Guild of America's collective bargaining agreements with producer associations representing the motion picture, television and commercial production industries. The DGA-Producer Pension and Health Plans are separate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

All-Inclusive Out-of-Pocket Limits Increase, Effective January 1, 2022 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, 2022, the Health Plan's All-Inclusive Network Out-of-Pocket Limit will increase from $8,550 individual/$17,100 family to $8,700 individual/$17,400 family for all coverage plans. If you reach the limit, the Health Plan will pay 100% of covered network expenses. **PH**

Enroll in Direct Deposit to Ensure Same-Day Benefit Payments

If you receive a monthly pension benefit from the Pension Plans office, you are encouraged to enroll in direct deposit to ensure same-day, reliable delivery of your pension funds.

To enroll in direct deposit, recipients in the U.S. should use the Direct Deposit Form. Recipients outside the U.S. should use the Wire Transfer Form (and should be aware that additional bank fees may apply for international wire transfers). Both forms are available at www.dgaplans.org/Enroll-in-Direct-Deposit. Your direct deposit will be set up at the earliest possible date.

Please return the completed form to the Plans' office by one of the preferred delivery methods below:

Email to pension@dgaplans.org; or

Fax to (323) 653-3560 **PH**

CONTINUED FROM COVER PAGE

No Surprises Act

Listed below are components of the No Surprises Act you can expect to see, beginning January 1, 2022. For complete details on Health Plan changes taking effect January 1, 2022 in response to the law, refer to the March 2020 Health Plan Summary Plan Description and its updates available at www.dgaplans.org/health-plan-booklet.

Summary of Changes Coming January 1, 2022

1. **Under certain circumstances, non-network providers and facilities will be banned from balance billing amounts not covered by insurance, and your cost sharing will be the same regardless of whether the services are provided by a network or non-network provider or facility.**

   Group health plans and insurers—including the DGA–Producer Health Plan ("Health Plan")—will be required to cover services with the same participant cost sharing whether the services are provided by a network or non-network provider or facility under the following three circumstances:

   - Emergency services provided at a non-network facility,
   - Services/items provided by a non-network provider at a network facility, or
   - Non-network emergency air ambulance services.

   Non-network providers and facilities may not bill you for any amounts not covered by the Health Plan in the three circumstances above.

   However, you may consent to treatment from a non-network provider and billing at the non-network rate.

   You may consent to be treated for non-emergency services by a non-network provider at a network facility, and such services will be covered at the non-network level if certain conditions are satisfied. Refer to the March 2020 Health Plan Summary Plan Description and its updates for details.

   If you consent, you will be responsible for payment of the applicable non-network co-insurance as well as any amount above the Reasonable and Customary amount (Refer to the *March 2020 Health Plan Summary Plan Description*, Health Plan Terms section, page 40 for more information on Reasonable and Customary).

2. **Medical coverage ID cards must include more information.**

   Beginning January 1, 2022, your medical coverage card must include the following: your plan's deductible amount, out-of-pocket limits, and a website address and phone number where participants can get assistance and information. Covered Health Plan participants will be sent new ID cards that meet the new requirement directly from Anthem Blue Cross in late December or early January.

3. **Plans must create a process to verify the accuracy of their provider databases and update at least every 90 days. If a Plan participant is informed that a provider is a network provider when in fact he/she/they are a non-network provider, the Plan cannot impose the higher cost sharing that would apply to a non-network provider and must apply any paid amounts to the participant's network deductible and out-of-pocket limits.**

   This requirement applies to all individual and group health plans, including the Health Plan, and shifts financial liability for inaccurate provider databases away from the consumer and back to the insurer. For the Health Plan, this will affect the Provider Finder, sponsored by Anthem Blue Cross and available at www.dgaplans.org/networkproviders under Medical Providers.

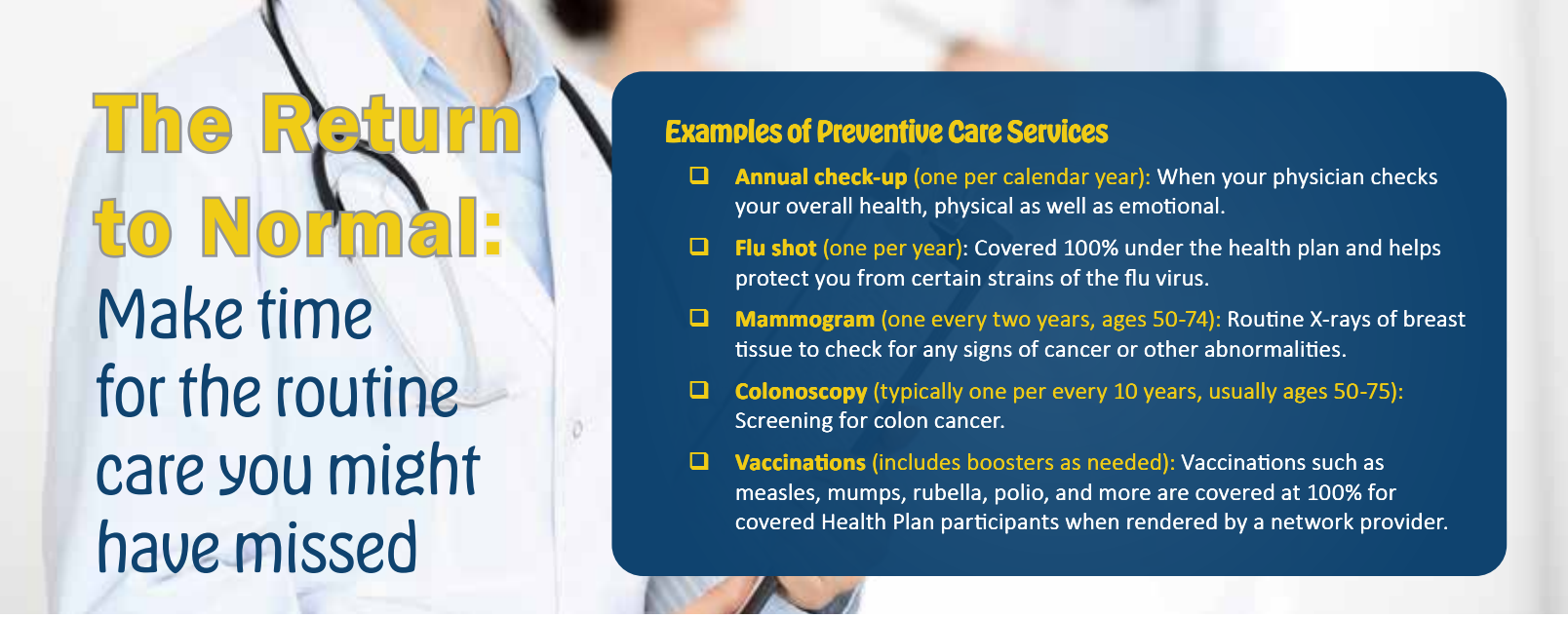
4. **Plans must notify individuals who are "continuing care patients" of the right to continue to receive care after termination of a provider/facility contract.**

   "Continuing care patients" include patients who are undergoing a course of treatment for a serious or complex condition, undergoing institutional or inpatient care, scheduled to undergo non-elective surgery including post-operative care, pregnant and undergoing treatment, or terminally ill and receiving services.

   Effective January 1, 2022, if you are a continuing care patient, the Health Plan will be required to notify you in a timely manner when Anthem Blue Cross terminates its contracts with the network provider or facility and inform you of your right to elect continued transitional care from the provider or facility. The Health Plan will also allow you ninety (90) days of continued coverage at network cost sharing to allow for a transition of care to a network provider.

You will be notified of further changes.

You will be notified of further changes on the Plans website and in subsequent *Spotlight on Benefits* newsletters. If you have questions regarding this information, please contact our Participant Services Department at (323) 866-2200, Ext. 401, Monday–Friday, 8:30 a.m.–5:00 p.m., Pacific Time. PH



The Return to Normal:

Make time for the routine care you might have missed

Examples of Preventive Care Services

- **Annual check-up** (one per calendar year): When your physician checks your overall health, physical as well as emotional.
- **Flu shot** (one per year): Covered 100% under the health plan and helps protect you from certain strains of the flu virus.
- **Mammogram** (one every two years, ages 50-74): Routine X-rays of breast tissue to check for any signs of cancer or other abnormalities.
- **Colonoscopy** (typically one per every 10 years, usually ages 50-75): Screening for colon cancer.
- **Vaccinations** (includes boosters as needed): Vaccinations such as measles, mumps, rubella, polio, and more are covered at 100% for covered Health Plan participants when rendered by a network provider.

Although the resurgence of the pandemic may have temporarily dampened prospects for a full and immediate return to normal, increasing vaccination rates and ongoing safety protocols are making it possible for people to start getting back to the business (and pleasures) of life. Along with the return of movies, live events, dine-in restaurants, and anything in person, it is vitally important that you also get back to any routine medical appointments you may have delayed during the height of pandemic.

Preventive care services, which include annual physicals, flu shots and other vaccinations, and screenings like mammograms and colonoscopies, save an estimated 100,000 lives a year through early detection and treatment of illness. However, despite being an essential aspect of maintaining good health, use of preventive care services declined by as much as 70% during the height of the pandemic and have yet to return to pre-pandemic levels.

With life slowly returning to normal, it's important that you prioritize the preventive care services recommended for your age and gender. Like changing the oil in your car or doing your taxes, neglecting preventive care could spell trouble in the long run.

No Cost Sharing for Network Preventive Care Services

The Health Plan covers certain preventive services at 100% with no deductible or co-payment if they are rendered by a network provider. The preventive care services to which this rule applies generally follow the recommendations of the United States Preventive Services Task Force. The Task Force's recommendations, which are subject to change, can be found here: www.healthcare.gov/coverage/preventive-care-benefits/.

Preventive care services from non-network providers will be covered with no cost sharing only if there is no qualified or available network provider to render or supply the service. Otherwise, the co-insurance for preventive care services from a non-network provider will be paid at the applicable non-network co-insurance level.

Lung and Colorectal Cancer Screenings Update, Effective January 1, 2022

Despite the current screening recommendations, lung cancer remains the second most common cancer after breast cancer and the leading cause of cancer death in the U.S. Colorectal cancer is the third leading cause of cancer death in the U.S. After assessing the net benefits of earlier screenings for these diseases, the United States Preventive Services Task Force recently updated its lung cancer and colorectal cancer screening recommendations, effective January 1, 2022, as follows:

- Lung cancer screening with low-dose computed tomography is now recommended for those aged 50-80 years who have a 20 pack/year smoking history and currently smoke or quit within the past 15 year. It is currently covered once every 10 years for ages 50-75 years for those who have a 30 pack/year smoking history and currently smoke or quit within the past 15 years .
- Colorectal cancer screening is now recommended to begin at age 45. It is currently covered for those aged 50-75 years, once every 10 years.

Neglecting your health is risky. If you've put off these routine, yet very important preventive care appointments during the pandemic, now is the time to get back on track to better stay on top of your health.

For more information on the Health Plan coverage of preventive services, visit: www.dgaplans.org/preventivecare.

If you have questions about your health benefits, contact the Participant Services Department at (323) 866-2200, Ext. 401 or email hpclaims@dgaplans.org. **PH**

Minimum Earnings Threshold for Coverage in the Health Plan's Choice and Premier Choice Plans Adjusted for Earning Periods Beginning on or after January 1, 2022

TRACK YOUR EARNINGS PROGRESS ON MYPHP. You can use the Contributions and Health Eligibility tabs in your myPHP online benefits portal account to easily track your earnings toward future eligibility for Health Plan coverage.

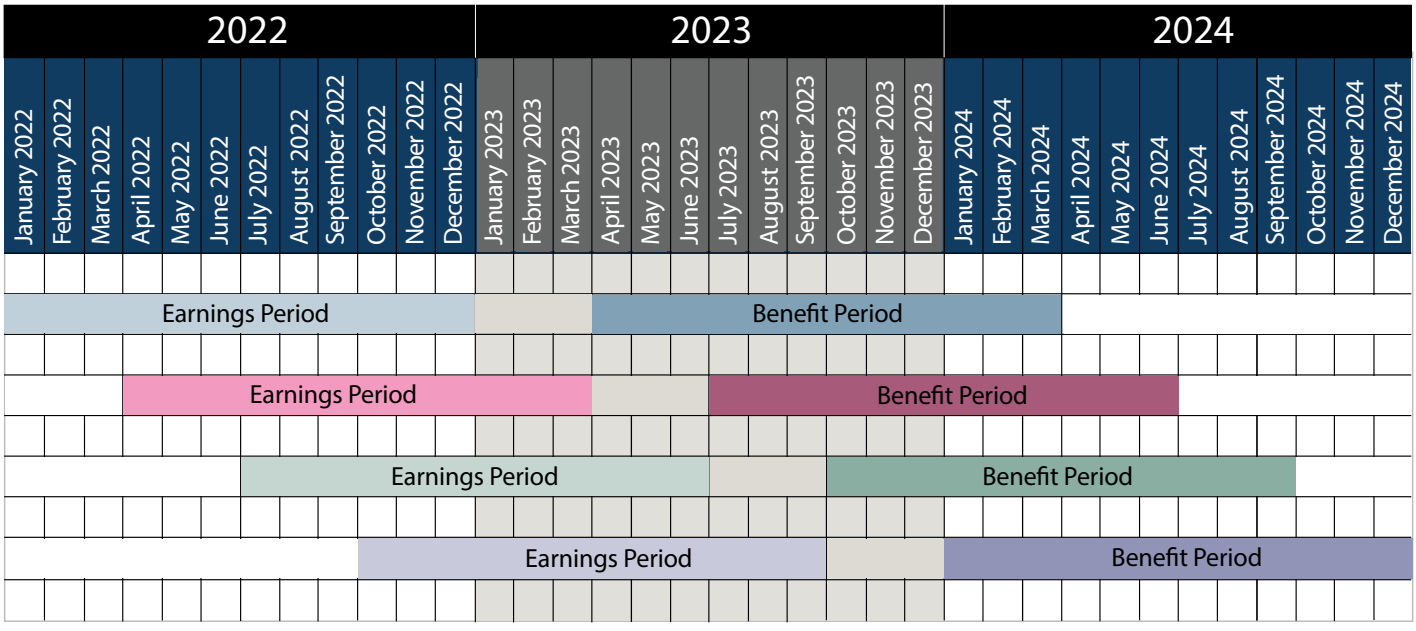
Effective with earning periods beginning on or after January 1, 2022, the minimum earnings required to qualify for Health Plan benefits will increase to $37,000 for the DGA Choice Plan and $120,000 for the DGA Premier Choice Plan. The adjustment aligns the Health Plan's minimum earnings threshold for coverage with wage increases negotiated by the DGA in its Collective Bargaining Agreements.

Under the new threshold, to qualify for benefits under the Choice Plan, you must earn a minimum of $37,000 during any 12-month period beginning January 1, April 1, July 1 or October 1 in 2022. Only allowable earnings covered under each Bargaining Agreement accrue toward the earnings threshold. The chart below reflects the related earning and benefit periods.

Track Your Earnings Progress with myPHP

With the myPHP online benefits portal, available free to Plans participants and their dependents at www.dgaplans.org/myPHP, you can easily track your progress toward the Health Plan's minimum earnings threshold. You can use myPHP's Contributions tab to total the contributions processed during a given time period or the Health Eligibility tab for an easy-to-read status update on whether you have qualified for coverage during the next benefit period.

If you have questions about your Health Plan eligibility, contact a Participant Services representative at (323) 866-2200, ext. 502, or by email at eligibility@dgaplans.org. PH



Managing Your Benefits Has Never Been Simpler

with the

myPHP online benefits portal

Six easy-to-use tabs keep your information organized

The myPHP online benefits portal organizes your benefits information into six simple tabs, making it easier to find exactly what you need whenever you need it.

1. **Inbox**. Instantly receive your pension and health documents electronically instead of waiting for the mail. myPHP notifies you via email whenever a new document is ready for viewing.
2. **Contributions**. View, sort, filter, or print your pension and health contributions processed by the Plans office.
3. **Pension**. Check your estimated Basic Plan benefits and view your Supplemental Pension Plan account balance.
4. **Health Eligibility**. Check your Health Plan Eligibility status.
5. **Health Plan Claims**. View claims information for you and your dependents. Print copies of your Explanations of Benefits.
6. **Documents and Forms**. View, print or download your pension and contributions statements. Upload documents directly to the Plans office.

How to create your free myPHP portal account

The myPHP online benefits portal is available to you and your dependents age 18 and over. Register today to access your benefits information wherever you have an internet connection.

To create your account, have your Plan ID number ready, and follow the simple steps below.

TO CREATE AN ACCOUNT:

1. Go to **www.dgaplans.org/myPHP**.
2. Click Register.
3. Follow the prompts to complete your registration.

For technical assistance with registering for your 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.

Flu Season is Approaching.

Schedule Your Annual Vaccination.

The CDC recommends flu shots for everyone six months of age and older.

With the start of flu season right around the corner and the relaxing of COVID-19 mask mandates and stay-at-home orders, both the flu and COVID-19 will have more opportunities to spread, so protecting yourself is as critical as ever.

Due to the high transmissibility of both viruses, vaccines are recommended as the best protection against severe infection. The CDC recommends flu shots for everyone six months of age and older. Enhanced, or high dose, vaccines are recommended for those 65 years of age and older. For a listing of the different types of flu vaccines available and information on the appropriateness for specific groups, refer to the CDC's Types of Vaccines page at www.cdc.gov/flu/prevent/different-flu-vaccines.htm.

Meanwhile, COVID-19 vaccines are recommended for those 12 years of age and older. (Pfizer has asked the FDA to authorize its COVID vaccine for children aged 5-11.) Both the flu and COVID-19 vaccines are recommended for women who are pregnant or might become pregnant in the future. Additionally, new studies have shown that it is safe to get both the flu and COVID-19 vaccines at the same time, so you don't need to wait to get vaccinated.

Though the CDC's website www.VaccineFinder.org has been temporarily rededicated exclusively to finding COVID-19 vaccines, you should be able to locate a flu vaccination site through your state or local health department or local pharmacy. CVS offers flu shots at many locations; you can find one at www.cvs.com.

For participants covered under the DGA-Producer Health Plan, flu shots are covered at 100% under the Affordable Care Act's preventive care benefits if administered by a network provider or network pharmacy. COVID-19 vaccinations, on the other hand, are provided free of charge under the Coronavirus Aid, Relief, and Economic Security (CARES) Act to everyone in the U.S., regardless of insurance or immigration status. You can easily schedule your flu and COVID-19 vaccines at CVS.com and other participating pharmacies or through your primary physician. **PH**

Additional Information

- To find a CVS location near you that offers the flu and COVID-19 vaccines, visit: www.cvs.com
- For more about the 2021-2022 flu season, including special information on the impact of the coronavirus, visit the CDC's Frequently Asked Questions page at www.cdc.gov/flu/season/faq-flu-season-2021-2022.htm
- If you experience flu-like symptoms, including fever, cough, or fatigue, you should get tested for COVID-19 as a precaution. As both the flu and COVID-19 are contagious respiratory illnesses with similar symptoms, getting tested can help ensure you receive an accurate diagnosis and proper treatment.

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Don't Miss Important Benefits Information

Remember to update **both** the DGA Plans & DGA

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The DGA-Producer Pension and Health Plans (the Plans) and the Directors Guild of America (the DGA) are separate entities. Updating your personal and contact information with the DGA does not result in your information being updated at the Plans office. To ensure your pension and health benefits information is mailed to the proper address, please contact the Plans' Demographics Department at (323) 866-2200 or demographics@dgaplans.org.

Contribution Rate and Allocation Formula Changes, Effective July 1, 2019 for Employers Not Subject To Master Agreements

A small number of Employers have negotiated Employer contribution rates that are lower than the standard negotiated rates required under the Basic, Commercial, and Freelance Live and Tape Television Agreements (the "Master Agreements"). The Pension Plans were amended effective July 1, 2019 to provide that any Employers with a Collective Bargaining Agreement ("CBA") already in effect as of such date that expressly provides for a lower Employer contribution rate than required under the Master Agreements shall continue making contributions at the same lower rate, and will continue to have contributions allocated in the same manner, until the expiration of such CBA.

After the CBA expires, the contribution allocation formula for these Employers will be adjusted going forward so that they contribute to the Basic Benefit Plan at the same rate as required under the Master Agreements. The balance of any contributions above that amount will be allocated to the Supplemental Benefit Plan. **PH**