SPECIAL INSERT: 2022 Annual Funding Notice

Spotlight ON BENEFITS

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End of National Emergencies Means End of Pandemic-Era Relief Measures

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...Regardless of Health Plan Status
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HAVE YOU MOVED? LET US KNOW.

- Call our Demographics Department at (323) 866-2200, Ext. 407.
- Complete a Change of Address form available at www.dgaplans.org/forms/demographics.
- Log into your myPHP portal account and go to My Profile. If you have not yet registered for your free account, visit www.dgaplans.org/about-myphp for more information.

Spotlight ON BENEFITS

Volume 31 | Number 1 | Spring 2023

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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.

End of National Emergencies Means End of Pandemic-Era Relief Measures

On January 30, 2023, the Biden Administration announced its intent to end the COVID-19-related National Emergency and Public Health Emergency, effective May 11, 2023. On April 10, 2023, however, President Biden signed legislation, which ended the National Emergency immediately. The Public Health Emergency is still expected to end on May 11, 2023.

The end of these emergency periods means that certain pandemic-era relief measures under the Directors Guild of America Producer Health Plan (the "Health Plan" or "Plan") will also end, effective as listed in the chart below. PH

RELIEF MEASURE	END DATE
Extension of deadlines for required Health Plan notices, claims and appeals, special enrollment, and COBRA. This relief temporarily provides participants extra time to file claims and meet certain deadlines related to appeals, special enrollments, and enrollment in COBRA, and the Plan with additional time to provide required notices and information. Under this relief, applicable deadlines can be tolled or suspended until the earlier of: (1) one year from the date the individual or Plan was first eligible for relief; or (2) 60 days after the announced end of the National Emergency period. This relief applies to the Health Plan from March 1, 2020 to July 10, 2023 (based on the previously announced National Emergency end date by the Department of Labor and Treasury Department in FAQs, Part 58).	**July 10, 2023**
Cost sharing waived for COVID-19 related testing. Effective for services and supplies rendered on or after March 18, 2020, all patient cost sharing (*i.e.*, deductibles, co-pays and co-insurance) and prior-authorizations have been waived for all testing for the detection and diagnosis of the COVID-19 virus and COVID-19 antibodies. This means you pay no cost-sharing for these services, regardless of whether they are provided in-person or via telemedicine/telepsychology and regardless of whether they are provided in-network or out-of-network when provided following an individualized health assessment by a healthcare provider.	**May 11, 2023** Applies to all over-the-counter tests and elective COVID-19 testing. Beginning May 11, 2023, coverage for all over-the-counter and elective COVID-19 testing is eliminated. The Health Plan will continue to cover medically necessary COVID-19 testing (excluding over-the-counter tests) from network and non-network providers in accordance with Health Plan rules and cost-sharing.
Coverage of at-home COVID-19 tests. Beginning January 15, 2022 and throughout the Public Health Emergency, the Health Plan is required to cover, with no cost-sharing, at-home COVID-19 tests purchased for personal use without a doctor's order or individual health assessment for covered participants and their eligible dependents. Tests purchased for employment, school and testing for public health surveillance or for any other purpose not intended for individualized diagnosis are not covered.	**May 11, 2023** Applies to all over-the-counter tests and elective COVID-19 testing. Beginning May 11, 2023, coverage for all over-the-counter COVID-19 testing is eliminated. The Health Plan will continue to cover medically necessary COVID-19 testing (excluding over-the-counter tests) from network and non-network providers in accordance with Health Plan rules and cost-sharing.
Coverage of COVID-19 vaccinations. Effective March 27, 2020, the Health Plan is required to cover 100% of the costs of any qualifying coronavirus preventive service, including a vaccine, without cost-sharing whether it was provided by a network or non-network provider.	**May 11, 2023** Applies to non-network providers only. Beginning May 11, 2023, COVID-19 vaccinations from non-network providers return to the usual rates: 30-40% of the Reasonable and Customary cost. The Health Plan will continue to cover network COVID-19 vaccination costs at 100% as required for preventive care services.

ATTENTION: The RxSavingsPlus® Card From CVS Caremark Can Help You Save on Prescription Drug Costs ...Regardless of Your Health Plan Enrollment Status

All Health Plan participants, beneficiaries and DGA members can now obtain the RxSavingsPlus card from CVS Caremark for free, regardless of your current Health Plan coverage status.

With the RxSavingsPlus card, you can save an average of 55% off the full cost of generic medications and 24% off brand-name medications at more than 65,000 participating pharmacies nationwide. The RxSavingsPlus card offers prescription drug discounts, not insurance. Discounts are also available on over-the-counter products with a doctor's written prescription, many diabetic supplies and certain pet medications. The card is available at no cost to all Health Plan participants, dependents and DGA members, regardless of current Health Plan enrollment status and can be used immediately.

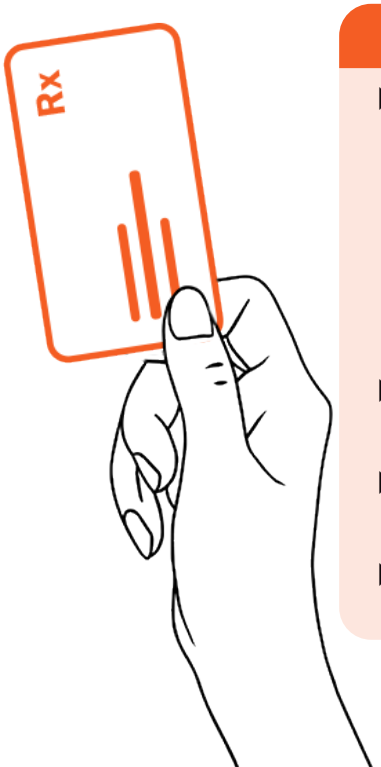
Discounts vary by medication and pharmacy and are not available for mail order medications. For more information about the RxSavingsPlus card, visit www.rxsavingsplus.com/dgaplans. PH

How It Works

1. **Get your free RxSavingsPlus card at www.rxsavingsplus.com/dgaplans.** All you will need is your email address. For added convenience, you can also download the card to your mobile device.
2. **Use the feature on the RxSavingsPlus website to get a price estimate** on your desired medication at your preferred participating pharmacy.
3. **Present your prescription and RxSavingsPlus card** at a participating pharmacy to get the discounted rate.

Covered Participants

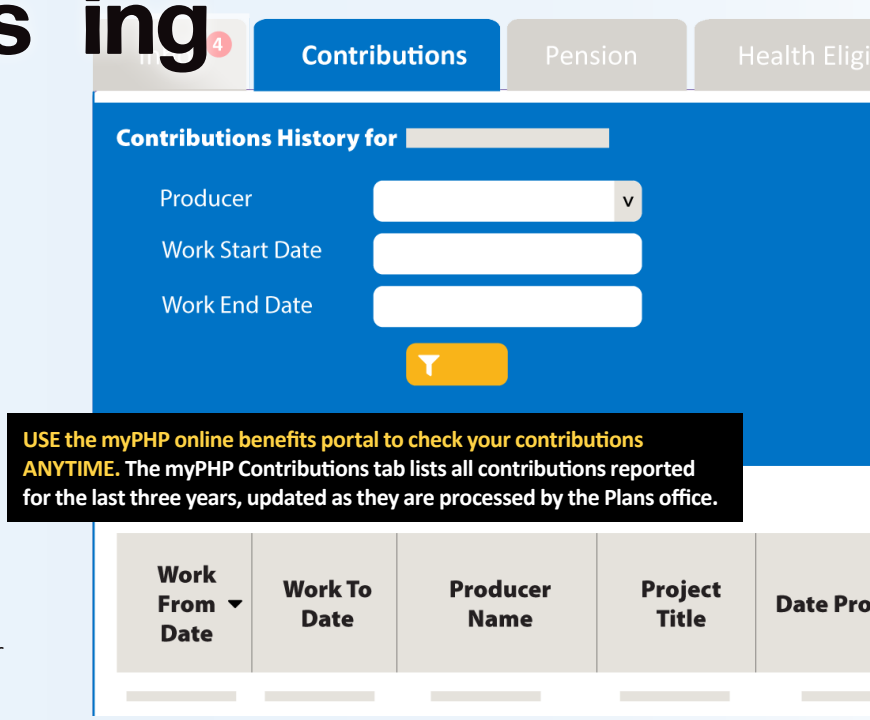
- **If you are prescribed a non-formulary brand name drug** and do not want to use a covered formulary alternative (generic drug), you can receive a discount off the retail price of the brand name drug using the RxSavingsPlus card.
- **Pet medications** that are also used to treat human conditions
- **Over-the-counter medications** with a doctor's prescription
- **Diabetes supplies**



NON Covered Participants

- **If you are prescribed any drug and are not covered under the Health Plan**, you can use the RxSavingsPlus card and the *Price Your Rx* feature to find a participating pharmacy and get a discount on the medication.
- **Pet medications** that are also used to treat human conditions
- **Over-the-counter medications** with a doctor's prescription
- **Diabetes supplies**

Th nk You'r Mis ing Contributi ns? They Might Not Be Due Yet.



Quarterly contributions statements are sent each January, April, July and October to help participants verify that their earnings and employer contributions are being reported correctly. Employer contributions are an important part of qualifying for certain pension and health benefits, including Health Plan coverage, so accurate reporting is key.

Quarterly statements include details of a participant's reportable work earnings for all covered employment performed during the quarter, residuals, and any adjustments received during that period. It is important to carefully review each quarterly statement so that you can work with the Plans to address any discrepancies. Make sure you carefully review these statements for accuracy.

Employers have until the end of the month following the month work was performed to report contributions

Keep in mind that employers have until the end of the month following the month you worked to report contributions to the Plans (although many employers report contributions on a more frequent basis), so all covered work performed during a quarter might not be listed on that quarter's statement. For example, work performed in March need not be reported until the end of April, so those contributions may not appear on a first quarter statement. Instead, they may appear on the second quarter statement if the contributions are reported on time.

If you discover inaccuracies on your statement, be sure to document them on the Quarterly Statement Discrepancy Reporting Form provided with your statement and return the form to the Plans office along with any supporting documentation. You are encouraged to return this form promptly to increase the ease and timeliness of recovering any misreported contributions.

Use myPHP to Check Your Contributions ANYTIME

Rather than wait for a quarterly statement to arrive in the mail, you can also monitor your contributions via the myPHP online benefits portal. Contributions are reflected in the portal as they are processed by the Plans office. You can even sort contributions by employer, date range or amount. To view your processed contributions, log into your myPHP account and go to the Contributions tab. To learn more about the myPHP portal—including a step-by-step video walkthrough of the registration process—or to register, visit www.dgaplans.org/about-myphp.

If you have questions regarding your quarterly contributions statement, call the Contributions, Collections and Compliance Department at (323) 866-2200, Ext. 567. PH

The New Weight Loss Drugs: What You Need to Know

Recently, a class of prescription drugs called GLP-1 agonists—under brand names like Ozempic, Wegovy, Trulicity and Rybelsus—originally used to treat type 2 diabetes, have gained in popularity for use as miracle weight loss drugs. If you or a loved one is considering one of these drugs for the purpose of losing weight, you should first know the details about how they work, what they might cost and how to avoid common pitfalls when obtaining them.

How Do These Drugs Work?

Ozempic, Wegovy, Rybelsus and the like belong to a class of drugs called GLP-1 agonists. GLP-1 agonist drugs, which may be taken orally or by injection, work by mimicking the GLP-1 hormone that occurs naturally in our bodies. The GLP-1 hormone regulates blood sugar, controls appetite and contributes to the feeling of fullness after a meal. Individuals with type 2 diabetes lack the proper amount of GLP-1.

GLP-1 agonists work to control blood sugar and appetite similar to the GLP-1 hormone. A common (and popular) side effect is that they also induce significant weight loss. The most popular formulation of a GLP-1 agonist is semaglutide, the main active ingredient in Ozempic, Wegovy and Rybelsus.

In 2021, Wegovy became the only semaglutide-based medication to win approval from the U.S. Food and Drug Administration for chronic weight management in those who are obese or overweight and meet other medical criteria. Since Wegovy's approval,

however, all GLP-1 agonists have become increasingly popular as weight-loss interventions to such a degree that Ozempic (although not FDA approved for weight loss) and Wegovy can now be found in medical spas and ordered online through telehealth providers.

The increased demand for these drugs, spurred by their use as weight loss medications, has led to widespread shortages, including for diabetic patients.

Does the Health Plan Cover GLP-1 Drugs?

The Health Plan does not guarantee coverage for GLP-1 agonist drugs and requires a pre-authorization for all drugs in this class whether being used to treat type 2 diabetes or weight loss. When purchased out of pocket, these drugs typically cost from $900 to $1,350 a month.

If your doctor would like to prescribe a GLP-1 agonist drug for you or your dependent, they must first request a pre-authorization from CVS Caremark at (855) 271-6601. Alternatively, you can pay out of pocket for the medication.

Exercise Caution Before Taking Weight Loss Drugs

Although GLP-1 agonists are increasingly popular and becoming more widely available, you should exercise caution before taking them.

1. Know the language. Semaglutide is not synonymous with Ozempic. Ozempic is not approved for weight loss. If a provider prescribes or sends you "semaglutide," your response should be "What's the brand name?" Wegovy is the only semaglutide-based drug currently approved for weight loss. If you use another medication like Ozempic or Rybelsus, neither of which is FDA-approved for that purpose, you could be putting yourself at risk.

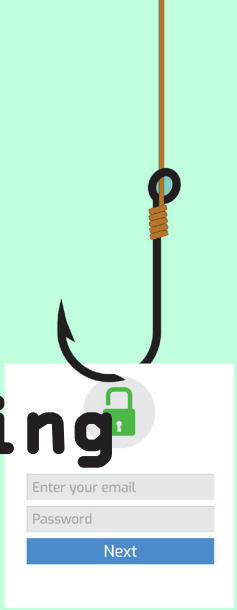
2. Know what you're getting. You are encouraged to obtain prescription drugs like these only at reputable pharmacies so that you can be confident you are obtaining the medication you have been prescribed. With GLP-1 agonists in such short supply, it has been reported that some providers are resorting to securing these medications by other means, like compounding, which might introduce impurities, subpar ingredients or outright counterfeited ingredients.

3. Know the side effects. All medications affect each person differently. Be aware of the side effects of whatever medications you are taking in case you need to seek medical attention or advice. Common side effects of GLP-1 agonist drugs include nausea, constipation, stomach pain, fatigue and headache. PH

> **The Health Plan requires a pre-authorization for all drugs in this class and does not guarantee coverage whether being used to treat type 2 diabetes or weight loss.**

CyberSmart(er)

Phishing Scams Are Getting More Sophisticated. Here's How to Outsmart Them.



Like any normal day, a Hillard, Ohio accounting assistant opened an email from one of the city's vendors, requesting that the assistant update the vendor's bank routing information on file with the city. The assistant complied with the request and made the city's usual payment to the vendor on the next day for $218,992.06.

Only one problem: Both the email request and the updated routing information were not from the vendor at all; they were from a cybercriminal who had used a classic spear phishing attack to trick the city employee.

In recent years, phishing attacks like this one have become increasingly sophisticated and harder to detect while also growing in popularity. According to a recent CNBC report, the rate of phishing attacks increased 61% in the six months ending October 2022 compared to the previous year.

At the Plans, we have implemented many security controls and best practices, including multifactor authentication and strong information security policies, among other administrative and technical controls to protect the confidentiality, integrity and availability of your information. Additionally, our employees undergo rigorous cybersecurity training. Just as information security is a priority on our end, we want you to have the information you need to keep your data safe on yours.

As part of an ongoing CyberSmart(er) series, this article explores phishing (the most common method of cyber-attack), its newest forms and what you can do to avoid cyberattacks.

The New Phishing Schemes

The classic phishing attack consists of a cybercriminal, pretending to be a legitimate individual or company, sending an email or text message that gets you to take an action—calling a number, clicking a link or opening an attachment—with the goal of stealing your personal data or installing malicious software onto your device. Cybercriminals can target you by using knowledge taken from various sources like the dark web or social media.

Historically, phishing attacks have been perpetrated mostly through a text message or email with a subject like "Password Check Required Immediately" to get you to take urgent action. However, in more recent attacks, criminals might use any form of communication or any tactic to commit their crimes.

For example, criminals might build trust with victims over multiple email exchanges before they ask you to take the action that compromises your data. In **voice phishing** attacks, criminals might make phone calls pretending to be a company's support representative to convince you to log in to your account or provide them information to address an urgent account problem. Malicious URLs and phone numbers are often provided as part of the "fix" for the issue. Attackers are increasingly hijacking the names of trusted platforms like Microsoft, SharePoint, Amazon, Google, UPS and Adobe to enact their schemes.

On an even more sophisticated level, **zombie phishing** involves taking over an email sender's account, then resuming a previous conversation with one of your contacts by responding to an old message with a malicious link. The recipient, recognizing both the sender and the conversation, might be more likely to think the email is legit and click the link. Scammers have also resorted to using abbreviated URLs like those created in Bitly because they might be harder to validate.

Protect Yourself from Phishing Attacks

Phishing attacks can greatly damage a victim's personal and professional life. Here's what you can do to protect yourself:

- Hover over links without clicking on them to see if the actual destination address matches the address you intend to visit.
- Review text messages and emails for spelling errors within subject lines, email addresses and URLs.
- Beware of pop-up windows.
- Never give out sensitive personal information over email or text message.
- Closely inspect emails and text messages that ask you to take urgent action.
- Do not share personal or professional information on social media platforms as it can be used to target you in a spear phishing attack.

For more online security tips, refer to the Department of Labor's Online Security Tips available on the Plans' website at **www.dgaplans.org/DOLsecuritytips.** PH

The Age You Must Begin Taking Withdrawals from the Basic and Supplemental Pension Plans Increases to 73

Under the Internal Revenue Code, all qualified retirement plans, including the DGA-Producer Pension Plans, must make required minimum distributions to participants by their Required Beginning Date.

Effective January 1, 2023, the Required Beginning Date for the Pension Plans increased to the April 1st following the year a participant turns age 73 (up from age 72). This applies to participants who turn age 72 after December 31, 2022 and allows participants to wait until April 1st of the year following the year they reach age 73 before they must begin receiving required minimum distributions.

The Setting Every Community Up for Retirement Enhancement Act 2.0 ("SECURE 2.0") increases the Required Beginning Date through 2033. Previously in January 2020, the Required Beginning Date increased from age 70½ to 72. The next change will be in 2033, when the Required Beginning Date is set to increase to age 75 for participants who turn age 74 after December 31, 2032.

The Pension Plans have been operating in accordance with the required changes under SECURE 2.0 for all required minimum distributions made on or after January 1, 2020. The Pension Plans will also make any required amendments in accordance with the applicable deadlines. PH

Is an Inpatient Stay Required for Your Treatment?

Know When and How the Health Plan Covers It.

Dealing with a condition that might require an inpatient stay or hospitalization can feel like a lot to handle. It can become even more overwhelming to sort through the costs and what might be covered by the Health Plan. Fortunately, there are steps you can take before and during an inpatient stay that can help you make informed decisions about your care and help you to better understand what your out-of-pocket costs might be.

Before an Inpatient Stay

An inpatient stay at any facility requires pre-authorization from Anthem Blue Cross' Utilization Management (UM) Department. You or your provider can initiate a request for pre-authorization by calling Anthem's Pre-Authorization Review line at (800) 274-7767. For your convenience, this number is also listed on the back of your Health Plan ID card.

The UM department will determine whether an inpatient stay is the appropriate level of care for your condition based on established medical standards and nationally accepted clinical criteria and afterwards send a decision letter to both you and your provider. The letter will explain whether the requested number of days has been authorized, partially authorized or denied entirely. In addition, this letter will provide the clinical criteria that led to the UM decision and, if denied, provide you and your provider the next steps to appeal.

Regardless of the outcome, pre-authorization will help you better understand your out-of-pocket costs. If you are not pre-authorized for an inpatient stay or for the total number of days you requested, you still have the option of receiving care at the desired facility, with the understanding that you will be responsible for the cost of any days not pre-authorized by Anthem.

EXAMPLE: *Howard's doctor has recommended he complete a 14-day inpatient detox at ABC Behavioral Health Center. The doctor contacted Anthem for pre-authorization and received authorization for 7 days at ABC. Howard begins his inpatient stay at the facility where only 7 days will be covered based on Anthem's pre-authorization.*

During an Inpatient Stay

If you have already begun an inpatient stay for which you have not obtained pre-authorization or if you are unsure whether you have obtained pre-authorization, make sure your provider has begun the pre-authorization process with Anthem's UM Department. If you have obtained pre-authorization before your stay, be sure to keep track of how many pre-authorized days you have been granted. Staying beyond that time means you will be responsible for paying the full cost of your stay for all unauthorized days, and those costs will not be eligible for Health Plan reimbursement.

If you or your provider feels that you need to continue inpatient hospitalization beyond your pre-authorized time, you or your provider can request an extension of your stay from the Anthem UM Department. You may also request that your review be expedited, which could get you a decision within 24 to 72 hours.

A decision on your extension request—which may be a partial approval, alternative care options, full approval or denial—will be sent to both you and your provider. If you elect to stay past your pre-authorized number of days, even while waiting to hear the results of an extension request, you may be financially responsible for any days that were not authorized. If your extension request is approved, make sure to note the number of additional days granted in the extension to avoid paying the costs for exceeding your covered time.

EXAMPLE: *Howard received pre-authorization for 7 days of inpatient treatment at the ABC Behavioral Health Center. On day 5 of his stay, Howard's doctor decides that Howard needs to complete the full 14-day detoxification treatment program on an inpatient basis and requests an extension of his inpatient stay from the Anthem UM Department. On day 7, Howard has not heard back from Anthem but decides to stay at ABC anyway. Howard learns on day 14 of his stay that his extension request was partially approved for 5 (instead of the requested 7) additional inpatient days with the recommendation that Howard transition to an intensive outpatient treatment center after the 5-day extension. In the end, Howard will be financially responsible for the additional 2 days of his stay that went beyond the approved 5-day extension and for any additional time that he elects to stay at ABC beyond the authorized extension.*

I Don't Agree with Anthem's Decision. Now What?

You may request an appeal of any decision from Anthem's UM department—including a denial of pre-authorization, a denial of an extension request, or a partial authorization of an extension. There may be up to three levels of review available to you.

1. Your first level of appeal is with the Anthem Grievance and Appeal Department.
2. If you do not agree with the decision of the Anthem Grievance and Appeal Department, you may then appeal directly to the Benefits Committee of the Health Plan's Board of Trustees, who will consider all available materials previously presented, and any additional information you choose to submit.
3. If you do not agree with the decision of the Benefits Committee, and the adverse determination involves medical judgment or a rescission of coverage, you may then request further external review by a contracted Independent Review Organization (IRO).

Making health-related decisions can be challenging, especially when you are determining whether to enter or continue inpatient treatment. The pre-authorization process is an excellent tool to help you navigate the treatment process and better understand your potential out-of-pocket expenses. If you have any questions, contact the Plans' Participant Services department at (323) 866-2200, Ext. 401, or refer to the Health Plan Summary Plan Description for more information, available at www.dgaplans.org/health-plan-booklet.

My E.R. Visit Turned into a Hospital Admission. What Should I Do?

Inpatient stays can sometimes begin when an emergency room patient gets admitted into the hospital. If your stay begins this way, it is important to know that in a medical emergency, the Health Plan understands that pre-authorization may not be possible while prioritizing your immediate health situation. Instead, the required authorization can be requested during or even after your stay, though it is recommended that you or your doctor request authorization as soon as possible.

CONTINUED ON BACK PAGE

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Is an Inpatient Stay Required for Your Treatment?

Authorization and Appeal Steps for Emergency Inpatient Stays:

1. Request or have the inpatient hospital request authorization for your inpatient stay from Anthem's UM Department as soon as possible.
2. If your initial review for authorization is denied—partially or entirely—you may file an appeal with Anthem's Grievance and Appeal Department.
3. If you do not agree with the decision of Anthem's Grievance and Appeal Department, you and your provider can appeal directly with the Health Plan. PH

HIPAA Notice of Privacy Practices

Health Plan participants can obtain a copy of the Health Plan's Notice of Privacy Practices at www.dgaplans.org/hipaa-notice-of-privacy-practices or by calling Participant Services at (877) 866-2200, Ext. 401. This Notice describes how the Plan may use and disclose your health information.

If you have any questions regarding the Notice of Privacy Practices, please contact the Plans' Privacy Officer at (323) 866-2200, Ext. 305. 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, 2022 and ending December 31, 2022 ("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. The Basic Plan's funded status increased for the third year in a row to 91.3% and remains in the Green Zone under the Pension Protection Act.

	2022 Plan Year	2021 Plan Year	2020 Plan Year
Valuation Date	January 1, 2022	January 1, 2021	January 1, 2020
Funded Percentage	91.3%	90.7%	88.6%
Value of Assets	$2,185,969,562	$2,011,591,116	$1,867,951,607
Value of Liabilities	$2,394,987,251	$2,217,960,825	$2,109,368,228

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, 2022	December 31, 2021	December 31, 2020
Fair Market Value of Assets	$2,029,959,234	$2,247,981,005	$2,073,692,403

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 14,556. Of this number, 8,516 were active participants, 3,693 were retired or separated from service and receiving benefits, and 2,347 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	6.4
U.S. Government securities	3.9
Corporate debt instruments (other than employer securities):	
Preferred	6.4
All Other	5.0
Corporate stocks (other than employer securities):	
Preferred	0.0
Common	1.8
Partnership/joint venture interests	34.4
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	26.3
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	6.4
Value of interest in registered investment companies (*e.g.* mutual funds)	8.5
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	0.9

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).
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> *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.