Spotlight ON BENEFITS

Volume 32, Number 1 | SPRING 2024

Board of Trustees Unanimously Approves Additional Three-Month Extension through June 2024 of Free Major Medical Plus Plan Coverage Under Health Plan for Eligible Participants, Beginning April 1, 2024

pg 3

ALSO IN THIS ISSUE

Inside the Spotlight

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Volume 32 | Number 1 | Spring 2024

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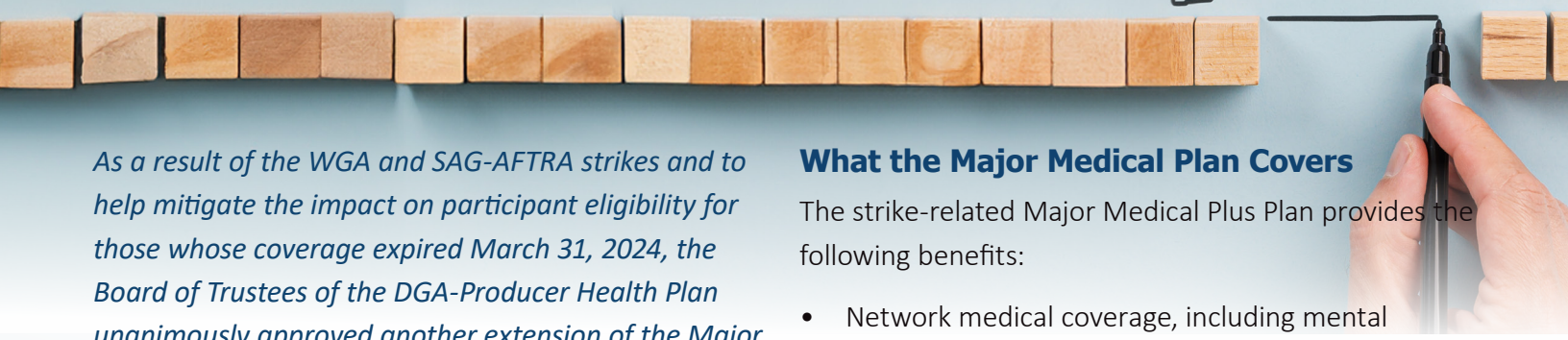
ABOUT THE PLANS

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.

Board of Trustees Unanimously Approves Additional Three-Month Extension through June 2024 of Free Major Medical Plus Plan Coverage Under Health Plan for Eligible Participants, Beginning April 1, 2024



As a result of the WGA and SAG-AFTRA strikes and to help mitigate the impact on participant eligibility for those whose coverage expired March 31, 2024, the Board of Trustees of the DGA-Producer Health Plan unanimously approved another extension of the Major Medical Plus Plan for three months beginning April 1, 2024 and ending on June 30, 2024 for participants who meet certain eligibility requirements.

On February 20, 2024, the Board of Trustees unanimously approved an additional three-month extension of free strike-related Major Medical Plus Plan coverage, recognizing that those who lost Earned Active or regular Carry-Over coverage as of March 31, 2024 may also be impacted by the WGA and SAG-AFTRA strikes. Like before, extended Major Medical Plus Plan coverage is available to eligible Plan participants and their dependents.

The Board of Trustees previously offered Major Medical Plus Plan coverage to participants and their eligible dependents who lost Earned Active or regular Carry-Over coverage as of June 30, 2023, September 30, 2023 and December 31, 2023. Those who elected the coverage were also eligible for the extended Major Medical Plus Plan coverage through June 30, 2024, provided they remained on the Major Medical Plus Plan through March 31, 2024.

What the Major Medical Plan Covers

The strike-related Major Medical Plus Plan provides the following benefits:

- Network medical coverage, including mental health and substance abuse benefits.
- In the case of Emergency Services provided at a non-network facility, when you receive emergency or non-emergency services from a non-network provider at certain network facilities, or emergency air ambulance services provided by non-network providers, non-network providers may not balance bill a patient and the patient will pay the same cost sharing that applies to network claims.
- Prescription drug coverage.

Hearing aids, chiropractic, acupuncture, and foot orthotics are excluded from coverage under the Major Medical Plus Plan, as are dental benefits, vision benefits, and special arrangements with UCLA Health/EIMG.

Who Qualifies

To qualify for the Major Medical Plus Plan, you must have worked under the Basic Agreement or the Freelance Live and Tape Television Agreement and satisfy the requirements on the next page. Individuals in Groups 1, 2 and 3 who previously elected, and

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remained on, the Major Medical Plus Plan through March 31, 2024 are also eligible for the most recent extension from April 1, 2024 through June 30, 2024:

- ✓ Group 1: You and your eligible dependents lost Earned Active or regular Carry-Over coverage as of June 30, 2023 and did not have sufficient earnings to requalify effective October 1, 2023 for the applicable work period July 1, 2022 to June 30, 2023 and have at least $10,000 in initial compensation during the work period July 1, 2022 to June 30, 2023 and the DGA-Producer Health Plan is your primary plan; OR
- ✓ Group 2: You and your eligible dependents lost Earned Active or regular Carry-Over coverage as of September 30, 2023 and did not have sufficient earnings to requalify effective October 1, 2023 for the applicable work period July 1, 2022 to June 30, 2023 and have at least $10,000 in initial compensation during the work period July 1, 2022 to June 30, 2023 and the DGA-Producer Health Plan is your primary plan; OR
- ✓ Group 3: You and your eligible dependents lost Earned Active or regular Carry-Over coverage as of December 31, 2023 and did not have sufficient earnings to requalify effective January 1, 2024 for the applicable work period October 1, 2022 to September 30, 2023 and have at least $7,500 in initial compensation during the work period October 1, 2022 to September 30, 2023 and the DGA-Producer Health Plan is your primary plan; OR
- ✓ Group 4: You and your eligible dependents lost Earned Active or regular Carry-Over coverage as of March 31, 2024 and did not have sufficient earnings to requalify effective April 1, 2024 for the applicable work period January 1, 2023 to December 31, 2023 and have at least $5,000 in initial compensation during the work period January 1, 2023 to December 31, 2023 and the DGA-Producer Health Plan is your primary plan.

Eligible participants may also cover their eligible dependents under the Major Medical Plus Plan.

If you were eligible for the Major Medical Plus Plan effective October 1, 2023 or January 1, 2024, you are also eligible for the extension through June 30, 2024, provided you elected and remained on the Major Medical Plus Plan through March 31, 2024.

Eligibility Exclusions

You are ineligible for free strike-related Major Medical Plus Plan if you fit within any of the following categories:

- ✗ You worked under an agreement other than the Basic Agreement or Freelance Live and Tape Television Agreement and lost coverage on either June 30, 2023, September 30, 2023, December 31, 2023 or March 31, 2024; OR
- ✗ You have Earned Inactive coverage based on residual compensation; OR
- ✗ You have any form of self-pay coverage (including COBRA, Extended Self-Pay, Retiree Carry-Over or Certified Retiree); OR
- ✗ You are covered by other insurance or if you qualify for Medicare as your primary coverage; OR
- ✗ You have available Carry-Over credits or Retiree Carry-Over credits or are eligible to begin Certified Retiree coverage. (You will be required to use your credits or Certified Retiree coverage.)

Eligible Participants Were Notified

Participants who qualify for the latest extension of coverage under the Major Medical Plus Plan have already been notified by the Health Plan. If you are eligible, you should have received a letter from the Health Plan with further information.

If you believe you should be eligible for extended Major Medical Plus Plan coverage, but have not received notification, or for any other questions, please speak to a Participant Services Representative at (323) 866-2200, Ext. 401. PH

New Health Plan Amendment Allows Surviving Dependent Children to Inherit Accrued Earned and Carry-Over Coverage When There Is No Surviving Spouse

The DGA-Producer Health Plan's Board of Trustees has voted to allow a deceased participant's surviving dependent children to inherit any of the participant's accrued Earned or Carry-Over Coverage for purposes of qualifying for survivor coverage, effective April 19, 2024.

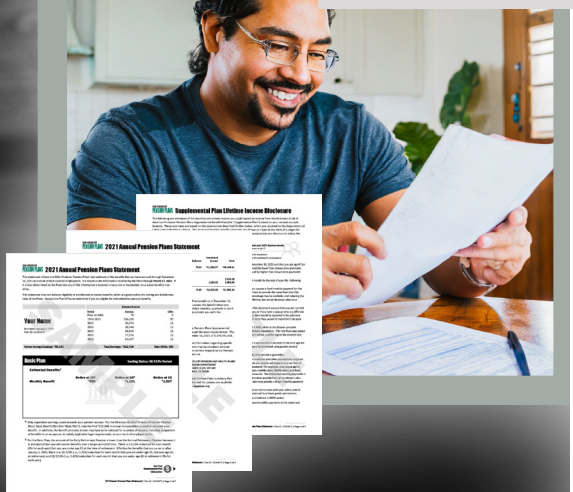
Under the prior Health Plan rules, only surviving spouses could inherit earned or carry-over credit following a participant's death, and surviving dependent children could only be covered under Earned or Carry-Over Coverage if there is a surviving spouse who elects coverage on their behalf (and pays the necessary premiums).

The amendment to Article III, Section 7(a) of the Health Plan's March 2020 Summary Plan Description allows both eligible surviving spouses and any eligible surviving dependent children covered at the time of the participant's death to inherit the remainder of a participant's accumulated Earned or Carry-Over Coverage. For coordination of benefits purposes, eligible surviving dependents with Earned Active Coverage will change to Earned Inactive Coverage effective the date of the participant's death.

To maintain this coverage, dependents must be eligible for Health Plan coverage, and dependent premiums must be paid on a timely basis. Eligible surviving spouses and eligible dependent children may also transition to self-pay coverage after their inherited accrued coverage ends.

For more information about Health Plan coverage after a participant's death, visit **www.dgaplans.org/deathofaparticipant**. PH

Have You Received Your Pension Plans Annual Statement?



By now, you should have received your 2023 Pension Plans' Annual Statement either by mail or online via the myPHP online benefits portal. Please be sure to review your Annual Statement carefully and contact the Plans office as soon as possible if there is a discrepancy.

For more on how to read your annual statement and what to look for, visit **www.dgaplans.org/annual-statements**.

If you have questions or if you have not yet received your statement, please contact a Pension Department representative by phone at **(323) 866-2200, Ext. 404**, or email **pension@dgaplans.org**. PH

My Child is Behaving Differently. The School Recommends We See Someone. What Should I Do Next? And Will It Be Covered?

A parent's drive to protect their child is instinctual. So, if your child begins exhibiting concerning behaviors—which can range from struggling to pay attention or difficulty naming a familiar object—you know that steps need to be taken to get to the bottom of it. But, where do you start, and what will be covered by insurance?

The Health Plan is here to support participants' and their eligible dependents' mental and physical health. However, when it comes to determining the level of support needed, it's important to understand the criteria the Health Plan uses to determine coverage and how they might affect your out-of-pocket costs for testing and treatment.

Who Do I Talk To, and What Will They Recommend?

When you are concerned about new behaviors your child is displaying or a teacher or school counselor recommends you speak with someone about your child, it may be best to start by consulting with your child's pediatrician about changes to the child's behavioral or cognitive health. This allows your doctor to evaluate how the new symptoms connect to your child's overall health, monitor those symptoms and follow up with referrals, if necessary.

Depending on the symptoms presented, a pediatrician or doctor may perform or recommend an assessment to determine a diagnosis for your child. Common assessment methods may include any of the following, among others:

- Initial psychiatric diagnostic evaluation;
- Questionnaire;
- Survey;
- Interview;
- Neuropsychological testing; and
- Behavioral observation

Your child's doctor might also refer you to a specialist (*e.g.*, a psychiatrist, neuropsychologist, clinical social worker, etc.) to perform testing.

What Will the Health Plan Cover?

The Health Plan covers only medically necessary testing and treatment. It does not cover any services or assessments received solely for the patient or provider's convenience, or for academic or psycho-educational purposes like school placement. This may be confusing for parents seeking answers about a new behavior their child is displaying, especially if that behavior also impacts the child's learning or was observed in a school setting.

With children, medical and mental health conditions may produce symptoms similar to a learning-related condition, but the process to diagnose both may look different and take place in different settings. This is why the Health Plan follows generally accepted medical practices in determining which evaluations it will cover and under what circumstances.

Despite a rise in neuropsychological testing to reach a diagnosis for symptoms such as those described above, according to generally accepted medical practices, a less-extensive form of evaluation (*e.g.*, an initial psychiatric diagnostic evaluation, questionnaire or interview) would likely be the appropriate first step and, therefore, more likely to be covered by the Health Plan. A neuropsychological test, on the other hand, would more likely be covered as a first-step evaluation only after a known brain injury or similar condition impacting the brain (*e.g.*, cerebral palsy, stroke, seizure condition, etc.).

If a doctor recommends that you begin with a more extensive evaluation like a neuropsychological test or that you visit a neuropsychological specialist even though other, less-extensive evaluations could be performed, the Health Plan will not cover the test if it is determined to be not medically necessary. The same is true of any tests performed for non-medical purposes.

It is important to note, however, that you can still choose the more extensive evaluation if you prefer to do so, but you will be responsible for any services deemed not medically necessary or that are not covered by the Health Plan.

How to Determine Possible Coverage Ahead of Time

Seeking help for your child can be a scary and overwhelming process, especially if you are also concerned about the costs. But there are options for estimating your costs ahead of time.

- **Have your doctor call the Health Plan.**

  To better understand your potential costs, you can ask your doctor to call the Health Plan at (877) 866-2200, Ext. 404, to check coverage of the recommended assessment before it is performed. Depending on the outcome, you can then make an informed decision about whether you would like to proceed.

- **Request a predetermination to estimate coverage.**

  You may also request a predetermination from the Health Plan before having your child undergo an evaluation. A predetermination is a written analysis that evaluates the medical necessity of treatment and provides you with information on how the Health Plan might apply benefits for the recommended service(s). A predetermination lets you know ahead of treatment what services will likely be covered under the Health Plan and at what level.

  Importantly, a predetermination does not guarantee coverage. A final determination of coverage can be made only after the service has been performed, the claim has been processed and any additional information submitted has been reviewed. To request a predetermination, contact the Health Plan's Participant Services Department at (877) 866-2200, Ext. 401. **PH**

CyberSmart(er): Cybersecurity tips for your daily life.

How to Stay SAFE and Social ONLINE

We are often taught that being a good person means giving other people the benefit of the doubt. We're told to trust someone until they give us a reason not to because that's how you build a healthy connection, right? Not necessarily.

As technology evolves and socializing online becomes the norm, cybercriminals are finding new ways to exploit these cultural changes for their own gain. Though it is possible to have safe connections with the people and content you find online, the sharing of personal or private information combined with our instinctual desire for validation, when channeled online, can become downright risky. Being able to filter safe content and safe people from the criminals and scams is a necessary skill when engaging in today's online community.

This installment of the ongoing Cybersmart(er) series focuses on social cybercrimes, including romance scams, social media account hijacking and sextortion, and tips on how you can protect your own identity, safety and finances.

Identity Threats

Job Scams

The sudden increase in remote working as a result of the pandemic has inadvertently led to an increase in online job scams, causing a reported $68 million in losses for Americans in 2022. In this cybercrime, victims unknowingly apply for a fraudulent job position, divulging personal information or even sending money during the application or onboarding process. Because this scam closely mirrors the typical hiring process, it can be hard to detect, but there are ways to protect yourself when applying for jobs online, including the following tips:

- Use discretion regarding the personal identifying information you share and when in the hiring process you share it;
- Be cautious about making cash payments of any kind, ask for an explanation if a payment is requested and be mindful that scammers will most likely request payment through Zelle, PayPal, Venmo, etc.;
- Scrutinize email addresses. Legitimate company recruiters often contact hires using an email account that ends with @companyname.com not a personal email like at @gmail.com, @yahoo.com, etc.; and
- If you find a job posting on a legitimate job search platform, check the actual company's website for the job posting and for the name of the contact listed in the job posting.

Account Takeovers

Although not commonly referenced as such, social media pages and online profiles can be likened to identification documents, similar to a virtual ID card or passport because of the mountain of information they hold. Cybercriminals can, therefore, have a lot to gain by hacking a social media account, which is why social media account hijacks, also called social media account takeovers, are increasing faster than any other type of identity crime.

In a social media account takeover, criminals combine social engineering, hacking and phishing techniques to take over a victim's account. Once in, they have access to the victim's sensitive data, including the identity of friends, and may lock you out of your own account. Then, criminals can wreak social havoc using your profile and can even sell your private information or

CONTINUED ON PAGE 10

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account on the black market.

To protect your social media account from takeovers:

- Install identity protection services on your devices to alert you of suspicious links and changes to privacy and security settings on social media accounts;
- Know the signs of social engineering and phishing;
- Pay special attention to inconsistencies in your friends' online communication patterns (*e.g.*, if a friend never sends you links to content but suddenly does, their account might be hijacked, and the link could be a phishing attempt); and

- Inform followers and/or friends immediately if your account has been compromised.

Physical Threats

Vacation robberies

If you regularly post photos from your travel or even a fun day out without a second thought, friends may not be the only people taking note. Criminals also use social media photos as a tool to determine which homes to target in vacation robberies, especially when location settings confirm you are away. To avoid giving information to criminals that may be shopping for their next target:

- Wait until you return from your trip or outing to post photos; and
- Do not add location tags to social media photos and posts.

Sextortion

Sextortion has occupied the news lately, especially after a recent Senate hearing with social media CEOs. Outraged advocates claim video games, online chats and social media platforms are being used by predators to target vulnerable victims and children.

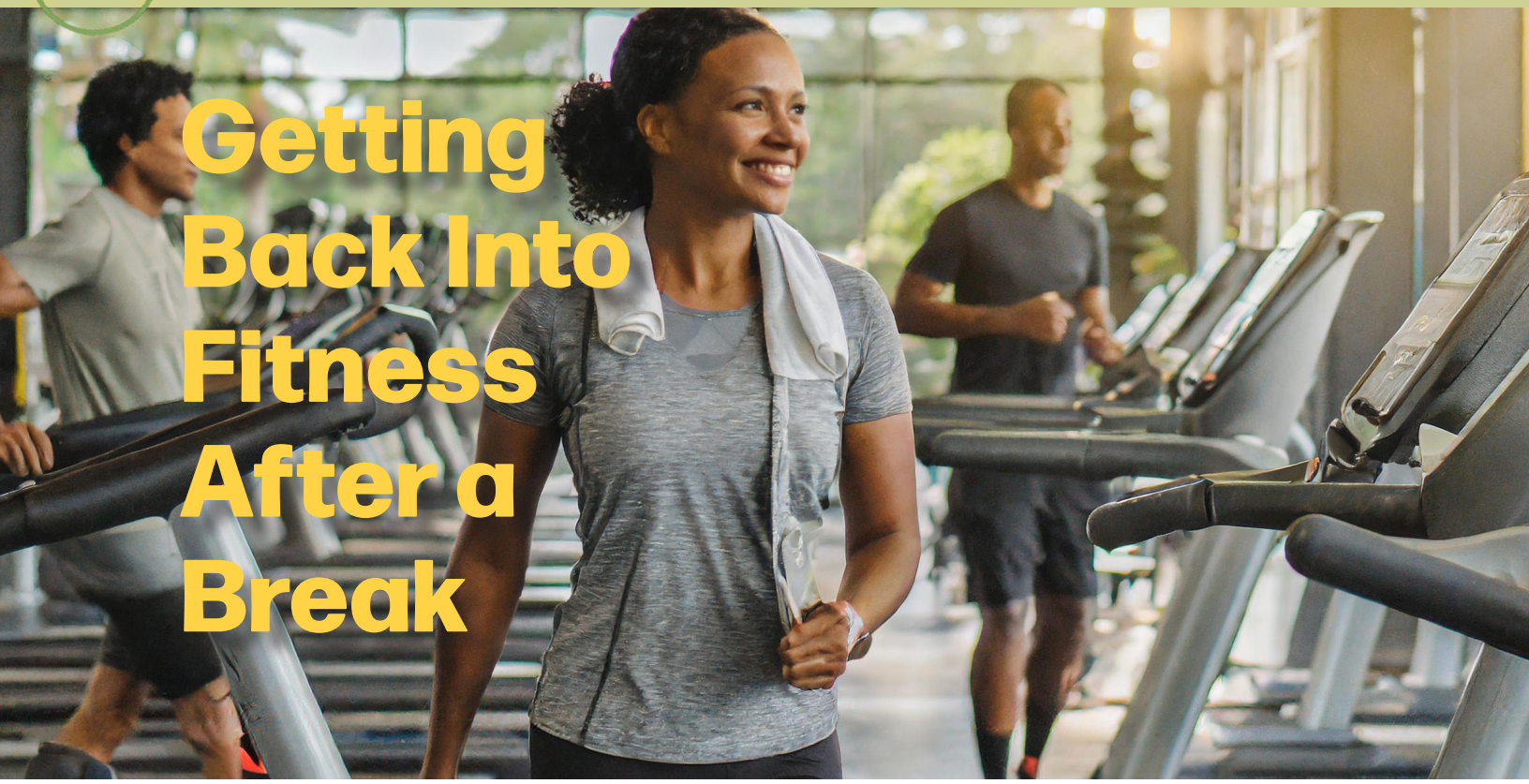
Sextortion online often begins as exchanges of images or media with someone with whom the victim has established a certain level of trust, only for such materials to be used as blackmail or shared with unintended third parties by the cybercriminal later. To avoid becoming a victim of this cybercrime:

- Refrain from sending sexual content or personal contact information virtually;
- Protect yourself from hacking attempts to steal sexual images by removing or refraining from posting explicit images on online platforms;
- Monitor children's online accounts for suspicious activity, review their social media privacy settings and teach them to report threats;
- Cover phone cameras, webcams and recording devices when not in use; and
- If you suspect that you or someone you know is communicating with a predator, save all conversations and report them to tips.fbi.gov.

Cyberstalking

Cyberstalking is the use of technology to stalk or harass someone online and is an extension of in-person

at www.dgaplans.org/safe-and-social-online



Getting Back Into Fitness After a Break

Exercise can be hard, especially when the demands of daily life leave most people little time for themselves. Even more difficult is trying to jump back into a workout routine after months or even years of not working out at all. Whether you're looking to recommit to a long abandoned New Year's resolution or prepare your body for a physically rigorous summer, returning to fitness, even after a break, is a goal easily within your reach.

What Happens to Your Body During an Exercise Break?

Scientists have found that **just three sedentary weeks** can bring challenges whenever you start working out again. You will likely feel more tired than usual because oxygen is not being delivered to your body as efficiently as before, causing your heart to work harder to circulate blood and oxygen to where it is needed. **After two months of inactivity**, you can expect the size and strength of your muscles to have decreased, which means that whenever you re-commit to strength workouts, you will likely experience muscle soreness.

What Can I Do to Make Getting Back into Shape More Manageable?

But all is not lost. Here are two simple, yet tried-and-true tips for reigniting your workout routine after a break or for starting one for the first time:

1. Start with just a *little* something. When it comes to getting back into shape or trying to avoid getting out of shape in the first place, something small is better than nothing at all. Taking the stairs or walking around the block during your lunch break can make a difference. In fact, doctors say even a few minutes each day of interval training can keep your blood volume elevated, allowing your body to work efficiently whenever you are ready for longer or more intense workouts.
2. Try to be consistent. When re-engaging with your workout routine, your main goal should be consistency, like exercising each day for whatever

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CONTINUED FROM PAGE 11

Getting Back Into Fitness

amount of time is manageable for you. Once you have established this habit, build subsequent goals around increasing the time or intensity of the workout, regardless of the type of exercise (*e.g.*, weightlifting, cardiovascular exercise, etc.).

How Long Will It Take to Get Fit Again?

Each person's body is different. The length of time it will take you to get back to the #fitnessgoals shape you are striving for depends on many factors like age, prior level of fitness, diet and genetics. The good news is that although you may experience some level of fitness loss when you stop exercising, muscular strength does not leave completely.

One study found that for older adults who took a 12-week break from exercise, less than eight weeks of retraining got them back to prebreak levels. Others believe that with less than two weeks of moderately hard workouts, you may be able to regain nearly half of your fitness.

Still, there's a reason for the phrase slow and steady wins the race. Personal trainers recommend listening to how your body responds to exercise before increasing the challenge of workouts. Keep in mind that consistency and gradual increases in workout difficulty are crucial parts to a long-lasting fitness routine and lasting physical health. **PH**

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, Ext. 407 or demographics@dgaplans.org.

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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, 2023 and ending December 31, 2023 ("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.

	2023 Plan Year	2022 Plan Year	2021 Plan Year
Valuation Date	January 1, 2023	January 1, 2022	January 1, 2021
Funded Percentage	89.8%	91.3%	90.7%
Value of Assets	$2,262,905,322	$2,185,969,562	$2,011,591,116
Value of Liabilities	$2,518,820,372	$2,394,987,251	$2,217,960,825

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, 2023	December 31, 2022	December 31, 2021
Fair Market Value of Assets	$2,224,002,067	$2,029,959,234	$2,247,981,005

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 15,052. Of this number, 8,890 were active participants, 3,827 were retired or separated from service and receiving benefits, and 2,335 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	6.8
U.S. Government securities	6.0
Corporate debt instruments (other than employer securities):	
Preferred	8.5
All Other	4.9
Corporate stocks (other than employer securities):	
Preferred	0.0
Common	1.8
Partnership/joint venture interests	33.0
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	26.4
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	5.1
Value of interest in registered investment companies (*e.g.* mutual funds)	7.1
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	0.4

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, Controller 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.