Spotlight ON BENEFITS

Volume 33, Number 4 | WINTER 2025

Board of Trustees Approves Initial Health Plan Changes to Address Healthcare Inflation

Reading Time: 5 minutes

We are all aware that the nation is in the midst of a healthcare crisis. Healthcare inflation has been raging for the past several years; the United States Government endured the largest shutdown in history, largely over health care subsidies, and more recently announced double digit increases in Medicare premiums. Our Health Plan is not immune to these factors.

The current healthcare inflationary environment presents a unique challenge to the Health Plan in that it has outpaced the negotiated wage increases on which contributions are based for the last several years. Furthermore, healthcare inflation is forecast to continue to outpace wage increases for the foreseeable future. Contributions on compensation are the Health Plan's largest source of funding and, as a self-funded plan, the Health Plan relies on these contributions to pay benefits.

The Health Plan's reserves, which were built up over the past two decades, are the intentional result of the judicious design of our benefit structure, prudent oversight and cost management by the Board of Trustees, and contribution increases negotiated by the DGA over the past few decades. This careful planning positioned the Health Plan to withstand the impact of the pandemic and the strikes, while also making benefit improvements, including infertility benefits, expanded abortion care and related travel benefits, and palliative care benefits. These efforts have resulted in the Health Plan remaining the best funded plan with one of the finest levels of benefits in the industry.

While the reserves have allowed us to sustain our current level of benefits despite benefit expenses exceeding contribution income, these losses are projected to continue this year and compound in the coming years. Unless addressed, the Health Plan's reserves will be depleted by the end of this decade.

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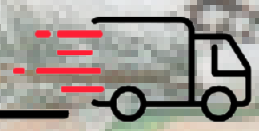
DGA-PRODUCER PENSION & HEALTH

Inside the Spotlight



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 account, visit www.dgaplans.org/about-myphp for more information.

Spotlight
ON BENEFITS
Volume 33 | Number 4 | Winter 2025

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ABOUT THE PLANS

The Pension and Health Plans were created as a result of the Directors Guild of America's collective bargaining agreements with producer associations representing the motion picture, television and commercial production industries.

The DGA-Producer Pension and Health Plans are separate from the Directors Guild of America and are administered by a Board of Trustees made up of DGA representatives and Producers' representatives.

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Initial Health Plan Changes to Address Healthcare Inflation

Accordingly, the Board has taken the initial steps outlined below to address these challenges. The Board of Trustees does not make benefits changes such as these without considerable deliberation and forethought. Future changes are being given the same careful consideration, with the main goal being to preserve the vitality of the Plan for years to come for you and your families.

Increase in minimum age for beginning Certified Retiree coverage from age 60 to 62, effective April 1, 2026

For decades, the Health Plan's rules for Certified Retiree coverage have remained in place without change. During that same time, however, work patterns have shifted so that it is now common for careers to extend well beyond age 60 (the age at which participants currently may begin Certified Retiree coverage). Recognizing this change, the Health Plan will adjust the age at which you may begin Certified Retiree coverage.

Currently, to qualify for Certified Retiree coverage:

- you must be at least age 60,
- have at least 20 years of Earned coverage; and
- must have retired from either the DGA–Producer Basic Pension Plan or DGA–Producer Supplemental Plan.

Effective April 1, 2026, the minimum age that a qualified participant may begin Certified Retiree coverage will increase from 60 to 62. All other requirements will remain unchanged.

Elimination of non-network inpatient benefits, effective March 1, 2026

The Health Plan contracts with Anthem Blue Cross to provide a broad network of inpatient facilities in the United States from which participants may choose to receive services. These network facilities have agreed to charge contracted, discounted rates, thereby reducing costs for both you and the Health Plan. Non-network facilities, on the other hand, may charge any amount they choose, which results in higher costs for both you and the Health Plan.

Given the extensive inpatient network offered by Anthem, the Health Plan will terminate coverage of all non-network inpatient benefits in the United States effective March 1, 2026. (Presently, more than 99% of inpatient claims paid are incurred at network facilities.) This means that, except for Emergency Services as defined beginning on page 66 of the March 2025 Health Plan Summary Plan Description, all non-network inpatient services, including hospitalizations, mental health and chemical dependency treatments, etc., must be provided at an Anthem network facility to qualify for coverage under the Health Plan.

For a list of network inpatient facilities, please visit our Provider Finder at www.dgaplans.org/networkproviders.

Increase in the annual deductible, effective January 1, 2027

The Health Plan's current annual deductible has remained unchanged since 2009, despite a significant rise in healthcare inflation over the intervening period. Given the rise in healthcare costs, the Health Plan's annual deductible will increase beginning in 2027.

Effective January 1, 2027, the Health Plan's annual deductible will increase from $325 per person/$975 per family to $400 per person/$1,200 per family. This means that, beginning January 1, 2027, you must pay

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Initial Health Plan Changes to Address Healthcare Inflation

out-of-pocket for Covered Expenses up to these amounts before the Health Plan will pay any benefits. Your annual deductible resets each Plan Year (which for the DGA–Producer Health Plan is the same as the calendar year) that you are covered.

The current deductible of $325 per person/$975 per family remains in effect for calendar year 2026.

Increase in minimum earnings required to qualify for Health Plan coverage

Effective with earnings periods beginning on or after January 1, 2026, the minimum earnings required to qualify for Health Plan benefits will increase from $39,820 to $41,215 for the DGA Choice Plan and from $129,150 to $133,670 for the DGA Premier Choice Plan. This 3.5% increase aligns with the most recent wage increase negotiated by the DGA in its Collective Bargaining Agreements and is consistent with past annual increases.

The Trustees' objective in making these changes is to protect the participants' benefits, while making judicious decisions about where cost savings can be achieved. **PH**

How You Can Help

Three Tips for Being a Prudent Healthcare Consumer

With healthcare inflation forecast to persist for the foreseeable future, you can take some simple steps today that not only help preserve the Health Plan's limited resources, but also save you money on out-of-pocket costs:

Use a network provider. To find them, go to www.dgaplans.org/networkproviders.

Shop around for the best price for planned services. Use Anthem's price estimator and comparison tools available in the Anthem Blue Cross online portal (visit www.anthem.com/ca) and Sydney Health mobile app.

Compare prescription drug costs using online tools like the CVS Drug Cost and RxCompare (visit www.caremark.com). Sometimes, you can get a lower price by NOT using your prescription drug benefits. Visit www.dgaplans.org/rxsavings. **PH**

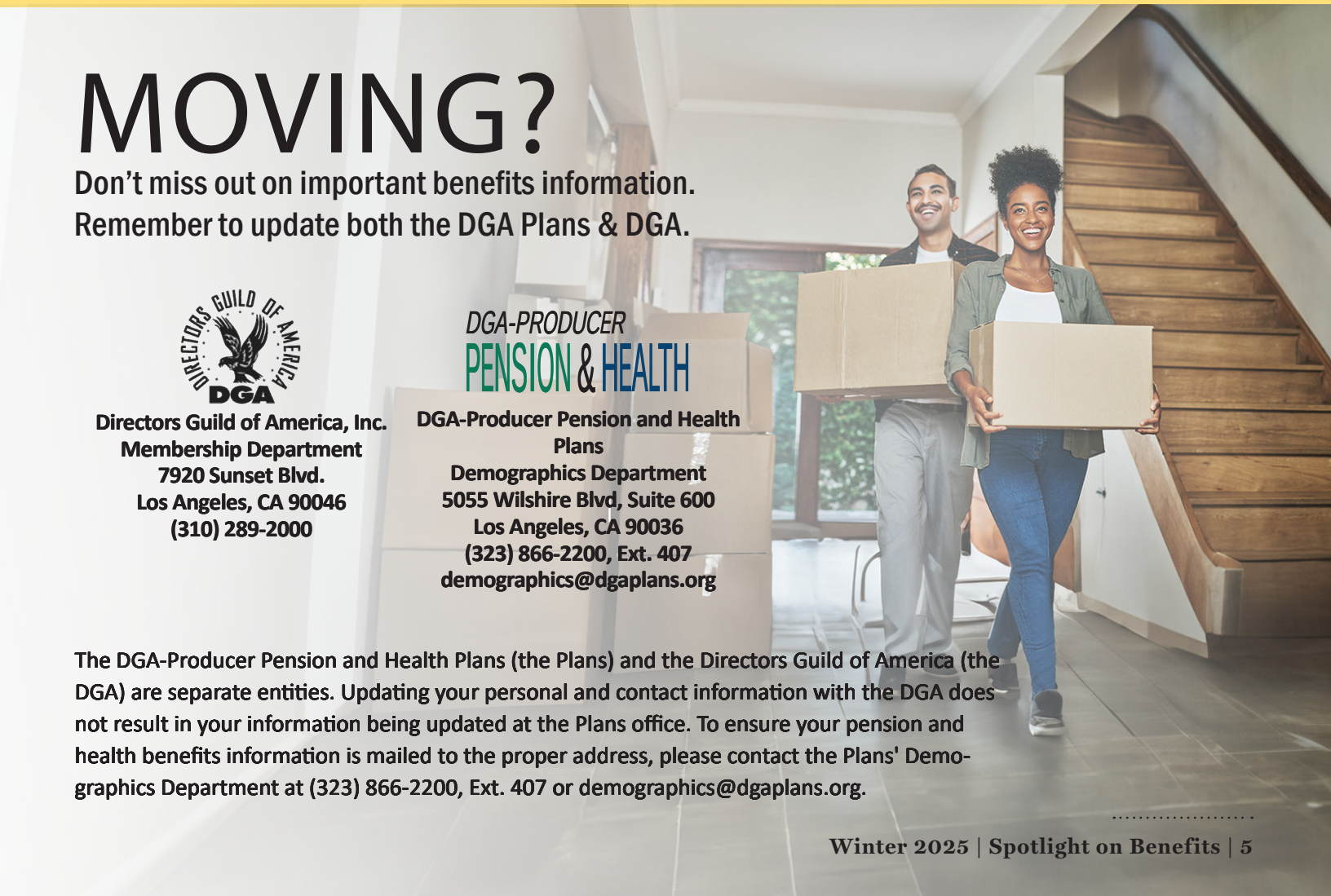
All-Inclusive Out-of-Pocket Limit Increases Effective January 1, 2026 to Limits Established Annually Under the Affordable Care Act

Reading Time: 1 minute

The All-Inclusive Network Out-of-Pocket Limit sets the maximum amount you pay out of pocket per calendar year for network benefits under the Health Plan, including deductibles, co-insurance and co-payments (including prescription drug co-payments, the $50 emergency room co-payment and the $10 co-payment for visits to the UCLA/EIMG health clinics).

The Health Plan evaluates this limit annually to ensure that it remains appropriate for the current economic climate and is in line with the amount established each year under the Affordable Care Act.

Accordingly, beginning January 1, 2026, the Health Plan's All-Inclusive Network Out-of-Pocket Limit will increase from $9,200 per individual/$18,400 per family to $10,600 per individual/$21,200 per family for all coverage plans. Once you reach the limit, the Health Plan will pay 100% of covered network expenses. **PH**



MOVING?

Don't miss out on 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.

CVS Caremark Formulary 101: What is a Formulary?

Reading Time: 2.5 minutes

Each year, CVS negotiates pricing with various drug manufacturers. Those negotiations ultimately result in CVS updating its formulary, which is a list of drugs that are covered under the Health Plan. With CVS Caremark's formulary, you and your doctor can determine which medications are covered under the Health Plan so that you can make more cost-effective decisions.

Why is it important to choose drugs on the formulary?

The CVS Caremark formulary lists the medications that are covered by the Health Plan. Choosing a drug that is included in the formulary can lower your out-of-pocket costs.

The formulary also categorizes the covered drugs as brand or generic—that is, medications your doctor can prioritize prescribing when medically appropriate. The formulary may include several generic and brand name medications that treat the same condition. When a generic medication appears on the formulary along with its brand-name counterpart, the generic drug is typically the less expensive option.

How do I use the formulary?

It is good practice to refer to the formulary at www.dgaplans.org/formulary whenever your doctor prescribes a new medication. Doing so enables you to confirm that any newly prescribed medication is covered by the Health Plan.

If you ever receive a letter from CVS notifying you that a medication you are taking will no longer be covered due to a change in the formulary, the letter will include information regarding the alternative medication(s)

CVS Updates Its List of Covered Medications Effective January 1, 2026

Reading Time: 1 minute

Effective January 1, 2026, CVS Caremark is updating its list of covered medications, referred to as its formulary. Changes to the formulary determine which medications are covered by the Health Plan and what your out-of-pocket costs for prescription medications may be.

If you are currently taking a medication that will be excluded from the updated formulary, CVS Caremark should have already mailed you a letter with information on alternatives. It is good practice for all covered Health Plan participants to review the updated CVS Caremark formulary for any status changes (*e.g.*, step therapy requirements) or exclusions to your current medications.

The complete list of excluded medications along with preferred alternatives is available at www.dgaplans.org/formulary. To learn more about how to best use the formulary, read "CVS Caremark Formulary 101: What is a Formulary?" on this page. PH

so that you may discuss options with your doctor. If your doctor determines that the alternative medication(s) is not medically appropriate to treat your condition, your doctor can request a coverage review from CVS Caremark to determine whether or not the medication is medically necessary to receive continued coverage.

Where to find prescription drug savings

Determining if your medication is covered is one thing, but finding the lowest cost is another. Use the tools below to find the best prices for covered and non-covered medications.

- **Check Your Drug Cost/Price a Drug tool:** Use these tools to check prescription coverage status and compare generic and brand name prices of covered medications. With the Check Your Drug Cost tool available at caremark.com and the Price a Drug tool on the CVS Caremark app, you can learn whether a medication is covered and view alternative medications that are available at a lower cost to you.
- **RxCompare:** For help finding the lowest prices for covered and non-covered medications, use CVS's RxCompare tool to search for discount cards available for various medications. Simply enter your zip code and the drug name to receive a price comparison list.
- **www.dgaplans.org/rxsavings:** For a list of ways to save on prescription drugs, visit www.dgaplans.org/rxsavings. Keep in mind that most drug savings coupons have specific criteria that might not apply to you (such as intended for use only by those who are uninsured).

  In addition, regardless of coverage status, you can get an RxSavingsPlus card from CVS Caremark free of charge to save on the full cost of brand name and generic medications at more than 65,000 participating pharmacies nationwide. Visit www.dgaplans.org/rxsavingspluscard for more information. **PH**

Infertility and Contact Lenses Coverage Clarifications

Reading Time: 1 minute

Contact Lenses

The Vision Benefits section of the Health Plan SPD clarifies the total allowance for non-network contact lenses. The maximum amount the vision benefit will cover for non-network contact lenses under the Plan is as follows: $105 per elective pair of lenses and $210 per Medically Necessary pair of lenses.

Infertility Diagnosis

The section of the Health Plan SPD titled "What's Not Covered Under Medical Benefits" clarifies that an initial diagnostic workup to determine the cause of infertility prior to the start of any infertility treatment remains covered when performed by a non-Carrot provider.

To read a full list of amendments to the March 2025 Health Plan Summary Plan Description, visit www.dgaplans.org/health-plan-booklet. **PH**

2024 Summary Annual Report for Directors Guild of America–Producer Pension Plan

Supplemental Benefit Plan

This is a summary of the annual report for the Directors Guild of America- Producer Pension Plan Supplemental Benefit Plan, E.I.N. 95-6027308, Plan No. 002, for the year ended December 31, 2024. The annual report has been filed with the Employee Benefits Security Administration, U.S. Department of Labor, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Basic Financial Statement

Benefits under the plan are provided through a trust fund or arrangements providing benefits partially through annuity contracts. Plan expenses were $135,140,335. These expenses included $11,309,036 in administrative expenses and $123,831,299 in benefits paid to or for participants and beneficiaries. A total of 25,726 persons were participants in or beneficiaries of the plan at the end of the plan year, although not all of these persons had yet earned the right to receive benefits.

The value of plan assets, after subtracting liabilities of the plan, was $2,299,905,520 as of December 31, 2024, compared to $2,143,366,815 as of January 1, 2024. During the plan year, the plan experienced an increase in its net assets of $156,538,705. This increase includes unrealized appreciation or depreciation in the value of plan assets; that is, the difference between the value of the plan's assets at the end of the year and the value of the assets at the beginning of the year, or the cost of assets acquired during the year. The plan had total income of $291,679,040 including employer contributions of $52,068,235, participant contributions of $28,074,334, rollovers of $11,920,279, gains of $9,105,526 from the sale of assets, earnings from investments of $190,478,623 and other income of $32,043.

Your Rights to Additional Information

You have the right to receive copies of the full annual report, or any part thereof, on request. The items listed below are included in that report:

1. An independent auditor’s report;
2. financial information and information on payments to service providers;
3. assets held for investment;
4. fiduciary information, including non-exempt transactions between the plan and parties-in-interest (that is persons who have certain relationships with the plan); and
5. information regarding any common or collective trusts, pooled separate accounts, master trusts or 103-12 investment entities in which the plan participates.

To obtain copies of the full annual report, or any part thereof, write or call the office of the Directors Guild of America - Producer Pension and Health Plans, 5055 Wilshire Boulevard, Suite 600, Los Angeles, California 90036, or call (323) 866-2200. The charge to cover copying costs will be $15.00 for the full annual report, or $0.25 per page for any parts thereof.

You also have the right to receive from the plan administrator, on request and at no charge, a statement of the assets and liabilities of the plan and accompanying notes, or statement of income and expenses of the plan and accompanying notes, or both. If you request a copy of the full annual report from the plan administrator, these statements and accompanying notes will be included as part of that report. The charges to cover copying costs given above do not include charges for the copying of these portions of the reports because these portions are furnished without charge.

You also have the legally protected right to examine the annual reports at the main office of the plan (5055 Wilshire Boulevard, Suite 600, Los Angeles, California 90036) and at the U.S. Department of Labor in Washington, D.C., or to obtain copies from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

2024 Summary Annual Report for Directors Guild of America–Producer Health Plan

This is a summary of the annual report of the Directors Guild of America- Producer Health Plan, E.I.N. 23-7067289, Plan No. 501, for the year ended December 31, 2024. The annual report has been filed with the Employee Benefits Security Administration, U.S. Department of Labor, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Basic Financial Statement

The value of plan assets, after subtracting liabilities of the plan, was $65,524,060 as of December 31, 2024, compared to $96,191,002 as of January 1, 2024. During the plan year, the plan experienced a decrease in its net assets of $30,666,942. This decrease includes unrealized appreciation and depreciation in the value of plan assets; that is, the difference between the value of the plan's assets at the end of the year and the value of the assets at the beginning of the year or the cost of assets acquired during the year. During the plan year, the plan had total income of $183,695,439 including employer contributions of $146,892,805, participant contributions of $13,980,879, gains of $1,623,153 from the sale of assets, earnings from investments of $21,185,298 and other income of $13,304.

Plan expenses were $214,362,381. These expenses included $10,009,427 in administrative expenses and $204,352,954 in benefits paid to or for participants and beneficiaries.

Your Rights to Additional Information

You have the right to receive copies of the full annual report, or any part thereof, on request. The items listed below are included in that report:

1. An independent auditor's report;
2. financial information and information on payments to service providers;
3. assets held for investment; and
4. information regarding any common or collective trusts, pooled separate accounts, master trusts or 103-12 investment entities in which the plan participates.

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The COVID-19 and MMRV Vaccines Remain Covered Under the Health Plan's Preventive Care Benefits

Reading Time: 1 minute

The Health Plan continues to cover both COVID-19 and childhood MMRV (measles, mumps, rubella and varicella/chickenpox) vaccines under its preventive care benefit.

Changes in COVID-19 Vaccine Availability

Although the CDC no longer recommends the COVID-19 vaccine for certain groups, recent studies show that the vaccine continues to reduce hospitalization and severe outcomes for its recipients across all populations. COVID-19 vaccinations are covered under the Health Plan's preventive care benefits at 100% of cost if administered by a network provider or pharmacy.

Please note that certain CVS pharmacies nationwide, excluding locations in California and New York, may now require a prescription to receive the vaccine. Additionally, it has been reported that there is limited availability of pediatric doses at some pharmacies. In either case, covered participants can still receive these vaccines from a network provider with no cost sharing.

MMRV Vaccines Remain Covered Under Preventive Care

Parents currently have two options for protecting their children against MMRV: (1) getting two shots — one for chickenpox and another that covers the rest — or (2) getting one combined shot, the MMRV vaccine. On September 18, 2025, the CDC changed its stance on the MMRV vaccine, no longer recommending the combined shot for children under 4 years old.

Regardless, the Health Plan continues to cover both options at 100% when administered by a network provider.

Where to Look for an Up-to-Date List of Covered Vaccines

For guidance on which vaccines the Health Plan covers under its preventive care benefits, visit www.dgaplans.org/preventivecare or review recommendations from the United States Preventive Services Task Force at www.uspreventiveservicestaskforce.org/uspstf/. PH

> **The Health Plan continues to cover both COVID-19 and childhood MMRV (measles, mumps, rubella and varicella/chickenpox) vaccines under its preventive care benefit.**

Aging Strong

Bone and Muscle Loss Can Be Prevented

Reading Time: 2.5 minutes

Help! "I've fallen, and I can't get up" is more than a cliché. Each year, it is estimated that one in every three adults ages 65 and older experiences a fall, and according to the CDC, falls lead to more than 800,000 hospitalizations a year for various injuries, including bone fractures, which for some can lead to more serious complications, long-term care or death. So, why are so many people of a certain age losing their balance?

Everyone's Bones and Muscles Weaken with Age

Many are familiar with the bone-weakening condition of osteoporosis, but what's less commonly known is that, although everyone's bone density may not decrease to a level considered below normal, everyone's bones do weaken over time to varying degrees. In fact, Mayo Clinic found that around 54 million people in the United States are affected by either osteoporosis or its precursor, osteopenia (low bone mass), and occurrences of osteoporosis in women age 50 years and older are four times higher compared to men, according to the National Institutes of Health. Studies indicate age-related muscle loss "can begin at around age 35 and occur at a rate of 1-2 percent a year for the typical person. After age 60, it can accelerate to 3 percent a year."

Muscles and bones work together to keep us strong and balanced. When muscles weaken, your bones will follow, along with the ability to make the quick adjustments necessary to avoid a fall.

And these are not the only culprits that weaken mobility and muscle function. With age, people tend to exercise and train less. Without these interventions, overall health, mobility and balance can deteriorate, increasing your frailty and risk of disability.

CONTINUED ON PAGE 15

What is Advance Care Planning? PART ONE

Reading Time: 4.5 minutes

Being faced with the decision of whether to administer life-saving measures for a critically injured and incapacitated loved one is one of the most difficult decisions a person can make. However, there are steps we can all take to prepare ourselves and our loved ones for such possibilities.

Advance care planning is the process of discussing and documenting your wishes for emergency medical treatment or care in the event your doctor is unable to determine what your medical wishes may be. It is recommended that everyone aged 18 and older have a documented advance care plan, regardless of your current health status.

Advance care planning prompts you to think about and document what matters most to you. Though plans can be informal (that is, communicated verbally), a formal advance care plan tangibly documents your wishes on forms such as a living will or health care power of attorney. Those documents are then shared with a trusted loved one and your medical team, increasing the chances of your wishes being followed.

The Four Steps to the Planning Process

The four steps of the advance care planning process are:

1. Understand your current health status
2. Reflect and prioritize your care goals
3. Designate a healthcare agent
4. Communicate your wishes to your healthcare agent and medical providers

This article is the first installment of the series to focus on advance care planning as described in the guidelines to planning advance directives published by Harvard Medical School. This series begins with a discussion of the first two advance care planning steps: (1) understand your current health status and (2) reflect and prioritize your care goals.

Step 1: Understand Your Current Health Status

Health care planning is appropriate at any stage of life and is recommended for all adults. Before documenting your wishes, especially if you are facing a major medical condition, it is important to talk to your doctor about your health status. This dialogue can help you better consider the possible medical scenarios you may experience in the future.

Some helpful questions may include the following:

- My family has a history of (applicable condition). Am I at risk of this in the future?
- What is the usual course of (any condition you may have or develop)?
- What are my chances of developing, recovering, worsening from a condition?
- What is the recommended treatment? Are there alternatives?
- Are there side effects of the illness and treatment?
- How will the recommended treatment affect my functioning?
- How will pain or discomfort be managed?

This conversation is also a good time to ask your doctor to clarify any unknown medical terms and procedures you may encounter in the future, as well as seek details of key terms that may appear in advance care planning documents (*e.g.*, intubation, brain death, coma, vegetative state, hospice, etc.). The circumstances around the use of these terms can vary greatly, so it's critical to understand them before addressing them in a planning document.

Artificial nutrition, for example, is a medical procedure used to treat someone who cannot eat or drink enough to sustain their health. It may be used to sustain life or may also be used in unexpected scenarios to heal, such as during severe burn treatment when the body requires more calories and protein to repair itself than food consumption alone can provide. With that understanding, you might not want your advance care plan to bar artificial nutrition under all circumstances, but instead only when administered for select conditions.

> **...a formal advance care plan tangibly documents your wishes on forms such as a living will or health care power of attorney.**

If you think you want to add a specific condition or procedure to your planning documents, make sure to ask your doctor under what circumstances the procedure might be administered to gain a full understanding of the nuances of its application.

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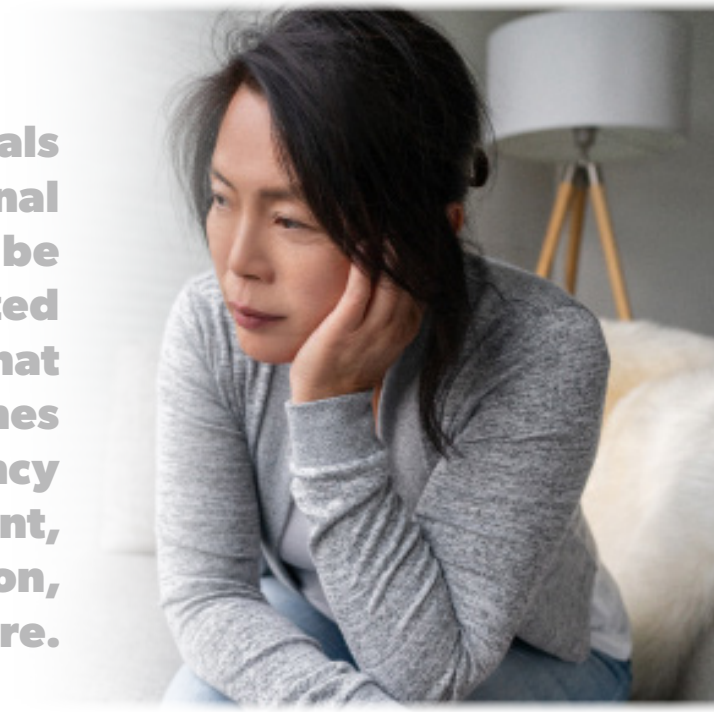
Advanced Care Planning

Step 2: Reflect and Prioritize Your Care Goals

Once you have a good understanding of your current health status and its potential trajectory, it's important to reflect on what your medical goals are. Generally, an advance care planning document centers around three goals: (1) prolonging life, (2) obtaining maximum comfort and (3) maintaining daily function.

It is up to you to decide if you would like to prioritize these or other goals in your planning and to reflect on the medical procedures you're willing to attempt to meet your goals.

> **...Your care goals are personal and should be individualized based on what your wishes for emergency treatment, incapacitation, and end of life are.**



Your care goals are personal and should be individualized based on what your wishes for emergency treatment, incapacitation and end of life are. To get started, some examples of care goals may be:

- Meaningful life allows me to look at and recognize my family members. If I can't...
- If treatment will cause me long-term physical pain, I would like... and would not like...
- It is important to me to remain independent. If I am unable to physically care for myself (*e.g.*, bathe, groom, etc.), I would like...
- If I am unable to breathe on my own, my preference is treatment that...

Once you've determined your goals, you will be able to make decisions on your planning documents that are in alignment with them.

Conclusion

Discussing medical wishes for what you would like to happen to you in the event you're unable to decide or communicate for yourself is a frightening thought for most people. However, reflecting on your health and discussing and documenting your medical wishes have the potential to make an emergency or even end of life scenario easier for you, your loved ones and medical providers. Look for more information on step 3 of the planning process (designate a health care agent) in the next installment of the advance care planning series. **PH**

CONTINUED FROM PAGE 11

Aging Strong

Add Strength Training to Your Exercise Routine for Muscle and Bone Preservation

Strength training, which is also called resistance training, uses varying forms of external resistance to improve your strength. Resistance forms may include your own body weight (*e.g.*, squats, lunges), medicine balls, dumbbells and/or resistance bands.

Research shows that along with remaining active, strength training two to three times a week can reduce bone loss and prevent four to six pounds of muscle loss per decade.

Before beginning a new strength training program, it is best to consult your physician, set goals for your training and start gradually (*e.g.*, calf raises, seated knee extensions, chair dips, etc.) two to three times a week.

Did you know strength training boasts these benefits?

- strengthens back muscles, which prevent or reduce lower back pain
- reduces arthritis pain and greater joint mobility
- promotes better balance and stability, reducing your chances of falling
- healthier weight

Additionally, women covered under the Health Plan who are age 65 and older, or under age 64 and have gone through menopause, are entitled to annual bone density screenings free of charge under the Health Plan's preventive care services when performed by a network provider. **PH**

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Women's Health and Cancer Rights Notice

Women who have had a mastectomy or expect to have one may be entitled to special benefits under the Women's Health and Cancer Rights Act of 1998. The Health Plan provides several important benefits to help women fighting breast cancer.

The following notice is made on an annual basis:

The Health Plan provides medical and surgical benefits for certain types of reconstructive surgery in connection with a mastectomy. This covers reconstruction of the breast on which the mastectomy was performed, surgery on the other breast to produce a symmetrical appearance, and prostheses and physical complications of all stages of mastectomy, including lymphedemas.

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