Spotlight ON BENEFITS

Volume 32, Number 2 | SUMMER 2024

Recognizing the Continued Impact of the Strikes, Board of Trustees Approves Two Additional Three-Month Extensions of Free Major Medical Plus Plan Coverage for Eligible Participants, Beginning July 1, 2024 and October 1, 2024

pg 3

ALSO IN THIS ISSUE

DGA-PRODUCER PENSION & HEALTH

Inside the Spotlight

Be. *Well.* How to Better Advocate for Yourself When Visiting the Doctor pg 12

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 32 | Number 2 | Summer 2024

DGA-PRODUCER PENSION & HEALTH

MAILING ADDRESS
5055 Wilshire Boulevard, Suite 600
Los Angeles, CA 90036

MAIN OFFICE NUMBERS
(323) 866-2200
(877) 866-2200 - Toll Free

OFFICE HOURS
Monday-Friday, 8:30 a.m. to 5:00 p.m.

DEPARTMENT DIRECTORY

Participant Services
(323) 866-2200, Ext. 401

myPHP Support
myPHP-support@dgaplans.org
(323) 866-2200, Ext. 409

Health Plan Eligibility
eligibility@dgaplans.org
(323) 866-2200, Ext. 502

Pension
pension@dgaplans.org
(323) 866-2200, Ext. 404

Demographics
demographics@dgaplans.org
(323) 866-2200, Ext. 407

Contributions and Compliance
(323) 866-2200, Ext. 567

COMMUNICATIONS STAFF
DeLon Howell, Communications Editor
Alicia Gordon, Staff Editor
communications@dgaplans.org

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 Approves Two Additional Three-Month Extensions of Free Major Medical Plus Plan Coverage for Eligible Participants, Beginning July 1, 2024 and October 1, 2024

Reading Time: 4 minutes

To help mitigate the impact of the WGA and SAG-AFTRA strikes on participant eligibility for those whose Earned Active or regular Carry-Over coverage expired June 30, 2024 or will expire September 30, 2024, the Board of Trustees of the DGA-Producer Health Plan unanimously approved an additional extension of the free Major Medical Plus Plan for two additional three-month periods beginning July 1, 2024 and October 1, 2024.

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, December 31, 2023, and March 31, 2024. Those who previously elected this coverage are also eligible for the extensions, provided that they remained on the Major Medical Plus Plan through June 30, 2024 for the extension on July 1, 2024 and through September 30, 2024 for the extension that begins October 1, 2024.

What the Major Medical Plus 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.

Exclusions: 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.

CONTINUED ON NEXT PAGE

CONTINUED FROM PAGE 3

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 below. Individuals who previously elected and remained on the Major Medical Plus Plan through June 30, 2024 (Groups 1-4) are also eligible for the most recent extensions beginning on July 1, 2024 and October 1, 2024, provided that they remained on the Major Medical Plus Plan through June 30, 2024 for the extension on July 1, 2024, and through September 30, 2024 for the extension that begins October 1, 2024.

The two new eligibility groups are detailed further below:

* **For Group 1-4 qualification details, visit www.dgaplans.org/majormedicalplus.**

- ✔ **Group 5:** You and your eligible dependents lost Earned Active or regular Carry-Over coverage as of June 30, 2024 and did not have sufficient earnings to requalify effective July 1, 2024 for the applicable work period April 1, 2023 to March 31, 2024, and have at least $5,000 in initial compensation during the work period April 1, 2023 to March 31, 2024 and the DGA-Producer Health Plan is your primary plan; OR
- ✔ **Group 6:** You and your eligible dependents will lose Earned Active or regular Carry-Over coverage as of September 30, 2024 and do not have sufficient earnings to requalify effective October 1, 2024 for the work period July 1, 2023 to June 30, 2024 and have at least $5,000 in initial compensation during the work period July 1, 2023 to June 30, 2024 and the DGA-Producer Health Plan is your primary plan.

Eligible participants may also cover their eligible dependents under the Major Medical Plus Plan provided they were included on their Earned Active or regular Carry-Over coverage that ended on June 30, 2023, September 30, 2023, December 31, 2023, March 31, 2024, June 30, 2024, or September 30, 2024 and they do not have other primary coverage.

Eligibility Exclusions

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

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

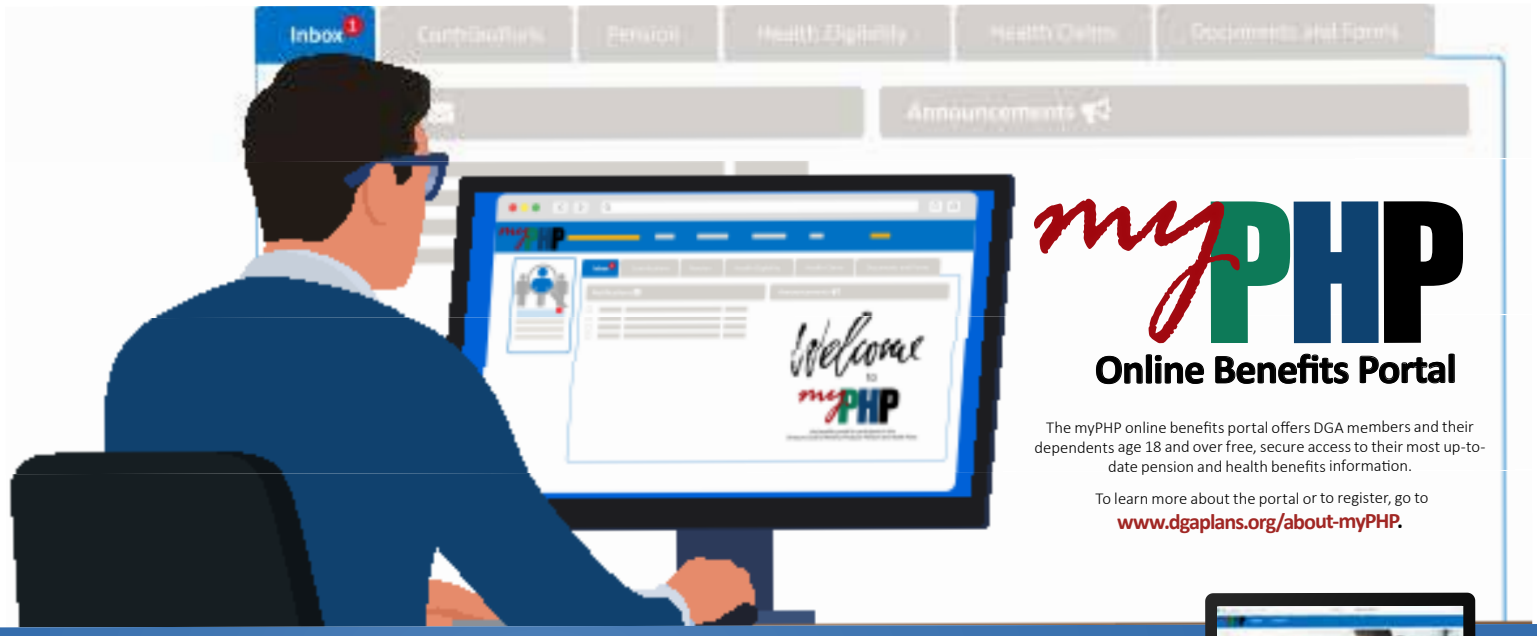
Eligible Participants Will Be Notified

Participants who qualify for the latest extensions of coverage under the Major Medical Plus Plan will be notified. If you are eligible, you will receive a letter from the Health Plan with further information.

If you believe you should be eligible for the extended Major Medical Plus Plan coverage but do not receive notification from the Health Plan, or for any other questions, please contact a Participant Services Representative at (323) 866-2200, Ext. 401. PH

CVS Caremark Updates List of Covered Medications, Effective July 1, 2024

Effective July 1, 2024, CVS Caremark is revising its list of covered medications, which is referred to as its "formulary." If you are currently taking a medication that will be excluded from coverage under the revised formulary, CVS Caremark should have already mailed you a letter with information on alternatives. If you are taking a maintenance medication, be sure to review the new revised formulary in case the status of your medication has changed. The complete 2024 list of excluded medications along with preferred alternatives is available at www.dgaplans.org/formulary. **PH**



myPHP

Online Benefits Portal

The myPHP online benefits portal offers DGA members and their dependents age 18 and over free, secure access to their most up-to-date pension and health benefits information.

To learn more about the portal or to register, go to **www.dgaplans.org/about-myPHP.**

The myPHP online benefits portal puts everything you need for managing your pension and health benefits at your fingertips. A myPHP online benefits portal account lets you:

- Check your estimated pension benefits
- Check your Health Plan eligibility status
- Verify your pension and health contributions
- Get Plans mail delivered electronically
- Upload documents directly to the Plans Office

LEARN MORE OR REGISTER AT:
www.dgaplans.org/about-myPHP

Health Plan Announces Changes to the Non-Network Claims Process and Payments

Reading Time: 4 minutes

The Health Plan contracted with Green Light to improve how non-network claims are paid and how you are reimbursed. Unfortunately, it did not work as expected. The Board has approved changes to ensure you are reimbursed at the same rate as prior to the contract. Retroactive payments will be going out to those affected.

On January 16, 2024, the Health Plan partnered with Green Light Cost Management ("Green Light") to help negotiate lower rates for non-network claims on behalf of Health Plan participants and protect them from balance billing whenever possible. Balance billing is when non-network providers charge participants for the billed amounts that exceed the maximum allowable charge under the Health Plan. In some cases, this can be thousands of dollars. When Green Light is able to negotiate pricing, you and the Health Plan benefit from lower pricing, and you receive protection from balance billing.

To assist Green Light with their negotiations with non-network providers, the Health Plan lowered the applicable benchmark for pricing non-network claims, called the Reasonable and Customary Charge, for non-network services. The maximum allowable charge for a non-network claim under the Health Plan is based on the Reasonable and Customary Charge amount.

In situations when non-network providers either: (1) require payment upfront, which is a common practice; or (2) refuse to further negotiate their billed amounts with Green Light, the reimbursement amount to participants can be lower based on the revised benchmark for determining the Reasonable and Customary Charge under the Health Plan, and participants are still not protected from balance billing in such cases. For these reasons, the Board of Trustees is making the following additional changes to the Health Plan to further protect participants in these scenarios. The changes will be retroactive to January 16, 2024.

How the Health Plan determines the Reasonable and Customary Charge has been revised

The maximum amount the Health Plan will reimburse you for a covered medical service rendered by a non-network provider is based on a benchmark called the Reasonable and Customary Charge. Previously, the Health Plan defined Reasonable and Customary Charge for non-network claims as the amount payable under the FAIR Health Index for the same or similar service in the applicable geographic area and would pay a maximum amount up to 80% of the FAIR Health rate*. After partnering with Green Light, the Health Plan amended the definition of Reasonable and Customary Charge to 150% of the Medicare reimbursement rate for that service, though there are exceptions.

Beginning January 16, 2024, the

Reasonable and Customary Charge will be determined as follows:

1. The Health Plan will reimburse non-network claims at 80% of the FAIR Health standard under the circumstances below:
   a. When you pay upfront and FAIR Health pricing exists; and
   b. When Green Light negotiations with the provider are unsuccessful.
2. The Health Plan will use the 150% of Medicare reimbursement rate when a FAIR Health rate does not exist for the service provided.
3. When you have not paid your non-network provider upfront, Green Light will attempt to negotiate with your provider regarding your billed charges. If Green Light is successful in negotiating a better rate, you will be protected from balance billing, and you and the Health Plan will benefit from lower pricing.

   Non-network providers will be prevented from balance billing you only when the claim has been successfully negotiated by Green Light. In all other cases, you may be subject to balance billing by the non-network provider. Whenever possible, you should have your non-network provider bill the Health Plan directly rather than making payment upfront. In situations when that is not possible, you should negotiate pricing before making an upfront payment.
4. When the Health Plan is not your primary plan, the Health Plan will begin by determining how much it would have paid had there been no other group coverage. Next it will find out what the primary plan paid. Then it will make a payment for the difference, if any, between the greater of the allowable amount and the amount paid by the primary plan, but not to exceed the amount the Health Plan would have paid if it was primary.
5. When there are Plan limits for a covered service (*e.g.*, chiropractic and ambulatory services), the Health Plan will reimburse up to the Plan limit amount. See Article 1, Section 1 *Visit and Benefit Amount Limitations* of the Health Plan's March 2020 Summary Plan Description for more information.

Additional payments will be made retroactively based on these changes.

These changes are effective retroactive to Green Light's implementation on January 16, 2024. The Board of Trustees approved additional payments to participants and providers who received lower reimbursements than would have been paid as a result of these changes. Participants who are receiving an additional payment will also receive an updated EOB.

A non-network provider may receive additional payment if a claim meets all of the following four criteria: (1) the provider was not paid upfront; (2) the provider submitted the claim through the normal claims submission process directly to the Health Plan; (3) the provider was paid at the 150% of Medicare reimbursement rate; and (4) FAIR Health pricing exists for that service. If all four criteria are met, the provider will receive additional payment based on the new rules.

Green Light will continue to negotiate non-network claims that are not paid upfront.

Green Light's successful negotiations with non-network providers continue to provide savings to both the Health Plan and participants. Whenever possible, Green Light will attempt to secure a lower price for non-network claims and agreement from the non-network provider to not balance bill you.

For details on the Health Plan's partnership with Green Light, see https://www.dgaplans.org/greenlight.

*FAIR Health is an independent organization that compiles healthcare claims records from around the U.S. to provide cost estimates (based on geography) for most medical services. PH

Weight Loss Prescription Coverage Requires Enrollment in the Health Plan's New Weight Management Benefits Provider, Flyte Medical, Effective July 1, 2024

Reading Time: 4 minutes

Beginning July 1, 2024, due to the significant costs of the new classes of weight loss drugs and to ensure continuing support to sustain weight loss, any medications prescribed for weight loss on or after July 1, 2024 for participants and dependents ages 18 and older will only be covered if you are enrolled in the Health Plan's new weight management benefits through Flyte Medical ("Flyte"), a medically supervised weight management program, and they are prescribed by a Flyte physician. **If you are prescribed any of these drugs for treatment other than weight loss, the Health Plan will continue to cover your prescription as before and you are not required to enroll in Flyte.**

Flyte connects eligible participants and dependents to a team of physicians, nurse practitioners and registered dietitians. These experts create a personalized treatment plan to help you manage your weight, as well as any related health conditions such as diabetes, heart disease, sleep apnea, and liver disease.

Flyte is available to all eligible participants and dependents over the age of 18, regardless of whether a weight loss drug is currently being prescribed. Participants who are under 18 years of age are ineligible for Flyte and are allowed to continue treatment from non-Flyte providers. Weight loss medications will continue to be subject to Health Plan rules and prior authorization from CVS Caremark.

Changes to Weight Loss Prescription Coverage

Flyte's treatment plan includes medications prescribed for weight loss, when clinically appropriate.

If you are currently taking medications prescribed for weight loss by a non-Flyte provider, the Health Plan continued to cover these prescriptions until July 31, 2024. After this date, your medications will no longer be covered unless prescribed by a Flyte provider. You will be notified by mail and email with instructions on how to start the Flyte enrollment process.

To start enrolling into the program, visit https://www.joinflyte.com/dgaplans and click *Get Started*.

Why the Change?

As the only health plan in the entertainment industry covering weight loss drugs, the Health Plan has seen a significant overall increase in the cost of covering these drugs, with that trend expected to continue for the foreseeable

future. Over the past year, the Health Plan has seen increased utilization and interest in the new class of weight loss drugs called GLP-1s—available under brand names like Ozempic, Rybelsus, Wegovy and Saxenda. Through its partnership with Flyte, the Health Plan will be better positioned to manage access to these weight management medications so that it can continue covering them when clinically appropriate. Most importantly, Flyte's weight management program is intended to help you through your weight loss journey and provide you the essential tools to sustain weight loss and a path toward better health.

What's Covered Under Weight Management Benefits?

Flyte offers a variety of program services, including:

- Weight loss medications;
- Nutritional coaching with a registered dietitian;
- Goal setting and regular feedback on your progress;
- Weight tracking using a scale provided by and automatically connected to Flyte;
- Blood pressure tracking device provided by and automatically connected to Flyte;
- Four virtual visits with your Flyte provider/nurse practitioner, and three visits with your registered dietitian within a consecutive 12-month period; and
- Educational courses related to health and weight management.

What Does This Program Cost Me?

The services described above, excluding medications, are free to those who enroll and not subject to co-payments or co-insurance. However, prescription drugs prescribed by Flyte physicians are subject to the Health Plan's normal prescription co-payments. (See *Important Note on Health Plan Change* on page 10 for changes coming October 1, 2024.) Additional visits with the Flyte care team beyond the seven allotted visits—unless approved by a Flyte provider—are subject to pre-authorization by the Health Plan. If additional visits are not pre-authorized, you will be responsible for the following per visit fee schedule: $250 for a physician visit, $213 for the nurse practitioner and $100 for the registered dietitian.

CONTINUED ON NEXT PAGE

CONTINUED FROM PAGE 9

Health Plan's New Weight Management Benefits Provider, Flyte Medical

Who Qualifies for Flyte?

To qualify for the Flyte program, you must:

- Be a covered DGA-Producer Health Plan participant or dependent ages 18 and older;
- Be physically located within the United States; and
- Have a BMI of 30* or higher; or have a BMI of 27 or higher AND a weight-related health condition* (such as diabetes, sleep apnea, cardiovascular disease or liver disease).

To learn more about weight management benefits through Flyte or to learn more about how to start the enrollment process, visit the Health Plan's Weight Management Benefits Overview webpage at www.dgaplans.org/weightmanagement.

*Even if your current BMI does not meet the program eligibility criteria, Flyte may consider your historical BMI or past weight-related condition in determining eligibility. You are encouraged to submit the complete eligibility questionnaire by going to https://www.joinflyte.com/dgaplans and clicking *Get Started*. **PH**

IMPORTANT NOTE ON HEALTH PLAN CHANGE

Weight Loss Medications Will Be Reclassified as Lifestyle Drugs, Requiring a Higher Co-Payment, Effective October 1, 2024

Reading Time: 2 minutes

The DGA-Producer Health Plan is the only health plan in the entertainment industry to cover weight loss drugs. Certain weight loss drugs, known as GLP-1s, are highly effective but availability is limited, and these medications are also very expensive. GLP-1s—commonly sold under names like semaglutide, Ozempic, Rybelsus, Wegovy, Zepbound, etc.—mimic the hormone that helps regulate blood sugar and promotes weight loss.

Recently, to ensure that those who are taking weight loss drugs are receiving support on their weight loss journey—even when no longer taking these medications—the Health Plan has introduced a new weight management program called Flyte. Effective July 1, 2024, any medications prescribed for weight loss for participants ages 18 and older will be covered only if you are enrolled in Flyte and the drugs are prescribed by a Flyte physician.

As part of the Health Plan's ongoing efforts to manage the costs and maintain coverage of these GLP-1 medications, effective October 1, 2024, all weight loss medications, including GLP-1 medications prescribed solely for weight loss (both on and off-label), will be reclassified to the Health Plan's Lifestyle Drugs co-payment tier, resulting in a higher co-payment. GLP-1 medications prescribed solely for diabetes are not Lifestyle Drugs and will continue to have the same brand co-payment of $24 for a 30-day supply or $60 for a 90-day supply. The chart below outlines the co-payment amounts for Lifestyle Drugs.

Lifestyle Tier Co-Payments

Up to 30-day supplies	Up to 90-day supplies
Greater of $40 or 50% of the cost of the medication	Greater of $60 or 50% of the cost of the medication

CONTINUED ON BACK COVER

Working After Retirement? Be Sure You Know the Basic Plan's Suspension of Benefits Rules.

Reading Time: 2.5 minutes

After you begin receiving a monthly pension benefit from the Basic Plan, it is not uncommon that at some point during your "retirement" you may work again. Under certain circumstances, however, continued work after your benefits commence may lead to your monthly Basic Plan benefit being suspended. This is called Suspendible Service, and it is an important part of financial planning.

Suspendible Service is defined as employment in the same industry, in the same trade or craft worked under Covered Employment, and in the same geographic area covered by the Plan. For example, if you worked as a 1st Assistant Director at all times prior to your retirement from the Basic Plan, any work as a 1st Assistant Director after retirement would be considered Suspendible Service. However, work as a Director after retirement would not be considered Suspendible Service, since you did not work in this same craft as a Director prior to retirement.

If you receive a monthly Basic Plan benefit and work in Suspendible Service before the date you must begin taking benefits—called your Required Beginning Date—the following Suspension of Benefits rules apply:

- If you work seven days or fewer of Suspendible Service in a calendar month, you will continue to receive your monthly Basic Plan benefit.
- If you work eight or more days of Suspendible Service in a calendar month, your Basic Plan benefit will be suspended for that month.

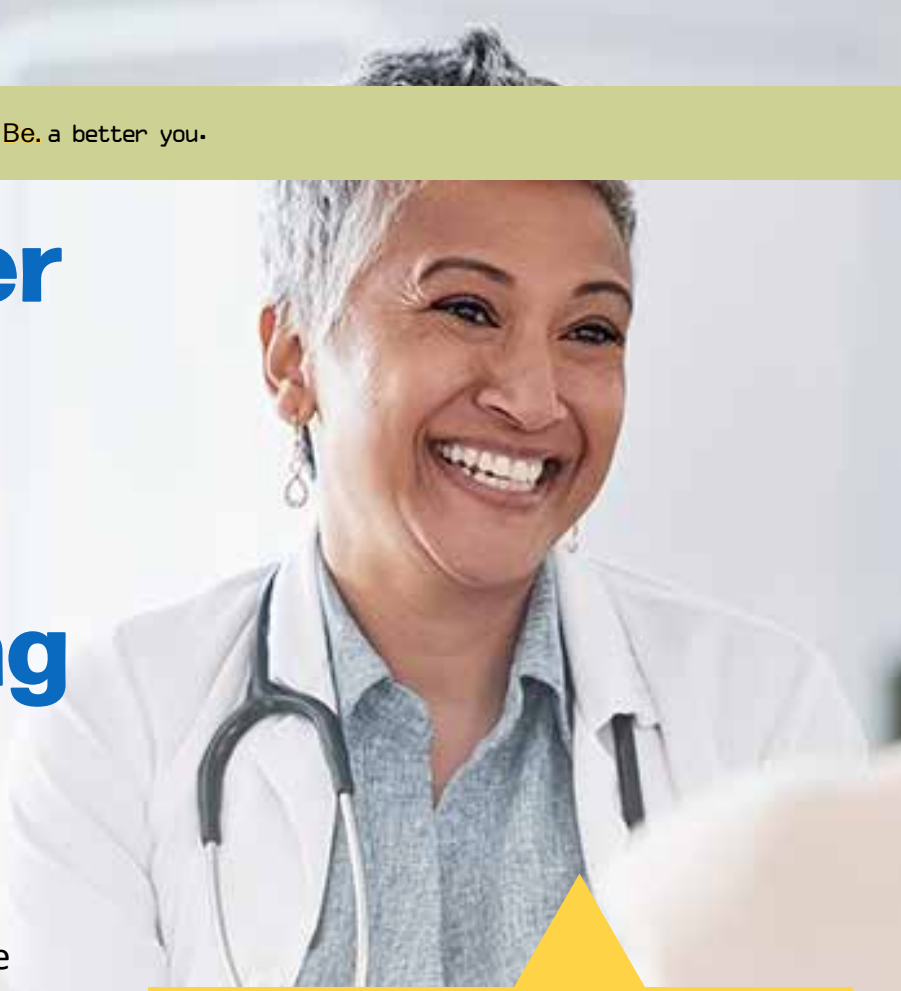
If you are receiving a monthly Basic Plan benefit, you must notify the Plans office, in writing, within 21 days upon starting employment that is considered Suspendible Service. You can do this by filling out and returning the Employment Recap Form available at www.dgaplans.org/forms/pension. If you do not notify the Plans office, and it is later determined that your benefits should have been suspended, the overpayments will be recovered from your future benefit payments.

Likewise, you should also notify the Plans office when you have stopped performing Suspendible Service. Once notified, your benefits will begin again in the month after the last month during which benefits were suspended.

Suspendible service rules only apply to work performed before your Required Beginning Date. Effective January 1, 2023, the Required Beginning Date for the Pension Plans increased to the April 1st following the year you turn age 73 (up from age 72). This applies to those 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. For example, if you turn 73 on December 31, 2024, your Required Beginning Date is April 1, 2025.

For full details on Suspendible Service, refer to the March 2020 Pension Plans Summary Plan Description and its updates. For further questions, contact a Pension Department representative by phone at (323) 866-2200, Ext. 404, or email pension@dgaplans.org. **PH**

How to Better Advocate for Yourself When Visiting the Doctor



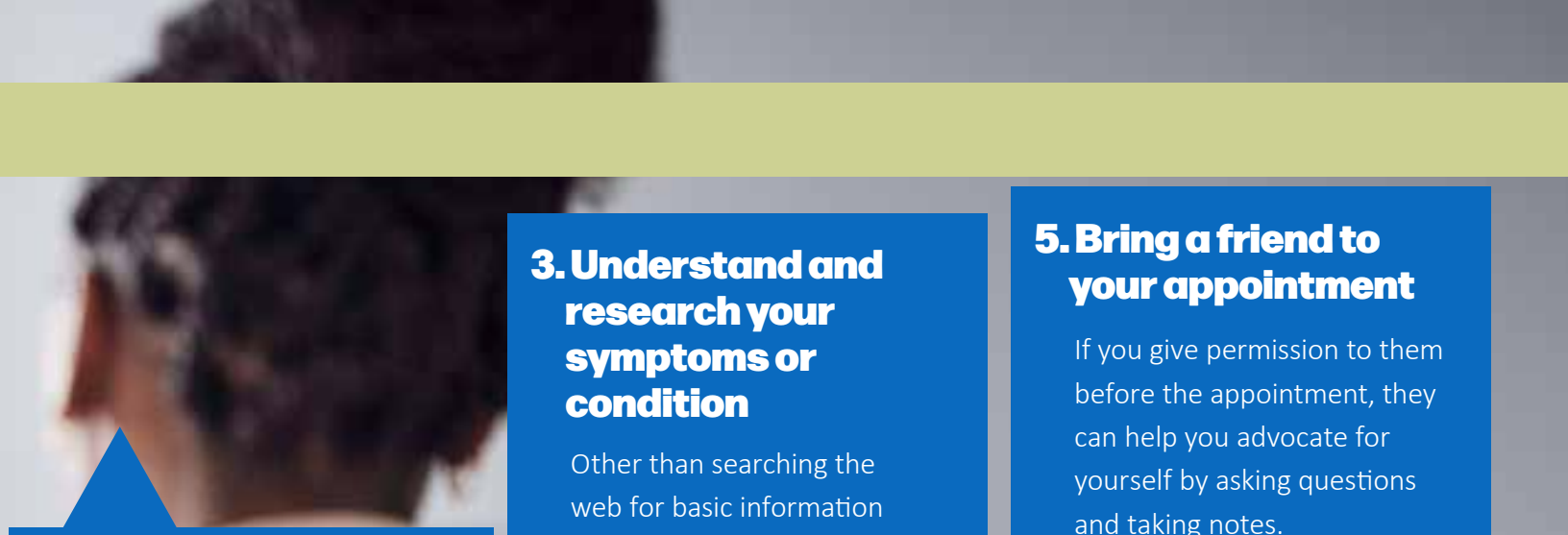
Reading Time: 3 minutes

Because doctors and nurses are often held in such high regard, it can be easy to forget that they are still human. Like the rest of us, they have good and bad days; their attention can vary from one day to the next; and they can even hold unconscious biases. As a patient, however, though it can be difficult to accept that the person you entrust with your health might not always be "all in" when it comes to your care, what can you really do about it? Assuming you have no medical degree of your own, what part can you play to steer your doctor visit toward a great outcome? Anticipation and advocacy are the most important concerns to assure a successful visit.

First, prepare adequately.

Adequate preparation is extremely important. Choosing the right physician and clearly describing your symptoms can improve your appointment experience. Below is a list of helpful steps you can take when searching for a doctor:

- Look for a physician who is board certified, well regarded and is trained in the area in which you are most concerned.
- Use a Provider Finder to search for providers who meet your specific needs.
- Read doctor's biographies on their facility's website or professional social profiles; and
- Search websites for a doctor who shares religious, cultural and other commonalities with you (*e.g.*, www.skinofcolorsociety.org, www.cathmed.org, etc.).



1. Make sure your doctor understands your concerns

A fundamental part of any doctor's appointment is effective communication of your concerns and questions. Make a list of your questions and concerns to bring with you and go over with your doctor. When stating your concerns, observe if your doctor appears to be engaged, waits for you to finish before they speak, writes notes or asks follow-up questions.

2. Have a prepared phrase ready

And if you suspect that they're not listening, lack empathy or are misunderstanding you, having a phrase ready can help you advocate for yourself in the moment. For example, stating "*Not sure I communicated clearly*" or "*That's not quite it. I'm feeling/experiencing…*" can allow you to make sure your concerns are heard in a clear way.

3. Understand and research your symptoms or condition

Other than searching the web for basic information about your condition, it can also benefit you to research common related tests and screenings your doctor might suggest or that you may need to request from your doctor.

Keep a symptom journal, and present a typed copy of your questions at the beginning of your appointment.

4. Question your prescriptions

Some examples of questions you may ask your provider include the following:

- Will this prescribed medication have any negative interaction with the medication(s) and/or supplement(s) I'm taking now?
- Is there an alternative or dose that decreases the side effects of this medication?

5. Bring a friend to your appointment

If you give permission to them before the appointment, they can help you advocate for yourself by asking questions and taking notes.

In the event you don't have a trusted companion, some hospitals and medical facilities have patient advocates, also called patient navigators, available, particularly for those facing a serious or complex diagnosis.

Takeaways

Everyone deserves to be heard and respected, especially when seeking help from a medical professional. But sometimes being heard requires not only the expertise and compassionate approach of a doctor, it requires your advocacy. Research shows that advocating for yourself with your doctor, even in the form of a symptom journal, can provide practical benefits like decreasing unnecessary testing and bettering outcomes, making the time investment well worth it. So, before your next appointment, remember that small acts of advocacy can make a big difference. PH

COMING SOON

Health Fair and Flu Shot Clinic

Los Angeles, CA • September 21
New York, NY • October 19

Saturday, September 21
9:00 a.m. to 12:00 noon.
(Flu shots available until 1:00 p.m.)

DGA Headquarters in Los Angeles
7920 Sunset Blvd, Lobby
Los Angeles, CA 90046

Saturday, October 19
2:00 p.m. to 5:00 p.m.

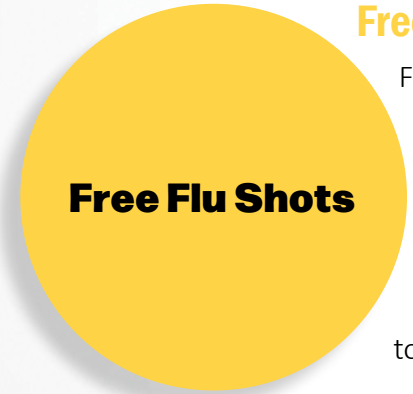
DGA Theater in New York City
110 West 57th Street
New York, NY 10019

The DGA-Producer Pension & Health Plans will be hosting its annual health fairs and free flu shot clinics exclusively for DGA members (regardless of Health Plan coverage status) and their families in Los Angeles and New York City this fall. Plan now for the event nearest you. **Reservations are required for all flu shots. Reserve yours today at www.dgaplans.org/flushots.**

Reservation Information

To reserve a flu shot:
www.dgaplans.org/flushots

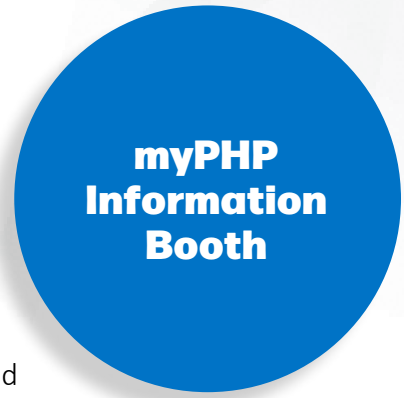
For general information about the health fair or flu shot clinic:
flushots@dgaplans.org or
(323) 866-2216



Free Flu Shots

Flu shots are available to all DGA members and their dependents ages 13 and over. The DGA Foundation is covering the cost of the flu shots for participants not covered under the Health Plan. Women who are pregnant or nursing can request a preservative-free flu shot. High dose vaccines will be available upon request for participants ages 65 and older. When making your reservation, you will be asked to specify the type of flu shot you want to ensure it is available for you.

myPHP Information Booth



Learn about the myPHP benefits portal, where participants in the Pension and Health Plans can access their personal benefits information—including Health Plan eligibility, medical claims, employer contributions, estimated pension benefit accruals and more—wherever you have internet access!

Participants who subscribe to myPHP for the first time and go paperless and current myPHP subscribers who go paperless at the Health Fair's myPHP information booth will be entered into a raffle drawing for an Apple HomePod smart speaker.

Back by Popular Demand

Free neck and shoulder massages

One-on-one time with Plans staff and representatives from the Health Plan's partners, including CVS, Delta Dental, VSP, MPTF and the Entertainment Community Fund (formerly the Actors Fund).

Raffle prizes and giveaways, including a chance to win an Apple Watch Series 9 with GPS + Cellular, gift cards and MORE!

Blood Drive

Blood supplies in the U.S. are at critically low levels. To do our part, the Plans are looking for volunteers to join us in our first-ever blood drive to be held alongside our annual health fairs and flu shot clinics in Los Angeles and New York City. The Red Cross has confirmed there is no danger in giving blood before or after getting a flu shot.

Please consider giving blood to give another person a chance at life. We need a minimum number of donors before we can move forward with the blood drive. If you are interested in helping us meet our goal, visit **www.dgaplans.org/flushots**. PH

DGA-PRODUCER PENSION & HEALTH
5055 WILSHIRE BLVD, SUITE 600
LOS ANGELES, CALIFORNIA 90036
ADDRESS SERVICE REQUESTED

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

your benefits information • at your fingertips • wherever you are

Visit Us Online
www.dgaplans.org

www.dgaplans.org/about-myPHP

CONTINUED FROM PAGE 10

Weight Loss Medications Will Be Reclassified as Lifestyle Drugs, Requiring a Higher Co-Payment, Effective October 1, 2024

To help lower some of the prescription co-payment, certain manufacturer's coupons and savings card programs may be available for weight loss medications. For a list of these discount savings, visit www.dgaplans.org/saveonweightloss.

For more information on Lifestyle Drugs, refer to the March 2020 Health Plan Summary Plan Description and its updates, which are available online at www.dgaplans.org/health-plan-booklet, or you may contact the Health Plan for a copy to be mailed to you at no cost. For more information about the Health Plan's prescription drug benefits, visit www.dgaplans.org/prescription-benefits-overview. **PH**