



A GUIDE TO YOUR RECORDING ACADEMY® EMPLOYEE BENEFITS

California Employees
Effective August 2008



GET TO KNOW YOUR BENEFITS...

The National Academy of Recording Arts & Sciences, Inc. (The Recording Academy), and its affiliated entities are pleased to present this overview of your employee benefits plans. We offer a variety of benefits to help you take good care of yourself and your family. You're eligible to participate in these plans if you are a full-time employee regularly scheduled to work at least 40 hours per week. Coverage under these plans begins on the first day of the month following your date of hire.

You may enroll your eligible dependents for medical, dental, and vision coverage and you may also enroll them in some of our voluntary benefit plans. Your eligible dependents include:

- Your spouse;
- Your qualified domestic partner;
- Your unmarried children (including your stepchildren, adopted children, and your domestic partner's children) up to age 25 who live with you and depend on you for support;
- Your unmarried children who are full-time students, up to age 25 for the medical plan, age 24 for the vision plan, and age 23 for the dental plan;
- Your unmarried children who do not live with you in a parent-child relationship, if you are compelled by a court order to provide health coverage for them; and
- Your mentally or physically disabled adult children, if they live with you and depend on you for support.

MEDICAL PLANS

The Recording Academy gives you a choice of two medical plans: the Anthem Blue Cross CaliforniaCare health maintenance organization (HMO) and the Anthem Blue Cross Prudent Buyer Plan preferred provider organization (PPO). Which plan is best for you depends on your health care needs, your budget, and how much flexibility you require when choosing a provider.

How the HMO Works. An HMO is a network of doctors and health care facilities that provide medical services at little or no out-of-pocket cost to plan members. There are no deductibles to pay and no claim forms to fill out. You'll make a small copayment (usually \$10) for certain services, like routine visits to your doctor; other care, such as hospitalization, is covered at no charge to you. When you enroll in the HMO, you (and each of your enrolled dependents) must choose a primary care physician (PCP) from the Anthem Blue Cross HMO network. That physician will oversee all your medical care, including any referrals to a specialist that may be necessary.

Remember, you must receive all of your non-emergency medical care within the HMO network—and under your PCP's direction—or the plan will not pay benefits.

How the PPO Works. A PPO is a network of doctors and hospitals that have agreed to provide services to plan members at special discounted rates. You can go to any doctor you like within the PPO network, including specialists. Anthem Blue Cross has more than 40,000 physicians and 400 hospitals throughout the state, so you should have no problem finding excellent care within the PPO network. If you decide you'd rather go to a doctor or health care facility that does not belong to the PPO network, you are free to do so—but your out-of-pocket costs will be higher.

When you enroll in the PPO, you must pay a portion of most medical expenses each calendar year before the plan will pay benefits; this amount is called your "deductible." The deductible is \$250 per person; the maximum deductible for you and all of your enrolled family members is \$750. After the deductible is paid, you will pay a portion of the cost for health care services you receive; this amount is called your "coinsurance." If your share of the medical expenses reaches an amount called the "out-of-pocket maximum," you will not have to pay any more coinsurance for the rest of the calendar year.

- **Maximum Savings and Convenience:** Using the PPO Network. If you receive health care services from a provider within the PPO network, your coinsurance will usually be 10% of the PPO provider's discounted rates. The annual out-of-pocket maximum for PPO network care is \$2,000 per person. There are no claim forms or other paperwork to complete when you go to a PPO network provider.
- **Maximum Freedom of Choice:** Going Outside the PPO Network. If you receive health care services from an out-of-network provider, your coinsurance will be 30% for most services. The annual out-of-pocket maximum for out-of-network care is \$6,000 per person. When you use an out-of-network provider, the plan pays benefits based on what Anthem Blue Cross has determined is the "reasonable and customary" (R&C) charge for a particular medical service in your area. If your doctor charges more than the R&C amount covered by the plan, you will have to pay the difference (in addition to your deductible and coinsurance). Also, when you go to an out-of-network provider, you must pay the full cost of your medical services up front. You will then file a claim with Anthem Blue Cross to be reimbursed for the covered amount.

Keep in mind that what you spend on your deductible, copayments, coinsurance for certain services (such as mental health and substance abuse treatment), and out-of-network charges that aren't covered by the plan does not count toward your out-of-pocket maximum.

The chart on the next page shows the highlights of your HMO and PPO plan benefits. Please see your Anthem Blue Cross materials and the plan document for complete information on each plan's benefits, limitations, and exclusions.

	Prudent Buyer Plan PPO		CaliforniaCare HMO
	PPO Network	Out-of-Network	
Where You Go for Care	All care must be provided by a PPO network physician or hospital	You may go to any physician or hospital you choose	All care must be coordinated through your primary care physician
Calendar Year Deductible	\$250/person \$750/family (3 or more people)		None
Calendar Year Out-of-Pocket Maximum	\$2,000/person	\$6,000/person	\$1,500/person, \$3,000/two-party \$4,500/family (3 or more people)
Lifetime Maximum Benefit	\$5,000,000/person		None
Physician Office Visits	You pay a \$15 copay with no deductible	Plan pays 70%	You pay a \$10 copay
Diagnostic Services (includes laboratory tests, X-rays, mammograms, pap smears, and prostate cancer screening)	Plan pays 90%	Plan pays 70%	Plan pays 100%
Inpatient Hospital Services (preauthorization required)	Plan pays 90%	Plan pays 70% of the reduced covered expenses ¹ after regular deductible plus a separate \$500 deductible/admission	Plan pays 100%
Outpatient Surgery (preauthorization required)	Plan pays 90%	Plan pays 70% (up to a maximum benefit of \$350/day)	Plan pays 100%
Preventive Care (includes routine physical exams and associated laboratory tests and X-rays)	You pay a \$15 copay/visit with no deductible; the most the plan will pay for preventive care is \$250/year	Not covered	You pay a \$10 copay
Well-Baby and Well-Child Care	Through age 6 only: You pay a \$15 copay/exam with no deductible; no charge for immunizations	Through age 6 only: Plan pays 70% (limited to \$20/exam and \$12/immunization)	You pay a \$10 copay; no charge for immunizations
Emergency Room Care	You pay a \$100 copay (waived if admitted); plan pays 90%	You pay a \$100 copay (waived if admitted); plan pays 90% for the first 48 hours in the hospital, then 70% (unless you cannot be safely moved to a network hospital)	You pay a \$100 copay (waived if admitted)
Mental Health Services ² Inpatient Care (preauthorization required)	Plan pays 90% (up to \$175/day)	Plan pays 70% of the reduced covered expenses ¹ (up to \$175/day)	You pay a \$100 copay/day (up to 30 days/calendar year)
Outpatient Care	Plan pays 90% (up to \$25/visit)	Plan pays 70% (up to \$25/visit)	You pay a \$35 copay/visit (limited to one visit/day and 30 visits/calendar year)
Substance Abuse Services Inpatient Care (preauthorization required)	Plan pays 90% (up to \$175/day and 30 days/calendar year; 30-day limit does not apply to detoxification)	Plan pays 70% of the reduced covered expenses ¹ (up to \$175/day and 30 days/calendar year; 30-day limit does not apply to detoxification)	You pay a \$100 copay/day (detoxification only)
Outpatient Care	Plan pays 90% (up to \$25/visit and 50 visits/calendar year)	Plan pays 70% (up to \$25/visit and 50 visits/calendar year)	Not covered
Retail Prescription Drugs (30-day supply)	You pay \$5 for generic drugs or \$15 for brand-name drugs	You pay \$5 for generic drugs or \$15 for brand-name drugs, plus 50% of the limited fee schedule and any amounts exceeding the fee schedule	Network pharmacy: You pay \$5 for generic drugs or \$10 for brand-name drugs, plus 50% of the limited fee schedule and any amounts exceeding the fee schedule Out-of-Network pharmacy: You pay \$5 for generic drugs or \$10 for brand-name drugs, plus 50% of the limited fee schedule and any amounts exceeding the fee schedule
Mail-Order Prescription Drugs (90-day supply)	You pay \$10 for generic drugs or \$30 for brand-name drugs		You pay \$10 for generic drugs or \$20 for brand-name drugs

¹ For nonemergency care in an out-of-network hospital, the plan reduces the amount of covered expenses it would normally pay by 25%. Your benefit will then be 70% of this reduced amount; you will have to pay the difference.

² These limits, exclusions, and benefit maximums do not apply to severe mental disorders or serious emotional disturbances of children. Please see your summary plan description for complete information.

Preauthorization: Unless it's an emergency, your physician must get approval from Anthem Blue Cross before you are admitted to the hospital or have outpatient surgery. Make sure your physician contacts Anthem Blue Cross at least 72 hours before your hospital admission or outpatient surgery. If you do not get preauthorization, you will have to pay an additional \$500 deductible.

DENTAL PLAN

The DeltaPremier dental plan is a preferred provider program that gives you the option of receiving treatment from any licensed dental provider you choose. If you go to a dentist who is a member of Delta's extensive preferred provider network, you will be able to take advantage of Delta's special discounted rates and reduce your out-of-pocket costs. Also, there are no claim forms to fill out when you go to a network dentist.

If you decide to go to an out-of-network dentist, the plan's benefits will be based on what Delta has determined is the "usual, customary, and reasonable" (UCR) charge for a particular dental service in your area. If your dentist charges more than the UCR amount allowed by the plan, you will have to pay the difference. You will have to complete a claim form when you go to an out-of-network dentist, and you may be required to pay the entire bill up front and wait for reimbursement.

DeltaPremier Dental Plan	
Calendar Year Deductible	\$50/person
Annual Maximum Benefit	\$1,500/person
Diagnostic and Preventive Services (includes oral exams, cleanings, X-rays, and fluoride treatments)	Plan pays 100% with no deductible
Basic Services (includes fillings, extractions, biopsies, root canals, periodontic treatment, and sealants)	Plan pays 80%
Major Services* (including crowns, bridges, dentures, jackets, and other cast restorations)	Plan pays 50%
Orthodontia* (for adults and eligible dependent children)	Plan pays 50%, to a maximum lifetime benefit of \$1,000/person

* You must be enrolled in the dental plan for at least 12 continuous months before you are eligible for these benefits.

Important! If you do not sign up for the dental plan when you are first eligible, you will not be able to join unless you have a special enrollment event, such as marriage or the birth or adoption of a dependent child. See Human Resources for more information.

VISION PLAN

Your vision care coverage is provided through Vision Service Plan (VSP). Under this plan, you can choose between network and out-of-network providers—but you will receive a higher level of benefits, and enjoy greater convenience, if you go to a provider in the VSP network. If you go to a VSP vision care provider, eye exams and lenses are covered in full after you make a \$10 copayment; frames are covered in full up to \$120, and elective contact lenses are covered up to \$120. If you decide to go to an out-of-network provider, you will be reimbursed for exams and eyewear according to a schedule of allowances.

FLEXIBLE SPENDING ACCOUNTS (FSAs)

FSAs allow you to save money by paying certain health and dependent care expenses on a before-tax basis. You may set aside up to \$2,000 per year for your health care FSA and up to \$5,000 per year for your dependent care FSA (if your tax filing status is "married filing jointly" or "head of household"). You pay no taxes on the money you put in these accounts, which means more take-home pay for you.

DISABILITY INSURANCE

The Recording Academy provides company-paid short-term disability (STD) and long-term disability (LTD) coverage through Mutual of Omaha, to help protect your income if you become disabled and unable to work. The STD plan pays the lesser of 60% of your weekly earnings or a maximum weekly benefit of \$2,308, if an accidental injury or illness keeps you out of work for 29 days or more. The LTD plan pays the lesser of 60% of your monthly salary or the maximum monthly benefit of \$6,000, if you have a disabling condition that lasts beyond 90 days. Please note, if you are an executive earning over \$375,000 annually, your maximum monthly LTD benefit is \$10,000.

LIFE AND AD&D INSURANCE

All full-time employees receive company-paid life and accidental death and dismemberment (AD&D) insurance through Anthem Blue Cross. Your benefit amount under each plan is equal to your annual salary, up to a maximum benefit of \$500,000.

401(k) PLAN

The Recording Academy offers a 401(k) plan to help you prepare for a comfortable retirement. The plan allows you to save for your retirement on a before-tax basis, and The Recording Academy will match 50% of your 401(k) contributions. Please contact Human Resources for information about the vesting requirements and other plan details.

VOLUNTARY BENEFITS

An array of voluntary benefit plans are available through AFLAC, including a supplemental dental plan, long-term care insurance, and supplemental life insurance for you and your dependents. If you choose to enroll in any of these plans, you will pay the full cost of your coverage through after-tax payroll deductions. See your AFLAC materials for more information.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

If you need help with a difficult situation affecting your home life or your work, the EAP is there for you (and everyone who lives in your home) 24 hours a day. This program is provided by the Recording Academy at no cost to you and is administered by The Holman Group. The EAP provides strictly confidential counseling through outside professionals to help you manage a variety of issues, including family concerns, stress, depression, substance abuse, work-related conflict, and legal matters. The EAP will cover up to eight free, in-person counseling sessions for each problem per year.

TIME OFF & SPECIAL PERKS

Full-time employees receive paid vacation plus sick time and floating holidays. In addition, the Recording Academy offers all sorts of special fringe benefits, including affordable on-site massage, discounted gym memberships at 24 Hour Fitness, a convenient weekly car wash service, and two credit unions.