# Summary Plan Description

## The J. Paul Getty Trust

## Health & Welfare Plan

The J. Paul Getty Trust
Getty Human Resources
1200 Getty Center Drive, #400
Los Angeles, CA 90049-1681
310.440.6523
HR@getty.edu

# Contents

# INTRODUCTION

The J. Paul Getty Trust Health & Welfare Plan is designed to provide benefits to you and your eligible dependents. This summary, together with the booklets, certificates and evidence of coverage documents (collectively, Benefit Booklets), is intended to serve as the Summary Plan Description (SPD), as required by the Employee Retirement Income Security Act of 1974 (ERISA). The SPD describes the benefits provided by the J. Paul Getty Trust Health & Welfare Plan (the Plan) for eligible employees and their eligible dependents.

The Plan will provide benefits in accordance with applicable federal laws including the Consolidated Omnibus Budget Reconciliation Act (COBRA), the Health Insurance Portability and Accountability Act (HIPAA), the Mental Health Parity Act (MHPA), the Newborns' and Mothers' Health Protection Act (NMHPA), the Women's Health and Cancer Rights Act (WHCRA), the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), the Genetic Information Nondiscrimination Act (GINA), and the applicable provisions of the Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act (collectively referred to as the Affordable Care Act).

This SPD is the Summary Plan Description (SPD) for the following plans:

- Medical
- Dental
- Vision
- Group Life/AD&D
- Business Travel Accident Insurance
- Long-Term Disability (LTD)

If there is any conflict between this SPD and the plan documents, the plan documents and insurance contracts will govern. This SPD supersedes any previously issued SPDs or booklets describing the above-mentioned plans. This booklet is not intended as a contract and should not be construed as creating contractual obligations. All benefits are subject to change solely at the discretion of the J. Paul Getty Trust.

You should read this information carefully, discuss it with your family, and keep it with your other important papers for future reference. It is also available at www.gettyhr.com

If you have any questions that are not answered in this SPD, call Getty Human Resources at 310.440.6523 or send an email to HR@getty.edu

# GENERAL INFORMATION

## *Eligibility, Cost & Enrollment*

As an active employee regularly scheduled to work 60 hours or more in a two-week period, and expected to be in the position for 90 days or longer, you are eligible for the plans indicated in the table below:

| Benefit Plans | Regular Employees<br>*Regularly scheduled to work 60 hours or more in a two-week period* | Limited-Term Employees 3 months or > |
|---|---|---|
| Medical, Dental, Vision | Yes | Yes |
| Life, AD&D, LTD, Business Travel | Yes | No |
| Flexible Spending Accounts (FSA) | Yes | No |
| Health Savings Accounts (HSA) | Yes | Yes |

## *Eligibility under the Affordable Care Act*

If you do not meet the eligibility requirements described above (for example, if your hours vary and you are not regularly scheduled to work at the minimum number of hours per week), you may still be eligible for benefits if you satisfy the following eligibility standard:

You may be eligible for coverage if you worked an average of 30 hours per week over the course of a measurement period (which is considered full-time under the Affordable Care Act). The J. Paul Getty Trust looks back at your prior service to determine whether you might be considered full-time and eligible for benefits coverage. For ongoing employees, the Standard Measurement Period will be based on payroll cycles from mid-October "looking back" to the prior mid-October.

If the J. Paul Getty Trust determines that you are eligible based on an Initial Measurement or Standard Measurement review, you will be notified. If you are eligible for Medical benefits, you may stay on benefits for a Stability Period (12 months), even if your hours or wages decrease during that Stability Period, so long as you remain an employee and continue to make any required contributions toward your coverage.

For details concerning benefits eligibility under the Affordable Care Act, contact Getty Human Resources.

## *Dependent Eligibility*

Dependents may be covered under the medical, dental and vision plans if they are your:

- Legal spouse;
- Domestic partner registered with the state of California, or equivalent;
- Children through December 31st of the year in which they turn 26; or Dependent children age 26 or older who are physically or mentally incapable of self-support.
- Children for whom the Plan is required to provide coverage under a Qualified Medical Child Support Order (QMCSO)

"Children" include biological children, stepchildren, children placed with you for adoption, legally adopted children, the biological or adopted children of a-domestic partner, and children for whom you are the legal guardian.

No one is eligible as a dependent while:

- Serving in the military of any country, or
- Residing outside the United States.

In the enrollment process, you must attest to the eligibility of a dependent. Upon request, you must be able to provide documentation of your dependent's eligibility, such as a birth certificate, marriage certificate, court order, California Declaration of Domestic Partnership Registration, etc.

## *When Coverage Begins*

Coverage begins on your first day of full-time employment provided you meet the eligibility requirements described on page 4 and have enrolled. Or the first of the month (or beginning of the next Plan year) following a determination that you are a full-time employee as defined by the Affordable Care Act. The date coverage will begin is dependent on the non-assessment period in place for that individual.

## *Cost to Employees*

### Medical, EAP, Dental & Vision

Participants are required to contribute to the cost of medical and dental coverage. When you enroll in one of the Getty's medical plans, you and your dependents are automatically enrolled in the EAP and Vision Plan at no additional cost. For a schedule of current costs, visit www.gettyhr.com under the heading "Health" or contact Getty Human Resources at ext. 6523 or send an email to HR@getty.edu

## *Section 125 Plan – Premium Conversion*

J. Paul Getty Trust has established a premium conversion plan under Internal Revenue Code Section 125 in order for you to be able to pay your contributions for the Medical/Vision and Dental coverages provided under the Plan on a pre-tax basis. Required participant contributions are made through payroll deductions.

## *Contributions for Non-Tax Dependents*

If you elect Medical/Vision and Dental coverage for your eligible domestic partner and his or her eligible children, and they do not qualify as your tax dependent, you will be required to pay contributions for domestic partner coverage on an after-tax basis. Also, the amount J. Paul Getty Trust contributes toward your domestic partner's coverage will be treated as imputed income. The amount of your imputed income will be added to your paychecks each payroll period and will be subject to income tax withholding. In addition, J. Paul Getty Trust will include the annual amount of this imputed income on your W-2 Form at the end of each year. Before enrolling your domestic partner and his or her eligible children, you should talk with your tax advisor about the tax implications for you.

### Group Life/AD&D, Business Travel Accident Insurance & Long Term Disability (LTD)

### Group Life/AD&D Coverage Amounts

These plans are provided to eligible employees at no cost to the participant. The Getty provides two times salary to all full time employees up to a maximum amount of $1,200,000. The Getty

also provides two times salary for Accidental Death and Dismemberment (AD&D) coverage while you are employed as a full time employee. You will be automatically enrolled in these two plans at the time you become benefits eligible. Your coverage amount will be adjusted to 65% of two times salary at age 65.

## Beneficiaries

You must designate beneficiary for your Group Life/AD&D coverage. You will need to make this designation with your enrollment in benefits in Employee Self Service (ESS).

## Accelerated Benefit Option

If you become terminally ill and are diagnosed with less than 12 months to live, you have the option to receive an Accelerated Death Benefit before you die. The benefit is a portion of the face value of the insurance in one lump-sum payment.

## Portability and Conversion Options

If your Getty provided basic life insurance ends, you may be entitled to continue the coverage. You will receive a letter about how to convert your policy from Human Resources shortly after your coverage ends. You will be able to contact MetLife for the conversion information.

## Accidental Death and Dismemberment

Accidental Death and Dismemberment (AD&D) Insurance provides coverage in the event you suffer an accidental loss of life, limb or sight within 90 days following an accident. Loss of limb includes loss of use of a limb. This coverage is provided by the Getty at no cost to you. The coverage amount is equal to 100% of your Group Life Insurance benefit.

The Dismemberment schedule pays the full amount if you:

- Lose both hands or both feet
- Lose sight in both eyes
- Lose one hand and one foot or
- Lose on hand or one foot and sight in one eye

The policy will pay out one-half the benefit if you:

- Lose one hand
- Lose one foot or
- Lose sight in one eye

## Business Travel Accident Insurance

The Getty provides you with Business Travel Accident Insurance that pays three times your salary to your beneficiary on file if you die while traveling on Getty business. The maximum coverage is $1,500,000. This coverage is provided by the Getty at no cost to you.

## Long-Term Disability

The Getty provides you with Long-Term Disability Insurance (LTD). The Long-Term Disability plan provides you with replacement income in the event you become disabled and cannot continue to work full-time.

The benefit waiting period is defined as the period for which you must be continuously disabled

before LTD benefits can become payable. No LTD benefits are payable during the benefit waiting period of 180 days.

## Definition of Disability

You are disabled if you meet one of the following definitions:

- Own Occupation Definition of Disability;
- Any Occupation Definition of Disability; or
- Partial Disability Definition.

## Own Occupation Definition of Disability

During the Benefit Waiting Period and the Own Occupation Period you are required to be disabled only from your own occupation. You are disabled from your own occupation if, as a result of physical disease, injury, pregnancy or mental disorder, you are unable to perform with reasonable continuity the material duties of your own occupation. The Own Occupation Period is as follows:

- Exempt employees - 24 months
- Non-exempt employees - 12 months

During the Own Occupation Period you may work in another occupation while you meet the Own Occupation Definition of Disability. However, you will no longer be disabled when your earnings from another occupation meet or exceed 80% of your indexed pre-disability earnings.

## Any Occupation Definition of Disability

During the Any Occupation Period you are required to be unable to perform duties from all occupations. You are disabled from all occupations if, as a result of physical disease, injury, pregnancy or mental disorder, you are unable to perform with reasonable continuity the material duties of any occupation.

## Partial Disability

During the Benefit Waiting Period and the Own Occupation Period, you are partially disabled when you work in your own occupation but, as a result of physical disease, injury, pregnancy or mental disorder, you are unable to earn 80% or more of your indexed pre-disability earnings in that occupation.

## Types of LTD Benefits

Your monthly benefit will equal 60⅔% of your monthly salary at the onset of your disability or $25,000, whichever is less, minus 100% of the amount of any disability benefits you receive or are eligible to receive under Social Security, Workers' Compensation or any government law, state disability benefits or any benefits you receive under any other plan of the J. Paul Getty Trust. In no event will your monthly disability benefit payable from this plan be reduced to less than $50 or 15% of your monthly benefit, whichever is the lesser amount.

## *Enrollment Process*

You must enroll in coverage under the medical and dental plans within **31 days of the date you become eligible**. This is called your Initial Eligibility Period. When you enroll in one of the Getty's medical plans, you and your dependents are automatically enrolled in the Vision Plan. If eligible, you are automatically enrolled in the Life, AD&D, and Long-Term Disability plans.

If you do not enroll as instructed below, you will not be able to enroll until Open Enrollment as described on page 7.

### How to Enroll

During your Initial Eligibility Period, use Employee Self Service (ESS) to enroll.

If you enroll dependents, you are required to attest to their eligibility and, if requested, you must submit documentation to establish proof of their eligibility. See page 9 for examples of documentation.

## *Declining Coverage*

If you decline coverage for yourself or any dependent, you may be able to enroll in the future, provided that you have a qualifying event and you request enrollment within 31 days of the event. See Qualified Status Changes below for more information.

## *Open Enrollment*

Open Enrollment occurs each year usually sometime mid-October through mid-November. During Open Enrollment, you can enroll or make changes to your coverage, as follows:

- Enroll in a medical or dental plan
- Switch to a different medical plan
- Add or end coverage for yourself or eligible dependents
- Enroll in a Flexible Spending Account *(See FSA SPD at www.gettyhr.com)*
- Increase employee Voluntary Life coverage (may be subject to health review by carrier)

Information about Open Enrollment is published at www.gettyhr.com in early October of each year.

## *HIPAA Special Enrollment Rights or Changing Coverage Elections*

Outside of your Initial Eligibility Period or Open Enrollment, you can make changes to your coverage only if you have a Qualified Status Change. The table on the next page describes events that are considered to be Qualified Status Changes, what action you may take as a result of each, and what documentation you must be able to provide if requested. If you have a Qualified Status Change, enter your election changes into Employee Self Service (ESS) by initiating a Benefits Life Event **within 31 days from the date of the event.** If you do not have a Qualified Status Change, you may make changes to your coverage only during the annual Open Enrollment period as described above. During the COVID-19 National Emergency, a Joint Notice issued by the DOL and Treasury temporarily waived the timeline for HIPAA Special Enrollments during the Outbreak Period.

## Qualified Status Changes

Qualified Status Changes are certain events that allow you to make changes to your coverage outside of your Initial Eligibility Period or Open Enrollment. If you have one or more of the following Qualified Status Changes, enter your election changes into Employee Self Service (ESS) by initiating a Benefits Life Event-**within 31 days of the date of the Qualified Status Change.**

**The following is a list of the most common types of Qualified Status Changes.**

| Qualified Status Changes | | |
|---|---|---|
| If this event occurs… | You may… | Examples of Required Documentation |
| • Birth<br>• Adoption<br>• Placement for Adoption<br>• Legal Guardianship | • Enroll new dependent<br>• End coverage for dependent<br>• Change medical plans | • Birth certificate<br>• Judicial decree of adoption<br>• Judicial order for placement for adoption or guardianship |
| • Marriage<br>• Domestic Partnership | • Enroll new dependent<br>• End coverage for yourself and/or dependent<br>• Change medical plans | • Marriage certificate<br>• CA Registry of Domestic Partnership or equivalent<br>• Income tax return<br>• Utility bill<br>• Bank account statement<br>• Mortgage statement |
| • Divorce<br>• End of Domestic Partnership<br>• Death | • Enroll yourself and/or dependent<br>• End coverage for a dependent<br>• Change medical plans | • Summary of Dissolution or other judicial document<br>• Declaration of Termination of Domestic Partnership<br>• Death certificate |
| • Dependent loses other coverage | • Enroll yourself and/or dependent<br>• Change medical plans | • COBRA Notice<br>• HIPAA Certificate<br>• Letter from other Plan Sponsor |
| • Dependent becomes eligible for other coverage | • End coverage for yourself<br>• End coverage for a dependent | • Letter from other Plan Sponsor<br>• Employee Notification of Qualified Status Change |
| • Dependent Child Turns Age 26 | • Dependent coverage is automatically terminated Dec. 31 of the year in which he/she turns age 26 | • n/a |
| • You and/or your dependent(s) move in / out of the carrier's network area | • Change medical plans<br>• Enroll in/terminate coverage | • Mortgage Statement<br>• Purchase Agreement<br>• Lease Agreement |
| • Change in Coverage Cost or Benefits for Other Coverage | • Enroll in/terminate coverage | • Letter from other Plan Sponsor |
| • Court order (QMCSO) requiring a parent to cover a dependent | • Change medical plans<br>• Enroll in/terminate coverage | • QMCSO order<br>• Judicial document |
| • You or a dependent begin / return from an unpaid leave of absence | • Enroll yourself and/or dependent<br>• End coverage<br>• Change medical plans | • If dependent, letter from employer or other coverage<br>• HIPAA Certificate<br>• COBRA Notice |

## Birth, Adoption, or Placement for Adoption

If you gain a family member through birth, adoption, or placement for adoption, you may add the new eligible dependent to your current coverage. You may also enroll yourself, your spouse, and all eligible children. You also may change your plan option. Coverage is effective on the date of birth, adoption, or placement of adoption provided you enter your enrollment change into ESS **within 31 days from the effective date of the change.**

## Legal Guardianship or Sole Managing Conservatorship

If you (or your spouse, separately or together) become the court-appointed legal guardian or managing conservator of a Dependent Child and the child meets all other requirements of the definition of an eligible dependent, **you have 31 days from the date the judgment is signed to enroll the child in your coverage**. Upon request, you must provide a copy of the court document signed by a judge appointing you (or your spouse separately or together) guardian or sole managing conservator.

## Marriage / Domestic Partnership

If you are enrolled in the Getty plans, you can enroll your new spouse or domestic partner and his or her eligible dependents (your stepchildren who live with you) for dependent coverage. You also may change your plan option. If you are not already enrolled for coverage, you can sign up for medical coverage for yourself, your new spouse/partner, and your eligible stepchildren. If you gain coverage under your spouse's health plan, you can cancel your coverage**. You must make these changes within 31 days following the date of your marriage or registry** by entering your enrollment changes into ESS

## Divorce / Termination of Domestic Partnership

Your former spouse/partner and any stepchildren are covered through the end of the month in which the divorce is final. You must notify Getty Human Resources as soon as your divorce is final. If you fail to do so within 60 days, your spouse and dependents will not be entitled to elect COBRA. You may also be liable for claims paid on behalf of the ineligible spouse and dependent as well as liable for falsifying company records. Please see COBRA Continuation Coverage on page 21 for more information.

If you lose coverage under your spouse's health plan on account of divorce, you can sign up for medical coverage for yourself and your eligible dependents. **You must enroll within 31 days following the date you lose coverage** under your spouse's plan or wait until Open Enrollment or another change in status. Coverage will be effective the day after coverage under your ex-spouse's plan terminates provided you enter your enrollment change into ESS within 31 days from the effective date of the change.

## Death

If you lose coverage under your spouse's health plan, you can sign up for coverage for yourself and your eligible dependents. **You must make these changes within 31 days following the date you lose coverage** or wait until Open Enrollment or another change in status.

As an employee, if you die while enrolled, your covered eligible dependents can continue coverage for up to 36 months at the same required premiums that employees pay. After 36 months, covered individuals are eligible for an additional 36 months of coverage under COBRA. See Continuing Your Coverage on page 21 for more information about COBRA.

## Dependent Loses Other Coverage

If your dependent loses coverage under another plan, you may add your eligible dependents to your coverage, add coverage for yourself, and / or change plans. The following are just a few examples of the events which would qualify:

- Coverage under your spouse's employer plan ends because his/her employment terminates;
- Your spouse's employment status is changed to part-time, causing him/her to lose coverage;
- Your adult child under age 26 is covered under his/her employer plan and that coverage ends.

## Dependent Becomes Eligible for Other Coverage

If your dependent becomes eligible for other coverage, you may end coverage for that dependent, yourself and other enrolled dependents. In this event, you and your dependents are not eligible for coverage continuation under COBRA.

## Your Dependent Turns Age 26

Effective December 31 of the year in which your child turns age 26, his/her coverage will be automatically terminated. In most cases, continuation coverage under COBRA may be available. See page 21 for more COBRA information.

## You or Your Dependent(s) Move

If you and/or your dependents move to an area that does not have access to your current medical plan's network, you may switch medical plans, add dependent coverage or end coverage altogether.

If you and/or your dependents move from an area that does not have access to a Getty medical plan's network to one that does, you may switch medical plans or add coverage for yourself and/or your dependents. For example:

1) You and your family are covered under the Signature Value Plan. One of your children moves to New York to go to college. You can remove this child from your coverage. Or you and your family can switch to the HDHP plan.

2) You are enrolled in the HDHP plan and currently live in a rural area more than 30 miles from a Signature Value Advantage provider. You then move closer to Los Angeles. You can switch to one of the HMO plans.

### Cost Increase or Benefit Provision Reductions of Other Coverage

If you and/or your dependents are enrolled in other coverage and the cost of that coverage increases, or the benefit provisions change drastically, you can add coverage for you and/or your dependents.

### Qualified Medical Child Support Order (QMCSO)

The Getty will follow established procedure in determining whether a medical child support order is a qualified medical child support order (a "QMCSO"), within the meaning of section 609(a) (2) (A) of ERISA and in administering any QMCSO.

To request a copy of the procedure, call Getty Human Resources at 310.440.6523 or send an email to HR@getty.edu.

### You or Your Dependent Begins or Returns from an Unpaid Leave of Absence

The following are examples of changes you can make to your coverage.

If you begin an unpaid leave of absence, you may:

- End coverage for yourself and/or dependents;
- Keep your coverage as long as you pay the required premium; or
- Change to a lower-cost plan.

If your dependent begins an unpaid leave of absence, you may:

- Add coverage for yourself and/or dependents; or
- Change to a lower-cost plan.

If you return from an unpaid leave of absence, you may:

- Add medical and/or dental coverage;
- Change to another Getty medical plan; or
- Add dependent coverage.

If your dependent returns from an unpaid leave of absence, you may:

- End coverage for yourself and/or dependents; or
- Change to another Getty medical plan.

## *Effects on Benefits While on a Leave of Absence*

### Paid Leave of Absence

Your benefits will not be affected while you are on a paid leave of absence. For more information please read the Staff Handbook which is available on Getty Online (GO).

### Unpaid Leave of Absence

If you are on an unpaid leave of absence, your coverage under the medical, dental and vision plans will remain in effect as long as you continue to pay your required premium. Getty Human Resources will notify you as to how much your premium is, when it is due, and where to submit your payment.

An employee who does not return to work at the Getty at the end of an approved leave for any reason or who terminates employment within 2 pay periods after returning to work is required to reimburse the Getty for the portion of insurance premiums paid for them by the Getty during any unpaid leave.

### Life, LTD and AD&D Insurance Plans

You will continue to be covered under these plans for up to 12 months while you are on a leave of absence. For additional on what happens with your Life and AD&D insurance if you become disabled, please contact Getty Human Resources at 310.440.6523 or send an email to HR@getty.edu.

## *When Your Coverage Ends*

### Medical, EAP, Dental, and Vision

Coverage under the medical, EAP, dental and vision plans ends on the last day of the calendar month in which:

- You terminate employment;
- You stop paying any required contribution;
- You cease to be an eligible employee;
- The plan terminates.

Dependent coverage ends on the last day of the month in which:

- Your coverage, as the employee, ends, or
- Your dependent is no longer an eligible dependent as described under Eligibility, Cost & Enrollment beginning on page 4.

Under certain circumstances, you and your dependents may continue health plan coverage after you leave the Getty.

### Other Plans

Coverage under the Life, AD&D, LTD, and Business Travel plans ends on the day:

- You stop working for the Getty;
- You cease to be an eligible employee; or
- The insurance contract terminates.

### Recovery of Overpayments

The Plan may recover any overpayment from you or any member of your family, if you or any member of your family received an overpayment. The Plan is also entitled to deny future claims or reduce subsequent benefits paid to you or any member of your family if you or a member of your family received an overpayment.

The Plan may also recover an overpayment from the medical provider who received an

overpayment. If the overpayment was made to the provider and occurred through no fault

of your own or any member of your family, the Plan will not try to recover the overpayment from you or a member of your family.

### *Plan Year*

The Plan Year for the plans presented in this Summary Plan Description is January 1 through December 31.

## MEDICAL PLANS

The Getty offers a choice of medical plans:

- UnitedHealthcare Signature Value Advantage Plan (lower cost HMO)
- UnitedHealthcare Signature Value Plan (higher cost HMO)
- Aetna HDHP or High Deductible Health Plan. Employees enrolled in the high deductible health plan may make pre-tax contributions to a Health Savings Account.

### *UnitedHealthcare (UHC) HMO Plans*

The HMO plans provide all medical care, pharmacy and mental health services for enrollees for a predetermined price. You pay only a small copayment for certain services, such as visits to the doctor. After the copayment, most care (including care from specialists) is paid at 100%.

To receive benefits from the plan, you must use the appropriate network of doctors and hospitals, and your care must be directed by your primary care physician (PCP). If you receive care outside of the HMO network, you are responsible for paying for that care. There is no lifetime maximum amount of covered medical benefits you may receive while covered by one of the HMO plans. Please go to www.gettyhr.com for more information.

### *Aetna HDHP Plan*

Under the HDHP plan, you can see any doctor you want. You will pay less if you see a doctor who is in the HDHP plan network. You pay the first part of medical, mental health and prescription drug expenses each year in the form of a deductible. Once you pay the deductible, the plan pays a percentage of expenses and you pay your share, called the *coinsurance*. To protect you from catastrophic medical expenses, there is a cap on how much you pay during a year, called the *out-of-pocket maximum*. There is no lifetime maximum limit to the amount of covered medical benefits you may receive while covered by the HDHP plan. Please go to www.gettyhr.com to find a schedule of covered services under the HDHP plan.

### *Aetna - Federal No Surprises Act of 2022*

This law provides new federal consumer protections against surprise medical bills. In the case of a surprise bill from an out-of-network provider, where you had no control of their participation in your covered services, you will pay the same cost share you would have if the covered services were received from a network provider. The cost share will be based on the median contracted rate. Contact Aetna member services immediately if you receive such a bill. You will find more

information about your rights and protection against Surprise Medical Bills at www.gettyhr.com.

## *Aetna - Timely Filing of Non-Participating Provider Claims.*

If you receive a bill directly from an out-of-network provider, you or your provider must send Aetna the bill within 12 months of the date you received services. This change applies to any claims with dates of service of January 1, 2022, or later. Claims with dates of service prior to January 1, 2022, will continue to have the 27-month filing period. Please contact Aetna member services for any questions.

## *Mental Health Parity and Addiction Equity Act*

This act is to ensure that health plans treat mental health and substance abuse disorder the same way they treat other health issues. Our plan provides coverage that is comparable to their coverage for general medical and surgical care. Limitations such as copayments, visit limits and preauthorization must generally be comparable with those for medical and surgical benefits.

# DENTAL PLAN

The Dental Plan is offered through MetLife and allows you to receive services from any licensed dentist. The amount of benefits you receive depends on the type of dental service. If you use a dentist in MetLife's Preferred Dentist Program, you can reduce your out-of- pocket expenses.

## *How the Plan Works*

You may receive dental services from any dentist practicing within the scope of his or her license.

After you meet the annual deductible (if applicable), the plan pays a percentage of the maximum allowed charge In-Network, or a percentage of reasonable and customary costs Out-of-Network. Each covered person may receive a specified maximum amount of dental benefits each calendar year. See Maximum Benefits on page 17 for more information.

## *Cost to Employees*

The premiums, or costs to be enrolled in coverage, are deducted from each biweekly paycheck. The employee cost chart is provided at New Employee Orientation and during Open Enrollment. The costs are also displayed in Employee Self Service and online at www.gettyhr.com

## *Deductible*

The dental deductible is separate from the Getty's HDHP plan / Aetna plan deductible. Go to the Summary of Dental Benefits at www.gettyhr.com for more information.

## *Preferred Dentist Program*

You have the option of using a provider in the MetLife Preferred Dentist Program (PDP). By using a provider in the PDP network, you lower your out-of-pocket expenses because in-network providers are contracted with MetLife to use negotiated fees and, for some services, the plan reimburses in-network services at a higher percentage.

Visit www.metlife.com/mybenefits or call MetLife at 800.942.0854 for a list of participating dentists.

## *Negotiated Fee / Reasonable and Customary Charges*

How much the plan pays and how much you pay are determined by whether you use an in-network provider. In-network cost are based on the negotiated fee which is the agreed upon amount the dentist will accept as payment for dental services.

For out-of-network providers, the plan pays based on reasonable and customary charges. The reasonable and customary charge is determined by MetLife and is the lowest of:

- The usual charge by the dentist for the same or similar services or supplies;
- The usual charge by most other dentists or other providers in the same or similar geographic area for the same or similar services or supplies; or
- The actual charge for the services or supplies.

## *Maximum Benefits*

During a calendar year, a covered individual may receive a maximum benefit of $2,000 in-network or $1,000 out-of-network in preventative, routine and major services. Go to the Summary of Dental benefits at www.gettyhr.com for more information.

## *Alternate Treatments*

There may be more than one way to treat a dental problem. If, in MetLife's view, an adequate method or material that costs less could have been used, benefits will be based on that method or material. This means that the rest of the cost will not be a covered dental expense. For example, removable dentures may serve as well as fixed bridgework, but fixed bridgework is installed. Benefits will be based on the cost of a removable denture unless adequate results can be achieved only with fixed bridgework.

## *Pre-Determination of Benefits*

Before you have dental work performed, it is important to know what is covered under the plan and how much the plan will pay. If you're having any service done that will cost more than $300, you should have your dentist submit a preauthorization to MetLife.

# VISION PLAN

When you enroll in one of the Getty's medical plans, you and your covered dependents are automatically enrolled in the Vision Plan at no cost to you. Vision benefits for you and your dependents are provided through Vision Service Plan (VSP). The Vision Plan is designed to cover visual needs rather than cosmetic or medical eye care.

## *Receiving Benefits: Two Choices*

You may choose to receive services from a VSP provider or a non-VSP provider. You'll generally pay less out-of-pocket when you use a VSP provider.

Services and supplies are covered according to the schedule shown at www.gettyhr.com.

## *Additional Information*

Please find the following information at www.gettyhr.com

- Group Life Insurance Program
- Business Travel Accident Insurance
- Long Term Disability

# APPEALING A CLAIM

Following is a summary of the claims procedures for the benefit plans described in this SPD.

For the claims procedures applicable to the Getty's HMO plans through UnitedHealthcare, please refer to the Combined Evidence of Coverage and Disclosure Form which you can view online at www.gettyhr.com under Resources, go to UnitedHealthcare.

An initial claim for benefits should be filed with the appropriate vendor in accordance with the vendor's procedures. You will be notified with respect to a determination regarding an initial claim or any appeal of a denied claim in accordance with the following procedures.

**Initial Claim Procedure**

The Vendor/Administrator will provide you with written notification of the decision with respect to your claim within the time frame as outlined on page 20.

If your claim is denied, your notice will provide the specific reasons for the denial, including reference to the Plan provisions on which the denial was based. You will also receive a description of the claims procedures, including the applicable time limits and your right to bring a civil action following the denial of an appeal under these procedures. If appropriate, the notice will specify any additional information needed to complete the review and will explain why this information is necessary. If an internal rule, guideline, or other criterion was used in deciding your claim, your notice of denial will include a copy of the criterion or will allow you to request a copy of the criterion free ofcharge. Finally, if the denial was based on medical necessity, experimental treatment or similar exclusion, your denial notice will include an explanation of the scientific or clinical judgment involved in applying the terms of the Plan or will allow you to request an explanation of the scientific or clinical judgment at no charge.

**Appeals Procedure**

If you are not satisfied with a claims decision from one of the plans listed above, you can request that the decision be reviewed by initiating an appeal.

1. To initiate an appeal, you must submit a request for an appeal in writing to the Vendor/Administrator within 365 days of receipt of the initial benefit decision notice. See page 24 for Carrier Contact Information. State the reason why you feel your appeal should be approved and include any information supporting your appeal.

At your request, you are entitled to receive (at no charge) reasonable access to all documents and records relevant to your claim, whether or not those records were considered or relied upon in the denial of your claim. This includes any reports and the identities of any experts whose advice was obtained with respect to your claim.

2. Your appeal will be reviewed by the Vendor/Administrator and the decision will be made by authorized individuals not involved in the initial decision.

Appeals involving medical necessity or clinical appropriateness will be reviewed by a health care professional.

The decision regarding your appeal will take all comments, documents, records and other information you submit into account whether or not the information was submitted or considered in the initial denial of your claim.

3. The Vendor/Administrator will respond in writing with a decision within the time frame outlined on page 20. If more time is needed to make the determination, you will be notified in writing prior to the end of the initial time frame that an extension is requested. The notification will specify any additional information needed to complete the review. Appeals of a denial of your urgent care claims are subject to an expedited review process, as outlined, and the request for an appeal of an urgent care claim may be oral or in writing.

"Urgent care claims" are health claims for which the application of non-urgent care time frames could seriously jeopardize the claimant's life, health or ability to regain maximum function, or, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain without the care or treatment that is the subject of the claim.

In deciding upon the appeal of a denied claim involving a medical judgment, the individual reviewing the claim will consult with a health care professional with appropriate training and experience in the appropriate field of medicine. The health care professional will be independent of any health care professional who participated in the initial determination of your claim. The Vendor/Administrator will also identify any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the denial of your claim, whether or not the Plan relied on the advice in deciding your claim.

4. If your appeal is denied, you will receive written notice of the denial within the time frame outlined on page 20. It will include the specific reasons for the denial, the Plan provisions upon which the decision was based, and an explanation of your right to bring a civil suit following denial of your appeal. Upon request, you will be entitled to reasonable access to, and copies of, all documents and records relevant to your claim, whether or not the documents were considered or relied upon in deciding your appeal, as well as any reports or the identities of any expert whose advice was obtained. If an internal rule, guideline or other criterion was used in deciding your claim, your notice of denial will either include a copy of the criterion or will allow you to request a copy of the criterion free of charge. Finally, if the denial was based on medical necessity, experimental treatment or similar exclusion, your denial notice will include an explanation of the scientific or clinical judgment involved (applying the terms of the Plan) or will allow you to request an explanation of the scientific or clinical judgment at no charge.

**Claim Filing Time Frames**

| Type of Claim | Plan Must Respond To Your Initial Claim Within*: | You Must Submit Your Appeal Within: |
|---|---|---|
| Medical, Dental, & Vision: | | |
| Pre-Service | 15 days | 180 days |
| Post-Service | 30 days | 180 days |
| "Urgent Care" Claims | 72 hours | 180 days |
| Group Life and AD&D | 90 days | 90 days |
| Long-Term Disability | 30 days | 180 days |

*This period may be extended by the Vendor/Administrator provided that the extension is necessary due to matters beyond the control of the Plan, and provided that the carrier or Plan Administrator notifies the claimant in writing or electronically prior to the expiration of the time period indicated above.

**Definitions:**

Pre-Service Claims - Health care claims that require approval of the benefit in advance of obtaining medical care.

Post-Service Claims - Health care claims that are not urgent care or pre-service claims.

Urgent Care Claims - Health care claims for which the application of non-urgent care time frames could seriously jeopardize the claimant's life, health or ability to regain maximum function, or in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain without the care or treatment that is the subject of the claim.

If you have questions regarding these procedures, or you would like a complete set of claims procedures, please call Getty Human Resources at 310.440.6523 or send an email to HR@getty.edu.

# COBRA - CONTINUING YOUR COVERAGE

## *Medical, Dental & Vision*

In certain situations, you and/or your dependents may be able to continue medical, dental and vision coverage after it would otherwise end under the Consolidation Omnibus Budget Reconciliation Act of 1985 (COBRA).

Under COBRA, you and/or your qualified beneficiaries can continue coverage if it would otherwise end because of change in dependent status, divorce or legal separation, layoff or reduction in your hours, termination of your employment, retirement or death.

It is very important that you understand your COBRA rights. For more information about COBRA, see the General Notice of COBRA Continuation Coverage Rights at www.gettybenefits.com.

## *Group Life Insurance*

You may be able to convert your Group Life Insurance into an individual policy when your coverage ends. When you leave the Getty's employment, Getty Human Resources

will send you a Notice of Conversion which gives instructions on how to convert your coverage.

For more information about conversion rights, call the insurance carrier directly. See page 24 for Carrier Contact Information.

## *Certificates of Coverage*

In order to provide proof to a new employer of your previous health coverage, the carrier will send you a certificate when coverage is lost under the Getty Health Plan identifying your (and your dependents') previous health coverage.

Please contact the insurance carrier directly to request your coverage certificate. If you have problems obtaining your coverage certificate, please contact Getty Human Resources at 310.440.6523 or HR@getty.edu.

If you elect COBRA continuation coverage, you will also receive a coverage certificate after COBRA coverage ends. Keep a copy of the coverage certificate(s) you receive. You may also request an additional coverage certificate within 24 months from the date coverage was lost.

# ERISA PLAN INFORMATION

| Official Plan Name | The J. Paul Getty Trust Health & Welfare Plan |
|---|---|
| Plan Document | This booklet is a Summary Plan Description (SPD) of the Plan. You should refer to the official insurance contracts for more extensive information. If there is any conflict between the information summarized in this SPD and the official plan contracts, the contracts will govern. |
| Employer Identification Number | 95-1790021 |
| Plan Number | 501 |
| Plan Administrator | The J. Paul Getty Trust<br>Attn: Director, Getty Human Resources<br>1200 Getty Center Drive, Suite 400<br>Los Angeles, CA 90049-1681<br>310.440.6523<br>HR@getty.edu<br>The administration of the Plan shall be under the supervision of the Plan Administrator. To the fullest extent permitted by law, the Plan Administrator shall have the discretion to determine all matters relating to eligibility, coverage and benefits under the Plan, and the Administrator shall have the discretion to determine all matters relating to the interpretation and operation of the Plan. Any determination by the Plan Administrator shall be final and binding, in the absence of clear and convincing evidence that the Plan Administrator acted arbitrarily and capriciously. |
| Type or Source of Funding | The benefits are funded by contributions made by the Getty; however, you are required to contribute to the Plan for medical and/or dental coverage. |
| Requests for Information | If you have questions about your benefits, please email Getty Human Resources at HR@getty.edu or call the Benefits Phone Line at 310.440.6523. All requests, appeals, elections and other communications should be in writing and should be hand delivered or sent by certified mail. |
| Continuing the Plan | The Getty intends to continue the Health & Welfare Plan indefinitely but reserves the right to change or end the Plan (including any of the individual plans) if necessary. If the Plan ends, all coverage under it will be discontinued immediately. From time to time, the Getty may find that changes to the Plan are necessary. After study of the situation, the Plan Administrator will implement the changes. |
| Assignment of Benefits | For the protection of your interests and those of your dependents, except for the Group Life Insurance Plan, your benefits under the Health & Welfare Plans cannot be assigned to someone else. To the extent permitted by law, your benefits are not subject to garnishment or attachment. However, if a qualified domestic relations order requires the Plan to set aside a portion of your benefit for your ex-spouse or children, you will have no rights to that portion of your benefit. |

# CARRIER CONTACT INFORMATION

| Plan | Carrier / Administrator | Phone Number |
|---|---|---|
| Medical – Aetna HDHP Plan<br>Policy #804104 | Aetna Life Insurance Company<br>www.Aetna.com<br><br>PO Box 14079<br>Lexington, KY 40512-4079 | 877-869-4077 |
| Medical – HMO Plans<br>• Signature Value Advantage<br>• Signature Value | UnitedHealthcare of California<br>P.O. Box 6006<br>Cypress, California 90630<br>www.uhcwest.com/thejpaulgettytrust | 877.630.5898 |
| Dental<br>Policy #74219 | MetLife<br>Group Dental Claims<br>P.O. Box 14093<br>Lexington, KY 40512-4093<br>www.metlife.com/mybenefits | 800.942.0854 |
| Vision<br>Policy #00102119 | Vision Service Plan (VSP)<br>P.O. Box 997100<br>Sacramento, CA 95899-9100<br>www.vsp.com | 800.877.7195 |
| Group Life and AD&D<br>Policy #74219<br><br>Business Travel Accident<br>Policy #01947040 | MetLife<br>P.O. Box 6115<br>Utica, NY 13504-6115<br>www.metlife.com/mybenefits | 877.ASK.MET7 |
| Employee Assistance Program (EAP) | West HealthAdvocate Solutions | 866-799-2728 |
| Long-Term Disability<br>Policy #83076198 | The Standard<br>P.O. Box 2800<br>Portland, OR 97208 | 800.368.1135 |

The insurers provide health benefits under contracts issued to the J. Paul Getty Trust. In most cases, these insurers are solely responsible for financing and providing all health benefits under their respective contracts, and the J. Paul Getty Trust has no liability for any benefits due, or alleged to be due, under such contracts.

# YOUR RIGHTS AS A PLAN MEMBER

Participants in the J. Paul Getty Trust Health and Welfare Plan have certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S.

Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of all Plan documents governing the operation of the applicable plan, including insurance contracts, copies of the latest annual report (Form 5500 Series) and an updated Summary Plan Description. The Plan Administrator may require a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of the Summary Annual Report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the applicable employee benefit plan.

The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies, without charge, of documents relating to the decision, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees if, for example, it finds that your claim is frivolous.

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200

Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

### Complaints about Professional Services

If you have any complaints about the service you receive from any of the benefits plans and programs discussed in this SPD, you should contact the insurance company in writing or by telephone, as appropriate. See page 24 for Carrier Contact Information. You should also inform Getty Human Resources of any complaints about service by calling 310.440.6523 or by sending an email to HR@getty.edu.

After the insurance company evaluates your complaint, the original provider will be contacted, if appropriate. You will receive notification on the disposition of your complaint generally within 15 days of its receipt.

# SPECIAL NOTICES

## *Medicaid and the Children's Health Insurance Program (CHIP)*

If you are eligible for health coverage from your employer but are unable to afford the premiums, some states have premium assistance programs that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, you can contact your state Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your local Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the state if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

If you live in one of the following states, you may be eligible for assistance in paying your employer health plan premiums. You should contact your state for further information on eligibility:

| State | Website | Phone |
|---|---|---|
| Alabama | www.medicaid.alabama.gov | (800) 362-1504 |

| | | |
|---|---|---|
| Alaska | https://health.hss.state.ak.us | (888) 318-8890 |
| Arizona | www.azahcccs.gov | (877) 764-5437 |
| Arkansas | www.arkidsfirst.com | (888) 474-8275 |
| California | www.dhcs.ca.gov | (888) 747-1222 |
| Colorado | www.chipplus.org | (303) 866-3243 |
| Florida | www.fdhc.stat.fl.us | (866) 762-2237 |
| Georgia | http://dch.georgia.gov | (800) 869-1150 |
| Idaho | www.accesstohealthinsurance.idaho.gov | (800) 926-2588 |
| Indiana | www.in.gov | (877) 438-4479 |
| Iowa | www.dhs.state.ia.us | (888) 346-9562 |
| Kansas | www.khpa.ks.gov | (800) 766-9012 |
| Kentucky | http://kidshealth.ky.gov/en/ | (800) 635-2570 |
| Louisiana | http://bhsfweb.dhh.louisiana.gov/lachip/ | (888) 342-6207 |
| Maine | http://www.maine.gov/dhhs/ | (800) 321-5557 |
| Massachusetts | www.mass.gov/MassHealth | (800) 462-1120 |

| State | Website | Phone |
|---|---|---|
| Minnesota | www.dhs.state.mn.us | (800) 657-3739 |
| Missouri | www.dss.mo.gov/mhd/index.htm | (573) 751-6944 |
| Montana | http://medicaidprovider.hhs.mt.gov | (800) 694-3084 |
| Nebraska | www.dhhs.ne.gov | (877) 255-3092 |
| Nevada | www.nevadacheckup.state.nv.org | (877) 543-7669 |
| New Hampshire | www.dhhs.state.nh.us | (800) 852-3345 |
| New Jersey | www.njfamilycare.org | (800) 701-0710 |
| New Mexico | www.hsd.state.nm.us/mad | (888) 997-2583 |
| New York | http://www.health.state.ny.us/health_care/medicaid | (800) 541-2831 |
| North Carolina | www.nc.gov | (919) 855-4100 |
| North Dakota | http://www.nd.gov/dhs/services/medicalserv/medicaid/ | (800) 755-2604 |
| Oklahoma | http://www.insureoklahoma.org/ | (888) 365-3742 |
| Oregon | www.oregonhealthykids.gov | (877) 314-5678 |
| Pennsylvania | http://www.chipcoverspakids.com/ | (800) 644-7730 |
| Rhode Island | www.dhs.ri.gov | (401) 462-5300 |
| South Carolina | http://www.dhhs.state.sc.us/ | (888) 549-0820 |
| Texas | http://www.chipmedicaid.org/ | (800) 440-0493 |
| Utah | http://health.utah.gov/medicaid/ | (866) 435-7414 |
| Vermont | http://ovha.vermont.gov | (800) 250-8427 |
| Virginia | www.famis.org | (866) 873-2647 |
| Washington | http://hrsa.dshs.wa.gov/applehealth/ | (877) 543-7669 |
| West Virginia | http://www.wvchip.org/ | (304) 342-1604 |
| Wisconsin | http://dhs.wisconsin.gov/medicaid/ | (800) 362-3002 |
| Wyoming | http://wdh.state.wy.us/healthcarefin/chip/index.html | (307) 777-7531 |

For more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Dept. of Health & Human Services
Centers for Medicare & MedicaidServices
www.cms.hhs.gov
1-877-267-2323

## *Your Rights under the Newborns' & Mothers' Health Protection Act*

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable) after birth. In any case, plans and insurers may not, under federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours as applicable).

## *Women's Health & Cancer Rights Act of 1998*

As required by the Women's Health & Cancer Rights Act of 1998 (WHCRA), the Getty's Health and Welfare Plan provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve a 7symmetrical appearance.

If you have any questions regarding this act, contact the insurance carrier. See page 24 for Carrier Contact Information.

## *Notice of Privacy Practices*

The J. Paul Getty Trust (the "Getty") is committed to protecting the privacy of health information maintained by its Health and Welfare Plan (the "Plan") AND by the Plan's Business Associates, which are outside vendors who perform services for the Plan, such as Aetna, UnitedHealthcare, MetLife, etc.

The Plan is required by law to protect the privacy of certain health information that may reveal your identity, and to provide you with a copy of this notice which describes the Plan's health information privacy practices. If you have any questions about this notice or would like further information, please email Getty Human Resources at HR@getty.edu or call the Benefits Phone Line at 310.440.6523.

### Purpose

The purpose of this notice is to provide you with notice of the Plan's health information protection practices and explain your rights as a participant in the Plan.

### The Plan's Responsibilities

The Plan abides by the terms of this notice currently in effect by maintaining the privacy of your health information and providing you with notice of the Plan's legal duties and privacy practices with respect to your health information.

### Notice Revisions

The Plan reserves the right to revise the terms of this notice and to make the revised terms effective for all health information that it maintains. If the Plan revises this notice, we will make the revised notice available to you within sixty (60) days.

### What Health Information is Protected?

The Plan is committed to protecting the privacy of health information about you. Some examples of protected health information are:

- Information regarding payment for your health care (such as your enrollment in a health plan);
- Information about your health condition (such as a disease you may have);
- Information about health care services you have received or may receive in thefuture (such as an operation);
- Geographic information (such as where you live or work);
- Unique numbers that may identify you (such as your Social Security Number, your phone number, or your driver's license number); and
- Other types of information that may identify who you are.

## How the Plan Uses and Discloses Information About You

The Plan will only use and disclose your health information without your authorization when necessary for:

1. *Treatment, Payment and Health Care Operations.* The Plan may use and disclose most health information about you for treatment, payment and health care operations without your written authorization. For example:
    - Treatment: The Plan may use or disclose your health information to coordinate treatment by a health care provider.
    - Payment: The Plan uses health information for payment processing, to verify that services provided were covered under the Plan.
    - Health Care Operations: The Plan uses and discloses health information to audit and review claims payment activity to ensure that claims were paid correctly, or to run the Plan's normal business operations.

    Your information may also be disclosed to other persons or organizations outside the Plan so that they may jointly perform certain types of payment activities and health care operations along with the Plan. In addition, the Plan may use or disclose health information that these persons or organizations have received or created about you.

2. *Disclosures to the Getty.* The Plan may disclose certain of your health information to the Getty to the extent permitted by law. For example, upon a request from the Getty, the Plan may disclose health information about you to enable the Getty to obtain premium bids from health plans that might provide health insurance coverage under the group health plan, or to modify, amend, or terminate the Plan. Under no circumstances will the Plan disclose your health information to the Getty for the purpose of employment-related actions or decisions (e.g., for employment termination) or for the purpose of administering any other plan that the Getty may offer.

3. *Friends and Family Involved in Your Care and Payment for Your Care.* The Plan may share your health information with friends and family involved in your care and the payment for your care without your written authorization. The Plan will always give you an opportunity to object unless there is insufficient time because of a medical emergency (in which case the Plan Administrator will discuss your preferences with you as soon as possible following the emergency).
4. *Emergencies or Public Need.* The Plan may use your health information and share it with others in order to treat you in an emergency or to meet important public needs. The Plan will not be required to obtain your written authorization or any other type of permission before using or disclosing your information for these reasons.
5. *Information that Does Not Identify You.* The Plan may use or disclose your health information if the Plan has removed any information that might reveal who you are, or for limited purposes if the Plan has removed most information revealing who you are and obtained a confidentiality agreement from the person or organization receiving your health information.

## Disclosure to the Plan's Business Associates

The Plan may disclose your health information to Business Associates who have agreed in writing to maintain the privacy of health information as required by law.

## Use or Disclosure Requiring Authorization

The Plan will not use or disclose your health information for purposes other than those described in this notice. If it becomes necessary to disclose any of your health information for other reasons, the Plan will request your written authorization.

*Revoking Authorization*: If you provide written authorization, you may revoke it at any time in writing, except to the extent that the Plan has relied upon the authorization prior to its being revoked.

## Use of Disclosure Required or Permitted by Law

The Plan may disclose your health information to the extent that the law requires for the following reasons:

- ***Public Health***: For public health activities or as required by a public health authority.
- ***Health Oversight***: To a health oversight agency for activities, such as audits, investigations and inspections. Oversight agencies include, but are not limited to, government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.
- ***Legal Proceedings***: In response to an order of a court or administrative tribunal or in response to a subpoena, discovery request or other lawful process.
- ***Law Enforcement:*** For law enforcement purposes including, but not limited to:
  - Legal process or as otherwise required by law;
  - Limited information requests for identification and location;
  - Use or disclosure related to a victim of a crime;
  - Suspicion that death has occurred as a result of criminal conduct;
  - If a crime occurs on the employer's premises; or
  - In a medical emergency where it is likely that a crime has occurred.
- ***Criminal Activity:*** As requested by law enforcement authorities, if the use of disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
- ***To Avert a Serious Threat to Health or Safety***: The Plan may use your health information or share it with others when necessary to prevent a serious threat to your health or safety, or the health or safety of another person or the public. In such cases, the Plan will only share your information with someone able to help prevent the threat.
- ***National Security and Intelligence Activities or Protective Services:*** The Plan may disclose your health information to authorized federal officials who are conducting national security and intelligence activities or providing protective services to the President or other important officials.
- ***Military and Veterans***: If you are in the Armed Forces, the Plan may disclose health information necessary to carry out their military mission(s). The Plan may

also release health information about foreign military personnel to the appropriate foreign military authority or authorities

- ***Workers' Compensation:*** The Plan may disclose your health information to the extent necessary to comply with laws relating to workers' compensation or similar programs that provide benefits for work-related injuries.

## Review Your Health Information

You have a right to inspect and obtain a copy of your health information. *If you feel your health information is incorrect, you have the right to request that it be amended.* Go to page 24 for Carrier Contact Information.

## Request to Restrict Your Health Information

You can request restrictions on the use and disclosure of your health information. The Plan is not required to agree to a requested restriction. For example, if a restriction request prevents the Plan from providing service to you or from performing payment-related functions, the Plan will not be able to agree to the request. Go to page 24 for Carrier Contact Information.

## Confidential Communication

When necessary, the Plan may mail your health information to your home. If you feel receiving a copy of your health information at your home could compromise your safety you may request in writing an alternate communication method and/or location. Go to page 24 for Carrier Contact Information.

For example: The participant may decide, for his or her safety, to have correspondence containing his/her health information sent somewhere other than to his/her home, or to have the information sent via fax rather than mailed. The Plan will not ask for an explanation for such requests but may request payment for this service.

## Accounting of Disclosures

If a disclosure of your health information was made for a reason other than treatment, payment or health care operations, you have a right to receive an accounting of the disclosure. If the disclosure was made to you, the Plan will not provide an accounting. To request this accounting, please contact the Plan by calling the toll-free phone number on your identification card, or go to page 24 for Carrier Contact Information.

## Receive a Copy

You can view and print a copy of this Notice of Privacy Practices at www.getty.edu/staff. You may also request a copy from Getty Human Resources.

## Complaints

If you believe that your privacy rights have been violated, submit a complaint to the Plan or to the U.S. Secretary of Health and Human Services at any time.

*To file a complaint with the Plan:*

a) Call the toll-free telephone number on your identification card; or
b) Contact Getty Human Resources at 310.440.6523 or send an email to HR@getty.edu

*To file a complaint with the U.S. Secretary of Health and Human Services:*

a) use the HIPAA Complaint Submission Form at http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html; or
b) send a letter to: U.S. Secretary of Health and Human Services
HIPAA Complaint
7500 Security Blvd., C5-24-04
Baltimore, MD 21244

No one will retaliate against you for filing a complaint.

## Contact Information

You may contact the Plan by calling the toll-free telephone number on your identification card or go to page 24 for Carrier Contact Information. To contact a Getty HR representative, call Getty Human Resources at 310.440.6523 or send an email to HR@getty.edu.

## *Qualified Medical Child Support Orders*

To request a copy of the Getty's Qualified Medical Child Support Order procedure without charge, call Getty Human Resources at 310.440.6523 or send an email to HR@getty.edu.

## *Employee Cost Share of Benefits*

To view employee cost share of benefits, please visit www.gettyhr.com or contact Getty Human Resources at 310.440.6523 or send an email to HR@getty.edu.