GENERAL INFORMATION

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 booklet, you should contact the insurance company in writing or by telephone, as appropriate. See page 48 for Contact Information. You should also inform HR Benefits of any complaints about service.

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.

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). To continue dental and vision coverage, you must elect to continue medical coverage.

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 http://www.getty.edu/staff/pdf/cobranotice.pdf or request a copy from your Human Resources Coordinator.

Conversion Rights – HMO Plans Only

When HMO medical coverage ends for you or any covered dependents, you may be able to apply for an individual medical policy. Converting to individual coverage will not require proof of insurability. You may elect conversion when:

- You do not elect COBRA continuation coverage and you and/or your enrolled eligible dependents apply for an individual policy within 31 days after you or your dependents' group coverage ends, or
- You elect COBRA continuation coverage and you or your enrolled eligible dependents apply for an individual policy no later than 31 days after your COBRA coverage ends.

For more information about conversion rights, call the insurance carrier directly. See page 48 for Contact Information.

Converting Group Life Insurance

You may be able to convert your Group Life Insurance into an individual policy when your coverage ends.

For more information about conversion rights, call the insurance carrier directly. See page 48 for Contact Information.

Certificates of Coverage

HIPAA (Health Insurance Portability and Accountability Act of 1996), a federal law, limits the circumstances under which coverage may be excluded for medical conditions present before you enroll in a health plan. Under the law, pre-existing condition exclusions generally may not be imposed for more than 12 months (18 months for a late enrollee). The 12-month exclusion period must be reduced by prior health coverage as long as there was no break in coverage equal to or exceeding 63 days (or longer if provided under applicable state law).

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

The carrier will provide you (and your dependents) with a coverage certificate after coverage is lost under the Plan. Please contact the insurance carrier directly to request your coverage certificate. If you have problems obtaining your coverage certificate, please contact HR Benefits at 310.440.6523 or Benefits@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 a coverage certificate within 24 months from the date coverage was lost.

Other Important Information

This section of your summary plan description gives you some basic facts about each of the plans.

Official Plan Name	**The J. Paul Getty Trust Health & Welfare Plan**
Plan Document	This booklet is a Summary Plan Description 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 booklet and the official plan contracts, the contracts will govern.
Employer Identification Number	95-1790021
Plan Number	501
Plan Administrator	The J. Paul Getty Trust Attn: Director, Human Resources 1200 Getty Center Drive, Suite 400 Los Angeles, CA 90049-1681 310.440.6523 Benefits@getty.edu 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 coverage.
Requests for Information	If you have questions about your benefits, please email HR Benefits at Benefits@getty.edu or call the Benefits PhoneLine 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 other Health & Welfare Plans cannot be assigned to someone else. And 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 benefits.

Contact Information

Plan	Vendor/Administrator	Phone Number
Medical – OAP Plan (formerly PPO Plan) Policy #3123016	CIGNA Healthcare P.O. Box 188032 Chattanooga, TN 37422-8032 www.cigna.com	800.251.0669
Medical – HMO Plans Signature Value Advantage Signature Value	PacifiCare of California P.O. Box 6006 Cypress, California 90630 www.pacificare.com	800.624.8822
Dental Policy #74219	MetLife Group Dental Claims P.O. Box 14093 Lexington, KY 40512-4093 www.metlife.com/mybenefits	800.942.0854
Vision Policy #00102119	Vision Service Plan (VSP) P.O. Box 997100 Sacramento, CA 95899-9100 www.vsp.com	800.877.7195
Group Life and AD&D Policy #74219	MetLife P.O. Box 6115 Utica, NY 13504-6115 www.metlife.com/mybenefits	877.ASK.MET7
Mental Health (OAP only)	ValueOptions P.O. Box 1290 Latham, NY 12110	866.393.3942
Long-Term Disability Policy #83076198	The Standard P.O. Box 2800 Portland, OR 97208	800.368.1135
Business Travel Accident Policy #01947040	Prudential P.O. 8517 Philadelphia, PA 19101	800.524.0542

These insurers provide fully insured medical benefits under contracts issued to the J. Paul Getty Trust. These insurers are solely responsible for financing and providing all medical benefits under their respective contracts and the J. Paul Getty Trust has no liability for any benefits due, or allegedly to be due, under such contracts.

Your Rights as a Plan Member

As a participant in the J. Paul Getty Trust Health and Welfare Plan, you 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.

Continue Group Health Plan Coverage

You are entitled to group health care coverage for yourself or eligible dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

There is a reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable

coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the group health plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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, for example, if 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 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.

Your Rights Under the Newborns' and 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 symmetrical appearance.

If you have any questions regarding this act, contact the insurance carrier. See page 48 for 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 the Plan's Business Associates, which are outside vendors who perform services for the Plan, such as CIGNA, PacifiCare, 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 HR Benefits at Benefits@getty.edu or call the Benefits PhoneLine 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 the future (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:

- *Public Health*: For public health activities or as required by the 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, 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 authorize 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. The Plan may also release health information about foreign military personnel to the appropriate foreign military authority.
- *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.* See page 48 for 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. See page 48 for 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. See page 48 for 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 list, please contact the Plan by calling the toll-free phone number on your identification card. See page 48 for Contact Information.

Receive a Copy
You can view and print a copy of this Notice of Privacy Practices on www.getty.edu/staff. You may also request a copy from your Human Resources Coordinator.

Complaints
If you believe that your privacy rights have been violated, you may 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 Benefits at 310.440.6523 or send an email to Benefits@Getty.edu.

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

a) use the HIPAA Complaint Submission Form at cms.hhs.gov/hipaa/hipaa2/default.asp; 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 see page 48 for contact information. To contact a Getty HR representative, call HR Benefits at 310.440.6523 or send an email to Benefits@Getty.edu.

Appealing a Claim

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

For the claims procedures applicable to the Getty's HMO plans through PacifiCare, please refer to the Combined Evidence of Coverage and Disclosure Form that is sent to participants on an annual basis.

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 59.

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 explain why the 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 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 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 48 for Vendor/Administrator addresses. 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 59. If more time is needed to make the determination, you will be notified in writing prior to the end of the initial time frame to request an extension. 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 where 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 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 59. It will include the specific reasons for the denial, the Plan provisions on 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 on 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 Claims	Plan Must Respond To Your Initial Claim Within*:	You Must Submit Your Appeal Within:
Medical, Dental, Mental Health, & 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 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 where 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 theses procedures, or would like a complete set of claims procedures, please call HR Benefits at 310.440.6523 or send an email to Benefits@Getty.edu.

Qualified Medical Child Support Orders

To request a copy of the procedure without charge, call HR Benefits at 310.440.6523 or send an email to Benefits@Getty.edu.

Overpayment of Benefits

If, for any reason, you receive more benefits than you are entitled to under any of the Plans described in this booklet, the Plan reserves the right to obtain a refund from you. If you do not promptly issue a refund, the Plan may reduce any future reimbursements under the Plan to recoup the overpayment. Even if the Plan incorrectly paid claims in the past, it reserves the right to recover incorrectly paid amounts.