Summary Plan Description

Retiree Medical Coverage

2010

The J. Paul Getty Trust

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INTRODUCTION

This booklet is the Summary Plan Description (SPD) for the J. Paul Getty Trust Retiree Medical Plan. It also describes the dental and vision plans available only through COBRA. Certain restrictions apply.

If there is any conflict between this booklet and the Plan document, the Plan document and insurance contracts will govern. This booklet supersedes any previously issued 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 booklet carefully, discuss it with your family, and keep it with your other important papers for future reference. If you have any questions that are not answered in this booklet, call HR Benefits at 310.440.6523 or send an email to Benefits@getty.edu.

THE MEDICAL PLAN FOR RETIREES

Eligibility

To be eligible to receive medical coverage as a retiree, you must meet the following criteria:

- You must have reached age 50 and had a minimum of five (5) years of benefit service as of December 31, 2008,
- You must be covered by the Medical Plan as an active employee,
- You must elect to receive your monthly Retirement Plan benefit upon retirement as described in the J. Paul Getty Trust Retirement Plan Summary Plan Description,
- You must have a minimum of ten (10) years of benefit service, and
- You must be employed by the Getty at the time you retire.

Dependents may be covered if they are your:

- Legal spouse
- Same-sex domestic partner registered with the state of California, or equivalent
- Unmarried children younger than age 19*
- Unmarried children age 19 through age 22*, who are full-time students at an accredited secondary school, college, or university*
- Dependent children age 19 or older, who are physically or mentally incapable of self-support, provided you applied for coverage within 31

days of the date prior coverage is lost (proof of incapacity must be furnished to the Plan within 31 days after it is requested)
- Children who must be covered under the Plan because of a Qualified Medical Child Support Order (QMCSO)

**Effective January 1, 2011, children can be covered through age 26.*

"Children" include:
- Your natural children
- Your adopted children from the date of placement with you as the adopting parent
- Your foster children, stepchildren, and any other children for whom you are the legal guardian
- Dependent child(ren), as described above, of a covered same-sex domestic partner.

No one is eligible as a dependent while:
- Covered as an employee of the Getty
- Serving in the military of any country, or
- Residing outside the United States.

Medical Plan Choices

As an eligible retiree, you and your eligible dependents may enroll in one the Getty's retiree medical plans by completing a Retiree Medical Plan Enrollment Form within 31 days from the effective date of your coverage. This form is available on www.getty.edu/staff or you can request a form by calling the Benefits PhoneLine at 310.440.6523.

Once you have enrolled, you will not be able to switch medical plans and/or add dependent coverage until Open Enrollment, which is held each year from mid-October through mid-November. Changes made during Open Enrollment are effective January 1 of the following year.

Remember, if you move to a location outside of the HMO service area, you must enroll in the OAP plan to retain medical coverage.

You must enroll in Medicare Parts A and B upon eligibility (age 65), regardless of which plan you choose. Your covered dependent must enroll in Medicare Parts A and B the later of when: i) you are eligible for Medicare; or ii) he/she reaches age 65.

Dental and vision coverage are not available for retirees. Your coverage under these plans ends on the last day of the month in which you retire. For example, if your last day worked is September 6, your dental and vision coverage will end on September 30.

Cost of Medical Coverage

Retirees contribute to the cost of medical coverage for themselves and their eligible dependents. The cost of this coverage changes annually and may vary depending on your eligibility for Medicare coverage.

You are required to have the cost of medical coverage automatically deducted from your Retirement Plan benefit. If your monthly Retirement Plan benefit does not cover the cost of medical coverage, you must pay your premiums directly to the J. Paul Getty Trust. You may pay by check or set up automatic payments via credit card. For more information, call the Benefits PhoneLine at 310.440.6523.

The current cost of this coverage is available from Human Resources, or visit www.getty.edu/staff for details.

When Retiree Medical Coverage Begins and Ends

Coverage begins the first of the month following your termination of employment. In order for coverage to begin, you must submit the Retiree Medical Plan Enrollment Form to Human Resources within 31 days from the coverage begin date.

If HR Benefits does not receive your enrollment form within the 31-day period, you will **lose your eligibility** for the Retiree Medical Plan and you will **not** be able to enroll in the future.

At some point during your retirement, you may decide that you no longer need or want the Getty medical coverage. Your written election to stop participating in this medical plan is irrevocable. Once you stop, you will not be able to re-enter the plan at a later date.

Currently, dependent medical coverage continues for three (3) years following the death of the retiree. After that period, medical coverage may be available at the group rates through COBRA for 36 months.

Changing Your Election

You may change your coverage or add/delete dependents for the following year during Open Enrollment, which occurs mid-October through mid-November. Information regarding Open Enrollment will be sent to your home address prior to the enrollment period. Be sure to keep HR Benefits informed if you move.

This will ensure that you receive these important notices. Changes made during Open Enrollment are effective January 1 of the following year.

If you have a qualified status change, you may enroll your eligible dependents within 31 days of the event. Your change action must be on account of and consistent with your status change. You are considered qualified status change if:

- You marry, divorce, become legally separated, or a covered dependent dies
- You gain a dependent by birth, adoption, marriage or same-sex domestic partnership
- Your spouse/eligible same-sex domestic partner begins or ends employment
- Your spouse/eligible same-sex domestic partner loses their coverage
- Your dependent meets or ceases to satisfy the requirements for dependent status due to an increase in age
- You are required to cover a dependent under the terms of a Qualified Medical Child Support Order (QMCSO)

Medicare Basics

The following is basic information about Medicare. For more information about Medicare, visit www.medicare.gov, the official U.S. Government Site for People with Medicare.

Medicare		
Eligibility:	Age 65	
Enrollment Process:	• You are automatically enrolled in Parts A & B if you are receiving a monthly Social Security Benefit. You can opt out of Part B if you are an active employee. • If you are not receiving a monthly Social Security Benefit, you must apply for coverage at www.medicare.gov or call (800)633.4227.	
	Part A	**Part B**
Cost:	No cost	2010 - $110.50 per month
Coverage:	Hospital Insurance - pays some of the costs of hospitalization, limited skilled nursing home care, home health services and hospice care.	Medical Insurance - primarily covers physicians' services, most outpatient hospital services, and certain related services.
Medicare Part D - If you are enrolled in the Getty's Retiree Medical Plan, it is not necessary for you to enroll in Medicare Part D – Prescription Drug Coverage. See Page 7.		

Medicare / CIGNA OAP Coordination of Benefits

If you are Medicare-eligible (age 65) when you retire from the Getty and you are enrolled in the CIGNA OAP Plan, then Medicare becomes your primary

coverage. This means that you must submit expenses to Medicare first and then to CIGNA.

Whether Medicare is the primary payer or the secondary payer depends on your age and whether you have other coverage. Use this chart to determine which plan is the primary payer and which is the secondary payer. Note: A "Retiree" is the covered individual who was an employee of the J. Paul Getty Trust and is receiving a monthly benefit from the Retirement Plan. A "Spouse" is an individual who is married to a "Retiree".

Status	Coverage when Retiree Is Under Age 65	Coverage when Retiree Is Age 65 or Older
Retiree - Not Married	CIGNA Only	Primary - Medicare Secondary - CIGNA
Retiree - Married & **Not** Covered Under Spouse's Group Plan	CIGNA Only	Primary - Medicare Secondary - CIGNA
Retiree - Married & Covered Under Spouse's Group Plan	Primary - CIGNA Secondary - Spouse's Group Plan	Primary - Medicare Secondary - CIGNA Third - Spouse's Group Plan
Spouse of Retiree - Under Age 65 & Not Covered Under His/Her Group Plan	CIGNA Only	CIGNA Only
Spouse of Retiree - Under Age 65 & Covered Under His/Her Group Plan	Primary - Spouse's Group Plan Secondary - CIGNA	Primary - Spouse's Group Plan Secondary - CIGNA
Spouse of Retiree* - Age 65 & Older, Not Covered Under His/Her Group Plan	Primary - CIGNA Secondary - Medicare	Primary - Medicare Secondary - CIGNA
Spouse of Retiree* - Age 65 & Older, Covered Under His/Her Group Plan	Primary - Spouse's Group Plan Secondary - Medicare Third - CIGNA	Primary - Spouse's Group Plan Secondary - Medicare Third - CIGNA

***Retirees** must enroll in Medicare Part A and B three months prior to when the **Retiree** turns age 65. Medicare is effective the first of the month in which the **Retiree** turns age 65. A spouse of a retiree does not have to enroll in either Medicare Part A or B until the Retiree turns age 65 even if the spouse is older than age 65.

How the CIGNA OAP Pays When Medicare Is Primary

The following example demonstrates how CIGNA determines the amount it will pay when Medicare is the primary payer. The amount of Covered Expenses is based on the amount of charges allowed under Medicare rules instead of those of the OAP Plan.

1. First, CIGNA determines how much it would pay **if** it were the Primary Payer:

1. CIGNA	
Office Visit – Physician's Charge	$100.00
Max. Allowable Amt. Under CIGNA	$95.00
Coinsurance 10%	$9.50
CIGNA 90%	$85.50

2. Next, the amount payable under Medicare for the same expenses is determined:

2. Medicare	
Office Visit	$100.00
Max. Allowable Amt. Under Medicare	$80.00
Coinsurance 20%	$16.00
Medicare 80%	$64.00

3. Calculate the difference between Step 1. CIGNA 90% and Step 2. Medicare 80%:

3. Difference Between Medicare & CIGNA	
CIGNA 90%	$85.50
Medicare 80%	$64.00
Difference Between Medicare & CIGNA	$21.50

4. The Retiree's Out-of-Pocket Expense is then calculated by subtracting the Medicare payment (#2) and the difference between the Medicare & CIGNA payments (#3) from the total Office Visit amount (#1):

4. Retiree's Out-of-Pocket Expense	
1. Office Visit	$100.00
2. Medicare 80%	($64.00)
3. Difference Between Medicare & CIGNA	($21.50)
4. Retiree's Out-of-Pocket Expense	$14.50

For information on how Medicare coordinates with the HMO plans, refer to the Evidence of Coverage available at https://www.getty.edu/staff/forms or call PacifiCare at 800.624.8822.

Prescription Drug Coverage

The J. Paul Getty Trust has determined that the prescription drug coverage available through the Getty's medical plans is, on average for all plan participants, expected to pay as much as the standard Medicare prescription drug coverage pays. Because of this, you may keep the Getty's coverage and you would not be required to pay a higher rate by Medicare if you later decide to enroll in the Medicare prescription coverage (Medicare Part D).

Individual's can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from November 15th through December 31st. You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

You should also know that if you drop or lose your coverage with the J. Paul Getty Trust and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may be required to pay more to enroll in Medicare prescription drug coverage later.

If you have a lapse in prescription drug coverage for 63 days or longer that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without coverage, your premium will always be at least 19% higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to enroll.

Waiving Your Medical Coverage under the Getty's Medical Plans

The current Getty medical plans cover health expenses in addition to prescription drugs. If you decide to waive your medical coverage through the J. Paul Getty Trust, you may not re-enroll in this plan at a later date. You should compare the current Getty plans' coverage as indicated on the next page, including which drugs are covered, to the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

The J. Paul Getty Retiree Medical
Prescription Coverage Comparison

Prescription Drug Coverage	HMO (PacifiCare) Signature Value Advantage Plan	HMO (PacifiCare) Signature Value Plan	OAP (CIGNA)
Prescriptions – Retail **Up to a 30-day supply**	Generic $ 5.00 Formulary $ 5.00 Non-Formulary $20.00	Generic $10.00 Formulary $25.00 Non-Formulary $40.00	Generic $10.00 Formulary $25.00 Non-Formulary $40.00
Prescriptions – Mail Order **Up to a 90-day supply**	Generic $10.00 Formulary $10.00 Non-Formulary $40.00	Generic $20.00 Formulary $50.00 Non-Formulary $80.00	Generic $20.00 Formulary $50.00 Non-Formulary $80.00

For a list of generic and formulary drugs, contract:

CIGNA (OAP)	PacifiCare (HMOs)
www.cigna.com	www.pacificare.com
800.251.0669	800.624.8822

For more information about your options under Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program
- Call 800.633.4227 (TTY 877.486.2048)

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 800.772.1213 (TTY 800.325.0778).

Continuation Privileges under COBRA

To continue dental and vision coverage, and/or if you are not eligible for the Medical Plan for Retirees, you may continue coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), which provides for continued coverage for a certain period of time at group rates.

If you are eligible for continued coverage under COBRA, HR Benefits will send you, via certified mail, a notice with information on how to apply for this coverage, and the cost of coverage. Under the law, you have 60 days from the date of loss of coverage or the date you are notified about COBRA to complete and return the election form. In order for your benefits to be effective you

must submit your first month's payment within 45 days from the date you elect coverage. If your payment is not received within this time, your coverage cannot be reinstated.

No exceptions can be made and coverage cannot be extended if the completed form is received after the election period.

It is very important that you understand your COBRA rights. For more information about COBRA, see "The General Notice of COBRA Continuation Rights" at http://www.getty.edu/staff/pdf/cobranotice.pdf or contact HR Benefits at 310.440.6523.

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 three medical plans:

- Open Access Plus Plan (OAP) through CIGNA
- Signature Value Plan (HMO) through PacifiCare
- Signature Value Advantage Plan (HMO) through PacifiCare

The key differences between the OAP Plan and the HMO Plans are shown in the chart below.

In the CIGNA OAP Plan:	In the PacifiCare HMO Plans:
You may use any doctor or hospital.	You must use **HMO doctors and hospitals**.
You pay a **deductible** each year before the Plan pays benefits.	You pay **no deductible**. You only pay a small **copayment** for certain services.
The Plan pays **90%** of covered expenses in-network and **70%** out-of-network (based on reasonable and customary charges.)	The Plan pays **100%** of most covered expenses (after a copayment for certain services).
You or your OAP doctor file **claim forms**.	There are **no claim forms** (except for emergency care outside the HMO service area).
You receive **mental health and substance abuse treatment** through ValueOptions.	You receive **mental health and substance abuse treatment** through the HMO.

OAP Plan

Under the CIGNA OAP, you can see any doctor you want. You will pay less if you see a doctor who is in the OAP network. You pay the first part of medical 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 OAP Plan.

For a schedule of covered services under the OAP Plan, refer to Appendix A in the back of this booklet.

You must enroll in Medicare Parts A and B upon eligibility (age 65), regardless of which plan you choose. Your covered dependent must enroll in Medicare Parts A and B the later of when: i) you are eligible for Medicare; or ii) he/she reaches age 65.

Mental Health and Substance Abuse Treatment – CIGNA OAP Only

This section does not apply to retirees who have selected one of the HMO plans. If you are in one of the HMO plans, you receive treatment for mental health or substance abuse from your HMO network.

The Getty has contracted with ValueOptions to provide mental health and substance abuse treatment for retirees enrolled in the OAP Plan. ValueOptions provides a wide variety of inpatient and outpatient services for this type of treatment. The ValueOptions mental health program is designed to provide clinically appropriate and medically necessary psychological therapy.

Case Managers: ValueOptions case managers can help you receive appropriate care and maximum benefits. They review and approve care given by ValueOptions network providers. Case managers include psychiatrists, psychologists, psychiatric social workers, licensed marriage, family and child counselors, psychiatric nurses, and registered nurses.

Confidentiality: When you call ValueOptions, no one at the Getty will be told about your call or about any treatment plan you might start unless otherwise authorized by you in writing or if required by law.

How the Plan Works

You and your dependents are eligible for mental health and substance abuse treatment benefits through ValueOptions if you are enrolled in the OAP.

You can seek treatment either from a ValueOptions network provider at a lower negotiated fee or, at a higher cost to you, from a provider not in the network. You pay the first part of 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*.

The ValueOptions program covers a range of treatment, including:

- Outpatient counseling
- Residential treatment
- Home health care
- Day treatment
- Inpatient hospital treatment
- Structured outpatient programs

Schedule of Mental Health and Substance Abuse Treatment Care Benefits

Benefit	ValueOptions Network	Out-of-network
Annual Deductible	**$250 Individual $500 Family**	**$450 Individual $900 Family**
Out of Pocket	**$1,000 Individual $3,000 Family**	**$3,000 Individual $9,000 Family**
Office Visits	**10% coinsurance**	**30% coinsurance**
Ambulance	**10% coinsurance**	**30% coinsurance**
Emergency Room	**0% coinsurance**	**$50 copayment, + 10% coinsurance**
Laboratory	**10% coinsurance**	**30% coinsurance**
Day Limits Per Year Inpatient	**Unlimited days**	**Unlimited days**
Session Limits Per Year Outpatient	**Unlimited sessions**	**Unlimited sessions**

How to Access Care

To access care for mental health and substance abuse treatment, call ValueOptions at 866.393.3942. A licensed clinician will assess your situation over the phone and refer you to an appropriate provider for an evaluation.

In case of an emergency, you or someone you know must call ValueOptions within 48 hours of when emergency services are sought.

Exclusion

Not all mental health and substance abuse treatments are covered under the Plan. The following are excluded:

- Custodial care, educational rehabilitation or treatment of learning disabilities
- State hospital treatment, except when such treatment is noncustodial in nature and determined to be medically necessary and appropriate
- Treatment for personal or professional growth, development, or training or professional certification
- Evaluation, consultations, or therapy for educational/professional training or investigational purposes relating to employment
- Psychiatric or psychological examinations, testing or treatments for purposes of obtaining or maintaining employment unless medically indicated and preauthorized by ValueOptions or related to judicial or administrative proceedings
- Academic education during residential treatment
- Therapies that do not meet national standards of the American Psychiatric Association for mental health profession practice, for example, Erhard/The Forum, primal therapy, bioenergetics therapy, crystal healing therapy
- Experimental or investigational therapies
- Court-ordered psychiatric or substance abuse treatment unless medically necessary
- Psychological testing, except where conducted for purposes of diagnosing a psychiatric disorder or when rendered in connection with a diagnosed psychiatric disorder (All testing requires pre-authorization)
- Charges for services, supplies, or treatment that are covered charges under the OAP Plan
- Prescription drugs, except where dispensed by a hospital, residential, or day treatment program to a covered individual who, at the time of dispensing, is receiving treatment at the appropriate facility or program
- Private duty nursing
- V codes
- Treatment for autism, mental retardation, congenital or organic disorders
- Marriage counseling, except when rendered in connection with a DSM III-R psychiatric disorder
- Treatment for stress, except when rendered in connection with a DSM III-R psychiatric disorder
- Treatment for smoking cessation, weight reduction, obesity, stammering or stuttering
- Inpatient treatment for eating disorders
- Aversion therapy

- Treatment for codependency
- Nonabstinence-based and nutritionally-based chemical dependency treatment
- Treatment for sexual addiction
- Treatment of chronic pain, except when rendered in connection with a DSM III-R psychiatric disorder, and
- Treatment or consultations provided via telephone.

HMO Plans

HMO plans provide all medical care for enrollees for a predetermined price. You pay only a small *copayment* for certain services, such as a visit to the doctor. Then, most care (including care from specialists) is paid at 100%. **To receive benefits from the Plan, you must use the HMO's network of doctors and hospitals, and your care must be directed by your primary care physician (PCP).** If you receive care outside the HMO, you are responsible for paying for that care. There is no lifetime maximum amount of covered medical benefits you may receive while covered by the HMO.

For more information on the HMO plans, visit www.getty.edu/staff or contact HR Benefits at 310.440.6523.

You must enroll in Medicare Parts A and B upon eligibility (age 65), regardless of which plan you choose. Your covered dependent must enroll in Medicare Parts A and B the later of when: i) you are eligible for Medicare; or ii) he/she reaches age 65.

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 16 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

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

Under COBRA, you 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 Rights" at http://www.getty.edu/staff/pdf/cobranotice.pdf or contact HR Benefits at 310.440.6523.

Other Important Information

This section gives you some basic facts about each of the Plans.

Official Plan Name	The J. Paul Getty 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 #	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, your benefits under the Plan 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 Policy #3208756	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
Mental Health (OAP only)	ValueOptions P.O. Box 1290 Latham, NY 12110	866.393.3942

Your Rights as a Plan Member

As a participant in the J. Paul Getty Trust Retiree Medical 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 make 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 medical 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 preexisting 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 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 length of 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). 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.

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 16 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 16 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 16 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 16 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 HR Benefits by calling 310.440.6523.

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 www.cms.hhs.gov/hipaa; 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 16 for contact information. To contact a Getty HR representative, call HR Benefits at ext. 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 26.

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 16 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 26. 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 26. 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 Timeframes

Type of Claims	Plan Must Respond To Your Initial Claim Within*:	You Must Submit Your Appeal Within:
Medical & Mental Health:		
Pre-Service	15 days	180 days
Post-Service	30 days	180 days
"Urgent Care" Claims	72 hours	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 these 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.

GLOSSARY OF TERMS

Appeal
A process used by a patient or provider to request re-consideration of a previously denied service.

Brand-name drug
A prescription drug that is manufactured and marketed under a trademark or name by a specific drug manufacturer and is identified as a brand-name product by the OAP Plan.

COBRA – (Consolidated Omnibus Budget Reconciliation Act)
A Federal statute that requires most employers to offer to covered employees and covered dependents that would otherwise lose health coverage for reasons specified in the statute, the opportunity to purchase the same health benefits coverage that the employer provides to its remaining employees. This continuation of coverage can only last a maximum specified period of time.

Coinsurance
The percentage of medical expenses you pay. For example, if you go to a network doctor under the OAP Plan, your coinsurance is 10%, and the Plan pays 90%. Coinsurance amounts can also be flat amounts.

Coordination of benefits
A provision in benefit plans designed to ensure that a person covered by more than one plan does not receive more than 100% reimbursement of his or her out-of-pocket costs.

Concurrent review
The process by which hospital admissions are certified for appropriateness and by which continued stays are verified for medical necessity and level of care.

Copayment
A flat dollar amount you pay for a service, such as the $10 copayment for a visit to the doctor in the Signature Value Advantage Plan (HMO). After the copayment, the Plan covers the rest of the reasonable and customary cost.

Deductible
The amount of covered expenses you must pay before the Plan begins paying benefits.

Domestic partners
Same-sex individuals involved in a personal relationship who:

- Have a common residence

- Are responsible for each other's financial welfare
- Are not blood relatives
- Are at least 18 years of age
- Are mentally competent
- Are life partners and would get legally married should the option become available
- Are registered as domestic partners if there is a local domestic partner registry
- Are not legally married to anyone
- Agree to inform the company in the event that the domestic partnership terminates

Emergency care
Emergency care is defined as medical care and treatment provided after the sudden onset of a medical condition manifesting itself by acute symptoms, including severe pain, which are severe enough that the lack of immediate medical attention could reasonably be expected to result in any of the following:

- The patient's health would be placed in serious jeopardy
- Bodily function would be seriously impaired
- There would be serious dysfunction of a bodily organ or body part.

Experimental, Investigational or Unproven Services
Medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time the OAP Plan makes a determination regarding coverage for a particular case are determined to be:

- Not approved by the U.S. Food and Drug Administration ("FDA") to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Services, or the United States Pharmacopoeia Dispensing Information, as appropriate for the proposed use, or
- Subject to review and approval by any institutional review board for the proposed use, or
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight, or
- Not demonstrated through prevailing peer-reviewed medical literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

The OAP Plan, in its judgment, may cover an experimental, investigational or unproven service for a life threatening sickness or condition if the service:

- Is proved to be safe with promising efficacy, and
- Is provided in a clinically controlled research setting, and
- Uses a specific research protocol that meets standards equivalent to those defined by the National Institute of Health.

Explanation of benefits (EOB)
A description, sent to patients by health plans, of benefits received and services for which the health care provider has requested payment.

Formulary
A list of preferred, commonly prescribed drugs. These drugs are chosen by a team of doctors and pharmacists because of their clinical superiority, safety, ease of use and cost.

Generic equivalents
A drug whose active ingredients, safety, dosage, quality and strength are identical to those of its brand-name counterpart.

Health Maintenance Organization (HMO)
An organization that arranges a wide spectrum of health care services which commonly include hospital care, physicians' services and many other kinds of health care services with an emphasis on preventative care.

Lifetime maximum
The maximum amount a person can receive in benefits during the time he/she is covered under a plan.

Medically Necessary or Medical Necessity
Health care services and supplies that the OAP Plan considers to be medically appropriate, and

1) necessary to meet the basic health needs of the covered person, and
2) rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the service or supply, and
3) consistent in type, frequency and duration of treatment with scientifically based guidelines of national medical, research, or health care coverage organizations or governmental agencies that the OAP Plan accepts, and
4) consistent with the diagnosis of the condition, and
5) required for reasons other than the convenience of the covered person or his or her physician, and
6) demonstrated through prevailing peer-reviewed medical literature to be either:

a. safe and effective for treating or diagnosing the condition or sickness for which their use is proposed, or
b. safe with promising efficacy
    i. for treating a life threatening sickness or condition, and
    ii. conducted in a clinically controlled research setting, and
    iii. using a specific research protocol that meets standards equivalent to those defined by the National Institute of Health.

(The term "life-threatening" is used to describe a sickness or condition that is more likely than not to cause death within one year of the date of the request for treatment.)

The fact that a physician has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular injury, sickness, mental illness or pregnancy does not mean that it is a medically necessary service or supply, as just defined. The definition of "medically necessary" used here relates only to coverage and differs from the way in which a physician engaged in the practice of medicine may define "medically necessary".

Network provider
A doctor, hospital or other health care giver belonging to a group that offers discounted fee arrangements. Examples are physicians who are part of the OAP Plan network.

Open Enrollment
A period of time each year when an eligible person can switch medical plans, enroll dependents and/or enroll in the FSAs. Open Enrollment is usually held mid-October through mid-November. Changes made during Open Enrollment are effective January 1 of the following year.

Out-of-Pocket maximum
The most you pay in a calendar year for medical expenses (not counting the deductible) before the Plan pays covered expenses at 100% of reasonable and customary charges for the rest of that year.

Participating provider
A therapist or other health care professional who participates in the corresponding program.

Post-service claim
Any group health plan claim that is not pre-service claims.

Preadmission review
The process of obtaining advance authorization for hospitalization under the OAP Plan. If you do not obtain this preadmission review, penalties apply.

Pre-existing condition
A physical and/or mental condition of an insured person that existed prior to the start of coverage under a Getty plan.

Preferred Provider Organization (OAP)
A network-based, managed care plan that allows the participant to choose any health care provider. However, if care is received from a "preferred" (participating in-network) provider, there are generally higher benefit coverages and lower deductibles.

Pre-service claim
Any request for an approval of a benefit where the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of receiving the health care (e.g., preauthorization).

Preventative care
Comprehensive care emphasizing priorities for prevention, early detection and early treatment of conditions, generally including routine physical examinations, immunization and well person care.

Primary Care Physician (PCP)
A physician, usually a family or general practitioner, internist or pediatrician, who provides a broad range of routine medical services and refers patients to specialists, hospitals and other providers as necessary. Under the Getty's HMO plans, a referral by the primary care physician is required to obtain services from other providers. Each covered member chooses his/her own PCP from the Plan's network of physicians.

Primary plan
Under a coordination of benefits provision, the Plan that pays first. If you are an employee, your coverage through the Getty is primary.

Provider Directory
Provider directories are listings of providers who have contracted with a managed care network to provide care to its participants. Participants may refer to the directory to select in-network providers.

Reasonable and customary
The amount usually charged for a particular medical service or supply in a geographic area. Reasonable and customary levels determine how much you

pay for non-network medical care under the OAP Plan and for out-of-network mental health and substance abuse care under the ValueOptions program.

Secondary plan
Under a coordination of benefits provision, the Plan that pays after the primary plan. If you are covered by your spouse's plan, your spouse's plan is secondary.

Urgent Care Claim
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.

APPENDIX A

This is a summary of benefits for your OAP Coinsurance plan. OAP is a Preferred Provider Organization. All deductibles and plan out-of-pocket maximums cross accumulate between in-network and out-of-network. Plan maximums and service-specific maximums (dollar and occurrence) cross-accumulate between in- and out-of-network. Pharmacy plan deductibles, out-of-pocket maximums, copays and annual maximums do not integrate with the employer medical program.

CIGNA HealthCare Benefit Summary
The J. Paul Getty Trust
Open Access Plus Plan (OAP)

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Lifetime Maximum	Unlimited	Unlimited
Coinsurance Levels	90%	70%
Calendar Year Deductible		
Individual	$250 per person Maximums cross accumulate	$450 per person Maximums cross accumulate
Family Maximum	$500 per family Maximums cross accumulate	$900 per family Maximums cross accumulate
Aggregate	Yes	Yes
Annual Out-of-Pocket Maximum		
Includes Deductible	No	No
Includes Copays	No	No
Individual	$1,000 per person Maximums cross accumulate	$3,000 per person Maximums cross accumulate
Family Maximum	$3,000 per family Maximums cross accumulate	$9,000 per family Maximums cross accumulate
Aggregate	Yes	Yes
Does not apply to: Benefits for accident or sickness (excludes mental health, alcohol and drug abuse benefits) are paid at 100% of charges once an individual's out-of-pocket has been reached.	Non-compliance penalties, deductibles and copays.	Non-compliance penalties, deductibles, copays or charges in excess of Reasonable and Customary
Physician's Services		
Primary Care Physician's Office visit	90% after deductible; 90% after deductible for x-ray/lab if billed by a separate outpatient diagnostic facility such as a hospital	70% after deductible
Specialty Care Physician's Office Visit *Office Visits* *Consultant and Referral Physician's Services*	90% after deductible; 90% after deductible for x-ray/lab if billed by a separate outpatient diagnostic facility such as a hospital	70% after deductible
Surgery Performed In the Physician's Office	90% after deductible	70% after deductible
Allergy Treatment/Injections	90% after deductible	70% after deductible
Preventive Care		
Routine Preventive Care for children birth through age 2 (including immunization) *Immunizations:*	100%, no calendar year deductible No charge	80%, no calendar year deductible
Adult Preventive Care *(Age 3 and over) – Includes Immunizations*	100%, no calendar year deductible	80%, no calendar year deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Routine Mammograms, PSA, Pap Smear	100%, no calendar year deductible	80%, no calendar year deductible
Second Opinions *(Services will be provided on a voluntary basis)*	90% after deductible; 90% after deductible for x-ray/lab if billed by a separate outpatient diagnostic facility such as a hospital.	70% after deductible
Outpatient Pre-Admission Testing *Charges Billed By Physician* *Specialist Physician's Office Visit* *Outpatient Hospital Facility* *Independent Xray and Lab Facility*	90% after deductible 90% after deductible; 90% after deductible for x-ray/lab if billed by separate outpatient diagnostic facility such as a hospital 90% after deductible 90% after deductible	70% after deductible 70% after deductible 70% after deductible 70% after deductible
Inpatient Hospital - Facility Services *Semi Private Room and Board* *Private Room* *Special Care Units (ICU/CCU)*	90% after plan deductible Limited to semi-private room negotiated rate Limited to semi-private room negotiated rate Limited to negotiated rate	70% after plan deductible Precertification required Limited to semi-private room rate Limited to semi-private room rate Limited ICU/CCU daily room rate
Outpatient Facility Services *Operating Room, Recovery Room, Procedure Room and Treatment Room*	90% after plan deductible	70% after plan deductible
Inpatient Hospital Physician's Visits/Consultations	90% after deductible	70% after deductible
Inpatient Hospital Professional Services *Surgeon* *Radiologist, Pathologist, Anesthesiologist*	90% after deductible 90% after deductible	70% after deductible 70% after deductible
Outpatient Professional Services *Surgeon* *Radiologist, Pathologist, Anesthesiologist*	90% after deductible 90% after deductible	70% after deductible 70% after deductible (covered expenses limited to 20% of the surgeon's allowable charge)
Emergency and Urgent Care Services *Physician's Office* *Hospital Emergency Room* *Urgent Care Facility or Outpatient Facility* *Ambulance*	 90% after deductible $50 copay, 90% after deductible $25 copay, 90% after deductible 90% after deductible	 90% after deductible $50 copay, 90% after deductible $25 copay, 90% after deductible 90% after deductible (except if not a true emergency, then 70% after deductible)
Inpatient Services at Other Health Care Facilities *Skilled Nursing Facility* Limited to 120 days per calendar year. No prior hospitalization required.	90% after deductible	70% after deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Laboratory and Radiology Services		
Other Laboratory and Radiology Services	90% after deductible	70% after deductible 70% after deductible
Outpatient Hospital Facility Independent Xray and/or Lab Facility	90% after deductible 90% after deductible	70% after deductible 70% after deductible
Outpatient Short-Term Rehabilitative Therapy and Chiropractic Services Limited to 90 visits Includes: Cardiac Rehab Physical Therapy Speech Therapy Occupational Therapy Chiropractic Therapy (includes Chiropractors)	90% after deductible	70% after deductible
Home Health Care Up to 120 visits per calendar year	90% after deductible	70% after deductible
Hospice		
Inpatient Services (limited to 6 months per lifetime)	90% after deductible	70% after deductible
Outpatient Services (limited to 6 months per lifetime)	90% after deductible	70% after deductible
Bereavement Counseling *Services provided as part of Hospice Care* (Limited to 3 Bereavement Counseling sessions per family per occurrence)	90% after deductible	70% after deductible
Maternity Care Services		
Initial Visit to Confirm Pregnancy	90% after deductible	70% after deductible
All Subsequent Prenatal Visits, Postnatal Visits, and Delivery	90% after deductible	70% after deductible
Delivery (Inpatient Hospital, Birthing Center)	90% after plan deductible	70% after plan deductible Precertification required
Abortion		
Non-Elective/Elective procedures		
Office Visit	90% after deductible	70% after deductible
Inpatient Facility	90% after plan deductible	70% after plan deductible Precertification required
Outpatient Surgical Facility	90% after plan deductible	70% after plan deductible
Physician's Services	90% after deductible	70% after deductible
Family Planning Services		
Office Visits (tests, counseling) *Maximum: subject to plan's Preventive Care dollar maximum*	90% after deductible	70% after deductible
Surgical Sterilization Procedure *for Vasectomy/Tubal Ligation (excludes reversals)*		
Inpatient Facility	90% after plan deductible	70% after plan deductible Precertification required
Outpatient Facility	90% after plan deductible	70% after plan deductible
Inpatient Physician's Services	90% after deductible	70% after deductible
Outpatient Physician's Services	90% after deductible	70% after deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Infertility Treatment *Coverage will be provided for the following services:* • *Testing and treatment services performed in connection with an underlying medical condition.* • *Testing performed specifically to determine the cause of infertility.* • *Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition).* *Services not covered include: In-vitro, Artificial Insemination, GIFT, ZIFT, etc.*		
Office Visit (tests, counseling)	90% after deductible Note: Charges billed by an independent Xray/Lab facility will be covered under the Plan's Independent Xray/Lab benefit	70% after deductible
Inpatient Facility	90% after plan deductible	70% after plan deductible
Outpatient Facility	90% after plan deductible	70% after plan deductible
Physician's Services	90% after deductible	70% after deductible
Organ Transplant *Includes all medically appropriate, non-experimental transplants*		Not Covered
Office Visit	90% after deductible	
Inpatient Facility	100% at Lifesource center , otherwise 90% after plan deductible	
Physician's Services	100% at Lifesource center; otherwise 90% after deductible	
Travel Services Maximum- only available for Lifesource facilities	$10,000	
Durable Medical Equipment *(unlimited)*	90% after deductible	70% after deductible
External Prosthetic Appliances *(unlimited)*	90% after deductible	70% after deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Dental Care *Limited to charges made for a continuous course of dental treatment started within six months of an injury to sound, natural teeth, hospital charges for room & board, and hospital charges for outpatient surgery.* *(Dental Care including but not limited to the following charges will be covered if there is an underlying medical need and the care is medically necessary)*		
Physician's Office	90% after deductible	70% after deductible
Inpatient Facility	90% after plan deductible	70% after plan deductible Precertification required
Outpatient Surgical Facility	90% after plan deductible	70% after plan deductible
Physician's Services	90% after deductible	70% after deductible
TMJ		
Surgical	90% after deductible; 90% after deductible for x-ray/lab if billed by a separate outpatient diagnostic facility such as a hospital.	70% after deductible
Physician's Office		
Inpatient Facility	90% after plan deductible	70% after plan deductible Precertification required
Outpatient Surgical Facility	90% after plan deductible	70% after plan deductible
Physician's Services	90% after deductible	70% after deductible
Non-Surgical	Not Covered	Not Covered
Routine Foot Disorders *(unlimited)*	90% after deductible	70% after deductible
Prescription Drugs *CIGNA Pharmacy Retail Drug Program* *Mandatory Generic, Formulary, Non-Formulary Plan* *Includes oral contraceptives and contraceptive devices* *Oral Fertility*	\$10 per 30-day supply for generic drugs \$25 per 30-day supply for Formulary \$40 per 30-day supply for Non-Formulary	\$10 per 30-day supply for generic drugs \$25 per 30-day supply for Formulary \$40 per 30-day supply for Non-Formulary
CIGNA Tel-Drug Mail Order Drug Program *Mandatory Generic, Formulary, Non-Formulary Plan* *Includes oral contraceptives and contraceptive devices*	\$20 per 90-day supply for generic drugs \$50 per 90-day supply for Formulary \$80 per 90-day supply for Non-Formulary	Not Covered

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Mental Health	Carved out to Value Options	Carved out to Value Options
Substance Abuse	Carved out to Value Options	Carved out to Value Options
Pre-existing Condition Limitation (PCL)	Applies to any injury or sickness for which a person receives treatment, incurs expenses or receives a diagnosis from a physician during the 90 days before the earlier of the date a person begins an eligibility waiting period or becomes insured for these benefits. Coverage for the pre-existing condition is excluded until one year of being continuously insured and/or is satisfying a waiting period. Usually the PCL is waived for the initial group, but if not, the insured will receive credit for any portion of the PCL waiting period that was satisfied under the previous plan if they are enrolled in the subsequent plan within 63 days (or the applicable timeframe required per state law).	
Pre-Admission Certification - Continued Stay Review ** CIGNA HealthCare PAC/CSR is not necessary for Medicare primary individuals.*	Standard Inpatient - Mandatory $250 penalty applied to hospital inpatient charges for failure to contact Intracorp to precertify admission (employee is responsible for contacting Intracorp) or for late notification. - 50% of charges reduction for any admission reviewed by Intracorp and not certified. - 50% of charges reduction (room and board) for any additional days not certified by Intracorp.	
Case Management	Coordinated by Intracorp. This is a service designated to provide assistance to a patient who is at risk of developing medical complexities or for whom a health incident has precipitated a need for rehabilitation or additional health care support. The program strives to attain a balance between quality and cost-effective care while maximizing the patient's quality of life.	

Benefit Exclusions (*by way of example but not limited to*):

Your plan provides coverage for medically necessary services. Your plan does not provide coverage for the following except as required by law:

1. Services that are not medically necessary;
2. Charges which the person is not legally required to pay;
3. Charges made by a hospital owned by or performing services for the U.S. government if the charges are directly related to a sickness or injury connected to military service;
4. Custodial services not intended primarily to treat a specific injury or sickness, or any education or training;
5. Experimental or investigational procedures and treatments;
6. Cosmetic surgery or therapy performed to improve appearance or self esteem unless: (a) a person receives an injury which results in bodily damage requiring surgery; (b) it qualifies as reconstructive surgery performed on a person following surgery, and both the surgery and the reconstructive surgery are essential and medically necessary; (c) it qualifies as reconstructive surgery following a mastectomy, includes surgery and reconstruction of the other breast to achieve symmetry.
7. Reports, evaluations, examinations, or hospitalizations not required for health reasons, such as employment, insurance or government licenses and court ordered forensic or custodial evaluations.
8. Treatment of the teeth or periodontium, unless such expenses are incurred for: (a) charges made for a continuous course of dental treatment started within six months of an injury to sound natural teeth; (b) charges made by a Hospital for Bed and Board or Necessary Services and Supplies; or (c) charges made by the outpatient department of a Hospital in connection with surgery.

9. Reversal of voluntary sterilization procedures, and certain infertility services;
10. Transsexual surgery and related services;
11. Treatment for erectile dysfunction. However, penile implants are covered when an established medical condition is the cause of erectile dysfunction;
12. Therapy to improve general physical condition;
13. Personal or comfort items such as personal care kits, television, and telephone rental in hospitals;
14. Eyeglasses, hearing aids or examinations and prescription fitting, except as provided in the Certificate;
15. Certain internal or external prostheses, or replacement of external prostheses due to wear and tear, loss, theft or destruction;
16. Surgical treatment for correction of refractive errors, includes radial keratotomy;
17. Prescription and non-prescription drugs, except as provided in the benefits section of the Certificate;
18. Amniocentesis, ultrasound, or any other procedures requested solely for sex determination of a fetus, unless medically necessary to determine the existence of a sex-linked genetic disorder;
19. Any injury resulting from, or in the course of, any employment for wage or profit;
20. Any sickness which is covered under any workers' compensation or similar law.
21. Charges for over the counter disposable or consumable supplies, includes orthotic devices.
22. Charges in excess of reasonable and customary limitations;
23. Charges for medical and surgical services intended primarily for the treatment or control of obesity which are not Medically Necessary. Excluded services include, but are not limited to, weight reduction procedures designed to restrict your ability to assimilate food, such as gastric bypass, gastric balloons, jaw wiring, stomach stapling and jejunal bypass.

This chart summarizes the benefit plan you requested; it has not been adjusted to reflect state benefit mandates. A complete description of the terms of the coverage, exclusions and limitations, including legislated benefits (if applicable), will be provided in your Certificate or Summary Plan Description.

Benefits are insured and/or administered by Connecticut General Life Insurance Company.

"CIGNA HealthCare" refers to various operating subsidiaries of CIGNA Corporation. Products and services are provided by these subsidiaries and not by CIGNA Corporation. These subsidiaries include Connecticut General Life Insurance Company, CIGNA Vision Care, Inc., Tel-Drug, Inc. and its affiliates, CIGNA Behavioral Health, Inc., Intracorp, and HMO or service company subsidiaries of CIGNA Health Corporation and CIGNA Dental Health, Inc. "CIGNA Tel-Drug" refers to Tel-Drug, Inc. and Tel-Drug of Pennsylvania, L.L.C., which are also operating subsidiaries of CIGNA Corporation.