

NYU Dental Assistance Plan

2007

Summary Plan Description

Participants

Faculty

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Introduction

This summary plan description (SPD) provides a concise overview of dental coverage available for you and your eligible dependents through New York University.

While this SPD contains detailed and important information about your benefit plans, every attempt has been made to communicate that information clearly and in easily understandable terms.

Benefits are determined under the terms of the plan in effect at the time you become eligible for the benefits in question. NYU reserves the right to discontinue or change the Dental Assistance Plan at anytime. The plan is not an employment contract or any type of employment guarantee.

In the event of a discrepancy between this SPD and the plan document, the plan document will govern.

The NYU Dental Assistance Plan, administered by MetLife, provides you with benefits for dental care and other services necessary for proper care of teeth. It covers a wide range of services and pays most benefits based on a Schedule of Covered Dental Procedures.

Under this plan, you may receive treatment from any dentist you wish. You must submit expenses to MetLife for payment.

You will need to satisfy the requirements described in this SPD to receive NYU Dental Assistance Plan coverage.

Eligibility

Employees

You are eligible for NYU Dental Assistance Plan coverage if you are:

- a full-time member of the Faculty

Your waiting period is three months from your date of hire or the date you move into a benefits eligible position if later.

Eligible Dependents

You can cover certain dependents under NYU Dental Assistance Plan coverage. You're required to provide proof of relationship of your dependents if you elect to cover them under the plan. This may include a copy of one of the following: marriage certificate, approved NYU statement of domestic partnership form, birth certificate that shows the names of both the parent and the child, final adoption papers, legal documentation substantiating placement for adoption, a court order (from a court of competent jurisdiction) showing legal guardianship, permanent or temporary custody. Your eligible dependents are any of the following:

- your legal spouse
- your domestic partner whom you registered with the NYU Benefits Office
- your unmarried, dependent child under age 19
- your unmarried, dependent child over age 19, up to age 25, if a full-time student at an accredited educational institution
- your unmarried, dependent child over age 19 if mentally or physically disabled

Your dependent children include:

- your natural child
- your stepchild
- your registered domestic partner's child
- your legally adopted child (or child placed with you for legal adoption)
- a child for whom you have been appointed legal guardian by a court of competent jurisdiction
- a child for whom you have been given temporary or permanent custody under an order issued by a court of competent jurisdiction

Your newborn child is eligible for coverage at birth.

In the case of an adoption, a child becomes eligible for coverage when the child is placed in your home or the adoption is final.

In order to obtain coverage for your new child you must enroll the child within 31 days of the date the child is placed in your home, the date the adoption is final, the date that you have been appointed legal guardian or the date you were awarded temporary or permanent custody.

In the case of temporary custody, you will be required to submit either another order which extends the period of temporary custody or an order of permanent custody in order for the child's coverage to remain in effect.

If both you and your spouse or registered domestic partner work for NYU, and are both eligible for the plan through NYU, only one of you can cover your child as a dependent under one plan. Both of you cannot cover your child at the same time. Also, your child has to meet the eligibility requirements.

If both you and your spouse or registered domestic partner work for NYU, you can cover your spouse or partner as a dependent under your plan or your spouse or partner can elect separate employee coverage. You and your spouse or partner cannot be covered as both an employee and as a dependent under a medical or dental plan through NYU.

Qualified Medical Child Support Order (QMSCO)

You or your dependents can obtain a description of procedures for Qualified Medical Support Order determinations at no charge from the NYU Benefits Office.

Enrollment

Enrolling in the plan

You enroll in the plan by completing the enrollment form found in your new hire enrollment kit or online at the NYU Benefits Resource Center web site. Coverage for yourself is automatic. You must enroll any dependents you want to cover within 31 days of your eligibility date. After that, you can change your dependent coverage during open enrollment, or if you have a qualifying status change. See **Life Events** for more details.

When you enroll in the NYU Dental Assistance Plan there are 4 levels of coverage from which to choose:

- yourself only
- yourself and your child or children
- yourself and your spouse (or registered domestic partner)
- yourself and your family

You're required to provide proof of relationship of your dependents if you elect to cover them under the NYU Dental Assistance Plan. This may include a copy of one of the following: marriage certificate, approved NYU statement of Domestic Partnership, birth certificate that shows the names of both the parents and the child, final adoption papers, and documentation substantiating placement for adoption, legal guardianship or custody.

Because coverage for you is provided at no cost, you may not waive coverage for yourself under the NYU Dental Assistance Plan.

When coverage begins

NYU Dental Assistance Plan coverage will start immediately after you satisfy the waiting period.

If you have a qualifying status change or other cause for a change in election and become eligible for coverage during the plan year, your NYU Dental Assistance Plan coverage will start on the date of the event as long as the waiting period is satisfied.

If you become eligible for the plan because you move into a position which makes you eligible for coverage under the plan, any service with NYU counts toward meeting the plan's waiting period.

If you are disabled and away from work on the date your coverage would normally take effect, your coverage will not take effect until you return to work and you work for one day. Note: This rule also applies if the plan is improved and your coverage is increased while you are away from work.

Making changes

You may change your NYU Dental Assistance Plan coverage election during the year if you have a qualifying status change; otherwise, you may only make changes during open enrollment.

Life events

If you have a qualifying status change, you can change your existing NYU Dental Assistance Plan coverage or enroll in coverage for the first time. Any change in election due to a qualifying status change must be consistent with the qualifying status change. You must make changes to your coverage within 31 days of your qualifying status change. The following is a list of events that are each considered to be a qualifying status change:

- your marital status changes (or you register or revoke a domestic partnership)
- you increase or decrease your number of dependents (birth, death, adoption or placement for adoption, guardianship, permanent or temporary custody)
- your dependent child is no longer eligible for coverage according to the terms of the plan(s) (exceeds age 19 or 25 if a full-time student or marries)

- a court decree that orders you must provide health coverage for your dependent
- your or your dependent's work site changes
- your or your dependent's residence changes
- your dependent's Medicare/Medicaid eligibility status changes
- your spouse's/partner's employer's plan has a different plan year and open enrollment period than NYU's
- coverage under your spouse's/partner's plan is significantly curtailed or ceases
- your spouse's/partner's employer adds new health plan options
- NYU adds new health plan options
- you or your spouse/partner commence or return from an FMLA leave

Changes you make after a qualifying status change become effective on the date of the event as long as you have satisfied the waiting period.

Special enrollment rules

If you become eligible for the plan because you move into a position which makes you eligible for coverage under the plan, any service with NYU counts toward meeting the plan's waiting period.

Open enrollment

You may change your NYU Dental Assistance Plan election once each year during open enrollment, except as provided in the **Life events** section.

During the open enrollment period, you may do any of the following:

- drop dependent coverage
- elect to cover eligible dependents

All changes in NYU Dental Assistance Plan coverage made during open enrollment will become effective on the first day of the new **plan year**. If you do not make an election during open enrollment, your dental coverage will stay the same.

Cost

Cost of coverage

The University pays for your dental coverage. You pay a portion of the cost for coverage for your dependents through pre-tax salary reductions.

If you elect NYU Dental Assistance Plan coverage for your domestic partner, you will be responsible for the imputed income tax. The University's contribution toward domestic partner coverage will, in most cases, be considered imputed income and will be taxable income to you.

Pre-tax salary reduction

You pay your portion of the cost of coverage for your dependents through pre-tax salary reductions. This means that contributions are taken from your paycheck before applicable federal, New York State, and New York City taxes are withheld. Log on to the NYU Benefits Resource Center web site for the current cost of coverage for your dependents.

How the plan works

Deductible

The annual deductible is the amount of money you must pay each calendar year for covered dental care before the plan begins to pay benefits. There is no deductible for preventive and diagnostic services. Under NYU Dental Assistance Plan, you are subject to an annual deductible. The plan has both individual and family deductibles. Deductible amounts are based on the level of coverage you elect.

Individual deductible

The individual deductible applies to each covered person. Once you meet the individual deductible, the plan begins paying benefits. The individual deductible under NYU Dental Assistance Plan is \$50 per calendar year.

Family deductible

Three family members covered under the plan must meet the individual deductible to satisfy the family deductible. The family deductible under NYU Dental Assistance Plan is \$150 per calendar year.

Common accident

In the event of an accident: If two or more covered family members are injured in the same accident, only one deductible will have to be paid for treatment of all family members' injuries which result from that accident for that calendar year and again in the next year.

Plan Benefit

Under this plan, you may receive treatment from any dentist you wish. You must submit expenses for payment. Some dental expenses are covered in full while others are reimbursed according to a schedule of benefits up to the annual benefit maximum. See **Appendix A** for the Dental Schedule of the current year's reimbursement amounts.

Type of service	Plan pays
Diagnostic and Preventive	100% of reasonable and customary charges (R&C)
Corrective and Restorative	Based on the fee schedule, after deductible
Periodontal	Based on the fee schedule, after deductible, up to the lifetime maximum
Orthodontia	Based on the fee schedule, after deductible, up to the lifetime maximum

Reasonable and customary amounts

Reasonable and customary (R&C) amounts are typical fees for services, treatments or supplies charged by most providers with similar training and experience in the same geographic area. To determine the R&C amount for a particular service, the claims administrator reviews charges submitted by providers in your location. R&C amounts are updated periodically.

Alternate benefits

There may be more than one way to treat a dental problem. If, in MetLife's view, an adequate method or material which costs less could have been used, the dental expense benefits will be based on the method

or material which costs less. The rest of the cost will not be a covered dental expense. Alternate benefits apply to all dental services. Some examples of alternate benefits are:

Inlays, Onlays, Crowns, and Gold Foil:

If a tooth can be repaired by a less costly method than an inlay, onlay, crown, or gold foil, benefits will be based on the adequate method of repair which costs the least.

Crowns, Pontics, and Abutments:

Veneer materials may be used for front teeth or bicuspid. However, benefits will be based on the adequate veneer materials which cost the least.

Bridgework and Dentures:

Benefits will be based on the adequate method of treating the dental arch which costs the least. In some cases, removable dentures may serve as well as fixed bridgework. If dentures are replaced by fixed bridgework, the benefits will be based on the cost of a replacement denture unless adequate results can only be achieved with fixed bridgework.

Annual benefit maximum

The benefit maximum is the maximum dollar amount NYU Dental Assistance Plan will pay for expenses you incur. The benefit maximum is based on the type of dental service you receive and the time frame covered. The maximum is \$2,000 per person per calendar year. Orthodontia, periodontal and TMJ expenses are credited toward the annual maximum.

Expenses that do not count toward the benefit maximum include:

- charges for services not covered by the plan
- charges over the reasonable and customary amounts

Refer to the **Expenses not covered** and the **Reasonable and customary** sections for more information.

Lifetime maximum

The lifetime maximum benefit is the limit the plan will pay in each covered person's lifetime. The lifetime maximum per person for NYU Dental Assistance Plan is:

- Orthodontics: \$1500
- Periodontics: \$2500
- Temporomandibular Joint Syndrome (TMJ) - non-surgical treatment only: \$1500

Requirements of precertification

You do not need to obtain precertification under the NYU Dental Assistance Plan. However, you may wish to obtain a pre-treatment estimate if your dental bill is expected to be over \$300. See pre-treatment estimate under How to File a Claim.

Covered Expenses

Covered expenses

NYU Dental Assistance Plan covers the following services:

Diagnostic and Preventive

- cleanings, scalings, and polishings - twice each calendar year
- fluoride treatments - twice each calendar year

- full mouth x-ray - once every 36 months
- routine oral exams - twice each calendar year
- sealants for children to age 19 (limit once every five years), permanent molars only
- space maintainers
- supplemental x-rays - twice each calendar year

Corrective and Restorative

- bridges
- crowns
- denture repair
- dentures
- fillings
- general anesthesia - covered with three or more routine extractions (unless two routine extractions are in different quads), or for two or more surgical extractions
- inlays
- onlays
- oral surgery
- orthodontia
- prosthodontics
- re-cement crowns
- root canal therapy
- temporomandibular joint syndrome (TMJ) - non-surgical treatment only
- tooth extractions

Periodontal

- gingivectomy
- periodontal cleaning and periodontal surgery
- root planing

Orthodontia

NYU Dental Assistance Plan will cover orthodontic expenses incurred for corrective treatment of maloccluded or malpositioned teeth by means of an active appliance. The plan does not cover the installation of a space maintainer or a surgical procedure to prevent malocclusion (abnormal coming together of the teeth). Orthodontic benefits are available to you and your eligible dependents. There is a lifetime maximum benefit for orthodontia.

The date your NYU Dental Assistance Plan coverage became effective will be considered the date orthodontic treatment is started. That means that if orthodontic work started prior to your NYU Dental Assistance Plan effective date and is continuing after your NYU plan effective date, payment for orthodontia for you or your covered dependent would commence after NYU's effective date and reimbursement would only be for whatever months of orthodontia treatment are remaining. MetLife will pro-rate the remaining months and the remaining fee charged.

Temporomandibular joint syndrome

NYU Dental Assistance Plan will cover non-surgical treatment of TMJ. There is a lifetime maximum benefit for temporomandibular joint syndrome.

Refer to the **Definitions** section for a list of definitions for covered services.

Out-of-area care

Dental coverage is in effect if you obtain services outside of the country. You may be required to submit a translation of the bill and the original bill for services with your claim form.

Expenses not covered

NYU Dental Assistance Plan does not cover the following:

- a service or supply which is for orthodontic treatment, except as specifically provided
- adjustment of a denture or bridgework which is made within six months after installation
- any appliance, service, or supply which was not ordered while the person was covered
- any exclusion listed here will not apply if: coverage is specifically provided by name in this booklet; or coverage of the charges is required under any law that applies to the coverage
- any service or supply for which any other dental benefit is paid in whole or in part under this plan or under any other plan sponsored by NYU
- charges covered by a Workers' Compensation Act or similar federal or state legislation
- charges for any duplicate appliance or prosthetic device
- charges for broken appointments with your dental provider
- charges for care, treatment, services, or supplies that are not prescribed, recommended, or approved by the individual's dentist or attending physician
- charges for completing forms
- charges for dental preventive services and supplies, except as specifically provided
- charges for oral care instruction, such as hygiene or diet
- charges for procedures, services, drugs, and other supplies that are, as determined by MetLife, experimental or still under clinical investigation by health professionals
- charges for sealants except as specifically provided
- charges for services and supplies which improve, alter, or enhance appearance
- charges for services and supplies which: are received before coverage under the NYU Dental Assistance Plan begins; are not necessary, as determined by MetLife, for the diagnosis, care, or treatment of the physical condition involved (this applies even if they are prescribed, recommended, or approved by the dentist or attending physician; any school system is required to provide under any law)
- charges for splinting
- charges related to an occupational disease or injury, whether or not covered by Workers' Compensation
- charges that a covered individual is not legally obliged to pay
- charges that are made only because coverage exists
- charges that MetLife determines are not reasonable
- first installation of dentures or fixed bridgework to replace congenitally missing teeth or to replace teeth all of which were lost while the person was not covered (this includes inlays and crowns as abutments)
- occupational injuries
- personalization or characterization of dentures
- services or supplies provided by a family member
- surgical procedures to correct temporomandibular joint dysfunction (TMJ)
- the repair or replacement of an orthodontic appliance

- the replacement of a lost, missing, or stolen crown, bridge, or denture
- to the extent allowed by law of the jurisdiction where the group contract is delivered, charges for services and supplies: furnished, paid for, or for which benefits are provided or required by reason of the past or present service of any individual in the armed forces of a government; furnished, paid for, or for which benefits are provided or required under any law of government (this does not include a plan established by a government for its own employees or their dependents or Medicaid)
- treatment by someone other than a dentist or physician licensed to do the dental work being performed (but the plan will cover some treatments by a licensed dental hygienist that are supervised by a dentist, including scaling of teeth, cleaning of teeth, and topical application of fluoride)

Note: In determining benefits under any portion of this plan, the amount of any such charges which are covered under that portion of this plan will not be included as part of an individual's expenses; no benefits are payable if the provision of such benefits is prohibited by any law of the jurisdiction in which the individual resides at the time the benefit liability is incurred.

Filing a claim

How to file a claim

You or your dentist must submit a completed claim form to receive plan benefits. Each claim should include:

- the name of the person receiving the service
- a description of the service provided, including the dates of service

You have 12 months to file a claim after service has been provided. You can obtain claim forms online at the NYU Benefits Resource Center web site or <https://mybenefits.metlife.com> or by contacting the NYU Benefits Office.

You can have benefits paid to you or directly to your dentist. To have the benefits paid to your dentist, sign the assignment section of the claim form.

If you participate in the Health Care Flexible Spending Account, MetLife will automatically forward your processed claim information to UnitedHealthcare. UnitedHealthcare will then process this information and, if applicable, reimburse your out-of-pocket dental expense from your Health Care Flexible Spending Account.

Please refer to <https://mybenefits.metlife.com> for services that you need. MyBenefits is a web site to help you manage your dental benefits. Once you've logged on, you can:

- View a list of your covered dependents and have quick links to their coverage description, so you know what procedures are covered before going to the dentist
- Track claims online and receive email alerts when a claim has been processed
- Download a claim form

Pre-treatment estimate

If a dental bill is expected to be \$300 or more, you can find out the maximum amount the plan will pay for the expense, before your dentist begins treatment. To do so, ask your dentist to submit a pre-treatment plan using a regular claim form. The plan should include the procedure to be performed, the cost of the

procedure, and supporting X-rays and other records. Send the form to the address shown on the form. MetLife will review the claim and determine the maximum amount the plan will pay.

Note: Pre-treatment estimates of benefits does not apply for emergency treatment, routine oral exams, X-rays, cleaning and scaling, and fluoride treatments, or dental services which are expected to cost less than \$300.

Coordination of benefits

If you or a covered dependent is covered by another dental plan, the NYU Dental Assistance Plan has a coordination of benefits feature to prevent duplication of benefit payments.

Coordination of benefits allows the plans to work together to cover eligible expenses. The plan that has the first obligation to pay is called the "primary plan;" the other plan is called the "secondary plan." Typically, a secondary plan will pay when its benefit is more generous than the primary plan.

A participant may be covered as a dependent under two or more plans. Certain rules govern which plan is primary and which is secondary. Those rules follow this order:

- A plan that has no coordination of benefits provision will be primary to a plan that does have a coordination of benefits provision.
- The plan of the participant whose birthday falls earlier in the calendar year is primary before the plan of the participant whose birthday falls later that year (based on month and day only).
- If both participants have the same birthday, the plan covering the person for the longest time is considered primary before the plan that covers the other person.
- If the other benefit plan doesn't have the rules described above, but instead has a rule based on the participant's gender, and if as a result the plans don't agree on the order of the benefits, the rule in the other benefit plan will determine the order of the benefits.

A participant may be covered as a dependent under two or more plans of divorced or separated parents. The following rules determine which plan is primary and which is secondary:

- If the other benefit plan doesn't have the rules described above, but instead has a rule based on the participant's gender, and if as a result the plans don't agree on the order of benefits, the rule in the other benefit plan will determine the order of benefits.
- If the parent with custody has remarried, the order of payment is the plan of the parent with custody will pay first, followed by the plan of the stepparent with custody, and followed by the plan of the parent without custody.
- If there is a court decree giving one parent financial responsibility for the medical, dental or other health expenses of the dependent child, this parent's plan will be primary to any other plan that covers the dependent child.
- If none of these rules apply, the plan that has covered the person for the longest time will be primary to all other plans.

Under coordination of benefits, if the NYU plan is the secondary payer, the NYU plan will pay the difference between the total covered charges and the amount the primary plan paid. The total payments of both plans can't be more than 100% of the covered expenses. The benefits paid by the NYU plan can't be more than the amount the plan would have paid if there was no other coverage, but together with the primary plan, most - if not all - of the covered expense may be paid.

Notification and explanation of benefits

You will receive a detailed statement called an **explanation of benefits** (EOB). The EOB will explain the amounts that have been paid and what amounts have not been paid. The EOB will explain the reason why

a claim has not been paid. An EOB will be sent within the following timeframes from the receipt of your claim:

- within five to 10 working days via email or paper, or you can go to <http://mybenefits.metlife.com> to view or download your Explanation of Benefits

About your coverage

If you leave the University

Your NYU Dental Assistance Plan coverage ends at the end of the month following the date in which you terminate from the university. At that time, you will be eligible for COBRA continuation coverage (refer to the **COBRA** section for more information).

Coverage when you are not working

Taking a leave of absence affects your NYU Dental Assistance Plan coverage. The impact depends on the type of leave that you take.

Leave of absence	How your coverage is affected
Family leave Maternity leave Disability leave	Coverage continues at your current contribution rate.

If you die while employed

If you die while employed by the University, your surviving dependents may be eligible for COBRA continuation of coverage which allows your dependents to continue coverage for up to 36 months. Refer to the **COBRA** section for more information.

If the University ends the benefit

The University has established the plan with the bona fide intention and expectation that it will be continued indefinitely, but the University shall not have any obligation whatsoever to maintain the plan for any given length of time, and may at any time amend or terminate the plan, in whole or in part, with respect to any or all of its participants and/or beneficiaries. Any such amendment or termination shall be effected by a written instrument signed by an officer of New York University, or an authorized delegate. No vested rights of any nature are provided under the plan.

When coverage ends

Your NYU Dental Assistance Plan coverage ends on any one of the following:

- the day before the day your coverage begins under another NYU Dental Assistance Plan option
- the day before the first day of any month for which you fail to make your contribution for the cost of coverage under the plan
- the day the plan ends
- the last day of the month in which you no longer meet eligibility requirements
- the last day of the month in which your employment with NYU terminates
- your date of death

Your spouse's coverage ends when any one of the following occurs:

- the day before the first day of any period for which you fail to enroll your dependents for coverage under the plan
- the day your dependent's coverage under the plan ends due to a qualifying status change
- the last day of the month in which you die
- the day before the day on which your dependent becomes an employee of NYU and is eligible for dental coverage under the NYU Dental Assistance Plan
- the day dependent coverage under this plan ends

Your dependent child's coverage ends on:

- the day before the first day of any period for which you fail to enroll your dependent for coverage under the plan
- the day your dependent's coverage under the plan ends due to a qualifying status change
- the last day of the month in which you die
- the day before the day on which your dependent becomes an employee of NYU and is eligible for dental coverage under the NYU Dental Assistance Plan
- the day dependent coverage under this plan ends

Extended benefit coverage

If coverage under the plan ends, expenses incurred after coverage ends will be covered for:

- A prosthetic device, if your dentist prepared the abutment teeth and made impressions while you were covered under the plan;
- A crown, if your dentist prepared the tooth for the crown while you were covered under the plan;
- and
- Root canal therapy, if your dentist opened the tooth while you were covered under the plan.

Note: This special rule applies only if the item is finally installed or delivered no more than 90 days after coverage ends.

COBRA

This section is intended to comply with the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 as amended, which requires continuation of dental coverage to certain eligible employees whose coverage would otherwise terminate. If this section is incomplete or in conflict with the law, the terms of the law will govern.

Continuation of coverage

You and your covered dependents may continue your current dental coverage if it ends because of one of the following:

- you voluntarily leave NYU
- the number of hours you are scheduled to work are reduced below those required for you to be eligible for benefits
- you are terminated for any reason other than gross misconduct

COBRA coverage also is available to your covered dependents if their coverage would otherwise end because of one of the following:

- your death
- your divorce, legal separation or annulment of your marriage

- a change in your employment status that results in a loss of benefits eligibility
- your dependent child becomes ineligible for coverage

COBRA coverage continues for up to 18, 29 or 36 months, depending on how you or your covered dependents become eligible. If you elect to continue coverage under COBRA, you are required to pay 102% of the cost of coverage in after-tax dollars. If you are disabled as determined by the Social Security Administration, you may elect to continue COBRA for up to 29 months and pay 102% of the cost for coverage.

Length of COBRA coverage	Reason coverage stops
18 months	Your employment ends You transfer to part-time or limited-hour status
29 months	The Social Security Administration determines that you or your dependent was permanently disabled at any time within the first 60 days of continuation coverage. You or your dependents provide notice of the Social Security Administration's determination within 60 days of receiving it.
36 months (for dependents)	You die You become entitled to Medicare Your dependent stops being eligible for coverage You divorce or legally separate

Electing COBRA

You and your covered dependents will receive election forms and more information about COBRA from EBPA, the COBRA billing administrator for New York University. In the case of a divorce, legal separation, annulment of your marriage or the ineligibility of a dependent child, you or your covered dependents must notify the NYU Benefits Office within 60 days of becoming eligible to elect COBRA.

If you wish to elect COBRA coverage, you must do so no later than 60 days after the date your University coverage ends or 60 days after the date of the notice of COBRA rights and your election is mailed to you by EBPA, whichever is later. You must pay any cost necessary to avoid a gap in coverage within 45 days of the date you elect COBRA.

If you elect COBRA coverage and the Social Security Administration determines that you or your covered dependent was permanently and totally disabled at any time within the first 60 days of the date of continuation coverage, you or your covered dependent must notify EBPA within 60 days of the determination. The notice must be received by EBPA within the initial 18 months of COBRA coverage so that you and your covered dependents can qualify for an additional 11 months of coverage.

If a 36-month event happens while a dependent is covered under COBRA, COBRA coverage may be continued for the dependent for another 18 months - up to a total of 36 months.

Required notices from qualified beneficiaries

To elect COBRA continuation coverage, you or your covered dependents are required to notify the NYU Benefits Office in writing within a maximum of 60 days after any of the following qualifying events:

- your divorce or legal separation
- your dependent child becomes ineligible for coverage

If you have elected continuation, you or your covered dependents are also required to notify EBPA in writing within a maximum of 60 days after any of the following:

- a second qualifying event such as divorce, legal separation, death or dependent child ceasing to be a dependent, or Medicare entitlement
- Social Security Administration determination of disability
- Social Security Administration determination of cessation of disability

The notification must include:

- name
- relationship to the employee
- a description of the qualifying event

When COBRA ends

COBRA coverage ends when one of the following events occurs:

- the COBRA period - 18, 29 or 36 months - ends
- premiums are not made on a timely basis
- NYU terminates the plan or amends the plan to eliminate coverage and does not provide any other group dental plans to employees
- the person who elected COBRA becomes covered under another group dental plan and meets any pre-existing condition prohibitions or limitations

Administrative information

The information presented in this summary plan description is intended to comply with the disclosure requirements of the regulations issued by the U.S. Department of Labor under the Employee Retirement Income Security of 1974 (ERISA).

If there is any inconsistency between the SPD and the plan document, the plan document governs.

If a claim is denied or reduced

In the event the claim for benefits has been denied in whole or in part, you can request a review of the adverse benefit determination at no cost to you. This request for review must be sent to MetLife, Group Claims Review, P.O. Box 14589, Lexington, KY 40512, within 180 days of the date you received notice of the adverse benefit determination. When requesting a review of an adverse benefit determination, please state the reason you believe the claim for benefits was improperly denied, and whether you are requesting

a first or second review. You may submit any comments, questions, documents, or information you deem appropriate.

How the plan will handle your appeal

MetLife will review your claim within 30 days of receipt and provide you with a written or electronic explanation of our benefit determination in a manner you can understand.

Your claim for benefits will receive a full and fair review involving someone other than the person who initially made the adverse benefit determination or their subordinate. In deciding an appeal of any adverse benefit determination that is based in whole or in part on a dental judgment, MetLife shall consult with a health care professional with appropriate training and experience. You have the right to request copies of all documents, records, and other information MetLife used in evaluating your claim at no cost to you. If an internal rule, guideline or other similar criterion was relied upon in making the adverse benefit determination, upon request MetLife will provide you with a copy free of charge. If the adverse benefit determination was made based on a lack of dental necessity or due to an experimental treatment or other similar exclusion or limit, upon request MetLife will provide an explanation of the scientific or clinical judgment for the adverse benefit determination free of charge.

If MetLife denies your first appeal in whole or in part, you may request a second level appeal and MetLife will respond to that request within a 30 day time period. At the end of the second level appeal, if you are not satisfied with our decision you may have rights under Section 502 (a) of ERISA to bring a civil action if you so desire. Your state may have additional internal appeal and/or external review processes available to you to resolve disputes. Additionally, you and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory Agency.

Right of recovery

If a benefit is paid that is larger than the amount allowed by the NYU Dental Assistance Plan, the plan has a right to recover the excess amount from the person or agency who received it. The insurance company must produce any instruments or papers necessary to ensure the right of recovery, unless prohibited by law, and present them to the person receiving benefits.

Assignment of benefits

When you file a claim, you can assign benefit payments to the service provider.

Conversion rights

If you or your covered dependents do not elect COBRA, your coverage will end. You cannot convert the coverage to an individual policy.

ERISA rights

As a participant in NYU Dental Assistance Plan, you are entitled to certain rights and protections under ERISA. ERISA entitles you to:

- examine, at the plan administrator's office and other specified locations, including work sites and union halls, if applicable, without charge, all plan documents governing the plan. These documents may include insurance contracts, collective bargaining agreements, if applicable and 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, after sending a written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, if appropriate, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. You may be asked to pay a fee for the copies.
- receive a written summary of the plan's annual financial report. The plan administrator is required by law to provide each participant with a copy of this summary annual report.

- continue dental coverage for yourself, spouse or 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.
- reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group dental plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group dental plan or dental insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, or when your COBRA continuation coverage ceases, if you request COBRA continuation coverage before losing coverage or up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

In addition to creating rights for plan participants, ERISA imposes duties on the people responsible for the operation of the plan. The people who operate your plan, called "fiduciaries," have a duty to do so prudently and in the best interest of you and other plan participants and beneficiaries. No one, including your employer, your union 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.

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 of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are several steps you can take to enforce your rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive it within 30 days, you may file a suit in 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 administrator's control.

If you have a claim for benefits that 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 of decision about the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If 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 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 sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees if, for example, it finds your claim is frivolous.

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

Subrogation

If you receive reimbursement from a third party for covered expenses as a result of legal action taken to recover your loss, which was due to negligence, wrongful acts, or omissions, Plan Administrator reserves the right to repayment of benefits paid for the same covered expenses.

In addition, if you or your covered family member suffers an injury or sickness as a result of a negligent or wrongful act or omission, Plan Administrator reserves the right to seek reimbursement (where permitted

by law) from that third-party for benefits it paid for covered expenses. In such case, you are obligated to provide Plan Administrator with any information necessary to enforce its rights under this provision.

Plan sponsor

New York University
c/o NYU Benefits Office
7 East 12th Street, 2nd Floor
Campus Mail Code: 8923
New York, NY 10003
(212)998-1270 (M-F 9am-5pm)
Email: benefits@nyu.edu

Plan name

NYU Dental Assistance Plan, a component of the New York University Health and Welfare Plan

Type of administration

Third Party Administration

Plan administrator

The plan administrator has the authority to control and manage the operations and administration of each plan. You can reach the administrator at:

Metropolitan Life Insurance Company
P. O. Box 981282
El Paso, TX 79998-1282
Phone: (800) 942-0854
Web site: <https://mybenefits.metlife.com>

Employer identification number (EIN)

The EIN is 13-5562308.

Plan number

The plan number is 84542.

Plan year

January 1 through December 31

Source of benefits funding

NYU and you pay the cost.

Agent for service of legal process

Office of Legal Counsel
New York University
Elmer Holmes Bobst Library

11th Floor
70 Washington Square South
New York, NY 10012

Claims administrator

Metropolitan Life Insurance Company
P. O. Box 981282
El Paso, TX 79998-1282
Phone: (800) 942-0854
Web site: <https://mybenefits.metlife.com>

Contacts

For appealing a claim

Metropolitan Life Insurance Company
P. O. Box 981282
El Paso, TX 79998-1282
Phone: (800) 942-0854
Web site: <https://mybenefits.metlife.com>

For claim forms

NYU Benefits Resource Center web site: www.home.nyu.edu, or
MetLife: <https://mybenefits.metlife.com>, or
New York University
C/O NYU Benefits Office
7 East 12th Street, 2nd Floor
Campus Mail Code: 8923
New York, NY 10003-4475
Phone: (212) 998-1270 (M-F 9am-5pm)
Email: benefits@nyu.edu

Issues with claims

Metropolitan Life Insurance Company
P. O. Box 981282
El Paso, TX 79998-1282
Phone: (800) 942-0854
Web site: <https://mybenefits.metlife.com>

For COBRA coverage

EBPA
P.O. Box 1150
Exeter, NH 03833-1150
(800) 258-7298 press "2"
or
New York University
C/O NYU Benefits Office
7 East 12th Street, 2nd Floor
Campus Mail Code: 8923
New York, NY 10003-4475
Phone: (212) 998-1270 (M-F 9am-5pm)
Email: benefits@nyu.edu

For sending a completed claim

Metropolitan Life Insurance Company

P. O. Box 981282

El Paso, TX 79998-1282

Phone: (800) 942-0854

Web site: <https://mybenefits.metlife.com>

The following terms are highlighted throughout the SPD as having definitions. In this section, you will find the definitions for these terms to help clarify their meaning and to provide information to better help you understand the provisions of your benefit plans.

Definitions

After-tax premium deductions

Contributions taken from your pay after applicable federal, state and local taxes are withheld.

Bitewing

The dental X-ray showing the crown portions of the upper and lower teeth.

Bridge

A strong connecting link between two or more teeth, replacing a missing tooth or teeth.

Crown

(cap)

A porcelain or gold tooth cover for a decayed, damaged, brittle or discolored tooth that has a strong base and roots.

Deductible

The amount of out-of-pocket expenses you must pay for service before the plan pays any expenses.

Dentures

Removable, artificial teeth to help you chew, restore your bite and improve your appearance.

Disability

A condition that causes you to be unable to perform one or more regular job duties.

Domestic partners

Two people who:

- agree to be jointly responsible for each other's common welfare and to share financial obligations
- live together in a long-term relationship of indefinite duration
- are not related by blood to a degree of closeness which would prohibit legal marriage in the state in which they legally reside

To apply for coverage for your domestic partner, register your domestic partner with the NYU Benefits Office.

Effective date

The earliest of:

- the date coverage begins
- the first day after the plan's waiting period

Employee

A person the University hires to do a job or activities that are controlled by the University (when, where and how to do the job).

Endodontics

The care of the pulp chambers and root canals of your natural teeth; it usually involves sterilization and filling.

Explanation of benefits

A statement you receive from your plan whenever you file a claim, giving specific details about how and why benefit payments were or were not made. It summarizes the charges submitted and processed, the amount allowed, the amount paid and the balance, if any.

Fluoride

A natural substance found in minerals that works with your tooth or bone structure to make it stronger and more resistant to acid decay.

Full-time

Employees who are scheduled to work for the University for the full, normal work week.

Gingivectomy

The surgical removal of the flaps of gum tissue that create pockets alongside teeth that have periodontal damage, designed to stop periodontal disease.

Group health coverage

Health plans designed to provide benefits to a specific group of people, like a University, union or professional organization.

Inlay

A cast, precious metal filling to help restore and strengthen a tooth.

Orthodontia

The branch of dentistry that deals with detecting, preventing and correcting abnormalities between teeth.

Part-time

Employees who are scheduled to work less than the normal work week.

Periodontics

The treatment of the supporting structure of the tooth - the gum and bone tissue.

Pretax salary reductions

Contributions taken from your paycheck before applicable federal, New York State, New York City and other taxes are withheld.

Qualified Medical Child Support Order (QMCSO)

A judgment, decree or order that meets all of the following criteria:

- is issued by a court pursuant to a domestic relations law or community property law
- creates or recognizes the right of an alternate recipient to receive benefits under a parent's employer's group or health plan
- includes certain information relating to the participant and alternate recipient

Qualifying status change

A qualifying status change occurs when: your marital status changes (or you register or revoke a domestic partnership), you increase or decrease your number of dependents (birth, death, adoption or placement for adoption, guardianship, permanent or temporary custody of a child), your dependent child is no longer eligible for coverage according to the terms of the plan(s) (exceeds age 19 or 25 if a full-time student or marries), a court decree that orders you must provide health coverage for your

dependent, your or your dependent's work site changes, your or your dependent's residence changes, your dependent's Medicare/Medicaid eligibility status changes, your spouse's/partner's employer's plan has a different plan year and open enrollment period than NYU's, coverage under your spouse's/partner's plan is significantly curtailed or ceases, your spouse's/partner's employer adds new health plan options, NYU adds new health plan options, your provider of dependent care changes, your cost for dependent care significantly increases or decreases, or you or your spouse/partner commences or returns from an FMLA leave.

The term "dependent" refers to any of the following as defined by the plan: your spouse, your domestic partner that you have registered with the NYU Benefits Office, your child, your step-child, your adopted child or child placed with you for adoption, or the child of your registered domestic partner, a child for whom you have been appointed legal guardian, a child for whom you have been awarded permanent or temporary custody.

Reasonable and customary charges

Reasonable and customary (R&C) charges are set by the claims administrator, and apply to covered services. R&C charges are based on the typical charge made by most providers for similar services or supplies in your geographic area. If the charge for services or supplies is more than the R&C limit set by the claims administrator, you pay the portion above the R&C limit for any service covered by the plan for which R&C applies in determining the benefit you receive.

Regular employee

An exempt or non-exempt employee who works on an ongoing basis instead of a temporary basis.

Root canal

A procedure to save an abscessed tooth by cleaning out the pulp chamber, disinfecting it and filling it with a permanent filling.

Salaried

To receive fixed compensation paid regularly for work or services, regardless of the number of hours worked each week.

Sealant

The protective plastic coating applied over grooves in your teeth to prevent decay.

Secondary payer

The plan that is second in responsibility under coordination of benefits.

Section 125

A section of the Internal Revenue Code that allows you to pay for certain benefits with pretax dollars, and regulates enrollment and eligibility requirements for these benefits.

Space maintainer

An appliance children use in their mouths so their teeth do not drift or crowd new teeth.

Spouse

Your husband or wife, married to you in a civil or ecclesiastical ceremony.

Summary plan description (SPD)

A legally required document describing your benefits in detail, how the plan operates, how to file claims, and your rights and responsibilities as a plan participant.

Temporary employee

Someone who is hired, usually through an agency on a per diem basis, for a short period of time. May or may not have a contract for the specific work period.

Termination date

The last day you are scheduled to work.

TMJ syndrome

A medical or dental problem related to the temporomandibular joint that links the jawbone and skull.

Waiting period

The amount of time you must wait before being able to participate in a plan.

Appendix A

2007 Dental Schedule

Procedure

Maximum Amount

Diagnostic

Oral exams not associated with other services (limit of 2 exams in any calendar year) Radiographs, intraoral-complete series (including bitewings) - limit of once every 36 months. Radiographs bitewings, complete series (4) - limit of twice per calendar year.

The reasonable charge for such procedure

Preventive

Dental prophylaxis, adults or children - all methods [limit of 2 prophylaxes (cleaning, scaling, and polishing) in any calendar year] Topical application of fluoride, per treatment (excluding prophylaxis) - limit to twice per calendar year. Sealants for children to age 19 (limit of once every five years), permanent molars only.

The reasonable charge for such procedure

Procedure	Maximum Amount
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Restorative	
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Amalgam, one surface primary or permanent	\$46
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Amalgam, two surfaces primary or permanent	\$69
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Amalgam, three surfaces primary or permanent	\$91
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Composite resin, one surface	\$57
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Composite resin, two surfaces	\$81
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Composite resin, three surfaces	\$114
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Gold foil, one surface	\$138
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Gold foil, two surfaces	\$217
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Gold foil, three surfaces	\$264
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Inlay metallic, one surface	\$274
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Inlay metallic, two surfaces	\$343
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Inlay metallic, three surfaces	\$400
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Inlay, porcelain	\$217
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Recement inlays, per tooth	\$34
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Sedative fillings, per tooth	\$34
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Crown, resin, single restorations only	\$286
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Procedure	Maximum Amount
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Restorative continued	
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Crown, resin with metal, single restorations only	\$493
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Crown, porcelain, single restorations only	\$469
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Crown porcelain with metal, single restorations only	\$584
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Crown, full cast, single restorations only	\$503
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Crown, stainless steel, single restorations only	\$114
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Crown, temporary for fractured tooth	\$182
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Recement crowns, per tooth	\$34
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Procedure	Maximum Amount
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Endodontics	
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Pulp capping, direct (excluding final restoration)	\$34
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Pulp capping, indirect (excluding final restoration)	\$23
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Vital pulpotomy (or pulpectomy)	\$57
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Root canal, anterior tooth	\$286
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Root canal, bicuspid tooth	\$400
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Root canal, molar tooth	\$529
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Root surgery, anterior	\$229
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Procedure	Maximum amount
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Periodontics	
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Gingivectomy / gingivoplasty - Per quadrant	\$229
Gingival flap procedure - Per quadrant	\$286
Periodontal scaling and root planning - Per quadrant	\$148
Periodontal lifetime maximum	\$2500

Procedure	Maximum amount
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Temporomandibular joint syndrome (TMJ)	
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Non-surgical treatment - Arthrogram, including injection	\$508
- Tomographic survey	\$255
TMJ appliance, occlusal orthotic device	\$564
TMJ lifetime maximum	\$1500

Procedure	Maximum amount
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Prosthodontics - removable*

Complete upper dentures, including adjustments	\$629
Complete lower dentures, including adjustments	\$629
Immediate upper complete dentures, including adjustments**	\$641
Immediate lower complete dentures, including adjustments**	\$515
Partial dentures, upper or lower, resin base	\$722
Partial dentures, upper or lower, cast metal base	\$802
Repair denture - resin base	\$57
Repair denture - cast framework	\$57
Repair denture - repair or replace broken clasp	\$57
Repair denture - replace broken teeth; per tooth	\$91
Repair denture - add tooth to existing partial	\$81
Repair denture - add clasp to existing partial	\$138
Relining upper or lower complete denture (office reline)***	\$138
Relining upper or lower complete denture (laboratory)	\$207

Procedure	Maximum amount
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Prosthodontics - fixed*	
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Bridge pontics, cast high noble metal	\$503
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Bridge pontics, porcelain fused to metal	\$584
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Bridge pontics, resin with high noble metal	\$493
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Inlay abutments, three or more surfaces, metallic inlay	\$400
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Bridge repair	\$81
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Procedure	Maximum amount
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Oral surgery

Extractions (including routine post-operative care) Simple extractions - Single tooth / first quadrant	\$57
Surgical extractions - Tooth erupted	\$69
- Soft tissue impaction	\$103
- Partial bony impaction	\$126
- Complete bony impaction	\$217
Residual root recovery	\$91
Oral antral fistula closure (and/or antral root recovery)	\$229
Surgical exposure of impacted or unerupted tooth for orthodontic reasons	\$148
Surgical repositioning of teeth	\$148
Alveoplasty (surgical preparation of ridge for dentures) - Per quadrant in conjunction with extractions	\$57 \$103
- Per quadrant not in conjunction with extractions	

Procedure	Maximum amount
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Orthodontic care

Maximum allowance for all orthodontic treatment combined during lifetime of any family member	\$1500
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* Replacement of existing removable denture or fixed bridgework is covered if needed due to loss of one or more natural teeth after existing denture or bridgework was installed or if it is needed because existing denture or bridgework can no longer be used and was installed at least five years before it is replaced. Adding teeth to existing partial removable denture or bridgework is covered when needed to replace one or more natural teeth removed after existing denture or bridgework was installed.

** Replacement of existing immediate temporary complete denture by a new permanent full denture is covered when existing denture cannot be made permanent and permanent denture is installed within 12 months after existing denture was installed.

*** Not covered first six months after denture is placed, then relining limited to once every 36 months.

Note: If a procedure is not listed, an amount will be determined by MetLife in a consistent manner. Its type and complexity will be taken into account along with exclusions and other restrictions that apply.