SUMMARY PLAN DESCRIPTION

OF THE

LINCOLN UNIVERSITY DENTAL PLAN
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SECTION 1. INTRODUCTION

This Summary Plan Description booklet, or "SPD," is intended to summarize for you the highlights of the dental benefits available to eligible employees of Lincoln University who participate in the Lincoln University Dental Plan and to their spouses and other dependents.

In order to be eligible for benefits under this Plan you are required to make an annual election to enroll for coverage. The details of such annual elections are described below in Section 3.

SECTION 2. SOME BASIC FACTS ABOUT THE PLAN

A. NAME THE PLAN

"Lincoln University Dental Plan"

B. EMPLOYER / PLAN SPONSOR

Lincoln University of the Commonwealth System of Higher Education
1570 Baltimore Pike
P.O. Box 179
Lincoln University, PA 19352

C. PLAN SPONSOR EMPLOYER IDENTIFICATION NUMBER

23-1352655

D. PLAN NUMBER

Plan No. 551

E. PLAN ADMINISTRATOR

Lincoln University of the Commonwealth System of Higher Education
1570 Baltimore Pike
P.O. Box 179
Lincoln University, PA 19352

F. TYPE OF PLAN

The Lincoln University Dental Plan is a fully insured employee welfare benefit plan providing dental benefits to eligible employees of Lincoln University. The dental benefits are sometimes referred to as "group health plan" benefits.

G. "PLAN YEAR"

The Plan operates on a calendar year, January 1 to December 31.

H. AGENT FOR SERVICE OF LEGAL PROCESS

Legal papers and process issued by a court may be served upon the Administrator at the following address:

Director of Human Resources
Lincoln University of the Commonwealth System of Higher Education
1570 Baltimore Pike
P.O. Box 179
Lincoln University, PA 19352
484-585-8059

I. TYPE OF ADMINISTRATION OF THE PLAN

Plan Administration

The Administrator of the Plan is Lincoln University of the Commonwealth System of Higher Education. The President or his or her designee is authorized by the Board of Trustees to act on behalf of the Plan Administrator. The day-to-day contact at the University for the Plan is Ms. Sharon Houston, Administrative Assistant – Benefits, Office of Human Resources (484) 365-7594.

The principal duty of the Plan Administrator is to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan. The administrative duties of the Plan Administrator include, but are not limited to, interpreting the Plan, prescribing applicable procedures, determining eligibility for and the amount of benefits, and gathering information necessary for administering the Plan. The Plan Administrator may delegate any of these administrative duties among one or more persons or entities.

The Plan Administrator has the discretionary authority to interpret the Plan in order to make eligibility and benefit determinations as it may determine in its sole discretion. The Plan Administrator also has the discretionary authority to make factual determinations as to whether any individual is entitled to receive any benefits under the Plan.

The University bears the incidental costs of administering the Plan.

Power and Authority of Insurance Company

The Lincoln University Dental Plan is administered by the Plan Administrator through a fully insured contract with Delta Dental of Pennsylvania. Certain important functions relating to the Plan's dental benefits are performed on behalf of the Plan by Delta Dental of Pennsylvania. These functions handled by Delta Dental include, but are not limited to, administration and processing of claims and claim appeals, determining eligibility for and the amount of any benefits payable, prescribing claims procedures to be followed and the claims forms to be used, administration of
pre-treatment estimates, coordination of benefits, and customer service assistance.

The name, address, telephone number, and website of the insurer are as follows:

Delta Dental of Pennsylvania
Administrative Offices
One Delta Drive
Mechanicsburg, PA 17055-6999
(717) 766-8500  Toll Free: (800) 932-0783
TTY/TDD: (888) 373-3582
www.deltadentalpa.com

Dental benefits are processed by Delta Dental of Pennsylvania in accordance with the procedures highlighted in this SPD (including the "Delta Dental Evidence of Coverage" Booklet portion of this SPD described in Section 14 below). The actual detailed terms of the insurance arrangement applicable to the Plan as of July 1, 2008, however, are set forth in the "Delta Dental PPO Dental Service Contract for Experience Rated Groups" effective July 1, 2008 between Lincoln University, as the Plan Sponsor/Employer, and Delta Dental of Pennsylvania. That contract, including any subsequent amendments, is considered a Plan Document of this Plan. A copy of that document is available by contacting the Office of Human Resources.

IMPORTANT DISCLAIMER: If the terms of this SPD conflict with the terms of that actual Delta Dental insurance contract, then the terms of the insurance contract will control, rather than this SPD, unless otherwise required by law.

Provider Networks

If plan benefits differ depending on whether care is given by, or accessed through, a network provider, you may obtain, without charge, a listing of network providers from the Plan Administrator, or may obtain information regarding participating providers in accordance with the "Locating a Delta Dental Participating Dentist" explanation on page 2 of the attached Delta Dental Evidence of Coverage Booklet incorporated by reference into this SPD as described in Section 14 below.

J. FUNDING MEDIUM – WHERE THE MONEY COMES FROM TO OPERATE THE PLAN

Insurance premiums for employees and their eligible family members are paid in part by the University out of its general assets and in part by employee contributions. Employee contributions are generally withheld from the participating employee’s pay at Lincoln University on a pre-tax basis in accordance with the University’s Premium Conversion Plan discussed below in Section 3(A). The University provides the applicable premiums during the initial and subsequent open enrollment periods and upon request. Such employee contributions are on a monthly basis paid over to the insurer as premiums after being withheld from pay.

The amounts that the University and employee contribute to the Plan will be determined at the University’s discretion from time to time, except that for employees who are in bargaining units represented by a union, the employee contribution rate may be determined by the applicable collective bargaining agreement.

SECTION 3. ELIGIBILITY AND PARTICIPATION REQUIREMENTS

A. ELIGIBILITY AND PARTICIPATION

This Dental Plan applies to eligible employees of Lincoln University, and their dependents. To the extent, but only to the extent, provided for in any applicable collective bargaining agreement, this Plan applies to employees of Lincoln University working in bargaining units represented by a union, and their dependents. Subject to the terms and restrictions of any applicable collective bargaining agreement for bargaining unit employees of the University, non-temporary common-law employees of the University are generally eligible to participate in the Lincoln University Dental Plan provided that they: (1) work at least 20 hours per week for an indefinite duration or, for employees in the faculty category, teach at least 6 course credits per semester; and (2) elect Dental coverage, and make required employee contributions, in accordance with the terms of the Lincoln University Premium Conversion Plan. The Premium Conversion Plan is commonly referred to as a "cafeteria plan."

Information about the Lincoln University Premium Conversion Plan is provided to employees in a separate SPD. Information about the Premium Conversion Plan can also be obtained by contacting Ms. Sharon Houston at the University’s Human Resources Department at (484) 365-7594.

Additional rules and details relating to the eligibility and enrollment of employees and dependents are set forth at page 14 of the Delta Dental "Evidence of Coverage" Booklet described below in Section 14.

B. WHEN COVERAGE BEGINS

Unless a different commencement date is provided for in a collective bargaining agreement, participation under this Plan will commence on the first day of the month immediately following your date of hire or, if later, the first day of the month following the date when you meet all conditions (including making any cafeteria plan elections) for eligibility to participate in the Plan.

Your eligibility will also depend upon your making an annual election whether to enroll for dental coverage. Information about enrollment procedures, including when coverage begins and ends for the various component benefit programs, is found SPD for the Lincoln University Premium Conversion Plan which is provided to you in addition to this SPD and is incorporated herein by reference. If you need another copy of that SPD, please contact the Office of Human Resources.
C. TERMINATION OF PARTICIPATION

Your participation and the participation of your eligible family members in the Plan will terminate on the last day of the month in which you terminate employment with the University. Coverage also may terminate if you fail to pay your share of an applicable premium, if your hours drop below any required hourly threshold, if you submit false claims, if you elect to drop dental coverage at an annual enrollment or at any other time when a change of elections may be permitted under the University's Premium Conversion Plan, or for any other reason as set forth in the Delta Dental Evidence of Coverage Booklet attached to this SPD at Section 14. You should consult the Delta Dental Evidence of Coverage Booklet for specific termination events and information.

As is discussed in the next Section of this SPD, if dental coverage for you or your eligible family members ceases because of certain "qualifying events" specified in COBRA (such as termination of employment, reduction in hours, divorce, death, or a child's ceasing to meet the definition of dependent), then you and your eligible family members may have the right to purchase continuation coverage for a temporary period of time. Continuation and reinstatement rights may also be available if you are absent from employment due to service in the uniformed services pursuant to "USERRA" or similar laws. More information about coverage available pursuant to USERRA is set forth below in Section 5.

SECTION 4. NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS / PROCEDURES

A. INTRODUCTION

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan, at your expense, when you would otherwise lose coverage under the terms of the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act ("COBRA"). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should contact the Human Resources Department at the telephone number set forth in the explanation below.

B. WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "Qualifying Event." Specific qualifying events are listed later in this notice. After a qualifying event, and after any required Notice of that event is properly provided to the Plan's Administrator, COBRA continuation coverage must be offered to each person who is a "Qualified Beneficiary." You, your spouse, and your dependent children could become Qualified Beneficiaries if coverage under the Plan is lost because of the Qualifying Event. Under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

C. WHO IS A "QUALIFIED BENEFICIARY"?

A Qualified Beneficiary is either you, your spouse, or any dependent covered under the plan.

D. WHEN CAN I ELECT CONTINUATION COVERAGE?

You may elect Continuation Coverage once your regular coverage ends due to a Qualifying Event as described under the next heading. You must elect the coverage within 60 days from the end of your regular coverage or your insurance will not continue.

In addition, each Qualified Beneficiary may make his own election for Continuation Coverage whether you elect it or not.

EXAMPLE: John quits his job at the University and decides not to elect Continuation Coverage for himself under this Plan. However, John's wife may elect Continuation Coverage for herself if she was covered under the Plan before he quit his job.

E. WHAT IS A "QUALIFYING EVENT"?

If you are a covered employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced;
- Your covered employment ends for any reason other than your gross misconduct. (If you take an FMLA leave of absence and do not return to active employment, the Qualifying Event of termination of employment occurs at the earlier of the end of the leave or the date that you give notice to the University that you will not be returning to your job.); or
- The employer becomes bankrupt.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of covered employment are reduced;
- Your spouse's covered employment ends for any reason other than his or her gross misconduct;
- The employer becomes bankrupt;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse (in a State where legal separation is a recognized status).
Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee’s hours of covered employment are reduced;
- The parent-employee’s covered employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The employer becomes bankrupt;
- The parents become divorced or legally separated (in a State where legal separation is a recognized status); or
- The child stops being eligible for coverage under the plan as a “dependent child.”

As is discussed below in detail, it is your obligation to inform the Plan Administrator of the occurrence of any Qualifying Event within 60 days of the event, other than a change in your employment status.

F. HOW MUCH DOES CONTINUATION COVERAGE COST?

If you elect Continuation Coverage, you must pay 102% of the applicable premium for the period of coverage. If the premiums are being paid for a disabled individual, then you must pay 102% of the applicable premium for the first 18 months and 150% of the applicable premium for the 19th month through the 26th month. You may pay the premium on a monthly basis and your first premium is due and payable 45 days after you make the initial election for coverage.

G. WHEN DOES CONTINUATION COVERAGE BECOME EFFECTIVE ONCE ELECTED?

Assuming the required premiums have been timely paid, Continuation Coverage is retroactive to the date you lost regular coverage under the Plan due to the occurrence of a Qualifying Event.

H. WHEN DOES THE CONTINUATION COVERAGE END?

You, as the covered employee, will be able to continue coverage for up to 18 months after the date of your termination of employment or reduction in hours. If during this 18-month period, the Social Security Administration determines you were disabled at the time of your Qualifying Event, you may extend your coverage up to 26 months from the date of the Qualifying Event. If you were entitled to Medicare benefits at the date of your Qualifying Event, then you and each of your dependents may elect separately to continue coverage up to 36 months.

Continuation coverage is available for up to 36 months to the following:

- Your spouse, if you and your spouse are divorced and your spouse is no longer covered under the Plan
- Your dependent child, if your child loses coverage because the child is no longer your dependent
- Your dependents, if you die
- Your dependents, if you become entitled to Medicare
- Any of your dependents, if the Qualifying Event was your employer's bankruptcy

Continuation Coverage automatically ends after the following:

- The date the University terminates all of its plans subject to COBRA
- Thirty (30) days after the due date of your premium if the premium was not paid
- The date the Qualified Beneficiary becomes covered under another plan that does not contain a preexisting condition clause
- The date the Qualified Beneficiary becomes entitled to Medicare
- For disabled Qualified Beneficiaries, the date the Social Security Administration determines that the Qualified Beneficiary is no longer disabled

I. WHAT ARE MY CONTINUATION COVERAGE RIGHTS IF I AM ABSENT FOR DUTY IN THE UNIFORMED SERVICES?

If you fail to work at least 30 hours per week for more than 31 days because of duty in the uniformed services, you and your covered dependents will be entitled to elect Continuation Coverage in the same manner as if you had experienced one of the Qualifying Events described above, unless you are covered by an applicable collective bargaining agreement that provides greater benefits. However, this extended coverage will last no more than 18 months and cannot be extended regardless of the occurrence of any other subsequent event. See explanation below in Section 5.

J. YOU MUST GIVE NOTICE OF SOME QUALIFYING EVENTS

For the certain Qualifying Events (including divorce of the covered employee and spouse or a dependent child’s losing eligibility for coverage as a dependent child), YOU (or someone on your behalf) must notify the Plan’s Administrator, IN WRITING, within 60 days after the later of: (1) the date of the qualifying event; or (2) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event. You must follow the notice procedures explained below and must mail or hand deliver this notice to Lincoln University Office of Human Resources at the following address:

Lincoln University of the Commonwealth System of Higher Education
Office of Human Resources
1570 Baltimore Pike
P.O. Box 179
Lincoln University, PA 19352
484-365-7584
Attention: Ms. Sharon Houston
K. PROCEDURES APPLICABLE TO NOTICE OF A QUALIFYING EVENT THAT YOU MUST GIVE:

Your notice to the Plan Administrator of a Qualifying Event must be in and must be mailed or hand delivered as noted above. Oral notice, including notice by telephone, is not acceptable. Electronic (including e-mailed or faxed) notices are not acceptable. If mailed, your notice must be postmarked no later than the deadline described above. If hand delivered, your notice must be received at the address specified above no later than the deadline described above.

L. YOUR NOTICE OF QUALIFYING EVENT MUST CONTAIN THE FOLLOWING INFORMATION

- The name of the Plan(s) under which you were covered (e.g., "Lincoln University Dental Plan");
- The name and address of the covered employee;
- The name(s) and address(es) of all Qualified Beneficiary(ies) who lost coverage due to the Qualifying Event (divorce, termination of regular spousal relationship, entitlement to Medicare Benefits under Part A, Part B or both, or dependent child’s loss of dependent status);
- A description of the Qualifying Event (e.g., divorce or a dependent child’s loss of dependent status);
- The date the Qualifying Event happened; and
- The signature, name, and contact information of the individual sending the notice.

If you are notifying the Plan Administrator of a divorce or legal separation, your notice must include a copy of the decree of divorce or evidence of the termination of the regular spousal relationship.

If your coverage is reduced or eliminated and later a divorce or legal separation occurs, and you are notifying the Plan Administrator that your Plan coverage was reduced or eliminated in anticipation of the divorce or termination of the regular spousal relationship, you must provide notice within 60 days of the date coverage was, or would be, lost, and must in addition provide evidence satisfactory to the Administrator that your coverage was reduced or eliminated in anticipation of the divorce or the termination of your spousal relationship.

If you provide a written notice that does not contain all of the information and documentation required by these Notice Procedures for Notice of Qualifying Event, such a notice will nevertheless be considered timely if all of the following conditions are met:

- The notice is mailed or hand delivered to the individual and address specified above;
- The notice is provided by the deadline described above;
- From the written notice provided, the Plan Administrator is able to determine that the notice relates to the Plan;
- From the written notice provided, the Plan Administrator is able to identify the covered employee and qualified beneficiary(ies), the Qualifying Event (the divorce, termination of regular spousal relationship, entitlement to Medicare Benefits under Part A, Part B or both, or Dependent child’s loss of Dependent status), and the date on which the Qualifying Event occurred; and
- The deficient notice is supplemented in writing with the missing information and documentation necessary to meet the Plan’s requirements within 15 business days after a written or oral request from the Plan Administrator for more information (or, if later, by the deadline for the Notice of Qualifying Event described above).

If any of these conditions is not met, the incomplete notice will be rejected and COBRA coverage will not be offered. If all of these conditions are met, the Plan will treat the notice as having been provided on the date that the Plan receives all of the required information and documentation but will accept the notice as timely.

The covered employee, Qualified Beneficiary with respect to the Qualifying Event, or a representative acting on behalf of either, may provide the notice. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who lost coverage due to the Qualifying Event described in the notice.

If your notice was regarding a dependent child’s loss of dependent status, you must, if the Plan Administrator requests it, provide documentation of the date of the Qualifying Event that is satisfactory to the Plan Administrator (for example, a birth certificate to establish the date that a dependent child reached the limiting age, a marriage certificate to establish the date that a dependent child married, or a transcript showing the last date of enrollment in an educational institution). This will allow the Plan Administrator to determine if you gave timely notice of the Qualifying Event and were consequently entitled to elect COBRA. If you do not provide satisfactory evidence within 15 business days after a written or oral request from the Plan Administrator that the dependent child ceased to be a dependent on the date specified in your Notice of Qualifying Event, his or her COBRA coverage may be terminated (retroactively if applicable) as of the date that COBRA coverage would have started. The Plan Administrator will require repayment to the Plan of all benefits paid after the termination date.

M. DISABILITY EXTENSION OF COBRA COVERAGE

If you are determined by the Social Security Administration to be disabled and you notify the Plan Administrator in writing in a timely fashion, all of the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months, subject to the Continuation Coverage Offset Rules. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a Qualifying Event that was the Covered Employee’s termination of employment or reduction of hours. The disability must have started at some time before the 61st day after the Covered Employee’s termination of employment or reduction of hours, and must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months, as described above).

The disability extension is available only if you notify the Plan Administrator in writing of the Social Security Administration’s determination of disability within 60 days after the latest of:
1. The date of the Social Security Administration's disability determination;

2. The date of the covered employee's termination of employment or reduction of hours; or

3. The date on which the Qualified Beneficiary loses (or would lose) coverage under the terms of the Fund as a result of the Covered Employee's termination of employment or reduction of hours.

You must also provide this Notice within 18 months after the Covered Employee's termination of employment or reduction of hours in order to be entitled to a disability extension.

If these procedures are not followed, or if the Notice is not provided in writing to the Plan Administrator during the 60-day notice period and within 18 months after the Covered Employee's termination of employment or reduction of hours, then there will be no disability extension of COBRA coverage.

N. SECOND QUALIFYING EVENT EXTENSION OF COBRA COVERAGE

If your family experiences another Qualifying Event while receiving COBRA coverage because of the Covered Employee's termination of employment or reduction of hours (including COBRA coverage during the Disability extension period described above), the spouse and dependent children receiving COBRA coverage can get up to 18 additional months of COBRA coverage, for a maximum of 36 months, subject to the continuation coverage offset rules. If Notice of the Second Qualifying Event is properly given to the Plan Administrator. This extension may be available to the spouse and any dependent children receiving coverage if the covered employee or former covered employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first Qualifying Event not occurred.

This extension due to a Second Qualifying Event is available only if you notify the Plan Administrator in writing of the Second Qualifying Event within 60 days after the later of: (1) the date of the Second Qualifying Event; or (2) the date on which the Qualified Beneficiary would lose coverage under the terms of the Plan as a result of the Second Qualifying Event (if it had occurred while the Qualified Beneficiary was still covered under the Plan).

O. MORE INFORMATION ABOUT INDIVIDUALS WHO MAY BE QUALIFIED BENEFICIARIES

- Children born to or placed for adoption with the active employee during COBRA coverage period

A child born to, adopted by, or placed for adoption with an active employee during a period of COBRA coverage is considered to be a qualified beneficiary provided that, if the active employee is a Qualified Beneficiary, the active employee has elected continuation coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the Plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the active employee. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements—for example, regarding age.

- Alternate recipients under QMCSO's

A child of the active employee who is receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order (QMCSO) received by the Plan Administrator during the active employee's period of coverage by the Plan is entitled to the same rights under COBRA as a dependent child of the active employee, regardless of whether that child would otherwise be considered a dependent.

P. COBRA ELECTION PROCEDURE

To elect COBRA after a qualifying event, you must complete the Plan's COBRA Election Form and submit it to the Plan Administrator. An Election Notice will be provided to qualified beneficiaries at the time of a Qualifying Event which will include any required Election Form. You may also obtain a copy of the Election Form without charge from the Plan Administrator. Under federal law, you must have 60 days after the date the COBRA Election Notice is provided to you at the time of your Qualifying Event to decide whether you want to elect COBRA coverage under the Plan.

Mail or hand deliver the completed Election Form to the Plan's Administrator at the following address:

Lincoln University of the Commonwealth System of Higher Education
Office of Human Resources
1570 Baltimore Pike
P.O. Box 179
Lincoln University, PA 19352
484-365-7594
Attention: Ms. Sharon Houston

The COBRA Election Form must be completed in writing and mailed or hand delivered to the address specified above. The following are not acceptable as COBRA elections and will not preserve COBRA rights: oral communications regarding COBRA coverage, including in-person or telephone statements about an individual's COBRA coverage; and electronic communications, including e-mail and faxed communications.

If mailed, your election must be postmarked (and if hand delivered, your election must be received by the Plan
Administrator at the address specified above) no later than 60 days after the date of the COBRA Election Notice provided to you at the time of your Qualifying Event. If you do not submit a completed Election Form by this due date, you will lose your right to elect COBRA coverage.

If you reject COBRA coverage before the due date, you may change your mind as long as you furnish a completed Election Form before the due date.

You do not have to send any payment with your Election Form when you elect COBRA coverage. Important additional information about payment for COBRA coverage is included below.

Each Qualified Beneficiary will have an independent right to elect COBRA coverage. For example, the covered employee's spouse may elect COBRA coverage even if the covered employee does not. COBRA coverage may be elected for only one, several, or for all dependent children who are Qualified Beneficiaries. Covered employees and spouses (if the spouse is a Qualified Beneficiary) may elect COBRA coverage on behalf of all of the Qualified Beneficiaries, and parents may elect COBRA coverage on behalf of their children. Any Qualified Beneficiary for whom COBRA coverage is not elected within the 60-day election period specified in the Plan's COBRA Election Notice will lose his or her right to elect COBRA coverage.

When you complete the Election Form, you must notify the Plan Administrator if any Qualified Beneficiary has become entitled to Medicare (under Part A, Part B, or both) and, if so, the date of Medicare entitlement. If you become entitled to Medicare (or first learn that you are entitled to Medicare) after submitting the Election Form, immediately notify the Plan Administrator of the date of your Medicare entitlement at the address specified above for delivery of the Election Form.

Qualified Beneficiaries who are entitled to elect COBRA coverage may do so even if they have other plan coverage or are entitled to Medicare benefits on or before the date on which COBRA coverage is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare benefits or becomes covered under other health plan coverage (but only after any applicable pre-existing condition exclusions of that other plan have been exhausted or satisfied).

Q. PLAN COBRA CONTACT INFORMATION:

The University's primary contact for COBRA matters is as follows:

Benefits Office of Human Resources
Lincoln University of the Commonwealth System of Higher Education
1570 Baltimore Pike
P.O. Box 179
Lincoln University, PA 19352
(484) 365-7594

SECTION 5. RIGHTS UNDER THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

A. BACKGROUND

The Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") established requirements that employers and plans must meet for certain employees who are involved in the Uniformed Services (defined below). In addition to the rights that you have under COBRA (described in Section 4 of this Summary Plan Description), you are entitled under USERRA to continue the coverage you had under the Plan.

B. YOU HAVE RIGHTS UNDER BOTH COBRA AND USERRA

Your rights under COBRA and USERRA are similar but not identical. Any election that you make pursuant to COBRA will also be an election under USERRA, and COBRA and USERRA will both apply with respect to the continuation coverage elected. If COBRA and USERRA give you (or your covered spouse or dependent children) different rights or protections, the law that provides the greater benefit will apply. The administrative policies and procedures described in Section 4 of this Summary Plan Description (for example, the procedures for how to elect COBRA coverage and for paying premiums for COBRA coverage) also apply to USERRA coverage. COBRA and USERRA coverage run concurrently.

C. DEFINITIONS

"Uniformed Services" means the U.S. Armed Services (including the Coast Guard), the Army National Guard and the Air National Guard (when engaged in active duty for training, inactive duty training, or full time National Guard duty), and the commissioned corps of the Public Health Service. Moreover, the President is authorized to expand the categories of Uniformed Services through the exercise of emergency or war powers.

"Service in the Uniformed Services" or "Service" means the performance of duty on a voluntary or involuntary basis in the Uniformed Services under competent authority, including active duty, active duty for training, initial active duty for training, inactive duty training, full time National Guard duty, and the time necessary for a person to be absent from employment for an examination to determine the fitness of the person to perform any of these duties.

D. DURATION OF USERRA COVERAGE

General Rule: 18 month maximum. When an covered employee takes a leave for Service in the Uniformed Services, USERRA coverage for the covered employee (and covered dependents for whom coverage is elected) begins the day after the covered employee (and covered dependents) loses coverage under the Plan, and it continues for up to 18 months. There are situations in which USERRA coverage will terminate before the maximum USERRA period expires.
COBRA and USERRA coverage are concurrent. This means that both COBRA coverage and USERRA coverage begin upon commencement of the covered employee’s leave, and they continue for up to 18 months. COBRA coverage (but not USERRA coverage) may continue for longer, as described in the University’s COBRA Election Notice. For example, a covered employee takes a leave of absence for service in the Uniformed Services and elects COBRA/USERRA continuation coverage and pays the required 102% of the insurance premium each month for the next 18 months. The covered employee’s COBRA and USERRA coverage both terminate at the end of this 18-month period, unless the coverage is terminated earlier due to non-payment of premiums or other permitted event.

E. PREMIUM PAYMENTS FOR USERRA CONTINUATION COVERAGE

If you elect to continue your health coverage (or your spouse or dependent children’s coverage) pursuant to USERRA, you will be required to pay 102% of the full premium for the coverage elected (the same rate as COBRA). However, if your Uniformed Service leave of absence is less than 31 days, you are not required to pay more than the amount that you pay as an covered employee for that coverage.

SECTION 6. QUALIFIED MEDICAL CHILD SUPPORT ORDER PROCEDURE

The Plan has special rules specifically relating the coverage of a child of a covered employee who might otherwise be eligible for dependent coverage under the regular rules of the Plan but who is recognized under a Qualified Medical Child Support Order (“QMCSO”) of a court as having a right to enrollment under the Plan with respect to the covered employee. Information regarding these rules can be obtained, without charge, by contacting the Human Resources Department.

SECTION 7. HOW TO OBTAIN A CERTIFICATE SHOWING THE AMOUNT OF “CREDITABLE COVERAGE” EARNED UNDER THIS PLAN

If you cease to be covered by this Plan and move to new plan that has a “preexisting condition exclusion” you may need to provide proof of how long you were covered by this Plan in order to receive credit for the time you were under this plan to be counted against any period of time the new plan applies to preexisting condition exclusions. This Plan issues “Certificates of Creditable Coverage” showing the amount of time that you have been covered by this Plan.

Certificates are automatically issued by the Plan when you (i) cease to be covered for regular coverage under the Plan, or (ii) when you cease to be covered under COBRA continuation coverage under the Plan. The Plan will also issue a Certificate of Creditable Coverage upon your request if the request is made not later than 24 months after the cessation of regular or COBRA continuation coverage. Certificates will be issued directly by the Insurer. To request a Certificate showing the period of Creditable Coverage you earned under this Plan, you should contact the Insurer. If you have any questions about how this works, you may also contact the Office of Human Resources for an explanation or for assistance.

SECTION 8. CIRCUMSTANCES THAT MAY AFFECT BENEFITS

Your benefits (and the benefits of your eligible family members) will cease when your participation in the Plan terminates. Your benefits will also cease in the event of a termination of the Plan.

Other circumstances can result in the termination, reduction, recovery (through subrogation or reimbursement), or denial of benefits. These limitations and rules are summarized in the attached Delta Dental Evidence of Coverage Booklet incorporated at Section 14 of this SPD.

SECTION 9. TERMINATION / AMENDMENT OF THE PLAN

Lincoln University, through its Board of Trustees, or the President as the Board’s designee, has the power and authority to amend or terminate the Plan.

The Vice President for Fiscal Affairs may sign insurance contracts for this Plan on behalf of the University, and may sign amendments to those contracts, and may adopt (by a written instrument) amendments to the Plan, including amendments that he or she considers to be administrative in nature or advisable in order to comply with applicable law.

SECTION 10. THIS SPD IS NOT A CONTRACT OR PROMISE OF EMPLOYMENT

The Plan and this SPD are not intended to create a contract of employment and do not change the at-will employment relationship of non-union employees nor the collectively bargained employment relationship of employees who are union bargaining unit members.

SECTION 11. CLAIMS PROCEDURES

For purposes of determining the amount of, and entitlement to, dental benefits provided under the governing insurance contract, Delta Dental, as the insurer, is a named fiduciary of the Plan, with the full power to interpret and apply the terms of the Plan as they relate to the benefits provided under the applicable insurance contract.

To obtain benefits from insurer Delta Dental you must follow the claims procedures under the applicable insurance contract described in the attached Delta Dental Evidence of Coverage Booklet (see Section 14 of this SPD), which may require you to complete, sign, and submit a written claim on the insurer’s forms. Any required forms, in addition to being available from the insurer, are also available, without charge, from the Plan Administrator.

The insurer will decide your claim in accordance with its reasonable claims procedures, as required by ERISA. The insurer has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide your claim. If the insurer denies your claim in whole or in part,
then you will receive a written notification setting forth the reason(s) for the denial.

If your claim is denied, you may appeal to the insurer for a review of the denied claim. The Insurer will decide your appeal in accordance with its reasonable claims procedures, as required by law. If you do not appeal on time, you will lose your right to file suit in a state or federal court, because you will not have exhausted your internal administrative appeal rights (which generally is a requirement for bringing suit in court).

See the attached Delta Dental Evidence of Coverage Booklet described at Section 14 of this SPD for complete information about how to file a claim and for details regarding the Delta Dental claims procedures.

SECTION 12. STATEMENT OF ERISA RIGHTS

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all plan participants shall be entitled to:

1. Examine, without charge, at the Plan Administrator's office, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series), if any, filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

2. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report and updated summary plan description (SPD). The Plan Administrator may make a reasonable charge for the copies.

3. Receive a summary of the Plan's annual report, if any is required by ERISA to be prepared, in which case the University, as Plan Administrator, is required by law to furnish each participant with a copy of this summary annual report.

COBRA AND HIPAA RIGHTS

You have the right to continue health care coverage for yourself, your spouse, or your 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. These rights are explained in Section 4 of this SPD.

You have the right to a reduction or elimination of any exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided with a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the 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 preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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 employee benefit plan. The people who operate your 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 Plan benefit or exercising your rights under ERISA.

ENFORCE YOUR RIGHTS

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps that you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report, if any, 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 University, as Plan Administrator, to provide the materials and pay you up to $110 per day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored in whole or in part, and if you have exhausted the claims procedures available to you under the Plan, you may file suit in a state or 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 whether you 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 your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor (listed in your telephone directory) or contact 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.

SECTION 13. NOTICE OF PRIVACY PRACTICES (HIPAA)

PLEASE REVIEW THIS NOTICE CAREFULLY

This Notice of Privacy Practices describes how the Plan Administrator may use and disclose your Protected Health Information. This Notice also sets out the Plan Administrator's legal obligations concerning your Protected Health Information and describes your rights to access and control your Protected Health Information. This Notice has been drafted in accordance with the HIPAA Privacy Rule, contained in the Code of Federal Regulations at 45 CFR Parts 160 and 164. Terms not defined in this Notice have the same meaning as they have in the HIPAA Privacy Rule.

Questions and Further Information. If you have any questions or want additional information about the Notice or the policies and procedures described in the Notice, please contact the Plan Administrator using the Contact Information provided at the end of this Notice.

A. THE PLAN ADMINISTRATOR'S RESPONSIBILITIES

The Plan Administrator is required by law to maintain the privacy of your Protected Health Information. It is obligated to provide you with a copy of this Notice setting forth the Plan Administrator's legal duties and its privacy practices with respect to your Protected Health Information. The Plan Administrator must abide by the terms of this Notice.

The Plan Administrator is required to protect the privacy of your health Information. The HIPAA Privacy Rules call this information "Protected Health Information," or "PHI" for short, and it includes information that can be used to identify you. The Plan Administrator must provide you with this Notice about its privacy practices that explains how, when and why it uses and discloses your PHI. With some exceptions, the Plan Administrator may not use or disclose any more of your PHI than is necessary to accomplish the purpose of the use or disclosure.

The Plan Administrator, however, reserves the right to change the terms of this Notice and its privacy policies at any time. Any changes will apply to the PHI the Plan Administrator already has. Before the Plan Administrator makes an important change to the policies, it will promptly change this Notice and provide you with a copy of it. You can also request a copy of this Notice from the entity listed in the "Contact Information" section of this Notice.

B. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

The following is a description of when the Plan Administrator is permitted or required to use or disclose your Protected Health Information.

Payment and Health Care Operations. The Plan Administrator has the right to use and disclose your Protected Health Information for all activities that are included within the definitions of "payment" and "health care operations" as defined in the HIPAA Privacy Rule.

Payment. The Plan Administrator will use or disclose your Protected Health Information to fulfill its responsibilities for coverage and providing benefits as established under the Plan Administrator. For example, the Plan Administrator may disclose your Protected Health Information when a provider requests information regarding your eligibility for benefits under the Plan Administrator, or it may use your information to determine if a treatment that you received was medically necessary, or for subrogated activities.

Health Care Operations. The Plan Administrator will use or disclose your Protected Health Information to support the Plan Administrator's business functions. These functions include, but are not limited to: (i) business management and general administrative activities; (ii) quality assessment and improvement; (iii) premium rating; (iv) activities relating to the creation, renewal or replacement of a contract for health insurance or health benefits; (v) placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess loss insurance); and (vi) reviewing provider performance, licensing, business planning, and business development. For example, the Plan Administrator may use or disclose your Protected Health Information: (i) to resolve internal claims appeals; (ii) to respond to a Participant Inquiry about the Participant's own information; or (iii) conducting or arranging for medical reviews, legal services and auditing functions.

Business Associates. The Plan Administrator contracts with service providers - called business associates - to perform various functions on its behalf. For example, the Plan Administrator may contract with a service provider to perform the administrative functions necessary to pay your medical claims. To perform these functions or to provide the services, business associates will receive, create, maintain, use, or disclose Protected Health Information, but only after the Plan Administrator and the business associate agree in writing to contract terms requiring the business associate to appropriately safeguard your information.

Other Covered Entities. The Plan Administrator may use or disclose your Protected Health Information to assist health care providers in connection with their treatment or payment activities, or to assist other covered entities in connection with certain health care operations. For example, the Plan Administrator may disclose your Protected Health Information to a health care provider when needed by the provider to perform treatment to you, and the Plan Administrator may disclose Protected Health Information to another covered entity to conduct health care operations in the areas of quality assurance and improvement activities, or accreditation, certification, licensing, or credentialing. This also means that the Plan Administrator may disclose or share your Protected Health Information with other health care programs or insurance carriers (such as Medicare, other insurers, etc.) in order to coordinate benefits, if you or your family members have other health insurance or coverage.
Required by Law. The Plan Administrator may use or disclose your Protected Health Information to the extent required by federal, state, or local law.

Public Health Activities. The Plan Administrator may use or disclose your Protected Health Information for public health activities that are permitted or required by law. For example, it may use or disclose information for the purpose of preventing or controlling disease, injury, or disability, or it may disclose such information to a public health authority authorized to receive reports of child abuse or neglect. The Plan Administrator also may disclose Protected Health Information, if directed by a public health authority, to a foreign government agency that is collaborating with the public health authority.

Health Oversight Activities. The Plan Administrator may disclose your Protected Health Information to a health oversight agency for activities authorized by law. For example, these oversight activities may include audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs, and government agencies that ensure compliance with civil rights laws.

Lawsuits and Other Legal Proceedings. The Plan Administrator may disclose your Protected Health Information in the course of any judicial or administrative proceeding or in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized). If certain conditions are met, the Plan Administrator may also disclose your Protected Health Information in response to a subpoena, a discovery request, or other lawful process, but only if efforts have been made to notify you about the request or to obtain an order protecting the information requested.

Abuse or Neglect. The Plan Administrator may disclose your Protected Health Information to a government authority that is authorized by law to receive reports of abuse, neglect, or domestic violence. Additionally, as required by law, if the Plan Administrator believes you have been a victim of abuse, neglect, or domestic violence, it may disclose your Protected Health Information to a governmental entity authorized to receive such information.

Law Enforcement. Under certain conditions, the Plan Administrator also may disclose your Protected Health Information to law enforcement officials for law enforcement purposes. These law enforcement purposes include, by way of example, (i) responding to a court order or similar process; (ii) as necessary to locate or identify a suspect, fugitive, material witness, or missing person; or (iii) as relating to the victim of a crime.

Coroners, Medical Examiners, and Funeral Directors. The Plan Administrator may disclose Protected Health Information to a coroner or medical examiner when necessary for identifying a deceased person or determining a cause of death. The Plan Administrator also may disclose Protected Health Information to funeral directors as necessary to carry out their duties.

Organ and Tissue Donation. The Plan Administrator may disclose Protected Health Information to organizations that handle organ, eye, or tissue donation and transplantation.

Research. The Plan Administrator may disclose your Protected Health Information to researchers when (i) their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your Protected Health Information, or (ii) the research involves a limited data set which includes no unique identifiers (information such as name, address, social security number, etc., that can identify you).

To Prevent a Serious Threat to Health or Safety. Consistent with applicable laws, the Plan Administrator may disclose your Protected Health Information if disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. It also may disclose Protected Health Information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military and Veterans. Under certain conditions, the Plan Administrator may disclose your Protected Health Information if you are, or were, Armed Forces personnel for activities deemed necessary by appropriate military command authorities. If you are a member of foreign military service, the Plan Administrator may disclose, in certain circumstances, your information to the foreign military authority.

National Security, Intelligence Activities and Protective Services. The Plan Administrator may disclose your Protected Health Information to authorized federal officials for conducting national security and intelligence activities, and for the protection of the President, other authorized persons, or heads of state.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, the Plan Administrator may disclose your Protected Health Information to the correctional institution or to a law enforcement official for: (i) the institution to provide health care to you; (ii) your health and safety; and the health and safety of others; or (iii) the safety and security of the correctional institution.

Workers’ Compensation. The Plan Administrator may disclose your Protected Health Information to comply with workers’ compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.

Disclosures to the Plan Sponsor. The Plan Administrator (or its health insurance issuers or HMOs) may disclose your Protected Health Information to the plan sponsor only to the extent permitted by law.

Others Involved in Your Health Care. The Plan Administrator may disclose your Protected Health Information to a friend or family member that is involved in your health care, unless you object or request a restriction (in accordance with the process described below under “Right to Request Restrictions”). The Plan Administrator also may disclose your information to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location. If you are not present or able to agree to these disclosures of your Protected
Health Information, then, using professional judgment, the Plan Administrator may determine whether the disclosure is in your best interest.

Disclosures to the Secretary of the U.S. Department of Health and Human Services. The Plan Administrator is required to disclose your Protected Health Information to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining the Plan Administrator’s compliance with the HIPAA Privacy Rule.

Disclosures to You. The Plan Administrator is required to disclose to you or your personal representative most of your Protected Health Information when you request access to this information. The Plan Administrator will disclose your Protected Health Information to an individual who has been designated by you as your personal representative and who has qualified for such designation in accordance with relevant law. Prior to such a disclosure, however, the Plan Administrator must be given written documentation that supports and establishes the basis for the personal representation. The Plan Administrator may elect not to treat the person as your personal representative if it has a reasonable belief that you have been, or may be, subjected to domestic violence, abuse, or neglect by such person; treating such person as your personal representative could endanger you; or the Plan Administrator determines, in the exercise of its professional judgment, that it is not in your best interest to treat the person as your personal representative.

C. OTHER USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

Other uses and disclosures of your Protected Health Information that are not described above will be made only with your written authorization. If you provide the Plan Administrator with an authorization, you may revoke the authorization in writing, and this revocation will be effective for future uses and disclosures of Protected Health Information. However, the revocation will not be effective for information that the Plan Administrator has used or disclosed in reliance on the authorization.

D. YOUR RIGHTS REGARDING PROTECTED HEALTH INFORMATION ABOUT YOU

The following is a description of your rights with respect to your Protected Health Information maintained by the Plan Administrator.

Right to Request a Restriction on Certain Uses and Disclosure. You have the right to request a restriction on the Protected Health Information the Plan Administrator uses or discloses about you for payment or health care operations. You also have a right to request a limit on disclosures of your Protected Health Information to family members or friends who are involved in your care or the payment for your care. You may request such a restriction using the Contact Information at the end of this Notice. The Plan Administrator is not required to agree to any restriction that you request. If the Plan Administrator agrees to the restriction, it can stop complying with the restriction upon providing notice to you. Your request must include the Protected Health Information you wish to limit, whether you want to limit the Plan Administrator’s use, disclosure, or both, and (if applicable), to whom you want the limitations to apply (for example, disclosures to your spouse).

Right to Request Confidential Communications. If you believe that a disclosure of all or part of your Protected Health Information may endanger you, you may request that the Plan Administrator communicate with you in an alternative manner or at an alternative location. For example, you may ask that all communications be sent to your work address. You may request a confidential communication using the Contact Information at the end of this Notice. Your request must specify the alternative means or location for communication with you. It also must state that the disclosure of all or part of the Protected Health Information in a manner inconsistent with your instructions would put you in danger. The Plan Administrator will accommodate a request for confidential communications that is reasonable and that states that the disclosure of all or part of your Protected Health Information could endanger you.

Right to Inspect and Copy. You have the right to inspect and copy Protected Health Information that may be used to make decisions about your benefits. You must submit your request in writing. For your convenience, you may request a form using the Contact Information at the end of this Notice. If you request copies, the Plan Administrator may charge a reasonable reproduction fee to copy your Protected Health Information, as well as postage if you request copies be mailed to you.

Note that under federal law, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and Protected Health Information that is subject to law that prohibits access to Protected Health Information. Depending on the circumstances, a decision to deny access may be reviewable. In some, but not all, circumstances, you may have a right to have this decision reviewed.

Right to Request an Amendment. You have the right to request an amendment of your Protected Health Information held by the Plan Administrator if you believe that information is incorrect or incomplete. If you request an amendment of your Protected Health Information, your request must be submitted in writing using the Contact Information at the end of this Notice and must set forth a reason(s) in support of the proposed amendment.

In certain cases, the Plan Administrator may deny your request for an amendment. For example, the Plan Administrator may deny your request if the information you want to amend is accurate and complete or was not created by the Plan Administrator. If the Plan Administrator denies your request, you have the right to file a statement of disagreement. Your statement of disagreement will be linked with the disputed information and all future disclosures of the disputed information will include your statement.

Right to Request an Accounting of Disclosures. You have the right to request an accounting of certain disclosures the Plan Administrator has made of your Protected Health Information. You may request an accounting using the Contact Information at the end of this Notice. You can request an accounting of disclosures made up to six years prior to the date of your request, except that the Plan Administrator is not required to account for

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disclosures made prior to April 14, 2003. You are entitled to one accounting free of charge during a twelve-month period. There will be a charge to cover the Plan Administrator's costs for additional requests within that twelve-month period. The Plan Administrator will notify you of the cost involved and you may choose to withdraw or modify your request before any costs are incurred.

E. COMPLAINTS

If you believe the Plan Administrator has violated your privacy rights, you may complain to the Plan Administrator or to the Secretary of the U.S. Department of Health and Human Services. You may file a complaint with the Plan Administrator using the Contact Information at the end of this Notice. All complaints must be submitted in writing. The Plan Administrator will not penalize you for filing a complaint.

F. CHANGES TO THIS NOTICE

The Plan Administrator reserves the right to change the provisions of this Notice and make the new provisions effective for all Protected Health Information that it maintains. If the Plan Administrator makes a material change to this Notice, the Plan Administrator will provide a revised Notice to you at the address that the Plan Administrator has on record for the participant enrolled in the Plan Administrator.

G. CONTACT INFORMATION

To exercise any of the rights described in this Notice, for more information, or to file a complaint, please contact:

Director of Human Resources / HIPAA Privacy Contact
Lincoln University of the Commonwealth System of Higher Education
1570 Baltimore Pike
P.O. Box 179
Lincoln University, PA 19352
(484) 385-8069

SECTION 14. SUMMARY OF PLAN BENEFITS—ATTACHED DELTA DENTAL “EVIDENCE OF COVERAGE” BOOKLET

The Plan provides you and your eligible dependents with dental insurance benefits through Delta Dental of Pennsylvania. A summary of benefits and of the applicable terms and provisions of that insured program is found in the Delta Dental “Evidence of Coverage” Booklet that is attached to this SPD immediately following this Section 14. That Booklet, including any updates, is considered to be a critical part of this SPD. (If for any reason the Delta Dental “Evidence of Coverage” Booklet was not provided to you with your copy of this SPD, please notify the Plan Administrator and one will be provided to you immediately.)