ALBRIGHT COLLEGE
DENTAL AND VISION COVERAGE
SUMMARY PLAN DESCRIPTION
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This Plan Description has been prepared in compliance with Public Law 93-406, better known as the Employee Retirement Income Security Act of 1974 (ERISA). The information furnished herein provides a Complete description of the benefits of your Plan, which are now available to eligible members and their eligible dependents.

Plan Sponsor: Albright College

Type of Plan: Employee and Dependent Dental and Vision Coverage

Employer ID#: 23-1352615

Plan Number: 506

Plan Year: June 1st through May 31st

Anniversary Date: June 1st

Agent for Service of Legal Process and Named Fiduciary: Albright College

Plan Administrator: Albright College or any person or organization appointed as a successor; in the event of Albright College Resignation or removal and the failure to appoint a successor Plan Administrator, the Plan Administrator shall be the Plan Sponsor.

Contributions: The plan is contributory for Employees and Dependents.

Plan Name: Albright College Dental and Vision Plan

Funding: The benefits payable under this Plan are funded by monthly contributions by employees of Albright College. Albright College internally provides for the adjudication of benefits herein described, claimed by the Plan participants.
Plan Year Requirement: 1000 hours

Eligibility for Employee Coverage:

An employee will be covered under the Plan providing he meets the eligibility requirements. This plan does not cover part-time employees, temporary employees or employees working less than 1000 hours per year.

Eligibility for Dependent coverage:

An Employee’s spouse and all unmarried children under 23 years of age are eligible for coverage under the Plan.

Upon receipt of due proof of incapacity, the Plan will cover Dependent children 23 years of age or older who are incapable of self-support due to a physical or mental handicap which occurred prior to age 23, and who were eligible for coverage as dependents prior to age 23.

EACH PERSON INCLUDED UNDER YOUR COVERAGE IS ENTITLED, SEPARATELY, TO THE BENEFITS DESCRIBED IN THIS PLAN DOCUMENT, EXCEPT WHERE NOTED OTHERWISE.

Effective Date for Eligible Employee Coverage:

Upon completion of a waiting period selected by the employer, the eligible employee will be covered for benefits under the Plan if working 1000 hours per year, in the regular business of, and compensated for service by a participating member Employer.

Effective Date for Eligible Dependent Coverage:

As of the employee’s effective date of coverage, provided the employee makes proper written application for Dependent Coverage.

Plan Eligibility Defined:

For purposes of clarification, these benefits are available exclusively to participating employees and dependents of Albright College.
Eligible Employees are those:

- Employees working for the Employer at least 1000 hours per year in the regular business of, and compensated for services by, the Employer.

- Employees who have satisfied the waiting period selected by the Employer.

ALL EMPLOYEES RECEIVE THE SAME BENEFITS UNLESS DULY NOTED ACCORDING TO THE ABOVE EMPLOYEE ELIGIBILITY REQUIREMENTS:

PROVISIONS AND BENEFITS OF THIS PLAN ARE LEGALLY ENFORCEABLE.
DENTAL BENEFITS

This Plan is available at the option of the Employer.

Benefits

Benefits will be provided for eligible dental services when billed by the licensed dentist in charge of the case. Unless otherwise indicated, payment will be made whether services are performed in or out of the hospital.

Payment for services performed by the Dentists will be made to the covered individual on the basis of 100% of the amount charged. Such payment will constitute full discharge of Albright College’s responsibility under the Plan.

Payment under the Plan is limited to a combined maximum of $1,000 per person for all services (Dental & Vision) rendered in any Plan year.

The Basic Program

1. Routine oral examinations and prophylaxis performed by a dentist including cleaning and polishing teeth (usually American Dental Association Procedure codes D0120, D1110), but not more than once each in any period of six consecutive months.

2. Routine periodontal maintenance (this procedure is for patients who have completed periodontal treatment surgical and/or nonsurgical periodontal therapies) and includes cleaning and polishing teeth (American Dental Association procedure codes D0450 and D4910) but not more than once each in any period of six consecutive months.

3. Topical application of fluoride for dependent children under 19 years of age, once in a six-month period.

4. Periapical X-rays as required, and bitewing x-rays once in any period of six consecutive months.

5. Full mouth x-rays, but not more than once in any period of 36 consecutive months.

6. Repair of broken partial or full removable dentures.

7. Space maintainers that replace prematurely lost teeth for dependent children under 19 years of age.

9. Sealants for dependent children to age 10 on permanent first molars and to age 15 on permanent second molars. Tooth surfaces to be sealed must be free of cavities and Previous restorations. Treatment is limited to one application per tooth in any period of 36 months.

10. Amalgam, silicate, acrylic, synthetic porcelain, and composite filing restorations to restore diseased or accidentally broken teeth. Gold foil restorations are not eligible.

11. Simple extractions.


13. Anesthetic services performed by (or under the direct personal supervision of) and billed for by a dentist other than the operating dentist or his assistant in connection with the performance of covered services. Anesthetic services consist of the administration of an anesthetic agent or anesthetic drug by injection or inhalation, the purpose of which is to render the patient unconscious. The administration of a local infiltration or block anesthetic is not covered.

14. Consultations, limited to one consultation per consultant during any one period of hospitalization, when the covered individual is an inpatient and his dental condition requires such consultation.

**General Exclusions and Limitations**

A. Payment will not be made for:

1. Treatment by other than a dentist (any licensed doctor of dental surgery, doctor of dental medicine, doctor of medicine or doctor of osteopathy acting within the authority of their license), unless the treatment is rendered under the direct supervision of the dentist.

2. Services or supplies that are cosmetic in nature, including, but not limited to, charges for personalization or characterization of dentures.

3. Charges incurred by the subscriber for failure to keep a scheduled visit with the dentist.
4. Services rendered through a medical department, clinic or similar facility provided or maintained by or on the behalf of an employer, mutual benefit association, labor union, trustee or similar persons or groups.

5. Services or supplies which are not necessary, according to accepted standards of dental practice, or which are not recommended or approve by the attending dentist.


7. Services related to the treatment of temporomandibular joint dysfunctions.

8. Services or supplies, which do not meet, accepted standards of dental practice, including charges for services or supplies, which are experimental in nature.

9. Services provided without cost by any governmental agency or services provided under any governmental program (such as Medicare, Title XIX, etc.) for which any periodic payment of rate is made by or for the subscriber.

10. Charges for the completion of any insurance forms.

11. Charges for plaque control programs and for oral hygiene and dietary instruction.

12. Implantology.

13. Unusual procedures and techniques.

14. Services for which the covered individual incurs no charge.

15. Services for any condition covered by Workers’ Compensation or similar legislation.

16. Services, the cost of which has been or is later recovered in any action at law or in compromise or settlement of any claim.

17. Services in a hospital performed by a dentist who in any case is compensated by the hospital for similar services performed for patients.

18. Services performed prior to the effective date of the contract.

19. Procedures, appliances or restorations necessary to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full
mouth rehabilitation, restoration of tooth structure lost from attrition and restoration for malalignment of the teeth.

20. Services of Assistant Surgeons except that the covered Individual, when an inpatient, will be entitled to the services of a dentist who actively assists the dentist in charge of the case in the performance of covered surgical services when the dental condition of the covered individual or the type of surgical service requires the assistance and when the hospital does not employ surgical interns, residents or house staff who are utilized for such assistance.

21. Local anesthesia when billed for separately by a dentist.


23. Services other than those specifically provided herein.

24. Services, supplies, or changes that are incurred after your termination date unless otherwise indicated.

25. Treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified self-insured plan.

B. Payment for services to covered individual will be limited as follows:

1. In the event a covered individual transfers from the care of one dentist to that of another dentist during the course of treatment, or if more than one dentist performs services for one dental procedure, the Plan shall be liable for not more than the amount it would have been liable for had but one dentist performed the service.

2. A contract between a covered individual and dentist, prior to the effective date of coverage under this contract, is not invalidated by a subsequent contract made between the plan and/or covered individual and/or dentist. The covered individual will be liable for any difference due to the dentist under such a contract after the plan liability has been satisfied.

3. Any additional treatment that is necessitated by lack of covered individuals cooperation with the dentist or non-compliance with prescribed dental care that results in additional liability will be the responsibility of the covered individual.
Subrogation

1. To the extent that benefits for covered services are provided or paid under this program, the sponsor shall be subrogated and succeed to any rights of recovery for expenses incurred against any person or organization except insurers on policies of health insurance issued to and in the name of the covered individual or where specifically prohibited by law.

2. You shall pay the sponsor all amounts recovered by suit, settlement, or otherwise from any third party or his insurer to the extent of the benefits provided or paid under this program.

3. You shall take such action, furnish such information and assistance, and execute such papers as the sponsor may require facilitating enforcement of its rights, and shall take no action prejudicing the rights and interests of the sponsor.
VISION BENEFITS

This Plan is available at the option of the Employer.

BENEFITS

Benefits will be provided for covered vision services when billed by a professional provider.

Payment for eye examination and refractive services performed by the professional providers will be made to the covered individual on the basis of the amount charged. Payment for post-refractive services is made on the basis of the indemnity schedule allowance or the amount charged, whichever is less. Such payment will constitute full discharge of Albright College's responsibility under the Plan. The covered individual shall be responsible for payment of the remaining charge.

BENEFIT DESCRIPTION

A. Eye Examination and Refractive Services

1. Payment for eye examination and refraction services will be made on the basis of the amount charged.

2. Eye examination and refractive services include, but are not limited to:

   Case history,
   Visual acuity (near and far)
   External examination (including biomicroscopy or other magnified evaluation of the anterior chamber),
   Objective, subjective and opthalmoscopic examinations,
   Binocular measure, and
   Summary, findings and recommendations.
B. Post-Refractive Services

1. Ordering lenses and frames (facial measurements, lenticular formula, any other specifications)

2. Cost of the materials

3. Verifications of the completed prescription upon return from the laboratory

4. Adjustment of the completed glasses to the patient’s face. Subsequent servicing, such as refitting, realigning, readjusting and tightening, for a period not to exceed 90 Days.

C. Post-Refractive Services Fee Schedule

<table>
<thead>
<tr>
<th>Frames</th>
<th>Lenses (Pair)</th>
<th>Contact Lenses (Pair)</th>
</tr>
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<tbody>
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<td>Hard $48</td>
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<td>Bifocal $36</td>
<td>Soft $48</td>
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<td></td>
<td>Aphakic $72</td>
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GENERAL LIMITATIONS

A. General Limitations

Payments for covered services are limited as follows:

1. Payment for an eye examination and refraction is limited to once every 12 months for subscribers under 19 years of age and once every 24 months for subscribers 19 years of age and older. Eligibility will be determined from the date of the last previous refraction.

2. Payment for lenses or contact lenses is limited to once every 12 months for subscribers under 19 years of age and once every 24 months for subscribers 19 years of age or older. Eligibility will be determined from the date of the last previous refraction.

3. Regardless of the age of the subscriber, payment is limited to one set of frames in any 24-month period. Eligibility will be determined from the date of the last previous refraction.
4. Payment will not be made for both frames and contact lenses within a 24-month period.

5. In cases involving services in which the professional provider and subscriber elect to utilize photogray or light sensitive lenses, the program will provide benefits, but will not provide any additional allowance in excess of those delineated in the indemnity schedule, provided the subscriber qualified for such benefits.

6. Payment for frames, lenses and/or contact lenses not supplied by a professional provider will be made only if they are prescribed by a professional provider, and in such case will be made to the subscriber.

7. Payment under the Plan is limited to a combined maximum of $1,000 per person for all services (Dental & Vision) rendered in any Plan Year.

GENERAL EXCLUSIONS

A. Payment will not be made for services, supplies or charges that:

1. Are for the cost of any insurance premiums indemnifying against losses for lenses or frames

2. Are for any illness or bodily injury, which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of any legislation of any governmental unit. This exclusion applies whether or not the subscriber claims the benefits or compensation

3. Are provided by any governmental unit

4. The subscriber would have no legal obligation to pay in the absence of this or any similar coverage

5. Are received from a medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group

6. Are performed prior to the effective date
7. Are incurred after your termination date except for lenses or frames prescribed prior to such termination and delivered within 31 days from such date.

8. Are not billed by a professional provider

9. The cost of which has been or is later recovered in any action at law or in compromise or settlement or any claim except where prohibited by law

10. Are rendered by a professional provider who in any case is compensated by the facility for similar covered Services performed for patients

B. Payment will not be made for:

1. Procedures determined by The Plan Administrator to be special or unusual, such as but not limited to, orthoptics, vision training, subnormal vision aids and tonography

2. Examinations or materials which are not listed in the agreement as a covered service or item of supply

3. Any lenses which do not require a prescription

4. Replacement of lost, stolen, broken or damaged lenses, contact lenses or frames unless the frequency limitations are met

5. Sunglasses, whether or not requiring a prescription. Tinted glasses with a tint other than Number 1 or Number 2 are considered to be sunglasses for the purpose of this exclusion

6. Industrial safety glasses and safety goggles

7. Medical or surgical treatment of the eye

8. Diagnostic services, such as diagnostic X-rays, cardiological, encephalographic examinations and pathological or laboratory tests

9. Drugs or any other medications

10. Eye examinations or material necessitated by employment or furnished as a condition of employment

11. Telephone consultants, charges for failure to keep a scheduled appointment, or charges for completion of a claim form
12. Duplicate and temporary devices, appliances and services

13. Treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified self-insured plan

MISCELLANEOUS PLAN PROVISIONS

A. **Continuation of Benefits - COBRA** (Required under Federal Law)

An individual whose coverage ends under this Employer Group health plan covering 20 or more employees may be entitled to elect continuation of coverage under his plan. Coverage for dependents may also be continued if they are already under this plan.

The period of coverage, which is normally extended to terminated employees, will be considered as part of COBRA Coverage and subsidized by the Employee, should COBRA be elected.

The individual must elect continuation during the election period, premium payment is required, and the individual’s coverage must have ended for one of the following Qualifying Events:

1. End of employment with the employer for any reason (this includes retirement and voluntary quitting) other than gross misconduct;

2. Reduction of hours;

3. Death of an employee;

4. Divorce or legal separation from the employee;

5. Attainment of the maximum age of eligibility by a dependent child;

6. Marriage of a dependent child;

7. Entitlement of the employee to Medicare benefits; or

8. An employer’s Chapter 11 reorganization resulting in a significant elimination of benefits.
Notification Requirements and Election Period

The employee or dependent must notify the Plan Administrator, named in the summary Plan Description, within 60 days when divorce, legal separation, or marriage or attainment of the maximum age would end coverage for a dependent.

In the case of an employee’s reduction of hours, termination of employment, death, or entitlement to Medicare the employer will notify the Plan Administrator.

Upon receiving such notification, the Plan Administrator will notify the eligible employee or dependent of their right to elect continuation.

The employee or dependent must elect continuation by the later of:

1. 60 days after the individual’s coverage ends; or

2. 60 days after the individual receives notification of their continuation right from the Plan Administrator.

Premium must be paid within 45 days of decision to elect Continuation of Coverage under COBRA.

End of Continuation

Continuation will end on the earliest of the following dates:

1. 18 months from the date continuation began for individuals whose coverage ended because of a reduction of hours or end of employment (29 months if disabled);

2. 36 months from the date continuation began for individuals whose coverage ended because of the death of the employee, divorce or legal separation from the employee, the marriage or attainment of the maximum age of eligibility by a dependent, or the employee’s entitlement to Medicare;

3. The end of the period for which premium is paid if the individual fails to make premium payment on the date specified by the employer

4. The date the individual becomes covered under any other group health plan;

5. The date the individual becomes entitled to Medicare; or
6. The date the group health plan ends.

If, before the end of 18 months of continuation, a continuing dependent becomes a surviving spouse, divorced or legally separated spouse, over-age or married dependent, or dependent of an employee who loses continuation due to eligibility for Medicare, such dependent may continue for the balance of 36 months, or, if sooner, he earliest of 3. through 6. above.

c. **Claim Provisions**

1. Written proof of loss must be furnished to the Plan Administrator on such forms as may be required by the Plan Administrator within ninety (90) days after

   a. the date of the loss

   Claim forms are available from the Plan Administrator.

2. Failure to furnish such proof within the required time shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible.

3. All benefits will be paid upon receipt or written proof of loss for which claim is made according to the benefits and coverages herein described.

4. If a claim is denied, the Plan Administrator will provide the claimant with a written notice setting forth

   a. The specific reason or reasons for denial;

   b. The specific Plan provision or provisions on which the denial is based, and:

   c. Any additional information necessary for the claimant to perfect the claim.

5. A claimant shall be allowed at least 60 days after receipt of the written notice of denial to request a review by Albright College of such denied claim, and Albright College shall make its decision based on such review within 60 days (120 days if special circumstances require more time) of its receipt of the request for review. The Plan Administrator's decision shall be in writing and shall clearly describe the reason for its decision.

6. No action at law or in equity shall be brought to recover under the Plan prior to the expiration of the claims procedure required above. No such action shall be brought more than three years after the expiration of the time within which proof of such loss is required.
D. Individual’s statements as to Coverage Subjected to Claim Provisions

All statements with respect to the benefit provided under this plan, which are made by a covered person, shall be deemed representations and not warranties. With respect to the amount of benefits for which a person is covered, no statement made by the person for the purpose of affecting such coverage will be considered as valid unless it can be clearly verified in the Plan Document.

E. Amendments

1. Albright College reserves the right at any time to amend the Plan or to merge, consolidate, divide or otherwise restructure the Plan. Albright College expressly reserves the right to change, reduce or eliminate the benefits provided under the Plan at any time and in any fashion. No person may rely on the future continuation of Plan benefits since Albright College has expressly reserved the right to change or reduce benefits or terminate the Plan at any time. Whether or not Albright College formally eliminates or reduces Plan benefits, such benefits shall only be provided to the extent they can be paid from assets of Albright College Reserves.

2. All amendments or other changes shall be adopted in writing by Albright College.

3. Any material modification of the Plan by amendment or termination shall be communicated to all interested parties and the Secretaries of Labor in the time and manner required by law.

F. Termination of Plan

The Plan is intended to be a permanent program, but Albright College shall have the right at any time to declare the Plan Terminated completely. With respect to incurred claims, the Plan Shall honor them to the extent they can be paid from assets of the Plan’s reserves.

G. Terminal Liability

No benefits will be paid or charge incurred after the termination date of (a) the Plan, and/or (b) a Plan participant except when specifically noted in the Plan Document.
H. Payments

1. In the event any amount becomes payable under the Plan to a minor or a person who, in the sole judgment of the Plan Administrator is considered to be unable to give a valid receipt for the payment by reason of physical or mental condition, the Administrator may direct that payment be made to any person found by the Administrator, in its sole judgment, to have assumed the care of the person in question. Any payment made pursuant to such a finding shall constitute payment by the Plan and result in a full release and discharge of the Plan Administrator, the Employer and their officers, directors, employee, agents and representatives.

2. Payment of benefits to the person entitled thereto may be made by a check sent via first class mail, address correction requested, to the last known address on file with the Plan Administrator. If, within six months from the date of issuance of the check, the payment letter cannot be delivered to the person entitled thereto or the check has not been negotiated, the payment shall be treated as forfeited.

I. Duty to Provide Data

1. Every person with an interest in the Plan or claiming benefits under the Plan shall furnish the Plan Administrator on a timely and accurate basis with such documents, evidence or information, as it considers necessary or desirable for the purpose of administering the Plan. The Plan Administrator may postpone payment of benefits until such information and such documents have been furnished.

2. Every person claiming a benefit under this Plan shall give written notice to the Plan Administrator of his post office address and each change of post office address. Any communication, statement or notice addressed to such a person at his latest post office address as filed with the Plan Administrator will, on deposit in the United States Mail with postage prepaid, be as binding upon such person for all purposes of the Plan as if it had been received, whether actually received or not. If a person fails to give notice of his correct address, the Plan Administrator, the Employer and Plan fiduciaries shall not be obligated to search for, or to ascertain, his whereabouts.

3. If benefits, which are otherwise currently payable, cannot be paid to the person entitled to the benefits because the individual has failed to comply with
this Section or other Plan provisions relating to claims for benefits, any unpaid past due amount shall be forfeited.

J. Limitations of Rights of Employees

1. Except as provided otherwise in any applicable collective bargaining or tenure agreement, the Plan is strictly a voluntary undertaking on the part of the Employer and shall not constitute a contract between the Plan and any Employee, or consideration for, or an inducement or condition of, the employment of an Employee.

2. Except as otherwise required by law or any applicable collective bargaining or tenure agreement, nothing contained in the Plan shall give any Employee the right to be retained in the service of the Employer or to interfere with or restrict the right of the Employer, which is hereby expressly reserved, to discharge or Retire any Employee at any time, in accordance with applicable Personnel policies.

3. Except as otherwise required by law, inclusion under the Plan will not give any Employee or other person any right or claim to any benefit hereunder except to the extent such right has specifically become fixed under the terms of the Plan and there are funds available therefore. The doctrine of substantial performance shall have no application to Employees, Qualified Dependents or anyone else claiming benefits hereunder.

K. Service of Process

Albright College is hereby designated as agent for the service of legal process on the Plan.

L. Governing Law

The Plan and trust shall be interpreted, administered and enforced in accordance with the Internal Revenue Code and ERISA, and the rights of all persons shall be determined in accordance with these laws. To the extent that state law is applicable, however, the laws of the State of Pennsylvania shall apply.

M. ERISA – Rights of Covered Employees

As a participant in the Albright College Voluntary Employee Benefit Plan, employees 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:
Examine, without charge, at the Plan Administrator’s Office, all Plan documents, and copies of all documents filed by the Plan with the U.S. Department of Labor such as detailed annual reports and plan descriptions.

Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan’s annual financial report (if applicable). The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

File suit in a federal court, if any materials requested are not received within 30 days of the participant’s request, unless the materials were not sent because of matters beyond the control of The Plan Administrator.

In addition to creating rights for Plan participants, ERISA imposes obligations upon the persons who are responsible for the operation of the Plan. These persons are referred to as “fiduciaries” in the Law. Fiduciaries must act solely in the interest of the Plan Participants and they must exercise prudence in the performance of their Plan duties. Fiduciaries who violate ERISA may be removed and required to make good any losses they have caused the Plan.

The Employer may not fire or discriminate against an employee to prevent him from obtaining a benefit or exercising his rights under ERISA.

If an employee is improperly denied a benefit in full or in part he has a right to file suit in a federal or state court. If Plan fiduciaries are misusing the Plan's money, the employee has a right to file suit in a federal court or request assistance from the U.S. Department of Labor. If the employee is successful in his lawsuit, the court may, if it so decides, require the other party to pay legal costs, including attorney’s fees.

If any employee has any questions about this statement regarding rights under ERISA, he should contact the Plan Administrator or the nearest Area Office of the U.S. Labor Management Service Administration, Department of Labor.

This plan is in full compliance with all Federal Regulations (COBRA) where applicable.

N. Plan Rules

As permitted by the Plan, the Plan Administrator may adopt plan rules for the administration and interpretation of the Plan. These rules may be changed from time to time in written or oral policy decisions made by Albright College and communicated in writing to the Plan Administrator. The Plan rules shall consist

O. **Plurals/Pronouns**

Where the context so indicates, the singular shall include the plural and vice versa, and masculine pronouns shall include the feminine.

P. **Right of Recovery**

Whenever payments have been made by the Plan with respect to Allowable Expenses in a total amount in excess of the maximum amount of payment necessary at that time to satisfy the intent of this document, this Plan shall have the right to recover such payments, to the extent of such excess, from among one or more of any persons to, for or with respect to whom such payments were made, as the Plan Administrator shall determine.

Q. **Claims Appeal**

You or your representatives may ask us to reconsider any claim or portion of a claim for which you believe benefits have been erroneously denied based on the limitations and/or exclusions of your Plan.

Your request may be made by either telephoning Albright College at (215) 921-7629 or writing to Albright College, P.O. Box 15234, 13th & Exeter Streets, Reading, PA 19612-5234.

You have the right to review pertinent documents. You may obtain from us a copy of material relative to your claim. In some cases, written authorizations to release certain information will be necessary and you will be informed accordingly.

Inquiries may be made within 12 months of the date you first were notified of the actions being taken to deny all or part of your Claim.