

**SUMMARY PLAN DESCRIPTION
MATERIAL MODIFICATIONS
for the**

**AUGUSTANA COLLEGE DEFINED CONTRIBUTION
RETIREMENT PLAN**

April 1, 2018

(1) **General.** This is a Summary of Material Modifications regarding the frozen Augustana College Defined Contribution Retirement Plan (the "Plan"). This is merely a summary of the most important changes to the Plan and information contained in the Summary Plan Description ("SPD") previously provided to you. It supplements and amends that SPD so you should retain a copy of this document with your copy of the SPD. If you have any questions, contact the Administrator. If there is any discrepancy between the terms of the Plan, as modified, and this Summary of Material Modifications, the provisions of the Plan will control.

(2) **Employer Information.** The legal name, address and Federal employer identification number of the Employer are:

Augustana College
639 38th Street
Rock Island, IL 61201

EIN: 36-2166962

(3) **Summary Description of Modification.** The Employer has amended the Plan in the following respects:

a. Use of Forfeitures to offset Qualified Nonelective Contributions. Notwithstanding any prohibition in the Plan to the contrary, effective January 1, 2017, to the extent the Plan permits forfeitures to be used to reduce any Employer Contributions, then such forfeitures may also be used to offset Employer Contributions that are Qualified Nonelective Contributions, Qualified Matching Contributions, and contributions made pursuant to Code §401(k)(12), if any are permitted under the Plan.

b. Disability Claim Procedures.

Notwithstanding anything in the plan or Summary Plan Description to the contrary, the following procedures apply with respect to claims for disability benefits after April 1, 2018. These procedures are limited to claims where benefits are based on disability and the Plan Administrator is determining whether you satisfy the Plan's definition of disability (e.g., where the plan is not relying on an independent determination, such as qualifying for Social Security disability benefits or where a participant's eligibility for disability benefits is determined under Employer's long term disability program).

These procedures are intended to meet ERISA requirements set forth in DOL Regulation §2560.503-1 and will be interpreted in accordance with such regulations. The procedures are designed to ensure that claimants are not unduly inhibited from making claims; that claimants may appoint an authorized representative in accordance with Plan rules; determinations will be made in accordance with the Plan documents; that Plan provisions are applied consistently; and that decisions are made by impartial and independent decision makers.

The Plan may offer additional voluntary appeal and/or mandatory arbitration procedures other than those described here. If applicable, the Plan will not assert that a claimant has failed to exhaust administrative remedies for failure to use the voluntary procedures, any statute of limitations or other defense based on timeliness is tolled during the time a voluntary appeal is pending; and the voluntary process is available only after exhaustion of the appeals process described in this section. If mandatory arbitration is offered by the Plan, the arbitration must be conducted instead of the appeal process described in this section, and the claimant is not precluded from challenging the decision under ERISA §501(a) or other applicable law.

The “claimant” refers to you, your authorized representative, or anyone else entitled to benefits under the Plan (such as a beneficiary).

For purposes of these procedures, a document, record, or other information shall be considered relevant to a claim if it:

- was relied upon in making the benefit determination;
- was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;
- demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or
- constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

How do I submit a claim for Plan benefits?

You may file a claim for benefits by submitting a written request for benefits to the Plan Administrator. You should contact the Plan Administrator to see if there is an applicable distribution form that must be used. If no specific form is required or available, then your written request for a distribution or a written assertion that your benefits under the Plan have been determined incorrectly, will be considered a claim for benefits.

The claim for benefits must include sufficient evidence to enable the Plan Administrator to determine whether you have met the Plan’s definition of disability.

Decisions on the claim will be made within a reasonable period of time appropriate to the circumstances. “Days” means calendar days. If the Administrator determines the claim is valid, then you will receive a statement describing the amount of benefit, the method or methods of payment, the timing of distributions and other information relevant to the payment of the benefit.

Initial Claims

A claim must be resolved, at the initial level, within forty-five (45) days of receipt by the Plan. A Plan may, however, extend this decision-making period for an additional thirty (30) days for reasons beyond the control of the Plan. The Plan will notify the claimant of the extension prior to the end of the forty-five (45) day period. If, after extending the time period for the first thirty (30) day period, the Plan Administrator determines that it will still be unable, for reasons beyond the control of the Plan, to make a decision within the extension

period, the Plan may extend decision making for a second thirty (30) day period.

Appropriate notice must be provided to the claimant before the end of the first forty-five (45) days and again before the end of each succeeding thirty (30) day period. This notice will explain the circumstances requiring the extension and the date the Plan Administrator expects to render a decision to the claimant. It will explain the standards on which entitlement to the benefits is based, the unresolved issues that prevent a decision, the additional issues that prevent a decision, and the additional information needed to resolve the issues.

The claimant will have forty-five (45) days from the date of receipt of the Plan Administrator's notice to provide the information required.

What if my benefits are denied?

If the Plan Administrator determines that all or part of the claim should be denied (an "adverse benefit determination"), it will provide a notice of its decision in written or electronic form explaining the claimant's appeal rights. An "adverse benefit determination" also includes a rescission, which is a retroactive cancellation or termination of entitlement to disability benefits. The notice will be provided in a culturally and linguistically appropriate manner and will state:

- (a) The specific reason or reasons for the adverse determination.
- (b) Reference to the specific Plan provisions on which the determination was based.
- (c) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary.
- (d) A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of the claimant's right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review.
- (e) A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
 - the views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;
 - the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; or
 - a disability determination made by the Social Security Administration regarding the claimant and presented by the claimant to the Plan.
- (f) If the adverse benefit determination is based on medical necessity or experimental and/or investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.
- (g) Either the specific internal rules, guidelines, protocols, or other similar criteria relied upon to

make a determination, or a statement that such rules, guidelines, protocols, or criteria do not exist.

(h) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

Review of Adverse Benefit Determinations

When a claimant receives a notice of an adverse benefit determination, the claimant may request a review of the decision. The request must be in writing and must be filed within one hundred eighty (180) days following receipt of the notice. In the case of an adverse benefit determination regarding a rescission of coverage, the claimant must request a review within ninety (90) days of the notice. The claimant or his authorized representative may submit written comments, documents, records, and other information relating to the claim. If the claimant so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

The review shall take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial adverse benefit determination and will be considered by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

If the initial adverse benefit determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the fiduciary shall consult with a health care professional who was neither involved in or subordinate to the person who made the original benefit determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified.

If the Plan considers, relies upon or creates any new or additional evidence during the review of the adverse benefit determination, the Plan will provide such new or additional evidence to the claimant, free of charge, as soon as possible and sufficiently in advance of the time within which a determination on review is required to allow the claimant time to respond.

Before the Plan issues an adverse benefit determination on review that is based on a new or additional rationale, the claimant must be provided a copy of the rationale at no cost to the claimant. The rationale must be provided as soon as possible and sufficiently in advance of the time within which a final determination on appeal is required to allow the claimant time to respond.

The claimant will be notified of the determination on review of the claim no later than 45 days after the Plan's receipt of the request for review, unless special circumstances require an extension of time for processing. In such a case, the claimant will be notified, before the end of the initial review period, of the special circumstances requiring the extension and the date a decision is expected. If an extension is provided, the Plan Administrator must notify the claimant of the determination on review no later than 90 days after receipt of the request for review.

Notice of Adverse Benefit Determination on Review

The Plan Administrator shall provide written or electronic notification to the claimant or his authorized representative in a culturally and linguistically appropriate manner. If the initial adverse benefit determination is upheld on review, the notice will include:

- (a) The specific reason or reasons for the adverse determination.
- (b) Reference to the specific Plan provisions on which the determination was based.
- (c) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.
- (d) A statement of claimant's right to bring a civil action under section 502(a) of ERISA and, if the Plan imposes a contractual limitations period that applies to claimant's right to bring such an action, a statement to that effect which includes the calendar date on which such limitation expires on the claim.

If the Plan offers voluntary appeal procedures, a description of those procedures and the claimant's right to obtain sufficient information about those procedures upon request to enable the claimant to make an informed decision about whether to submit to such voluntary appeal. These procedures will include a description of the claimant's right to representation, the process for selecting the decision maker and the circumstances, if any, that may affect the impartiality of the decision maker. No fees or costs will be imposed on the claimant as part of the voluntary appeal. A claimant's decision whether to use the voluntary appeal process will have no effect on the claimant's rights to any other Plan benefits.

- (e) A discussion of the decision, including an explanation of the basis for disagreeing with or not following:

- the views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;
- the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; or
- a disability determination made by the Social Security Administration regarding the claimant and presented by the claimant to the Plan.

- (f) If the adverse benefit determination is based on medical necessity or experimental and/or investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

- (g) Either the specific internal rules, guidelines, protocols, or other similar criteria relied upon to make the determination, or a statement that such rules, guidelines, protocols, or criteria do not exist.

