PARTICIPANTS
Claim Administration and Procedure Flow Chart

Event	Claim Administration and Procedure
Inquiries	An inquiry about your pension benefit, including inquiries about the amount of vested or credited service, by itself, will not be considered a claim for purposes of the Plan's claim procedures. If you disagree with the information provided by the Fund Office, be advised that you may submit additional information and file a claim for review and, if appropriate, correction or modification of the Fund Office's records. However, any such claim must be filed pursuant to the Plan's claim procedures outlined below.
***Step 1:* You Must File an Initial Application or Claim for Benefits**	**Initial Application:** To receive benefits from the Plan, you must file a written application with the Fund Office on an application form provided by the Fund Office. **Claim:** If you believe you are entitled to a Plan benefit that differs from the benefit determined for you by the Fund Office, you must file a written claim with the Fund Office **Contacting the Fund Office:** The Fund Office can be reached at the phone number below. Furthermore, written applications and claims must be delivered to the address below. ▪ Phone Number: o Toll Free 1.800.522.4161; or o 973.778.5800 ▪ Fax Number: o 973.778.1725 ▪ Address: o UFCW Local 1262 and Employers Pension Fund 1389 Broad Street Clifton, NJ 07013

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Step 2: **Fund Office's Review of Your Initial Application or Claim for Benefits**	**Timing of Review:** The Fund Office will review your initial written application or claim and a written notice of the disposition of the claim or application will be furnished to you within 90 days for a non-disability claim and within 45 days for a disability claim beginning from the date the Fund Office receives your application or claim. **Extension:** The time schedules listed above will apply unless the Fund Office determines that special circumstances require an extension of up to 90 additional days for a non-disability claim (or up to two additional 30 day extensions for a disability claim). **Exception:** If an extension is the result of your failure to submit necessary information related to a determination of disability, the "clock stops running" on the period of time the Fund Office has to decide the claim until the Fund Office receives that information, or (if earlier) until the period of time you have been given to provide the information has expired. You will be provided with at least 45 days to provide requested information regarding a disability. **Note:** The Fund Office will let you know if (and why) it needs an extension by providing you with a written notice before the end of the period that is being extended.
Step 3**: If Your Initial Application or Claim for Benefits is Denied**	Once the Fund Office reviews your application for benefits, a decision will be made as to the amount of the benefit you are eligible to receive, if any. If the Fund Office denies your initial application or makes an adverse determination on your written claim, the Fund Office will provide you with a written statement that will outline the following information: ▪ Specific reason(s) for any denial or adverse determination; ▪ Specific reference to the pertinent Plan provision(s) upon which any denial or adverse determination was based; ▪ Description of any additional material or information necessary to complete the claim and provide an explanation as to why such additional information is necessary; ▪ The Plan's claim review procedures and the time limits that apply to the procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of ERISA following an adverse determination on appeal; and ▪ An offer to provide you, on request, free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim for benefits (including a statement of policy or guidance concerning a disability claim).

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***Step 4:* After a Denial or Adverse Determination You May File a Written Appeal Challenging the Decision of the Fund Office**	**Your Appeal Rights:** If your initial application or claim for benefits is denied or you believe you did not receive the full amount of benefits to which you are entitled, or otherwise believe that you have been adversely affected, you have the right to appeal the denial or adverse determination. To appeal the denial or adverse determination, you must submit your request: ▪ To the Board of Trustees (the "Trustees"); ▪ In writing; ▪ Within 60 days (180 days for a disability claim) following the date that you receive the decision on your initial claim from the Fund Office. **Right to Submit Evidence and Access to Available Information:** In preparing for your appeal, you or your authorized representative may, upon request and without charge, be provided with: ▪ Copies of all documents, records, and other information that is relevant to your claim. Additionally, you may include in your request any written comments, documents, records, and other information that is relevant to your claim.
***Step 5:* You Also Have a Right to Request a Hearing**	In lieu of filing a written appeal, you have the right to request that a hearing be held to consider your claim. You are permitted to attend such hearing and/or be represented by legal counsel or other representation of your choice. You must follow the same procedures outlined above in *Step 4* when submitting your request to have a hearing held to decide the merits of your claim.

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Step 6: **Review of Your Appeal by the Sub-Committee of the Trustees**	**Authority of the Sub-Committee:** Under the terms of the Plan, the Trustees have elected to delegate its authority to review your appeal to a designated sub-committee (the "Committee") comprised of four members of the Trustees. In accordance with this delegation of authority, the Committee will consider and rule upon the merits of your appeal. **When will Your Appeal be Reviewed?** The Committee will review your written appeal no later than the date of the next regularly scheduled meeting of the Trustees after receipt of your appeal. ▪ **30 Day Exception:** If your appeal is received within 30 days before the next regularly scheduled meeting of the Trustees a decision on your appeal will generally be made at the second regularly scheduled meeting after receipt of your appeal. ▪ **Additional Extension:** In the event special circumstances require additional time to review your appeal, the Committee will decide the outcome of your appeal no later than the third regularly scheduled meeting of the Trustees arising after receipt of your appeal. If special circumstances require the additional extension, you will be provided with a written notice of the extension, describing the special circumstances and the date upon which the benefit determination will be made, prior to the commencement of the extension. **Review of Your Appeal:** The Committee's review of your appeal will take into account all comments, documents, records, and other information that you submit relating to the claim, without regard to whether that information was submitted or considered in the initial benefit determination by the Fund Office. If medical judgment is required to determine a disability claim, the Committee will consult with (and provide for identification of) a health care professional who did not consult (and is not subordinate to the professional who did consult) on the initial adverse determination. With respect to a disability claim, no deference will be afforded to the initial adverse determination and vocational experts consulted will be identified. **Written Notice of Decision:** After the hearing or review of your appeal, the Committee will issue a written decision reaffirming, modifying, or reversing the original decision or action by the Fund Office regarding the claim in question.

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Step 7: **If the Sub-Committee Unanimously Affirms, Modifies or Reverses the Decision of the Fund Office**	If, after the hearing or review of your appeal, the decision of the four-member Committee unanimously concurs, modifies or reverses the decision previously made by the Fund Office, then the Committee will issue you a written decision (see *Step 9* below for details on what will be included in the written decision), on behalf of the Trustees, reaffirming, modifying or reversing the original decision or action by the Fund Office regarding the claim in question.
Step 8: **If the Sub-Committee is Not Unanimous in its Decision to Affirm, Modify or Reverse the Decision of the Fund Office**	If, after the hearing or review of your appeal, the decision of the four-member Committee is not unanimous, then your appeal will be presented to the full board of the Trustees at its next regularly scheduled meeting. At that time, you will again be permitted to attend the hearing and/or be represented by legal counsel or other representation of your choice. In addition, as outlined above, in *Step 4*, you will have the right to present evidence relevant to your claim at the hearing. If, after the hearing or review of your appeal, the Trustees concur, modify or reverse the decision previously made by the Fund Office, then the Trustees, or a selected delegate, will issue you a written decision (see *Step 9* below for details on what will be included in the written decision), reaffirming, modifying or reversing the original decision or action by the Fund Office regarding the claim in question.
Step 9: **If Your Appeal is Wholly or Partially Denied**	If the Committee or the Trustees denies or returns an adverse determination with regard to your appeal, you will be provided with a written statement, on behalf of the Trustees, that contains the following information: ▪ Specific reason(s) for the determination; ▪ Reference to the specific Plan provision(s) on which the denial or adverse determination was based; ▪ Offer to provide you, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim for benefits (including a statement of policy or guidance concerning a disability claim and the identity of any medical or vocational expert whose advice was obtained in connection with a disability claim); ▪ A statement of your right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974 ("ERISA").

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Step 10: **Your Right to Seek Arbitration**	**Right to Arbitration:** If you are dissatisfied after you receive the Committee's or the Trustees' written decision, you have the right to appeal the matter to arbitration in accordance with the rules of the American Arbitration Association. **Request for Arbitration:** If you request arbitration, your request must be in writing within 60 days after you receive the Committee's or the Trustees' written decision. **Arbitrator's Review:** The arbitrator will decide whether the Committee or the Trustees was in error upon an issue of law; acted arbitrarily or capriciously in the exercise of its discretion; or made findings of fact that were not supported by substantial evidence. The decision of the arbitrator will be final and binding upon you and the Committee or the Trustees. **Costs:** The administration fees of the American Arbitration Association will be borne equally by you and by the Trust Fund. The arbitrator's fee and expenses will also be borne equally. Each party will be responsible for their own expenses and counsel fees.
Step 11: **Your Right to File Suit**	The decision of the Committee or the full board of the Trustees, as the case may be, is final and conclusive on all persons claiming benefits under the Plan, subject to applicable law. If you are not satisfied with the decision on your appeal, you have the right to sue the Fund under ERISA to recover the benefits to which you believe you are entitled, along with attorney's fees if you are successful. If you are unsuccessful, however, you may be liable to pay the Fund's attorney's fees incurred as a result of your suit, if, for example, the court finds that your claims were frivolous.

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Step 12: **Information that You May Obtain Upon Request from the Fund Office**	As a participant you may request that the Fund Office supply the following documents: ▪ The appropriate application form upon which you can file your initial application to receive benefits; ▪ Free copies of all documents, records and other information relevant to your claim when you or your authorized representative is preparing for your appeal; ▪ Free copies of all documents, records and other information relevant to your claim after your appeal has been wholly or partially denied. In addition, ERISA entitles all participants to receive certain information about the Plan and benefits. ▪ You must be provided with the right to examine, without charge, at the Plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits security Administration; ▪ Upon written request to the Plan administrator, you must be provided with copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary Plan description. However, you may be required to pay a reasonable charge to cover the cost of the copies; ▪ The Plan administrator is required by law to furnish you with a copy of the Plan's annual financial report.