

PLAN SUMMARY OF COVERAGE

G.M.P. – EMPLOYERS RETIREE TRUST

Plan as of January 1, 2013



The health benefits described in the Plan of Benefits booklet and in this document are provided by the G.M.P. – Employers Retiree Trust (the “Trust”). These benefits are payable out of the Trust’s assets on a self-funded basis. The life insurance (for retirees only) described in the Plan of Benefits and in this document is provided under group insurance policies issued by Aetna Life Insurance Company (“Aetna”), 151 Farmington Ave., Hartford, CT 06156. Premiums for the group life insurance are paid by the Trust. Except for life insurance claims appeals, which are referred to Aetna for disposition as described on page 8, Aetna provides consultative and administrative services to the Trust that do not include the processing or disposition of claims for benefits.

Keep this document with your Plan of Benefits.

Visit www.gmptrust.com for up-to-date Trust benefit information including the Plan of Benefits document referenced above, benefits by employer, articles on healthy living, and much more.



5245 Big Pine Way, S.E.
Fort Myers, FL 33907-5998
Telephone: (239) 936-6242

Marilyn S. Barnes – Executive Director

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International Union (AFL-CIO, CLC)
608 East Baltimore Pike
Media, PA 19063

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Glass, Molders, Pottery, Plastics & Allied Workers
International Union (AFL-CIO, CLC)
608 East Baltimore Pike
Media, PA 19063

J. Rickey Hunter

International Vice-President
Glass, Molders, Pottery, Plastics & Allied Workers
International Union (AFL-CIO, CLC)
608 East Baltimore Pike
Media, PA 19063

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One Michael Owens Way
Perrysburg, OH 43551-2999

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Vice-President Human Resources
Ardagh Group, Glass - North America
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Suite 2800
Tampa, FL 33602

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1509 S. Macedonia Avenue
Muncie, IN 47307

ELIGIBILITY

You are in an eligible class if you are in one of the three classes below.

First, on December 31, 2007, you (either as a retiree or as an eligible lawful spouse or surviving lawful spouse of a retiree) were a participant in this Plan, according to the governing provisions of the Plan at that time.

Second, on and after January 1, 2008, you (as a retiree) meet the following conditions:

1. Your last day of work prior to your retirement is under a labor contract providing for contributions by your employer to the Trust;
2. You retire on a normal, early or disability retirement under your employer's pension plan and you are receiving retirement benefits under your employer's pension plan (or, if your employer does not have a pension plan of such type, the Trustees will consider other pertinent factors in considering whether or not you are a retiree for purposes of this Plan); and
3. You reach age 60. (This third condition is not applicable if you retire under a contract with a contributing employer that provides for contributions to the Trust at the highest contribution level in effect on January 1, 2008, or if you become medically eligible for Medicare before or after retirement.)

Third, on and after January 1, 2008, you (as a lawful spouse of a retiree who meets the conditions in one and two above) meet the following conditions:

1. You are the lawful spouse of such retiree at the time of his or her retirement;
2. You remain the lawful spouse of such retiree;
3. You are not employed under a labor contract providing for contributions by your employer to the Trust; and
4. You reach age 60, but only if the retiree to whom you are married retired on or after January 1, 1995. (This fourth condition is not applicable if the retiree to whom you are lawfully married retires under a contract with a contributing employer that provides for contributions to the Trust at the highest contribution level in effect on January 1, 2008, or if you become medically eligible for Medicare before or after your lawful spouse's retirement.)

- An individual who has only deferred vested pension benefits under a participating employer's pension plan is not eligible for coverage under this Plan as a retiree.
- An individual who dies while covered under a participating employer's active group insurance program is not eligible under this Plan as a retiree.
- An individual who is covered by a participating employer's active health benefits program under a labor contract providing for contributions by that employer to the Trust is not eligible for coverage under this Plan, either as a retiree or as a spouse.
- No individual may be covered under this Plan both as a retiree and as a spouse.
- No individual may be covered under this Plan as a spouse upon either divorce or remarriage, including after the retiree's death.
- No individual may receive multiple coverage under this Plan because of connections with two or more participating employers either as a retiree or a spouse.
- If an eligible spouse does not take spouse coverage at the time of the retiree's retirement, he or she cannot apply until January 1 of the following year. If, however, an eligible spouse has other coverage, cancels it, and provides proof of termination, the waiting period (January 1 of the following year) does not apply. Written notice of the cancellation of other coverage enables coverage through the Trust within 30 days.
- The monthly premium for spouse coverage is paid when due.

Coverage for all individuals, including continuations of coverage for all participants at any time, will be subject to the current governing provisions of the Plan. For possible additional grounds for termination of coverage, please refer to the other material in the Plan of Benefits booklet. If your coverage as a spouse terminates upon divorce, you have the right to choose continuation coverage at your expense.

More information will be found in the Trust's COBRA CONTINUATION COVERAGE notice, previously distributed to all retirees and eligible spouses. If you need a copy of this notice, contact the Trust office. For additional materials on eligible spouse coverage, please refer to details in the Plan of Benefits booklet.

LIFE INSURANCE BENEFITS

Life insurance is for retirees only. There is no coverage for spouses.

The life insurance described in the Plan of Benefits booklet is provided by the Aetna Life Insurance Company.

Classification Amount

All retirees \$2,000

COMPREHENSIVE MEDICAL EXPENSE COVERAGE UNDER THE TRUST’S INDEMNITY PROGRAM

For retirees and their eligible spouses

Benefits

Individuals who are not eligible for Medicare:

- 80 percent of covered medical expenses (as described in your Plan of Benefits booklet) after the annual calendar year deductible has been satisfied.

Individuals who are eligible for Medicare:

- 80 percent of covered medical expenses (as described in your Plan of Benefits booklet) after the annual calendar year deductible has been satisfied.
- In addition to this 80 percent benefit, this Plan, after the annual deductible has been met, coordinates with Medicare to pay up to 90 percent on certain covered medically necessary expenses.

Deductible

Individuals who are not eligible for Medicare:

- An amount equal to a multiple of the Medicare Part B monthly premium, rounded to the nearest \$10, currently set by the Trustees at 37.5 times the Medicare Part B monthly premium. (This amount is for participants under contracts with employers who are contributing to the Trust at the highest level. For participants under contracts with employers not contributing to the Trust at the highest level the annual deductible is, as applicable, 60 times the Medicare Part B monthly premium).
- Annual Deductible in 2013 is \$2,400 for participants whose employers are contributing to the Trust at the highest level.
- Annual Deductible in 2013 is \$4,500 for participants whose employers are contributing to the Trust below the highest level.

Individuals who are eligible for Medicare:

- An amount equal to a multiple of the Medicare Part B monthly premium, rounded to the nearest \$10, currently set by the Trustees at 20 times the Medicare Part B monthly premium.
- Annual Deductible in 2013 is \$1,350 for participants whose employers are contributing to the Trust at the highest level.
- Annual Deductible in 2013 is \$1,740 for participants whose employers are contributing to the Trust below the highest level.

Other Limits

Out-of-pocket maximum:

- An amount equal to three times the individual’s deductible.

Hearing aid maximum.....\$400

- Once every 36 months.

Private room limit:

- The institution’s semi-private rate.

Lifetime maximum benefit.....\$170,000*

* For participants under contracts with contributing employers not at the highest contribution level, the lifetime maximum benefit is \$100,000.

This replaces any Plan Summary of Coverage booklet previously in effect under the group contracts. Requests for amounts of coverage other than those to which you are entitled according to this booklet cannot be accepted.

NOTE: In determining covered medical expenses under this Plan, it is assumed an individual has coverage for Part A and Part B of Medicare, regardless of whether or not coverage is currently in effect. Therefore, we highly recommend that participants enroll in Medicare Part B, the voluntary portion of Medicare. This Plan covers only admissions or charges covered by Medicare. If an admission or a charge is or would be denied by Medicare, that admission or charge is not covered by this Plan.

PRESCRIPTION DRUG BENEFITS

Participants whose former employer is contributing to the Trust at the highest rate can take advantage of a prescription drug benefit, which carries a separate annual deductible of \$650. Prescription drug deductible and coinsurance amounts do not apply to the Out-of-Pocket maximum. This program is through Express Scripts (formerly Medco Health Solutions, Inc). The prescription drug benefit is available through both the Indemnity program and the PPO option. There is NO ADDITIONAL FEE to participate in the prescription program, however, the applicable PPO and/or spouse premiums still apply.

The Prescription Drug Benefit applies to retail pharmacy and to mail-order prescription drugs. After the deductible is satisfied, prescription drugs are covered as follows:

- Generic prescription drugs are covered at 90 percent;
- "Plan-preferred" brand-name prescription drugs are covered at 75 percent;
- "Non-plan-preferred" brand-name prescription drugs are covered at 60 percent.
- For maintenance prescription drugs, the above 90/75/60 percent benefit levels apply only if you participate in the mail-order program. If you do not participate in the mail-order program for your maintenance prescription drugs, your prescriptions are covered as follows:
 - Generic prescription drugs are covered at 50 percent;
 - "Plan-preferred" brand-name prescription drugs are covered at 50 percent;
 - "Non-plan-preferred" brand-name prescription drugs are covered at 25 percent.

"Plan-preferred" prescription drugs are sometimes called "formulary" prescription drugs. These prescription drugs are reviewed by an independent group of practicing doctors and pharmacists for safety and effectiveness.

To take advantage of the prescription drug program, simply show your Trust I.D. card when you visit a participating pharmacy.

To find a list of plan-preferred prescription drugs or to find a participating pharmacy near you, visit www.express-scripts.com.

The pharmacy will apply your deductible and the appropriate coinsurance at the time of purchase. You will pay the pharmacy the amount owed and, if your former employer is contributing to the Trust at the highest rate, you will not have to file a claim.

Medicare participants enrolled in a Part D plan are not eligible to participate in the Trust's Prescription Drug Program. If you join a Medicare Part D plan for prescription drugs you must notify the Trust.

Participants whose former employer is contributing to the Trust below the highest rate receive a discount by showing their Trust I.D. card. These participants are responsible for submitting receipts to the Trust office for consideration. The discount varies by prescription drug.

VOLUNTARY DISEASE MANAGEMENT PROGRAMS

The Trustees have researched health care companies and programs to find coverage most likely to serve Trust participants well, from preventive care to care for chronic and serious medical conditions. The Trust offers heart disease and diabetes management programs to eligible Non-Medicare participants through Nurtur. Nurtur's programs are free to Trust participants who have a:

- History of cardiovascular disease; or
- Diagnosis of diabetes; or
- Diagnosis of congestive heart failure.

Counselors work with enrollees to develop personalized plans designed to improve quality of life. The programs enhance, but do not replace, medical care received from a doctor. Enrollment is voluntary and confidential. On average, participation in the program lasts 24 months. For questions, or to determine if you are eligible, contact Nurtur toll free at 1-877-676-7700, or visit www.nurturhealth.com.

UNDERSTANDING THE PPO OPTION

A Preferred Provider Organization, or PPO, is a health care benefit plan where medical providers agree to offer their services at a discount. In return, the plan offers members incentives to choose these providers who have chosen to participate in this "network." Coverage for services from other health care providers is available, but at a higher out-of-pocket cost to the member. PPO providers are subject to a screening process to verify they have appropriate licensing and certification.

Eligibility and Enrollment

Only retirees and eligible spouses who are not yet Medicare eligible may enroll in the PPO option. If you have or are eligible for Medicare Part A and/or Part B you cannot enroll in the PPO option.

If you are interested in the PPO option, you must complete a PPO enrollment form and submit it to the Trust office for consideration (see "How to Enroll" on page 6). Your enrollment form will be reviewed and, if you are eligible, you will be enrolled in the PPO option as soon as possible. Initially, you may enroll in the PPO option at any time.

If an eligible spouse does not take spouse coverage at the time of the retiree's retirement, he or she cannot apply until January 1 of the following year. If, however, an eligible spouse has other coverage, cancels it, and provides proof of termination, the waiting period (January 1 of following year) does not apply. Written notice of the cancellation of other coverage enables coverage through the Trust within 30 days.

Voluntary PPO Termination

If you want to drop the PPO option and return to the Trust's Indemnity program, you may do so at any time, but you must notify the Trust office in writing of your intent. Your termination date will be the earliest possible date after the Trust has received the written notification. Termination dates cannot be retroactive unless your status changed making you ineligible for PPO coverage.

If you want to re-enroll in the PPO option at a later date you will not be eligible for the PPO option for two years from the following January 1st after your PPO termination (see "Termination of Coverage" on page 7 for more information).

In-voluntary PPO Termination

If your monthly PPO premiums are not paid or kept current:

- Retirees will be automatically enrolled in the Indemnity Plan and will not be eligible for the PPO option for two years from the following January 1st after your PPO termination date.
- Spouses will be terminated and may not re-enroll in the Indemnity Plan or the PPO option for two years from the following January 1st after your PPO termination date.

COMPARING THE TRUST'S NON-MEDICARE INDEMNITY AND PPO OPTION PROGRAMS

NON-MEDICARE INDEMNITY PROGRAM		
Plan Benefits	Highest contribution level	Below the highest contribution level
Annual deductible	\$2,400	\$4,500
You pay	20%, after you pay the annual deductible (+ \$35 per month for eligible spouse)	20%, after you pay the annual deductible (+ \$35 per month for eligible spouse)
Annual out-of-pocket maximum	\$7,200	\$13,500
Lifetime maximum	\$170,000	\$100,000

PPO OPTION				
Plan Benefits	In-network		Out-of-network	
	Highest contribution level	Below the highest contribution level	Highest contribution level	Below the highest contribution level
Annual deductible	\$745	\$1,690	\$2,235	\$5,070
You pay	10% (+\$45 per month per participant)	10% (+\$45 per month per participant)	30% (+\$45 per month per participant)	30% (+\$45 per month per participant)
Annual out-of-pocket maximum	\$2,235	\$5,070	\$6,705	\$15,210
Lifetime maximum	\$250,000	\$100,000	\$250,000	\$100,000

ASSOCIATED COSTS – AND SAVINGS*

If your employer contributes to the Trust at the highest level and you visit in-network providers:

Annual Deductible		Annual Out-of-pocket Maximum	
Indemnity program	\$2,400	Indemnity program	\$7,200
PPO option*	\$745	PPO option*	\$2,235
Difference in deductibles	\$1,655	Difference in annual out-of-pocket maximum	\$4,965
Less the annual PPO premium	\$540	Less the annual PPO premium	\$540
Your annual savings	\$1,115	Your annual savings	\$4,425

*Using the in-network level of benefits

ADVANTAGES

If you are eligible to enroll in the PPO option, there are many advantages over the Trust's Indemnity program:

- **Much lower deductibles.** When you use in-network providers, the PPO's deductible is a fraction of the Indemnity program's current deductible.
- **Much lower annual out-of-pocket maximum.** When using in-network providers, the out-of-pocket maximum is considerably lower.
- **Much higher lifetime maximum.** The lifetime maximum is a good deal higher.
- **Urgent or emergency care.** If you're away from home and become ill or have an accident, you are usually covered as if you were at home under the care of in-network providers.
- **Service and credentials.** Network providers are required by the health care companies to meet guidelines for quality of service, including patient satisfaction.

HOW TO ENROLL

There are several ways to apply for the PPO option:

1. If you are eligible, the form will be included in your enrollment packet.
2. You may go to www.gmptrust.com and print a form.
3. You may call the Trust office at 239-936-6242 to request a form.

Fill out the enrollment form and return it to:

G.M.P. – Employers Retiree Trust

PPO Option Enrollment

5245 Big Pine Way S.E.

Fort Myers, FL 33907-5998

Your enrollment form will be reviewed and, if you are eligible, you will be enrolled in the PPO option as soon as possible. Soon thereafter, you will receive an identification card from the health care company providing coverage. Initially, you are allowed to enroll in the PPO option at any time. PPO coverage is always effective on the first day of a month.

Once you are enrolled, you must select your preferred method for paying the monthly cost of PPO option coverage, currently \$45 per month, per participant. Currently, your options are:

1. Monthly, have the required amount automatically withdrawn from your bank account. Or,
2. Be billed directly each quarter.

You are not required to include payment with your enrollment form.

TERMINATION OF COVERAGE

When you become eligible for Medicare (either by reaching age 65 or becoming medically eligible), you no longer are eligible for the PPO option. (Participants with end-stage renal disease may remain in the PPO option until age 65.) You may then choose either Medicare and the Trust's Indemnity program or, if available, a Medicare supplemental insurance policy (also called "Medigap") and the Indemnity program. To find out if Medigap coverage is available in your area, contact Medicare directly at 1-800-633-4227.

You may drop your PPO option coverage at any time by notifying the Trust office in writing. If you want to re-enroll in the PPO option at a later date you will not be eligible for two years from the following January 1st after your PPO cancellation date.

PLAN ADMINISTRATION INFORMATION

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA). Your Plan administrator has determined that this information, together with the information contained in your Plan of Benefits booklet, is the Summary Plan Description required by ERISA.

Plan Administrator:

G.M.P. – Employers Retiree Trust
5245 Big Pine Way, S.E.
Fort Myers, FL 33907-5998
(239) 936-6242

Type of Administration:

1. Life insurance: Aetna Life Insurance Company
2. Indemnity program (medical): G.M.P. – Employers Retiree Trust (self-insured)
3. PPO option (medical): BlueCross BlueShield
4. Prescription coverage: Express Scripts (formerly Medco Health Solutions, Inc)

Plan Sponsor:

Trustees of G.M.P. – Employers Retiree Trust

Federal Employer Identification Number:

23-6411794

Plan Number:

501

Agent for Service of Legal Process:

Any member of the Board of Trustees or the Executive Director of G.M.P. – Employers Retiree Trust,
5245 Big Pine Way, S.E., Fort Myers, FL 33907-5998

Plan Year:

The financial records of the Plan are based on the Trust's fiscal year, which begins January 1 and ends December 31.

You may call these other service providers for information or assistance:

BlueCross BlueShield

PPO Option
PO Box 100121, Cola, SC 29202
1 (800) 830-1501

Express Scripts (formerly Medco Health Solutions, Inc.)

Prescription drug benefits
100 Parsons Pond Drive, Franklin Lake, NJ 07417
1 (800) 841-5318

CLAIMS PROCESSING AND APPEALS

Under the Indemnity program:

Your I.D. card includes information for providers to file your medical claims to the Trust. In addition, the Trust has contracted with COBC, CMS' national crossover contractor, to receive Medicare claims directly at the Trust office after Medicare has made their payment/determination.

Your Plan of Benefits booklet contains information about reporting claims. Ordinarily, the Trust office will contact you and/or your provider about any claim filed within 30 days of receipt. If your claim is incomplete or there are other special circumstances, you and/or your provider will be notified. In the case of an incomplete claim, you and/or your provider will be notified of information needed to complete your claim, and you will have 45 days from receipt of the notice to provide the information.

Under the PPO option:

Ordinarily, it is not necessary to file a claim under the PPO option. Call the member services number on your member I.D. card if you have any questions.

Under both the Indemnity program and the PPO option:

If a claim is denied (in whole or in part), you will receive a written explanation. You may appeal the denial, and you may review all documents involved in your claim. These documents will disclose, among other things, the identity of any medical or vocational expert whose advice was considered. Your written appeal should be submitted in writing to the Trust office within 180 days of the denial.

The Trust's Executive Director (or designate, who is not subordinate to the person who made the initial decision) will review your appeal without respect to the initial decision. For denials based on medical judgment, this individual will consult with a health care professional who has appropriate training and experience in the field of medicine involved. This person will not be an individual who was consulted in the initial decision or who is a subordinate. Absent special circumstances, the Trust office will notify you of the final decision within 60 days of receipt of your appeal.

For life insurance claims only, the Trust office will forward your appeal and file to Aetna Life Insurance Company for review and final decision. If you would like a representative to act on your behalf in pursuing a claim or appeal, you must complete and sign a Trust-approved form identifying your authorized representative and return it to the Trust office. Contact the Trust office to request a copy of this form.

COLLECTIVE BARGAINING AGREEMENTS

The Trust is maintained under more than 10 separate collective bargaining agreements. These agreements provide that participating employers will make contributions to the G.M.P. – Employers Retiree Trust. These agreements specify the rates of the employer's contributions.

The foregoing is a Plan Summary of Coverage for the Trust's Indemnity and PPO option programs. Of necessity, many of the substantive Plan provisions mentioned have been set forth in summary form. For a more complete and more detailed description, please refer to the material contained in the Plan of Benefits booklet.

The only party authorized by the Board of Trustees to answer questions concerning the Trust Fund and Plan is the Trust office. All questions about Plan participation, eligibility, or regarding any matter of the Trust Fund or Plan administration, should be referred to the Trust office. No participating employer, employer association, or labor organization, nor any individual employed by one of these organizations has any authority to respond.

ERISA RIGHTS

As a participant in G.M.P. – Employers Retiree Trust Plan of Benefits, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all Plan participants are entitled to:

1. Examine, without charge, at the Plan administrator's office, all Plan documents, including insurance contracts, collective bargaining agreements, and copies of any documents filed with the U.S. Department of Labor (such as detailed annual reports and Plan descriptions).
2. Obtain copies of all Plan documents and other Plan information upon written request to the Plan administrator. The administrator may make a reasonable charge for the copies.
3. Receive a summary of the Plan's annual financial report. The Plan administrator is required by law to make available to each participant a copy of this summary annual report. The report is also available on the Trust's website at www.gmptrust.com.
4. Continue health care coverage for an eligible spouse if there is a loss of coverage under the plan as a result of a qualifying event. The spouse may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.
5. Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer under the following scenarios:
 - a) when you lose coverage under the plan;
 - b) when you become entitled to elect COBRA continuation coverage;
 - c) when your COBRA continuation coverage ceases, if you request it before losing coverage; or
 - d) if you request COBRA continuation coverage up to 24 months after losing coverage.

Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

In addition to creating rights for Plan participants, ERISA imposes obligations upon the people responsible for operating the employee benefit Plan.

The people who operate your Plan, called “fiduciaries,” have a duty to do so responsibly and in the interest of you and other Plan participants and beneficiaries.

No one may discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

If your claim for a welfare benefit is denied in whole or in part, you will receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials 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 Plan administrator to provide the materials and pay you up to \$100 a 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 that is denied or ignored (in whole or in part), you may file suit in a state or federal court. In such a case, the court may require the Plan administrator to provide the materials and pay you up to \$100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees if, for example, it finds your claim frivolous.

If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Pension and Benefits Administration, U.S. Department of Labor, 200 Constitution Ave. N.W., Washington, D.C. 20210.

A copy of the collective bargaining agreement applicable to you is available at the office of the Plan administrator. You may obtain a complete list of contributing employers upon written request to the Plan administrator, or a copy will be made available for examination at the Trust office and certain other locations. The only sponsoring employee organization is the Glass, Molders, Pottery, Plastics & Allied Workers International Union (AFL-CIO, CLC), 608 East Baltimore Pike, P.O. Box 607, Media, PA 19063. The Summary Plan Description describes only the main features of the Plan. Your rights and benefits under the Plan are controlled by the Trust Agreement, by the Plan of Benefits booklet, and by the applicable group contracts.

KEEP THIS PLAN ADMINISTRATION INFORMATION WITH YOUR PLAN OF BENEFITS BOOKLET.

IF YOU DO NOT HAVE A COPY OF YOUR PLAN OF BENEFITS BOOKLET, YOU MAY OBTAIN ONE AT WWW.GMPTRUST.COM OR FROM THE TRUST OFFICE.

This Plan is maintained according to provisions of the current Trust Agreement for the G.M.P. – Employers Retiree Trust and is administered by the Trustees in accordance with that Trust Agreement and applicable law. It is subject to modification, change or discontinuance by the Trustees at any time and in any manner.

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