G.M.P. – Employers
RETIREE TRUST

Plan of Benefits

Jointly administered by the Glass, Molders, Pottery, Plastics and Allied Workers International Union (AFL-CIO, CLC) and contributing employers
Plan as of January 1, 2018

Plan of Benefits of the G.M.P. – Employers Retiree Trust
Certificate of Insurance Aetna Life Insurance Company

The benefits described in this document are available, as described, for you and your lawful eligible spouse.

The health benefits described in the Plan Summary of Coverage 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 Summary of Coverage 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 and claims appeals, which are referred to Aetna for disposition as described below, Aetna provides consultative and administrative services to the Trust that do not include the processing or disposition of claims for 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.

G.M.P. – Employers
RETIREE TRUST

Plan of Benefits • G.M.P - Employers Retiree Trust

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Life Insurance Coverage

BENEFITS

This Plan will pay as a life insurance benefit the amount of life insurance in force for you (as a retiree) if you die from any cause while insured. You are insured for the amount shown in the Plan Summary of Coverage. You designate your beneficiary, which you may change at any time.

BENEFICIARIES

Please submit a beneficiary form to the Trust office to designate or change your beneficiary. Forms may be provided by calling the Trust, or can be obtained on our website at www.gmptrust.com. The change will be effective on the date you execute the request, but Aetna will be completely discharged of its obligations if any payment is made before receiving your request at the Trust office.

Except as may be otherwise specifically provided by the retiree:

1. If more than one beneficiary is designated, designated beneficiaries will share equally;
2. If any designated beneficiary dies before the retiree, the share the beneficiary would have received will be payable equally to the remaining designated beneficiaries, if any, who survive the retiree; and
3. If you have not named a primary or contingent beneficiary, or if the person you have named dies before you, payment will be made as follows to those who survive you:
   a. Your spouse, if any.
   b. If there is no spouse, in equal shares to your children.
   c. If there is no spouse; or you have no children, to your parents, equally or to the survivor.
   d. If there is no spouse; or you have no children, or parents, in equal shares to your brothers and sisters.
   e. If none of the above survives, to your executors or administrators.

TERMINATION AND CONVERSION

Group insurance coverage may be terminated under several circumstances. These are described in the section titled, "Termination of Coverage," beginning on page 9.

LIFE INSURANCE CLAIMS

The beneficiary must submit a death certificate and beneficiary's Social Security Number to the Trust office. Submittal forms and instructions can also be found on the Trust's website, www.gmptrust.com.

Common Questions About Life Insurance

Can my spouse apply for life insurance through the Trust?

No. Life insurance is only for retirees. There is no benefit for spouses.

Do insurance benefits have to be applied to the claims of creditors?

Life insurance benefits may be exempt from legal or equitable process for your debts or those of your beneficiary, as permitted by applicable law.

Can my life insurance be assigned?

Yes. Benefits may, on occasion, be assigned to a funeral home. Contact the Trust office for more information.

How will life insurance benefits be paid?

Benefits will be paid as soon as possible after the necessary written proof to support the claim is received in the Trust office. Any benefit will be paid according to the beneficiary designation and the contract provisions. Payment will be made in one sum. Payments made to beneficiaries are subject to policy provisions that allow benefits to be paid to someone else if your beneficiary is a minor or otherwise not legally able to give a valid payment receipt.

Is there any life insurance after termination?

Yes. Under most circumstances, the retiree only is entitled to apply for an individual life policy according to the conversion privilege within 31 days following termination of group life insurance. If a retiree dies during this 31-day period, and before any insurance under the individual policy becomes effective, the amount payable under the group contract is the maximum amount available under the individual policy, whether or not application was actually made or the first premium was paid.

How will group life be converted?

If you become ineligible to receive life insurance, the amount of insurance which ceases (or a lesser amount if desired) may be converted to an individual life insurance policy. Your converted policy may be any kind of individual policy being issued by Aetna for the amount being converted and for your age (or your nearest birthday) on the date it will be issued, except a term policy or one with disability or other supplementary benefits.

To convert, you must submit a written application for an individual policy and pay the first premium on it within 31 days after cessation of insurance for any of the reasons listed on page 9.

No evidence of insurability is required. The individual policy will become effective at the end of the 31-day period during which conversion is possible.

The premiums for the converted policy will be Aetna's customary rates for the same policy issued to any other person of the same class of risk and age at the time the policy becomes effective. After an individual policy becomes effective, that policy will replace all benefits and privileges under the group contract for the person involved and the amount converted.

When life insurance ceases because that part of the group contract discontinues and life insurance has been in force under the group contract for at least five consecutive years prior to the discontinuance, the amount that ceases (less the amount of any group life insurance for which the individual becomes eligible within 31 days of discontinuance) may be converted to an individual policy. The maximum amount that can be converted by each covered retiree in the event of group contract discontinuance is the amount in force at the time of continuance.

Comprehensive Medical Expense Coverage (Indemnity Coverage)

(For retirees and their covered eligible spouses)

This coverage is designed to cover certain medical expenses as follows:

BENEFITS

This program pays a benefit as follows: (Except for any different benefit level that may be provided under one of the Plan's PPO options or for certain expenses described later in this booklet.)

Individuals who are not eligible for Medicare:

- 80% of covered medical expenses incurred in a calendar year that exceed your deductible, except for any different benefit level that may be provided under one of the Plan's PPO options.

Individuals who are eligible for Medicare (This Program coordinates with Medicare to pay):

- Out Patient: Up to 90% on certain covered medically necessary expenses.
- In Patient: 80% of remaining balance on Medicare approved and paid covered expenses.

Optional PPO Coverage

(For retirees and their covered eligible spouses)

Retirees and eligible spouses who are not yet Medicare eligible may enroll in a PPO option instead of having Indemnity program coverage. If your employer contributes to the Trust at the highest rate, you may enroll in either the PPO Plus or PPO option. If your employer contributes below the highest level, you may only enroll in the PPO option.

PPO PLUS COVERAGE

- 90% of in-network covered medical expenses incurred in a calendar year that exceed your in-network deductible and 70% of out-of-network covered medical expenses that exceed your out-of-network deductible.
- Prescription Drug Program deductible with the Plus option is 50% lower than the PPO option.

PPO COVERAGE

- 90% of in-network covered medical expenses incurred in a calendar year that exceed your in-network deductible and 70% of out-of-network covered medical expenses that exceed your out-of-network deductible.

Premiums, Lifetime maximums, the annual deductible for in-network and out-of-network covered medical expenses, the annual out-of-pocket maximum amounts for in-network and out-of-network covered medical expenses, and the prescription drug benefit differ depending upon the option and former employer's contributing rate. See the Plan Summary of Coverage for detailed coverage levels.

The Indemity Coverage and PPO Options include an out-of-pocket maximum provision that limits the amount a covered individual may have to pay during a calendar year. Benefits are also subject to a lifetime maximum amount. These features and others are described briefly below.

Important Coverage Terms

DEDUCTIBLE

This is the amount of covered medical expenses you pay each calendar year before benefits are payable under this coverage. A separate deductible applies to you and your eligible spouse. Any expense incurred during the last three months of a calendar year that is applied against an individual's deductible also reduces the deductible for the next year. The Trustees evaluate the deductible each year in relation to the Medicare Part B monthly premium changes. The deductible is subject to change each year.

OUT-OF-POCKET MAXIMUM

This is the maximum amount that a covered individual would have to pay for covered medical expenses each calendar year. When the total out-of-pocket costs for covered expenses equals the out-of-pocket maximum, this Plan pays an amount equal to 100 percent of covered expenses for the remainder of that year. In other words, your total out-of-pocket costs for covered expenses in any one year will not exceed three times the amount of your deductible for that year.

LIFETIME MAXIMUM BENEFIT

This is the maximum amount that will be payable under the Plan for any covered retiree or spouse during their lifetime. (See the Plan Summary of Coverage for the lifetime maximum for each participant.)

The Plan's benefits, deductibles, out-of-pocket maximums, and lifetime maximum benefit also apply to a covered spouse.

Covered Medical Expenses

These are the reasonable expenses for certain hospital and other medically necessary services and supplies that you incur while covered by the Plan in connection with treatment of a non-occupational injury or non-occupational disease. In general, they are expenses that would have been covered under Medicare. Coverage is not provided for custodial care.

Descriptions of covered medical expenses are listed below. Please note certain limitations appear in these descriptions. Certain other limitations begin on page 5 while certain exclusions begin on page 6.

HOSPITAL EXPENSES

Charges made by a hospital for its room and board and other medically necessary services and supplies are covered. Room and board charges include all hospital charges for services, such as general nursing care, made in connection with room occupancy. Not included is any charge for daily room and board in a private room (over the hospital's semi-private rate).

SURGICAL EXPENSES

Reasonable and customary charges made by a physician for

medically necessary surgical services are covered.

Surgical services are those provided by a physician during a surgical procedure (including usual and related pre-operative and post-operative patient care).

A "surgical procedure" is any procedure in the following categories:

1. The incision, excision or electrocauterization of any part of the body;
2. The manipulative reduction of a fracture or dislocation;
3. The suturing of a wound; or
4. The removal by endoscopic means of a stone or other foreign object from the larynx, bronchus, trachea, esophagus, stomach, urinary bladder, or ureter.

Surgical charges made for the following are not included:

1. Dental work or oral surgery, except as noted under "Dental Care" on page 5; and
2. Cosmetic surgery, unless necessary for the prompt repair of an injury. See "Cosmetic Surgery" on page 5.

HOSPICE CARE

A hospice is a public agency or private organization that is primarily engaged in providing pain relief, symptom management, and supportive services to terminally ill people and their families. A Medicare-approved hospice usually gives hospice care in your home or other facility where you live such as a nursing home.

The Plan can help pay for hospice care if the following conditions are met:

1. A physician certifies that a patient is terminally ill; and
2. Care is provided by a Medicare-certified hospice; and
3. You have 6 months or less to live.
4. The Plan can pay for these services as part of hospice care:
5. Nursing services;
6. Physician services;
7. Prescription drugs, including outpatient prescription drugs for pain relief and symptom management;
8. Certain home health aide and homemaker services;
9. Medical social services;
10. Certain durable medical equipment; and
11. Counseling.

OUTPATIENT HOSPITAL EXPENSES

The following reasonable and customary charges made by a hospital for medically necessary services are covered:

1. Services provided in an emergency department or outpatient clinic;
2. Laboratory tests billed by the hospital;
3. X-rays and other radiology expenses billed by the hospital;
4. Medical supplies such as splints and casts; and
5. Prescription drugs that cannot be self-administered.

OTHER MEDICAL EXPENSES

The following reasonable and customary charges for medically necessary services are covered:

1. Charges made by a physician who meets the definition of physician under Medicare;
2. Charges made by a registered nurse (R.N.), but not by one who resides in your home, or who is a member of your or your eligible spouse's family;
3. Prescription drugs.
4. Diagnostic laboratory and X-ray examinations;
5. X-ray, radium and radioactive isotope therapy;
6. Anesthetics and oxygen;
7. Rental and purchase of durable medical or surgical equipment. In lieu of rental, the following may be covered:
   a. The initial purchase of equipment if long-term care is planned and the equipment either cannot be rented or is likely to cost less to purchase than to rent; or,
   b. Repair or replacement of purchased equipment if there is a change in the person's physical condition. If the cost to repair an item is greater than the cost to replace it, the item should be replaced;
8. Artificial limbs and artificial eyes, but not eye examinations, eye glasses, or orthopedic shoes or other supportive devices for the feet;
9. Professional ambulance service only if:
   a. The ambulance, equipment and personnel meet Medicare requirements;
   b. Transportation in any other vehicle could endanger the patient's health; and,
   c. The ambulance transportation is from the scene of an accident to a hospital, from your home to a hospital or skilled nursing facility, between hospitals and skilled nursing facilities, or from a hospital or skilled nursing facility to your home;
10. The cost of un-replaced blood;
11. Hearing aids when recommended by a physician certified as an otolaryngologist (ear, nose, throat doctor) as described on page 6; and
12. Mammogram charges to diagnose a disease or injury. Covered medical expenses also include routine mammogram charges.

PRESCRIPTION DRUGS

A prescription drug program is available through the Trust to eligible participants in both the Indemnity program and the PPO options to help defray the cost of important prescription medications. There is NO ADDITIONAL FEE to participate. This program is part of your comprehensive benefits. Simply show your Trust I.D. card when you visit a participating pharmacy. See Plan Summary of Coverage for benefit details.

If you choose a Medicare Part D prescription drug plan, you must cancel your prescription drug coverage through the Trust. Through the Trust, you have

prescription drug coverage that is at least as good as or better than Medicare's basic drug benefit. This means you can join a Medicare private drug plan later without penalty if you need it. A "Notice of Creditable Coverage" is posted on the Trust's website at www.gmptrust.com.

SKILLED NURSING FACILITY EXPENSES

Skilled nursing facility expenses are the charges made by a Medicare-certified skilled nursing facility for room and board when you meet all of the following conditions:

1. A physician certifies that you need, and you actually receive, nursing or skilled rehabilitation services daily; and
2. The Medicare intermediary or the facility's Utilization Review Committee approves your stay.

Coverage is not provided for custodial care.

HOME HEALTH CARE

If you need part-time skilled health care in your home for the treatment of an illness or injury, the Plan can help pay for covered home health visits furnished by a participating home health agency. Home health care may be provided by a public or private agency that specializes in giving skilled nursing services and other therapeutic services, such as physical therapy in your home, and that satisfies the definition of "home health care agency" on page 11. (A facility that mainly provides skilled nursing or rehabilitation services cannot be considered your home.)

The Plan can help pay for home health visits only if all of the following four conditions are met:

1. The care you need includes intermittent skilled nursing care, physical therapy, or speech therapy;
2. You are confined to your home;
3. A physician determines you need home health care and sets up a home health plan for you; and
4. The home health agency providing services is participating in Medicare.

OUTPATIENT PHYSICAL AND OCCUPATIONAL THERAPY AND SPEECH PATHOLOGY SERVICES

The Plan can help pay for covered outpatient physical and occupational therapy or speech pathology services, if the following three conditions are met:

1. Your physician prescribes the service;
2. Your physician or therapist sets up a plan of treatment; and
3. Your physician periodically reviews the plan.

You may receive physical therapy, occupational therapy, or speech pathology services as an outpatient of a participating hospital or skilled nursing facility, or from a Medicare-approved home health agency, clinic, rehabilitation, or public health agency.

Limitations on Coverage

There is limited coverage for the following:

DENTAL CARE

Dental care is a covered medical expense only if it involves:

1. Pulling of the teeth to prepare the jaw for radiation treatment.
2. Dental exams prior to a kidney transplant.

If you are hospitalized due to the severity of a dental procedure, the Plan may cover your hospital stay even if the dental care itself is not covered by the Plan. (For purposes of dental work and oral surgery covered by this benefit, the term "physician" includes a duly licensed dentist.)

Most dental care is not covered. Among the procedures not covered are the following: care in connection with the treatment, filling, removal or replacement of teeth; root canal therapy; surgery for impacted teeth; and other surgical procedures involving the teeth or structures directly supporting the teeth.

COSMETIC SURGERY

Expenses incurred in connection with cosmetic surgery that is necessary for the prompt repair of a non-occupational accidental bodily injury, or to improve the functioning of a malformed part of the body, are included as covered medical expenses. No other expenses for cosmetic surgery are included as covered medical expenses.

CHIROPRACTIC SERVICES

Covered medical expenses for chiropractic services include medically necessary manual manipulation to correct a subluxation (when one or more of the bones of your spine move out of position). Treatment must be provided by a licensed chiropractor participating with Medicare. Charges for maintenance therapy, X-rays or any other diagnostic or therapeutic services furnished by a chiropractor are not covered. Maintenance therapy is defined as a treatment plan that seeks to prevent disease, promote health, and prolong and enhance the quality of life; or therapy that is performed to maintain or prevent deterioration of a chronic condition.

PODIATRY SERVICES

Foot care can be a covered medical expense if you have a medical condition affecting the lower limbs (such as diabetes) that requires such care to be performed by a podiatrist or physician. Not covered are the following: routine foot care, which includes hygienic care; treatment for flat feet or other structural misalignments of the feet; and the removal of corns, calluses and most warts.

OPTOMETRY SERVICES

This Plan can help pay for the vision care services of optometrists, if the services are among those covered by Medicare and if the optometrist is legally authorized to perform such services in your state. The Plan does not pay for routine eye exams or for eye glasses or corrective lenses unless they are prosthetic lenses that replace the natural lens of the eye.

HEARING AIDS

The Plan pays a benefit when hearing aids are recommended by a physician certified as an otolaryngologist (ear, nose, throat doctor). The Plan will pay 80 percent of the covered hearing aid expenses for the cost of one or more hearing aids up to the maximum amount as shown in the Plan Summary of Coverage in any period of three consecutive years.

Replacements are covered only if the hearing aid being replaced has been in use for at least three years and the replacement is made upon the written recommendation of a physician certified as an otolaryngologist.

Covered expenses do not include and no benefits are payable for:

1. Expenses for which benefits are payable under any workers' compensation law;
2. Hearing examinations; or
3. Costs for repairs or replacement of individual parts of a hearing aid.

This benefit is not subject to the deductible, but the amount payable will count against the individual lifetime maximum benefit.

Chemical Dependency Treatment Expenses

Confinements and outpatient expenses for chemical dependency are covered as described below.

If an individual is hospitalized for treatment of chemical dependency, hospital expenses incurred are considered covered medical expenses as if incurred for any other disease. This is covered only if there is not a separate chemical dependency non-hospital residential facility section.

If an individual is a full-time patient at a chemical dependency non-hospital residential facility, room and board expenses and expenses for other necessary services and supplies furnished by the facility and incurred during the first 30 days of confinement (per calendar year) will be covered. If the patient has also been hospitalized during the year for chemical dependency, the 30-day maximum period will be reduced by those days of confinement. The lifetime maximum per individual is 90 days of confinement in a non-hospital residential facility.

If private accommodations in a chemical dependency non-hospital residential facility are used, any excess of daily room and board charges over the semi-private rate will not be paid.

These provisions concerning chemical dependency treatment apply only to confinements resulting from diagnosis or recommendation by a physician, and only to expenses for treatment recognized by the medical profession as appropriate according to widely accepted standards.

Charges made by a hospital or non-hospital residential facility and incurred by an individual while not confined as a full-time inpatient are covered if they are for effective treatment of chemical dependency (including group, family or individual counseling); except that:

1. While the individual is participating in a partial confinement treatment program, benefits will not be payable for more than 30 treatment sessions in one calendar year. A treatment session begins when the individual enters the hospital or non-hospital residential facility and ends when the individual leaves the institution upon completion of one day or night care treatment; or
2. While the individual is not participating in a partial hospitalization treatment program, benefits will not be payable for more than 60 visits during any one calendar year and for more than 120 visits during the individual's lifetime.

These outpatient treatment provisions apply only to treatment resulting from diagnosis or recommendation by a physician and recognized as appropriate in accordance with broadly accepted standards of medical practice.

General Exclusions

No benefits are payable under this Plan for the charges listed below or for services not recognized by Medicare, unless specifically provided under this Plan. The amount of any such charges will be deducted from the individual's expenses before the benefits of this Plan are determined and do not apply to the deductible or out-of-pocket maximum:

1. Charges incurred by you or your eligible spouse while not covered under this Plan; or
2. Charges that would not have been made if no coverage existed or charges that neither you nor your eligible spouse is required to pay; or
3. Charges for services or supplies which are not necessary for treatment of the injury or disease, even if prescribed, recommended or approved by the attending physician, or charges to the extent that they are unreasonable; or
4. Charges in connection with occupational accidental bodily injuries and diseases; or
5. Charges for elective services such as routine physicals, eye examinations, hearing examinations, or other preventive services and supplies; or
6. Charges for services or supplies which are paid for or otherwise provided for by reason of the past or present service of any person in the armed forces of a government; or
7. Charges for services or supplies which are paid for or otherwise provided for under any law of a government. Where the payments or the benefits are provided under a program specifically established by a government for its own civilian employees and their dependents, however, this exclusion does not apply; or
8. Charges for which benefits are payable under a plan for active employees of a participating employer; or
9. Charges for custodial care, acupuncture, or a naturopath's services; or
10. Charges for personal convenience items such as radio, television, telephone, etc.

CARE IN A FOREIGN HOSPITAL

This Plan does not generally pay for hospital or medical services outside the United States. (Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands are considered part of the United States, along with the 50 states and the District of Columbia.) The Plan can help pay for care in qualified Canadian or Mexican hospitals in three situations:

1. You are in the United States when an emergency occurs and a Canadian or Mexican hospital is closer than the nearest United States hospital which can provide the emergency services you need; or
2. You live in the United States and a Canadian or Mexican hospital is closer to your home than the nearest United States hospital which can provide the care you need, regardless of whether or not an emergency exists; or
3. You are in Canada traveling by the most direct route to or from Alaska and another state and an emergency occurs which requires that you be admitted to a Canadian hospital. (This coverage does not apply if you are on vacation in Canada.)

Effect Of Medicare and Other Plans

This is a "maintenance of benefits" plan, which means all medical expense benefits under this Plan will be reduced by any benefits for which you are eligible under Medicare or any other plan. The Plan benefits, when combined with payments from Medicare and any "other plan", will not exceed 100 percent of the Plan's allowed charges. For example, you may be covered as a dependent under another plan and, as such, may be eligible for benefits under other plans in addition to your benefits under this Plan. In that case, the benefits from the other plans will be taken into account so the combined benefits will not be more than what this Plan would pay if there were no other benefits payable.

In coordinating with "other plans," when two medical or dental coverage plans apply and only one has coordination of benefits, the plan without coordination is called "primary." The primary plan pays benefits without regard to an "other plan." When the Plan is "secondary," benefits are adjusted so those payable during a calendar year under both plans are not more than would normally be payable under the Plan.

Neither plan pays more than it would without coordination of benefits.

If you are eligible for Medicare:

1. All benefits payable under the Plan will be reduced by any Medicare and/or "other plan" benefits available for those expenses.
2. Medicare benefits will be taken into account for any covered participant who is eligible for Medicare whether or not they are enrolled in Medicare. Example: For a participant who does not elect Medicare Part B, the Trust will still process claims that would have been covered under Part B by estimating the payment Medicare would have made prior to the Trust determining their benefit amount. In this case, the participant could be responsible for approximately 90% of the total charges.

To administer the "maintenance of benefits" provisions properly, and to determine whether this Plan will reduce its regular benefits, the order of how the various plans will pay benefits must be determined, except for Medicare which is always treated as primary to the Plan.

This will occur as follows:

1. A plan with no provision for coordination with other benefits will be considered to pay its benefits before a plan that contains such a provision.
2. A plan that covers a person other than as a dependent will be considered to pay its benefits before a plan that covers the individual as a dependent.
3. Where (1) and (2) above do not establish the order of payment, the plan under which the person is covered as an active employee upon returning to work for another employer, or the plan under which the person is covered as a dependent of an active eligible spouse will be considered to pay its benefits before the other.
4. Where (1) , (2) and (3) above do not establish the order of payment, the plan under which the person has been covered for the longer period of time will be considered to pay its benefits before the other.

"Other plan" means any other plan of medical or dental expense coverage provided by:

1. Medicare, or
2. Group insurance or any other arrangement of coverage for individuals in a group, whether or not the plan is insured, or
3. An individual plan (e.g., Medicare Supplement), or
4. Benefits available through a healthcare exchange plan, or
5. "No-fault" automobile insurance, which is required under any law of a government and is provided on other than a group basis, but only to the extent of the level of benefits required by the "no-fault" law.

Coverage will not be changed at any time when the Plan's compliance with federal law requires this Plan's benefits to be determined before benefits are available under Medicare.

The Plan reserves the right to release or obtain any information and make or recover any payments it considers necessary to administer this provision.

The Plan is designed to pay only covered expenses for which payment is not available from anyone else, including any insurance company. To help a covered person in a time of need, however, the Plan may pay covered expenses that may be or become the responsibility of another person, provided that the Plan later receives reimbursement for those payments (hereinafter called "reimbursable payments"). Therefore, by enrolling in the Plan, as well as by applying for payment of covered expenses, a covered person is subject to, and agrees to, the following terms and conditions with respect to the amount of covered expenses paid by the Plan:

1. **Assignment of Rights (Subrogation).** The covered person automatically assigns to the Plan any rights the covered person may have to recover all or part of the same covered expenses from any party, including an insurer, but limited to the amount of reimbursable

payments made by the Plan. This assignment includes, without limitation, the assignment of a right to any funds paid by a third party to a covered person or paid to another for the benefit of the covered person. This assignment applies on a first-dollar basis (i.e., has priority over other rights), applies whether the funds paid to (or for the benefit of) the covered person constitute a full or a partial recovery, and even applies to funds paid for non-medical or dental charges, attorney fees, or other costs and expenses. This is intended to supersede the "make-whole" or "common fund" rule. This assignment also allows the Plan to pursue any claim that the covered person may have, whether or not the covered person chooses to pursue that claim. The Plan's right to recover from insurers does not include such recovery rights against no-fault auto insurance carriers in a situation where no third party may be liable.

2. **Equitable Lien and other Equitable Remedies.** The Plan shall have an equitable lien against any rights the covered person may have to recover the same covered expenses from any party, including an insurer, but limited to the amount of reimbursable payments made by the Plan. The equitable lien also attaches to any right to payment from workers' compensation, whether by judgment or settlement, where the Plan has paid covered expenses prior to a determination that the covered expenses arose out of and in the course of employment. Payment by workers' compensation insurers or the employer will be deemed to mean that such a determination has been made. This equitable lien shall also attach to any money or property that is obtained by anybody (including, but not limited to, the covered person, the covered person's attorney, and/or a trust) as a result of an exercise of the covered person's rights of recovery (sometimes referred to as "proceeds"). The Plan shall also be entitled to seek any other equitable remedy against any party possessing or controlling such proceeds. At the discretion of the Plan Administrator, the Plan may reduce any future covered expenses otherwise available to the covered person under the Plan by an amount up to the total amount of reimbursable payments made by the Plan that is subject to the equitable lien.

3. **Assisting in Plan's Reimbursement Activities.** The covered person has an obligation to assist the Plan to obtain reimbursement of the reimbursable payments that it has made on behalf of the covered person and to provide the Plan with any information concerning any other person or entity (including their insurer(s)) that may be obligated to provide payments or benefits to or for the benefit of the covered person. The covered person is required to:
   a. Notify the Plan of reimbursements made on behalf of a covered person;
   b. Cooperate fully in the Plan's exercise of its right to subrogation and reimbursement; and
   c. Not do anything to prejudice those rights (such as settling a claim against another party without including the Plan as a co-payee for the amount of the reimbursable payments and notifying the Plan).

Failure by a covered person to follow the above terms and conditions may result, at the discretion of the Plan Administrator, in a reduction from future benefit payments available to the covered person under the Plan of an amount up to the aggregate amount of reimbursable payments that has not been reimbursed to the Plan.

Reporting Medical Claims

All claims must be submitted to your Plan Administrator and must include proof of the nature and extent of the loss. The Trust office will certify your eligibility and, if all requirements are met, will begin processing your claim. If it is necessary to request additional information, a delay in payment will occur.

HOW THE CLAIMS PROCESS WORKS

If you are on Medicare:	Claims filed with Medicare are automatically forwarded to the Trust for processing.
If you are not eligible for Medicare and are in the Indemnity program:	Typically, your provider will file your claim for you. In the rare case where your provider does not file a claim with the Trust, you will need to mail your claim to the Trust for processing.
If you are not eligible for Medicare and are participating in a PPO option:	Your provider will automatically file your claim to the PPO carrier for you.

MEDICAL CLAIMS

A medical claim should be reported **within one year** after the date of the loss causing the claim. If it is impossible for you to meet the deadline for filing a claim due to incapacitation or other unique circumstances, your claim may still be accepted if you file within two years following the end of the initial filing deadline. Otherwise, late medical claims will not be covered.

To collect benefits, it is not required for medical bills to be accompanied by receipts. Bills, Medicare, and/or other insurance statements, etc., will be retained by the Trust office for audit purposes and cannot be returned. If you need copies, please make them before submitting a claim. You will receive an Explanation of Benefits (EOB) that will describe your claim; whether it was paid, denied (an explanation for the denial will be included), or whether we need additional information to continue processing your claim. Keep this EOB for income tax and other purposes. If you have any questions about your claim, contact the Trust office.

PRESCRIPTION DRUG CLAIMS

Participants whose former employer is contributing to the Trust at the highest rate must show their Trust I.D. card to the pharmacy, pay the applicable prescription deductible and/or coinsurance. To receive the highest possible discount for maintenance prescription drugs, you must use the convenient mail-order option.

Participants whose former employer is contributing to the Trust below the highest rate must also show their Trust I.D. cards, pay for their prescription in full, and submit the original prescription receipt or itemized statement from the pharmacy to the Trust office for consideration.

HOSPITAL ADMISSIONS

For those eligible for Medicare: Present your Medicare and Trust I.D. cards to the hospital admissions clerk at the time of admission. For those NOT eligible for Medicare: Present the hospital with your Trust I.D. card or PPO I.D. card at the time of admission. PPO participants may have additional admission requirements, please check with your PPO carrier.

PAYMENT OF MEDICAL BENEFITS

The Plan will pay hospital benefits directly to the provider unless you submit a fully documented statement to the Trust office showing that the bill has been paid. The Trust office will notify you of its payment to the provider by sending you an EOB. It may be your responsibility to pay the provider any difference between the total bill and the benefits payable. The Trust has the right to pay any medical benefits directly to an institution or person providing services covered under this Plan.

RECORDS OF EXPENSES

Keep careful, complete records of the medical expenses of each covered individual as they may be required when a claim is made. When submitting a claim, the following are very important:

1. You or your provider must use the current HIPAA-compliant claim forms including CMS 1500 or UB-04 which are the most recently approved forms. The Trust no longer accepts non-compliant HIPAA forms.
2. The forms must be complete, legible and able to be scanned or they will be returned.

RIGHT OF APPEAL

If your claim for medical benefits is denied, in whole or in part, you may appeal. See the Plan Summary of Coverage for a description of the appeal procedure.

PHYSICAL EXAMINATIONS

At its own expense, the Trust has the right to require the person who is the basis of any claim to submit to an examination at any reasonable time while that claim is pending.

LEGAL ACTION

No participant or beneficiary can bring legal action to recover any benefit after two years from the deadline for filing the claim. However, this does not apply to life insurance.

Termination of Coverage

Medical expense coverage can be terminated under several different circumstances.

Life insurance coverage under this Plan terminates when the applicable group contract discontinues the coverage.

When medical benefits amounting to the lifetime maximum benefit shown in the Plan Summary of Coverage have been paid on behalf of you or your eligible spouse, medical benefits will be suspended. (Please see the Plan Summary of Coverage for the per participant lifetime maximum benefit.)

When a participating employer withdraws from the Trust, or otherwise ceases to make sufficient contributions to the Trust, the fund allocation provisions of the Trust Agreement will be followed and all coverage — both life insurance and medical benefits — will eventually terminate for that employer's retirees and their eligible spouses when the allocated funds are depleted.

A curtailment or termination of any or all coverage could also result from the modification or discontinuance of the Trust Agreement or any group contract by action of the Trustees.

The Trust Agreement also provides that, upon its termination, the Trustees will initially apply the Fund to pay the debts of the Trust and the expenses of its liquidation and will then apply any remaining balance to provide benefits for retirees and eligible spouses until the Fund is fully depleted. The Trustees also have full discretion in these applications of the Fund, but, in doing so, they are to follow the further provisions of the Trust Agreement as to the Trust's purposes and not permit any part of the Fund directly or indirectly to revert or accrue to the benefit of any employer or the Union.

ELIGIBLE SPOUSE COVERAGE

An eligible spouse's coverage will also terminate at the earliest to occur of any of the following:

1. Upon discontinuance of all spouse coverage; or
2. When an eligible spouse becomes covered as an employee of a participating employer; or
3. When such person ceases to meet this Plan's definition of an eligible spouse, including in case of a divorce or remarriage; or
4. When the applicable spouse premium is not paid within 30 days of its due date. If you are terminated due to non-payment, you must wait one year from the following January 1st after your coverage was terminated before you are eligible to re-enroll for spouse coverage. You must re-enroll during open-enrollment held during the month of November prior to the coverage plan year. However, if you had other coverage that is cancelled, and you provide the Trust proof of the other coverage and its termination, the waiting period does not apply. Written verification of the cancellation of the other coverage must be received by the Trust within 30 days of cancellation.

If your coverage as an eligible spouse terminates upon divorce, you have the right to choose continuation coverage at your expense. More information can be found in the Trust's COBRA Continuation Coverage notice previously distributed to all retirees and eligible spouses. If you need a copy of that notice, contact the Trust office or visit www.gmptrust.com.

Coverage for your eligible spouse does continue after your death unless it is discontinued for other reasons. If you die while covered under any part of this Plan, any medical expense coverage then in force for your surviving eligible spouse will continue. Your surviving eligible spouse's coverage will also cease when any of the following occurs:

1. Your surviving eligible spouse remarries, or
2. Discontinuance of spouse coverage under this Plan, or
3. The spouse premium is not paid when due.

General Provisions

The following additional provisions apply to your coverage:

1. You cannot receive duplicate or multiple coverage under this Plan because you were connected with two or more participating employers in the Trust or for any other reason.
2. In the event of a misstatement affecting your coverage under this Plan, the Plan Documents will control.

The Plan is set forth completely in the group contracts issued by Aetna (for those benefits that are insured), in this Plan of Benefits booklet, in the accompanying Plan Summary of Coverage booklet, and in the current Trust Agreement, which governs all other Plan matters. If you have any questions about the terms of the Plan or about the proper payment of benefits, contact the Trust office. The Plan of Benefits is maintained according to the provisions of the Trust Agreement 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.

CHANGES YOU SHOULD REPORT

You must notify the Trust office if:

1. You or your spouse become eligible for Medicare; or
2. Your marital status changes; or
3. Your address, phone or e-mail changes; or
4. If you have obtained, or there has been a change, to your power of attorney; or
5. If you wish to change your beneficiary (change of beneficiary form can found at www.gmptrust.com).

Disclosures

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 AND ERISA SECTION 713

In the case of a participant who is receiving benefits under the Plan in connection with a mastectomy and who elects breast reconstruction in connection with the mastectomy, the Plan provides coverage for:

1. Reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and physical complications at all states of the mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

This coverage is subject to the Plan's otherwise applicable annual deductibles and coinsurance provisions.

NEWBORNS' AND MOTHER'S HEALTH PROTECTION ACT OF 1996 AND ERISA SECTION 711

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of-stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. Federal law generally does not, however, prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length-of-stay not in excess of 48 hours (or 96 hours).

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

The Trust is complying with HIPAA, a federal statute that seeks to protect the confidentiality and security of patient health information. To review a copy of the Trust's HIPAA Privacy Statement, visit www.gmptrust.com or call 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.

Important Definitions To Know

Room and board charges: An institution's charges for room and board and its charges for other necessary services and supplies, made regularly as a condition of occupancy.

Chemical dependency treatment: A program of chemical dependency therapy that is prescribed and supervised by a physician and meets either of the following:

1. The physician certifies that a follow-up program has been established that includes therapy by a physician, or group therapy under a physician's direction, at least once per month, or
2. It includes attendance at least twice a month at meetings of organizations devoted to the therapeutic treatment of chemical dependency. Treatment solely for detoxification or primarily for maintenance care is not considered effective treatment. Detoxification is care aimed primarily at overcoming the aftereffects of a specific episode. Maintenance care consists of providing an environment without access to alcohol or drugs.

Custodial care: Services and supplies, including room and board and other institutional services, that are provided to an individual, whether disabled or not, primarily to assist with daily living. Such services and supplies are custodial care, even if the provider by whom they are prescribed, recommended or performed is a medical professional.

Day care treatment program: A partial hospitalization treatment program provided to an individual during the day without a room charge. The hospital or non-hospital residential facility's treatment program must be available for at least six hours during the day and at least five days a week to qualify as a day care treatment program.

Home health care agency: An agency or organization that meets the definition of a home health care agency under Medicare, and participates under Medicare.

Hospital: An institution that meets the definition of a hospital under Medicare, and participates under Medicare.

Medically necessary: A service or supply that is appropriate for the diagnosis, care or treatment of the disease or injury, and is:

1. As likely to produce a significant positive outcome (and no more likely to produce a negative outcome than) as any alternative service or supply typically used to treat the disease or injury; or
2. A diagnostic procedure, called for by the health status of the person, and likely to result in information that could affect the course of treatment for the disease or injury involved; and
3. No more costly (taking into account all health expenses incurred in connection with the service or supply) than any alternative service or supply.

In determining if a service or supply is appropriate under the circumstances, the following will be taken into consideration:

1. Information provided on the individual's health status;
2. Reports in peer-reviewed medical literature;
3. Reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;
4. Generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care or treatment;
5. The opinion of health professionals in the generally recognized health specialty involved; and
6. Any other relevant information presented to support the claim. In no event will the following services or supplies be considered necessary:
   a. Those that do not require the technical skills of a medical, health or dental professional; or
   b. Those furnished mainly for the personal comfort or convenience of the person, any person who cares for him or her, any person who is part of his or her family, any health care provider or health care facility; or
   c. Those furnished solely because of the setting if the service or supply could safely and adequately be furnished in a physician's or a dentist's office or other appropriate setting.

Medicare: Medicare as used in this booklet means the "Health Insurance for the Aged and Disabled" portion of the Social Security Act of the United States.

Night care treatment program: A partial hospitalization treatment program provided to an individual involving confinement during the night including a room charge. The hospital or non-hospital residential facility's treatment program must be available for at least eight hours a night and at least five nights a week to qualify as a night care treatment program.

Non-hospital residential facility: An institution (or distinct part thereof) which meets fully every one of the following criteria:

1. It is primarily engaged in providing, for compensation from its patients, a program for diagnosis, evaluation and effective treatment of chemical dependency; and
2. It provides all medical detoxification services on the premises, 24 hours a day; and
3. It provides all normal infirmary-level medical services required during the treatment period, whether or not related to the chemical dependency. Also, it provides, or has an agreement with a hospital in the area to provide, any other medical services that may be required; and
4. At all times during the treatment period, it is under the supervision of a staff of physicians and provides skilled nursing services by licensed nursing personnel under the direction of a full-time registered nurse; and
5. It prepares and maintains a written individual plan of treatment for each patient based on a diagnostic assessment of the patient's medical, psychological and social needs with documentation that the plan is under the supervision of a physician; and
6. It meets any applicable licensing standards established by the jurisdiction in which it is located.

Non-occupational disease: A disease that does not arise out of (or in the course of) any work for pay or profit, nor in any way results from a disease that does. If proof is furnished that the individual is covered under a workers' compensation law or similar law, but is not covered for a particular disease under such a law, that disease will be considered "non-occupational," regardless of the cause.

Non-occupational injury: Accidental bodily injury that does not arise out of (or in the course of) any work for pay or profit, nor in any way results from an injury that does.

Partial hospitalization treatment program: A planned program of services for treating chemical dependency, provided in a hospital or in a non-hospital residential facility on less than a full-time inpatient basis and meeting both of the following requirements:

1. It involves generally accepted forms of evaluation and treatment of a condition diagnosed as chemical dependency which does not require full-time confinement in a hospital or non-hospital residential facility; and
2. It is supervised by a physician who both reviews the program and evaluates its effectiveness at least one a week.

Physician: A person who meets the definition of a physician under Medicare.

Reasonable: Only that part of a charge that is reasonable is covered. The reasonable charge for a service or supply is the lowest of:

1. The provider's usual charge for furnishing it; and
2. The charge determined to be appropriate, based on factors such as the cost of providing the same or a similar service or supply; and
3. The charge determined to be the prevailing charge for the geographic area where it is furnished.

In determining the reasonable charge for a service or supply that is unusual, not often provided in the area, or provided by only a small number of providers in the area, other factors may be taken into

account such as:

1. The complexity;
2. The degree of professional skill needed;
3. The type of specialty of the provider;
4. The range of services or supplies provided by a facility; and
5. The usual and customary charge in other areas.

If usual and customary charges for a service or supply cannot be determined because of an absence of data, the above and other prevailing factors will be taken into account to determine if the charge is reasonable.

Respite care: Short-term, temporary care provided to people with disabilities so their families can take a break from the daily demands and stress associated with caring for a seriously ill loved one. Respite services may sometimes involve overnight care for an extended period of time, allowing families to take short vacations.

Semi-private rate: The daily room and board charge an institution applies to the greatest number of beds in its semi-private rooms (containing two or more beds). If the institution has no semi-private rooms, the semi-private rate will be the daily room and board commonly charged for semi-private rooms by similar institutions in the area. The term "area" means a city, a county, or any greater area necessary to obtain a representative cross-section of similar institutions.

Skilled nursing facility: An institution that meets the definition of a skilled nursing facility under Medicare and one that participates under Medicare.

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