Plan Summary of Coverage

G.M.P. – Employers Retiree Trust
Plan as of January 1, 2018

SUMMARY PLAN DESCRIPTION, PLAN #501

This document, together with the Plan of Benefits and the Aetna Certificate of life insurance, constitutes the Summary Plan Description required by §102 of the Employee Retirement Income Security Act of 1974, as amended ("ERISA")

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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 11, Aetna provides consultative and administrative services to the Trust that do not include the processing or disposition of claims for benefits.

PLEASE NOTE THE COVERAGE DETAILS AS TO BENEFIT LEVELS AND PARTICIPANT COSTS SET FORTH IN THIS PLAN SUMMARY OF COVERAGE AND THE PLAN OF BENEFITS ARE IN EFFECT FOR 2018 ONLY. ALL BENEFITS ARE SUBJECT TO CHANGE ON AN ANNUAL BASIS. ANY SUCH CHANGES WILL BE COMMUNICATED DURING THE OPEN ENROLLMENT PERIOD FOR ANY PLAN YEAR AND THROUGH THE TRIBUNE, IF YOUR FORMER EMPLOYER CONTRIBUTES AT THE HIGHEST RATE, OR THROUGH THE GAZETTE, IF YOUR FORMER EMPLOYER CONTRIBUTES BELOW THE HIGHEST RATE.

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.

Eligibility for Benefits

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

First, on December 31, 2018, 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 the time.

Second, on or after January 1, 2019, you (as a retiree) meet the following conditions:

1. You retire from a position under a labor contract providing for contributions by your employer to the Trust; and;
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 in the form of a lifetime annuity, or you were eligible for such payment and received a lump sum distribution thereof (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, 2019, or if you become medically eligible for Medicare before or after retirement.)

Third, on and after January 1, 2019, 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, 2019, or if you become medically eligible for Medicare before or after your lawful spouse's retirement.)

Additional Eligibility Guidelines

- An individual who has only deferred vested pension benefits under a participating employer's pension plan (i.e., not eligible for a normal, early or disability retirement at the termination of employment) is not eligible for coverage under this Plan as a retiree.
- An individual who, at the termination of his/her employment, is eligible for a normal, early or disability retirement under a participating employer's pension plan, but who postpones receipt of such benefit, is eligible for coverage under this Plan, but not until the individual begins to receive such retirement benefit.
- An individual who receives a lump sum or life annuity from a participating employer's cash balance pension plan is not eligible for coverage under this Plan unless, at the termination of employment, the individual is 60 or more years of age (or 55 or more years of age with 10 or more years of credited service under the employer's pension plan).
- An individual who is covered by, or dies under, any employer's active health benefits program is not eligible for coverage under this Plan, either as a retiree or as an eligible 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 an eligible spouse upon either divorce or remarriage, including after the retiree's death.
- No individual may receive multiple coverages under this Plan because of connections with two or more participating employers either as a retiree or an eligible spouse.
- If an eligible spouse does not take spouse coverage at the time of retirement, he or she will not be eligible until January 1 of the following year. Request for enrollment must me made during the November open enrollment period. If, however, an eligible spouse does not take coverage at the time of retirement due to having other coverage, cancels it, and provides proof of termination, the waiting period (January 1 of the following year) does not apply. This written notice of cancellation of other coverage must be received at the Trust within 30 days of cancellation.
- If a participant's coverage was terminated due to non-payment or by request, the participant must wait one year, from January 1 following the year in which coverage terminated, before becoming eligible to re-enroll. Request for enrollment must be made during the November open enrollment period. However, if you had other coverage, cancelled it, and provide the Trust proof of termination, the waiting period does not apply. This written notice of cancellation of other coverage must be received at the Trust within 30 days of cancellation.
- To remain eligible for coverage, the monthly premium for spouse coverage must be 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 or go to the Q&A section of our website at www.gmptrust.com. For additional materials on eligible spouse coverage, please refer to details in the Plan of Benefits booklet.

Life Insurance Benefits

Life insurance is only for retirees. 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
$2,000 per retiree

Comprehensive Medical Expense Coverage Under The Trust's Indemnity Program

For retirees and their eligible spouses. There is no charge for retirees to participate in the Indemnity program, but spouses pay a premium for the coverage. The 2018 monthly spouse premium is $35.00.

BENEFITS

Individuals who are not eligible for Medicare:

- 80 % 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 (This Plan coordinates with Medicare to pay):

- Out Patient: Up to 90% on certain covered medically necessary expenses after the annual calendar year deductible has been satisfied.
- In Patient: 80% of remaining balance on Medicare approved and paid covered expenses after the annual calendar year deductible has been satisfied.

DEDUCTIBLE

Individuals who are not eligible for Medicare:

- Annual Deductible in 2018 is $2,400 for participants whose employers are contributing to the Trust at the highest level.
- Annual Deductible in 2018 is $4,500 for participants whose employers are contributing to the Trust below the highest level.

Individuals who are eligible for Medicare:

- Annual Deductible in 2018 is $1,350 for participants whose employers are contributing to the Trust at the highest level.
- Annual Deductible in 2018 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:

Individuals who are not eligible for Medicare:

- $200,000 for participants whose employers are contributing to the Trust at the highest level.
- $130,000 for participants whose employers are contributing to the Trust below the highest level.

Individuals who are eligible for Medicare:

- $400,000 for participants whose employers are contributing to the Trust at the highest level.
- $130,000 for participants whose employers are contributing to the Trust below the highest level.

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.

Understanding the PPO Options

A Preferred Provider Organization, or PPO, is a health care benefit program where medical providers agree to offer their services at a discount. In return, the program 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

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

PPO OPTIONS

Participants whose former employer contributes to the Trust at the highest rate may enroll in either the PPO Plus or PPO options. Participants whose former employer contributes to the Trust below the highest rate may only elect the PPO option. There is a charge for both retirees and spouses for this coverage.

ENROLLMENT

If you are interested in a PPO option, you must complete a PPO enrollment form and submit it to the Trust office for consideration. (see "How to Enroll" later on this page). 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 coverage at the time of the retiree's retirement, he or she will not be eligible for PPO coverage until January 1 of the following year and the request for enrollment must be made during the preceding November open enrollment period. If, however, an eligible spouse does not take coverage at the time of the retiree's retirement due to having other health coverage, cancels it, and provides proof of the termination, the one year waiting period does not apply. This written verification of the cancellation of other coverage enables coverage through the Trust within 30 days.

Advantages

If you are eligible to enroll in a 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.
- **Pays a higher benefit.** Pays 90% of covered charges after 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. (*For the companies that have contributed at the highest level.)
- **Usually no claim forms.** By choosing network doctors and health care facilities, you receive an explanation of benefits form for your records, but you are rarely responsible for completing and filing claim forms.
- **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 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 PPO Enrollment form; or
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
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 the month.

DEDUCTIBLE

Please see plan option charts on pages 8 and 9.

Once you are enrolled, you must select your preferred method for paying the monthly cost of PPO option coverage, currently $45 per month for PPO or $72 per month for the PPO Plus, per participant.

1. Direct Payment Plan, which is an automatic monthly withdrawal from your bank account. Or,
2. Quarterly Billing, you will receive an invoice by mail.

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. Through the PPO option of coverage, the Trust offers heart disease and diabetes management programs to eligible non-Medicare participants. 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.

Termination of Coverage

MEDICARE ELIGIBILITY

When you become eligible for Medicare (either by reaching age 65 or become medically eligible), you no longer are eligible for a PPO option. (Patients with end-stage renal disease may remain in the PPO until the end of the 30 month coordination period.) 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.

VOLUNTARY PPO TERMINATION

If you want to drop the PPO option and return to the Trust 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 one year from the following January 1 after your PPO termination.

INVOLUNTARY PPO TERMINATION

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

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

Prescription Drug Benefits

IF EMPLOYER CONTRIBUTING AT THE HIGHEST RATE

Participants whose former employer is contributing to the Trust **at the highest rate** can take advantage of a discount Prescription Drug Program, which carries a separate annual deductible. Prescription drug deductible and coinsurance amounts do not apply to the Out-Of-Pocket maximum. This program is through Express Scripts.

The Prescription Drug Program is available through both the Indemnity program and the PPO options. There is NO ADDITIONAL FEE to participate in the prescription program, however, the applicable PPO and/or spouse premiums still apply.

DEDUCTIBLE

Individuals who are eligible for Medicare:

- Annual Deductible in 2018 is $650

Individuals who are not eligible for Medicare:

- PPO Plus - Annual Deductible in 2018 is $325
- PPO - Annual Deductible in 2018 is $650
- Indemnity - Annual Deductible in 2018 is $650

The Prescription Drug Program benefit applies to retail pharmacy and to mail-order prescription drugs. After this separate 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 90/70/60 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.

IF FORMER EMPLOYER CONTRIBUTED BELOW THE HIGHEST RATE

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. The prescription drug benefit covers 80% of eligible prescription drug charges after you satisfy the annual deductible under your coverage option.

Plan Administration Information

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974, as amended, (ERISA).

NAME OF PLAN:

G.M.P. – Employers Retiree Trust

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 options (medical): Blue Cross Blue Shield
4. Prescription coverage: Express Scripts

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 insurers and other service providers for information or assistance:

BLUE CROSS BLUE SHIELD

PPO Option
PO Box 100121
Columbia, SC 29202
1-800-830-1501

EXPRESS SCRIPTS

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

AETNA LIFE INSURANCE SERVICE CENTER

PO Box 14549
Lexington, KY 40512-4548
1-800-523-5065

PLAN OPTIONS FOR G.M.P. – EMPLOYERS RETIREE TRUST

For companies that contributed at the highest level
Non-Medicare Eligible Participants:

2018 Plan Year	PPO Plus (BCBS)	PPO (BCBS)	Indemnity Program
Premium Payment	$72.00 per month (lower prescription deductible)	$45.00 per month	Spouse: $35.00 per month Retiree: no monthly premium
Annual Deductible	$745 In-Network $2,235 Out-of-Network	$745 In-Network $2,235 Out-of-Network	$2400
*Coinsurance (amount you pay)	10% In-Network 30% Out-of-Network	10% In-Network 30% Out-of-Network	20%
**Annual out-of-pocket maximum	$2,235 In-Network $6,705 Out-of-Network Limit	$2,235 In-Network $6,705 Out-of-Network Limit	$7,200
Lifetime maximum	$400,000	$400,000	$200,000
Prescription Drug Program	**Separate Deductible: $325** **If you participate in the mail order program:** Generic drugs are covered at 90% "Plan-preferred" brand-name drugs are covered at 75% "Non-plan-preferred" drugs are covered at 60%	**Separate Deductible: $650** **If you participate in the mail order program:** Generic drugs are covered at 90% "Plan-preferred" brand-name drugs are covered at 75% "Non-plan-preferred" drugs are covered at 60%	

Medicare Eligible Participants:

2018 Plan Year	Medicare Indemnity Program
Premium Payment	Spouse: $35.00 per month Retiree: no monthly premium
Annual Deductible	$1,350
*After Deductible is Met	This Plan coordinates with Medicare to pay: Out Patient: Up to 90% on certain Medicare approved medical expenses. In Patient: 80% of remaining balance on Medicare approved and paid covered expenses.
**Annual out-of-pocket maximum	$4,050
Lifetime maximum	$400,000
Prescription Drug Program	**Separate Deductible: $650** **If you participate in the mail order program:** Generic drugs are covered at 90% "Plan-preferred" brand-name drugs are covered at 75% "Non-plan-preferred" drugs are covered at 60%

*See the Plan of Benefits booklet for detail of covered expenses
**Annual deductible applies to out of pocket expense

PLAN OPTIONS FOR G.M.P. – EMPLOYERS RETIREE TRUST

For companies that contributed below the highest level
Non-Medicare Eligible Participants:

2018 Plan Year	PPO (BCBS)	Indemnity Program
Premium Payment	$45.00 per month	Spouse: $35.00 per month Retiree: no monthly premium
Annual Deductible	$1,690 In-Network $5,070 Out-of-Network	$4500
*Coinsurance (amount you pay)	10% In-Network 30% Out-of-Network	20%
**Annual out-of-pocket maximum	$5,070 In-Network $15,210 Out-of-Network Limit	$13,500
Lifetime maximum	$130,000	$130,000
Prescription Drug Program	The prescription drug benefit covers 80% of eligible prescription drug charges after you satisfy the annual deductible.	

Medicare Eligible Participants:

2018 Plan Year	Medicare Indemnity Program
Premium Payment	Spouse: $35.00 per month Retiree: no monthly premium
Annual Deductible	$1,740
*After Deductible is Met:	This Plan coordinates with Medicare to pay: Out Patient: Up to 90% on certain Medicare approved medical expenses. In Patient: 80% of remaining balance on Medicare approved and paid covered expenses.
**Annual out-of-pocket maximum	$5,220
Lifetime maximum	$130,000
Prescription Drug Program	The prescription drug benefit covers 80% of eligible prescription drug charges after you satisfy the annual deductible.

*See the Plan of Benefits booklet for detail of covered expenses
**Annual deductible applies to out of pocket expense

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 (Coordination of Benefits Contractor), the national crossover contractor for CMS (The Centers for Medicare and Medicaid Services), 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 you file 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 it.

UNDER THE PPO OPTIONS:

Ordinarily, it is not necessary to file a claim under either 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 OPTIONS:

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.

LIFE INSURANCE CLAIMS:

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, as amended (ERISA). 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. This report is also available on the Trust's website at www.gmptrust.com.
4. Continued 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.

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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