

AMENDMENT NO. 1 TO THE SHEET METAL WORKERS
LOCAL UNION 268 WELFARE PLAN

(As Amended and Restated as of July 1, 2012)

The Trustees of the Sheet Metal Workers Local Union 268 Welfare Plan hereby amend the Plan Document and Summary Plan Description ("SPD") in the manner set forth below, effective February 1, 2013.

1. The subsection entitled "Bargained Employees" in the "Termination of Coverage" section on page 28 of the SPD is hereby amended to read as follows:

Bargained Employees. A covered Bargained Employee's coverage will immediately terminate on the earliest of:

- (1) the date the Plan is terminated; or
- (2) the date the Bargained Employee withdraws from the Sheet Metal Workers International Association Local 268; or
- (3) the date the Employer no longer makes a contribution to the Fund; or
- (4) the first day of any month of any year in which either:
 - (a) the Bargained Employee failed to complete 750 or more Hours of Covered Service in the immediately preceding 12 consecutive month period; or
 - (b) the Bargained Employee failed to complete 2,250 or more Hours of Covered Service in the immediately preceding 24 consecutive month period, unless the Bargained Employee pays the required contribution necessary to continue benefits in effect from that time until such time as the Bargained Employee is re-qualified. The amount of the required contribution will be in the sole discretion of the Plan Administrator. Once the Bargained Employee's coverage is terminated for failure to meet the requirements set forth in this paragraph, the Bargained Employee must meet the initial eligibility requirements as set out in the section entitled "Eligibility and Commencement of Coverage";

provided, however, if the Bargained Employee becomes eligible for the Disability Extension of Coverage, the Bargained Employee's eligibility status under the Plan will be frozen and remain frozen until the Bargained Employee is no longer eligible for the Disability Extension of Coverage; or

- (5) the date the Bargained Employee (or any person seeking coverage on behalf of the Bargained Employee) performs an act, practice or omission that constitutes fraud; or
- (6) the date the Bargained Employee (or any person seeking coverage on behalf of the Bargained Employee) makes an intentional misrepresentation of a material fact.

2. The following new subsection entitled "Disability Extension of Coverage" is hereby added after the subsection entitled "Dependents of Employees and Retirees" and before the subsection entitled "Continuation During Family and Medical Leave (FMLA)" in the "Termination of Coverage" section on page 29 of the SPD:

Disability Extension of Coverage. In the event a covered Bargained Employee becomes Disabled due to an Injury or Illness covered under workers' compensation or a similar law prior to the time the Employee is no longer eligible for Plan coverage based on hours worked, medical and prescription drug benefits under the Plan will be continued for the Bargained Employee and the Bargained Employee's covered Dependents until the earlier of (a) twelve months following the date of the Injury or Illness that is covered under workers' compensation or a similar law, or (b) the date the Bargained Employee's Physician releases the Bargained Employee to return to work.

In order to qualify for the Disability Extension of Coverage, the Bargained Employee's Disability must be under continuous treatment by a Physician. The Plan Administrator reserves the option of requesting periodic physical examinations from either the current Physician on the case or a Physician of the Plan Administrator's choice. Failure to provide requested Physicians' statements will result in termination of benefits. The Bargained Employee is responsible for providing the following information in a clearly understandable format:

- (1) history regarding when symptoms first appeared or accident happened;
- (2) diagnosis;
- (3) dates of treatment;
- (4) nature of treatment;
- (5) progress;
- (6) prognosis;
- (7) suitability for rehabilitation; and
- (8) Physician's signature and tax I.D. number.

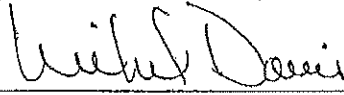
Additional information may be required based upon the Bargained Employee's Illness or Injury.

IN WITNESS WHEREOF, the Plan is so amended as of February 1, 2013.

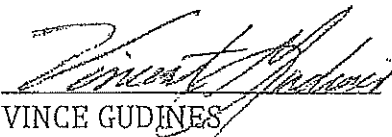
UNION TRUSTEES



JONATHAN MENTZ 2/12/13
Date

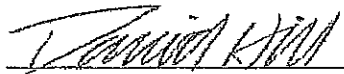


MICHAEL L. DAVIS 3/12/13
Date

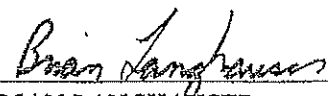


VINCE GUDINES 3/12/13
Date

EMPLOYER TRUSTEES



DAVID HILL 3/12/13
Date



BRIAN LANGHAUSER 3-12-13
Date

BARBARA WEIR Date

**AMENDMENT NO. 2 TO THE SHEET METAL WORKERS
LOCAL UNION 268 WELFARE PLAN**

(As Amended and Restated as of July 1, 2012)

The Trustees of the Sheet Metal Workers Local Union 268 Welfare Plan hereby amend the Plan Document and Summary Plan Description ("SPD") in the manner set forth below, effective June 1, 2013.

1. The "Preferred Provider Organization" subsection in the "Benefit Schedules" section on page 4 of the SPD is hereby deleted and replaced with the following:

Preferred Provider Organization

The Plan includes an arrangement with a Preferred Provider Organization. The current Preferred Provider Organization is HealthLink, whose name, address and phone number is printed on the Employee's identification card.

HealthLink has agreements with certain Hospitals, Physicians and other health care providers, which are called Participating or In-Network Providers. These Participating Providers have agreed to charge reduced fees to Covered Persons covered under the Plan. The Plan saves money because services are performed at a lower cost, the provider gains new clientele, and the Plan Participant receives a cost effective benefit.

When a Covered Person uses a Participating Provider, the Covered Person will receive a higher payment from the Plan than when a Non-Participating or Out-of-Network Provider is used. It is the Covered Person's option to select a Participating or Non-Participating Provider.

HealthLink has two separate networks. The network known as "HealthLink Open Access HMO" offers greater incentives. The network known as "HealthLink PPO" offers incentives that are, in some cases, less than the HealthLink Open Access HMO network. Generally, both networks offer incentives over the use of Out-of-Network Providers.

It is the Covered Person's responsibility to verify a provider's current participation as a Participating Provider and whether the provider participates in the HealthLink Open Access HMO network or the HealthLink PPO network by calling the HealthLink number on the ID card or by accessing the website, Mymeritain.com.

The HealthLink PPO benefit level will be paid for certain Out-of-Network Provider services under the following circumstances:

**AMENDMENT No. 3 to the
SHEET METAL WORKERS LOCAL UNION 268 WELFARE PLAN**

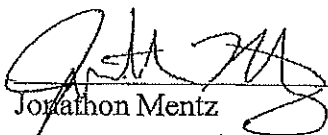
The Trustees of the Sheet Metal Workers Local Union 269 Welfare Plan hereby amend the Plan effective September 18, 2013 by deleting the definition of Spouse in the definitions section and replacing it with the following:

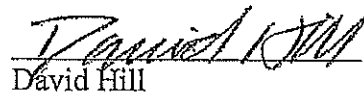
Spouse: Effective September 18, 2013, the term "Spouse" means: 1) your legal spouse as defined under the laws of the State of Illinois; and 2) any individual to whom you are lawfully married under any state law, including individuals married to a person of the same sex who are legally married in a state that recognizes same sex marriages, even if you are domiciled in a state that does not recognize such marriage. The term "Spouse" shall not mean domestic partners or individuals in civil unions.


IN WITNESS WHEREOF, the Plan is so amended as of the date set forth above.

EMPLOYEE TRUSTEES

EMPLOYER TRUSTEES

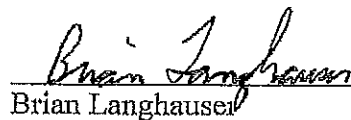

Jonathon Mentz 12/4/13
Date


David Hill 12/4/13
Date


Michael Davis 12/4/13
Date

Gregory Reynolds Date


Vince Gudines 12-4-13
Date


Brian Langhause 12-4-13
Date

#4

**AMENDMENT TO
SHEET METAL WORKERS LOCAL UNION 268 WELFARE PLAN
PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION
(As Amended and Restated as of July 1, 2012)**

Effective July 1, 2014, the Trustees of the Sheet Metal Workers Local Union 268 Welfare Plan (the "Plan") hereby amend the Plan Document and Summary Plan Description in the manner set forth below.

- A. In the "Schedule of Medical Benefits" on page 6, the annual maximum benefit of \$2,000,000 is deleted.
- B. In the "Schedule of Medical Benefits" on page 8, the Benefit for Spinal Manipulation/Chiropractic is revised to read:
- Maximum of 24 visits per calendar year. Coverage is limited to spinal manipulation, diagnostic testing and x-rays.
- C. In the "Schedule of Medical Benefits" on page 9, the Benefit for Jaw Joint/TMJ is revised by deleting the \$1,000 lifetime maximum and adding the following:
- Coverage is limited to one Medically Necessary surgery (non-surgical treatment is not covered).
- D. In the "Eligibility and Commencement of Coverage" Section, the subsection entitled "Eligibility Rules for Bargained Employees" on page 21 is revised by adding the following to subparagraph (3):
- If required contributions are not promptly received from the Employer, the Employee will be given credit for Hours of Covered Service upon the Fund's receipt of verification of hours worked.
- E. In the "Eligibility and Commencement of Coverage" Section, paragraph (3) of the subsection entitled "Eligibility Rules for Non-Bargained Employees" on page 21 is revised to read as follows:
- (3) the plan must receive two (2) consecutive months of contributions by the Employer.
- F. In the "Eligibility and Commencement of Coverage" Section, paragraph (3) of the subsection entitled "Eligibility Rules For Dependents—All Classes" on page 22 is revised to read as follows:
- (3) A covered Employee's or Retiree's Dependent Child until the end of the month in which the Dependent Child attains age 26.
- G. In the "Eligibility and Commencement of Coverage" Section, the subsection entitled "Pre-Existing Conditions Limitation" on pages 26-27 is deleted in its entirety.
- H. In the "Medical Benefits" Section, the subsection entitled "Maximum Benefit Amount" on page 40 is deleted in its entirety.

- I. In the "Health Reimbursement Arrangement" Section, the subsection entitled "Eligibility" on page 55 is amended by adding the following:

You may permanently opt out of the HRA and waive future reimbursements from your HRA account by submitting a written request to the Plan Administrator's office. Any balance remaining in the account will be transferred to the Plan Trust.

- J. In the "Health Reimbursement Arrangement" Section, the subsection entitled "Disposition of HRA Account if Plan Coverage Terminates as an Active Employee" on page 57 is amended by revising the fourth paragraph to read as follows:

In addition to the eligible health care expenses listed under the "How the HRA Works" section above, surviving Dependents can also submit premiums, copayments, deductibles and the coinsurance balances that an eligible Dependent incurs under another group health plan or group insurance policy through which the eligible Dependent has health care coverage provided such group plan or policy meets the minimum value standards set forth in the Patient Protection and Affordable Care Act and applicable regulations. Surviving eligible Dependents may also permanently opt out of the HRA and waive future reimbursements from the HRA account. If the surviving eligible Dependents have not opted out of the HRA and they do not exhaust the balance of the HRA account within 60 months after the death of the Bargained Employee or Retiree, the remaining balance will be forfeited and transferred to the Plan Trust.

- K. In the "Health Reimbursement Arrangement" Section, the subsection entitled "Disposition of HRA Account if Plan Coverage Terminates as an Active Employee" on page 57 is amended by revising the second sentence of the sixth paragraph to read as follows:

In addition to the eligible health care expenses listed under the "How the HRA Works" section above, you can also submit premiums, copayments, deductibles and the coinsurance balances that you or your eligible Dependents incur under another group health plan or group insurance policy through which you or your eligible Dependent has health care coverage provided such group plan or policy meets the minimum value standards set forth in the Patient Protection and Affordable Care Act and applicable regulations. You or, in the event of your death, your surviving eligible Dependents may also permanently opt out of the HRA and waive future reimbursements from the HRA account. If you or your surviving Dependents have not opted out of the HRA and you (or they) do not exhaust the balance of the HRA account within 60 months after the date your Plan coverage terminates, the remaining balance will be forfeited and transferred to the Plan Trust.

- L. In the "Plan Administration, Amendment and Termination" section, the subsection entitled "Participants Rights Under ERISA" on page 76 is revised by adding the following under the "Continue Group Health Plan Coverage" heading:

The following provision is effective until December 31, 2014. At that time, a Certificate of Creditable Coverage will no longer be necessary as no plan may apply a pre-existing condition limitation pursuant to the provisions of the Patient Protection and Affordable Care Act.

IN WITNESS WHEREOF, the Plan is so amended, effective July 1, 2014.

UNION TRUSTEES

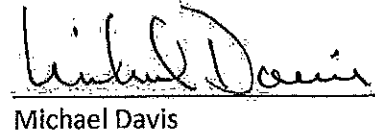
EMPLOYER TRUSTEES


Jonathan Mentz

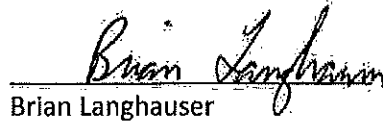
9/30/14
Date

David Hill

Date


Michael Davis

9/30/14
Date


Brian Langhauser

9-30-14
Date


Vincent Gudines

9/30/14
Date

Gregory Reynolds

Date

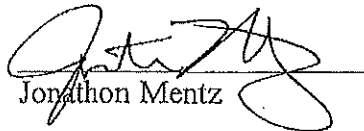
**AMENDMENT No. 5 to the
SHEET METAL WORKERS LOCAL UNION 268 WELFARE PLAN**

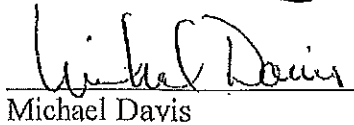
The Trustees of the Sheet Metal Workers Local Union 269 Welfare Plan hereby amend the Plan effective June 26, 2013 by deleting the definition of Spouse in the definitions section and replacing it with the following:

Spouse: Effective June 26, 2013, the term "Spouse" means: 1) your legal spouse as defined under the laws of the State of Illinois; and 2) any individual to whom you are lawfully married under any state law, including individuals married to a person of the same sex who are legally married in a state that recognizes same sex marriages, even if you are domiciled in a state that does not recognize such marriage. The term "Spouse" shall not mean domestic partners or individuals in civil unions.

IN WITNESS WHEREOF, the Plan is so amended as of the date set forth above.


EMPLOYEE TRUSTEES


Jonathon Mentz 6/3/14
Date

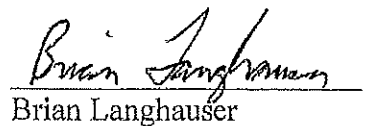

Michael Davis 6-3-14
Date


Vince Gudines 6-3-14
Date

EMPLOYER TRUSTEES


David Hill 6/3/14
Date

Gregory Reynolds Date


Brian Langhauser 6-3-14
Date

AMENDMENT NO. 6 TO THE
SHEET METAL WORKERS LOCAL UNION 268 WELFARE PLAN

The Trustees of the Sheet Metal Workers Local Union 268 Welfare Plan hereby amend the Plan, effective _____, 2015, as follows:

In the ELIGIBILITY AND COMMENCEMENT OF COVERAGE ARTICLE, the Section titled Eligibility Rules for Retirees is hereby amended by adding the following between the second and third paragraphs of the section:

"Effective on _____, 2015, a Retiree (including a non-bargained participant) is eligible for the Plan if the Retiree meets all of the following:

(1) The Retiree has had at least ten (10) consecutive years of coverage under the Sheet Metal Workers Local Union 268 Welfare Plan; and

(2) The Retiree has been a participant under the Sheet Metal Workers Local Union 268 Welfare Plan for at least five (5) consecutive years immediately prior to the earliest of:

(a) the date the Retiree becomes permanently and totally disabled as determined by the Social Security Administration; or

(b) the date the Retiree leaves covered employment after the Retiree reaches age 55; or

(c) the Retiree's annuity starting date under an approved pension plan; and

(3) The Retiree continues to pay the self-payment contribution required by the Plan to continue coverage."

IN WITNESS WHEREOF, the Plan is so amended as of the date set forth above.

EMPLOYEE TRUSTEES

EMPLOYER TRUSTEES

_____/_____
Jonathan Mentz Date

_____/_____
David Hill Date

_____/_____
Michael Davis Date

_____/_____
Gregory Reynolds Date

_____/_____
Vince Guidines Date

_____/_____
Brian Langhauser Date

AMENDMENT NO. 7 TO
SHEET METAL WORKERS LOCAL UNION 268 WELFARE PLAN
PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION
(As Amended and Restated as of July 1, 2012)

Effective August 1, 2015, the Trustees of the Sheet Metal Workers Local Union 268 Welfare Plan (the "Plan") hereby amend the Plan Document and Summary Plan Description in the manner set forth below.

- A. In the "Schedule of Medical Benefits" on page 6, the description of covered "Routine Care" is revised to read:

Includes routine examinations, routine wellness care, laboratory tests, annual mammogram, pap smear, prostate tests, school/sports physicals, immunizations (including HPV immunizations) and routine colonoscopies.

- B. In the "Covered Medical Expenses" Section on page 45, Paragraph (9)(x) is revised to read:

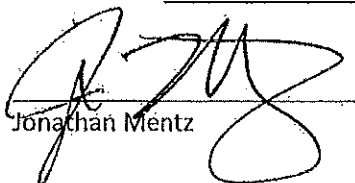
Preventive or Routine Care. Covered charges under Medical Benefits are payable for Routine Care as outlined in the Schedule of Medical Benefits. Routine colonoscopies are covered in accordance with the U.S. Preventive Services Task Force recommendations with a rating of A or B.

- C. "Exclusions and Limitations" Item 44, "Routine colonoscopy," on page 48 is deleted in its entirety, with the list of exclusions renumbered accordingly.

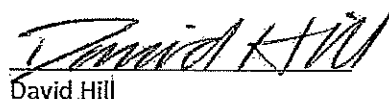
IN WITNESS WHEREOF, the Plan is so amended, effective August 1, 2015.

UNION TRUSTEES

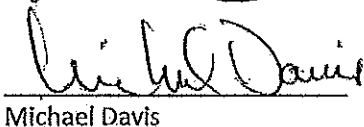
EMPLOYER TRUSTEES


Jonathan Mentz

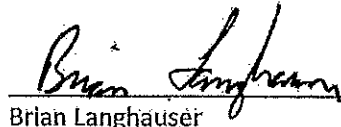
8/1/15
Date


David Hill

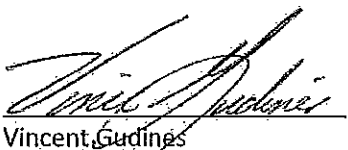
8-1-15
Date


Michael Davis

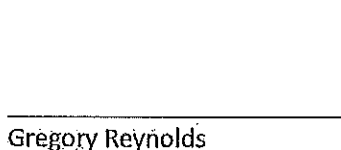
8/1/2015
Date


Brian Langhauser

8-1-15
Date


Vincent Gudines

8-1-15
Date


Gregory Reynolds

Date

**AMENDMENT NO. 8 TO THE SHEET METAL WORKERS
LOCAL UNION 268 WELFARE PLAN
(As Amended and Restated as of July 1, 2012)**

The Trustees of the Sheet Metal Workers Local Union 268 Welfare Plan hereby amend the Plan Document and Summary Plan Description ("SPD") in the manner set forth below, effective January 1, 2016.

1. The first bullet point in the last paragraph of the "Preferred Provider Organization" subsection in the "Benefits Schedules" section on page 4 is amended to read as follows:

- If a Covered Person has a Medical Emergency requiring immediate care while outside of the HealthLink Open Access HMO and HealthLink PPO areas, the Plan will pay the HealthLink PPO benefit level for covered health care provided to the Covered Person until such time as care by a HealthLink Open Access HMO and HealthLink PPO Provider can be obtained without jeopardizing the Covered Person's health.

2. In the "Schedule of Medical Benefits" on page 6, "Deductibles" is amended to read as follows:

Deductibles:			
Individual	\$300	\$300	\$300
Family	\$600	\$600	\$600

3. In the "Schedule of Medical Benefits" on page 6, "Maximum Out-of-Pocket" is amended to read as follows:

Maximum Out-of-Pocket (does not include the deductible):			
Individual	\$650	\$1,300	\$3,900
Family	\$1,300	\$2,300	\$7,800

4. In the "Schedule of Medical Benefits" on page 6, the copayment for "Routine Care" from Healthlink Open Access HMO Participating Providers is increased to \$10.
5. In the "Schedule of Medical Benefits" on page 6, the copayment for "Routine Mammogram" from Healthlink Open Access HMO Participating Providers is increased to \$10.
6. In the "Schedule of Medical Benefits" on page 8, "Emergency Room (including all related expenses)" is amended to read as follows:

Emergency Room (including all related expenses)	\$30 copay per visit, then 90% coinsurance; deductible does not apply	\$65 copay per visit, then deductible. After deductible is met, 80% coinsurance applies.	\$90 copay per visit, then deductible. After deductible is met, 70% of U&C coinsurance applies.
The Emergency Room copay is waived if the Covered Person is admitted to the Hospital for a Medical Emergency.			

7. In the "Schedule of Medical Benefits" on page 8, "Urgent Care Facility Visit" is amended to read as follows:

Urgent Care Facility Visit	\$10 copay per visit, then 100% coinsurance; deductible does not apply.	\$20 copay per visit, then deductible. After deductible is met, 80% coinsurance applies.	After deductible is met, 70% of U&C coinsurance applies.
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8. In the "Schedule of Medical Benefits" on page 9, "Physician's Office/Home Visits" is amended to read as follows:

Physician's Office/Home Visits	\$10 copay per visit, then 100% coinsurance; deductible does not apply.	\$20 copay per visit, then deductible. After deductible is met, 80% coinsurance applies.	After deductible is met, 70% of U&C coinsurance applies.
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9. In the "Schedule of Prescription Drug Benefits" on page 11, "Retail Pharmacy Option (31-day supply)" is amended to read as follows:

Retail Pharmacy Option (31-day supply)	Copayment
Generic drugs	\$10
Formulary Brand Name drugs	\$25
Non-Formulary Brand Name drugs	\$45
Prescription drug is covered at 100% after copayment.	

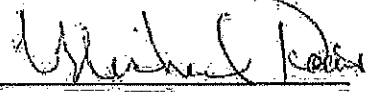
IN WITNESS WHEREOF, the Plan is so amended as of January 1, 2016.

UNION TRUSTEES

EMPLOYER TRUSTEES



JONATHAN MENTZ
Date 9/9/15


DAVID HILL
Date 9/9/15


MICHAEL L. DAVIS
Date 9/9/15


BRIAN LANGHAUSER
Date 9-9-15


VINCE GUDINES
Date 9/9/15


GREGORY REYNOLDS
Date 9/9/15

**AMENDMENT NO. 9 TO THE SHEET METAL WORKERS
LOCAL UNION 268 WELFARE PLAN
(As Amended and Restated as of July 1, 2012)**

The Trustees of the Sheet Metal Workers Local Union 268 Welfare Plan hereby amend the Plan Document and Summary Plan Description ("SPD") in the manner set forth below, effective January 1, 2016.

1. The "Preferred Provider Organization" subsection in the "Benefits Schedules" Section on page 4 is amended to read as follows:

The Plan includes an arrangement with a Preferred Provider Organization. The current Preferred Provider Organization is Coventry Health Care, whose name, address and phone number is printed on the Employee's identification card.

Coventry has agreements with certain Hospitals, Physicians and other health care providers, which are called Participating or In-Network Providers. These Participating Providers have agreed to charge reduced fees to Covered Persons covered under the Plan. The Plan saves money because services are performed at a lower cost, the provider gains new clientele, and the plan Participant receives a cost effective benefit.

When a Covered Person uses a Participating Provider, the Covered Person will receive a higher payment from the Plan than when a Non-Participating or Out-of-Network Provider is used. It is the Covered Person's option to select a Participating or Non-Participating Provider.

Participating Providers are classified as either Tier 1 or Tier 2, based on their network affiliation. Tier 1 has two separate networks, which offer greater incentives—"CMR" in Illinois and Missouri and "Aetna Choice POS II" outside of Illinois and Missouri. The Tier 2 Network, known as "First Health," offers incentives that are, in some cases, less than the Tier 1 networks. Generally all three networks offer incentives over the use of Out-of-Network Providers.

It is the Covered Person's responsibility to verify a provider's current participation as a Participating Provider and whether the provider participates in the CMR, Aetna Choice POS II or First Health network by calling the number on the ID card or by accessing the website, Mymeritain.com.

- If a Covered Person has a Medical Emergency requiring immediate care while outside of the Tier 1 or Tier 2 network areas, the Plan will pay the Tier 2 benefit level for covered health care provided to the Covered Person until such time as care by a Tier 1 or Tier 2 Provider can be obtained without jeopardizing the Covered Person's health.

#10

**AMENDMENT NO. 10 TO THE SHEET METAL WORKERS
LOCAL UNION 268 WELFARE PLAN
(As Amended and Restated as of July 1, 2012)**

The Trustees of the Sheet Metal Workers Local Union 268 Welfare Plan hereby amend the Plan Document and Summary Plan Description ("SPD") in the manner set forth below, effective August 1, 2016.

1. In the "Prescription Drug Benefits" Section, the "Prescription Drug Program" subsection is revised to read as follows:

This Prescription Drug Program is an independent program, separate from medical coverage. LDI Integrated Pharmacy Services participating Pharmacies have contracted with the Plan to charge Covered Persons reduced fees for covered Prescription Drugs. In order to receive the full benefit of the Prescription Drug Program, a Covered Person must use participating Pharmacies and present the Covered Person's ID card. LDI Integrated Pharmacy Services is the administrator of the Prescription Drug Program.

2. In the "Prescription Drug Benefits" Section, the last sentence of the "Direct Reimbursement" subsection is revised to read as follows:

In order for reimbursement to occur, the Covered Person must complete a direct reimbursement form, obtained from the Plan Administrator, attach the receipt, and submit it to the Prescription Drug Program administrator at the following address:

LDI Integrated Pharmacy Services
701 Emerson Road, Suite 301
Creve Coeur, Missouri 63141

3. In the "Prescription Drug Benefits" Section, the subsection entitled "Specialty Pharmacy Program" is deleted in its entirety and is replaced with the following:

Specialty Drugs

Specialty medications are used in treating serious illnesses and condition such as cancer, hemophilia, hepatitis C, multiple sclerosis, and rheumatoid arthritis. Specialty drugs will be filled through LDI's specialty pharmacy.

For specialty drugs, the plan will pay the first 50% of the cost of the specialty medication obtained through LDI's specialty pharmacy. LDI will then assist the individual in applying for any available copay assistance and coupons from pharmaceutical manufacturers and for payment from other plans covering the individual.

If payment from other sources is received, the Plan will pay the remaining cost of the medication after the third party payments are applied with no amount due from the individual.

If there is no payment available from other sources, the individual will only be responsible for the brand copay amount as shown in the prescription drug schedule of benefits.

Coupons, copay assistance and other forms of financial assistance and any amounts not paid out of the participant or dependent's "pocket" are not counted towards the out-of-pocket maximum.

4. In the "Filing a Claim" Section, the second paragraph of subsection (2), "Claims for Prescription Drug Benefits," is revised to read as follows:

If for any reason you have not used the Prescription Drug card or you are denied a Prescription Drug or believe you were charged too much for the Prescription Drug or used a non-participating Pharmacy, you may file a claim for Prescription Drug benefits with LDI. You must obtain a Prescription Drug claim direct reimbursement form from the Plan Administrator's office, attach the receipt and any other supporting documentation, and submit the claim to the Prescription Drug Program administrator at the following address:

LDI Integrated Pharmacy Services
701 Emerson Road, Suite 301
Creve Coeur, Missouri 63141

5. In the "General Plan Information" Section, the last sentence of the third paragraph is revised to read as follows:

The name, address and website for the PBM are:

LDI Integrated Pharmacy Services
701 Emerson Road, Suite 301
Creve Coeur, Missouri 63141
1-866-516-3121 or 314-652-3121
www.ldirx.com


IN WITNESS WHEREOF, the Plan is so amended as of August 1, 2016.

UNION TRUSTEES


EMPLOYER TRUSTEES


Jonathan Mentz


6/14/16
Date


David Hill


6/14/16
Date


Michael Davis


6/14/2016
Date


Brian Langhauser

6-14-16
Date


Vincent Gudines

6-14-16
Date


William Theiss

6-14-16
Date

**AMENDMENT NO. 11 TO THE SHEET METAL WORKERS
LOCAL UNION 268 WELFARE PLAN
(As Amended and Restated as of July 1, 2012)**

The Trustees of the Sheet Metal Workers Local Union 268 Welfare Plan hereby amend the Plan Document and Summary Plan Description ("SPD") in the manner set forth below, effective January 1, 2016.

1. The "Preferred Provider Organization" subsection in the "Benefits Schedules" Section on page 4 is amended to read as follows:

The Plan includes an arrangement with a Preferred Provider Organization. The current Preferred Provider Organization is Coventry Health Care, whose name, address and phone number is printed on the Employee's identification card.

Coventry has agreements with certain Hospitals, Physicians and other health care providers, which are called Participating or In-Network Providers. These Participating Providers have agreed to charge reduced fees to Covered Persons covered under the Plan. The Plan saves money because services are performed at a lower cost, the provider gains new clientele, and the plan Participant receives a cost effective benefit.

When a Covered Person uses a Participating Provider, the Covered Person will receive a higher payment from the Plan than when a Non-Participating or Out-of-Network Provider is used. It is the Covered Person's option to select a Participating or Non-Participating Provider.

Participating Providers are classified as either Tier 1 or Tier 2, based on their network affiliation. Tier 1, which offer greater incentives, is known as "CMR" in Illinois and Missouri. The Tier 2 Network, known as "Aetna Choice POS II," offers incentives that are, in some cases, less than the Tier 1 networks. Generally both networks offer incentives over the use of Out-of-Network Providers.

It is the Covered Person's responsibility to verify a provider's current participation as a Participating Provider and whether the provider participates in the CMR or Aetna Choice POS II network by calling the number on the ID card or by accessing the website, Mymeritain.com.

- If a Covered Person has a Medical Emergency requiring immediate care while outside of the Tier 1 or Tier 2 network areas, the Plan will pay the Tier 2 benefit level for covered health care provided to the Covered Person until such time as care by a Tier 1 or Tier 2 Provider can be obtained without jeopardizing the Covered Person's health.

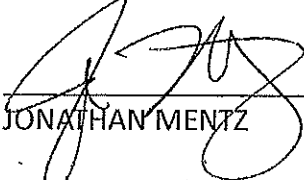
- If a Covered Person receives services from an Out-of-Network emergency room Physician, anesthesiologist, radiologist or pathologist while being treated at a Tier 1 or Tier 2 Hospital or emergency care facility, the Plan will pay the Tier 2 benefit level for covered health care provided to the Covered Person.

2.. Throughout the document, on all references to pre-admission notification, medical management, prior notification and precertification, the phone number should be amended to read "800-242-1199".

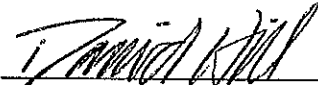
IN WITNESS WHEREOF, the Plan is so amended as of January 1, 2017.

UNION TRUSTEES


EMPLOYER TRUSTEES



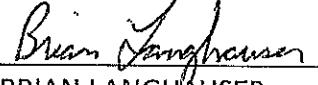
 JONATHAN MENTZ 1/10/17
 Date



 DAVID HILL 1/10/17
 Date



 MICHAEL L. DAVIS 1/10/2017
 Date



 BRIAN LANGHAUSER 1-10-17
 Date



 VINCE GUDINES 1-10-2017
 Date



 WILLIAM THEISS 1-10-17
 Date