AMENDMENT NO. 1 TO THE WISCONSIN ELECTRICAL EMPLOYEES HEALTH AND WELFARE PLAN RESTATED RULES AND REGULATIONS

The Plan's Restated Rules and Regulations shall be amended as of the effective dates set forth below to:

- clarify termination of coverage provisions for other Dependents entering active military duty;
- exclude coverage for services related to motor vehicle accidents for Participants residing in Michigan;
- add coverage for COVID-19 testing and related office visits, consistent with the Families First Coronavirus Response Act;
- add coverage for telehealth and virtual office visits;
- temporarily remove the requirement that an Active Hourly Employee receiving Supplemental Unemployment Benefits after six weeks provide evidence that he or she is available for work; and
- allow a Participant who is a Medicare-eligible retiree to remove a Dependent provided the Participant elects to continue medical coverage by making Self-Payments for Retirees and the Dependent has other group health plan coverage.

To reflect these changes, the Rules and Regulations are amended as follows:

1. Effective January 1, 2020, Section 2.7(c), Termination of Dependent Coverage, is amended to reinstate and amend subsection (ii) to read as follows:

(c) Termination of Dependent Coverage. The coverage of a Dependent will terminate on the earliest of the following dates:

(i) The date of termination of the Participant's coverage;

(ii) The date a Dependent, as defined in Plan Section 1.14(c), enters active military duty;

(iii) The date the Dependent ceases to qualify as a Dependent unless otherwise set forth in that definition;

(iv) The date the Plan is discontinued; or

(v) The date the Participant's eligibility ceases on account of a Withdrawal.

2. Effective March 1, 2020, a new Article XVII, Temporary COVID Relief, is added to the Plan to read as set forth in attached Exhibit A.

3. Effective June 1, 2020, Section 5.8, Covered Charges, subsection (h)(ii), is amended to read as follows:

(h) Medical Services. Benefits are payable for medical services rendered by a Physician as follows:

(ii) Office visits, including telehealth and virtual visits;

4. Effective July 1, 2020, Section 9.1, Exclusions and Limitations, is amended to add the following new section (ggg):

(ggg) With respect to an Eligible Individual who is a Michigan resident, a Bodily Injury or Illness that results from a motor vehicle accident.

Additionally, section 10.1, Coordination of Benefits, subsection (b), No-Fault Automobile Insurance, is amended to read as follows:

(b) No-Fault Automobile Insurance. Benefits under This Plan will be coordinated with minimum coverages required under any no-fault statute and any other applicable No Fault Law. If a "No Fault" policy provides coverage in excess of the minimum required by State Law then This Plan will coordinate benefits with those coverages in effect.

The benefits of This Plan will not be available to an Eligible Individual to the extent of minimum benefits required by the "No Fault" Law. However, This Plan does not coordinate benefits relating to any other person injured in a motor vehicle accident if the injured person is a non-owner operator, passenger or a pedestrian and such other person is not covered by No Fault Automobile Insurance. The foregoing notwithstanding, an Eligible Individual who is a Michigan resident is not eligible for benefits related to a motor vehicle accident.

5. Effective August 1, 2020, Section 2.7(c), Termination of Dependent Coverage, is amended to add a new subsection (vi) to read as follows:

(c) Termination of Dependent Coverage. The coverage of a Dependent will terminate on the earliest of the following dates:

(i) The date of termination of the Participant's coverage;

(ii) The date a Dependent, as defined in Plan Section 1.21(c), enters active military duty;

(iii) The date the Dependent ceases to qualify as a Dependent unless otherwise set forth in that definition;

(iv) The date the Plan is discontinued;

(v) The date the Participant's eligibility ceases on account of a Withdrawal; or

(vi) The date a Medicare-eligible retiree elects to remove the Dependent from coverage in conjunction with the Participant electing to continue medical coverage under Self-Payment for Retirees, provided the Participant demonstrates that the Dependent has other group health plan coverage in accordance with Plan Section 2.18(a).

Additionally, Section 2.8, Self-Payment for Retirees, is amended to read as follows:

2.8 Self-Payment for Retirees. If all of the eligibility requirements described below are met, Active Employees, Self-Pay Active Hourly Employees and Self-Pay Disabled Employees currently covered under the Plan may elect, upon retirement, to continue coverage for themselves and their Dependents, by making self-payments directly to the Plan at the applicable rate established by the Board of Trustees. Active Employees who have lost eligibility under section 2.2(e)(v), (vi) or (vii) and section 2.3(d)(vi) cannot continue coverage under this provision. An Early Retiree or a Retiree who was married when they began participating as an Early Retiree or Retiree and failed to enroll their spouse at that time may, on a one-time basis, enroll their spouse as a Dependent upon the spouse's loss of group health plan coverage provided that the spouse provides satisfactory written proof of continuous group health plan coverage. A Medicare-eligible retiree may remove a Dependent upon electing to make self-payments under this provision, provided the Medicare-eligible retiree can demonstrate that the Dependent has other group health plan coverage meets the requirements in Plan Section 2.18(a). Any Eligible Individual who is otherwise eligible to make self-payments under this section 2.8 and who is enrolled in a Medicare Part D plan other than an EGWP shall be ineligible for the Prescription Drug Benefits described in Article XV effective on the date of enrollment in such Medicare Part D plan.

Finally, Section 2.18, Opt-Out For Dependents For High Deductible Health Plan and Participants Electing Retiree Coverage, subsection (a), Opt-Out Eligibility Rules, is amended to read as follows:

(a) Opt-Out Eligibility Rules. A Dependent may elect to opt-out of coverage under this Plan if he can provide the Plan Office with acceptable written proof that he is eligible to enroll in a High Deductible Health Plan ("HDHP") offered by the Dependent's employer (or the parent's employer in the case of a Dependent child) in conjunction with a Health Savings Account ("HSA") upon waiver of Plan benefits. Additionally, a Participant who is Medicare-eligible retiree can remove a Dependent when electing to continue medical coverage by making Self-Payments for Retirees, provided the Medicare-eligible retiree demonstrates that the Dependent is enrolled in other group health plan coverage. To opt-out of

coverage where the Dependent is enrolling in HDHP coverage, the Dependent must meet all of the following requirements:

(i) The Dependent must complete and sign a Dependent Coverage Opt-Out Form acknowledging that he is opting out of coverage under this Plan and its Flexible Benefit Account.

(ii) The Dependent's coverage under this Plan (including the Flexible Benefit Account) will terminate at the end of the last day of the month during which a completed and signed opt-out election form is received by the Plan Office.

(iii) The Dependent's opt-out election will automatically renew each year unless the Dependent again reinstates coverage under the terms of the opt-in provision.

(iv) If a Dependent elects to opt-out of coverage under this Plan, no Flexible Benefit Account reimbursement will be made for any health care expenses incurred on the Dependent's behalf, including dental, vision or preventive care benefits, even if such health care expense would qualify as being a reimbursable expense under the Flexible Benefit Account.

The undersigned Trustees of the Wisconsin Electrical Employees Health and Welfare Plan do hereby certify that the foregoing Amendment to the Restated Rules and Regulations was adopted by requisite vote of the Trustees at a duly-called meeting held on July 28, 2020.

Union Trustee

Employer Trustee

EXHIBIT A

ARTICLE XVII

TEMPORARY COVID-19 RELIEF

17.1 Adoption and Effective Date of Amendment. Effective March 1, 2020 until the end of the COVID-19 National Emergency, the Plan is amended to:

(a) Provide 100% coverage of in-vitro diagnostic COVID-19 testing that is authorized by the FDA or otherwise required by Federal Law and 100% coverage of corresponding services administered in an office visit (including a telehealth visit), urgent care visit or emergency room visit that results in ordering or administering a COVID-19 test, consistent with the Families First Coronavirus Response Act and other applicable law. Coverage applies without regard to whether the test is provided in-network or out-of-network and no prior authorization or medical management requirements will apply to the qualifying COVID-19 testing. UCR limits will apply to testing for out-of-network tests and visits to the extent permitted by applicable law.

(b) Provide 100% coverage of medically necessary telehealth and virtual visits, in-network and out-of-network incurred between March 1, 2020 and May 31, 2020, subject to UCR limits.

17.2 Temporary Amendment to Supplemental Unemployment Benefits. Effective March 1, 2020, the Plan will temporarily waive the requirement that an Active Hourly Employee receiving Supplemental Unemployment Benefits (if Employee has benefit under a Collective Bargaining Agreement) after six weeks must provide evidence (Local Union's referral process) that he or she is available for work. Evidence of receiving state unemployment benefits must still be provided.