BLUE CROSS AND BLUE SHIELD OF MINNESOTA

WELFARE BENEFIT PLAN

RETIREE MEDICAL PLAN (including special transition benefit)

SUMMARY PLAN DESCRIPTION 2024

About This Summary

This Summary Describes Eligibility, Coverage Options and ERISA Rights

This summary, together with the medical plan summary plan description and insurance certificate booklets, describes the Retirement Health Care Program (also referred to as the Retiree Medical Plan) provided under the Blue Cross and Blue Shield of Minnesota Welfare Benefit Plan (the "Plan"). This summary describes the requirements to be eligible to receive retirement health benefits and the retirement coverage options available to eligible former associates of Blue Cross and Blue Shield of Minnesota ("Blue Cross") under both the transition plan and new plan effective on June 1, 2000. This summary also describes an associate's rights in connection with claims for benefits under the plan and the Employee Retirement Income Security Act of 1974 ("ERISA").

There are Other Booklets You Should Read

The health care benefits available under the Retiree Medical Plan are described in separate summary plan descriptions or insurance certificate booklets. These booklets are available by contacting the Human Resources department.

Read the Entire Summary and Insurance Certificate

It is important that all of this summary and the separate booklets be read. Reading only portions can be confusing and misleading.

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Definitions

Transition Participant

An associate who was (i) actively employed by Blue Cross on June 1, 2000, and whose (ii) combined age and service equal 85 or more on June 1, 2010, or date of termination if earlier or (iii) have at least 30 years of service on June 1, 2010, or the date of his/her termination of employment if earlier.

Rule of 85

Associate's combined age and years of service equal 85 or more at time of termination.

Spouse/Dependent Eligibility

The Medical Plan offerings cover only eligible members who reside in the United States or its Territories. If eligible members reside in foreign countries, they are not eligible for coverage.

Those dependents that are eligible for coverage must have been a dependent at the time the employment ended but did not need to be covered under the associate medical plan at the time they terminated.

Spouse

1. Legally married spouse;
2. Legally separated spouse;
3. Qualified domestic partner (opposite, same or different) of an eligible associate, if all the following criteria are met:

    1) is not related to the other partner by blood or adoption

    2) is unmarried, at least 18 years of age, resides with the other partner and intends to continue to reside with the other partner for an indefinite period of time

    3) is the sole domestic partner of the other partner and has been a member of this domestic partnership for the last 12 months

    4) agrees to be jointly responsible for basic living expenses and welfare of the other partner and meets (or agrees to meet) the requirements of any applicable federal, state, or local laws or ordinances for domestic partnerships which are currently enacted, or which may be enacted in the future

Spouse/Dependent Eligibility (continued)

Dependent Children

1. Natural-born dependent children to age 26.

2. Legally adopted children and children placed with you for legal adoption to age 26. Date of placement means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of adoption of the child. The child's placement with a person terminates upon the termination of the legal obligation of total or partial support.

3. Stepchildren to age 26 provided the stepchild parent remains covered as a spouse.

4. Dependent children for whom you or your spouse have been appointed legal guardian to age 26. After initial proof, the Claims Administrator may request proof annually.

5. Grandchildren to age 26 provided:

   a. they are members of the associate's household; and

   b. are claimed as exemptions on the associate's or spouse's Federal income tax return and

   c. for whom you or your spouse have legal custody or have been appointed legal guardian

Grandchildren who were eligible prior to age 19 may remain on the Plan to age 26 without needing to be claimed as an exemption on the associate's or spouse's Federal income tax return. After initial proof, the Claims Administrator may request proof annually.

6. Foster children placed with you by an authorized placement agency or by judgment decree, or other order of any court of competent jurisdiction. After initial proof, the Claims Administrator may request proof annually.

Spouse/Dependent Eligibility (continued)

Disabled Dependent Children

Disabled dependent children who reach the limiting age while covered under this Plan if all of the following apply:

a. chiefly dependent upon Associate for support and maintenance; and,

b. incapable of self-sustaining employment because of developmental disability, mental illness or disorder or physical disability; and

c. for whom application for extended coverage as a disabled dependent child is made within 31 days after reaching the age limit. After this initial proof, the Claims Administrator may request proof again two (2) years later, and each year thereafter; and

d. must have become disabled prior to reaching limiting age.

Associate Coverage

Eligibility

Retiree health coverage is provided to former Blue Cross associates who (i) terminate employment at age 55 or older (unless eligible under the special transition rule, and (ii) complete at least 10 years of service and (iii) are a participant in the Company's health plan at the time of termination of employment (iv) and were hired or rehired prior to September 1, 2019. There are various levels of premium subsidies. The Company will pay a fixed dollar amount of the cost of this coverage through cost sharing as described below. ***There is a special transition rule for some associate's described in this Summary Plan Description.***

If you were hired or rehired after September 1, 2019, you are not eligible for the Retiree Medical Plan. See section If Former Associate Returns to Work.

Cost Sharing

The Company will provide a fixed dollar amount toward the monthly cost of retiree health as follows:

- $15 per month for each full year of service toward Pre65 retiree health coverage.
- $7.50 per month for each full year of service toward Post65 retiree health coverage.

The fixed dollar amount is the same regardless of family status or coverage elected. There will be no cash paid if cost is less than subsidy provided.

Example of Cost Sharing

Peter terminates employment at age 55 after 20 years of service with the Company. Peter has a spouse.

The Company will pay up to $300 per month towards Peter's Pre65 coverage ($15 x 20 years = $300 per month). The $300 will first be applied each month towards Peter's coverage. Peter must pay the difference.

If the monthly cost at time of termination is $700, the Company will pay $300 toward Peter's coverage. Peter will pay the entire cost for his spouse coverage, which in this example is $700.

When Peter reaches age 65, the Company will pay up to $150 per month towards Peter's Post65 coverage ($7.50 x 20 years = $150 per month). When Peter's spouse reaches age 65, Peter will pay the entire cost for his spouse's coverage.

Coverage Options

Same Spouse Rule

Only a spouse of the associate at the time of the associate's termination of employment is eligible for retiree health and the dependent subsidy if any. The spouse will not be covered under the medical plan unless the former associate is also covered, unless the former associate has died.

If spouse coverage is waived, it cannot be obtained later unless the coverage was waived (postponed) because of other medical coverage (see "If Associate Has Other Health Coverage").

If Associate Dies

If the former associate dies, his or her spouse and/or eligible dependent children may continue health coverage by paying their portion of the health premium. The subsidy will be 50% of the former associate's flat dollar amount at the time of the death. If retiree health cost is based on the special transition rule, then subsidy calculated at termination of employment will continue. This would also apply if the former associate had elected to postpone coverage until a later date (see "If Associate Has Other Health Coverage").

If the associate dies while actively employed by Blue Cross and would have been eligible for the Retirement Health Care Program the day before death, then the spouse and/or eligible dependent children will receive either 50% of the flat dollar amount for which the associate would have been eligible based on "Cost Sharing", page 4 or the subsidy under the transition rule, see "Special Transition Rules".

Coverage Options continued

If Under Age 65

Coverage for a former associate and spouse under age 65 will be provided through various Pre65 Blue Cross retiree medical plan offerings. Coverage offerings are described in the summary plan description of the medical plan enrolled.

Disabled Participant

Coverage for a former associate and spouse under age 65 with a qualifying disability may be provided through the Post65 Blue Cross retiree medical plan offering. To qualify the member must receive 24 months of Social Security Disability Insurance (SSDI) benefits and be enrolled in Medicare Part A and Part B.

If Over Age 65

Coverage for a former associate and spouse age 65 and over will be provided through the Post65 Blue Cross retiree medical plan offering. Coverage offerings are described in the appropriate insurance certificate booklets.

Coverage With Dependent Children

When employment with the Company was terminated, eligible dependent children will continue to be covered under a Pre65 retiree medical plan offering. Family coverage is effective only while there are at least three individuals covered and all family members must be enrolled in the same medical plan coverage.

When an associate or spouse reaches age 65, that person will convert to a Post65 policy under the Blue Cross retiree medical program. The subsidy for the premium will be determined under the rules set forth in this Summary Plan Description.

An example of how the family subsidy is calculated can be found on the next page and if eligible for the transition rules.

Coverage on dependent children will end upon reaching age 26. There are no COBRA continuation coverage after retiree medical benefits have ended.

Coverage Options continued

Example of Family Cost Sharing

Jim terminates employment at age 64 after 30 years of service with the Company. At the time of termination, Jim is covering a spouse and a dependent child under the plan.

The Company will pay up to $450 per month towards Jim's Pre65 coverage ($15 x 30 years = $450 per month).

If the monthly cost for family coverage at time of termination is $2,000, the Company will pay $450 toward Jim's family coverage. Jim will pay $1,550 ($2,000 - $450 = $1,550).

Six months later, Jim turns age 65. At this time each of the family members will convert to an individual policy. The Company will pay up to $225 per month toward Jim's coverage ($7.50 x 30 years = $225).

If the monthly cost for Post65 coverage is $350, the Company will pay $225 for Jim's coverage. Jim will pay $125 ($350 - $225 = $125). If the cost for the Pre65 plan is $700 per person, Jim will pay the entire cost for coverage for his spouse and dependent child.

Under age 65 premiums

The premiums for the Retirement Health Care Program for Pre65 retirees, their spouse and dependent children are 50% higher than costs under the Blue Cross Associate Plan.

Those who retire before age 65, on or after January 1, 2011, will see their Pre65 premiums set to fully reflect the cost of medical coverage for the retiree, spouse, and dependent children. Premiums will be based on the full cost of medical coverage minus the amount Blue Cross contributes to the Pre65 retiree medical plan.

Those who retired before January 1, 2011, will have a cost model, which have premiums set at 50% more than the Blue Cross active associate group minus the amount Blue Cross contributes to the Pre65 plan.

Coverage Provisions

If Associate Has Other Health Coverage

If, after the associate leaves the Company and the former associate and spouse has coverage elsewhere, coverage may be postponed under the Blue Cross Retiree Medical Plan. If coverage is postponed when employment is terminated because of other coverage, and later coverage under the other plan is lost, the former associate, eligible spouse, and eligible dependent child(ren) may enroll in the Blue Cross Retiree Medical Plan subject to the following:

- The flat dollar amount (see "Cost Sharing", page 4) the Company will provide will be based on the years of service of the associate at the time of termination of employment from Blue Cross. If the associate qualified for the special transition rules, then the retiree health cost will be based on the percentage the associate was eligible for at termination of employment from the Company (see "Special Transition Rules").

- If at termination of employment, the associate was eligible for benefits under the special transition rules, the amount of subsidy for the spouse and/or dependent children is based on the premium in effect when employment was terminated.

- Proof of continuous medical coverage which includes prescription drugs from the date of the associate's termination of employment from the Company to the time of enrollment in the retiree medical plan must be provided by those enrolling (former associate, spouse and/or dependent children).

If Former Associate Returns to Work

If you were hired or rehired on or after September 1, 2019, you are not eligible for the Retiree Medical Plan.

- If you met the criteria for a Retiree Medical Plan benefit when you left the company and then returned on or after September 1, 2019, you will retain the benefit that you previously earned based on similarly situated retirees and the terms of the plan. However, you will not earn any additional benefit. If you enrolled in the Retiree Medical Plan when you return to the company, you may suspend your Retiree Medical Plan coverage in lieu of taking the associate plan for yourself (and dependents, if applicable) and then begin the Retiree Medical Plan coverage again when you leave the company.

- If you did not meet the criteria for Retiree Medical Plan when you left the company and then returned on or after September 1, 2019, you are not eligible for Retiree Medical.

Loss of Employment Due to Corporate Restructuring

If an associate loses employment with the Company due to corporate restructuring and is within 12 months of satisfying plan eligibility requirements, the associate will be treated as being eligible for the premium subsidy based on the actual number of full years of active eligible employment.

For those eligible for coverage under the "Special Transition Rules", see page 12 for details regarding loss of employment.

Special Transition Rules for Associates

Special Transition Rules

There are special transition rules for associates who satisfy certain service requirements.

1) Associate must be within 10 years of the Rule of 85 or 30 years of service on June 1, 2000, and
2) Associate must be a participant in the Company's health plan at the time of termination and
3) Associate must have at least 10 years of service in which they were regularly scheduled to work a minimum of 30 or more hours a week

If the above special transition rules are met, the Company will subsidize the former associate's retiree health premiums based on the following:

- Associates within 9 years and 1 day to 10 years of the Rule of 85 or 30 years of service will receive a 50% subsidy.
- Associates within 8 years and 1 day to 9 years of the Rule of 85 or 30 years of service will receive a 60% subsidy.
- Associates within 7 years and 1 day to 8 years of the Rule of 85 or 30 years of service will receive a 70% subsidy.
- Associates within 6 years and 1 day to 7 years of the Rule of 85 or 30 years of service will receive an 80% subsidy.
- Associates within 5 years and 1 day to 6 years of the Rule of 85 or 30 years of service will receive a 90% subsidy.

Associates not eligible under the special transition rules may still be eligible for cost sharing described in this document.

Loss of Employment Due to Corporate Restructuring

If an associate loses employment with the Company due to corporate restructuring, Retiree Medical Plan eligibility remains in effect.

Special Transition Rules - Provisions and Options

No Other Benefits

An associate who terminates employment without satisfying any of the eligibility conditions (Rule of 85 or 30 years of service or who is not currently participating in the medical plan) is not eligible to receive benefits under the transition rules.

One-Time Benefit Elections at Time of Enrollment

At the time of enrollment in the Retiree Medical Plan, the former associate will make a one-time written election to receive either the subsidy under the transition rules or the current plan. Once this election is made, it cannot be changed in the future. This one-time written election must be made at time of enrollment.

Subsidy for Spouse Coverage

In addition to having the Company subsidize a portion of retiree health costs, an associate may be eligible for spouse. The spouse subsidy is a fixed dollar amount, which is based on a percentage of the cost of coverage for the richest Pre65 and Post65 retiree medical coverage offerings when employment with the Company terminates.

Dollar Subsidy for Spouse is Frozen at Termination of Employment

The dollar amount of the subsidy for spouse coverage is based on the richest Pre65 and Post65 retiree medical coverage offerings at the associate's termination of employment and will not change even if the premiums under these plans increase. This means the amount an associate must pay for spouse coverage will increase if the premium for coverage increases. In addition, if a spouse is initially covered under a Pre65 plan and later is covered under a Post65 plan, the dollar amount of the subsidy that Blue Cross pays will decrease. See the discussion of "Effect of Coverage Options on Spouse Subsidy".

If an associate satisfies the Rule of 85 or has at least 30 years of service when employment terminates, the spouse subsidy will be a fixed dollar amount which is based on a percentage of the cost of health coverage under the richest Pre65 and Post65 plan offerings at the associate's termination. See the transition percentages as outlined in this document.

Example of Former Associate and Spouse Subsidy if Rule of 85 or 30 Years of Service

Sue had 30 years of service when she left the Company. She is eligible for a transition rule subsidy equal to 50% of the monthly premium. She is also eligible for a spouse fixed dollar subsidy equal to 50% of the cost of the premium at the time of termination.

Sue's Coverage	
Monthly Cost at Time of Termination of Employment	$700
50% Subsidy Blue Cross Pays	$350
Amount Sue Pays	$350

Sue's Spouse Coverage	
Monthly Cost at Time of Termination of Employment	$700
Fixed Dollar Subsidy Blue Cross Pays	$350
Amount Spouse Pays	$350

The Company will pay 50% of the cost for Sue and a fixed dollar subsidy for her spouse.

Sue's Coverage	
Monthly Cost Year 2	$770
50% Subsidy Blue Cross Pays	$385
Amount Sue Pays	$385

Sue's Spouse Coverage	
Monthly Cost Year 2	$770
Fixed Dollar Subsidy Blue Cross Pays	$350
Amount Spouse Pays	$420

The Company continues to pay 50% of the cost for Sue and a fixed dollar subsidy (calculated at the time of termination of employment) for her spouse.

Effect of Coverage Options on Spouse Subsidy

As noted earlier, the subsidy for spouse coverage is based on the cost of each type of coverage in effect when the associate terminated employment. If the spouse was under age 65 when employment terminated, the subsidy will be based on the richest Pre65 premium until he or she reaches age 65. After age 65 the subsidy is based on richest Post65 premium. The subsidy under any of the coverage options is based on its cost when employment was terminated.

Coverage for the former associate and spouse will be converted to individual policies at time of associate's termination of employment. See "Coverage with Dependent Children".

Example of Family Subsidy if Rule of 85 or 30 Years of Service

If an associate achieves Rule of 85 or 30 years of service when employment is terminated, the family subsidy will be calculated at the time of termination of employment as follows:

Blue Cross will pay a percentage of the cost for an individual retiree medical policy under the richest Pre65 plan. That amount will be subtracted from the cost of a family retiree medical policy to determine the dependent portion of the family premium. The dependent portion will then be multiplied by the percentage to determine the fixed subsidy for the spouse and/or dependent children.

(This example is continued on the next page.)

Example of Family Subsidy if Rule of 85 or 30 Years of Service cont.

Beth terminated employment at age 55 after 30 years of service with the Company and has a spouse and two dependent children. She is eligible for 80% employee coverage and a fixed dependent subsidy. Coverage for a family policy would be calculated as shown:

Monthly Cost for Family Coverage at Termination	$2,000
Monthly Cost for Former Employee Coverage	- $ 700
Monthly Cost for Dependent Coverage	$1,300

Monthly Cost for Former Employee Coverage	$700
80% Subsidy Blue Cross pays	- $560
Amount Beth pays	$140

Monthly Cost Dependent Coverage	$1,300
Fixed Dollar Subsidy Blue Cross pays ($1,300 x 80%)	- $1,040
Amount Beth pays	$260

Total Amount Beth pays for Family Coverage ($140 + $260)	$400

Blue Cross will pay 80% of the cost for Beth and a fixed dollar subsidy for her spousal and dependent children.

Monthly Cost for Family Coverage Year 2	$2,200
Monthly Cost for Former Employee Coverage	- $ 770
Monthly Cost for Dependent Coverage	$1,430

Monthly Cost for Former Employee Coverage	$770
80% Subsidy Blue Cross pays	- $616
Amount Beth pays	$154

Monthly Cost Dependent Coverage	$1,430
Fixed Dollar Subsidy Blue Cross pays	- $ 1,040
Amount Beth pays	$ 390

Total Amount Beth pays for Family Coverage ($154 + $390)	$544

Blue Cross continues to pay 80% of the cost for Beth and a fixed dollar subsidy (calculated at time of termination of employment) for her spouse and dependent children.

General Information

Name of Plan

The Retirement Health Care Program described in this booklet is part of the Blue Cross and Blue Shield of Minnesota Welfare Benefit Plan (the "Plan"). The Welfare Benefit Plan provides other welfare benefits for active associates, which are described in a separate booklet.

Type of Plan

The Plan is a welfare benefit plan subject to ERISA.

Plan Sponsor and Administrator

For purposes of federal law, Blue Cross and Blue Shield of Minnesota is the "Plan Sponsor" and "Plan Administrator" of the Plan. Communication to Blue Cross should be directed as follows:

Blue Cross and Blue Shield of Minnesota
P.O. Box 64560 M430
St. Paul, MN 55164-0560
(651) 662-1230

In addition to Blue Cross and Blue Shield of Minnesota, Stella Resources Co. Inc. ("Stella") has adopted the Plan and is a participating employer in the Plan. Stella's Employer Identification Number is 82-2935829.

Plan Years

The Plan Year for the Plan is the 12-month period beginning each March 1. Beginning in 2001, the Plan Year will begin January 1.

Plan Number

The Plan has been assigned identification number 501.

Employer Identification Number

Blue Cross's Federal Employer Identification Number is 41-0984460.

Agent for Service of Legal Process

Legal process may be served on the Plan Administrator.

Amendment and Termination

Blue Cross expressly reserves the right to amend, modify or terminate retirement health benefits at any time. Plan participants and associates will be notified if Blue Cross intends to modify, reduce or eliminate retirement health benefits.

Failure to Pay Premiums

If a plan participant fails to make three successive payments coverage will stop and cannot be reinstated.

Claims Procedure

Filing a Claim

The procedures for filing health benefit claims are set forth in the separate coverage booklets for the medical plans offered. If you do not have a copy of your coverage booklet, you can get one from Human Resources.

If your claim is denied or you believe that you are entitled to a greater benefit, you must file a written claim for the denied amount or additional amount. We will ordinarily respond to the claim within 90 days of the date on which it is received. However, if special circumstances require an extension of the period of time for processing a claim, the 90-day period can be extended for an additional 90 days by giving you written notice of the extension and the reason that the extension is necessary.

If the claim for a benefit is approved, you will receive written notice of the amount of your benefit and the date on which payments will begin. If your claim is denied, in whole or in part, you will be told in writing the specific reasons for the decision and you will receive an explanation of the procedures for reviewing the decision.

Appeals

If you do not agree with the decision, you can request that the decision be reviewed by filing a written request for review within 60 days after receiving notice that the claim has been denied. You or your representative can also present written statements which explain why you believe that the claim benefit should be paid and you may review all pertinent plan documents.

Generally, the decision will be reviewed within 60 days after we receive a request for review. However, if special circumstances require a delay, the review may take up to 120 days. If a decision cannot be made within the 60-day period, you will be notified of this fact in writing. You will receive a written notice of the decision, which will explain the reasons for the decision by making specific reference to the Plan provisions on which the decision is based.

Blue Cross has the sole discretionary authority to determine your eligibility for benefits under the Retirement Health Care Program and to construe the provisions of the Plan. If you disagree with any benefit determination we make, you must use the appeal procedure described above. You cannot bring a court action for Retirement Health benefits under the Plan until the claims review procedure described above, including appeals, has been completed.

Statement of Rights of Plan Participants

ERISA Rights

As a Participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Plan Participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at certain other locations, all Plan documents and copies of all documents filed by the Plan with the U.S. Department of Labor, such as annual reports and Plan descriptions.
- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. A reasonable charge may be made for the copies.
- Receive a summary of the Plan's annual financial reports. The Plan Administrator is required by law to furnish each Participant with a copy of this summary financial report.

Enforcement of ERISA Rights

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 $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond its control. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that 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 federal court. The court will decide who should pay 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, for example, if it finds your claims frivolous.

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the U.S. Labor Management Services Administration, Department of Labor.