BLUE CROSS AND BLUE SHIELD
OF
MINNESOTA

WELFARE BENEFIT PLAN

RETIREMENT HEALTH CARE PROGRAM

SUMMARY PLAN DESCRIPTION FOR
GRANDFATHER PROVISIONS
2024

About This Summary

This Summary Describes Eligibility, Coverage Options and ERISA Rights

This summary, together with the insurance certificate booklets, describes the Retirement Health Care Program (also referred to as Retiree Medical Plan) provided under the Blue Cross and Blue Shield of Minnesota Welfare Benefit Plan (the "Plan") for a group of associates considered grandfathered. This summary describes the requirements to be eligible to receive retirement health benefits and the coverage options available to eligible former associates of Blue Cross and Blue Shield of Minnesota ("Blue Cross"). 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 That Should Be 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 Certificates

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

Grandfathered Particpant

An associate who was (i) actively employed by the Company on June 1, 2000 and whose (ii) combined age and service equal 85 or more on June 1, 2005 or date of termination if earlier or (iii) have at least 30 years of service on June 1, 2005 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.

Rule of 55

Associate is at least age 55 and was credited with 10 or more years of service with the Company at the 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:
    a. is not related to the other partner by blood or adoption
    b. 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
    c. is the sole domestic partner of the other partner and has been a member of this domestic partnership for the last 12 months
    d. agrees to be jointly responsible for basic living expenses

Spouse/Dependent Eligibility (continued)

e. 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

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:

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

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

3. 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

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

Associate Coverage

Eligibility

To be eligible under this plan, the associate must be (i) a grandfathered participant and (ii) a participant in the Company's health plan at the time of termination of employment and (iii) regularly scheduled to work at least 30 hours a week. There are various levels of premium subsidies. The age and service eligibility requirements for each level of subsidy are set forth below.

100% Premium Subsidy for Rule of 85 or 30 Years of Service

The Company provides retiree health and will subsidize 100% of the terminated associate's health premium if either of the following requirements are met:

- The associate's age plus years of service with Blue Cross equaled 85 or more (the "Rule of 85") at termination of employment, or
- The associate was credited with 30 or more years of service with Blue Cross at termination of employment.

Rule of 55

Blue Cross will subsidize a portion of the premium for retiree health coverage if the associate was age 55 or older and was credited with 10 or more years of service with Blue Cross when employment was terminated (the "Rule of 55").

Early Termination Factor Under Rule of 55

The percentage that the Company subsidizes under the Rule of 55 varies according to age and service with Blue Cross at termination of employment. The subsidy is calculated as follows:

3.33% x Years of Service x Early Termination Factor = Subsidy

The early termination factor equals 100% minus 3% for each year that the associate was under age 65 when employment with Blue Cross was terminated.

Transition Rules

Associates hired on or before December 31, 1989, may be eligible for special transition rules if they were close to termination at that time. The transition rule works as follows:

- Associates who were 55 years old, and who had 15 years of service as of March 1, 1990, will be credited with 5 additional years of service.
- Associates who were 60 years old, and who had 20 years of service as of March 1, 1990, will be credited with 10 additional years of service.

Example of Early Termination Factor Under Rule of 55

Ann, a grandfathered associate, terminates employment at age 60 with 22 years of service with the Company. She is eligible for partial coverage of her premiums because she was over 55 with more than 10 years of service with the Company when she terminated employment. The portion of her retirement health cost the Company will subsidize is determined as follows:

3.33% x 22 years of service =	73%
multiplied by	x
early termination factor*	85%

*(100% minus 3% for each year of service before age 65)

Percentage of premium The Company will subsidize 62%

No Other Benefits

An associate who terminates employment without satisfying any of the eligibility conditions (Rule of 85, 30 years of service, or age 55 plus 10 years of service or who is not currently participating in the medical plan) is not eligible to receive benefits under the grandfathered provisions.

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 completing 30 years of service or satisfying the Rule of 85 or the Rule of 55, he or she shall be treated as being eligible for premium subsidies as described below:

- An associate who is within 12 months of completing 30 years of service or satisfying the Rule of 85 when his or her employment terminates, will qualify for the premium subsidy as if they had completed 30 years of service or satisfied the Rule of 85.

- An associate, who is within 12 months of reaching age 55 and has at least 15 years of service with The Company when his or her employment terminates, will qualify for retirement health benefits under the Rule of 55.

An associate should contact the Human Resources Department to see if they will be eligible for retirement health benefits.

If an associate who loses employment with The Company due to corporate restructuring returns to The Company within 12 months, he or she will continue to be covered under the grandfathered provisions.

If Former Associate Returns to Work at The Company

If an associate covered under the Retirement Health Care Program returns to work at The Company or one of its subsidiaries, he or she will pay the lesser of the premium for active associates or the premium under the retiree health plan. When employment is terminated again, the retiree health benefit will be recalculated, and the associate will begin paying premiums under the Retirement Health Care Program with an increase in benefit if applicable.

If an associate not eligible for the Retirement Health Care Program at the time of termination returns to work at The Company or one of its subsidiaries, he or she is not eligible for the grandfathered provisions. The associate may be covered under the plan provisions in effect at that time.

Spouse Coverage

Subsidy for Spouse Coverage

In addition to having The Company subsidize a portion of retiree health costs, an associate may be eligible for spouse coverage benefits. The spouse subsidy is a fixed dollar amount, which is based on a percentage of the cost of coverage under the Pre65 and/or Post65 Plans (Medicare Supplement Plan) when employment with The Company terminates. See the "Effect of Coverage Option on Spouse/Subsidy" section for a discussion of the effect of the different coverage options on the spouse subsidy.

Dollar Subsidy for Spouse is Frozen at Termination of Employment

The dollar amount of the subsidy for spouse/ coverage is based on the cost of and/or the Medicare Supplement Plan 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 either the Medicare Supplement Plan, the dollar amount of the subsidy that The Company pays may decrease. See the discussion of "Effect of Coverage Option 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 100% of the cost of health coverage under Medicare Supplement Plan at termination.

If an associate does not satisfy the Rule of 85 or 30 years of service when employment is terminated, the subsidy will be a fixed dollar amount based on a percentage of the cost of health coverage under the Medicare Supplement Plan at termination. The percentage equals one-half (50%) of the percentage of the former associate's retirement health cost that The Company pays under the Rule of 55.

Example of Spouse Subsidy if Rule of 85 or 30 years of service

John had 30 years of service when he left the Company. He is eligible for a spouse subsidy benefit equal to 100% of the cost of the premium at the time of termination.

Monthly cost at time of termination of employment	$280
Fixed dollar subsidy The Company pays	$280
Amount spouse pays	$0
Monthly cost year 2	$300
Fixed dollar subsidy The Company pays	$280
Amount spouse pays	$20

Example of Spouse Subsidy if Rule of 55

Jean was age 60 with 22 years of service when she terminated employment. Since she satisfied the Rule of 55, she is eligible for a subsidy equal to the following percentage of her monthly premiums:

3.33% x 22 years of service =	73%
multiplied by	x
early termination factor = (100% minus 3% for each year before age 65)	85%
Percent of Jean's premium subsidized by The Company	62%

Spouse subsidy = 31%* (62% ÷ 2)

*The fixed dollar amount is based on this percentage.

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. In addition, the spouse must be (i) covered under the medical plan at the time of termination and (ii) coverage must be elected at the time the associate elects coverage under the Retirement Health Care Program. If spouse coverage is waived, it cannot be obtained later unless the coverage was waived because of coverage with a different employer (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. 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 The Company 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 the benefit under the plan provisions at time of death.

Coverage Options

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.

If an associate had family coverage with dependent children when employment with The Company was terminated and at least three covered participants are under the age of 65, each family member will continue to be covered under a family policy under the Health Plan. Family coverage is effective only while there are at least three individuals covered under one the Pre65 Plans and no one has reached age 65.

An example of how the family subsidy is calculated can be found in this document.

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.

When an associate or spouse reaches age 65, that person will convert to an individual policy under the Medicare Supplement Plan. The subsidy for the premium will be determined under the rules set forth in this Summary Plan Description.

Coverage With Dependent Children

Coverage on dependent children will end when they are no longer eligible based on the terms of the Pre65 retiree medical booklet. Cobra coverage will then be provided.

Example of Family Subsidy

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:

The Company will pay the equivalent of 100% of the cost for an individual retiree medical policy under age 65. That amount will be subtracted from the cost of a family retiree medical policy to determine the fixed flat dollar subsidy for the spouse/ and/or dependent children. The associate cost and the fixed flat dollar amount will be added together to determine the amount the Company will pay.

Tom terminates employment at age 55 after 30 years of service with the Company and has a spouse/ and a dependent child. He is eligible for 100% employee coverage and a dependent subsidy equal to 100%. Coverage for a family policy would be calculated as shown:

Monthly Cost for Family Coverage at Termination	$800
Monthly Cost for Former Employee Coverage	- 300
Monthly Fixed Dollar Amount for Family Subsidy	$500
Tom's Monthly Cost for Family Coverage	$0

The Company will pay the entire cost for Tom and a fixed dollar amount for his family members.

Monthly Cost for Family Coverage Year 2	$850
Monthly Cost for Former Employee Coverage	- 325 (paid at 100%)
Remaining Balance	$525
The Company Pays Fixed Dollar Amount for Family Coverage	$500 per month
Tom's Cost for Family Coverage	$ 25 per month

The Company continues to pay 100% of the cost for Tom and a fixed dollar amount for his family members until they no longer fit the definition of family as described previously.

Under age 65 premiums

The premiums for dependents under the Retiree Medical Plan for Pre65 is 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 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 employed elsewhere)

If Associate Has Other Health Coverage

If, after the associate leaves The Company and the associate or spouse is employed elsewhere and has medical coverage with another employer, coverage may be postponed under the Blue Cross Retirement Health Care Program. If coverage is postponed when employment is terminated because of other coverage, and later coverage under the other employer plan is lost, the associate and spouse may enroll in the Blue Cross Retirement Health Care Program subject to the following:

- The amount the Company will subsidize will be based on the years of service and age of former associate at the time of termination of employment from the Company.
- The amount of the subsidy for spouse is based on the premium in effect for the richest plan 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).

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 Health Care Plan and the Medicare Supplement Plan. 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 claim 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.