10.2025

2025–2026 Annual Notices

Important information: Action may be required

To make sure that you have all the information you need to make informed decisions for you and your family, the law requires CF Industries, Inc. to provide you with notice of certain legal rights that you may have and legal obligations that apply to the CF Industries Holdings, Inc. ("CF Industries") Employee Welfare Benefit Plan (“Plan”). These rights and obligations are described in more detail in the enclosed notices.

Annual Notices

You should review these notices closely and keep them with other materials that you receive about benefits available under the Plan. If you have any questions about any of the legal rights and obligations described below or the Plan, you should write:

CF Benefits Group
benefits@cfindustries.com

The following notices are not intended to be a description of the benefits offered under the Plan. For more information about specific benefits, refer to the Summary Plan Descriptions for the Plan, which are available on **CFTotalRewards.com**.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please **see page 9** for more details.

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Patient Protection Disclosure Notice

The CF Industries Holdings, Inc. Employee Welfare Benefit Plan (the "Plan") generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, the Plan designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact CF Benefits Group at **benefits@cfindustries.com**.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Blue Cross Blue Shield of Illinois (BCBSIL) at the number listed on the back of your medical card.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Important Notice about the Women's Health and Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under your group health plan coverage.

Refer to your Summary of Benefits and Coverage (SBC) for deductibles and coinsurance.

For more information on benefits under the Women's Health and Cancer Rights Act of 1998, contact **benefits@cfindustries.com**.

Important Notice about Group Health Plan Special Enrollment Rights

This notice is being provided so that you understand your right to apply for group health plan coverage outside of the open enrollment period. You should read this notice regardless of whether or not you are currently covered under the CF Industries Holdings, Inc. Employee Welfare Benefit Plan.

You may have the right to enroll in certain group health plan options if certain events (listed below) occur at any time during the year:

The following are the events for which you may have a special enrollment right:

Loss of Other Group Health Plan Coverage or Health Insurance

If you decline coverage for yourself or your dependents because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in any of the group health plan options for which you are eligible if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Marriage, Birth or Adoption

If you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents in any of the group health plan options for which you are eligible. However, you must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

Loss of Coverage under Medicaid or State Children's Health Insurance Program

If you decline coverage for yourself or your dependents while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in any of the group health plan options for which you are eligible if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage under Medicaid or state children's health insurance program ends.

Eligibility for State Premium Assistance Subsidy

If you or your dependents become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to group health plan coverage under this Plan, you may be able to enroll yourself and your dependents in any of the group health plan options for which you are eligible. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

More information about these subsidies is included in "Important Notice about Free or

Low-Cost Health Coverage for Children and Families under Medicaid and the Children's Health Insurance Program" below.

To request special enrollment or obtain more information, contact:

CF Benefits Group
benefits@cfindustries.com

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2025. Contact your State for more information on eligibility.

ALABAMA — Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA — Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
http://health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS — Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA — Medicaid
Health Insurance Premium Payment (HIPP) Program
Website: http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO — Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado
Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/ State Relay 711
CHP+: https://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program (HIBI):
https://www.mycohibi.com/
HIBI Customer Service: 1-855-692-6442

FLORIDA — Medicaid
Website:https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA — Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1

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GA CHIPRA Website:
https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: (678) 564-1162, Press 2

INDIANA — Medicaid
Health Insurance Premium Payment Program
All other Medicaid
Website: https://www.in.gov/medicaid/
http://www.in.gov/fssa/dfr/
Family and Social Services Administration
Phone: 1-800-403-0864
Member Services Phone: 1-800-457-4584

IOWA — Medicaid and CHIP (Hawki)
Medicaid Website: Iowa Medicaid | Health & Human Services
Medicaid Phone: 1-800-338-8366
Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services
Hawki Phone: 1-800-257-8563
HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov)
HIPP Phone: 1-888-346-9562

KANSAS — Medicaid
Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

KENTUCKY — Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP)
Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website:https://kynect.ky.gov
Phone: 1-877-524-4718
Kentucky Medicaid Website:
https://chfs.ky.gov/agencies/dms

LOUISIANA — Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE — Medicaid
Enrollment Website:
https://www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740
TTY: Maine relay 711

MASSACHUSETTS — Medicaid and CHIP
Website: http://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA — Medicaid
Website: https://mn.gov/dhs/health-care-coverage/
Phone: 1-800-657-3672

MISSOURI — Medicaid
Website: https://dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA — Medicaid
Website: https://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA — Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA — Medicaid
Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE — Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll free number for the HIPP program:
1-800-852-3345, ext. 15218
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY — Medicaid and CHIP
Medicaid Website:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Phone: 1-800-356-1561
CHIP Premium Assistance Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710 (TTY: 711)

NEW YORK — Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA — Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

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NORTH DAKOTA — Medicaid
Website: https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

OKLAHOMA — Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON — Medicaid and CHIP
Website: http://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

PENNSYLVANIA — Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html
Phone: 1-800-692-7462
CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)
CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND — Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA — Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA — Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS — Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services
Phone: 1-800-440-0493

UTAH — Medicaid and CHIP
Utah's Premium Partnership for Health Insurance (UPP)
Website: https://medicaid.utah.gov/upp/
Email: upp@utah.gov
Phone: 1-888-222-2542
Adult Expansion Website: https://medicaid.utah.gov/expansion/
Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/
CHIP Website: https://chip.utah.gov/

VERMONT — Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access
Phone: 1-800-250-8427

VIRGINIA — Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON — Medicaid
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA — Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/
http://mywvhipp.com/
Medicaid Phone: 304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN — Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING — Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Important Notice about Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with CF Industries and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. CF Industries has determined that the prescription drug coverage offered by the CF Industries Holdings, Inc. Employee Welfare Benefit Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current CF Industries will be affected. Your current coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will not still be eligible to receive all of your current health and prescription drug benefits. If you drop your current prescription drug coverage and enroll in Medicare prescription drug coverage, you may not enroll back into the CF Industries benefit plan during an open enrollment period under the CF Industries benefit plan.

If you do decide to join a Medicare drug plan and drop your current CF Industries coverage, be aware that you and your dependents will not be able to get this coverage back.

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When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with CF Industries and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through CF Industries changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit **www.medicare.gov**
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call **1-800-MEDICARE** (1-800-633-4227). TTY users should call **1-877-486-2048**.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at **www.socialsecurity.gov**, or call them at **1-800-772-1213** (TTY **1-800-325-0778**).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Notice of Privacy Practices

CF Industries Holdings, Inc. Employee Welfare Benefit Plan

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices (Notice) describes the privacy practices and obligations of:

- The health, mental health, dental and vision benefits available under the CF Industries Holdings, Inc. Employee Welfare Benefit Plan

For your convenience, this Notice uses the term "Plan" to refer to these different benefits.

Your health information is highly personal, and the Plan is committed to safeguarding your privacy. This Notice describes how your protected health information held by the Plan may be used or disclosed, in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law. It also describes your ability to access and control the use and disclosure of your protected health information.

This Notice does not apply to CF Industries benefit plans or policies that are not health plans, such as disability, life insurance, accidental death and dismemberment insurance and leave of absence. In addition, some of the benefits under the Plan are provided through insurance. If you receive Plan benefits through insurance companies, you may receive separate notices from the Plan's insurers describing how they use and disclose protected health information.

The Plan reserves the right to change the terms of this Notice at any time and to implement new notice provisions effective for all PHI held by or on behalf of the Plan. In the event of a change to this Notice, an updated Notice will be mailed to your address on file.

Plan Responsibilities

In General

The Plan is a "covered entity" as this term is defined in the HIPAA. HIPAA requires the Plan to:

- Maintain the privacy of your protected health information (PHI);
- Provide you with certain rights with respect to your PHI;
- Give you a copy of this Notice explaining the Plan's legal duties and privacy practices regarding PHI;
- Notify an individual following a breach of unsecured PHI; and
- Follow the terms of the Notice that is currently in effect.

Generally, PHI is individually identifiable information created or received by, or on behalf of, the Plan that relates to: (1) your past, present or future physical or mental health or condition; (2) the provision of health care to you; or (3) the past, present or future payment for the provision of health care to you.

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How the Plan May Use or Disclose Your PHI

The following categories describe the different ways that the Plan may use or disclose your PHI without first obtaining your authorization. For each category of uses and disclosures, the Notice explains what the category means generally and presents examples. Not every possible use or disclosure in a category will be listed. However, all of the ways the Plan is permitted to use and disclose PHI without first obtaining your authorization will fall within one of these categories.

- **Treatment:** The Plan may use or disclose your PHI to facilitate medical treatment or services by providers (e.g., doctors and hospitals). For example, the Plan may share your PHI with your doctor or other health care provider who needs such information to treat you properly.
- **Payment:** The Plan may use or disclose your PHI for payment-related purposes, such as determining your eligibility for Plan benefits, coordinating coverage between the Plan and another plan, and facilitating payment for services you receive. For example, the Plan may share your PHI with another health plan to coordinate payment of benefits.
- **Health Care Operations:** The Plan may use or disclose your PHI for various administrative purposes that are called "health care operations" of the Plan. For example, your PHI might be included as part of any audit designed to ensure that the Plan's outside claims administrator is properly performing its job, or your PHI might be included each year to set appropriate premiums for the Plan or to help secure insurance. In no event, however, will the Plan use or disclose your PHI that is genetic information for underwriting purposes.
- **Business Associates:** The Plan may contract with service providers, called business associates, to perform various administrative functions on its behalf. For example, the Plan's claims administrators and pharmacy benefits manager are business associates of the Plan. The Plan is permitted to use or disclose your PHI to a business associate when the business associate needs the information to perform administrative tasks for the Plan, but only after the Plan and the business associate agree in writing to require the business associate to keep your PHI confidential.
- **Disclosures to CF Industries:** Generally, CF Industries (the Plan sponsor) does not maintain any PHI. However, the Plan may disclose certain PHI to designated CF Industries employees when such disclosure is necessary to enable CF Industries, Inc. to fulfill its administrative duties as Plan sponsor. For example, the Plan may disclose enrollment information to CF Industries to facilitate payroll deductions for your required premium contributions.

  CF Industries has agreed to prevent unauthorized uses or a disclosure of any PHI disclosed by the Plan and has agreed to limit access to such information. In no event may CF Industries use PHI it receives from the Plan for benefit programs that do not provide health benefits, to make any employment-related decisions, or for any other purpose other than as required by law or permitted by the Plan.

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Disclosures Permitted or Required by Law:

The Plan may disclose your PHI to you or to your legal representative. HIPAA also allows the Plan to use or disclose PHI without obtaining your written authorization in the following situations:

- **Workers' Compensation:** To comply with workers' compensation or similar laws providing benefits for work-related injuries or illnesses.
- **Organ Donation:** To an organ procurement organization to facilitate organ or tissue donation and transplantation.
- **Death:** To coroners, medical examiners and funeral directors to help identify decedents or determine cause of death.
- **Law Enforcement:** For law enforcement purposes, including to report wounds/injuries and crimes or for the purpose of identifying or locating a suspect, fugitive, material witness or missing person.
- **Domestic Violence:** To government agencies for victims of abuse, neglect or domestic violence.
- **Public Health:** For public health activities, such as preventing or controlling disease and reporting reactions to medications.
- **Legal Proceedings:** For judicial and administrative proceedings, such as lawsuits or other disputes in response to a court order or subpoena.
- **HHS/Government Health Oversight:** To health oversight agencies for oversight activities authorized by law (audits, investigations, inspections, licensure, etc.).
- **Research:** For research purposes in certain, limited circumstances.
- **National Security/Intelligence:** To authorized Federal officials for the purpose of conducting intelligence, counter-intelligence and other national security activities.
- **Military/Veterans Activities:** To military authorities if you are a member of the armed services, and the appropriate military command authorities follow specific procedures related to the disclosure.
- **Correctional Institutions:** To correctional institutions or law enforcement officials, regarding individuals in custody.
- **Limited Data Set:** As part of a "limited data set" for research, public health and health care operations, to certain third parties who have agreed in writing to limit their use and disclosure of the information contained in the limited data set. A "limited data set" generally is information that summarizes claims history, expenses or types of claims, but which excludes certain direct identifiers as required by HIPAA.

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Disclosures to Family Members/Individuals Involved in Your Care: The Plan may disclose your PHI to your family members or close personal friends if (1) the information is relevant to the individual's involvement in your health care or payment for that care; and (2) you have either agreed to the disclosure or the Plan gave you an opportunity to object and you have not objected. If you are unavailable, incapacitated, or facing a medical emergency and the Plan determines that a limited disclosure may be in your best interest, the Plan may share limited PHI with such individuals without your approval. The Plan also may disclose PHI to a parent or legal guardian in the case of services provided to a minor child or an incapacitated adult.

Uses and Disclosures Authorized by You: PHI will not be used for marketing purposes and PHI will not be sold unless the individual authorizes the use of PHI in that way. There will be no disclosure of psychotherapy notes without the individuals' authorization. Uses and disclosures that are not described above will be made only with your written authorization. You may revoke your authorization at any time in writing, but the revocation will apply only to the extent that the Plan has not already acted in reliance on your authorization.

Substance Use Disorder Treatment Information: If the Plan receives or maintains any substance use disorder treatment records from federally assisted substance use disorder treatment programs that are covered by 42 CFR Part 2 ("Part 2 Programs") or testimony relaying the content of such records through a general consent you provide to the Part 2 Program to use and disclose such PHI for purposes of treatment, payment, or health care operations, the Plan may use and disclose your Part 2 Program record for treatment, payment, and health care operations, as described in this notice. Part 2 Program records, or testimony relaying the content of such records, will not be used or disclosed in civil, criminal, administrative, or legislative proceedings against an individual unless based on specific written consent, or a court order after notice and an opportunity to be heard is provided to the individual or the holder of the record, where required by law or regulations. A court order authorizing use or disclosure for Part 2 Program records must be accompanied by a subpoena or other similar legal mandate compelling disclosure before the requested record is used or disclosed.

Your Rights

Right to Receive Privacy Notice

You have the right to receive a paper copy of this Notice at any time, even if you have previously agreed to receive this Notice electronically. You should submit your request for a paper copy of this Notice to the Contact Person listed below.

Right to Request Restrictions

You may request restrictions on certain uses and disclosures of your PHI that would otherwise be used to carry out treatment, payment or health care operations purposes.You also have the right to request limits on information the Plan may disclose to someone involved in your care or the payment for your care, like a family member.

To request a restriction, you must submit your request in writing to the Contact Person listed below. Your request must describe the PHI that you wish to limit and to whom you want the limitations to apply.

Except in limited circumstances, the Plan is not required to agree to your restriction request. If the Plan does agree to honor your request, it will follow the restriction until you revoke the restriction, or until the Plan notifies you that it is removing the restriction prospectively.

If you pay out-of-pocket in full for any health care item or service, you may ask your health care provider not to disclose to the Plan any protected health information regarding that item or service.

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Right to Request Confidential Communications

You may ask to receive communications about PHI in a certain way or at a certain location (e.g., you may ask that the Plan contact you only at your work telephone number or address). To request confidential communications, you must submit a written request to the Contact Person listed below. The Plan will not ask you the specific reason for your request, and the Plan will accommodate reasonable requests. If your request clearly states that the disclosure of all or part of your PHI by the usual means could endanger you, your request will be accommodated.

Right to Access Your PHI

You may request access to inspect and copy your PHI that is maintained by the Plan. To the extent the Plan maintains your PHI in an electronic health record, you may request access to the electronic health record, and you may direct the Plan to transmit the electronic health record (in electronic form) to an individual or entity you designate.

You must submit your request in writing to the Contact Person listed below, or you may make a request directly to the relevant HMO, insurer or claims administrator. The Plan may charge you a fee for the costs of copying, mailing or other supplies associated with a request to access and copy PHI, or for the labor costs associated with processing a request to access PHI maintained in an electronic health record.

The Plan will provide the requested information within 30 days if the Plan maintains the information on site or within 60 days if the Plan maintains the information offsite. The Plan may extend the deadline with a single 30-day extension if the Plan is unable to comply with the deadline. If an extension is required, the Plan will send you a written statement of the reasons for the delay and the date by which the Plan will respond.

The Plan may deny your request to access PHI in certain very limited circumstances. If your request to access PHI is denied, the Plan will send you a written notification explaining the reason for the denial and, if applicable, any right you may have to request review of the denial.

Right to Amend Your PHI

If you believe your PHI maintained by the Plan is incorrect or incomplete, you may request that the Plan amend your PHI. You must submit your request in writing to the Contact Person listed below, or you may make a request directly to the relevant HMO, insurer or claims administrator.

The Plan has 60 days after the Contact Person receives the request to amend to act on the request. The Plan may extend this deadline with a single 30-day extension if the Plan is unable to comply with the deadline. If an extension is required, the Plan will send you a
written statement of the reasons for the delay and the date by which the Plan will respond.

In certain cases, the Plan may deny your request – for example, if the Plan does not maintain the PHI or did not create the PHI, or if the Plan determines that the PHI is accurate and complete without the amendment. If the Plan denies your request for amendment, the Plan will send you a written notification explaining the reason for the denial and your right to file a statement of disagreement to be included with any subsequent disclosures of the relevant PHI.

If the Plan agrees to amend your PHI, it may notify business associates or others (such as your provider) that have copies of the uncorrected PHI if the Plan believes that such notification is necessary.

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Right to Receive an Accounting of Disclosures of Your PHI

You have the right to receive an accounting of disclosures of your PHI that the Plan has made without your authorization. You must submit your request in writing to the Contact Person listed below, or you may make a request directly to the relevant HMO, insurer or claims administrator. If you request more than one accounting in a 12-month period, you may be charged a reasonable, cost-based fee.

Generally, an accounting will cover disclosures made during the six-year period prior to your request and will not include disclosures made for treatment, payment or health care operations purposes. However, to the extent required by HIPAA, if your PHI is maintained in an electronic health record, the accounting will also include information about disclosures made for treatment, payment and health care operations purposes during the three-year period prior to your request.

If the Plan cannot provide the accounting within 60 days after it receives your request, the Plan may extend the response deadline once for an additional 30 days. If an extension is required, the Plan will send you a written statement of the reasons for the delay and the date by which the Plan will provide the accounting.

Right to be Notified of a Breach

You have the right to be notified in the event that the Plan (or one of its business associates) discovers a breach of your unsecured PHI. Notice of any such breach will be made in accordance with federal requirements.

Additional Information

Complaints

If you believe your privacy rights with respect to your PHI under the Plan have been violated, you may file a complaint with the Plan or with the Secretary of Health and Human Services, Office for Civil Rights (OCR). Complaints to the Plan should be filed in writing with the Contact Person listed below. You will not be penalized in any way for filing such a complaint.

More detailed information about how to file a complaint with the OCR regional office is located on the OCR website at: **http://www.hhs.gov/ocr/privacy/hipaa/ complaints/index.html**.

Contact Person

For questions about this Notice, the Plan's privacy practices, or to exercise any of your rights described above, please contact:

CF Benefits Group
benefits@cfindustries.com

Claims Administrators

Contact information for HMOs, insurers, and claims administrators is listed in the summary plan description for each Plan.

Notice for employer-sponsored wellness programs

CF Industries Wellbeing Program is a voluntary wellbeing program available to all eligible employees and spouses covered under the CF medical plans. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellbeing program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You may also complete a biometric screening, which will include a blood test for cholesterol, sugar levels, etc. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellbeing program will receive an incentive. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive the incentive.

Additional incentives may be available for employees who participate in certain health-related activities or achieve certain health outcomes. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting **benefits@cfindustries.com**. Further information on earning incentives may be found at: **cftotalrewards.com**.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellbeing program, such as coaching. You also are encouraged to share your results or concerns with your own doctor.

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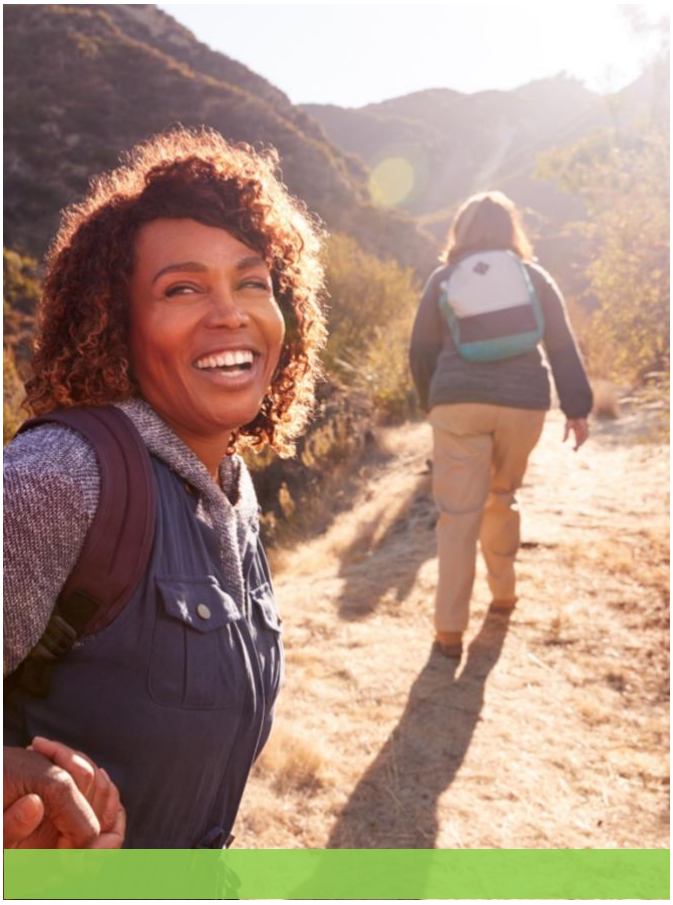
Protections from Disclosure of Medical Information



We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellbeing program and CF Industries may use aggregate information it collects to design a program based on identified health risks in the workplace, the CF Industries Wellbeing Program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellbeing program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellbeing program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellbeing program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellbeing program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellbeing program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) on-site clinic personnel or a health coach in order to provide you with services under the wellbeing program.

In addition, all medical information obtained through the wellbeing program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellbeing program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellbeing program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellbeing program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact **benefits@cfindustries.com**.

Rights Pursuant to Genetic Information Nondiscrimination Act of 2008 (“GINA”)

CF Industries Holdings, Inc. complies with GINA and, therefore, does not:

- Increase group premium or contribution amounts based on genetic information;
- Request or require an individual or family members to undergo genetic testing; or
- Request, require or purchase genetic information prior to or in connection with enrollment or at any time for underwriting purposes.

“Genetic information” is information about (1) an individual’s genetic tests; (2) the genetic tests of an individual’s family members; (3) the manifestation of a disease or disorder in an individual’s family members; or (4) any request or receipt by the individual of his or her family members of genetic information. Genetic information does not include blood tests that are not designed to obtain information relating to genotypes, mutations or chromosomal changes; cholesterol tests; or information about the age or sex of an individual or family member.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in- network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You are protected from balance billing for:

1. **Emergency services**
   If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

2. **Certain services at an in-network hospital or ambulatory surgical center**
   When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

Generally, your health plan must:

- Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
- Cover emergency services by out-of-network providers.
- Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
- Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you think you've been wrongly billed, you may contact the Federal No Surprises Helpdesk at **1-800-985-3059.** Visit **https://www.cms.gov/nosurprises** for more information about your rights under federal law.

Mental Health Parity and Addiction Equity Act of 2008 (“MHPAEA”)

The Mental Health Parity and Addiction Equity Act of 2008 (“MHPAEA”) provides that if any benefit option under the CF Industries Holdings, Inc. Employee Welfare Benefit Plan (“Plan”) (i) provides for both medical and surgical benefits and mental health or substance use disorder benefits, and (ii) is not subject to increased cost exemption (within the meaning of the MHPAEA), the following conditions apply:

- The benefit program may not apply annual or lifetime limits for mental health or substance use disorders that are lower than those for medical and surgical benefits.
- The benefit program may not apply more restrictive financial requirements or treatment limitations to mental health or substance use disorder benefits in any classification than the predominant limitations applied to substantially all of the medical and surgical benefits in any classification.
- The criteria for medical necessity determinations made under any health insurance option with respect to mental health or substance use disorder benefits will be made available by the Plan Administrator (in accordance with the MHPAEA) to any current or potential participant upon request.
- The reason for any denial under the Plan for reimbursement or payment for services with respect to mental health or substance use disorder benefits in the case of any participant will, on request or as otherwise required under the MHPAEA, be made available by the Plan Administrator to the participant in accordance with the claims procedures applicable to the group medical coverage feature.
- The Plan will be operated and constructed in all respects in compliance with the MHPAEA.

“Mental health benefits” and “substance use disorder benefits” are defined in the Plan documents applicable to the medical benefit option, pursuant to applicable state and federal law, and consistent with generally recognized standards of current medical practice.