CF Industries

Health and Welfare

Summary Plan Description

January 2023

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CF INDUSTRIES BENEFITS

CF Industries (the Company) offers a wide variety of benefits to all full-time, non-bargaining employees schedule to work more than 30 hours per week.. This summary plan description (SPD) describes the:

- CF Industries Holdings, Inc. Employee Welfare Benefit Plan, including:
    - Medical (including prescription drug coverage, wellness program, and Health Savings Account)
    - Dental
    - Vision
    - Health Care and Dependent Care Flexible Spending Accounts (FSA)
    - Employee Assistance Program (EAP)
    - Short-Term Disability (STD) and Long-Term Disability (LTD)
    - Life and Accidental Death & Dismemberment (AD&D) Insurance
    - Accident and Business Travel Accident Insurance (BTA)
    - On-Site Clinics

These benefits are referred to as the Plan or the CF Industries Plan in the SPD. Please read this SPD to help you understand and manage your benefits and keep it for future reference. You may have some additional CF Industries benefits that are not described in this SPD. If so, please see the prior SPD or other documentation that you received for information on those benefits.

This SPD is a summary of the key provisions of the Plan as of January 1, 2023. The SPD also provides a brief description of your rights as a participant under the Plan. Complete details of the Plan are contained in the official Plan documents, contracts and certificates. Every attempt was made to make this SPD as accurate as possible. However, if a discrepancy exists between this SPD and the official Plan documents, contracts and certificates, the Plan documents, contracts and certificates will govern. The Company reserves the right to modify, amend or terminate at any time for any reason, the Plan, any component of the Plan, or benefits for employees or their dependents.

If you have any questions about your benefits, you can contact the claims administrator for the benefit (see Claims Administrators and Service Providers) or your Human Resources Department.

Eligibility

This section includes information on eligibility for:

- You
- Your spouse
- Your children
- Your household family members (for EAP only)

For You
You are eligible for the CF Industries, Inc. benefits as shown below:

Benefit Programs	Your Eligibility Requirements
• CF Industries Holdings, Inc. Employee Welfare Benefit Plan (except EAP, which is shown in next row)	You are eligible on your first day of work if you are a regular, non-bargained full-time employee of CF Industries or its subsidiaries. Seasonal, temporary, contract, leased employees and union employees are not eligible.
• Employee Assistance Program (EAP) • Business Travel Accident Insurance	You are eligible on your first day of work if you are a full-time or part-time employee of CF Industries or its subsidiaries. . Seasonal, temporary, contract, leased employees and union employees are not eligible.
• Medical Coverage Only	You are eligible if you are a part-time employee regularly scheduled to work 30 hours per week. . Seasonal, temporary, contract, leased employees and union employees are not eligible.

For Your Spouse
When you enroll for coverage for yourself, you can elect Medical, Dental, Vision and Dependent Life Insurance coverage for your eligible spouse. Your eligible spouse is automatically covered by the EAP, whether or not he or she is enrolled in other benefits.

Your eligible spouse is the person who is recognized as your spouse for purposes of the Internal Revenue Code, unless otherwise set forth in a component benefit document. Common law spouses are not eligible.

If your spouse is also covered as a CF Industries employee, your spouse is not eligible to be covered as a dependent.

For any fully-insured benefit, domestic partner coverage may be available depending on the state insurance code. A fully-insured benefit is one where the insurance carrier receives a premium and assumes all the risk for the coverage. See Administrative Information for a list of fully-insured benefits.

For Your Children
When you enroll in coverage for yourself, you can elect Medical, Dental, Vision and Dependent Life Insurance coverage for your eligible children who are younger than age 26. Your eligible children are automatically covered by the EAP, whether or not they are enrolled in other benefits.

Eligible children include:

- Children under age 26 that are your:
  - Natural children;
  - Stepchildren;
  - Children who are adopted before reaching age 18;
  - Children for whom you can show proof that you are the permanent legal guardian, including foster children; and

Children who are or become totally disabled before reaching age 26 may be eligible to continue coverage beyond age 26.

Coverage continues until the first day following the event date:

- The child no longer meets the definition of an eligible child (without regard to the child's age);
- Your over age 26child no longer meets the definition of totally disabled;
- The insurance carrier asks for proof of disability and dependency, and this proof is not provided within 60 days of the request; or
- Coverage ends for any other reason than your child reaching age 26.

Children who are covered as CF Industries employees are not eligible to also be covered as a dependent. No child may be covered as an eligible dependent of more than one employee.

For purposes of this section, your child will be considered totally disabled under the Plan if he or she cannot earn a living because of a mental deficiency or physical handicap. To qualify under this provision, your child must also depend solely on you for support and a doctor's statement confirming the disability is required. The insurance carrier may request proof of the continuation of the disability as often as is reasonable.

Qualified Medical Child Support Order

A qualified medical child support order (QMCSO) is any judgment, decree or order issued by a court of competent jurisdiction, or a properly completed National Medical Support Notice, requiring you to provide health care benefits for your eligible child. You will be notified if any of your children are affected by a QMCSO. If so, the administrator provides information to the child, custodial parent or legal guardian on how to obtain benefits and submit claims. If you are required to provide health coverage as a result of a Qualified Medical Child Support Order (QMCSO), coverage takes effect on the date of the court order. The child(ren) will be added to your current coverage per the order. The administrator pays eligible claims to the child or the child's custodial parent or legal guardian, except to the extent paid directly to a service provider on behalf of the child.

For Your Household Members

Members of your household, whether or not they are dependents, are automatically covered by the EAP on your first day of work.

Choosing Your Coverage

CF Industries offers a wide variety of benefits and coverage options in which you can enroll. By providing you with meaningful options, CF Industries gives you the opportunity to build the

benefit program that best meets your needs. Most of your CF Industries benefits are paid with pre-tax dollars.

The chart below lists the CF Industries benefits in which you can enroll and the benefits in which you are provided automatic coverage:

You Can Enroll In…	You Automatically Participate In…
• Medical • Dental • Vision • Flexible Spending Accounts • Supplemental Long-Term Disability (LTD) • Voluntary Life Insurance • Dependent Life Insurance • Voluntary Accidental Death & Dismemberment (AD&D) Insurance	• Employee Assistance Program (EAP) • Basic Life and AD&D Insurance • Business Travel Accident Insurance (BTA) • Short-Term Disability • Basic Long-Term Disability • 401(k) Plan • Holidays • Vacation

You also select a coverage level for the Medical, Dental and Vision Plans. Coverage levels are:

- Employee only;
- Employee plus spouse;
- Employee plus child(ren); and
- Family (employee plus spouse and children).

It is important to carefully consider the type and amount of coverage you want.

Default Coverage

If you don't enroll when you are first eligible or during annual enrollment, you will have the following coverage:

Enrollment Period for…	You Automatically Participant In…
New Hire	You will have only those Company-provided benefits that you automatically receive as an employee.
Annual Enrollment	Typically, you will have the same coverages you had during the prior year, except for the Flexible Spending Accounts and Health Savings Account (HSA). To participate in a Flexible Spending Account or the Health Savings Account (HAS), you must make a new election each year. The Company may require an active enrollment for all benefits. You will be notified if you must actively enroll in coverage.

Your Options during Annual Enrollment

During annual enrollment, you choose your options for the next year. However, for certain plans, there are some limits on changes you may make. Generally, changes you make during annual enrollment become effective on January 1 of the following year. Increases in optional life

insurance (employee or spouse coverage) are effective the later of January 1 or the date the increase is approved by the insurance company. Please review the list below to understand what you may and may not do:

Medical, Dental and Vision:

- You may begin coverage;
- You may change your Plan option, if applicable; or
- You may change your coverage level by adding or deleting eligible dependents. Birth and marriage certificates may be required to add dependents or may be requested periodically to substantiate eligibility

Flexible Spending Accounts (FSA):

- You may begin or re-enroll. Current elections do not roll forward into the next calendar year

Supplemental LTD:

- You may begin or stop coverage.

Voluntary Life, Dependent Life and Voluntary AD&D Insurance:

- You may begin, change or stop coverage.

Health Savings Account (HSA)

You may begin or re-enroll. Current elections do not roll forward into the next calendar year. Changes to your HSA may also be made at any time during the year.

Cost of Coverage

You and CF Industries pay for the cost of coverage, as follows:

CF Industries Pays for Coverage	You and CF Industries Share the Cost of Coverage	You Pay the Full Cost of Coverage

• Employee Assistance Program (EAP)
• Basic Life* and AD&D Insurance
• Business Travel Accident Insurance (BTA)
• Short-Term Disability
• Basic Long-Term Disability
• The H S A employer contribution and the employer H S A match
	• You pay your share on a pre-tax basis for:
	  ○ Medical
	  ○ Dental
	  ○ Vision
		• On a pre-tax basis for your contributions to the Health Savings Account and Flexible Spending Accounts
		• On an after-tax basis for:
		  ○ Voluntary Life Insurance
		  ○ Dependent Life Insurance
		  ○ Voluntary Accidental Death & Dismemberment (AD&D) Insurance
		  ○ Supplemental Long-Term Disability

*Coverage amounts over $50,000 are subject to taxation which is often referred to as imputed income.

If your salary changes during the year, the cost of your coverage may change for Voluntary Life, Voluntary AD&D and Supplemental Long-Term Disability. Your cost for other coverage may change if you have an eligible mid-year change to your family status or a special mid-year enrollment period (described in Mid-Year Changes).

An important advantage of the Plan is that you pay for a number of your benefits with pre-tax dollars. When you pay on a pre-tax basis — that is, before federal and Social Security taxes (and in most cases, state and local taxes) are deducted from your pay — your taxable income is reduced so you pay less in taxes. While this may slightly reduce your future Social Security or disability benefits, the value of your tax savings generally outweighs any such reduction.

When Coverage Begins
Generally coverage begins on your date of hire or when you become eligible for coverage. You must complete and submit an enrollment election in Workday within 30 days of the date you become eligible for coverage (your eligibility date). You must be actively at work for benefit coverage to begin.

If you do not enroll within 30 days of your eligibility date, your next opportunity to enroll is:

- During the annual enrollment period; or
- If you have a change to your family status or a special mid-year enrollment period (described in Mid-Year Changes).

For benefits in which you automatically participate, coverage begins on the first day you work for CF Industries or the date you become eligible for coverage.

Mid-Year Changes
Your coverage elections as a new hire are effective until December 31 of the year you are hired. Your coverage elections during annual enrollment are effective from January 1 through December 31 of the following year. You can only make changes to these elections within 30 days of an eligible family status change or special enrollment period. To request a change, you must complete and submit a Benefits Change request in Workday. The new coverage will become effective on the date of the status change for a birth or adoption, and on the first payroll after notification of your family status change for all other changes. You may only add or drop coverage or dependents, you may not switch between coverage options.

Your election change must meet all of the following criteria:
- The change must be because of a qualifying change in status.
- The election change is subject to the insurance carrier's acceptance.
- The election change must correspond to the qualifying change in status, as shown in the chart below:

Event and Required Proof	Medical, Dental and Vision Plans	Voluntary Life & AD&D Insurance*	Dependent Life Insurance*	Health Care FSA**	Dependent Care FSA
Birth, adoption or placement for adoption of a child under age 18 Birth certificate and, if applicable, legal adoption papers	Add newborn or adopted child	Elect or increase level of coverage	Elect spouse or child coverage or increase level of coverage	Begin or increase contributions	Begin, stop, increase or decrease contributions
Marriage Marriage certificate	Add spouse and any stepchildren; drop all coverage	Elect, increase or decrease level of coverage	Elect spouse or child coverage or increase level of coverage	Increase contributions	Begin, stop, increase or decrease contributions
Dependent no longer eligible Birth certificate	Drop coverage for the dependent	Decrease level of coverage	Drop spouse or child coverage or decrease level of coverage	Decrease or stop contributions	Decrease or stop contributions
Dependent becomes eligible If applicable, court appointed guardianship and birth certificate, physician's disability confirmation	Add coverage for child	Elect or increase level of coverage	Elect spouse or child coverage or increase level of coverage	Begin or increase contributions	Begin or increase contributions

Event and Required Proof	Medical, Dental and Vision Plans	Voluntary Life & AD&D Insurance*	Dependent Life Insurance*	Health Care FSA**	Dependent Care FSA
Death of a child Death certificate	Drop coverage for the child	Decrease level of coverage	Drop child coverage or decrease level of coverage	Decrease contributions	Decrease or stop contributions
Divorce, legal separation or annulment Legal decree, separation or marriage annulment document	Drop coverage for spouse; drop or add coverage for a child	Increase or decrease level of coverage	Add or drop spouse or child coverage; increase or decrease level of coverage	Decrease contributions	Begin, stop, increase or decrease contributions
Death of spouse Death certificate	Drop coverage for spouse; add coverage for a child	Increase or decrease level of coverage	Drop spouse coverage; increase or decrease child coverage level	Decrease contributions	Begin, stop, increase or decrease contributions
Gain/loss of spouse's employment, significant change in coverage due to your spouse's employment, or change from full- to part-time or vice versa for spouse Certificate of coverage, spouse's enrollment letter	Drop or add coverage for you, your spouse or your child	Increase or decrease level of coverage	Add or drop spouse coverage; increase or decrease child coverage level	Increase or decrease contributions	Begin, stop, increase or decrease contributions

Event and Required Proof	Medical, Dental and Vision Plans	Voluntary Life & AD&D Insurance*	Dependent Life Insurance*	Health Care FSA**	Dependent Care FSA
You change from full- to part-time or vice- versa None	Drop or add coverage for you, your spouse or your child	Elect, increase or decrease level of coverage	Add or drop spouse or child coverage; increase or decrease level of coverage	Begin or stop contributions	Begin, stop, increase or decrease contributions
Work-related changes (e.g., strike or lockout) for you, your spouse or your dependent	Drop or add coverage for you, your spouse or your child	Elect, increase or decrease level of coverage	Add or drop spouse or child coverage; increase or decrease level of coverage	Begin or stop contributions	Begin, stop, increase or decrease contributions
Start of or return from an unpaid leave of absence by you or your spouse	Drop or add coverage for you, your spouse or your child	Elect, increase or decrease level of coverage	Add or drop spouse or child coverage; increase or decrease level of coverage	Begin or stop contributions	Begin, stop, increase or decrease contributions
QMCSO (Qualified Medical Child Support Order) Court order	Add coverage for child	NA	NA	Begin or increase contributions	NA

* *Evidence of insurability is required if you add or increase the level of coverage.*

** *You cannot reduce your FSA contribution below the greater of the amount already deducted from your pay or the amount already paid to you.*

No changes are permitted for Supplemental Long-Term Disability Insurance.

See Special Enrollment Periods for more information.

Dropping Eligible Dependents

You may cancel an eligible dependent's coverage within 30 days of an eligible status change (see the chart under Mid-Year Changes). The dropped dependent is eligible for continued

coverage under COBRA. To drop a dependent, you need to complete and submit a Benefits Change request on Workday.

If a dependent you dropped from the CF Industries Medical Plan loses coverage under another group plan, you may re-enroll your eligible dependent in the CF Industries Medical Plan. You must provide proof that the dependent's coverage has ended. If you notify CF Industries by submitting a Benefits Change request on Workday within 30 days after your eligible dependent loses coverage, that dependent's coverage under the CF Industries Medical Plan will become effective when the dependent's other coverage ends.

If you fail to notify CF Industries and submit a Benefits Change request on Workday within those 30 days, you cannot enroll any eligible dependents until the next annual enrollment period.

Special Enrollment Periods

If you decline enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, and if that other health insurance ends, you may be able to enroll yourself or your dependents in the CF Industries Plan. You must request enrollment within 30 days after your other coverage ends. In addition, 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 provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

Children's Health Insurance Program and Medicaid

You have 60 days to enroll for coverage if:

- You or your dependent has coverage terminated under Medicaid or a state Children's Health Insurance Program (CHIP) as a result of loss of eligibility (not available if the loss of coverage is due to non-payment); or
- You or your dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP.

Events That Could Affect Your Coverage
Certain events can affect your coverage such as if you:

- Go from full-time to part-time status
- Work Past Age 65
- Take a leave of absence
- Become disabled
- Are on Military Leave
- Retire
- Are on layoff
- Leave the Company
- Die

Going from Full-Time to Part-Time Status

Benefit Plan	Effect On Coverage
Medical Plan	If you meet certain requirements, you may continue to participate in the Medical Plan. To be eligible for this continued coverage as an active, part-time employee, you must obtain management approval for the employment status change and meet all of the following criteria: • Change from full-time to part-time status without terminating CF Industries employment; and work the requisite number of hours in the ACA stability period
Dental, Vision and Health Care FSA	You may continue CF Industries coverage under COBRA
Long-Term Disability, Basic Life and AD&D Insurance, Supplemental LTD, Voluntary Life Insurance, Business Travel Accident	Coverage ends. If your life insurance ends, you may convert to a private policy within 31 days after coverage ends by applying to the insurance carrier.

Working Past Age 65

<table>
<tr><th>Benefit Plan</th><th>Effect On Coverage</th></tr>
<tr><td>Medical Plan</td><td>If you work for CF Industries full-time after you or your spouse attains age 65, you are still eligible for coverage through the Plan. Your CF Industries' medical insurance continues as your primary coverage for you and your dependents as long as you are employed at CF. This means that the CF Industries Medical Plan will pay benefits first, and then Medicare will pay any additional charges eligible under its provisions if you enroll in Medicare.
Note: If you enroll in Medicare, you will be ineligible to participate in the Health Savings Plan. Please consult with your tax advisor on timing and tax implications.</td></tr>
<tr><td>Long-Term Disability and Supplemental LTD Insurance</td><td>Long term disability coverage remains in place. If you become disabled and your disability starts at age 65 or older, your maximum payment period varies from 12 to 42 months based on your age when the disability starts.</td></tr>
<tr><td>Basic Life and AD&D Insurance</td><td>Your total coverage amount is reduced by 35% on the day you reach age 65.</td></tr>
<tr><td>Voluntary Life, Dependent Life and Voluntary AD&D Insurance</td><td>Benefits will be reduced, as follows:
For you: Your total coverage amount is reduced by 35% on the day you reach age 65.
For your spouse: There is no age reduction for your spouse. However, coverage will end once your spouse reaches age 70.</td></tr>
<tr><td>Business Travel Accident</td><td>Your total coverage amount is reduced when you reach the following age increments:<table><tr><th>Age</th><th>Percentage of Benefit Amount</th></tr><tr><td>65 but less than 70</td><td>65%</td></tr><tr><td>70 but less than 75</td><td>45%</td></tr><tr><td>75 but less than 80</td><td>30%</td></tr><tr><td>80 or over</td><td>20%</td></tr></table>.</td></tr>
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Medicare Parts B and D Delayed Enrollment

While you continue to work for CF Industries and you (and your spouse if applicable) are covered under the CF medical plan, you (and your post-65 spouse) can delay Medicare Part B enrollment because you are employed and have group health plan coverage. You may sign up for Medicare Part B later during a Special Enrollment Period and will not be subject to higher premiums because of delayed enrollment. You can sign up:

- Anytime you are still covered by a group health plan through your or your spouse's employment; or

- During the eight months following when the employment ends or the group health plan coverage ends (whichever is first).

Contact Medicare.gov or CMS.Gov for specific information on Medicare benefits and deadlines to enroll.

While you continue to work for CF Industries, you (and your post-65 spouse) can retain your CF Industries coverage and delay your enrollment in Medicare Part D. Because your prescription drug coverage under the CF Industries Medical Plan is on average at least as good as Medicare Part D, you are able to enroll in Part D coverage upon leaving CF Industries without having to pay late enrollment premiums.

Note that if you begin Social Security payments, you will likely be auto-enrolled in Medicare Part A. If you enroll in any part of Medicare, you will not be eligible contribute to a Health Savings Account (HSA). This includes both employee and employer contributions.

If You Take a Leave of Absence

Benefit Plan	Effect On Coverage
Medical Plan	If you elected medical coverage during the enrollment period prior to your leave, you and your eligible dependents are eligible to continue medical coverage during your leave — provided you continue to pay your employee contributions. If you fail to return to work or fail to pay the required contributions as agreed, coverage will be cancelled effective the last date of coverage for which contributions were paid.
Dental and Vision Plans	If you elected dental and vision coverage during the enrollment period prior to your leave, you and your eligible dependents are eligible to continue dental and vision coverage during your leave – provided you continue to pay your employee contributions. If you fail to return to work or fail to pay the required contributions as agreed, coverage will be cancelled effective the last date of coverage for which contributions were paid.
Flexible Spending Accounts (FSA)	Contributions to one or both Flexible Spending Accounts will continue as long as you receive a paycheck. You are eligible to receive reimbursement from your FSA — including reimbursement for those expenses that were incurred prior to your initial leave of absence date.
Short-Term Disability(STD)	Short-Term Disability coverage may continue throughout your leave. Contact your Human Resources Department for information on how to file a STD claim with New York Life.
Long-Term Disability Plan (LTD)	Long-Term Disability (LTD) Plan coverage will continue. If you elected supplemental LTD coverage, you must pay your share of the cost during your leave of absence. If your leave of absence is the result of your own serious health condition and you are not able to return to

	work after a period of six months, you may be eligible to receive Long Term Disability Plan benefits.
Basic Life and AD&D Insurance	Basic Life and AD&D insurance benefits will continue during your leave of absence. Your coverage amount is the amount of your Basic Life and AD&D in effect on your last day actively at work.
Voluntary Life Insurance Dependent Life Insurance Voluntary AD&D	Voluntary Life Insurance, Dependent Life Insurance and Voluntary AD&D coverage continues while you are on leave of absence as long as you pay your share of the cost. Your coverage amount is the amount in effect on your last day actively at work.
Business Travel Accident (BTA)	Business Travel Accident coverage is suspended during your leave.

See Mid-Year Changes for additional information about the impact of a leave of absence on benefits.

If You Become Disabled

Generally, your employment with CF Industries terminates after two years of Long-Term Disability.

Benefit Plan	Effect On Coverage
Medical Plan	If you elected medical coverage during the enrollment period prior to your leave, you and your eligible dependents are eligible to continue medical coverage during your leave — provided you continue to pay your employee contributions. If you fail to return to work or fail to pay the required contributions as agreed, coverage will be cancelled effective the last date of coverage for which contributions were paid. When your employment endsyou will be eligible to continue coverage under COBRA, provided you elected to continue your medical coverage during your leave of absence.
Dental and Vision Plans	If you elected dental and vision coverage during the enrollment period prior to your leave, you and your eligible dependents are eligible to continue dental and vision coverage during your leave — provided you continue to pay your employee contributions. If you fail to return to work or fail to pay the required contributions as agreed, coverage will be cancelled effective the last date of coverage for which contributions were paid. When your employment endsyou will be eligible to continue coverage under COBRA, provided you elect to continue your dental and vision coverage during your disability leave of absence.
Flexible Spending Accounts(FSA)	If you participated in the flexible spending account prior to your disability leave of absence, you are eligible to receive reimbursement for those expenses incurred prior to your initial leave of absence date.

	During your disability leave of absence, you are eligible to make contributions to your flexible spending accounts under COBRA.
Basic Life Insurance	Basic Life Insurance benefits will continue during your leave of absence. Your coverage amount is the amount of your Basic Life and AD&D in effect on your last day actively at work. If you are under age 60 at the time of disability, premiums are paid by CF Industries. After nine months of continuous disability, the insurance carrier will automatically apply for the waiver of premium. If waiver of premium is approved, your Basic Life coverage will continue at no cost to you or CF Industries. If the waiver of premium is denied, you may convert or port your Basic Life coverage to an individual policy. If you are over age 60 at the time of disability, you are not eligible for the waiver of premium. If you are over age 60 at the time of disability, coverage continues and CF Industries pays the premiums for two years of continuous disability. After 2 years, coverage ends and may be eligible to be converted or ported to an individual policy without proof of insurability.

Benefit Plan	Effect On Coverage
Voluntary Life Insurance	Voluntary Life Insurance coverage continues while you are on leave of absence as long as you pay your share of the cost. Your coverage amount is the amount in effect on your last day actively at work. If you are under age 60 at the time of disability, you must continue to pay your premiums. After nine months of continuous disability, the insurance carrier will automatically apply for waiver of premium. If waiver of premium is approved, your coverage will continue at no cost to you or CF. If the waiver of premium is denied your Voluntary Life Insurance you may convert or port your coverage to an individual policy. If you are over age 60 at the time of disability, you are not eligible for the waiver of premium. If you are over age 60 at the time of disability, coverage continues for two years while you are on continuous disability if you continue to pay your premiums. After two years, coverage ends and may be eligible to be converted or ported to an individual life policy without proof of insurability.
Dependent Life Insurance	Dependent Life Insurance coverage continues while you are on leave of absence as long as you pay your share of the cost. Your coverage amount is the amount in effect on your last day actively at work. Your dependent life coverage ends when you are no longer eligible for Voluntary Employee Life Insurance or when you fail to make payment for coverage.

AD&D and Voluntary AD&D Insurance	AD&D Insurance, as well as any Voluntary AD&D Insurance for you or your dependents, will continue for the first twelve months while you are on LTD as long as you pay your share of the cost. After twelve months, you may convert your and your dependents' coverage to an individual policy without evidence of insurability.
Business Travel Accident	Business Travel Accident coverage is suspended during your leave.

If You Are on Military Leave

Military Service — Short Term (not to exceed 30 days): While on military duty under this provision, you will remain in active status and all benefits will remain the same.

Military Leave of Absence (30 days to 5 years):

Benefit Plan	Effect On Coverage
Medical, Dental and Vision Plans	If called to active duty for more than 31 days, coverages may continue for you and your covered dependents during your leave by paying 102% of the full premium via personal check. The benefit continuation period is the lesser of 24 months, or the day after the date on which you fail to return to work with CF Industries, or fail to pay the appropriate premium. Any benefit changes that apply to active employees will also apply to you. On return to work with CF Industries, you may continue coverages or may elect to begin coverage.
Flexible Spending Accounts (FSA)	You may continue to file claims incurred during your leave under your Flexible Spending Accounts if you continue contributing to your account. The benefit continuation period ends on the earlier of the end of the current calendar year, or the day after the date on which you fail to return to work with CF Industries, or the date you fail to continue contributing to your account. On return to work with CF Industries, you may continue the existing accounts or may elect to begin new accounts.
Short-Term Disability(STD)	Coverage ends when your leave begins. On return to work with CF Industries, eligibility for coverage begins immediately. The period served in the uniformed services is considered service for determining a benefit service plateau.
Long-Term Disability, Basic Life and AD&D Insurance, Supplemental LTD, Voluntary Life, Dependent Life and Voluntary AD&D Insurance, Business Travel Accident	Coverage ends when your leave begins. Upon return to full-time work with CF Industries, eligibility for coverage begins immediately.

If You Are on Layoff or Part of a Reduction in Workforce

Benefit Plan	Effect On Coverage
Medical, Dental and Vision Plans	Your coverage ends on the last day you work. You may continue coverage under COBRA.
Flexible Spending Accounts	You may submit claims for expenses incurred through the last day you work. You may continue to file health claims incurred after your last day worked through the end of the year if you continue contributing to your Health Care FSA under COBRA. Your Dependent Care FSA participation ends on the last day you work.
Short-Term Disability and Long-Term Disability (core and supplemental LTD)	Coverage ends on the last day you work.
Basic Life and AD&D Insurance	Coverage ends on the last day you work. You may convert to an individual policy within 31 days of the date your coverage ends.
Voluntary Life, Dependent Life and Voluntary AD&D Insurance	Coverage ends on the last day you work. You may convert to an individual policy within 31 days of the date your coverage ends.
Business Travel Accident	Coverage ends on the last day you work.

If You Retire

Benefit Plan	Effect On Coverage
Medical Plan	Coverage ends on your last day of employment. You may continue coverage under COBRA. See your Human Resources Representative for more information.
Dental and Vision Plans	Coverage ends on the last day you work. You may continue coverage under COBRA.
Flexible Spending Accounts (FSA)	**Health Care Flexible Spending Account or Limited Purpose Health Care Flexible Spending Account** You have 90 days from your last day of employment to submit claims incurred through your retirement date. You may elect to continue participation in the health care flexible spending account or limited purpose health care FSA under COBRA. See Continuing Coverage Under COBRA for more information. **Dependent Care Flexible Spending Account** Your Dependent Care FSA participation ends on your retirement date. Claims incurred prior to your retirement date must be submitted within 90 days of your retirement date.
Short-Term Disability (STD)and Long-TermDisability(LTD) (core and supplemental)	Coverage ends on the last day you work.
Basic Life and AD&D Insurance	Coverage ends on the last day you work. You may convert to an individual policy within 31 days of the date your coverage ends.
Voluntary Life, Dependent Life and Voluntary AD&D Insurance	Coverage ends on the last day you work. You may convert to an individual policy within 31 days of the date your coverage ends.
Business Travel Accident	Coverage ends on your the last day of employment.

If You Leave the Company

If you leave the Company for reasons other than retirement, reduction in workforce or death, see below:

Benefit Plan	Effect On Coverage
Medical, Dental and Vision Plans	Coverage ends on the last day you work. You may continue coverage under COBRA.
Flexible Spending Accounts(FSA)	**Health Care Flexible Spending Account or Limited Purpose Health Care Flexible Spending Account** You have 90 days from your last day of employment to submit claims incurred through your last day of employment. You may elect to continue participation in the health care flexible spending account or limited purpose health care FSA under COBRA. See Continuing Coverage Under COBRA for more information. **Dependent Care Flexible Spending Account** Your Dependent Care FSA participation ends on your last day of employment. Claims incurred prior to your retirement date must be submitted within 90 days of your last day of employment.
Short-Term Disability(STD) and Long-Term Disability(LTD)(core	Coverage ends on your last day of employment.
Basic Life and AD&D Insurance	Coverage ends on the last day you work. You may convert to an individual policy within 31 days of the date your coverage ends.
Voluntary Life, Dependent Life and Voluntary AD&D Insurance	Coverage ends on the last day you work. You may convert to an individual policy within 31 days of the date your coverage ends.
Business Travel Accident	Coverage ends on your last day of employment.

If You Die

Benefit Plan	Effect On Coverage
Medical Plan	Your surviving spouse and eligible dependents may continue coverage under COBRA for up to 36 months.
Dental and Vision Plans	Coverage for your covered surviving spouse and eligible dependents may be continued under COBRA for up to 36 months at 102% of the full monthly premium.
Flexible Spending Accounts(FSA)	Your beneficiary has the option of continuing your Health Flexible Spending Account through the end of the plan year in which you die by continuing to make payments via personal check. Expenses incurred during the period of continued contributions would be eligible for reimbursement. Your Dependent Care FSA participation ends as of the date of your death.
Short-Term Disability(STD) and Long-Term Disability(LTD), Supplemental LTD Insurance	Coverage ends on your date of death.
Basic Life and AD&D Insurance	Your beneficiaries are notified of the amount of insurance that you carried and provided with the appropriate documents to submit a claim. Proceeds are paid out by the insurance carrier through an interest-bearing checking account.
Voluntary Life Insurance	Your beneficiaries are notified of the amount of insurance that you carried and provided with the appropriate documents to submit a claim. Proceeds are paid out by the insurance carrier through an interest-bearing checking account.
Dependent Life Insurance	Your covered dependents are given the option to convert this coverage to an individual policy. Conversion application must be made within 31 days of the date of your death.
Voluntary AD&D Insurance	Your beneficiaries receive payment from this Plan if you die as the result of an accident. Your beneficiaries are notified of the amount of insurance which you carried and provided with the appropriate documents to submit a claim. Proceeds are paid in a lump sum payment.
Business Travel Accident	Your beneficiaries may receive payment from this Plan if you die as the result of an accident while you are traveling on Company business. If applicable, your beneficiaries will be notified of the amount of insurance which you carried and provided with the appropriate documents to submit a claim. Proceeds are paid in a lump sum payment.

Coordination of Benefits

The CF Industries Medical and Dental Plan works with other group health plans that may cover you or your eligible dependents. When an individual is covered by two or more group plans, these plans coordinate to pay benefits. The two plans together will not pay a benefit that is greater than the maximum allowable expense.

Coordination with Other Medical and Dental Plans

When coordinating benefits, the insurance carrier determines which plan is "primary" or pays first, and which plan is secondary:

- A plan that does not have a coordination of benefits provision is primary.
- A plan that covers you as an employee or former employee is primary over a plan that covers you as a dependent.
- If a dependent is covered under two plans, the employee whose birthday comes first in a calendar year will have the primary plan. If the other plan does not have this "birthday rule," the rule set forth in that plan will determine which plan is primary.
- For a dependent child whose parents are divorced or separated, the plan of the parent who is legally responsible for the child's medical expenses will be primary. The plan of a step-parent will pay secondary and the plan of the other natural parent will pay last.
- If no legal responsibility has been assigned, the plan of the parent with full custody will be primary, the plan of a step-parent with custody will pay secondary and the plan of a parent without custody will pay last.

If none of the above apply, the plan that covers the employee or dependent the longest will be primary.

Group Health Plan

A group health plan includes group insurance or any other arrangement for coverage for covered persons in a group, whether on an insured or uninsured basis, including but not limited to:

- Hospital indemnity benefits and hospital reimbursement-type plans that permit the covered person to elect indemnity at the time of the claim;
- Hospital or medical service organizations on a group basis, group practice and other group pre-payment plans;
- Hospital or medical service organizations on an individual basis having a provision similar in effect to this provision;
- A licensed Health Maintenance Organization (HMO);
- Any coverage for students that is sponsored by or provided through a school or other education institution;
- Any coverage under a governmental program, and any coverage required or provided by any statute;
- Group automobile insurance;
- Individual automobile insurance coverage on an automobile leased or owned by an employer; or
- Any individual automobile insurance, including no fault automobile insurance on an individual basis.

Coordination of Benefits with Medicare

If you are eligible and enrolled in for Medicare and you continue to work for the Company after age 65, you may continue your CF Industries Plan coverage. The CF Industries Plan is primary and pays benefits first for:

- You, if you are at least age 65 and working for the Company.
- Your spouse, if your spouse is at least age 65 and participating in the Plan based on your current employment status.
- Social Security disabled individuals who are covered by the CF Industries Plan on the basis of current employment status (their own or a family member's current employment status) and who are entitled to Medicare benefits (e.g., disabled spouse or dependent of an active associate).
- The first 30 months of Medicare entitlement for certain individuals who become eligible for Medicare because of end-stage renal disease, regardless of the reason for the Company's coverage.

Medicare is the primary payer if you or your spouse have COBRA continuation coverage. Medicare is also the primary payer if you or a family member has COBRA continuation coverage and Medicare because of a disability.

For more information on Medicare, visit medicare.gov or CMS.gov.

When Coverage Ends
In addition to the reasons shown below, there are a number of events that can affect your coverage under the Plan. Refer to “Events that Could Affect Your Coverage” for more information. Your coverage under the CF Industries Medical Plan will end when:

For You
- Your employment with CF Industries ends or you cease to be in an eligible class of employees;
- Coverage under the group contract ends; or
- You fail to make a required contribution.

For Your Eligible Dependents
Your eligible dependents’ coverage under the CF Industries Medical Plan will end when:
- Your coverage ends;
- A dependent no longer meets the definition of an eligible dependent — coverage ends as of midnight the day before his or her 26th birthday;
- An eligible dependent becomes covered as an employee; or
- All eligible dependent’s coverage under the contract is terminated.

Rescissions of Coverage
Once you or any of your dependents are enrolled in the Medical Plan, your coverage may not be rescinded unless:
- You or your dependent performs an act, practice or omission that constitutes fraud; or
- You or your dependent make an intentional misrepresentation of a material fact.
- You fail to timely pay premiums.

Continued Coverage under COBRA
When certain events occur that would cause you to lose coverage, you and your eligible dependents may be eligible to continue Medical, Dental, Vision, Health Flexible Spending Account and EAP coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

The qualifying events that give you an opportunity to continue coverage are:
- Termination of your employment for any reason other than gross misconduct; or
- A reduction in the number of hours you are employed, which would otherwise result in the termination of your coverage.

Your eligible dependents may elect to continue coverage if:
- Your coverage ends for a reason named above;
- You die;
- You and your spouse become divorced or legally separated;
- You become entitled to Medicare benefits; or
- Your eligible dependents cease to be eligible dependents.

Each covered individual has independent election rights to continue coverage after a qualifying event.

Note: If you wish to elect continued coverage under COBRA, you need to do so within 60 days of the date your coverage would end, or the date CF Industries or the COBRA administrator informs you of your rights under COBRA, whichever is later.

Continued coverage under COBRA will be the same as the coverage you were enrolled in before the qualifying event occurred. Any benefit changes that apply to active employees will also apply to you while under COBRA coverage. Wellness incentives are not available for COBRA participants.

You or your eligible dependents must pay the full cost of continued coverage, plus a 2% additional charge to cover administrative fees. Once you elect continued coverage, you have 45 days to make the initial premium payment. Coverage will not be reinstated until the monthly premium is remitted to the COBRA administrator.

You become eligible for continued coverage on the day after the qualifying event occurs. The COBRA administrator will notify you (or your eligible dependents in the event of your death) of eligibility to continue coverage. If there is a divorce or legal separation between covered individuals, or if a dependent child no longer qualifies as an eligible dependent, **you must notify your Human Resources Department of that change by completing a Benefit Change request on Workday within 30 days of the qualifying event.**

If a Benefit Change request on Workday is not completed within 30 days of the qualifying event or the date on which the coverage would be lost because of the event, then right to continuation coverage may be forfeited.

If you or your eligible dependents choose to continue coverage, your coverage and premiums will begin on the day after the qualifying event. Coverage will continue until the earliest of:

- The date CF Industries ends coverage under the Plan;
- The date you or your eligible dependents fail to make the full required payments on time;
- The date you or your eligible dependents first become covered under another health plan.
- The date you became entitled to Medicare benefits; or
- The date which applies to your situation shown on the following table.

Qualifying Event	Maximum Period of Continuation	Medical Program
Voluntary or involuntary termination of employment (other than cases of gross misconduct) or reduction of hours employed: • Employee • Spouse • Eligible Dependents	18 Months	COBRA
Divorce/legal separation • Ex-Spouse • Eligible Dependents	36 Months	COBRA
Dependent child ceasing to be an eligible dependent child	36 Months	COBRA
Death of employee in active status • Surviving Spouse • Surviving Eligible Dependents	36 Months	COBRA

If an eligible dependent is receiving continued coverage because of your termination or reduction in hours and a subsequent qualifying event occurs, the eligible dependent may elect continuation for up to an additional 18 months. In no event will a period of continuation extend beyond 36 months from the original qualifying event.

If, during the coverage continuation period, a qualifying event occurs, you can change your coverage status. Premium rates will be adjusted to reflect the changes you and/or your eligible dependents make. The addition of new eligible dependents does not extend the original continuation period. For more information see "When Coverage Begins" in this section.

If you or a covered eligible dependent is totally disabled (as defined by Social Security) at the time of your termination or reduction in work hours, or during the first 60 days of COBRA continuation coverage, all qualified beneficiaries' coverage will be continued for 29 months instead of 18 months. During this 11 month extension period, you will be charged 150% of the full cost of continued coverage. To qualify for this extension, you or your eligible dependents must notify your Human Resources Department within 60 days of the time you or the eligible dependent is determined to be disabled by Social Security and within 18 months of the qualifying event. You will need to provide your Human Resource Department with written documentation of Social Security's determination. If the eligible individual is determined to be no longer disabled, that individual must notify your Human Resources Department within 31 days.

If you do not elect continuation coverage during the election period, but are determined to be eligible for trade adjustment assistance under the Trade Act of 2002 because your employment was adversely affected by international trade, you may be allowed another 60-day period to elect continuation coverage. You will receive additional information if this applies to you.

If you or your eligible dependents choose not to continue coverage under the Plan, your coverage will end.

MEDICAL PLAN

Please Note: These summary plan descriptions reflect plans currently in effect. Any changes to benefit plans will be reflected in updated summary plan descriptions after those changes take effect. Additional detail on your medical benefits can be obtained at BCBSIL.com.

The CF Industries Medical Plan is an important part of the CF Industries employee benefits. The Medical Plan provides financial protection for you and your family in the case of an injury or illness by helping to pay hospital, surgical and other medical expenses. The Medical Plan also helps to keep you and your family well by covering 100% of the costs for most in-network preventive care services.

You can choose between two medical plan options:

CF Advantage PPO with HSA — The CF Advantage PPO is a high deductible health plan which includes a Health Savings Account. The plan provides in and out of network coverages administered by Blue Cross Blue Shield of Illinois (BCBSIL). When you use a network provider, you receive higher benefits (i.e., the Plan pays a higher percentage of the covered costs). Also, network providers have agreed to accept negotiated fees that are typically lower than those charged by out-of-network providers. Your Health Savings Account (HSA) is administered by Fidelity.

CF Standard PPO — The CF Standard PPO provides in an out of network coverages administered by Blue Cross Blue Shield of Illinois (BCBSIL). When you use a network provider, you receive higher benefits (i.e., the Plan pays a higher percentage of the covered costs). Also, network providers have agreed to accept negotiated fees that are typically lower than those charged by out-of-network providers.

Prescription Drug coverage is administered by Prime Therapeutics in partnership with BCBSIL.

For more information on the Plan, see:

Medical Plans at a Glance

CF Advantage PPO

Feature/Type of Care	Blue Cross Blue Shield of Illinois	
	In-Network	**Out-of-Network***
Calendar-Year Deductible	$1,500 per individual; $3,000 per family	$3,000 per individual; $6,000 per family
Health Savings Account (HSA) Contribution from CF	$250 for individual coverage $500 if you cover one or more dependents (amounts are prorated for new hires)	
Health Savings Account Match from CF	Dollar for dollar, up to $500 for individual coverage; $1,000 if you cover one or more dependents	
Calendar-Year Out-of-Pocket Maximum (includes medical copays)	$3,000 per individual; $6,000 per family	$6,000 per individual; $12,000 per family
Physician Services		
Preventive Care	Plan pays 100%; deductible waived	Plan pays 70%; deductible
Physician Office Visit	Plan pays 90% after deductible	Plan pays 70% after deductible
Specialist Office Visit	Plan pays 90% after deductible	Plan pays 70% after deductible
Urgent Care Center Visit	Plan pays 90% after deductible	Plan pays 70% after deductible
Non-urgent Use of Urgent Care Center	Not Covered	Not Covered
Virtual Visits	Plan pays 100%; deductible waived. (includes MDLive visits)	Plan pays 70% after deductible
Maternity		
Maternity (precertification required)	• Initial visit to confirm pregnancy: Plan pays 90% after deductible • Routine prenatal visits: Plan pays 100% with no deductible required • Lab tests: Plan pays 90% after deductible	Plan pays 70% after deductible

	• Hospital/delivery charges: Plan pays 90% after deductible	

Feature/Type of Care	Blue Cross Blue Shield of Illinois	
	In-Network	**Out-of-Network***
Hospital Services		
Emergency Room	Plan pays 90% after deductible	Plan pays 90% after deductible
Non-emergency Use of Emergency Room	Not covered	Not covered
Inpatient and Outpatient Care (pre-certify inpatient stays)	Plan pays 90% after deductible	Plan pays 70% after deductible
Other Common Services		
Labs and X-Rays	Plan pays 90% after deductible	Plan pays 70% after deductible
Skilled Nursing Facility (limit 120 days per calendar year)	Plan pays 90% after deductible	Plan pays 70% after deductible
Home Health Care (limit of 120 visits per calendar year)	Plan pays 90% after deductible	Plan pays 70% after deductible
Private Duty Nursing (limit 120 8-hour shifts per calendar year)	Plan pays 90% after deductible	Plan pays 70% after deductible
Physical Therapy (limit 45 visits per calendar year)	Plan pays 90% after deductible	Plan pays 70% after deductible
Occupational Therapy (limit 70 visits per calendar year)	Plan pays 90% after deductible	Plan pays 70% after deductible
Speech Therapy (limit per calendar year is 30 visits; additional 20 visits for treatment of pervasive developmental disorders)	Plan pays 90% after deductible	Plan pays 70% after deductible
Chiropractic Care (manipulation maximum benefit of 30 visits per calendar year)	Plan pays 90% after deductible	Plan pays 70% after deductible

Feature/Type of Care	Blue Cross Blue Shield of Illinois	
	In-Network	**Out-of-Network***
Mental Health/Chemical Dependency Inpatient	Plan pays 90% after deductible	Plan pays 70% after deductible
Outpatient	Plan pays 90% after deductible	Plan pays 70% after deductible

** If using out-of-network providers, Plan benefits are determined based on the Maximum Allowable Charge for the applicable service or supply. You are responsible for paying the provider for any amount of charges that is in excess of the Recognized Charge.*

CF Advantage PPO — Prescription Drug Coverage

Feature/Type of Care	Blue Cross Blue Shield of Illinois	
	In-Network	**Out-of-Network***
Prescription Drugs		
Retail — up to 34-day supply	Plan pays 90% after deductible	Plan pays 70% after deductible
Retail (at Prime's Extended Supply Network Pharmacies) — 35-day to 90-day supply	Plan pays 90% after deductible	Plan pays 70% after deductible
Mail Order — 90-day supply	Plan pays 90% after deductible	Plan pays 70% after deductible
Lifetime Maximum Benefits	Unlimited NA	

** When using an out-of-network pharmacy, you will have to pay for the full cost of your medication up front and will then have to submit a prescription drug claim form to BCBSIL to get reimbursed.*

CF Standard PPO

Feature/Type of Care	Blue Cross Blue Shield of Illinois	
	In-Network	**Out-of-Network***
Calendar-Year Deductible (does not include copays)	$1,000 per individual; $2,000 per family	$2,000 per individual; $4,000 per family
Calendar-Year Out-of-Pocket Maximum (includes medical copays)	$2,500 per individual; $5,000 per family	$5,000 per individual; $10,000 per family
Physician Services		
Preventive Care	Plan pays 100%; deductible waived	Plan pays 70%; after deductible
Physician Office Visit	Plan pays 90% after deductible	Plan pays 70% after deductible
Specialist Office Visit	Plan pays 90% after deductible	Plan pays 70% after deductible
Urgent Care Center Visit	Plan pays 90% after deductible	Plan pays 70% after deductible
Non-urgent Use of Urgent Care Center	Not Covered	Not Covered
Virtual Visits	Plan pays 100%; deductible waived. (includes MDLive visits)	Plan pays 70% after deductible
Maternity		
Maternity (precertification required)	• **Initial visit to confirm pregnancy:** Plan pays 90% after deductible • **Routine prenatal visits**: Plan pays 100% with no deductible required • **Lab tests:** Plan pays 90% after deductible • **Hospital/delivery charges:** Plan pays 90% after deductible	Plan pays 70% after deductible
Hospital Services		
Emergency Room	Plan pays 90%	Plan pays 90% after deductible
Non-emergency Use of Emergency Room	Not covered	Not covered

Inpatient and Outpatient Care (pre-certify inpatient stays)	Plan pays 90% after deductible	Plan pays 70% after deductible
Feature/Type of Care	**Blue Cross Blue Shield of Illinois**	
	In-Network	**Out-of-Network***
Other Common Services		
Labs and X-Rays	Plan pays 90% after deductible	Plan pays 70% after deductible
Skilled Nursing Facility (limit 120 days per calendar year)	Plan pays 90% after deductible	Plan pays 70% after deductible
Home Health Care (limit of 120 visits per calendar year)	Plan pays 90% after deductible	Plan pays 70% after deductible
Private Duty Nursing (limit 120 8-hour shifts per calendar year)	Plan pays 90% after deductible	Plan pays 70% after deductible
Physical Therapy (limit 45 visits per calendar year)	Plan pays 90% after deductible	Plan pays 70% after deductible
Occupational Therapy (limit 70 visits per calendar year)	Plan pays 90% after deductible	Plan pays 70% after deductible
Speech Therapy (limit per calendar year is 30 visits; additional 20 visits for treatment of pervasive developmental disorders)	Plan pays 90% after deductible	Plan pays 70% after deductible
Chiropractic Care (Manipulation maximum benefit of 30 visits per calendar year)	Plan pays 90% after deductible	Plan pays 70% after deductible
Mental Health/Chemical Dependency Inpatient	Plan pays 90% after deductible	Plan pays 70% after deductible
Outpatient	Plan pays 90% after deductible	Plan pays 70% after deductible

** If using out-of-network providers, Plan benefits are determined based on the Maximum Allowable Charge for the applicable service or supply. You are responsible for paying the provider for any amount of charges that is in excess of the Recognized Charge.*

CF Standard PPO — Prescription Drug Coverage

Feature/Type of Care	Blue Cross Blue Shield of Illinois	
	In-Network	**Out-of-Network***
Prescription Drugs		
Retail — up to 34-day supply	You pay: • $10 Generic • $40 Formulary • $55 Non-Formulary	You pay 30%
Retail — 35-day to 90-day supply	You pay: • $20 Generic • $110 Formulary • $155 Non-Formulary	You pay 30%
Mail Order — 90-day supply	You pay: • $10 Generic • $75 Formulary • $105 Non-Formulary	You pay 30%
Lifetime Maximum Benefits	Unlimited NA	

** When using an out-of-network pharmacy, you will have to pay for the full cost of your medication up front and will then have to submit a prescription drug claim form to BCBSIL to get reimbursed.*

How Medical Plan Benefits Work

Under both medical plan options, you are free to receive medical services from any qualified health care provider. However you generally receive the highest level of benefits when you use providers who participate in the Blue Cross Blue Shield Participating Provider Organization (PPO) network. Plus, network providers usually file claims for you. If you use an out-of-network provider, the Plan pays benefits only up to Maximum Allowable Charge. You also may be responsible for paying for services when you receive them and filing a claim for reimbursement.

The Company and you share in the cost of benefits. The amount the Company pays and your portion of the expenses differs depending on your medical option and where you receive your medical services.

Depending upon the plan you elected, you might be responsible for paying the following:

- Medical Deductible — the amount you pay each calendar year before the Plan begins to pay benefits. (The deductible is not required for preventive services.)
- Medical Copayment — a flat dollar amount you pay for certain covered services and items.
- Medical Coinsurance — the percentage of charges you pay under the Plan for covered services.
- Maximum Allowable Charge — the maximum amount the Plan will pay for a given covered service or item.
- Amounts for services or supplies that are not necessary or not covered by the Plan.
- Penalties for not precertifying hospital or skilled nursing facility admissions, home health care, hospice care or skilled nursing care.

Also be sure to review the annual out-of-pocket limit that caps your share of costs in any given calendar year.

Network Providers

A network is a group of providers (doctors, hospitals, outpatient centers, urgent care centers, clinics, labs or other covered provider types and facilities) that have contracted with BCBSIL to provide care at negotiated or contracted rates. These negotiated rates represent a discount over the provider's regular rates.

- If you use a network provider, you receive the discounted negotiated rates and may also save money through lower deductibles, lower coinsurance or copays, and lower out-of-pocket limits.
- If you use an out-of-network provider, there is no network discount and you face higher deductibles, higher coinsurance and out-of-pocket limits. In addition, you are responsible for any charges in excess of the Maximum Allowable Charge that applies to out-of-network services. Many providers do charge more — sometimes much more — than the Maximum Allowable Charge. These excess charges do not count toward your out-of-pocket limit, so for a high-cost procedure, using an out-of-network provider could cost you considerably more.

If you cannot locate a network provider, contact a BCBSIL Health Advocate for assistance by calling the phone number listed on your ID card.

In the case of an anesthesiologist (or other "ologist"), if the facility or attending physician is in the network, the anesthesiologist is paid at the network level, regardless of whether or not the anesthesiologist is a network member. However, if an "ologist" claim arrives before the facility or attending physician claim, then the "ologist" (if out-of-network) is paid at the out-of-network levels, and the payment can be subsequently adjusted by calling the claims administrator.

In some states, use of an out-of-network provider that results in "balance billing" to you, may require you to arbitrate any disputed amounts owed by you. The Plan will not pay for the arbitration.

Online Provider Directory

Provider Finder® is BCBSIL's online provider directory. Provider Finder gives you the most recent information on the doctors, hospitals and other providers in the BCBSIL network. For each doctor or other health care provider, you can learn about his or her credentials and practice, including education, board certification, languages spoken, office location and hours, and parking and handicapped access. You can also provide feedback on a primary care physician (PCP), specialist or other medical professional after receiving services, using the online survey available at Provider Finder.

To access Provider Finder, go to www.bcbsil.com and follow the prompts.

Calendar-Year Deductible

For both medical plan options you pay 100% of the cost for non-preventive medical services until you reach the deductible. Depending on your medical plan option, the deductibles apply differently.

For the **CF Advantage Plan**, if you have family coverage, any covered family member or combination of family members must satisfy the family deductible first before the plan pays benefits, even if only one person uses the plan.

For the **CF Standard Plan**, when one family member satisfies the individual deductible, the plan pays benefits for that individual. Then any covered family member or any combination of family members can satisfy the family deductible.

Calendar-Year Deductible			
CF Advantage PPO		**CF Standard PPO**	
In-Network	**Out-of-Network**	**In-Network**	**Out-of-network**
$1,500 per individual; $3,000 per family	$3,000 per individual; $6,000 per family	$1,000 per individual; $2,000 per family	$2,000 per individual; $4,000 per family

Coinsurance
Coinsurance refers to the percentage of charges for covered services and supplies that the Company and you pay under the Plan. Both plans cover in-network charges at 90% and you pay the remaining 10% as coinsurance.

Note: If the Plan covers the out-of-network service you receive at 70% of the Maximum Allowable Charge after the deductible, you pay the remaining 30% as coinsurance. You also pay any amounts above the Maximum Allowable Charge.

CF Advantage PPO & CF Standard PPO		
Feature/Type of Care	**In-Network**	**Out-of-Network**
Physician Services for Preventive Care	Plan pays 100% with no deductible required	Plan pays 70% after deductible
Most other categories of services	Plan pays 90% after deductible	Plan pays 70% after deductible

Calendar-Year Out-of-Pocket Maximum
After you reach the calendar year out-of-pocket maximum, the Medical Plan will begin to pay 100% of your eligible expenses for the remainder of that calendar year. The out-of-pocket maximum includes the deductible. There are separate out-of-pocket expense limits applicable to covered services received from network providers and out-of-network providers. Your out-of-pocket maximum for services rendered depends on your Medical Plan option, as follows:

CF Advantage PPO		CF Standard PPO	
In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
$3,000 per individual; $6,000 per family	$6,000 per individual; $12,000 per family	$2,500 per individual; $5,000 per family	$5,000 per individual; $10,000 per family

If you enroll yourself and at least one dependent in either medical plan option, the family out-of-pocket maximum applies. Any combination of family members' expenses can be added together to meet the family out-of-pocket maximum. Alternatively, any covered family member can meet the individual out-of-pocket maximum amount and then the Plan will begin to pay 100% of his or her covered costs for the remainder of the calendar year.

The calendar-year out-of-pocket maximum:

- Does not include non-precertification penalties;
- Does not include charges that exceed the eligible charge or the portion of charges from a non- network provider that exceed the maximum allowable charge;

Maximum Allowable Charge

The Medical Plan has a maximum amount it will pay for covered services. The maximum amount depends on whether you receive care from a network provider or an out-of-network provider.

- **If you use a network provider**, the rate is the negotiated or contracted amount agreed to by the provider and network. You are **not** responsible for any amounts in excess of the contracted amounts.
- **If you use an out-of-network provider**, you **are** responsible for all fees above the Maximum Allowable Charge.

Medically Necessary/Medical Necessity

To be covered by the Medical Plan, services and supplies must be necessary. Necessary (or "medically necessity") means that a specific medical, health care, supply or hospital service is required for the treatment or management of a medial symptom or condition, and that the service supply or care provided is the most efficient and economical service which can safely be provided. The service or supply must be:

- Provided in accordance with generally accepted standards of medical or dental practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration;
- Considered effective for the patient's illness, injury or disease;
- Not primarily for the convenience of the patient, physician, dentist or other health care provider; and
- Not more costly than an alternative service or sequence of services that would be at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "generally accepted standards of medical or dental practice" means standards that are:

- Based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical or dental community; or
- Otherwise consistent with physician or dental specialty society recommendations and the views of physicians or dentists practicing in relevant clinical areas and any other relevant factors.

Precertification Services/Prior Authorization
Your CF Industries Medical Plan offers special precertification services, also referred to a prior authorization, to assist you in making informed medical care decisions. Under both medical options, if your out-of-network physician recommends hospitalization, you must call to pre-certify before you are admitted. Under both medical options, your in-network provider is responsible for obtaining precertification and there is no penalty to you if they don't pre-certify care.

Type of Service	When Out-of-Network Care Must Be Precertified
Hospital Inpatient Care • You or your physician must request precertification for inpatient confinement in an out-of-network hospital	To request precertification, call a BCBSIL Health Advocate at the number on your ID Card: • Emergency admission: within 48 hours of admission or as soon as reasonably possible • Urgent admission: before you are scheduled to be admitted • Other admissions: at least 14 calendar days prior to admission

Alternatives to Hospital Inpatient Care
You need to request precertification for the following hospital alternatives if your provider is not in the BCBSIL network:
• Skilled nursing facility care
• Home health care services
• Hospice care — inpatient and outpatient
• Private duty nursing
	To request precertification, call a BCBSIL Health Advocate at the number on your ID card:
	• Inpatient confinements: same as hospital inpatient care (above)
	• Outpatient care:
	  • Non-emergency care — at least 14 calendar days in advance or as soon as reasonably possible
	  • Emergency care — as soon as reasonably possible

After the precertification call, you or your provider receives a verbal verification of whether a stay is approved. You and your provider then receive a letter confirming the precertification call and outlining the length of stay. An extension of your stay may be granted based on your medical condition. If it is determined that the proposed hospital admission is not medically necessary, coverage may exclude some hospital days, certain services or perhaps the entire hospitalization.

Case Management
Case management is a collaborative process that assists you with the coordination of complex care services. A claim administrator case manager is available to you as an advocate for cost-effective interventions. Case managers are also available to you to provide assistance when you need alternative benefits.

Alternative benefits will be provided only so long as the claim administrator determines that the alternative services are medically necessary and cost-effective. The total maximum payment for

alternative services shall not exceed the total benefits for which you would otherwise be entitled under Plan.

Recommended Clinical Review –
An optional voluntary review of your provider's recommended medical procedure, treatment, or test, that does not require prior authorization/precertification, to make sure it meets approved medical policy guidelines and medical necessity requirements.

The CF Advantage PPO Plan with HSA
The CF Advantage PPO Plan includes a Health Savings Account (HSA). Under this medical plan, you can choose physicians, hospitals and other approved medical providers from the Blue Cross Blue Shield Participating Provider Organization (PPO) network. You may also choose any physician out of the network. However, when you use a network physician, you receive higher benefits.

All hospital admissions (including maternity and emergency admissions), home health care, skilled nursing care and private duty nursing must be pre-certified. BCBSIL provides the network and administrative services.

The CF Advantage PPO Plan has these important features:

- **Preventive care and wellness visits** for you and your covered family members are covered and, when you use network providers, the Plan pays 100%, with no deductible required.
- **You have access to a Health Savings Account through Fidelity Investments.** Once you enroll in the Advantage PPO Plan and complete the online authorization, a HSA will automatically be opened on your behalf. CF will contribute $250 to your HSA if you have employee-only coverage and $500 if you have family coverage (or employee plus spouse or employee plus children coverage). For new hires, the CF contribution amount will be pro-rated depending on your date of hire. In addition, CF will also match a portion of your contributions dollar for dollar, up to $500 for single coverage or up to $1,000 if you cover yourself and other family member.
- The Plan has an individual calendar-year deductible for employee only coverage and a family deductible for all other coverage levels (i.e. employee + spouse, employee + children or family) The Advantage PPO is a high deductible health plan and the application of the deductible works differently if you are covering other family members. With family coverage (as well as employee + spouse or children), any covered family member or combination of family members must satisfy the family deductible before the plan will start to pay benefits, even if only one person uses the plan. Plan benefits then begin after you have met the calendar-year deductible.
- **You have the freedom to choose any doctor** whenever you need care, but choosing an in-network health care provider makes it certain that you receive the highest level of benefits.
- **After you have met the deductible, the Plan pays 90% for most categories of covered services** when you use an in-network provider. If you choose an out-of-network provider, the Plan pays 70% for most categories of covered services.

Covered Services
The following chart summarizes the expenses covered and any benefit limits for the CF Advantage PPO Plan. Benefit payments are based on the Maximum Allowable Charge.

Plan Feature	Network		Out-of-Network	
Calendar-Year Deductible	$1,500 per individual; $3,000 per family		$3,000 per individual; $6,000 per family	
Calendar-Year Out-of-Pocket Maximum (includes the deductible)	$3,000 per individual; $6,000 per family	$6,000 per individual; $12,000 per family	$3,000 per individual; $6,000 per family	$6,000 per individual; $12,000 per family
Covered Service	**Network**		**Out-of-Network**	
Office Visits (physicians & specialists)	Plan pays 90% after deductible		Plan pays 70% after deductible	
Well Child Care and Immunizations (routine)	Plan pays 100%, no deductible		Plan pays 70% afterdeductible	
Well Adult Care Routine physical exam	Plan pays 100%, no deductible		Plan pays 70% after deductible	
Routine Mammograms	Plan pays 100%, no deductible		Plan pays 70% after deductible	
Routine Ob/Gyn Exam (includes one Pap smear and related lab fees)	Plan pays 100%, no deductible		Plan pays 70% after deductible	
Routine Prostate Screening • PSA and DRE for men	Plan pays 100%, no deductible		Plan pays 70% after deductible	
Allergy Shots / Treatments	Plan pays 90% after deductible		Plan pays 70% after deductible	
Inpatient Hospitalization**	Plan pays 90% after deductible		Plan pays 70% after deductible	
Inpatient Physician Services*	Plan pays 90% after deductible		Plan pays 70% after deductible	
Bariatric Surgery	Plan pays 90% after deductible		Plan pays 70% after deductible	
Emergency Room**	Plan pays 90% after deductible		Plan pays 90% after deductible	
Non-emergency Use of Emergency Room	Not covered		Not covered	
Ambulance Service	Plan pays 90% after deductible		Plan pays 90% after deductible	

Covered Service	Network	Out-of-Network
Urgent Care Center Visit	Plan pays 90% after deductible	Plan pays 70% after deductible
Non-urgent Use of Urgent Care Center	**Not covered**	Not covered
Walk-in Clinic	Plan pays 90% after deductible	Plan pays 70% after deductible
Outpatient Facility*	Plan pays 90% after deductible	Plan pays 70% after deductible
Outpatient Surgery*	Plan pays 90% after deductible	Plan pays 70% after deductible
Outpatient X-Rays and Labs*	Plan pays 90% after deductible	Plan pays 70% after deductible
Second Surgical Opinion	Plan pays 90%, no deductible	Plan pays 70% no deductible
Private Duty Nursing** (limit 120 8-hour shifts per calendar year)	Plan pays 90% after deductible	Plan pays 70% after deductible
Physical Therapy (limit 45 visits per calendar year)	Plan pays 90% after deductible	Plan pays 70% after deductible
Occupational Therapy (limit 70 visits per calendar year)	Plan pays 90% after deductible	Plan pays 70% after deductible
Speech Therapy (limit per calendar year is 30 visits; additional 20 visits for treatment of pervasive developmental disorders)	Plan pays 90% after deductible	Plan pays 70% after deductible
Chiropractic Care (Manipulation maximum benefit of 30 visits per calendar year)	Plan pays 90% after deductible	Plan pays 70% after deductible
Contraceptive Devices and Injectables (provided and billed by a physician — includes office visit, insertion/administration)	Plan pays 100%, no deductible	Plan pays 70% after deductible
Infertility Treatment (certain limits apply)	Plan pays 90% after deductible	Plan pays 70% after deductible
Abortion (where permitted by law)	Plan pays 90% after deductible	Plan pays 70% after deductible

Covered Service	Network	Out-of-Network
Voluntary Sterilization — women	Plan pays 100%, no deductible	Plan pays 70% after deductible
Voluntary Sterilization — men	Plan pays 90% after deductible	Plan pays 70% after deductible
Hospice Care** (must have a terminal illness with a life expectancy of one year or less)	Plan pays 90% after deductible	Plan pays 70% after deductible
Skilled Nursing Facility (120 days per calendar year)	Plan pays 90% after deductible	Plan pays 70% after deductible
Home Health Care (120 visits per calendar year)	Plan pays 90% after deductible	Plan pays 70% after deductible
Durable Medical Equipment	Plan pays 90% after deductible	Plan pays 70% after deductible
Foot Orthotics (one pair per year)	Plan pays 90% after deductible	Plan pays 70% after deductible
Transplants (for certain human organ transplants)	Plan pays 90% after deductible	Plan pays 70% after deductible
Mental Health/Chemical Dependency • Inpatient**	Plan pays 90% after deductible	Plan pays 70% after deductible
• Outpatient	Plan pays 90% after deductible	Plan pays 70% after deductible
Temporomandibular Joint Dysfunction (TMJ) Benefits available for appliances, diagnosis and treatment of TMJ.	Plan pays 90% after deductible	Plan pays 70% after deductible
Oral Surgery (see Oral Benefits)	Plan pays 90% after deductible	Plan pays 70% after deductible
Routine Eye Exams (once per calendar year)	Plan pays 90%, no deductible	Plan pays 70%, after deductible
Routine Hearing Care Exams (once per calendar year)	Plan pays 90%, after deductible	Plan pays 70%, after deductible

Hearing Aids (maximum $5,000 per calendar year)	Plan pays 90% after deductible	Plan pays 70% after deductible

Covered Service	Network	Out-of-Network
Diabetic Supplies	Plan pays 90% after deductible	Plan pays 70% after deductible
Autism Spectrum Disorders (psychiatric care, psychological assessments, and treatments, habilitative or rehabilitative treatment, and/or therapeutic care)	Plan pays 90% after deductible	Plan pays 70% after deductible

** If the facility or attending physician is in the network, the "ologist" (i.e., anesthesiologist,) is paid at the network level, regardless of whether or not the "ologist" is a network member.*

*** Precertification is required. You and/or your physician must pre-certify if using an out-of-network provider. Room allowance based on hospital's most common semi-private room rates.*

For more information on specific covered services, see Additional Coverage Details and Limits or you may obtain a copy of the BCBS Booklet for the Advantage PPO Plan with HSA (249478) online at www.BCBSIL.com

Health Advocacy Solutions provided by BCBSIL

A health advocate serves as a personal assistant for your health care needs. If you are enrolled in one of the medical plans administered by BCBSIL, you may contact a health advocate to help address your medical benefits questions, concerns and issues — at no additional cost to you.

A health advocate can help you and your covered family members:

- Get personal assistance with your health care matters
- Understand your health benefits
- Talk to your BCBSIL clinician about health questions
- Sort out a new diagnosis and what to do next
- Shop for quality, lower-cost health care

It's easy to reach a health advocate. Call 888-902-8293 (toll-free). You may also call a health advocate to help you find an in-network provider and understand your benefits. You'll get support from 7 a.m. to 7 p.m. CT Monday through Friday.

Health Savings Account (HSA)

A Health Savings Account (HSA), administered by Fidelity, is an individual savings account used in conjunction with the CF Advantage PPO Plan to cover out-of-pocket qualified medical expenses on a tax-advantaged basis. Your HSA belongs entirely to you and will rollover from year-to-year. It can be used to pay for both current and future qualified medical expenses for you and your eligible dependents. You can contribute to your account, withdraw contributions to pay for current qualified medical expenses, and potentially grow your account on a tax-free basis by investing your savings in a wide array of investment options. Upon enrolling in the CF Advantage PPO, plan you are eligible to open your HSA. During the enrollment process you will

be prompted to provide HSA authorization which allow an account to be automatically opened at Fidelity on your behalf.

HSA contributions

There are two ways you can have tax-free contributions in your HSA:

- If you are enrolled in the Advantage PPO with HSA CF will contribute $250 to your HSA if you have employee-only coverage and $500 if you have family coverage (or employee plus spouse or employee plus children coverage). For new hires, the CF contribution amount will be pro-rated depending on your date of hire. In addition, CF will also match a portion of your contributions dollar for dollar, up to $500 for single coverage or up to $1,000 if you cover yourself and other family member.

You can also fund your HSA through pre-tax contributions from each paycheck, up to the IRS limits of $3,650 for single coverage and $7,300 for family coverage. If you are age 55 or older, you can contribute an additional $1,000 per year to your HSA

HSA Rules

As Health Savings Accounts provide tax-advantages, you are required to meet certain conditions in order to participate in one, you:

- Must be enrolled in the CF Advantage PPO, a high deductible health plan.
- Cannot be enrolled in any part of Medicare.
- Cannot be claimed as a dependent on someone else's tax return.
- Cannot participate in a Health Care Flexible Spending Account (FSA) unless it is a limited purpose health care FSA.
- Cannot be covered by another health insurance plan that is not a High Deductible Health Plan.

If you have a Health Care FSA from the prior year, you must use all of your FSA money no later than December 31st. Otherwise, if you carry an FSA account balance into the new plan year, you will not be able to participate in your HSA until April 1st of that plan year.

Prescription Drugs

Prescription drug coverage is administered by Prime Therapeutics, a BCBSIL partner. The network-based prescription drug program uses a list of preferred medications called a "formulary." There are three tiers on the formulary:

- **Generic medications:** Your prescriptions are filled with generic drugs unless your physician indicates that substitutions are not allowed. Generic drugs are essentially equivalent to the brand-name drug for all the active ingredients.
- **Preferred brand medications:** In general, these drugs do not yet have a generic equivalent, but may in the future.
- **Non-preferred brands:** Some non-preferred brands may be covered on the Prime Therapeutics formulary list. Those medications not on the list will not be covered by the plan.

Note: Coverage for contraceptives and self-injectables are the same as any other drug subject to the applicable copay or coinsurance depending on where you fill your prescription.

Preventive drugs, as defined by the Affordable Care Act (ACA), are covered at 100% with no cost to you. The CF Advantage PPO Plan offers an additional list of preventive medications where you pay the 10% coinsurance with the deductible waived.

If you have a question about the formulary list, contact a BCBSIL Health Advocate at 888-902-8293 or visit www.bcbsil.com. You can also visit Prime Therapeutics directly at www.myprime.com.

Prescription Drug Coverage
The Plan starts paying prescription drug benefits after you meet the plan deductible.

Feature/Type of Care	Blue Cross Blue Shield of Illinois	
	In-Network	**Out-of-Network***
Prescription Drugs		
Retail — up to 34-day supply	Plan pays 90% after deductible	Plan pays 70% after deductible
Retail (at Prime's Extended Supply Network Pharmacies) — 35-day to 90-day supply	Plan pays 90% after deductible	Plan pays 70% after deductible
Mail Order — 90-day supply	Plan pays 90% after deductible	Plan pays 70% after deductible
Lifetime Maximum Benefits	Unlimited NA	

** When using an out-of-network pharmacy, you will have to pay for the full cost of your medication up front and will then have to submit a prescription drug claim form to BCBSIL to get reimbursed.*

What is an Extended Supply Network Pharmacy? Most retail pharmacies can only fill up to a 30-day supply of medicine. An extended supply network pharmacy can fill up to a 90-day supply of maintenance medications. These are usually medicines that you take every day to treat a chronic condition like high blood pressure or cholesterol, or for preventative purposes.

Prescription Drug Programs

Prior Authorization
Prior authorization is required for certain drugs. This means that your doctor will need to submit a prior authorization request for coverage of these medications and the request will need to be approved before the medication will be covered under the plan.

Dispensing Limits
Drug dispensing limits are designed to help encourage medication use as intended by the FDA. Coverage limits are placed on medications in certain drug categories. If you require a prescription in excess of the dispensing limit, ask your health care provider to submit a request for clinical review on your behalf. The request will be approved or denied after evaluation of the submitted clinical information. If Medically Necessary criteria is not met, you will be responsible for the full cost of the prescription beyond what your coverage allows.

Day Supply
The prescribed day supply must be medically necessary and must not exceed the maximum day supply limitation in order to be eligible for coverage.

Specialty Medications Program

Specialty medicines are used to treat chronic, complex or rare conditions. Specialty medicines may:

- Be given by infusion (intravenously), injection or taken orally
- Cost more than traditional medicines
- Have special storage and handling requirements
- Need to be taken on a strict schedule

If you are prescribed a specialty medication, you will be notified by Prime Therapeutics about its specialty medications program through Accredo.

Accredo is a specialty pharmacy with experienced, specialty-trained pharmacists and patient care advocates who understand the complexities of your condition and are available to offer you personalized, one-on-one support.

You can call a Patient Care Advocate at 833-721-1619 anytime day or night. The Patient Care Advocate can:

- Help arrange reliable, on-time medicine delivery.
- Provide you with valuable information to help you stay on track with your therapy.
- Help you manage any side effects that you may feel.
- Help you with insurance issues.
- Work with you to find options if you need financial assistance.
-

Receiving Specialty Medications

Since many specialty drugs have unique shipping or handling needs, shipments will be arranged with you through Accredo. Medications are shipped in plain, secure, tamper-evident packaging. Before your scheduled fill date, you will be contacted to:

- Confirm your drugs, dose and the delivery location
- Check any prescription changes your doctor may have ordered
- Discuss any changes in your condition or answer any questions about your health

Step Therapy

Step therapy helps lower costs through safe, less expensive drugs. This program uses a “step” approach with drugs for certain conditions. This means that you may have to first try a safe, lower-cost drug, or one that may be more clinically effective, before “stepping up” to a different drug.

When you or your doctor sends a prescription to the pharmacy, the pharmacist will enter it into the system. If the drug you have been prescribed has a utilization management program attached to it, the pharmacist will get an alert about the program type and will let you know the next steps. If you have questions you can call a Health Advocate Specialist at 888-902-8293

Requesting Out-of-Network Prescription Drug Benefits

When you fill a prescription out-of-network, you will have to pay for the full cost of your medication up front and will then have to submit a prescription drug claim form to BCBSIL to get reimbursed.

The CF Standard PPO Plan

Under the CF Standard PPO Plan, you can choose physicians, hospitals and other approved medical providers from the Blue Cross Blue Shield Participating Provider Organization (PPO) network. You may also choose any physician out of the network. However, when you use an in-network physician, you receive higher benefits.

Covered Services

The following chart summarizes the expenses covered and any benefit limits for the CF Standard PPO Plan. Benefit payments are based on the Maximum Allowable Charge.

Covered Service	Network	Out-of-Network
Office Visits (physicians & specialists)	Plan pays 90% after deductible	Plan pays 70% after deductible
Preventive Immunizations (routine)	Plan pays 100%, no deductible	Plan pays 70% after deductible

Feature/Type of Care	Blue Cross Blue Shield of Illinois	
	In-Network	**Out-of-Network***
Calendar-Year Deductible (does not include copays)	$1,000 per individual; $2,000 per family	$2,000 per individual; $4,000 per family
Calendar-Year Out-of-Pocket Maximum (includes medical copays)	$2,500 per individual; $5,000 per family	$5,000 per individual; $10,000 per family
Well Adult Care • Routine physical exam	Plan pays 100%, no deductible	Plan pays 70% after deductible
Routine Mammograms	Plan pays 100%, no deductible	Plan pays 70% after deductible
Routine Ob/Gyn Exam (includes one Pap smear and related lab fees)	Plan pays 100%, no deductible	Plan pays 70% after deductible
Routine Prostate Screening • PSA and DRE for men	Plan pays 100%, no deductible	Plan pays 70% after deductible
Allergy Shots / Treatments	Plan pays 90% after deductible	Plan pays 70% after deductible
Inpatient Hospitalization**	Plan pays 90% after deductible	Plan pays 70% after deductible
Inpatient Physician Services*	Plan pays 90% after deductible	Plan pays 70% after deductible
Bariatric Surgery	Plan pays 90% after deductible	Plan pays 70% after deductible
Emergency Room**	Plan pays 90% after deductible	Plan pays 90% after deductible
Non-emergency Use of Emergency Room	Not covered	Not covered

Ambulance Service	Plan pays 90% after deductible	Plan pays 90% after deductible
Feature/Type of Care	**Blue Cross Blue Shield of Illinois**	
	In-Network	**Out-of-network***
Urgent Care Center Visit	Plan pays 90% after deductible	Plan pays 70% after deductible
Non-urgent Use of Urgent Care Center	Not covered	Not covered
Walk-in Clinic	Plan pays 90% after deductible	Plan pays 70% after deductible
Outpatient Facility*	Plan pays 90% after deductible	Plan pays 70% after deductible
Outpatient Surgery*	Plan pays 90% after deductible	Plan pays 70% after deductible
Outpatient X-Rays and Labs*	Plan pays 90% after deductible	Plan pays 70% after deductible
Second Surgical Opinion	Plan pays 90%, no deductible	Plan pays 70% no deductible
Private Duty Nursing** (limit 120 8-hour shifts per calendar year)	Plan pays 90% after deductible	Plan pays 70% after deductible
Physical Therapy (limit 45 visits per calendar year)	Plan pays 90% after deductible	Plan pays 70% after deductible
Occupational Therapy (limit 70 visits per calendar year)	Plan pays 90% after deductible	Plan pays 70% after deductible
Covered Service	**In-Network**	**Out-of-Network**
Speech Therapy (limit per calendar year is 30 visits; additional 20 visits for treatment of pervasive developmental disorders)	Plan pays 90% after deductible	Plan pays 70% after deductible
Chiropractic Care (Manipulation maximum benefit of 30 visits per calendar year)	Plan pays 90% after deductible	Plan pays 70% after deductible
Contraceptive Devices and Injectables (provided and billed by a physician — includes office visit, insertion/administration)	Plan pays 100%, no deductible	Plan pays 70% after deductible
Infertility Treatment (certain limits apply)	Plan pays 90% after deductible	Plan pays 70% after deductible
Abortion(where permitted by law)	Plan pays 90% after deductible	Plan pays 70% after deductible

Covered Service	In-Network	Out-of-Network
Voluntary Sterilization — men	Plan pays 90% after deductible	Plan pays 70% after deductible
Hospice Care** (must have a terminal illness with a life expectancy of one year or less)	Plan pays 90% after deductible	Plan pays 70% after deductible
Skilled Nursing Facility (120 days per calendar year)	Plan pays 90% after deductible	Plan pays 70% after deductible
Home Health Care (120 visits per calendar year)	Plan pays 90% after deductible	Plan pays 70% after deductible
Durable Medical Equipment	Plan pays 90% after deductible	Plan pays 70% after deductible
Foot Orthotics (one pair per year)	Plan pays 90% after deductible	Plan pays 70% after deductible
Transplants (for certain human organ transplants)	Plan pays 90% after deductible	Plan pays 70% after deductible
Mental Health/Chemical Dependency • Inpatient**	Plan pays 90% after deductible	Plan pays 70% after deductible
• Outpatient	Plan pays 90% after deductible	Plan pays 70% after deductible
Temporomandibular Joint Dysfunction (TMJ)	Plan pays 90% after deductible	Plan pays 70% after deductible
Oral Surgery (see Oral Benefits)	Plan pays 90% after deductible	Plan pays 70% after deductible
Routine Eye Exams (once per calendar year)	Plan pays 90%, no deductible	Plan pays 70%, after deductible
Routine Hearing Care Exams (once per calendar year) **Hearing Aids** (maximum $5000 per calendar year)	Plan pays 90%, after deductible Plan pays 90% after deductible	Plan pays 70%, after deductible Plan pays 70% after deductible
Diabetic Supplies	Plan pays 90% after deductible	Plan pays 70% after deductible
Autism Spectrum Disorders (psychiatric care, habilitative or rehabilitative treatment, and/or therapeutic care)	Plan pays 90% after deductible	Plan pays 70% after deductible

Hearing Aids (maximum $5,000 per calendar year)	Plan pays 90% after deductible	Plan pays 70% after deductible

** If the facility or attending physician is in the network, the "ologist" (i.e., anesthesiologist,) is paid at the network level, regardless of whether or not the "ologist" is a network member.*

*** Precertification is required. You and/or your physician must pre-certify if using an out-of-network provider. Room allowance based on hospital's most common semi-private room rates.*

For more information on specific covered services, see Additional Coverage Details and Limits or you may obtain a copy of the BCBS Booklet for the Standard PPO Plan (248035 online at www.BCBSIL.com

Prescription Drugs
Prescription drug coverage is administered by Prime Therapeutics, a BCBSIL partner. The network-based prescription drug program uses a list of preferred medications called a "formulary." There are three tiers on the formulary:

- **Generic medications:** Your prescriptions are filled with generic drugs unless your physician indicates that substitutions are not allowed. Generic drugs are essentially equivalent to the brand-name drug for all the active ingredients.
- **Preferred brand medications:** In general, these drugs do not yet have a generic equivalent, but may in the future.
- **Non-preferred brands:** Some non-preferred brands may be covered on the Prime Therapeutics formulary list. Those medications not on the list will not be covered by the plan.

Note: Coverage for contraceptives and self-injectables are the same as any other drug subject to the applicable copay or coinsurance depending on where you fill your prescription.

Preventive drugs, as defined by the Affordable Care Act (ACA), are covered at 100% with no cost to you.

If you have a question about the formulary list, contact a BCBSIL Health Advocate at 888-902-8293 or visit www.bcbsil.com. You can also visit Prime Therapeutics directly at www.myprime.com.

Prescription Drug Network Copayments
The Plan starts paying network prescription drug benefits after you pay a flat dollar amount called the copayment (or copay).

Feature/Type of Care	Prime Therapeutics	
	In-Network	**Out-of-Network***
Prescription Drugs		
Retail — up to 34-day supply	You pay: • $10 Generic • $40 Formulary • $55 Non-Formulary	You pay 30%
Retail — 35-day to 90-day supply	You pay: • $20 Generic • $110 Formulary • $155 Non-Formulary	You pay 30%
Mail Order — 90-day supply	You pay: • $10 Generic • $75 Formulary • $105 Non-Formulary	You pay 30%
Lifetime Maximum Benefits	Unlimited	

	NA

** When using an out-of-network pharmacy, you will have to pay for the full cost of your medication up front and will then have to submit a prescription drug claim form to BCBSIL to get reimbursed.*

What is an Extended Supply Network Pharmacy? Most retail pharmacies can only fill up to a 30-day supply of medicine. An extended supply network pharmacy can fill up to a 90-day supply of maintenance medications. These are usually medicines that you take every day to treat a chronic condition like high blood pressure or cholesterol, or for preventative purposes.

Prescription Drug Programs

Prior Authorization
Prior authorization is required for certain drugs. This means that your doctor will need to submit a prior authorization request for coverage of these medications and the request will need to be approved before the medication will be covered under the plan.

Dispensing Limits
Drug dispensing limits are designed to help encourage medication use as intended by the FDA. Coverage limits are placed on medications in certain drug categories. If you require a prescription in excess of the dispensing limit, ask your health care provider to submit a request for clinical review on your behalf. The request will be approved or denied after evaluation of the submitted clinical information. If Medically Necessary criteria is not met, you will be responsible for the full cost of the prescription beyond what your coverage allows.

Day Supply
The prescribed day supply must be medically necessary and must not exceed the maximum day supply limitation in order to be eligible for coverage.

Specialty Medications Program
Specialty medicines are used to treat chronic, complex or rare conditions. Specialty medicines may:

- Be given by infusion (intravenously), injection or taken orally
- Cost more than traditional medicines
- Have special storage and handling requirements
- Need to be taken on a strict schedule

If you are prescribed a specialty medication, you will be notified by Prime Therapeutics about its specialty medications program through Accredo.

Accredo is a specialty pharmacy with experienced, specialty-trained pharmacists and patient care advocates who understand the complexities of your condition and are available to offer you personalized, one-on-one support.

You can call a Patient Care Advocate at 833-721-1619 anytime day or night. The Patient Care Advocate can:

- Help arrange reliable, on-time medicine delivery.
- Provide you with valuable information to help you stay on track with your therapy.
- Help you manage any side effects that you may feel.
- Help you with insurance issues.
- Work with you to find options if you need financial assistance.
-

Receiving Specialty Medications

Since many specialty drugs have unique shipping or handling needs, shipments will be arranged with you through Accredo. Medications are shipped in plain, secure, tamper-evident packaging. Before your scheduled fill date, you will be contacted to:

- Confirm your drugs, dose and the delivery location
- Check any prescription changes your doctor may have ordered
- Discuss any changes in your condition or answer any questions about your health

Step Therapy

Step therapy helps lower costs through safe, less expensive drugs. This program uses a "step" approach with drugs for certain conditions. This means that you may have to first try a safe, lower-cost drug, or one that may be more clinically effective, before "stepping up" to a different drug.

When you or your doctor sends a prescription to the pharmacy, the pharmacist will enter it into the system. If the drug you have been prescribed has a utilization management program attached to it, the pharmacist will get an alert about the program type and will let you know the next steps. If you have questions you can call a Health Advocate Specialist at 888-902-8293

Requesting Out-of-Network Prescription Drug Benefits

When you fill a prescription out-of-network, you will have to pay for the full cost of your medication up front and will then have to submit a prescription drug claim form to BCBSIL to get reimbursed.

Additional Coverage Details and Limits

This section describes additional coverage details or restrictions that apply to both the **CF Advantage PPO Plan** and the **CF Standard PPO Plan** options. Among the benefits included are:

- Wellness care
- Hearing exam
- Vision care
- Coverage while traveling internationally
- Cardiac rehabilitation services
- Oral (dental) benefits

- Maternity benefits
- Infertility
- Bariatric Surgery
- Human organ transplants
- The National Medical Excellence Program
- Short-term Rehabilitation (Physical, Occupational and Speech Therapy)
- Hospice care
- Home Health Care
- Skilled Nursing Facility
- Experimental or Investigational Services

Wellness Care
These preventive care services are covered:

The Plan covers charges for routine physical exams. Included as part of the exam are:
- X-rays, laboratory services and other tests given in connection with the exam.
- Immunizations for infectious diseases and the materials needed to administer the immunizations.
- Testing for tuberculosis.

The exam must be given by a physician or under the direction of a physician.

If an exam is given to diagnose or treat a suspected or identified injury or disease, it is not considered a routine physical exam.

The Plan does not pay benefits for school or employment-related exams, or for those needed to take part in school athletic programs.

The following are not covered as part of a routine physical exam:
- Medicines, drugs, appliances, equipment or supplies
- Immunizations required solely for travel or employment
- Psychiatric, psychological, personality, or emotional testing or exams
- Premarital exams

Screening and Counseling Services
The Plan covers charges made by your primary care physician for the following in an individual or group setting:
- Screening and counseling services to help you lose weight if you are obese.
- Tobacco use screening and cessation interventions for tobacco users.
- Unhealthy alcohol use screening and counseling.

The Plan's preventive care coverage includes the following services for women:
Screening and counseling services for:
- Interpersonal and domestic violence;

- Sexually transmitted diseases; and
- Human Immune Deficiency Virus (HIV).
- High risk Human Papillomavirus (HPV) DNA testing for women age 30 and older.
- Genetic counseling and BRCA (breast cancer) testing.
- Screening for gestational diabetes.

Routine Cancer Screenings
The Plan covers the following without age or frequency limits:

- Mammograms for women.
- Colorectal cancer screening for adults over age 50
- Digital rectal exam (DRE) and prostate specific antigen (PSA) for men.

Routine Ob/Gyn Exams
The Plan covers one annual routine ob/gyn exam, including one Pap smear and related laboratory fees.

Hearing Exam
The plan covers benefits for a routine hearing examination at 100% (for in-network services) of the Maximum Allowable Charge per calendar year and your program deductible will not apply

Benefits for hearing care, other than a routine hearing examination, are covered once every calendar year. Coverage for hearing aids is provided up to a maximum of $5,000 person per calendar year. Refer to the Covered Services table for applicable coverage levels.

Vision Care
The Medical Plan covers one routine eye exam per calendar year for you and your dependents. Refer to the Covered Services Chart for the coverage level that applies to your plan.

Coverage While Traveling Internationally

Blue Cross Blue Shield Global® Core

If you are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard service area"), you may be able to take advantage of Blue Cross Blue Shield Global Core when accessing Covered Services. Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although Blue Cross Blue Shield Global Core assists you with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when you receive care from providers outside the BlueCard service area, you will typically have to pay the providers and submit the claims yourself to obtain reimbursement for these services.

If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, you should call the service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

Inpatient Services

In most cases, if you contact the service center for assistance, hospitals will not require you to pay for covered inpatient services, except for your cost-share amounts/deductibles, coinsurance, etc. In such cases, the hospital will submit your claims to the service center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for covered services. You must contact the claim administrator to obtain preauthorization for non-emergency inpatient services.

Outpatient Services

Outpatient Services are available for emergency care, physicians, urgent care centers and other outpatient providers located outside the BlueCard service area. They will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for covered services.

Submitting a Blue Cross Blue Shield Global Core Claim

When you pay for covered services outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a Blue Cross Blue Shield Global Core International claim form and send the claim form with the provider's itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from the claim administrator, the service center online at www.bcbsglobalcore.com. If you need assistance with your claim submission, you should call the service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week.

To learn more about Blue Cross Blue Shield Global Core:

- Visit www.bcbsglobalcore.com.
- Use the Blue Cross Blue Shield Global Core app for Android*, iPhone, and iPod touch. (Rates from your wireless provider may apply).
- Call your BCBS company.
- Call the Service Center at 1.800.810.2583 or collect at 1.804.673.1177, 24 hours a day, seven days a week.

Cardiac and Pulmonary Rehabilitation Services

The Plan covers:

- Outpatient cardiac rehabilitation following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction. The services must be part of a treatment plan based on your risk level and recommended by your physician.
- Outpatient pulmonary rehabilitation to treat reversible pulmonary disease.

Oral Benefits (Oral Surgery)

While the CF Industries' Dental Plan covers basic dental services, the Medical Plan covers other mouth- related health services. Medical Plan coverage for oral surgery is limited to the following:

- Surgical removal of complete bony impacted teeth;
- Excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and
- Floor of the mouth;
- Surgical procedures to correct accidental injuries of the jaws, cheeks,
- Lips, tongue, roof and floor of the mouth and;
- Excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bone; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation of, or excision of, the temporomandibular joints.

The following services are also part of your surgical benefits:

- Anesthesia Services — if administered at the same time as a covered surgical procedure in a Hospital or Ambulatory Surgical Facility or by a Physician other than the operating surgeon or by a Certified Registered Nurse Anesthetist. However, benefits will be provided for anesthesia services administered by oral and maxillofacial surgeons when such services are rendered in the surgeon's office or Ambulatory Surgical Facility.

In addition, benefits will be provided for anesthesia administered in connection with dental care treatment rendered in a Hospital or Ambulatory Surgical Facility if (a) a child is age 6 and under, (b) you have a chronic disability, or (c) you have a medical condition requiring hospitalization or general anesthesia for dental care.

Except as described above, the Plan does **not** cover charges:

- For dental-in-nature oral surgery expenses;
- For in-mouth appliances, crowns, bridgework, dentures, tooth restorations, or any related fitting or adjustment services, whether or not the purpose of those services or supplies is to relieve pain;
- For root canal therapy;
- To remove, repair, replace, restore or reposition teeth lost or damaged in the course of biting or chewing;
- To repair, replace or restore fillings, crowns, dentures or bridgework;
- For dental cleaning, in-mouth scaling, planning or scraping; or
- For myofunctional therapy. This is muscle training therapy or training to correct or control harmful habits.

Maternity Benefits

The Plan covers prenatal, delivery and postnatal maternity care. In accordance with the Newborns' and Mothers' Health Protection Act, the Plan covers inpatient care of the mother and newborn child for a minimum of:

- 48 hours after a vaginal delivery; and
- 96 hours after a cesarean section.

If you and your attending physician agree to an earlier discharge from the hospital, the Plan will pay for one post-delivery home visit by a health care provider.

Precertification is not required for the first 48 hours of hospital confinement after a vaginal delivery or 96 hours after a cesarean delivery. Any days of confinement over these limits must be precertified according to the Plan's regular precertification requirements.

The Plan does not cover home births. This is childbirth that takes place outside a hospital or birthing center, or in a place that is not licensed to perform deliveries.

Birthing Center

The Plan covers prenatal, delivery and postnatal maternity care provided by a birthing center. Postnatal care must be given within 48 hours after a vaginal delivery, or 96 hours after a cesarean section.

Breast Feeding Support, Counseling and Supplies

The Plan covers:

- Breast feeding assistance, training and counseling services by a certified lactation support provider in a group or individual setting.
- Initial purchase of a standard (not hospital-grade) electric breast pump or manual breast pump during pregnancy or while breast feeding.
- Purchase of the accessories needed to operate the breast pump.
- For each subsequent pregnancy:
    - Purchase of a replacement manual breast pump.
    - Purchase of a replacement standard electric breast pump, if:
        - You have not purchased a standard electric pump within the past three years; or
        - The initial electric pump is broken or out of warranty.
- Purchase of a new set of breast pump supplies.

If the newborn child needs treatment for an illness or injury, benefits will be available for that care — provided you add the newborn child to your coverage. You may enroll the child in the CF Industries Medical Plan within 31 days of the date of the baby's birth and coverage will then be effective from the date of birth. If you do not enroll your child within 31 days of birth, the child cannot be enrolled until the next annual enrollment period.

Infertility

Infertility

Means a disease, condition, or status characterized by:
1. The inability to conceive a child or to carry a pregnancy to live birth after one year of regular unprotected sexual intercourse for a woman 35 years of age or younger, or after 6 months for a woman over 35 years of age (conceiving but having a miscarriage does not restart the 12 month or 6-month term for determining Infertility);
2. A person's inability to reproduce either as a single individual or with a partner without medical intervention; or
3. A licensed Physician's findings based on a patient's medical, sexual, and reproductive history, age, physical findings, or diagnostic testing.

Infertility Treatment

Benefits will be provided the same as your benefits for any other condition for Covered Services rendered in connection with the diagnosis and/or treatment of Infertility, including, but not limited to, in-vitro fertilization, uterine embryo lavage, embryo transfer, six artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer and intracytoplasmic sperm injection.

Infertility means a disease, condition, or status characterized by;
1. The inability to conceive a child or to carry a pregnancy to live birth after one year of regular unprotected sexual intercourse for a woman 35 years of age or younger, or after 6 months for a woman over 35 years of age (conceiving but having a miscarriage does not restart the 12 month or 6-month term for determining Infertility);
2. A person's inability to reproduce either as a single individual or with a partner without medical intervention; or
3. A licensed Physician's findings based on a patient's medical, sexual, and reproductive history, age, physical findings, or diagnostic testing.

Unprotected sexual intercourse means sexual union between a male and female without the use of any process, device or method that prevents conception including, but not limited to, oral contraceptives, chemicals, physical or barrier contraceptives, natural abstinence or voluntary permanent surgical procedures and includes appropriate measures to ensure the health and safety of sexual partners.

Benefits for treatments that include oocyte retrievals will be provided only when you have been unable to attain or maintain a viable pregnancy or sustain a successful pregnancy through reasonable, less costly medically appropriate Infertility treatments; however, this requirement will be waived if you or your partner has a medical condition that renders such treatment useless. Benefits for treatments that include oocyte retrievals are limited to a lifetime maximum of six (6) completed oocyte retrievals, except that if a live birth follows a completed oocyte retrieval, then two more completed oocyte retrievals shall be covered.

Benefits will also be provided for medical expenses of an oocyte or sperm donor for procedures used to retrieve oocytes or sperm and the subsequent procedure to transfer the oocytes or sperm to you. Associated donor medical expenses are also covered, including, but not limited to, physical examinations, laboratory screenings, psychological screenings, and prescription drugs.

If an oocyte donor is used, then the completed oocyte retrieval performed on the donor shall count as one completed oocyte retrieval.
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Special Limitations
Benefits will not be provided for the following:
1. Services or supplies rendered to a surrogate, except those costs for procedures to obtain eggs, sperm, or embryos from you will be covered if you choose to use a surrogate.

2. Expenses incurred for cryo-preservation or storage of sperm, eggs, or embryos, except for those procedures which use a cryo-preserved substance.

3. Non-medical costs of an egg or sperm donor.

4. Infertility treatments which are deemed Investigational, in writing, by the American Society for Reproductive Medicine or the American College of Obstetricians or Gynecologists.

6. Infertility treatment rendered to your dependents under age 18.

In addition to the above provisions, in-vitro fertilization, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer and intracytoplasmic sperm injection procedures must be performed at medical facilities that conform to the American College of Obstetricians and Gynecologists guidelines for in-vitro fertilization clinics or to the American Society for Reproductive Medicine minimal standards for programs of in-vitro fertilization.

Bariatric Surgery
The plan covers inpatient or outpatient charges made by a hospital or physician for the medically necessary surgical treatment of morbid obesity.
Note: the plan does not cover bariatric surgery done for cosmetic reasons.

Human Organ Transplants

Your plan benefits for certain human organ transplants are the same as your benefits for any other condition. Benefits will be provided only for cornea, kidney, bone marrow, heart valve, muscular-skeletal, parathyroid, heart, lung, heart/lung, liver, pancreas or pancreas/kidney human organ or tissue transplants. Benefits are available to both the recipient and donor of a covered transplant as follows:

- If both the donor and recipient have coverage each will have their benefits paid by their own program.
- If you are the recipient of the transplant, and the donor for the transplant has no coverage from any other source, the benefits described in this benefit booklet will be provided for both you and the donor. In this case, payments made for the donor will be charged against your benefits.
    - If you are the donor for the transplant and no coverage is available to you from any other source, the benefits described in this benefit booklet will be provided for you. However, no benefits will be provided for the recipient.

Benefits will be provided for:

- Inpatient and outpatient covered services related to the transplant surgery;
- The evaluation, preparation, and delivery of the donor organ;
- The removal of the organ from the donor;
- The transportation of the donor organ to the location of the transplant surgery. Benefits will be limited to the transportation of the donor organ in the United States or Canada.

In addition to the above provisions, benefits for heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplants will be provided as follows:

- Whenever a heart, lung, heart / lung, liver, pancreas, or pancreas/kidney transplant is recommended by your Physician, you must contact the claim administrator by telephone before your transplant Surgery has been scheduled. The claim administrator will furnish you with the names of Hospitals which have Claim Administrator approved Human Organ Transplant Programs. No benefits will be provided for heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplants performed at any Hospital that does not have a claim administrator approved Human Organ Transplant Program.
- If you are the recipient of the transplant, benefits will be provided for transportation and lodging for you and a companion. If the recipient of the transplant is a dependent child under the limiting age of this benefit booklet, benefits for transportation and lodging will be provided for the transplant recipient and two companions. For benefits to be available, your place of residency must be more than 50 miles from the hospital where the transplant will be performed.
- Benefits for transportation and lodging are limited to a combined lifetime maximum of $10,000. The maximum amount that will be provided for lodging is $50 per person per day.
- In addition to the other exclusions of this benefit booklet, benefits will not be provided for the following:
    - Cardiac rehabilitation services when not provided to the transplant recipient immediately following discharge from a Hospital for transplant surgery.
    - Travel time and related expenses required by a provider.
    - Drugs which do not have approval of the Food and Drug Administration.
    - Storage fees.
    - Services provided to any individual who is not the recipient or actual donor, unless otherwise specified in this provision.
    - Meals.

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Short-term Rehabilitation (Physical, Occupational and Speech Therapy)

Physical Therapy
Benefits will be provided for Physical Therapy when rendered by a licensed professional Physical Therapist; provided, however, when the therapy is beyond the scope of the Physical Therapist's license, the Physical Therapist must be under the supervision of a Physician, and the therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and the Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals.

Occupational Therapy
Benefits will be provided for occupational therapy when these services are rendered by a registered occupational therapist under the supervision of a physician. This therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals.

Speech Therapy
Benefits will be provided for speech therapy when these services are rendered by a licensed speech therapist or speech therapist certified by the American Speech and Hearing Association. Inpatient Speech Therapy benefits will be provided only if Speech Therapy is not the only reason for admission.

The plan limits benefits for physical, occupational and speech therapy to the maximums shown in the Covered Services Charts. Note: benefits will be provided for an additional 20 visits for speech therapy for treatment of pervasive developmental disorders.

Hospice Care
The plan covers hospice care benefits for a person who is terminally ill. Charges from a hospice facility, hospital or skilled nursing facility are covered under inpatient hospital benefits.

Program Services described below are covered when these services are rendered to you by a hospice care program provider.

- Coordinated Home Care;
- Medical supplies and dressings;
- Medication;
- Nursing Services - Skilled and non-Skilled;
- Occupational Therapy;
- Pain management services;
- Physical Therapy;
- Physician visits;
- Social and spiritual services;
- Respite Care Service.

The following services are not covered under hospice care:

- Durable medical equipment;
- Home delivered meals;
- Homemaker services;
- Traditional medical services provided for the direct care of the terminal illness, disease or condition;
- Transportation, including, but not limited to, Ambulance Transportation.

Home Health Care
The Plan covers home health care services when ordered by a physician and given to you under a home health care plan while you are homebound. Coverage includes:

- Part-time nursing care that requires the medical training of, and is given by, an RN or by an LPN if an RN is not available. The services must be provided during intermittent visits of four hours or less.
- Part-time home health aide services, when provided in conjunction with, and in direct support of, care by an RN or LPN. The services must be provided during intermittent visits of four hours or less.
- Medical social services by a qualified social worker, when provided in conjunction with, and in direct support of, care by an RN or LPN.
- Medical supplies, prescription drugs and lab services given by (or for) a home health care agency. Coverage is limited to what would have been covered if you had remained in a hospital.

Skilled Nursing Facility
The Plan covers charges made by a skilled nursing facility during an inpatient stay, up to the maximum shown in Covered Services Chart, including:

- Room and board charges, up to the semi-private room rate. The Plan covers up to the private room rate if it is appropriate because of an infectious illness or a weak or compromised immune system.
- General nursing services.
- Use of special treatment rooms.
- Radiology services and lab work.
- Oxygen and other gas therapy.

Experimental or Investigational Services
In general, the Plan does not cover drugs, devices, treatments or procedures that are experimental or investigational. There are, however, some situations where the Plan will cover a drug, device, treatment or procedure that would otherwise be considered experimental or investigational.

Benefits will be provided for routine patient care in conjunction with experimental/investigational treatments when medically appropriate and you have cancer or a terminal condition that according to the diagnosis of your physician is considered life threatening, if a) you are a qualified individual participating in an approved clinical trial program; and b) if those services or supplies would otherwise be covered under this benefit booklet if not provided in connection with an approved clinical trial program. You and/or your physician are encouraged to call a BCBSIL Health Advocate at the toll-free number on your identification card in advance to obtain information about whether a particular clinical trial is qualified.

What's Not Covered by the Medical Plan
Some services and supplies are not covered by the Medical Plan as follows:

- That do not meet accepted standards of medical and/or dental practices; or are not considered necessary as determined by the claims administrator;
- From employment covered under any Workers' Compensation law or other similar laws whether or not you make a claim for such compensation or receive benefits;
- That are furnished by or available from the local, state or federal government (e.g., Medicare) whether or not they are received;
- Occurring on or after your coverage date as a result of war or an act of war;
- That are investigational, other than as described in this booklet;
- Custodial care, long term care and inpatient private duty nursing;
- Respite care service, except as covered as part of Hospice benefits;
- Received during an inpatient stay primarily related to behavioral, social maladjustment, lack of discipline or other antisocial actions that are not the result of mental illness;
- Cosmetic surgery, except for the correction of congenital deformities or for conditions resulting from accidental injuries, scars, tumors or diseases;
- You're not required to pay for or you've no legal obligation to pay if you didn't have this coverage;
- Charges for failure to keep a scheduled visit or to complete a claim form;

- Personal hygiene, comfort or convenience items commonly used for other than medical purposes such as air conditioners, humidifiers, physical fitness equipment, televisions and telephones;
- Special braces, splints, specialized equipment, appliances, ambulatory apparatus, battery implants, except as specifically mentioned in this Plan;
- Blood derivatives which are not classified as drugs in the official formularies;
- Eyeglasses, contact lenses or cataract lenses, except as specifically mentioned in this Medical Plan;
- For flat foot conditions and the prescription of related supportive devices; and subluxations of the foot;
- Routine foot care, unless diagnosed with diabetes;
- Immunizations, unless otherwise specified in this Plan;
- Maintenance occupational, physical and/or speech therapy; and maintenance care;
- Speech therapy for psychosocial speech delay, behavioral problems (including impulsive behavior and impulsivity syndrome), attention disorder, conceptual handicap or mental retardation;
- Wigs (also referred to as cranial prostheses), unless the wig or hairpiece is prescribed by a physician as a prosthetic for hair loss due to injury, disease, or treatment of a disease;
- Duplicated because the dependent is a CF Industries employee covered separately under this Plan;
- Diagnostic service as part of routine physical exams or check-ups, premarital exams, determination of the refractive errors of the eyes, auditory problems, surveys, case finding, research studies, screening or similar procedures and studies or tests which are investigational unless otherwise specified in this Plan;
- Procurement or use of prosthetic devices, special appliances and surgical implants for cosmetic purposes, your comfort and convenience, or unrelated to the treatment of a disease or injury;
- For human organ or tissue transplants other than those specifically named in this Plan;
- Reversal of elective sterilizations.

Requesting Medical Plan Benefits
In order to obtain your benefits under this benefit program, it is necessary for a claim to be filed with the claims administrator. To file a claim, usually all you will have to do is show your identification card to your hospital or physician (or other provider). They will file your claim for you. Remember however, it is your responsibility to ensure that the necessary claim information has been provided to the claim administrator.

Once the claim administrator receives your claim, it will be processed and the benefit payment will usually be sent directly to the hospital or physician. You will receive a statement telling you how your benefits were calculated. In some cases the claim administrator will send the payment directly to you or if applicable, in the case of a Qualified Medical Child Support Order, to the designated representative as it appears on the claim administrator's records.

In certain situations, you will have to file your own claims. This is primarily true when you are receiving services or supplies from providers other than a hospital or physician. An example would be when you have had ambulance expenses. To file your own Claim, follow these instructions:

- Complete a BCBSIL claim form. These are available from your Human Resources Department or from the claim administrator.
- Attach copies of all bills to be considered for benefits. These bills must include the provider's name and address, the patient's name, the diagnosis, the date of service and a description of the service and the claim charge.
- Mail the completed claim form with attachments to:

Blue Cross and Blue Shield of Illinois
P. O. Box 805107
Chicago, Illinois 60680-4112

In any case, claims should be filed with the claim administrator on or before December 31st of the calendar year following the year in which your covered service was rendered. (A covered service furnished in the last month of a particular calendar year shall be considered to have been furnished the succeeding calendar year.) Claims not filed within the required time period will not be eligible for payment.

Should you have any questions about filing claims, contact a BCBSIL Health Advocate for assistance by calling the phone number listed on your ID card.

See Claim Denials and Appeals for information on how to appeal a denied claim. Additional detailed information is available in the BCBS Booklet. The booklet is available online at **www.BCBSIL.com,** under Coverage / Coverage and Benefits/ Benefit Highlights.

Well-Being Program
Strive is CF's well-being program, designed to help you and your spouse (covered under a CF Medical plan), reach for greater possibilities. Whether your well-being goals are physical, financial, emotional, or work related, Strive can help you get where you want to be.

Our Strive program has an online portal through our well-being partner, Propel. Once you create your user profile and complete your Well-Being Assessment, the portal becomes personalized for you based on your participation and your interests. Strive then offers you activities, suggestions, and tools aligned with your interests that can help you reach your goals.

Access Strive from any desktop computer or mobile device to update and track your progress, try new activities, or check in with your social network. Visit Strive | CF Industries Total Rewards United States (cftotalrewards.com)to get started. ,

If you need help to register, log in, or reset your password, please contact us at 888.339.4131 or email: support@propelwellness.zendesk.com.

Your Rights and Protections Against Surprise Billing
Out-of-network providers may be permitted to bill you for the difference between what the Plan agreed to pay and the full amount charged for a service. This is called "balance billing." This amount will most likely be more than what the in-network cost would have been for the same service, and it also might not count toward your annual out-of-pocket limit. "Surprise billing" is an unexpected balance bill.

You are protected from balance billing in the following circumstances:

- **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 cannot be balance billed for these emergency services, or even services services you may receive once you are in stable condition, unless you give up your protections and provide written consent to be balance billed for these post-stabilization services.
- **Certain services at an in-network hospital or ambulatory surgical center:** If you receive services at an in-network hospital or ambulatory center where the provider is out-of-network, the most you may be billed is your plan's in-network cost-sharing amount. These providers cannot balance bill you and may not ask you to give up your protections not to be balance billed. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services.

You are never required to give up your protections from balance billing. You also are not required to get care out-of-network. You can choose a provider or facility in your plan's network. When balance billing is not allowed, you are only responsible for paying your share of the cost, such as copayments, coinsurance, and deductibles that you would pay if the provider or facility

was in-network. The Plan will pay out-of-network providers and facilities directly. Generally, the Plan must:

- Cover emergency services without requiring you to get approval for services in advance (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; and
- Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit. If you believe you have been wrongly billed, you may contact the **Federal No Surprises Helpdesk at 1-800-985-3059.**

DENTAL PLAN

Please Note: These summary plan descriptions reflect plans currently in effect. Any changes to benefit plans will be reflected in updated summary plan descriptions after those changes take effect.

An important part of proper health care is maintaining good dental health. CF Industries offers a Dental Plan that provides dental care for you and your eligible dependents. The Plan covers preventive care (e.g. cleanings) at 100% with no deductible. Restorative care (e.g. fillings, crowns) are covered at 80% or 50%, depending on the type of service, after the deductible has been met. Orthodontia is also covered for eligible dependent children (less than 19 years of age) up to the Plan limit, with no deductible.

The Dental Plan is flexible. You can visit any qualified dental care provider, but you will generally get the most for your money if you use a Total Cigna PPO Network provider. Network providers have agreed to accept predetermined fees that are typically lower than those charged by out-of-network providers.

For more information on the Plan, see:

Dental Plan Benefits at a Glance

Dental Plan Benefits	Network*	Out-of-Network*
Network	Total Cigna PPO Network www.myCIGNA.com 1-800-244-6224	NA
Deductible Does not apply to preventive/diagnostic services or orthodontia	$50 single / $150 family	$50 single / $150 family
Annual Maximum Benefit Does not apply to preventative/diagnostic services or orthodontia	$1,500 per person	$1,500 per person
Preventive/Diagnostic Services • Two exams and cleanings per calendar year • Two bitewing X-rays per calendar year • One panoramic X-ray every three calendar years • One fluoride treatment per calendar year (to age 19) • Sealants (to age 14; 1 treatment per tooth in any 3 calendar years) • Space maintainers (through age 19; for non-orthodontic treatment) • Non-routine X-rays • Emergency care to relieve pain	Plan pays: 100% (deductible does not apply) You pay: 0%	Plan pays: 100% (deductible does not apply) You pay: 0%

Dental Plan Benefits	Network*	Out-of-Network*
Basic Restorative Services and Implants • Fillings ("silver" and "white" non-molar fillings) • Endodontics (root canals) • Oral surgery (all extractions, including impacted teeth) • Periodontics (gum treatments) • Anesthesia • Implants	After you've met your deductible: Plan pays: 80% You pay: 20%	After you've met your deductible: Plan pays: 80% You pay: 20%
Major Restorative Services • Single crowns, inlays, onlays • Prosthodontics (bridges, dentures) • Relines, rebases and adjustments • Repairs: bridges, crowns, inlays and dentures	After you've met your deductible: Plan pays: 50% You pay: 50%	After you've met your deductible: Plan pays: 50% You pay: 50%
Orthodontia Coverage for eligible dependent children up to age 19	Plan pays: 50% You pay: 50%	Plan pays: 50% You pay: 50%
Orthodontia Lifetime Maximum (children & adults)	$2,000 per person	$2,000 per person
Reimbursements	Use your Dental ID card or provide your ID number to your dentist and they will file your claim for you	The out-of-network dentist may request full payment. A claim form must be submitted to CIGNA for reimbursement.

** Network and out-of-network benefits are combined.*

How Dental Benefits Work
Under the Dental Plan, you are free to receive dental services from any qualified dentist. However you generally receive the highest level of benefits and the deepest discounts when you use a Dental Network Provider. Plus, network providers file claims for you.

If you use an *out-of-network provider*, the Plan pays benefits only up to the maximum reimbursable charge (MRC). Also, if you use an out-of-network provider you may also be responsible for paying for services when you receive them and filing your own claim for reimbursement.

Under the Dental Plan you are responsible for paying the following:

- A Dental deductible — the amount ($50 per individual, $150 per family) you pay each calendar year before the Plan begins to pay benefits. (The deductible is not required for preventive, diagnostic and orthodontia services.)
- Dental coinsurance — the percentage of charges you pay under the Plan for covered services.
- Fees incurred in a calendar year after you have reached the Plan's annual maximum benefit.
- Orthodontia fees incurred after you have reached the Plan's orthodontia lifetime maximum benefit.
- Fees incurred for out-of-network services to the extent the fees are in excess of the maximum reimbursable charge.
- Fees for services not covered by the Plan.

The dental care services you receive and who provides them is always your choice.

Dental Network Providers

The Dental Plan uses the Total Cigna PPO Network of providers. You can save money when you receive care from network providers because:

- Network providers have agreed to accept predetermined fees for their services.
- Network providers charge fees that are typically lower than those charged by an out-of-network provider.
- Fees for network providers are always within the maximum reimbursable charge amount.

In addition, a network provider will submit the dental claim on your behalf. You will only be responsible for your portion of the claims at the time of service.

You can locate Total Cigna PPO Network providers through the online directory available at www.myCIGNA.com. To find a participating dentist:

- Click “Find cost and care” at the top of the page;
- Type “Dentist” in the search criteria

You can also call CIGNA at 1-800-244-6224 and use the automated Dental Office Locator or speak to a customer service representative for help locating a dentist or specialist.

Dental Out-of-Network Providers

Because out-of-network dentists do not necessarily charge the same fees that network dentists agree to charge, the benefits you receive when you see an out-of-network dentist are based on the lesser of the:

- Dentist’s actual charges; or
- Maximum reimbursable charge.

Out-of-network dentists usually cost you more because:

- Out-of-network dentists can charge more than CIGNA’s contracted fee, meaning you might receive fewer services before reaching your annual maximum benefit (the most the Plan pays in a year).
- Out-of-network dentists can charge you up to their full fees and you are responsible for all charges in excess of the maximum reimbursable charge.
- The out-of-network dentist may request full payment. A claim form must be submitted to CIGNA for reimbursement. Claim forms are available on the CF Total Rewards site or at www.mycigna.com.

Dental Deductible

For all services except preventive, diagnostic and orthodontia, you and each covered dependent must pay an amount each calendar year — called a deductible — before the Plan begins to pay benefits. There is only one annual deductible for both in-network and out-of-network covered expenses. Once you reach your annual deductible ($50 for individual, $150 for family), the Plan begins to pay a percentage of covered services, subject to certain limits. A new deductible applies each calendar year.

The following charges do **not** count toward your annual deductible:

- Charges above the maximum reimbursable charge for out-of-network care;
- Amounts above any coverage limit; and
- Amounts for services not covered by the Plan.

Payments that help satisfy a covered individual's deductible for the year will also count toward the family deductible. If the family deductible amount is reached, the Plan can begin to pay benefits for all covered family members.

Dental Coinsurance

Coinsurance is the percentage of charges for covered services you pay under the Dental Plan. For example, if the Plan covers the service you receive at 80% of maximum reimbursable charge after the deductible, you pay the remaining 20% as coinsurance. You also pay any amounts above the maximum reimbursable charge and/or the Plan's maximums.

Annual Maximum Benefit

The Dental Plan pays an annual maximum benefit of $1,500 per covered individual for all eligible dental expenses, excluding preventative/diagnostic services and orthodontia. This maximum benefit is the most you can receive in dental benefits from the Plan each year.

Orthodontia Lifetime Maximum Benefit

The Plan has an individual lifetime maximum benefit for orthodontia coverage of $2,000. This is the most you or a covered dependent can receive in orthodontia benefits from the Dental Plan during his or her lifetime.

Orthodontia expenses paid by any CF Industries Dental Plan count toward the orthodontia lifetime maximum benefit.

Out-of-Network Maximum Reimbursable Charge
When you use out-of-network providers, you are responsible for all fees above the maximum reimbursable charge. The maximum reimbursable charge is the lesser of:

- Actual charges; or
- The amount determined by CIGNA for specific services in your geographic area. This amount is calculated at the 80th percentile of all provider charges in the geographic area.

For example, let's assume you were charged $110 for a tooth filling by an out-of-network dentist. If the average charge among all providers in your geographic area is $100 for this service, the maximum reimbursable charge for this service is $80 (the lesser of the $110 actual charge or 80% of all provider charges within the geographic area).

Covered Dental Services
The Dental Plan covers dental services that are:

- Ordered or prescribed by a dentist;
- An essential and appropriate service for the covered person's dental well-being;
- Within the scope of coverage limits (e.g. not over the annual maximum benefit);
- Not in excess of the amount allowed under the alternate benefits provision; and
- Started and completed while coverage is in effect (with an exception for services described in the Dental Benefits Extension section).

Pre-determination
If your dental treatment is expected to cost $200 or more, you should file an advance claim review with the claims administrator at least three weeks before treatment is to start. Pre-treatment claim forms are available at www.myCIGNA.com. Send the completed forms and supporting documentation to:

PO Box 188037
Chattanooga, TN 37422-8037

Supporting documentation includes a description of the dentist's proposed treatment plan and expected cost along with supporting preoperative X-rays and other diagnostic materials as requested by CIGNA's dental consultant. If there is a change in the treatment plan, a revised plan should be submitted.

The claims administrator evaluates the proposed treatment plan, determines covered dental expenses and informs your dentist and you of the expected covered cost. If alternate treatments are available that could be expected to reduce the cost of the procedure while providing comparable results, the claims administrator will inform you of these alternate procedures. The Plan pays benefits based on coverage of the least expensive treatment.

Pre-determination is voluntary. However, if you do not file an advance claim review, or if you do not provide the materials needed to verify the necessity of your dental treatment, the claims administrator may not be able to verify that your treatment is necessary. In this case, your benefits may be lower than you expected.

The estimate you receive from the claims administrator is not a guarantee of benefits.

Preventive and Diagnostic Services

The Dental Plan covers charges for preventive and diagnostic services at 100% of covered charges, with no deductible required.

The following are preventive and diagnostic services covered under the Dental Plan:

- Oral exams: two each calendar year per person;
- Palliative (emergency) treatment of dental pain, including minor procedures, when no other services are done (X-rays in connection with such treatment is a separate service);
- Bitewing X-rays: two each calendar year per person;
- Complete series of Panoramic X-rays: one every three calendar years per person;
- Panoramic X-rays: one every three calendar years per person;
- Cleanings (prophylaxis): two each calendar year per person;
- Periodontal maintenance procedures following active therapy; periodontal prophylaxis; 2 per calendar year
- Fluoride treatments: once each calendar year for each covered dependent up to age 19 (excluding prophylaxis);
- Sealant applications on posterior teeth: for each covered dependent to age 14, only one treatment per tooth every three calendar years; and
- Space maintainers (fixed unilateral): for non-orthodontic treatment.

If you choose to use an out-of-network provider, you will be responsible for paying all charges that are in excess of the maximum reimbursable charge.

Basic Restorative Services

For basic restorative services, you pay 20% of the covered charges as your coinsurance, after your annual deductible. The Dental Plan pays 80% of the covered cost, up to the Plan's annual maximum benefit amount.

Basic restorative services include:

- Amalgam filling;
- Composite/resin filling;
- Root canal therapy (any X-ray, test, laboratory exam or follow-up care is part of the allowance for root canal therapy and not a separate service);
- Osseous surgery (flap entry and closure is part of the allowance and not a separate service);
- Periodontal scaling and root planning (entire mouth);
- Routine extractions;
- Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth; and
- Removal of impacted tooth:
    - Soft tissue;
    - Partially bony; and
    - Completely bony.

Local anesthetic, analgesic and routine postoperative care for extractions and other oral surgery procedures are not separately reimbursed. They are considered as part of the submitted fee for the global surgical procedure.

General anesthesia and or sedation is paid as a separate benefit only when medically or dentally necessary, and administered in conjunction with complex oral surgical procedures which are covered under this Plan.

If you choose to use an out-of-network provider, you will be responsible for paying all charges that are in excess of the maximum reimbursable charge.

Implants
For dental implant services, you pay 20% of the covered cost as your coinsurance, after your annual deductible. The Dental Plan pays 80% of the covered cost, up to the Plan's annual maximum benefit amount.

Implant services include:
- Surgical placement of the implant body or framework of any type;
- Any device, index or surgical template guide used for implant surgery;
- Prefabricated or custom implant abutments; or
- Removal of an existing implant (only if the implant is not serviceable and cannot be repaired).

If you choose to use an out-of-network provider, you will be responsible for paying all charges that are in excess of the maximum reimbursable charge.

Major Restorative Services

For major dental services you pay 50% of the covered costs as your coinsurance, after your annual deductible. The Dental Plan pays 50% of the covered cost, up to the Plan's annual maximum benefit amount.

Major restorative services include:

- Crowns (where crown restorations are considered dental services only when the tooth, as a result of extensive caries or fracture, cannot be restored with amalgam, composite/resin, silicate, acrylic or plastic restoration):
    - Porcelain fused to high noble metal;
    - Full cast, high noble metal; and
    - Three-fourths cast, metallic;
- Removable Appliances:
    - Complete (full) dentures, upper or lower;
    - Partial dentures;
    - Lower, cast metal base with resin saddles (including any conventional clasps, rests and teeth); and
    - Upper, cast metal base with resin saddles (including any conventional clasps, rests and teeth);
- Fixed appliances:
    - Bridge pontics:
        - Cast high noble metal;
        - Porcelain fused to high noble metal; and
        - Resin with high noble metal;
- Retainer Crowns:
    - Resin with high noble metal;
    - Porcelain fused to high noble metal; and
    - Full cast, high noble metal;
- Prosthesis over implant (prosthetic device, supported by an implant or implant abutment);
- Replacement of any type of prosthesis with a prosthesis supported by an implant (or implant abutment) is only payable if the existing prosthesis is at least five calendar years old, is not serviceable and cannot be repaired; and
- Adjustments – complete denture (any adjustment of or repair to a denture within six months of its installation is not a separate service).

If you choose to use an out-of-network provider, you will be responsible for paying all charges that are in excess of the maximum reimbursable charge.

Orthodontic Services
The Dental Plan covers orthodontia services for you and your covered dependents. You pay 50% of the covered costs as your coinsurance with no deductible required. If you choose to use an out-of-network provider, you will be responsible for paying all charges that are in excess of the maximum reimbursable charge. Also, if you or your covered dependent has reached the orthodontia lifetime maximum benefit, you will be responsible for paying all subsequent orthodontia.

Each month of active treatment is a separate service. Covered expenses include:

- Orthodontic work-up, including X-rays, diagnostic casts and treatment plan and the first month of active treatment including all active treatment and retention appliances;
- Continued active treatment after the first month; and
- Fixed or removable appliances — only one appliance per person (for tooth guidance or to control harmful habits).

Benefit payments for comprehensive, full-banded orthodontic treatment are **made in installments every three months.** The first payment is payable when the appliance is installed. Subsequent payments are made following the end of each three-month period, with the remaining benefits prorated over the estimated duration of treatment. Payments are made for services provided only while your or your covered dependent is covered under the Dental Plan. If coverage ends or treatment stops, payment for the last three-month period is adjusted accordingly.

Alternate Benefits
If more than one covered service will treat a dental condition, payment is limited to the least costly service, provided it is a professionally-accepted, necessary and appropriate treatment.

If you request or accept a more costly covered service, you are responsible for expenses that exceed the amount covered for the least costly service. Therefore, you should get a pre-determination estimate before major treatment begins (see Pre-determination for information on requesting an estimate).

Dental Benefits Extension
If your Dental Plan coverage would otherwise end, coverage will be extended up to three additional months for the following treatments in progress:

- **Fixed bridgework and full or partial dentures**, the first impressions are taken and/or abutment teeth fully prepared while you are covered by the Plan and the prosthesis is inserted within three calendar months after your coverage ends;
- **A crown, inlay or onlay**, the tooth is prepared while you are covered by the Plan and the crown, inlay or onlay is installed within three calendar months after your coverage ends; or
- **Root canal therapy**, the pulp chamber of the tooth is opened while you are covered by the Plan and the treatment is completed within three calendar months after your coverage ends.

What's Not Covered by the Dental Plan
In addition to the limits and exclusions shown in the benefit descriptions, this section lists some of the services the Dental Plan does not cover, or covers only in part. If you have questions about the services the Plan covers, call the Plan claims administrator.

No payment will be made for expenses incurred for you or any one of your Dependents:

- for or in connection with an Injury arising out of, or in the course of, any employment for wage or profit;
- for or in connection with a Sickness which is covered under any workers' compensation or similar law;
- for charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected condition;
- services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared;
- to the extent that payment is unlawful where the person resides when the expenses are incurred;
- for charges which the person is not legally required to pay. For example, if Cigna determines that a provider is or has waived, reduced, or forgiven any portion of its charges and/or any portion of copayment, deductible, and/or coinsurance amount(s) you are required to pay for a Covered Service without Cigna's express consent, then Cigna in its sole discretion shall have the right to deny the payment of benefits in connection with the Covered Service, or reduce the benefits in proportion to the amount of the copayment, deductible, and/or coinsurance amounts waived, forgiven or reduced, regardless of whether the provider represents that you remain responsible for any amounts that your plan does not cover. In the exercise of that discretion, Cigna shall have the right to require you to provide proof sufficient to Cigna that you have made your required cost share payment(s) prior to the payment of any benefits by Cigna. This exclusion includes, but is not limited to, charges of a Non-Participating Provider who has agreed to charge you or charged you at an in-network benefits level or some other benefits level not otherwise applicable to the services received;
- charges arising out of or relating to any violation of a healthcare-related state or federal law or which themselves are a violation of a healthcare-related state or federal law;
- for charges which would not have been made if the person had no insurance;
- to the extent that billed charges exceed the rate of reimbursement as described in the Schedule;
- for charges for unnecessary care, treatment or surgery;
- to the extent that you or any of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;
- for or in connection with experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society.

See Coordination of Benefits (COB) for information on payment of benefits if you have coverage under more than one plan.

Requesting Dental Benefits
Your network provider automatically submits invoices to the claims administrator. For out-of-network providers, you are responsible for ensuring a claim for reimbursement is filed. Claim forms are available by visiting www.myCIGNA.com or on the CF Industries Total Rewards website (cftotalrewards.com) .

You must send the completed claim form to:

Cigna
PO Box 188037
Chattanooga, TN 37422-8037

Each time you complete a claim form, attach a copy of the bill that indicates the following:

- Your full name and Social Security number;
- Patient's full name;
- Date the service was rendered;
- Type of service or supply provided; and
- Itemized charges.

Claims must be filed with the claims administrator within one year from the date your covered service was rendered. Claims not filed within this time are not eligible for payment. It is your responsibility to ensure that the necessary claim information has been provided to the claims administrator.

See the Claim Denials and Appeals section for information about steps you may take if your claim is denied in whole or in part.

VISION PLAN

Please Note: These summary plan descriptions reflect plans currently in effect. Any changes to benefit plans will be reflected in updated summary plan descriptions after those changes take effect.

CF Industries offers vision care coverage to help protect your visual wellness. The Vision Plan covers annual exams which can help prevent future vision problems with early detection. The Vision Plan also covers eyewear (glasses and contacts).

The Vision Plan is flexible. You can visit any qualified vision care provider, but you will generally get the most for your money if you use a CIGNA Vision Network provider. You receive a discount on services when you use network providers. A CIGNA Vision Network provider may also offer discounts on the price of services and supplies that exceed the Plan's specified allowance. For example, if you choose a frame that exceeds the Plan allowance for frames, you are responsible for the difference in cost. By using a network provider, you may receive a discount on the amount above the Plan allowance.

For more information on the Plan, see:

Vision Plan Benefits at a Glance

The Vision Plan covers exams, lenses, frames and contact lenses. The Vision Plan also provides discounts for exams and eyewear over the allowance and, if a CIGNA Vision provider is used, discounts for laser surgery.

Vision Plan Benefits	In-Network	Out-of-Network
Network	CIGNA Network Vision www.myCIGNA.com 1-877-478-7557	NA
Eye Exam (once every calendar year)	One eye exam per person per calendar year, covered at 100% after a $10 copay	One eye exam per person per calendar year, up to a $60 allowance
Materials Copay (once every calendar year)	$25	N/A
Eyeglass Lenses Allowances: (once every calendar year)		
Single Vision	Covered 100% after Copay	Up to $40
Bifocal	Covered 100% after Copay	Up to $65
Trifocal	Covered 100% after Copay	Up to $75
Progressive	Covered 100% after Copay	Up to $75
Lenticular	Covered 100% after Copay	Up to $100
Contact Lenses Allowances: (one pair or single purchase per calendar year)		
Elective	$300	Up to $225
Therapeutic	Covered 100%	Up to $210
Frame Retail Allowance (once every calendar year)	Up to $200	Up to $133
Reimbursements	Use your Vision ID card, your provider will file your claim for you	You pay the entire charge at the time of service, then request reimbursement from the claims administrator by filing a claim form (which is available on the Company intranet)
Definitions: **Copay:** the amount you pay towards your exam and/or materials, lenses and/or frames. (Note: copays do not apply to contact lenses). **Coinsurance**: the percentage of charges Cigna will pay. You are responsible for the balance. **Allowance:** the maximum amount Cigna will pay. You are responsible for any amount over the allowance. **Materials:** eyeglass lenses, frames, and/or contact lenses.		

How the Vision Plan Works
The Vision Plan covers exams and eyewear. You are free to receive covered vision care services and eyewear from any qualified vision provider. However, you will generally pay less when you use a CIGNA Vision Network provider. Keep in mind, you always have the choice of providers you use and what services you receive regardless of what is covered.

Vision Network Providers
The Vision Plan uses the CIGNA Vision Network of providers. Directories are available online at www.mycigna.com or by calling 1-877-478-7557.

When you use a CIGNA Network Vision provider, you generally receive a 15% to 20% discount, depending on the services provided.

Use your vision card when you make an appointment or receive services. During your visit, you can ask whether the services and eyewear are covered by the Plan.

Vision Out-of-Network Providers
If you choose to see a provider who does not participate in CIGNA Vision Network, the Vision Plan will reimburse you up to the specified calendar-year allowance. Unlike when you visit a network provider, you receive no discount when you visit an out-of-network vision provider and out-of-network benefits do not ensure full payment. You will be responsible for paying the entire bill from the provider and then filing a claim with CIGNA Vision. Claim forms are available at www.mycigna.com or by calling 877-478-7557, and on the CF Total Rewards website at cftotalrewards.com.

Plan Allowances
The Vision Plan covers services up to the specified calendar-year allowance. An allowance is a specific dollar amount that you can receive as a reimbursement for covered expenses. You are responsible for paying the provider all applicable costs not covered by the Plan, such as amounts over the Plan allowance.

Covered Vision Services
The Vision Plan covers annual eye exams, frames, lenses and contact lenses. Some vision services may also be covered under the Medical Plan.

Annual Eye Exam
The Plan provides benefits for one eye exam per person per calendar year for a $10 copay in-network and up to a $60 allowance out-of-network. This coverage is for a routine eye exam performed by an optometrist or ophthalmologist (a medical doctor who specializes in treatment of the eyes).

Frames, Lenses and Contact Lenses
The Plan provides benefits for one purchase per person per calendar year, of either eyeglasses (frames and lenses) or a single purchase of a supply of contact lenses. This coverage is for the materials and construction of prescription frames and lenses or contact lenses, including fitting by an optician, optometrist or ophthalmologist.

Type of Care	Vision Plan Pays	
	In-Network	**Out-of-Network**
Eye Exam (once every calendar year)	One eye exam per person per calendar year, covered 100% after a $10 Copay	One eye exam per person per calendar year, up to a $60 allowance
Materials Copay (once every calendar year)	$25	N/A
Eyeglass Lenses Allowances: (once every calendar year) Single Vision Bifocal Trifocal Progressive Lenticular	 Covered 100% after Copay Covered 100% after Copay Covered 100% after Copay Covered 100% after Copay Covered 100% after Copay	 Up to $40 Up to $65 Up to $75 Up to $75 Up to $100
Contact Lenses Allowances: (one pair or single purchase per calendar year) Elective Therapeutic	 $300 Covered 100%	 Up to $225 Up to $210
Frame Retail Allowance (once every calendar year)	Up to $200	Up to $133

Additional Vision Benefits
Some vision services may be covered under the Medical Plan. These services may include exams, prescriptions and materials to diagnose or treat injuries or diseases of the eye. For example, the Medical Plan can cover diagnoses of, and treatment for, glaucoma.

See the Medical Plan section for more information.

What's Not Covered by the Vision Plan

A few services and supplies are not covered by the Vision Plan as follows:

- Charges in excess of the maximum reimbursable charge;
- Charges incurred after the policy ends or the insured's coverage under the policy ends;
- Charges for which reimbursement is not requested within one year of when services are rendered;
- Any eye exam, or any corrective eyewear, required by an employer as a condition of employment;
- Safety glasses or lenses requirement for employment (refer to the Company's safety glasses program for information about coverage of these items);
- Charges that the person is not legally required to pay or that are unlawful where the person resides when the expenses are incurred;
- Charges by a hospital owned or operated by, or which provides care or services for, the United States Government if such charges are directly related to a military service-connected condition, unless the insured is legally required to pay in the absence of insurance;
- Services related to an injury or sickness which are payable under any Workers' Compensation, occupational disease or similar law;
- Services or supplies received as the result of disease, defect or injury due to an act of war, declared or undeclared;
- Any non-prescription eyeglasses, lenses or contact lenses;
- Charges for unnecessary care, treatment or surgery;
- Charges that would not have been made if the person had no insurance;
- Experimental or non-conventional treatment or devices, and experimental procedures or treatment methods not approved by the America Optometric Association or the appropriate vision specialty society;
- High index lenses or any material type;
- Magnification or low vision aids;
- Medical or surgical treatment of the eyes;
- Orthoptic or vision training and any associated supplemental testing;
- Non-prescription sunglasses;
- Spectacle lens treatments, add-ons or lens coating, except rose tints (#1 and #2) and oversize lenses;
- Two pair of glasses in lieu of bifocals or trifocals; and
- VDT (video display terminal)/computer eyeglass benefit.

Requesting Vision Benefits
If you use a CIGNA Vision Network provider, your provider will automatically file a claim with CIGNA Vision. If the provider does not file the claim, you will need to file any claims directly with CIGNA Vision. Claim forms are available by visiting www.myCIGNA.com or by calling 1-877-478-7557 or on the CF Total Rewards website at cftotalrewards.com.
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Each time you complete a claim form, attach a copy of the bill that indicates the following:

- Your full name and Social Security number;
- Patient's full name;
- Date the service was rendered;
- Type of service or supply provided; and
- Itemized charges.

Send your claim to:

CIGNA Vision
P.O. Box 385018
Birmingham, AL 35238-5018

Claims must be filed with the claims administrator within one year from the date your covered service was rendered. Claims not filed within the required period are not eligible for payment. It is your responsibility to ensure that the necessary claim information has been provided to the claims administrator.

See the Claim Denials and Appeals section for information about steps you may take if your claim is denied in whole or in part.

FLEXIBLE SPENDING ACCOUNTS (FSA)

The Flexible Spending Accounts (FSAs) offer a way to help you save money on your eligible out-of- pocket health care and dependent care expenses. You have the option to enroll in either Health Care FSA Plan (i.e. General Purpose Health Care FSA or Limited Purpose Health Care FSA) and / or the Dependent Care FSA. Note: Your eligibility to enroll in either Health Care FSA depends on your medical plan enrollment.

A flexible spending account allows you to set aside pre-tax funds to pay for eligible expensesYou may be eligible to enroll in the following accounts:
Health Care FSA – this a general purpose account is used to reimburse eligible health care expenses for you and your eligible family members.

- Eligible expenses include unreimbursed medical, dental, vision and prescription drug expenses.
- Available if you enroll in the CF Standard PPO medical plan or if you waive CF medical plan coverage
- Your full election is available to use for eligible expenses at the beginning of the coverage period regardless of how much has been contributed.
- You will receive a Fidelity NetBenefits Access debit card to pay for eligible expenses or
- You may file your claims online at Netbenefits.com

Limited Purposed Health Care FSA – this account can only be used to reimburse eligible dental and vision expenses for you and your eligible family members.

- Eligible expenses include unreimbursed dental and vision expenses only.
- This plan is available if you are enrolled in the CF Advantage PPO plan.
- Your full election is available to use for eligible expenses at the beginning of the coverage period regardless of how much has been contributed.
- You will receive a Fidelity NetBenefits Access debit card to pay for eligible expenses or
- You may file your claims online at Netbenefits.com
- **Dependent Care FSA** – this account is used to reimburse expenses for dependent day care that allows you and/or your spouse to work or seek work or for your spouse to attend school full time.
- Money is available as it is contributed to your account, typically each payroll cycle.
- Access your funds by submitting a claim online at www.NetBenefits.com
-

A flexible spending account (FSA) allows you to pay for eligible health care and/or dependent care expenses with pre-tax dollars. Here's a quick look at how the FSAs work:

- You choose how much to contribute to an FSA for the calendar year, up to Plan limits.
- Your contributions are taken out of your paycheck before taxes are calculated.
- You use the applicable FSA to reimburse yourself for eligible expenses with pre-tax dollars.

FSA Plan at a Glance

FSA Features	Health Care FSA(HCFSA)	Dependent Care FSA(DCFSA)
How Account Is Used	Two options are available to pay for health care expenses for you and your eligible family members. • General Purpose Health Care FSA can be used for eligible medical, dental, vision and prescription expenses. • The Limited Purpose Health care FSA can only be use for eligible dental and vision expenses.	Pay expenses for dependent day care that allows you and/or your spouse to work or seek work or for your spouse to attend school full time.
Your Elected Calendar Year Pre-tax Contributions	You can contribute a minimum of $120 to a maximum of $3,050 (eff 1.1.23) annually.	You can contribute a minimum of $120 to a maximum $5,000 annually.
Whose Expenses Are Eligible	Your and any of your eligible dependent's expenses are eligible even if you do not have medical coverage through the Company.	Your expenses for dependents as follows: • Children under age 13, • Handicapped children of any age, or • Spouse/parent incapable of self-care.
Eligible Expenses For more details see IRS Publication 502 for Health Care FSA or IRS Publication 503 for Dependent Care FSA available on www.irs.gov.	Under the General Purpose Health Care FSA eligible expenses include health-related expenses not covered by your medical, dental, vision or prescription coverage, such as: • Copays, coinsurance and deductibles; • Prescription drugs; and • Glasses, contact lenses and solutions. Under the Limited Purpose Health Care FSA eligible expenses include dental and vision expenses not covered by your dental and vision coverage, such as: Dental/vision copays, coinsurance and deductibles; Glasses, contact lenses and solutions	Many child care expenses not claimed for a federal dependent tax credit on your federal tax return. This includes day care center charges for dependent children or care of an elderly dependent, nursery school expenses, or Social Security and unemployment taxes paid on behalf of a care provider.
Requesting Reimbursement	You can pay for eligible expenses with your Health FSA NetBenefits	You can pay for eligible expenses by submittingit claims online at

	AccessCard or submit claims for eligible expenses. You are reimbursed up to the *full amount of your annual contribution* – whether or not those contributions have actually been made at time of reimbursement.	netbenefits.com. You can only be reimbursed up to your *current account balance (the amount contributed to date).*

How FSAs Work
Following is the process for establishing, funding and using the FSAs to reimburse health care and/or dependent day care expenses:

Before the calendar year begins…

- Enroll — During open enrollment (or when you first become eligible), you decide whether to participate in a flexible spending account Remember, if you enroll in the CF Advantage Plan with HSA, you are not permitted to enroll in the general purpose healthcare spending account. However, you may enroll in the Limited Purpose Health Care FSA. When you enroll, you decide how much money to save for the calendar year. Carefully estimate your Health Care FSA and/or Dependent Care FSA expenses for the year before you decide how much to save.

  Keep in mind that your FSA election applies for the whole calendar year. You can only make changes during the year if you experience certain qualifying family status changes or other event for which an election change is allowed (see Changing Your Elections during the Year).

During the calendar year…

- **Contributions Deducted from Pay** — The Company deducts contributions from your pay in equal amounts each pay period for the year. The amount is taken before your Social Security, federal and, in most locations, state and local income taxes are figured.

During the calendar year …

- **Use Your Healthcare FSA NetBenefits AccessCard debit card** — to pay for eligible expenses directly from your FSA with your NetBenefis AccessCard .
- **Request FSA Benefits (Health Care FSA or Dependent Care FSA)** — When you pay for an eligible expense out of pocket,save your receipt. Then file your claim online at NetBenefits.com. You need to provide information on the type of service or provider, the date performed/date of service and the cost.
- **Tax-Free Reimbursement** — Once your claim is approved, you are reimbursed with tax-free dollars.

Contributions
When you enroll, you decide how much you want to contribute to each account on a pre-tax basis. The amount you elect is deducted equally from your paychecks during the year. The maximum annual contribution amounts are shown in the FSA Plan at a Glance.

Under IRS regulations, if your spouse also participates in his or her employer's FSA, you may not be reimbursed for the same eligible expenses under both this Plan and your spouse's plan. You also are responsible for making sure any prior contributions you made to an FSA with a previous employer for the Plan year don't exceed IRS annual limits. Also:

- **For the general purpose Health Care FSA or Limited Purpose Healthcare FSA**, you may still contribute the maximum amount shown in the FSA Plan at a Glance and your spouse may contribute the maximum amount in his or her own employer's health care account.
- **For the Dependent Care FSA**, your combined annual contributions cannot be more than the maximum amount shown in the FSA Plan at a Glance. If you receive employer-provided day care through your spouse's employer, the maximum you can contribute to your Dependent Care FSA is reduced by the value of that day care.

The Company must comply with IRS regulations governing FSA plans. So, it may sometimes become necessary for the Company to cut back the level of contributions of certain "highly compensated" employees. The Company will notify you if this limit affects you.

Tax Advantages
Your contributions are deducted from your pay before federal (and most state and local) income taxes are taken out. That means your taxable income is lower, so you pay less in taxes. As a result, you have more pay left in your paycheck than you otherwise would. (Reducing your Social Security wages may have a slight effect on your Social Security benefits.)

Paying for coverage on a pre-tax basis doesn't affect your other Company benefits. Benefit amounts are figured using pay before any FSA deductions.

Please consult your tax or other financial adviser for more information on the effect your participation will have on your tax situation.

Plan Ahead: Use It or Lose it
The Flexible Spending Accounts (FSAs), are based on IRS regulations and are subject to 'use it or lose it' rules. This means a portion, or all unused funds may be forfeited.

- **For the HCFSA and Limited Purpose HCFSA:** All eligible expenses must be incurred by December 31 of the plan year and submitted to **Fidelity** for reimbursement by March 31 of the following year. A minimum of $25 and up to $610 of your unused 2023 year-end balance can be carried over to the 2024 plan year. Balances over $610 and under $25 will be forfeited.

- **For the DCFSA:** Eligible expenses can be incurred during the calendar year through March 15 of the following year. All claims must be submitted to **Fidelity** by March 31 of the following year. After March 31, any unused funds will be forfeited.

For more information about the Tax-Advantaged Accounts, call Fidelity at **800-835-5095** or visit **netbenefits.com**.

Any forfeited dollars are used by the Company to offset administrative expenses of the FSAs.

Health Care FSA
The Health Care FSA allows you to pay for your and your dependents' eligible out-of-pocket health care expenses with pre-tax dollars. You can either pay for eligible expenses:

- Directly from your Health Care FSA using your NetBenefits AccessCard; or
- Out of your own pocket and then you submit a claim for reimbursement from your Health Care FSA.

Your Health Care FSA Dependents
Your dependents whose expenses are eligible for reimbursement under the Health Care FSA include anyone you can list as a dependent on your federal income tax return and unmarried adult children up to age 26. In case of divorce, children can be dependents of both parents. See Eligibility for more information.

What's Covered in the Health Care FSA
Because you pay for your health care expenses with pre-tax dollars, the IRS restricts the use of this money. The IRS defines expenses eligible for reimbursement from a Health Care FSA as expenses that are:

- For medical care as defined in section 213 of the Internal Revenue Code;
- Incurred by you or your eligible family members within the eligible time frame; and
- Not reimbursed from elsewhere or claimed as a tax deduction.

Please note, an expense is incurred when the medical treatment or service is actually provided, not when you receive the bill or pay for the medical expense.

Examples of Eligible Health Care FSA Expenses for the General Purpose Health Care FSA. The following list provides examples of eligible expenses.

- Acupuncture;
- Birth control pills;
- Braille books and magazines;
- Breast pump;
- Car controls for the disabled;
- Chiropractic care;
- Copayments and/or coinsurance for eligible medical, dental, vision and prescription drug expenses;
- Deductibles for you and your dependents;
- Medical, dental and vision expenses that exceed Plan limits;
- Fertility treatments;
- Guide dog;
- Hearing services (including exams, hearing aids and batteries, and ear plugs if prescribed by a doctor for a specific medical condition);
- LASIK eye surgery;
- Medical alert bracelet or necklace if related to the treatment of a medical condition (e.g., diabetes);
- Medicare Part B premiums;
- Medicines prescribed by a doctor and insulin (see note below);
- Orthodontia expenses;
- Orthopedic shoes;
- Oxygen;
- Smoking cessation programs;
- Special schools for the disabled;
- Speech therapy;
- Sterilization;
- Student health fees for medical services;
- Telephone for the hearing impaired;
- Transportation expenses to receive medical care;
- Vaccinations (e.g., flu shot);
- Weight loss membership and weekly fees if the program is prescribed to treat a medical condition; and
- Wigs for patient who has lost hair due to a disease when doctor recommends purchase for patient's mental health.

Examples of Eligible expenses for the Limited Purpose Health Care FSA only include dental and vision expenses such as:

- Copayments and/or coinsurance for eligible dental and vision expenses
- Orthodontia and dental expenses that exceed plan limits
- Vision expenses that exceed plan limits
-

For More Information on Eligible Expenses
For a listing of eligible and ineligible expenses, visit http://www.irs.gov or call 1-800-829-1040). Eligible Health Care FSA expenses must be expenses the IRS allows you to deduct on your income tax return. However, in some cases expenses that may be deducted on your return are not eligible for reimbursement from the Health Care FSA (most notably, long-term care expenses).

What's Not Covered in the General Purpose Health Care FSA
Some types of health care expenses are not reimbursable under IRS plan rules. Examples include:

- Most capital expenditures (e.g., health spa, whirlpool, exercise equipment); see Publication 502 and/or contact your tax adviser for more information;
- Cosmetic surgery, except for surgery necessary to improve a deformity from congenital abnormality, personal injury or disfiguring disease;
- Cosmetics, toiletries, toothpastes, etc.;
- Custodial care at home or in an institution;
- Discount program fees (e.g., for prescription drugs);
- Funeral and burial expenses;
- Genetic testing;
- Hair growth products (unless prescribed to treat an illness or disease — documentation required);
- Health insurance premiums;
- Health club or YMCA dues;
- Household and domestic help (even when recommended by a qualified doctor for general health improvement);
- Illegal treatments;
- Legal fees;
- Long-term care services;
- Maternity clothes, diaper services, etc.;
- Nursing services to care for a healthy newborn;
- Premiums for accident or health insurance coverage;
- Rogaine or Retin-A prescribed for cosmetic purposes;
- Swimming lessons;
- Teeth bleaching;
- Transportation expenses to and from work, even though a physical condition may require a special means of transportation;
- Vacation, social activities or travel taken for general health purposes (even when recommended by a qualified doctor for general health improvement);
- Vitamins and/or herbal supplements (unless prescribed by a doctor);
- Weight loss program membership and weekly fees, supplies and meals (membership and weekly fees may be eligible if prescribed to treat a medical condition);
- Expenses incurred while not covered by the Plan;
- Expenses incurred by your domestic partner or your domestic partner's children unless you can claim them as dependents under Section 152 of the IRS Code;
- Expenses not eligible for a tax deduction from the IRS; and

- Expenses you plan to itemize on your federal income tax return (you may itemize only if your expenses exceed 7.5% of your adjusted gross income).

Requesting Reimbursement for Health Care FSA Benefits START HERE

All eligible expenses must be incurred by December 31 of the plan year and submitted to **Fidelity** for reimbursement by March 31 of the following year. A minimum of $25 and up to $610 of your unused 2023 year-end balance can be carried over to the 2024 plan year. Balances over $610 and under $25 will be forfeited.

Under the Health Care FSA, you may be reimbursed up to the full amount you elected to contribute for the calendar year. You have two ways to access the money in your Health Care FSA:

- **Use** NetBenefits AccessCard— Pay eligible expenses directly from your Health Care FSA with your NetBenefits AccessCard® . Using the card lets you pay the expense directly from your Health Care FSA, so you don't have to pay with other funds, file a claim and wait for reimbursement. Be sure to save your receipts to verify for the Plan administrator or IRS that your expenses were eligible.
- **Submit a Claim** — When you pay an eligible expense, save your receipt. Then file your claim online NetBenefits.com. You need to provide information on the type of service, the date performed and the cost. Your reimbursement will be deducted from your Health Care FSA and reimbursed to you.

You can also contact a customer service representative at 833.299.5089.

Overpayment

If you or your covered dependents receive a benefit payment from the Plan that exceeds the amount that should have been paid, the Plan has the right to recover the excess amount. By accepting payment of benefits under the Plan, you or your covered dependent receiving such overpayment agree to repay such amounts. The Plan may:

- Deduct the excess amount from subsequent benefit payments; or
- Request full reimbursement of the overpaid amount, with reimbursement to be made within 31 days.

Dependent Care FSA
The Dependent Care FSA reimburses you for expenses you incur for eligible dependent care, such as a day care facility or a caregiver, provided to an eligible dependent. To qualify for reimbursement, IRS rules require that the care for your dependents be necessary for you (or you and your spouse, if you are married) to work, look for work or allow you to work if your spouse is a full-time student for at least five months during the year, or if your spouse is disabled and incapable of self-care.

Expenses are not eligible for services provided while you go out for non-work purposes, like attending personal social events or going on vacation.

Your Dependent Care FSA Dependents
Eligible dependents for the Dependent Care FSA are:

- Your tax dependent children under age 13, who:
    - Are your children (including step, adopted or foster children); grandchildren; and brother, sister, stepbrother, stepsister or a descendant of any such relative (e.g., niece or nephew);
    - Lives with you for more than one-half of the year; and
    - Does not provide over one-half of his or her own support for the calendar year.

Special rules apply to divorced or separated parents that may allow you to use your Dependent Care FSA to cover dependent care for a child for whom you have custody but whom you do not claim as a dependent on your tax return. If you are unsure how these rules apply to you, please consult your tax adviser.

- Your spouse who:
    - Is physically or mentally incapable of self-care; and
    - Lives with you for more than one-half of the year.
- Other dependents of any age (elderly parent or older child) who:
    - Are physically or mentally incapable of self-care; and
    - You claim as a dependent on your federal income tax return. (An individual will qualify as your disabled eligible dependent for the Dependent Care FSA even if you cannot claim the individual as a tax dependent for federal income tax filing purposes because such individual has an annual gross income of $3,650 or more in 2010 [indexed for inflation in future years]).

For more information on eligible dependents, visit the IRS website at www.irs.gov to print your own copy of Publication 503.

What's Covered in the Dependent Care FSA

Because you pay for your Dependent Care FSA expenses with pre-tax dollars, the IRS restricts the use of this money. The IRS has defined certain eligible expenses that qualify for reimbursement from the account as follows:

- Care at a nursery school, day camp or day care center (and the facility complies with state and local regulations, serves more than six non-resident individuals and receives fees for services);
- Services from individuals who provide dependent day care in or outside your home, unless the provider is your spouse, your own children under age 19 or any other tax dependent;
- Licensed preschool fees (only the cost of care is an eligible expense if it can be separated from the cost of schooling);
- After-school care for children under age 13;
- Household services related to the care of an elderly or disabled adult who lives with you;
- Your portion of FICA and other taxes you pay for a care provider; and
- Any other services that qualify as dependent care expenses under IRS regulations.

When submitting claims and filing your annual tax returns, you must include the provider's tax ID or Social Security number. If services are done in your home, you must file IRS Form 942 – Employer's Quarterly Return for Household Employees. You must pay Social Security and other applicable taxes on your household employee's wages.

For more information on eligible expenses, visit the IRS website at www.irs.gov to print your own copy of Publication 503 or call 1-800-829-1040 to request a copy by mail.

Cost of Care and Cost of Schooling

If you can separate the cost of care (care for the person's well-being and protection) from the cost of schooling, the cost of care is a reimbursable expense under the Dependent Care FSA. This applies to expenses for the care of children up to age 13. Expenses to attend kindergarten or a higher grade are not expenses for care.

For example, let's assume you:

- Place your 10-year old child in a boarding school so you can work full-time. Your Dependent Care FSA can reimburse you the portion of the cost that is for the care of your child.
- Take your child to a preschool at a cost of $2,000. The preschool provides lunch and a few educational activities as part of its preschool child-care service. Your Dependent Care FSA can reimburse you $2,000.

What's Not Covered in the Dependent Care FSA

Under IRS rules, some dependent care expenses are not reimbursable such as:

- Food, clothing or education (unless incidental to the care);
- Transportation between your house and the place that provides day care services, or the cost of transportation for a care provider;
- Dependent care when either you or your spouse is not working;
- Convalescent or nursing home care for a parent or disabled spouse;
- Kindergarten;
- Overnight camp;
- Dependent care so you or your spouse can do volunteer work;
- Expenses paid to your spouse, your own children under age 19 or any other dependent;
- Expenses for which you take the federal child care tax credit;
- Expenses to care for a child after he or she reaches age 13; and
- Expenses incurred while you were not a participant in this Plan.

Dependent Care Tax Credit

Under current tax law, you can be reimbursed for eligible dependent care expenses with pre-tax dollars through the Dependent Care FSA, or you can claim a tax credit for dependent care expenses when you file your federal income tax return. The federal dependent care tax credit applies to up to $3,000 in expenses for one qualifying dependent or up to $6,000 in expenses for two or more qualifying dependents. You may be able to use both approaches, but the amount of expenses that will qualify for a tax credit will be reduced, dollar for dollar, by any amount you receive from the Dependent Care FSA.

Here are the key differences between using the Dependent Care FSA and taking the federal child and dependent care tax credit.

Using the Dependent Care FSA	Using the Federal Child Care Tax Credit*
Maximum annual contribution is $5,000 ($2,500 if you are married and you and your spouse file separate federal income tax returns)	Maximum annual expense applicable toward the tax credit is for two or more children
Contributions are excluded from taxable income	A percentage of expenses is applied as a credit against taxes owed
Contributions are free from Social Security taxes, which may slightly reduce your Social Security benefits	Tax credit does not affect Social Security taxes
You must decide on your contribution amount at the beginning of the year before you incur expenses; you forfeit any unused amount	You determine the amount of your tax credit at the end of the year, after you incur all expenses; there is nothing to forfeit

** If you are married, you can claim the tax credit only if you file a joint income tax return.*

Consider the tax advantages of both the after-tax dependent care tax credit and the Dependent Care FSA before you enroll in the Dependent Care FSA. For specific advice about your situation, consult a tax adviser to determine which method of tax relief is the best for you.

Additional Tax Considerations

Due to the tax advantages of the Dependent Care FSA, the IRS places strict limits on the benefits that certain highly compensated employees may receive, compared to those received by non-highly compensated employees. If eligible highly compensated employees receive a disproportionate Dependent Care FSA benefit, it may be necessary for such employees to stop contributions during the Plan year. Some or all benefits provided to these employees may become taxable. You will be notified if this affects you.

Estimating Your Dependent Care FSA Contributions

Use this worksheet to help figure out your Dependent Care FSA contribution amount. While the Dependent Care FSA offers significant savings, you should only include those expenses you are certain of since you forfeit any unused money in your account.

As you estimate, be sure to take into account time during the year when you will not be paying for day care such as during vacation and when your child starts school.

Estimate Your Expenses	
Day care center fees for dependent children or eligible adults	$
Preschool or day camp fees	$
Fees for dependent care services provided in your home	$
Compensation (including Social Security and other taxes) paid to a housekeeper who regularly provides dependent care services for an eligible dependent	$
Other eligible services	$
Total (Consider contributing this amount to your Dependent Care FSA.)	$

Requesting Dependent Care FSA Benefits

You have until March 31 following the calendar year you participate to file claims for reimbursement of eligible expenses you incur through March 15th of the following calendar year. If you do not file your claim by March 31, you forfeit any money remaining in your account.

Under the Dependent Care FSA, you may be reimbursed up to your account balance to date. If your claim is larger than your account balance, your claim is held until further contributions are made to your account. To file for reimbursement:

- **Submit a Claim** — When you pay an eligible expense, save your receipt. Then submit your claim online at netbenefits.com. You need to provide information on the type of service, the date performed and the cost. Your reimbursement will be deducted from your Dependent Care FSA and reimbursed to you.

You can also contact a customer service representative at 833-299-5089

Overpayment

If you or your covered dependents receive a benefit payment from the Plan that exceeds the amount that should have been paid, the Plan has the right to recover the excess amount. By accepting payment of benefits under the Plan, you or your covered dependent receiving such overpayment agree to repay such amounts. The Plan may:

- Deduct the excess amount from subsequent benefit payments; or
- Request full reimbursement of the overpaid amount, with reimbursement to be made within 31 days.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Personal problems, planning for life events or simply managing daily life can affect your work, health and family. The feeling “I can handle it myself” can be adding to the pressures you may feel at work and at home.

The Employee Assistance Program is designed to provide support, resources and information to you and your household family members on a confidential basis, at no charge to you. Services include support for:

- Stress;
- Family and relationship problems;
- Work-life balance;
- Depression;
- Mental illness;
- Legal or financial issues;
- Substance abuse; and
- Caring for children or aging parents.

You can be assured that, unless required by law, your personal information will not be disclosed to anyone without your written approval.

EAP at a Glance

Feature	Provisions
Enrolling	You do **not need to** enroll in the EAP. Coverage for you and your household family members is automatic and starts on your first day of work.
Contributions	The Company pays the total cost for your and your dependents' EAP coverage.
EAP Benefits	The EAP is designed to provide confidential support services to you and your household family members in dealing with whatever life throws your way, including: • Managing stress • Handling relationship issues • Balancing work and home life • Quitting alcohol, tobacco, or drug use • Caring for children or aging parents • Exploring career development options • Dealing with conflict or violence • Working through grief and loss issues • Controlling depression and anxiety You and your dependents can access the EAP in two ways: • Call the EAP at 1-866-465-8943 day or night to speak with a trained professional. • Explore the online resources at www.guidanceresources.com. As a new user, you will need to register by submitting your personal information and the **Company Web ID: CFIND**. Either way, it's confidential. Your personal information will not be disclosed to anyone without your written approval except to the extent required or permitted by law.

How the EAP Works

Personal issues, planning for life events or simply managing daily life can affect your work, health and family. The Employee Assistance Plan (EAP) provides support, resources and information for personal and work-life issues. The EAP is confidential and provides — at no charge to you and your dependents — up to five (5) face-to-face sessions per issue, per year. EAP benefits include:

- Confidential counseling for:
    - Stress, anxiety and depression;
    - Relationship/marital conflicts;
    - Problems with children;
    - Job pressures;
    - Grief and loss; and
    - Substance abuse.
- Financial information and resources for:
    - Getting out of debt;
    - Credit card or loan problems;
    - Tax questions;
    - Retirement planning;
    - Estate planning; and
    - Saving for college.
- Legal support and resources for:
    - Divorce and family law;
    - Debt and bankruptcy;
    - Landlord/tenant issues;
    - Real estate transactions;
    - Civil and criminal actions; and
    - Contracts.
- Work-life solutions for:
    - Child and elder care;
    - Moving and relocation;
    - Making major purchases;
    - College planning;
    - Pet care; and
    - Home repair.
- Guidance resources online, including:
    - Timely articles, information sheets, tutorials, streaming videos and self-assessment;
    - “Ask the Expert” personal responses to your questions; and
    - Child care, elder care, attorney and financial planner searches.

Receiving EAP Services

You or your dependents can access the EAP in two ways:

- Call the EAP at 1-866-465-8943 day or night to speak with a trained professional. EAP representatives are available 24 hours a day, 7 days a week, to provide referral and emergency crisis intervention services.
- Explore the online resources at www.guidanceresources.com. As a new user, you need to register by submitting your personal information and the Company Web ID: CFIND.

Either way, it's confidential. Your personal information will not be disclosed to anyone without your written approval, and when allowed except to the extent required or permitted by law.

Your Household Members

Members of your household, whether or not they are dependents, are automatically covered by the EAP on your first day of work.

Covered EAP Services

The EAP provides benefits for confidential counseling, financial information and resources, legal support and resources and work-life situations, as follows.

Confidential Counseling

You and each of your dependents are eligible to participate in up to five in-person sessions per issue each calendar year (as considered clinically necessary by the EAP). If you receive in-person counseling together with another dependent such as your spouse, the total number of in-person sessions for which you and the other person are eligible for that problem is still five. The number of sessions does not increase simply because more than one person participates in counseling. There is no lifetime maximum on the number of sessions.

In-person services are available only through Guidance Consultants — highly trained master's and doctoral level clinicians. In many cases, the problem is resolved within the five in-person sessions available through the EAP. However, if you need more sessions or other health care services, you may be referred to an outside source for assistance.

Confidential counseling
This no-cost counseling service helps you address stress, relationship and other personal issues you and your family may face. Services are provided by highly trained master's- and doctoral-level clinicians who will listen to your concerns and quickly refer you to in-person counseling and other resources for:

- Stress, anxiety and depression;
- Relationship/marital conflicts;
- Problems with children;
- Job pressures;
- Grief and loss; and
- Substance abuse.

Financial information and resources
Speak by phone with a Certified Public Accountant or Certified Financial Planner on a wide range of issues, including:

- Getting out of debt;
- Credit card or loan problems;
- Tax questions;
- Retirement planning;
- Estate planning; and
- Saving for college.

Legal support and resources
Talk by phone with an attorney. If you require representation, you will be referred to a qualified attorney in your area for a free, 30-minute consultation with a 24% reduction in customary legal fees thereafter. You can call about:

- Divorce and family law;
- Debt and bankruptcy;
- Landlord/tenant issues;
- Real estate transactions;
- Civil and criminal actions; and
- Contracts.

Work-life solutions
Work-life specialists can provide qualified referrals and customized resources for:

- Child and elder care;
- Moving and relocation;
- Making major purchases;
- College planning;
- Pet care; and
- Home repair.

Financial Information and Resources
Speak by telephone with a Certified Public Accountant or a Certified Financial Planner on a wide range of financial issues, including:

- Getting out of debt;
- Credit card or loan problems;
- Tax questions;
- Retirement planning;
- Estate planning; and
- Saving for college.

There is no restriction on the number of times you may use the financial resources.

Legal Support and Resources
Speak by telephone with an attorney regarding legal issues, including:

- Divorce and family law
- Debt and bankruptcy
- Landlord/tenant issues
- Real estate transactions
- Civil and criminal actions
- Contracts
- Child care

There is no restriction on the number of times you may use the legal resources. However, you may not access legal consultation services on a continuing basis to undertake your own representation.

If you require representation, you will be referred to a qualified attorney in your area for a free 30-minute consultation, generally with a 25% reduction in customary legal fees thereafter. However, the EAP cannot guarantee the availability of discounted fees in certain areas and, the Plan Sponsor and the Plan Administrator do not assume liability with regard to the services performed.

Work-Life Situations
The EAP also provides telephone consultation, information, education and referral services in connection with child and elder care, automobile purchases, moving and relocation, pet care and home repair.

If you choose to obtain elder care or child care, it will be up to you to evaluate each dependent care resource to determine the right arrangement for your loved one and to monitor the quality and appropriateness of the arrangement. The EAP does not endorse or recommend any of the dependent care resources identified. While the Plan Administrator makes reasonable efforts to ensure the accuracy of the information provided about dependent care resources, the information is obtained from those resources and The Plan Administrator and Plan Sponsor cannot guarantee the accuracy of the information. The final decision about your dependent care arrangement is yours.

Guidance Resources Online

The EAP offers online guidance resources, including expert information on relationships, work, school, children, wellness, legal, financial, free time and more. You will find timely articles, information sheets, tutorials, streaming videos and self-assessments. An "Ask the Expert" feature will provide personal responses to your questions, and searches can be done for services relating to child care, elder care, legal assistance and financial planning.

What's Not Covered by the EAP

The EAP does not include the following services:

- Acupuncture;
- Aversion therapy;
- Biofeedback and hypnotherapy;
- Charges for completing claim forms;
- Charges for failure to keep a scheduled visit;
- Court-mandated counseling or evaluations required by a state or federal judicial officer or other governmental agency or to be used in legal actions of any kind (e.g., child custody proceedings);
- Direct treatment for mental retardation, learning disabilities or autism;
- EAP services when you sue, or threaten to sue, the Company;
- Evaluations for fitness for duty or excuses for leaves of absence or time off;
- Exams and diagnostic services in connection with:
    - Obtaining employment or a particular employment assignment;
    - Admission to or continuing in school;
    - Securing any kind of license (including professional licenses); or
    - Obtaining any kind of insurance coverage;
- Financial advice or instruction as to any course of action (and note that the financial consultants are not responsible for any decisions you make about your financial planning);
- Inpatient treatment;
- Legal assistance for employment issues, commercial enterprise, second opinions or third-party advice, such as:
    - A relative's legal problem;
    - Matters considered frivolous or harassing by the consulting attorney;
    - Matters involving ComPsych, the Company, the legal services vendors or its plan attorneys; or
    - Any matter that would involve a violation of ethical rules;
- Medication, medication management or treatment of any condition for which medication is required, unless you are seeing a doctor who prescribes medication for that condition and oversees your use of the medication;
- More than five in-person EAP sessions per issue each year;
- Psychiatric services or other medical care, including prescription drugs;
- Psychological, psychiatric, neurological, educational or IQ testing;
- Recommendation or endorsement of a specific attorney to represent you; the final decision regarding whether a particular attorney is suitable for your needs can only be made by you

- Remedial education services such as:
    - Evaluation or treatment of learning disabilities, and developmental and learning disorders;
    - Behavioral training; and
    - Cognitive rehabilitation;
- Services or supplies not needed for treatment or not approved by your EAP counselor;
- Services or supplies rendered by a family member or for which there is no charge;
- Services or supplies required by or paid for under any government law, including Workers' Compensation or other federal, state or local law;
- Services rendered before coverage became effective or after coverage ends;
- Sleep therapy;
- Testimony in legal proceedings or preparation for legal proceedings;
- Treatment by someone other than an EAP counselor for whom a ComPsych representative opened a case;
- Treatment for any physical illness;
- Treatment for any problem or condition that cannot be resolved in brief counseling (e.g., a psychosis or any other condition that requires inpatient treatment or more than five sessions); and
- Treatments, procedures or devices considered experimental or investigational in nature as determined by the EAP administrator.

Requesting EAP Benefits

You do not have to file EAP claims, and there are no copays, coinsurance or deductibles. You should not make any payment to a provider for EAP services. However, you are responsible to pay for services you obtain without contacting ComPsych to open an EAP case with a particular EAP counselor.

DISABILITY PLANS

CF Industries is committed to helping you and your family in times of need. That's why we provide two Disability Income Protection Plans — Short-Term Disability (STD) and Long-Term Disability (LTD). The Plans can be a valuable source of financial protection for you and your family if an illness or injury prevents you from working.

The Disability Income Protection Plans provide, at no cost to you:

- During the first 26 weeks of a disability, Short-Term Disability (STD) replaces income based on a percentage of your base salary:
    - 100% of base salary for the first eight weeks of disability; and
    - 66 2/3% of your base salary after eight weeks of payments, up to a total of 26 weeks.
- After 26 weeks of disability, basic LTD replacement income equal to 50% of your base salary.

You also have an opportunity to pay for Supplemental LTD protection. Supplemental LTD increases your total LTD replacement income (Basic LTD plus Supplemental LTD) to 60% of your annual base salary.

For more information on the Plan, see:

- Eligibility
- Events That Could Affect Your Coverage
- When Coverage Ends
- Administrative Information
- Claim Denials and Appeals
- Required Notices
- Definitions

Disability Plans at a Glance

The following chart provides an overview of your Disability Plans.

Plan	Coverage
Short-Term Disability (STD)	The STD Plan can start paying benefits after you are disabled for five consecutive calendar days. The Plan pays a percentage of your base salary for a maximum of 26 weeks, as follows: • 100% of your base salary for up to eight weeks; then • 66 2/3% of your base salary up to the remainder of the 26-week benefit period. In the event of a work absence due to occupational illness or injury — and you are receiving workers' compensation benefits — STD plan payments are reduced by the amount of workers' compensation benefits so as to avoid duplication of benefits. The benefits shown above will be reduced by benefits payable from other sources. For more information, see Coordination of Benefits with Other Plans.
Long-Term Disability (LTD)	The LTD Plan pays benefits for employees who are totally and continuously disabled for more than 26 weeks. There are two levels of LTD coverage available to you: • **Basic LTD** — The LTD Plan provides a benefit equal to 50% of your base salary, up to a maximum monthly benefit of $5,000. • **Supplemental LTD** — You may elect to supplement your Basic LTD coverage by purchasing, at your own cost, coverage equal to an additional 10% of your base salary. In this way, the LTD Plan provides a benefit equal to 60% of your base salary, up to a maximum monthly benefit of $10,000. • **Minimum LTD benefit** — The minimum monthly LTD Plan benefit is equal to the greater of $100 or 10% of your monthly benefit before any reductions for other income benefits. The benefits shown above will be reduced by benefits payable from other sources. For more information, see Coordination of Benefits with Other Plans.

How the STD Plan Works
The Short-Term Disability (STD) Plan pays the entire cost of your short-term disability continuation benefit. The goal is to help you recover from a disability so you can return to productive work as quickly as possible. The STD Plan can provide protection if you are disabled due to an illness or injury lasting up to 26 weeks. (See How the LTD Plan Works for disabilities lasting longer than 26 weeks.)

The STD Plan starts paying benefits retroactively to your date of disability after you are disabled for five consecutive calendar days (the waiting period). Administrative services for the STD Plan are provided by New York Life, who is also the insurance carrier for the LTD Plan. You can reach New York Life directly by calling 800.362.4462

Requesting STD Benefits
Although STD Plan benefits do not begin until you have been disabled for five consecutive calendar days, STD Plan benefits are retroactive to your date of disability.

Contact New York Life and your supervisor as soon as you know you will be absent:
- If you are expected to be absent from work for more than 5 consecutive calendar days due to your own disability; or
- If you have a serious health condition that makes you unable to perform the functions of your job and you expect to be absent from work for:
- More than 3 consecutive calendar days;
- Intermittent periods of time (non-consecutive hours or days away from work); or
- Hospitalization for any amount of time.

Contacting New York Life (NYL)
Request your leave of absence by calling New York Life at 800-362-4462or online at www.MYNYLGBS.com IFor Spanish-speaking employees, call 866-562-8421. Please have this information ready before you call:
- Your name, phone number, home address, birth date, Social Security number and reason for your leave;
- Your employer's name, email address and phone number;
- Date and cause of the illness or injury and the first day you were absent from work, as well as your anticipated return-to-work date (and, if the absence is due to maternity leave, you will need to provide the actual or expected date of delivery);
- Name, address and phone number of each doctor you are seeing or have seen for the illness or injury causing the disability; and
- Date of the first treatment or appointment with your doctor for the injury or illness and the next treatment or appointment.

You may also be asked to provide some medical information, including your previous history of illness or injury, any diagnostic testing that was performed, the diagnosis, the treatment plan and medications the physician has recommended.

During the call, the agent will ask you for your permission to get your medical information. This will help to process your claim more quickly. Here's how it works.

- After you finish giving your claim information, the phone agent will transfer you to a recorded message.
- Listen to the recording and answer "Yes" or "No" to the questions.
- At the end of the recording, say "Yes" if you give permission or "No" if you do not. You can cancel your recorded permission at any time by calling your Cigna Claim Manager.

To make a determination about your leave, NYL will contact your:

- Site HR representative to verify your employment and last day worked.
- Attending physician and request medical certification for your leave of absence in order to verify the appropriateness of your leave and determine whether the leave qualifies under the Family and Medical Leave Act.

NYL will send a letter to your home to let you know the decision – generally within 5 to 7 days of your request. A copy of the letter will also be sent to your Site HR representative. The letter will include a form for you to sign and return giving NYL permission to obtain the information needed to process your claim. Please sign and return that form. Check with your doctor to see if other forms are need to release medical records.

A NYL Claim Manager will call you and your employer for a list of your job requirements. The Claim Manager will also call your doctor for your medical records. This information will allow NYL to determine how long you may be out of work and the benefits you may be eligible to receive.

After your Site HR representative receives approval of your leave, updates can be made to the payroll and HR systems to reflect your status change. If your leave of absence is due to medical reasons for yourself, you may be eligible to continue receiving a paycheck with short-term disability benefit payments from the Company.

Waiting Period

To receive STD benefits you must have a medically certified illness or injury for five (5) consecutive calendar days and your disability is approved by New York Life (NYL). The five-day waiting period begins with the day you become disabled. The waiting period does not need to begin or end on a scheduled work day.

If you are waiting for a disability decision (either initial decision or decision to extend your disability claim) from NYL or your disability is not approved by NYL, you may use your available sick time or vacation time to supplement pay during your absence. If you do not have sick time or vacation time available your absence will be unpaid.

If your you use available sick time or vacation to supplement pay and are later approved for disability, your sick time or vacation time used will be returned to your sick time/vacation bank.

STD Benefit Amount

The STD Plan can start paying benefits after you are disabled for five consecutive calendar days. The Plan pays a percentage of your base salary for a maximum of 26 weeks, as follows:

- 100% of your base salary for up to eight weeks; then
- 66 2/3% of your base salary up to the remainder of the 26-week benefit period.

The benefits shown above will be reduced by benefits payable from other sources. For more information, see Coordination of Benefits with Other Plans.

If you are absent from work because of a non-work-related illness or injury, you may qualify for STD Plan benefits. To qualify for STD Plan benefits, you must be receiving appropriate and regular care for your condition from a doctor. And you must be unable to perform the material and substantial duties of your regular occupation

Workers' Compensation is a separate plan. Work-related injuries must be reported to your supervisor immediately and are handled through Workers' Compensation. To avoid duplication of benefit, your STD benefits are reduced by any worker's compensation pay you receive.

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How STD Benefits Affect Other CF Benefits

All of your other CF benefits remain in effect with premiums and voluntary contributions continuing to be deducted from your paychecks. Coverage amounts of your Life Insurance will be the amounts in effect on the last day you worked your regular duties.

While you are receiving STD Plan benefits, you are not eligible for any salary adjustments.

See If You Become Disabled in the Events that Could Affect Your Coverage section for more information.

Modified Work Assignment

In some cases, with the approval of your physician, CF may make a modified work assignment available to you on a temporary basis while you are on STD. Contact your local HR representative to discuss if a modified work assignment is appropriate.

If you receive such a job assignment, you are required to return to work at that job until you are able to return to your own job or the modified work assignment ends. If you are given an assignment under this provision and refuse to return to work, you will be considered to have resigned from CF Industries. However, an employee whose STD leave is also covered by the Family Medical Leave Act (FMLA) may refuse such assignments. In these instances, the employee will remain on FMLA; however, STD benefits will cease. The compensation you receive from your modified work assignment plus your gross STD benefit will equal an amount no greater than 100% of your base earnings rate prior to disability.

A modified work assignment typically lasts no more than three or four weeks. In any case, your modified work assignment will cease on the earliest of the following:

- The date your modified work assignment ends;
- The date you are no longer disabled; or
- The end of the maximum payable benefit period.

Returning to Work

About one week before you return to work, call your supervisor and NYL to advise them of your anticipated return to work date. You will be required to provide NYL and CF Industries with a Physician's Release/Return to Work Statement from your physician. This statement must indicate that you are physically and mentally able to return to your position. CF Industries has the right to request an exam, at the Company's expense, or request other proof that you are able to return to work.

In addition, you may be asked to participate in a job-specific evaluation conducted by an independent occupational or physical therapist. The evaluation is designed to help you:

- Return to work as quickly as practical
- Ease the transition from disability to work
- Resume your job duties safely
- Reduce the chances of re-injury that could occur by returning to work too early

Note: NYL does not determine if or when you are able to return to work. Your treating physician provides a release to return to work information based on their evaluation of your progress, test results, your medical treatment, test results, medical notes, improvements etc.

Working Part-Time During STD

Under certain circumstances and with your doctor's approval, you may be able to return to work part-time during Short-Term Disability. The addition of part-time work would allow you to earn more money, by combining disability benefits and part-time earnings, than you would receive from disability benefits alone. For example, an employee who returned to work for 20 hours per week would receive:

- Pay for the 20 hours worked and
- STD benefits for the remaining 20 hours (assuming the employee normally works a 40-hour week)

Your benefits under the disability plan, together with all other sources of income, may not exceed 100% of your eligible earnings before your disability.

In addition, working part-time would not affect the 26-week maximum STD period.

Recurring STD
If you have a second period of disability (from the same cause or a related cause) that begins less than 30 calendar days after you return to your regular duties on a full-time basis, the second disability will be treated as a continuation of the first.

Example:
Assume Bob is entitled to 26 weeks of STD Plan benefit payments. Bob receives STD Plan benefits for six weeks then returns to his regular duties on a full-time basis. Two weeks later Bob suffers a related disability. In this example, Bob is eligible for 20 additional weeks of STD Plan payments. This is determined as follows:

26 weeks of STD payments
MINUS
6 weeks of benefit payments Bob already received
EQUALS
20 weeks of additional STD payments

Note: If the disability is unrelated — even if it occurs within 30 days — this is considered a new STD period.

A related disability which occurs 30 days or more after the end of a prior disability or is from an unrelated cause is subject to:
- A new waiting period; and
- A new 26-week maximum payable benefit period.

What's Not Covered for STD
The STD Plan does not pay benefits for any disability that results, directly or indirectly, from:
- Active participation in a riot;
- Commission of a felony;
- Cosmetic surgery or surgical procedure that is not medically necessary;
- Revocation, restriction or non-renewal of an employee's license, permit or certification necessary to perform the duties of his or her occupation unless due solely to injury or sickness otherwise covered by the Plan;
- Suicide, attempted suicide or self-inflicted injury or sickness while sane or insane;
- War or any act of war, whether or not declared;
- Voluntary procedures that are not deemed medically necessary; and
- An injury or illness from working a second job.

Additionally, the Plan will not pay benefits for any period of disability:
- During which you are incarcerated in a penal or corrections institution;
- That begins after your employment ends or when you are on layoff;
- That you are not under the care of a licensed physician;
- That is not supported by objective medical findings (e.g., tests, procedures or clinical exams usually done for the disabling conditions); and
- That doesn't meet the Plan's definition of disability.

How the LTD Plan Works

The Long-Term Disability (LTD) Plan is intended to help you recover from a disability so you can return to productive work as quickly as possible. The LTD Plan provides protection if you are totally and continuously disabled due to an illness or injury lasting longer than 26 weeks. (For information about disabilities of fewer than 26 weeks, see How the STD Plan Works.)

Administrative services for the LTD Plan are provided by New York Life (NYL), who is also the administrator for the Short-Term Disability Plan. You can reach NYL directly by calling c or MyNYLGBS.com.

Requesting LTD Plan Benefits

If you are receiving Short-Term Disability (STD) Plan benefits under the Disability Income Protection Plans, and if your disability extends beyond six months, the insurance carrier will transition you to LTD benefits.

If you are receiving benefits under a state's Workers' Compensation Law, and your disability appears that it may extend beyond six months, you should call New York Life's toll-free number at v 866- 562-4462 and a knowledgeable NYL Intake Specialist will walk you through the process. For Spanish- speaking customers, call C 866-562-8421. The appropriate forms to apply for LTD Plan benefits can be found on the company intranet.

Once your claim has been approved and benefit payments have begun, NYL will request periodic progress reports about your condition and may request an independent evaluation by another physician.

LTD Plan benefits are paid at regular intervals, no less than once a month from NYL.

If you also receive disability benefits through Social Security, you may be eligible to begin benefit payment under a company-sponsored pension plan and 401(k) plan. In this case, your LTD Plan benefits may be offset (reduced) by your Company-sponsored retirement plan benefit payments.

A portion of your LTD Plan benefits will be considered taxable income. You will pay federal income taxes on the portion of your LTD benefit attributable to the group premiums the Company pays for the three calendar-year period prior to the year in which LTD payments begin. At the end of every year, you will receive a W-2 statement showing your taxable LTD Plan income.

Defining Total Disability

For the first two years of LTD, to receive benefits for total disability you must be:

- Unable to perform the substantial and material duties of your regular job because of sickness or injury; and
- Unable to earn 80% or more of your indexed earnings from working in your regular occupation.

After two years of continuous LTD, "total disability" means that you must be:

- Unable to engage in any occupation for which you are and become qualified through education, training or experience; and
- Unable to earn 60% or more of your indexed earnings.
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Elimination Period for LTD Plan Benefits

The elimination period must be satisfied before you are eligible to receive benefits. It is the 26-week period for which you qualify for STD Plan benefits. It starts on the day you become disabled and is continuous through your 26-week elimination period. See Recurring LTDs for more information.

Pre-Existing Condition Exclusion

The LTD Plan covers disabilities from pre-existing conditions after you have been an LTD Plan participant for three months. The LTD Plan pays benefits based on an increase in coverage level (e.g., Basic to Supplemental) or increase in salary for a pre-existing condition after you have been an LTD Plan participant for 12 months after the date the coverage increase was effective.

LTD Plan Benefit Amount

The Long-Term Disability (LTD) Plan pays benefits for employees who are totally and continuously disabled for more than 26 weeks. There are two levels of LTD coverage available to you:

- **Basic LTD** – The LTD Plan provides a benefit equal to 50% of your base salary, up to a maximum monthly benefit of $5,000.
- **Supplemental LTD** – You may elect to supplement your Basic LTD coverage by purchasing, at your own cost, coverage equal to an additional 10% of your base salary. In this way, the LTD Plan provides a benefit equal to 60% of your base salary, up to a maximum monthly benefit of $10,000.
- **Minimum LTD benefit** – The minimum monthly LTD Plan benefit is equal to the greater of $100 or 10% of your monthly benefit before any reductions for other income benefits.

The benefits shown above will be reduced by benefits payable from other sources. For more information, see Coordination of Benefits with Other Plans.

If a benefit is payable for less than one month, it will be paid on the basis of 1/30th of the monthly benefit for each day of disability.

Example:
Assume Pat is entitled to Supplemental LTD Plan benefits after receiving STD Plan benefits for 26 weeks. Pat's Supplemental LTD benefits are determined as follows:

- Multiply Pat's monthly base salary by 60%
- The maximum Supplemental LTD benefit is $10,000 a month
- Take the lesser amount of 60% of base salary or $10,000 and subtract other sources of income (see Coordination of Benefits with Other Plans) – this is Pat's net monthly benefit

Base Salary Defined

Your base salary as of your date of disability is used to determine your benefit under the LTD Plan.

How LTD Plan Benefits Affect Other CF Benefits

For the first two years you are receiving disability benefits from the company sponsored Long-Term Disability (LTD) Plan, you will be designated as an active employee on leave, including for purposes of eligibility for the various company-sponsored benefit plans.

After two years of continuous Long-Term Disability (LTD), if you continue to be disabled and continue to receive disability benefits from the company-sponsored Long-Term Disability (LTD) Plan, the company will consider you a terminated employee rather than an active employee on leave. You may continue to be eligible to receive Long-Term Disability (LTD) benefits even if CF Industries terminates your employment status. For information about how coverage under other benefit plans is affected, see If You Become Disabled in the Events that Could Affect Your Coverage section for more information.

Maximum Payable Benefit Period

Payments continue while you are disabled to the maximum payment period is as follows:

Age at Disability (last day worked)	Maximum Payment Period
62 or younger	The later of your 65th birthday or the date the 42nd monthly benefit is payable
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 or older	12 months

Social Security Disability

It is important for you to know that Social Security Disability benefits can begin after five full months of disability if your condition is expected to last for one year or more. Because the claims process can take several months, you should apply during the third or fourth month of absence from work by contacting your Social Security Administration office.

It is possible that the insurance carrier may overpay claims during the first months of your disability if your Social Security application is approved retroactively. In the event of a retroactive Social Security Disability award, the insurance carrier will calculate the amount of overpayment and request reimbursement from you. If direct reimbursement is not possible, future LTD Plan payments will be reduced to account for the earlier overpayment.

Recurring Disabilities
Your elimination period and LTD payments are affected by recurring disabilities as follows:

Feature	Effect of Recurring Disabilities
During the Elimination Period	• If you return to work for 90 days or less, the Plan treats your disability as continuous. The days that you are not disabled do not count toward your elimination period. Any increases you receive in monthly earnings during your return to work period are not taken into consideration when calculating your monthly benefit. • If you return to work for a period greater than 90 days and become disabled again, you begin a new elimination period.
After Receiving LTD Plan Payments	• If you return to your job after receiving LTD benefits and are disabled again **from the same cause or a related cause within six consecutive months** of returning, LTD benefits may resume as a continuation of the previous disability. Any payment limits that applied to the previous disability will apply to the new disability. • If you return to your job after receiving LTD benefits and are disabled **from a different, unrelated cause within six consecutive months** of returning, the new disability will be considered a separate event and may be eligible under the STD Plan. • If you have a new or related disability more than six months after returning to work, the new disability will be considered a separate event and may be eligible under the STD Plan.

Survivor Benefit
If you die after having received LTD Plan benefits, the Plan will pay a survivor benefit. The survivor benefit is payable in a single lump sum equal to three monthly payments (figured before reductions for any disability earnings).

What's Not Covered for LTD

LTD disability benefits will not be paid:

- For any disability period that begins after your employment ends or when you are on layoff;
- For any period during which you are not under the care of a licensed physician;
- For any disability that is not supported by objective medical findings (e.g., tests, procedures or clinical exams usually done for the disabling conditions);
- For a disability not caused by, contributed to or resulting from an injury or sickness as defined in this Plan document;
- For a disability caused by, contributed to or resulting from attempted suicide, while sane or insane, or intentional self-inflicted injury or sickness;
- For a disability caused by, contributed to or resulting from commission of or attempt to commit an act which is a felony in the jurisdiction in which the act occurred;
- For a disability resulting from war (declared or undeclared) or service in the Armed Forces;
- For a disability beyond 24 months of LTD Plan payments if it is due to a mental or nervous disorder, alcoholism or drug abuse or addiction (and, if confined for more than 14 consecutive days, that period does not count against the limit);
- Active participation in a riot; and
- During which the employee is incarcerated in a penal or correction institution.

Coordination of Benefits with Other Plans

Payments you are eligible to receive from any of the sources named below will be subtracted from your Short-Term Disability (STD) Plan or Long-Term Disability (LTD) Plan payments. The other sources are as follows:

- Workers' Compensation or any other act or law that provides benefits for job-related injuries or sickness. Workers' Compensation is a separate benefit covered under Workers' Compensation benefit based on state laws.
- Social Security Disability or Retirement payments, including any amounts for which your dependents may be eligible because of your disability or retirement
- Disability benefits paid under any other group insurance plan, sick leave plan, or salary continuance
- Any state statutory disability plans, state mandated sick plans or any other state mandate pay plans that would result in duplication of benefits.
- Any other benefits provided under a government program or law (for example, a state disability benefit law)
- Any Pension Plan payments administered by CF Industries (this includes the Terra Pension)
- Disability benefits paid under any No Fault Auto Motor Vehicle coverage
- Any amounts paid because of loss of earnings or earnings capacity through settlement, judgment or arbitration

NYL will not reduce your monthly benefit by any of the following:

- Deferred compensation arrangements such as 401(k), 403(b) or 457 plans;
- Credit disability insurance;
- Pension plans for partners;
- Military pension and disability income plans;
- Franchise disability income plans;
- Individual disability income plans;
- A retirement plan from another employer;
- Profit sharing plans;
- Thrift or Savings plans;
- Individual retirement account (IRA); and
- Stock ownership plan.

It is your responsibility to apply for any other disability income benefits to which you may be entitled while you are disabled. Your responsibility includes:

- Filing the necessary applications;
- Complying with whatever claim procedures are involved; and
- Furnishing the insurance carrier with copies of all correspondence, claims decisions and benefit payments you receive.

Work Incentive Benefit

If you are receiving disability benefits and cannot work at the job you held before your disability, you may be able to be gainfully employed at another job for which you are or become qualified through education, training or experience. A work incentive benefit is coordinated through the Plan administrator.

Rehabilitation

If the Plan administrator determines you are a suitable candidate for rehabilitation, the Plan may require you to participate in rehabilitation. The Plan administrator has the sole discretion to approve your participation in the rehabilitation plan and to approve a program as a rehabilitation plan. If you fail to fully cooperate in all required phases of the rehabilitation plan without good cause, no disability benefits are paid.

LIFE AND AD&D INSURANCE

CF Industries offers life insurance coverage designed to provide financial protection for you and your survivors in the event of death. The following related life insurance options work together to provide coverage:

- Basic Life Insurance
- Basic Accidental Death & Dismemberment (AD&D) Insurance
- Voluntary Life Insurance
- Dependent Life Insurance for your spouse and eligible children
- Voluntary AD&D Insurance for you, your spouse and your eligible children

As an eligible employee, you automatically receive Basic Life and AD&D Insurance coverage at no cost to you. In addition, you may choose to purchase Voluntary Life Insurance for yourself, Dependent Life Insurance for your spouse and your eligible children, and/or Voluntary AD&D Insurance for yourself, your spouse and your eligible children.

For more information on the Plan, see:

- Eligibility
- Choosing Your Coverage
- Events That Could Affect Your Coverage
- When Coverage Ends
- Administrative Information
- Claim Denials and Appeals
- Required Notices
- Definitions

Life and AD&D Insurance at a Glance
The following chart provides an overview of your life insurance options.

Plan or Feature	Coverage
Basic Life for you	One times your annual salary rounded to the next higher $1,000, up to $1 million
Basic AD&D for you	One times your annual salary rounded to the next higher $1,000, up to $1 million
Voluntary Life for you	You may choose up to five times your annual salary rounded to the next higher $1,000, up to $1 million, in one times your annual salary increments*
Dependent Life for your spouse and your children	You choose for your: • **Spouse:** Up to $500,000 in $10,000 increments* • **Children:** Up to $20,000 in $5,000 increments
Voluntary AD&D for you, your spouse and your children	You choose for: • **Yourself:** Up to $500,000 in $50,000 increments (amounts over $300,000 are limited to 10 times your annual salary) • **Your spouse:** Up to $500,000 in $50,000 increments • **Your children:** Up to $20,000 in $5,000 increments (limited to $500 for children age 14 day through six months)
You and/or your spouse is age 65 or older	Benefits will be reduced (but premiums remain the same, if applicable), as follows: • **For you:** Your total coverage amount is reduced by 35% on the day you reach age 65 • **For your spouse:** Coverage ends once your spouse reaches age 70.

** Evidence of insurability may be required.*

How Life and AD&D Insurance Works
As an eligible employee, you automatically receive Basic Life and AD&D Insurance coverage at no cost to you. In addition, you may choose to purchase Voluntary Life Insurance for yourself, Dependent Life Insurance for your spouse and your eligible children, and/or Voluntary AD&D Insurance for yourself, your spouse and your eligible children.

If you die while covered, the Plan pays benefits to your beneficiaries. If you suffer an accidental dismemberment that qualifies for benefits, you are automatically the beneficiary. Also, you are automatically the beneficiary for any benefits that become payable based on coverage of your spouse and children.

Naming a Beneficiary
When you enroll in life insurance coverage, you will be asked to name your beneficiaries who will receive benefits from the Plan in the event of your death, or the death of a covered family member. You may name anyone you want (including a trust) as your beneficiary. You are required to name beneficiaries either in writing or online. If you name more than one beneficiary, you will need to indicate the percentage of benefits each should receive.

You can change your beneficiaries at any time on Workday. After you log on to Workday, click on Benefits in the Applications section. Then, click on Beneficiaries under the Change section and follow the prompts from there. When you change your beneficiary online, you automatically cancel any previous beneficiary designations.

If there is no designated beneficiary on file at the time of your death or if all designated beneficiaries have died before you, death benefits (or any dismemberment benefits that remain unpaid at your death) are payable to the first of the following:

- Surviving lawful spouse, if not legally separated or divorced;
- Surviving natural child, adopted child, foster child, stepchild or other child for whom you have legal guardianship in equal shares;
- Surviving parents, whether natural, step or adoptive, in equal shares;
- Surviving siblings, whether natural, step or adoptive, in equal shares; or
- Your estate.

If Your Salary Changes
Because the Basic Life and AD&D Insurance and Voluntary Life Insurance are based on your salary, the amount of your coverage is automatically adjusted if your salary changes. Your premium costs are also adjusted. The amount of an increase in your coverage may be up to 25%.

Voluntary Life rates are based on age brackets. The bracket is determined by your age and will change on your birthday each year.

Life Insurance

Basic Life Insurance
Your Basic Life Insurance equals one times your base salary, up to $1 million. CF Industries pays the cost of this coverage. If your base salary is not an even $1,000 increment, your Basic Life Insurance coverage will be rounded up to the next $1,000.

If your death qualifies for benefits, this Plan pays the benefits to your beneficiary.

Taxation of Group Term Life (GTL) Insurance – Imputed Income.
The Internal Revenue Code requires that the value of your employer-provided group term life insurance (such as Basic Life Insurance) coverage in excess of $50,000 be treated as taxable income. This is often referred to as 'imputed income'. The amount of taxable income is determined using the IRC Table I Rates(see below) and varies with your age. Each pay period this "income" is reflected on your earnings statement as 'group term life', on a pay period basis as well as year-to-date, and is included on your W-2 Form.

IRC Table I Rates

If you are this age (at the end of the Company's tax year)…	For each $1,000 of company-provided life insurance coverage over
Under 25	$0.05
25 to 29	$0.06
30 to 34	$0.08
35 to 39	$0.09
40 to 44	$0.10
45 to 49	$0.15
50 to 54	$0.23
55 to 59	$0.43
60 to 64	$0.66
65 to 69	$1.27
70 and older	$2.06

This income is included in your wage base for the purposes of withholding Social Security and Medicare taxes. No withholdings are made for federal and state income taxes.

Voluntary Life Insurance
Voluntary Life Insurance is optional coverage that allows you to increase your life insurance by adding to your Basic Life Insurance. You may elect Voluntary Life Insurance for yourself up to five times your annual salary but not in excess of $1 million. You pay the cost of this coverage which varies on the amount of coverage you choose, your salary and your age.

Evidence of insurability is required when you choose coverage of four or more times your salary or if the coverage amount is over $400,000.

See What's Not Covered for Basic, Voluntary and Dependent Life Insurance.

Evidence of Insurability
During each annual enrollment period, you may change your life insurance coverage. If you elect to increase your coverage or add coverage, you must provide evidence of your insurability by completing and submitting a Statement of Health Form to the insurance carrier. This form is available on the CF Total Rewards site. You can also request a change within 30 days after a family status change or special enrollment period by providing evidence of insurability. See Mid-Year Changes for more information.

If approved by the insurance carrier, your Voluntary Life coverage will be changed. If the increase in coverage is denied, your life insurance will remain in effect at the current level.

Dependent Life Insurance
You have the following options for Dependent Life Insurance coverage of your spouse and/or your children:

- Spouse coverage: You may choose coverage for your spouse in multiples of $10,000 up to $500,000. On life insurance elected above $50,000, your spouse must submit a Statement of Health Form also known as Evidence of Insurability (EOI). Coverage elections above $50,000 will depend on approval by the insurance carrier. Spouse life insurance coverage is not available after ate 70. You must be enrolled in voluntary life coverage to elect voluntary spouse life coverage.
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- Children coverage: You may choose coverage in multiples of $5,000 up to $20,000 for each of your eligible children unsolicited.

If a benefit is payable based on the death or disablement of your spouse or one or more of your covered children, the Plan will pay benefits to you as the beneficiary. See What's Not Covered for Basic, Voluntary and Dependent Life Insurance.

What's Not Covered for Life Insurance
Voluntary Life Insurance benefits are not paid if you commit suicide, while sane or insane, within two years from the effective date of your coverage. Instead, your beneficiary is paid an amount equal to any premiums paid, without interest.

If you commit suicide, while sane or insane, more than two years after the effective date of your coverage, but within two years from the effective date of any increase in the amount of your Voluntary Life benefits, such increased amount is not paid. Instead, the beneficiary is paid:

- An amount equal to all premiums paid for the increased amount, without interest; plus
- An amount equal to the amount of Voluntary Dependent Life Insurance benefits in effect on the day before the effective date of such increased amount.

Dependent Life benefits are not paid if a dependent commits suicide, while sane or insane, within two years from the effective date of your coverage. Instead, your beneficiary is paid an amount equal to any premiums paid, without interest. Voluntary Dependent Life Insurance coverage ends for your spouse on the date your dependent spouse turns age 70.

If a dependent commits suicide, while sane or insane, more than two years after the effective date of your coverage, but within two years from the effective date of any increase in the amount of your Voluntary Dependent Life Insurance benefits, such increased amount is not paid. Instead, the beneficiary is paid:

- An amount equal to all premiums paid for the increased amount, without interest; plus
- An amount equal to the amount of Voluntary Dependent Life Insurance benefits in effect on the day before the effective date of such increased amount. Note: If a dependent child commits suicide and is survived by other dependent children covered under the same certificate, no premium refund is paid.

Accidental Death & Dismemberment Insurance

Accidental Death & Dismemberment (AD&D) Insurance provides coverage for accidental death and dismemberment. If you or a covered dependent die or are dismembered within one year of an accident, as a result of that accident, this Plan pays benefits for Basic AD&D and Voluntary AD&D according to the following:

Loss of	Percentage of Total Coverage Amount Paid
• Life • Both hands or both feet • One hand and one foot • One hand and sight of one eye • One foot and sight of one eye • Sight of both eyes • Speech and hearing in both ears • Quadriplegia	100%
• Paraplegia	75%
• Hemiplegia • One hand • One foot • Sight of one eye • Speech • Hearing in both ears	50%
• Severance and reattachment of one hand or one foot Thumb and index finger of same hand • Uniplegia • Four fingers of same hand	25%
• Five toes of same foot	20%
• Coma	1% monthly benefit for up to 11 continuous months, payable at the end of each month during which you remain comatose At the start of 12 continuous months in a coma, a one-time benefit equal to 100%

If you sustain more than one covered loss from any one covered accident, benefits will be paid for the covered loss with the largest payable benefit, up to your total coverage amount. The total payment for all losses due to any one accident will not be more than 100% of the covered person's coverage amount at the time of the accident.

If you are an active employee at age 65, your total coverage amount will be reduced by 35%, effective on the day that you reach age 65.

Loss

A loss means:

- **Hand or Foot**: Complete severance through or above the wrist or ankle joint.
- **Sight**: Total, permanent loss of sight in one eye irrecoverable by natural, surgical or artificial means.
- **Speech:** Total, permanent loss of audible communications irrecoverable by natural, surgical or artificial means.
- **Hearing**: Total, permanent loss of ability to hear any sound in both ears irrecoverable by natural, surgical or artificial means.
- **Thumb and Index Finger of the Same Hand or Four Fingers of the Same Hand**: Complete severance through or above the metacarpophalangeal joints of the same hand.
- **Toes:** Complete Severance through the metatarsophalangeal joint.
- **Paralysis or Paralyzed**: Total loss of use of a limb. A physician must determine the loss of use to be complete and not reversible at the time the claim is filed.
- **Quadriplegia**: Total paralysis of both upper and lower limbs.
- **Hemiplegia**: Total paralysis of the upper and lower limbs on one side of the body.
- **Paraplegia**: Total paralysis of both lower limbs or both upper limbs.
- **Uniplegia**: Total paralysis of one upper or one lower limb.
- **Coma**: Profound state of unconsciousness from which you are not likely to be aroused through powerful stimulation. The coma must begin within 30 days of the accident and continue for 60 consecutive days. It must be diagnosed and treated regularly by a physician. This does not mean unconsciousness induced during the course of treatment unless the state of unconsciousness results from the administration of anesthesia in preparation for surgical treatment of injuries from a covered accident.
- **Severance**: Complete separation and dismemberment of the part from the body.

Basic AD&D Insurance
The Basic AD&D Insurance benefit equals one times your base salary, up to $1 million. CF Industries pays the cost of this coverage.

Exposure and Disappearance
Loss from exposure to the elements following a forced landing, sinking, stranding or wrecking of a vehicle will be covered if such loss is otherwise payable under this Plan.

If you are not found within one year after the disappearance, sinking or wrecking of a conveyance in which you are riding at the time a covered accident occurred, you will be presumed to have suffered loss of life resulting from injury caused by an accident.

Seatbelt and Airbag
If you are entitled to AD&D benefits because of a car accident, the seatbelt benefit can increase the AD&D coverage amount by 10%, up to a maximum of $25,000, if:

- The injury is sustained while driving or riding in a four-wheel vehicle; and
- A police report establishes that, at the time of the accident, you were strapped in a seatbelt.

The Plan will pay an additional 5%, up to a maximum of $10,000, if:

- The injury is sustained while driving or riding in a four-wheel vehicle that is equipped with a factory- installed supplemental restraint system;
- You must be sitting in a seat designed to be protected by an air bag and must be strapped in the seatbelt when the air bag inflates; and
- The police report must establish that the air bag inflated upon impact. A minimum default benefit of $1,000 is available.

No benefit will be paid for any loss while:

- Driving or riding in any four-wheel vehicle used in a race, speed or endurance test or for acrobatic or stunt driving;
- Not wearing a seat belt for any reason;
- Sharing a seatbelt; or
- The operator of the vehicle is intoxicated or under the influence of drugs unless taken as prescribed by a licensed physician.

Voluntary AD&D Insurance
You have the following options for Voluntary AD&D Insurance coverage for yourself, your spouse and/or your children:

- **Employee coverage**: You may choose coverage for yourself in multiples of $50,000, up to $500,000. Amounts in excess of $300,000 are limited to 10 times your annual salary.

If you have selected Voluntary AD&D Insurance coverage for yourself, you may also choose:

- **Spouse coverage**: You may choose coverage for your spouse in multiples of $50,000, up to the $500,000.
- **Children coverage**: You may choose coverage in multiples of $5,000 up to $20,000 for each of your eligible children.

If you or a covered dependent die as the result of an accident, the applicable beneficiaries will receive payments from this Plan. If you or a covered dependent loses a limb, sight, speech or hearing due to an accident, benefits will be paid as shown in the table of losses.

Child Care Center Benefit
If you or your covered spouse suffer a loss of life due to an accident, Voluntary AD&D benefits will pay an additional benefit to the surviving parent for child care expenses.

The benefit payable is the lesser of:

- 3% of your AD&D benefit; or
- $3,000 per child per year.

This benefit is payable for each of your dependent children up to the date the child reaches age 13, up to four years after the loss.

Common Carrier Benefit
This benefit will increase your spouse's Voluntary AD&D coverage amount to a total of 100% of your coverage amount if:

- Loss of life benefits are payable for both you and your spouse under this Plan; and
- Coverage for your spouse is in force on the date of the accident and either:
- You and your spouse die as a result of injuries sustained in the same accident; or
- You and your spouse die as a result of injuries sustained in separate accidents that occur with the same 24-hour period.

The total of this benefit for you and your spouse is subject to a maximum of $500,000.

Exposure and Disappearance
Loss from exposure to the elements following a forced landing, sinking, stranding or wrecking of a vehicle will be covered if such loss is otherwise payable under this Plan.

If you are not found within one year after the disappearance, sinking or wrecking of a conveyance in which you are riding at the time a covered accident occurred, you will be presumed to have suffered loss of life resulting from injury caused by an accident.

Seatbelt and Airbag
An additional benefit may be provided to your beneficiaries if you sustain a covered loss resulting in the loss of your life, directly or independently of all other causes, from a covered accident while wearing a seatbelt and operating or riding as a passenger in a private passenger automobile (e.g., not a taxi or public transportation vehicle).

An additional benefit may be provided if you were also positioned in a seat protected by a properly- functioning and properly deployed supplemental restraint system (air bag).

Verification of the proper use of the seatbelt at the time of the covered accident and that the supplemental restraint system properly inflated upon impact must be part of the official police report or be certified, in writing, by the investigating officer.

The separate seatbelt and airbag benefit is equal to 10% of your total coverage amount, up to $25,000 (each). If verification of proper use cannot be determined, a default benefit of $1,000 may be paid.

Special Education Benefit
If you or your covered spouse suffer a loss of life due to an accident, the Voluntary AD&D Plan will pay an education reimbursement benefit to your dependent children equal to 3% of your AD&D benefit, up to a maximum of $3,000, for each surviving dependent child per year for up to four consecutive years of enrollment. In the case of a minor child, payment will be made to the child's legal guardian.

Spouse Retraining Benefit
If you, as the covered employee, suffer a loss of your life within one year after a covered accident, Voluntary AD&D Plan benefits can pay an additional benefit to enable your surviving spouse (or, if there is no surviving spouse, your beneficiary) to obtain occupational or educational training needed for employment. This benefit is equal to 3% of your Voluntary AD&D coverage amount, up to a maximum of $3,000.

To qualify for this benefit, your surviving spouse must enroll in an accredited school within three years after your death.

What's Not Covered for Basic and Voluntary AD&D Insurance

Basic and Voluntary AD&D Insurance benefits will not be paid for any covered injury or covered loss which, directly or indirectly, in whole or in part, is caused by or results from any of the following, unless coverage is specifically provided:

- Activities of active duty service in the military, navy or air force of any country or international organization. (Covered accidents that occur while engaged in Reserve or National Guard training are not excluded until training extends beyond 31 days.)
- Bungee jumping, parachuting, skydiving, parasailing or hang-gliding.
- Commission or attempt to commit a felony or an assault.
- Declared or undeclared war or act of war.
- Flight in, boarding or alighting from an aircraft or any craft designed to fly above the earth's surface:
    - Except as a passenger on a regularly scheduled commercial airline.
    - Being flown by the covered person or in which the covered person is a member of the crew.
    - Being used for crop dusting, spraying or seeding, giving and receiving flying instruction, firefighting, sky writing, sky diving or hang-gliding, pipeline or power line inspection, aerial photography or exploration, racing, enduring tests, stunt or acrobatic flying, or any operation that required a special permit from the FAA, even if it is granted. (This does not apply if the permit is required only because of the territory flown over or landed on.)
    - An ultra-light or glider.
    - Being used by any military authority, except an aircraft used by the Air Mobility Command or its foreign equivalent.
    - Being used for the purpose of parachuting or skydiving.
    - Designed for flight above or beyond the earth's atmosphere.
- Intentionally self-inflicted injury, suicide or any attempt thereat while sane or insane.
- Operating any type of vehicle while under the influence of alcohol or any drug, narcotic or other intoxicant including any prescribed drug for which the covered person has been provided a written warning against operating a vehicle while taking it. (Under the influence of alcohol, for purposes of this exclusion, means intoxicated, as defined by the law of the state in which the covered accident occurred.)
- Participation in a riot or insurrection.
- Sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment thereof, including exposure, whether or not accidental, to viral, bacterial or chemical agents for any bacterial infection resulting from an accidental external cut or wound or accidental ingestion of contaminated food.
- Travel in any aircraft owned, leased or controlled by the Company or any of its subsidiaries or affiliates. (An aircraft will be deemed to be controlled by the Company if the aircraft may be used as the company wishes for more than 10 straight days or more than 15 days in any year.)
- Voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a physician and taken in accordance with the prescribed dosage.

In addition, benefits will not be paid for services or treatment rendered by any person who is:

- Employed or retained by the Company;
- Living in the covered person's household;
- A parent, sibling, spouse or child of either the covered person or the covered person's spouse;
- The covered person; or
- Providing homeopathic, aroma therapeutic or herbal therapeutic services.

Additional Features

Assignment of Benefits

You may assign the rights to your life insurance to another individual or trust only with the written consent of the insurance carrier. By assigning your benefits, you are transferring all right, title, interest and incidents of ownership, both present and future, of your benefits.

Accelerated Benefits (You or Spouse)

Under this provision, if you are diagnosed as having a terminal illness and are expected to die within 12 months, you may apply to receive:

- For yourself: up to 80% of the life insurance coverage in force or $500,000; and
- For your spouse: up to $400,000.

The amount of any accelerated benefits paid to you reduces the life insurance benefits payable to your beneficiaries and the amount of benefits available for you to convert. Accelerated benefits are payable only once.

Coverage While Totally Disabled

Waiver of Premium

If you are totally disabled (as determined by the claims administrator) before age 60 and your disability lasts for at least nine months, your Basic Life and Voluntary Employee LifeInsurance is continued automatically — provided the insurance carrier approves this coverage. You are considered totally disabled when you are completely unable to work in any occupation due to the injury or sickness. You will need to provide proof of continuing disability each year. If approved, your coverage continues until you are no longer disabled or you reach age 70 — whichever occurs first. Your coverage amount is the amount of your Basic Life and your Voluntary Employee Life Insurance in effect on your last day worked.

Extended Death Benefit
If you are under age 60 and die before you qualify for wavier of premium, you and your dependents premiums are waived if you remained disabled during that period. You are considered disabled if, because of injury or sickness, you are unable to perform all the material duties of your regular occupation, or you are receiving disability benefits from the CF Industries Disability Plan. Regular occupation means your occupation, as routinely performed in the general labor market, at the time your disability begins.

Approval of extended death benefit is subject to determination by the claims administrator and is independent of the disability carrier's decision to award LTD benefits.

If your coverage ends, you may be able to covert to an individual policy. See Converting to an Individual Policy for more information.

Continuation if You Are Age 60 or Older
If you are over age 60 or older at the time of disability, you are not eligible for the waiver of premium. If you are under age 65 at the time of disability, coverage continues and CF Industries pays the premiums for two years of continuous disability or until you reach age 65, whichever occurs first.

If you are age 65 or older at the time of disability, coverage ends and is eligible to be converted to a whole life policy without proof of insurability.

Converting to an Individual Policy
If your life insurance ends, you and/or your spouse may be eligible to continue life insurance through the conversion privilege. You may want to consider purchasing a conversion policy if you terminate employment for any reason and do not qualify for an individual life policy because of your age or medical condition. You may convert life insurance coverage only for you and your spouse. Conversion privileges do not apply to AD&D coverage or any dependent child coverage.

You may convert your Basic Life and Voluntary Life Insurance coverage to an individual policy of an equal or lesser amount of coverage within 31 days from the date coverage is terminated. You will not have to undergo a medical exam or submit proof of insurability for this conversion policy. You will receive a conversion notice from the insurance carrier following your termination of employment. You should follow up with the insurance carrier directly if you do not receive information within 15 days of your termination.

Requesting Benefits
All claims for life and AD&D insurance should be filed in writing with CF Industries, Human Resources Department within 31 days of the date of loss, or as soon as reasonably possible, but in no case any longer than 15 months after the date of the loss. Benefits may be reduced or invalidated if the claim is not given in a timely manner, unless you or your beneficiaries can show it was not reasonably possible to give notice or file the claim within the 31-day time frame and notice was given as soon as possible.

To claim loss of life benefits, you or your designated beneficiaries must submit the following within 90 days of the loss:

- Social Security number and birth date of the deceased; and
- Certified copy of the death certificate listing the reason/cause of death.

To claim other benefits, you must submit the following within 90 days of the loss:

- Acceptable proof that you received an accidental bodily injury; and
- Acceptable proof that you sustained a loss shown in the Table of Losses within one year of the date of injury.

Claims must be submitted to:

Human Resources Department CF Industries
4 Parkway North, Suite 400
Deerfield, Illinois 60015-2590

How Benefits Are Paid
You are automatically the beneficiary for all dependent life insurance coverage(s) available under the Plan. Payment will be made to your beneficiaries in the event of your death.

BUSINESS TRAVEL ACCIDENT INSURANCE

CF Industries provides valuable financial protection when you are traveling. Business Travel Accident (BTA) Insurance pays a benefit if you suffer a covered loss in an accident. To be eligible for benefits under this Plan, the injury must occur while you are traveling on Company business. Daily commutes to and from work are not considered traveling on business.

For more information on the Plan, see:

- Eligibility
- Events That Could Affect Your Coverage
- When Coverage Ends
- Administrative Information
- Claim Denials and Appeals
- Required Notices
- Definitions

Business Travel Accident Insurance at a Glance
The following chart provides an overview of your Business Travel Accident (BTA) Insurance Plan.

Feature	Coverage	
Loss of life (total coverage amount)	Two times your annual base salary, rounded to the next higher $1,000; maximum of $1 million.	
Other losses	**Loss of…**	**Percentage of Total Coverage Amount Paid**
	• Both hands or both feet • One hand and one foot • One hand and sight of one eye • One foot and sight of one eye • Sight of both eyes • Speech and hearing in both ears • Quadriplegia	100%
	• Paraplegia	75%
	• Hemiplegia • One hand • One foot • Sight of one eye • Speech • Hearing in both ears	50%
	• Severance and reattachment of one hand or one foot • Thumb and index finger of same hand • Uniplegia • Four fingers of same hand	25%
	• Five toes of same foot	20%
	• Coma	1% monthly benefit for up to 11 continuous months, payable at the end of each month during which you remain comatose At the start of 12 continuous months in a coma, a one-time benefit equal to 100%

Age 65 or older benefit reduction	Age	Your coverage amount is reduced to the following percentage…
	65 – 69	65%
	70 – 74	45%
	75 – 79	30%
	80 and older	20%

If you sustain more than one covered loss from any one covered accident, benefits will be paid for the covered loss with the largest payable benefit, up to your total coverage amount. The total payment for all losses due to any one accident will not be more than 100% of the covered person's coverage amount at the time of the accident.

How Business Travel Accident Insurance Works

If you are injured while traveling on Company business, the Plan provides you with a benefit based on the severity of the injury. The injury must be related to an accident occurring during or within 72 hours before or after the course of authorized business travel. The covered loss must occur within one year after the accident that caused the injury.

Naming a Beneficiary

You are automatically the beneficiary for all Business Travel Accident (BTA) Insurance benefits under the Plan (except those benefits payable in the event of your death). You will be asked to name your beneficiaries who will receive benefits from the Plan in the event of your death. You may name anyone you want (including a trust) as your beneficiary. You are required to name beneficiaries on Workday. If you name more than one beneficiary, you will need to indicate the percentage of benefits each should receive.

You can change your beneficiaries at any time on Workday. After you log on to Workday, click on Benefits in the Applications section. Then, click on Beneficiaries under the Change section and follow the prompts from there. When you change your beneficiary online, you automatically cancel any previous beneficiary designations.

If there is no designated beneficiary on file at the time of your death or if all designated beneficiaries have died before you, death benefits (or any dismemberment benefits that remain unpaid at your death) are payable to the first of the following:

- Surviving lawful spouse, if not legally separated or divorced;
- Surviving natural child, adopted child, foster child, stepchild or other child for whom you have legal guardianship in equal shares;
- Surviving parents, whether natural, step or adoptive, in equal shares;
- Surviving siblings, whether natural, step or adoptive, in equal shares; or
- Your estate.

What's Covered for Business Travel Accident
Business Travel Accident (BTA) Insurance benefits are paid for covered losses that occur as a direct result of an accident occurring during, or within 72 hours before or after, the course of authorized business travel. To qualify for BTA benefits, the loss must also occur within one year of the accident.

Your coverage begins when you leave your residence, usual place of work or other location, whichever is later, for the purpose of traveling on Company business. Coverage ends when you return from such business trip to your residence, usual place of work or other place following the end of business activities, whichever occurs first.

If, within one year from the date of an accident, injury results in a loss, benefits are payable as shown in the BTA at a Glance chart. A loss means:

- **Hand or Foot**: Complete severance through or above the wrist or ankle joint.
- **Sight**: Total, permanent loss of sight in one eye irrecoverable by natural, surgical or artificial means.
- **Speech**: Total, permanent loss of audible communication irrecoverable by natural, surgical or artificial means.
- **Hearing**: Total, permanent loss of ability to hear any sound in both ears irrecoverable by natural, surgical or artificial means.
- **Thumb and Index Finger of the Same Hand or Four Fingers of the Same Hand**: Complete severance through or above the metacarpophalangeal joints of the same hand.
- **Toes**: Complete severance through the metatarsal phalangeal joint.
- **Paralysis or Paralyzed**: Total loss of use. A doctor must determine the loss of use to be complete and irreversible at the time the claim is submitted.
- **Quadriplegia**: Total paralysis of both upper and lower limbs.
- **Hemiplegia**: Total paralysis of the upper and lower limbs on one side of the body.
- **Paraplegia**: Total paralysis of both lower limbs or both upper limbs.
- **Uniplegia**: Total paralysis of one upper or one lower limb.
- **Coma**: Profound state of unconsciousness from which you are not likely to be aroused through powerful stimulation. The coma must begin within 30 days of the accident and continue for 60 consecutive days. It must be diagnosed and treated regularly by a doctor. This does not mean unconsciousness induced during the course of treatment unless the state of unconsciousness results from the administration of anesthesia in preparation for surgical treatment of injuries from a covered accident.
- **Severance**: Complete separation and dismemberment of the part from the body.

If you are age 65 years or older, your total coverage amount is reduced to a certain percentage shown in the BTA at a Glance chart based on your age.

Exposure and Disappearance
Loss from exposure to the elements following a forced landing, sinking, stranding or wrecking of a vehicle is covered if such loss is otherwise payable under this Plan.

If you are not found within one year after the disappearance, sinking or wrecking of a conveyance in which you are riding at the time a covered accident occurred, you are presumed to have suffered loss of life resulting from injury caused by an accident.

Hijacking and Air Piracy Coverage
Loss resulting, directly or independently of all other causes, during a hijacking, air piracy or unlawful seizure or attempted seizure from an aircraft is covered if such loss is otherwise payable under this Plan.

Owned Aircraft Coverage
Loss resulting, directly or independently of all other causes, during travel or flight in, including getting in or out of, any aircraft that is owned, leased, operated or controlled by the Company or any of its subsidiaries or affiliates is covered if such loss is otherwise payable under this Plan.

Home Alteration and Vehicle Modification Benefit
An additional benefit may be provided to modify your home or vehicle if you suffer a loss resulting, directly or independently of all other causes, from a covered accident. This benefit is payable if all of the following conditions are met:

- Before the date of the covered accident, you did not require the use of any adaptive devices or adaptation of residence and/or vehicle;
- As a direct result of the covered loss, you now require an adaptive device or adaptation of your residence and/or vehicle to maintain an independent lifestyle; and
- You require home alteration or vehicle modification within one year of the covered accident. The benefit is equal to 10% of your total BTA Insurance coverage amount, up to $25,000.

Rehabilitation Benefit
An additional BTA Insurance benefit may be provided for rehabilitation purposes if you suffer a loss resulting, directly or independently of all other causes, from a covered accident. You must require rehabilitation within two years after the date of the covered loss.
The benefit is equal to 5% of your total coverage amount, up to $10,000.

Seatbelt and Airbag Benefit
An additional BTA Insurance benefit may be provided to your beneficiaries if you sustain a covered loss resulting in the loss of your life, directly or independently of all other causes, from a covered accident while wearing a seatbelt and operating or riding as a passenger in a private passenger automobile (e.g., not a taxi or public transportation vehicle).

An additional benefit may be provided if you were also positioned in a seat protected by a properly- functioning and properly deployed supplemental restraint system (airbag).

Verification of the proper use of the seatbelt at the time of the covered accident and that the supplemental restraint system properly inflated upon impact must be part of the official police report or be certified, in writing, by the investigating officer.

The separate seatbelt and airbag benefit is equal to 10% of your total coverage amount, up to $25,000 (each). If verification of proper use cannot be determined, a default benefit of $1,000 may be paid.

What's Not Covered
BTA benefits are not paid if a loss results in part from, is contributed to, or is a natural or probable consequence of any of the following:

- Activities of active duty service in the military, navy or air force of any country or international organization. (Covered accidents that occur while engaged in Reserve or National Guard training are not excluded until training extends beyond 31 days.)
- Any activity not authorized, organized or reimbursable by the Company.
- Commission or attempt to commit a felony or an assault.
- Declared or undeclared war or act of war.
- Driving any vehicle for pay or hire.
- Flight in, boarding or alighting from an aircraft or any craft designed to fly above the earth's surface:
- Except as a fare-paying passenger on a regularly scheduled commercial or charter airline.
- Being flown by the covered person or in which the covered person is a member of the crew.
- Being used for crop dusting, spraying or seeding, giving and receiving flying instruction, firefighting, sky writing, sky diving or hang-gliding, pipeline or power line inspection, aerial photography or exploration, racing, enduring tests, stunt or acrobatic flying, or any operation that required a special permit from the FAA, even if it is granted (this does not apply if the permit is required only because of the territory flown over or landed on).
- An ultra-light or glider.
- Being used by any military authority, except an aircraft used by the Air Mobility Command or its foreign equivalent.
- Being used for the purpose of parachuting or skydiving.
- Designed for flight above or beyond the earth's atmosphere.
- Intentionally self-inflicted injury, suicide or any attempt thereat while sane or insane.
- Normal commuting to and from work.
- Operating any type of vehicle while under the influence of alcohol or any drug, narcotic or other intoxicant including any prescribed drug for which the covered person has been

provided a written warning against operating a vehicle while taking it (Under the influence of alcohol, for purposes of this exclusion, means intoxicated, as defined by the law of the state in which the covered accident occurred).

- Participation in a riot or insurrection.
- Performing job duties during work hours and in a residence work area.
- Personal side trip, unless noted in this SPD.
- Sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment thereof, including exposure, whether or not accidental, to viral, bacterial or chemical agents for any bacterial infection resulting from an accidental external cut or wound or accidental ingestion of contaminated food.
- Travel in any aircraft owned, leased or controlled by the Company or any of its subsidiaries or affiliates (An aircraft will be deemed to be controlled by the Company if the aircraft may be used as the Company wishes for more than 10 straight days or more than 15 days in any year).
- Travel to another location where the covered person is expected to be assigned for more than 60 days.
- Voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a physician and taken in accordance with the prescribed dosage.

In addition, benefits will not be paid for services or treatment rendered by any person who is:

- Employed or retained by the Company.
- Living in the covered person’s household.
- A parent, sibling, spouse or child of either the covered person or the covered person’s spouse.
- The covered person.

Requesting Business Travel Accident Benefits
All claims for Business Travel Accident Insurance should be filed in writing with CF Industries, Human Resources Department within 31 days (90 days for death) of the date of loss, or as soon as reasonably possible, but in no case any longer than 15 months after the date of the loss. If the claim is not given in a timely manner and you or your beneficiaries fail to show notice was given as soon as reasonably possible, benefits may be reduced or not paid.

To claim loss-of-life benefits, your designated beneficiaries must file the following within 90 days of the loss:

- Social Security number and birth date of the deceased;
- Proof of accidental death while traveling on business of the Company; and
- Certified copy of the death certificate in the event of an accidental loss of life.

To claim benefits for other losses, you must file the following within 90 days of the loss:

- Proof that you received an accidental bodily injury while traveling on business of the Company; and
- Proof of a covered loss within one year of the date of injury.

Claims must be submitted to:

Human Resources Department CF Industries
4 Parkway North, Suite 400
Deerfield, Illinois 60015-2590

How Benefits Are Paid
You are automatically the beneficiary for all BTA benefits (except those benefits payable in the event of your death). For death benefits, your beneficiaries are as listed on your completed enrollment form.

ADMINISTRATIVE INFORMATION

Some of the benefit programs described in this SPD are subject to a Federal law known as the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA requires that we provide certain information to you about the benefit plans and your legal rights with respect to the plans in which you participate. The following sections contain information that is required under ERISA and highlight certain characteristics of the Plan and its components.

Name of Plan	CF Industries Holdings, Inc. Employee Welfare Benefit Plan
Plan Number	501
Type of Plan	Health and Welfare, including the following: Medical Prescription Drug Wellness Program Dental Vision Employee Assistance Program Health Care Flexible Spending Account Dependent Care Flexible Spending Account Short-Term Disability Long-Term Disability Life and AD&D Business Travel Accident Insurance On-Site Clinics
Plan Sponsor	CF Industries, Inc. Benefit Plan Committee 4 Parkway North, Suite 400 Deerfield, IL 60015-2590 1-847-405-2400 EIN: 36-2097061
Plan Administrator	CF Industries, Inc. Benefit Plan Committee 4 Parkway North, Suite 400 Deerfield, IL 60015-2590 1-847-405-2400 EIN: 36-2097061
Agent for Service of Legal Process (legal process may also be made upon a plan trustee or the plan administrator)	General Counsel CF Industries, Inc. 4 Parkway North, Suite 400 Deerfield, IL 60015-2590
Plan Trustee	CF Industries, Inc. Benefit Plan Committee 4 Parkway North, Suite 400 Deerfield, IL 60015-2590

	1-847-405-2400 EIN: 36-2097061

Is this plan collectively bargained?	No
Sources of Plan Contributions	Employer and Employee
Plan Funding	Insurance and general assets
End of Plan Year	December 31
ERISA plan?	Yes

Claim Denials and Appeals – Welfare Benefit Plans
This section relates to your legal rights with respect to participation in the CF Industries Holdings, Inc. Employee Welfare Benefit Plan only.

Claims for Plan benefits (including claims based on eligibility determinations) are administered by the appropriate claims administrator as described in Claims Administrators and Service Providers. See each benefit section for information on requesting benefits. In general, there is no need to file claims for EAP benefits as you do not pay for any EAP services.

With limited exceptions, you must exhaust these claim procedures before filing a civil action for benefits under section 502(a) of ERISA. If your claim for benefits is denied or ignored, in whole or in part, you may file suit in a state or federal court.

Assigning Benefits
Rights and benefits cannot be assigned to anyone except when allowed under the Plan. You may authorize the administrator to make payments directly to providers for covered services. However, the administrator reserves the right to make payments directly to you. You may not assign your rights under ERISA for breach of fiduciary duty to any provider, medical professional or other person or entity.

Payments may also be made to an alternate recipient, or that person's custodial parent or designated representative. Any payments made by the administrator fulfill the Plan's obligation to pay for covered services.

You cannot assign your right to receive payment to anyone else without the written consent of the Plan, except as required by a qualified medical child support order (QMCSO) or any applicable state law. Once a provider performs a covered service, the administrator will not honor a request to withhold payment of the claims submitted.

Claims and Appeals Procedures

The following claim review and appeal procedures apply to all benefit claims (including rescissions of coverage) and eligibility claims of any nature related to the Plan, as specified.

You, your covered dependents or your authorized representative may file a claim with the claims administrator. The claims administrator for each employee benefit Plan is responsible for claim and appeal procedures. When you file a claim, the claims administrator reviews the claim and makes a decision to approve or deny the claim. The claims administrator has the full discretionary authority to:

- Interpret the provisions of the Plan — such interpretation will be final and conclusive on all persons;
- Determine eligibility for benefits;
- Provide you with reasonable notification of your benefits available under the Plan; and
- Approve reimbursement requests and authorize the benefit payments.

If your claim is denied, in whole or in part, you'll receive written notification from the claims administrator within the time frames noted in the following table. A claim denial is any denial, reduction or termination of a benefit or a failure to provide or make a payment, in whole or in part, for a benefit. A claim denial also includes a rescission (or cancellation) of coverage on a retroactive basis.

Internal Claims and Appeals Procedures

Timing for Notification of Claim Decision*

*You should confirm with the Claim Administrator, as they may have slightly different timing, depending on the type of benefit and type of claim.

Urgent Care Clinical Claims

Type of Claim	Type of Notice or Extension	Timing
Medical	If your Claim is incomplete, the Claim Administrator must notify you within:	24 hours
	If you are notified that your Claim is incomplete, you must then provide completed Claim information to the Claim Administrator within:	48 hours after receiving notice
The Claim Administrator must notify you of the Claim determination (whether adverse or not):		
	if the initial Claim is complete as soon as possible (taking into account medical exigencies), but no later than:	48 hours
	after receiving the completed Claim (if the initial Claim is incomplete), within:	48 hours

Pre-Service Claims

Type of Claim	Type of Notice or Extension	Timing
Medical	If your Claim is filed improperly, the Claim Administrator must notify you within:	5 days
	If your Claim is incomplete, the Claim Administrator must notify you within:	15 days
	If you are notified that your Claim is incomplete, you must then provide completed Claim information to the Claim Administrator within:	45 days after receiving notice
The Claim Administrator must notify you of the Claim determination (whether adverse or not):		
	1. if the initial Claim is complete, within:	15 days**
	2. after receiving the completed Claim (if the initial Claim is incomplete), within:	30 days
	If you require post-stabilization care after an Emergency within:	The time appropriate to the circumstance not to exceed on hour after the time of request.

This period may be extended one time by the Claim Administrator for up to 15 days, provided that the Claim Administrator both (1) determines that such an extension is necessary due to matters beyond the control of the Claim Administrator and (2) notifies you, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Claim Administrator expects to render a decision.**

Post-Service Claims

Type of Claim	Type of Notice or Extension	Timing
Medical	If your Claim is incomplete, the Claim Administrator must notify you within:	30 days
	If you are notified that your Claim is incomplete, you must then provide completed Claim information to the Claim Administrator within:	45 days after receiving notice
The Claim Administrator must notify you of any adverse Claim Determination:		
	if the initial Claim is complete, within:	30 days*
	after receiving the completed Claim (if the initial Claim is incomplete), within:	45 days

*This period may be extended one time by the Claim Administrator for up to 15 days, provided that the Claim Administrator both (1) determines that such an extension is necessary due to matters beyond the control of the Claim Administrator and (2) notifies you in writing, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Claim Administrator expects to render a decision.

Type of Claim	Notice of Claim Decision	Extension
Medical and Dental: Urgent pre-service care claims Including urgent care claims that are also concurrent care claims	As soon as possible, taking into account health demands, but no later than 72 hours after the Plan receives your claim. If the claim is incomplete, you are notified about the specific information you need to submit no later than 24 hours after receipt of your claim. You have at least 48 hours to provide this information. You are notified of the decision as soon as possible, but no later than 48 hours after receipt of the information or, if earlier, the end of the period given to provide this information. If you receive a verbal notice, a written notice follows no more than three days later.	Not applicable.

Type of Claim	Notice of Claim Decision	Extension
Medical and Dental: Pre-service claims Including non-urgent concurrent care claims	Within a reasonable time, but not later than 15 days after the Plan receives your claim. If you fail to file a pre-service claim in accordance with the Plan's procedures, the claims administrator notifies you of the improper filing, and how to correct it. If a previously approved ongoing course of treatment is cut short from continued coverage, the claims administrator must cover through the end of the appeal period.	Initial notification may be extended up to 15 days if necessary due to matters beyond the control of the Plan. You are notified before the end of the first 15-day period why the extension is necessary and when the Plan expects to make a decision. If you did not submit necessary information, the notice specifies what information is necessary, and you have at least 45 days to provide it. If provided within the 45 days, the claims administrator notifies you of its decision within 15 days after receipt of the information. If not received within 45 days, the claim is denied.
Medical and Dental: Post-service claims Including non-urgent concurrent care **Vision** **Health Care Flexible Spending Account**	Within a reasonable time, but not later than 30 days after the Plan receives your claim. If a previously approved ongoing course of treatment is cut short from continued coverage, the claims administrator notifies you sufficiently in advance to allow you to submit an appeal.	Initial notification may be extended up to 15 days if necessary due to matters beyond the control of the Plan. You are notified before the end of the first 30-day period why the extension is necessary and when the Plan expects to make a decision. If you did not submit necessary information, the notice specifies what information is necessary, and you have at least 45 days to provide it. If provided within the 45 days, the claims administrator notifies you of its decision within 15 days after receipt of the information. If not received within 45 days, the claim is denied.
Disability (STD, LTD and applicable AD&D claims)	Within a reasonable time, but not later than 50 days after the Plan receives your claim.	Initial notification may be extended for up to two 30 day periods if necessary due to matters beyond the control of the Plan. You are notified before the end of the first 50-day period why the extension is necessary and when the Plan expects to make a decision.
Life and BTA (death claims)	Within a reasonable time, but not later than 90 days after the Plan receives your claim.	Initial notification may be extended for up to 90 days if necessary due to matters beyond the control of the Plan. You are notified before the end of the first 90-day period why the

		extension is necessary and when the Plan expects to make a decision.

Key Terms

Urgent care claim: Your claim for care or treatment is an urgent care claim if the use of the normal pre-service claim procedures could seriously jeopardize your life, health or your ability to regain maximum functions. In addition, your claim for medical care or treatment is an urgent care claim if, in the opinion of a physician with knowledge of your condition, you would be subject to severe pain if you do not receive the care or treatment that is the subject of the claim. The determination of whether your claim is an urgent care claim is to be determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, your claim for medical care or treatment is automatically an urgent care claim if a physician with knowledge of your condition determines that your claim is an urgent care claim.

Pre-service claim: Your claim for care or treatment is a pre-service claim if the terms of the Plan require, in whole or part, approval of the benefit before you can obtain care.

Post-service claim: Your claim for care or treatment is a post-service claim if your claim is filed after medical care has been received and does not fall within the definition of an urgent care claim, pre-service claim or concurrent care claim.

Concurrent care claim: Your claim for care or treatment is a concurrent care claim if your claim has been approved to provide an ongoing course of treatment over a period of time or number of treatments, and either involves a reduction or termination by the Plan of such course of treatment (other than by Plan amendment or termination) or a request by you or on your behalf to extend or expand your treatment.

If Your Claim Is Denied

If your claim for benefit is denied, in whole or in part, you'll receive a written notice of the denial. Such notice will include all of the following, as applicable:

- The specific reasons for the denial.
- The specific Plan provisions on which the denial is based.
- A description of any additional material or information needed to complete the claim and an explanation of why it's necessary.
- If an internal rule, guideline, protocol or other similar criterion (collectively called criteria) was relied on to determine a claim, you'll receive either a copy of the actual criteria or a statement that the criteria was used and how you can request a copy of it free of charge.
- If the denial is based on a provision such as medical necessity, experimental treatment or a similar exclusion or limit, you'll receive either an explanation of the scientific or clinical judgment for the determination based on the Plan terms and your medical circumstances, or a statement that you can receive the explanation free of charge upon request.
- An explanation of the expedited claim review procedure for an urgent care claim.
- For a group health plan:
    - Information sufficient to identify the specific claim (such as the date of the service, name of the health care provider, diagnosis or treatment).
    - A statement of your right to bring a civil action under ERISA section 502(a) following a denial on review.
    - A description of available internal appeals and external review processes and applicable time limits.
    - Contact information for any applicable office of health insurance consumer assistance or ombudsman, if any, established by the Department of Health and Human Services to assist in internal claims and appeals and the external review process.
    - A description of the Plan's standard, if any, used in denying the claim (e.g., if a medical necessity standard is used to deny the claim, the notice must describe the medical necessity standard).

Appeal of Denied Claim

If your claim for benefits is denied, you, or your authorized representative may appeal a claim decision by writing to your claims administrator. You must make your initial request for appeal in writing within the timeframe shown below:

- Medical and Disability (LTD and AD&D, if applicable) claims: 180 days after receipt of the Level 1 claim denial or 60 days after receipt of a Level 2 claim denial.
- Dental and Vision claims: 365 days after receipt of the claim denial.
- Life and BTA (death claims): 60 days after receipt of the claim denial.

As part of the appeal process, you or your authorized representative will be given reasonable access to all documents, records and information relevant to the claim for benefits, and you may request copies free of charge upon request. You can also submit to your claims administrator written comments, documents, records and other information relating to the claim for benefits. Review of your claim will take into account all comments, documents, records and other information that is submitted, without regard to whether such information was submitted or considered in the initial benefit determination.

For an urgent care claim, there will be an expedited review process where you can submit, orally or in writing, a request for review. Necessary information may be transmitted between you and the claims administrator by phone, fax or any other similarly expeditious method. To request a fax number or other method of submitting information, contact the claims administrator.

Your request for appeal must include the following:

- The initial denial letter;
- The reason you believe the claim should be paid; and
- Any documentation or other written information to support your request for claim payment.

Deciding the Appeal

The claim will be reviewed again and a decision made based on all comments, documents, records and other information you've submitted. In reviewing your claim. For group health plans, the following applies:

- The review on appeal will not afford deference to the initial denial of your claim.
- A person other than the original reviewer (including a subordinate of such person) will review the claim decision.
- If the denial was based, in whole or in part, on a medical judgment, the person will consult with a health care professional who has appropriate training and experience in the field involving the medical judgment. This health care professional cannot be the same person who made the initial decision of denial, nor a subordinate of the person.
- The identity of medical or vocational experts who were consulted in the initial claim denial shall be disclosed to you without regard to whether their advice was relied upon in making the claim determination.

You will also receive, free of charge, any new or additional evidence or rationale considered, relied upon or generated by the claims administrator in connection with your group health plan claim. This evidence and rationale will be provided to you as soon as possible and sufficiently in advance of the date on which notice of final determination of your claim is required to be provided to give you a reasonable opportunity to respond before that date.

Notification of Appeal Decision

You will receive the claims administrator's written or electronic notification of the decision within the following time frames after the claims administrator receives your request for review:

Type of Claim	Timing of Notification
Medical and Dental: Expedited urgent care claim Including urgent concurrent care	As soon as possible, taking into account health demands, but no later than 36 hours after the Plan receives your appeal. If you receive a verbal notice, a written notice follows no more than three days later.
Medical and Dental: Pre-service claim Including non-urgent concurrent care	**First Level:** A reasonable time, but no later than 15 days after the Plan receives the request for review. **Second Level:** A reasonable time, but no later than 15 days after the Plan receives the request for review.
Medical: Post-service claim Including non-urgent concurrent care **Vision** **Health Care Flexible Spending Account** **Life and BTA (death claims)**	**First Level:** A reasonable time, but no later than 30 days after the Plan receives the request for review. **Second Level:** A reasonable time, but no later than 30 days after the Plan receives the request for review.
Dental: Post-service claim Including non-urgent concurrent care	**First Level:** A reasonable time, but no later than 30 days after the Plan receives the request for review. **Second Level:** A reasonable time, but no later than 30 days after the Plan receives the request for review.
Disability (LTD and AD&D, if applicable)	A reasonable time, but no later than 50 days after the Plan receives the request for review.

If your appeal is denied, in whole or in part, you'll receive a written notice that contains all of the information listed in If Your Claim Is Denied along with:

- A statement describing any additional mandatory or voluntary appeal procedures offered by the Plan, including the opportunity for you to request an external review (by an independent review organization).
- An explanation of your right to request reasonable access to and copies of all documents, records and other information relevant to your claim without charge.
- A discussion of the decision if the denial on appeal is based on the Plan's standard, if any, used in denying the claim.

External Review Process for Medical
If, upon review, your claim is still denied and you disagree with the claims administrator's decision, you, your beneficiary or your authorized representative may request an external review of a final determination by writing to your claims administrator.

In most circumstances, before you may submit your claim to the external review process, you must first follow the internal claims and appeal procedures outlined above, including requesting an appeal of a claim denial with your claims administrator. However, in certain circumstances (described below), you may receive an expedited external review. In this case, you may not have to exhaust the internal claims and appeal procedures before filing a request for external review.

You must make your request for external review in writing to the claims administrator within 123 calendar days of receipt of the denial of your claim. However, if that date is a federal holiday or weekend, the filing date is extended until the next business day. Your written request for external review may (but is not required to) include issues, comments, documents, records and other information relating to your claim that you want considered in reviewing your claim.

You may request an expedited external review under the following circumstances:
- For urgent care claims, at the same time you request an appeal of the denied claim.
- For other claims, if your claim is denied after the appeal, and:
    - The time for completing the external review process would jeopardize your life, health or ability to regain maximum function; or
    - The denial of the claim on appeal concerned the admission, availability of care, continued stay or health care item or service for which you received emergency services, but you have not been discharged from a facility.

Standard (Non-Expedited/Preliminary) External Review for Medical
Within five business days after receipt of the external review request, the claims administrator completes a preliminary review of your request to determine if your claim is eligible for external review. Your claim is eligible for external review if:
- You are or were covered under Plan when the health care item or service was requested or provided;
- The claim or appeal denial does not relate to your failure to meet the Plan's eligibility requirements;
- You have exhausted the Plan's internal claims and appeal process (unless you are not required to do so); and
- You have provided all information and forms required to process the external review.

Within one business day after completion of the preliminary review, the claims administrator will notify you in writing regarding whether your claim is eligible for external review. If your request is complete but not eligible for external review, the notice will include the reasons your request is ineligible and contact information for the Employee Benefits Security Administration. If your request is incomplete, the notice will describe the information needed to complete the request. You will have until the later of the end of the 123-day period you had to file a request for an

external review or the 48-hour period following receipt of the notice to provide all of the needed information.

External Review by an Independent Review Organization for Medical

If the claims administrator determines your claim is eligible for external review, your claim will be assigned to an independent review organization (IRO). The IRO will notify you that your claim is eligible for external review and that the review process is beginning. The notice will also inform you that you have 10 business days following receipt of the notice to provide additional information to the IRO for it to consider. The IRO will not defer to the decisions made during the internal appeal process and will consider all the information and documents that it receives in a timely manner when making its decision.

The IRO and/or the claims administrator will provide written notice of the final external review decision within 50 days after it receives the request for external review. If the IRO reverses the denial of your claim, the decision will be final and the Plan must immediately provide coverage or payment.

Expedited External Review for Medical

The Plan must allow you to request an expedited external review at the time:

- You receive an adverse benefit determination, if:
    - That determination involves a medical condition for which the timeframe form completing an expedited internal appeal (the standard Level 1 and Level 2 appeal process) would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function; and
    - You have filed a request for an expedited internal appeal; or
- You exhaust the internal appeal process (Level 1 and Level 2), if:
    - You have a medical condition where the timeframe for completing a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function; or
    - It concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

As soon as Blue Cross Blue Shield of Illinois receives your request for an expedited external review, Blue Cross Blue Shield of Illinois will determine whether the request meets the reviewability requirements for standard external review and immediately notify you of its determination.

If your request for an expedited external review is approved, Blue Cross Blue Shield of Illinois will assign an IRO. The IRO will make a decision as quickly as your medical condition or circumstances require, and within 72 hours after the IRO receives your request for the expedited review. If the IRO gives you its decision orally, the IRO must follow up with written confirmation to you, Blue Cross Blue Shield of Illinois and the Plan within 48 hours of making the decision.

All claim decisions of the external independent review organization are final.

Medical Plan Claim Fiduciary
CF Advantage PPO Plan and CF Standard PPO plan claim decisions are made by the Claim Fiduciary in accordance with the provisions of the medical plan. The Claim Fiduciary has complete authority to review denied claims for benefits. This includes, but is not limited to, determining whether hospital or medical treatment is, or is not, medically necessary. In exercising its fiduciary responsibility, the Claim Fiduciary has discretionary authority to:

- Determine whether, and to what extent, employees and covered dependents are entitled to benefits; and
- Interpret the provisions of the plan when a question arises.

The Claim Fiduciary has the right to adopt reasonable policies, procedures, rules and interpretations of the plan to promote orderly and efficient administration. The Claim Fiduciary may not act arbitrarily or capriciously, which would be an abuse of its discretionary authority.

Blue Cross Blue Shield of Illinois is the Claim Fiduciary for the medical plan and has the discretionary authority to review all denied claims for benefits under the plan.

CF Industries Holdings, Inc., is responsible for making reports and disclosures required by ERISA, including the creation, distribution and final content of:

- Summary Plan Descriptions;
- Summary of material modifications; and

Legal Actions
You may not take any legal action to recover benefits more than three years after the Plan requires you to file a claim.

In most situations, you may not initiate a legal action against the Plan until you complete the mandatory claims and appeal process described in this SPD.

Overpayment
If the insurance carrier has made an overpayment to you, it has the right to collect such overpayment from you, from the provider of services or supplies, or from another insurance carrier, service Plan or organization that should have paid benefits.

Facility of Payment
A payment made under another group health plan may include an amount that should have been paid under the CF Industries Plan. If it does, the CF Industries Plan may pay that amount to the organization that made the original payment. That amount is then treated as though it were paid under the CF Industries Plan. The CF Industries Plan will not be required to pay that amount again.

Reimbursement Provision

If you or one of your covered dependents incur expenses for a sickness or injury that occurred due to the negligence of a third party and benefits are provided for covered services, you agree:

- The insurance carrier has the right to reimbursement for all benefits provided from any and all damages collected from the third party for these same expenses whether by action at law, settlement or compromise, by you, your covered dependent or your legal representative as a result of that sickness or injury, in the amount of the total eligible charge or provider's claim charge for covered services for which the insurance carrier has provided benefits to you, reduced by any Average Discount Percentage ("ADP") applicable to your claim or claims.
- The insurance carrier is assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits the insurance carrier provided for that sickness or injury.

The insurance carrier shall have the right to first reimbursement out of all funds you, your covered dependents or your legal representative, are or were able to obtain for the same expenses for which the insurance carrier has provided benefits as a result of that sickness or injury.

You are required to furnish any information or assistance or provide any documents that the insurance carrier may reasonably require in order to obtain the insurance carrier's rights under this provision. This provision applies whether or not the third party admits liability.

Claims Administrators and Service Providers

This section relates to your legal rights with respect to participation in the CF Industries Holdings, Inc. Employee Welfare Benefit Plan.

The Company has different claims administrators and service providers for the Plan as shown below:

Claims Administrator and/or Service Providers…	For…	Address for Filing Claims…
CF Industries, Inc. Benefit Plan Committee 4 Parkway North, Suite 400 Deerfield, IL 60015-2590 1-847-405-2400	Plan administration and eligibility appeals	CF Industries, Inc. Benefit Plan Committee 4 Parkway North, Suite 400 Deerfield, IL 60015-2590
Blue Cross Blue Shield of Illinois 888-902-8293 Fax 888-235-2936	Medical benefits and claims under the CF Advantage PPO Plan and CF Standard PPO Plan options. This includes the initial claim, first level of claims appeals and the external review process	Initial Claim Blue Cross and Blue Shield of Illinois P. O. Box 805107 Chicago, Illinois 60680-4112 Claim Appeal The Claim Administrator Claim Review Section P.O. Box 2401 Chicago, Illinois 60690

Claims Administrator and/or Service Providers…	For…	Address for Filing Claims…
Prime Therapeutics 888-902-8293	Prescription drug claims for the CF Advantage PPO Plan and CF Standard PPO Plan options	Prime Therapeutics P.O. Box 25136 Lehigh Valley, PA 18002-5136
CIGNA 1-800-244-6224 www.myCigna.com	Dental and vision claims, benefit amounts and terms/provisions of the Dental and Vision Plans	Dental Claims: CIGNA Dental Claims Department P.O. Box 188037 Chattanooga, TN 37422-8037 1.800.CIGNA24 or 1.800.244.6224 Vision Claims: CIGNA Vision Claims Department P.O. Box 385018 Birmingham, AL 35238-5018 Contact Information: 1-800-244-6224 www.myCigna.com
ComPsych (a Guidance Resource Company) NBC Tower; 13th Floor 455 N. Cityfront Plaza Chicago, IL 60611 1-866-465-8943 TDD: 1-800-697-0353 www.guidanceresources.com (your Company Web ID: CFIND)	Employee Assistance Program (EAP) claims, benefit amounts and terms/provisions of the program	ComPsych NBC Tower; 13th Floor 455 N. Cityfront Plaza Chicago, IL 60611 1-866-465-8943 TDD: 1-800-697-0353 www.guidanceresources.com (your Company Web ID: CFIND)
BASIC COBRA 916-303-7100 COBRA@BasicPacific.com	COBRA Administration	BASIC COBRA PO Box 631325 Cincinnati, OH 45263
Life Insurance Company of North America 1601 Chestnut Street Philadelphia, PA 19192-2235 1-800-732-1603 TTD: 1-800-552-5744	Short- and Long-Term Disability, Life and AD&D and Business Travel Accident Insurance claims, benefit amounts and terms/provisions of the program	Life Insurance Company of North America 1601 Chestnut Street Philadelphia, PA 19192-2235 1-800-732-1603 TTD: 1-800-552-5744

Claims Administrator and/or Service Providers…	For…	Address for Filing Claims…
FIDELITY REIMBURSEMENT ACCOUNT SERVICES Fidelity at (833) 299-5089	Flexible Spending Accounts	FSA Claims are filed online Fidelity Flexible Spending and Reimbursement Accounts Services PO Box 2703 Fargo, ND 58108 Log in to netbenefits.com
Fidelity - (800) 835-5095	Health Savings Account	Netbenefits.com

Your 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 provides that all Plan participants have the following rights and protections:

Receive Information about Your Plan and Benefits

Under ERISA, you have the right to:

- Examine all Plan documents, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. You must be allowed to review these documents, without charge, at the Plan administrator's office and at other specified locations, such as work sites and union halls;
- Obtain copies of documents — including insurance contracts and collective bargaining agreements — governing the operation of the Plan, along with copies of the latest annual report (Form 5500 Series) and the updated summary Plan description. To obtain copies of these documents, you must submit a written request to the Plan administrator and, if required, pay reasonable copying charges;
- Receive a summary of the Plan's annual financial report. By law, the Plan administrator must furnish each participant with a copy of this summary annual report; and

Prudent Actions by Plan Fiduciaries

Along with providing participant rights, ERISA imposes duties on Plan fiduciaries, that is, the people responsible for the operation of the employee benefit Plan. These people have the duty to operate the Plan in a prudent manner and in the interest of you, other Plan participants, and Plan beneficiaries. No one — not your employer, your union, or any other person — can fire you or otherwise discriminate against you in any way to prevent you from obtaining a pension (welfare) benefit, or exercising your rights under ERISA.

Enforce Your Rights

If your claim for pension (welfare) benefits is denied in whole or in part, you have the right:

- To know why your claim was denied;

- To obtain, without charge, copies of documents relating to the decision; and
- To appeal any denial. Certain time schedules apply to all of these rights.

Under ERISA, you can take certain steps to enforce these rights. For instance, if you request copies of Plan documents or the Plan's latest annual report and do not receive them within 30 days, you can file suit in a federal court. In such a case, the court can require the Plan administrator to provide the requested documents and to pay you a daily fine until you receive them, unless they were not sent for reasons beyond the administrator's control. If you have a claim for benefits that is denied or ignored in whole or in part, you can file suit in a state or federal court. In addition, if you disagree with the Plan's decision — or failure to make a decision — concerning the qualified status of a domestic relations order or a medical child support order, you can file suit in federal court.

If Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you can seek assistance from the U.S. Department of Labor, or you can file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court can order the other party to pay your court costs and legal fees. If you lose, the court might order you to pay the other party's costs and fees — for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan administrator. If you have any questions about this statement or your ERISA rights, or if you need assistance obtaining documents from your Plan administrator, you should check your telephone directory and contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave., N.W., Washington, D.C. 20210. You also can obtain certain publications about your rights and responsibilities under ERISA by calling EBSA's publications hotline at 800-998-7542.

Required Notices

Subrogation

If you or your covered dependent has expenses for a sickness or injury that occurs due to the act or omission of a third party and benefits are provided for covered services described in this SPD, you agree:

- The Plan has the right to be reimbursed for all benefits the Plan provides from any and all damages collected from the third party for those same expenses, whether by action at law, settlement or compromise, by you or your legal representative due to your sickness or injury.
- The Plan is assigned the right to recover from any or all third parties, under any legal theory of any type, all services and benefits the Plan has paid on your behalf relating to a sickness or injury caused by a third party.
- If you receive payment from a third party or insurer for a sickness or injury, you are a constructive trustee over the funds that make up such payment for the benefit of the Plan.
- The Plan automatically has a lien on amounts recovered by you or on your behalf to the extent of benefits paid by the Plan for the treatment of a sickness or injury for which the third party is liable. The lien remains in effect until the Plan is repaid in full.
- The Plan has the right to first reimbursement out of all funds you, your covered dependents or your legal representative is or was able to obtain for the same expenses the Plan provided benefits as a result of that sickness or injury. You are obligated to reimburse the Plan in full, in first priority, regardless of whether the judgment, settlement or compromise specifically designates all or part of the recovery as including medical expenses.
- You must furnish information, assistance or documents that the Plan reasonably requires to obtain the Plan's rights under this provision. This provision applies whether or not the third party admits liability. If you do not cooperate with the Plan or its agents, it is considered a breach of contract. As such, the Plan may terminate your benefits, deny future benefits, and/or set off from any future benefits the value of benefits the Plan has paid relating to a sickness or injury caused by any third party to the extent not recovered by the Plan due to you or your legal representative not cooperating with the Plan.

Definitions
Use the following definitions to help you understand your Plan benefits.

Appropriate Care: Appropriate care means the determination of an accurate and medically supported diagnosis of your disability by a physician, or a plan established by a physician of ongoing medical treatment and care of your disability that conforms to generally accepted medical standards, including frequency of treatment and care.

Base Salary: Base salary is your annual salary on your date of disability, excluding bonus, shift differential, overtime pay and other compensation.

Claim Payment: The benefit payment calculated by the insurance carrier after you submit a claim.

Calendar Year Maximum This is the maximum benefit amount (cost or number of visits) allowed within the calendar year. Once you reach the maximum amount, you will be responsible for paying any costs for the remainder of the benefit period.

Coinsurance: A percentage of an eligible expense that you are required to pay toward a covered service.

Contracted Fee — CIGNA Dental Preferred Provider: Contracted fee refers to the total compensation level that a provider has agreed to accept as payment for dental procedures and services performed on you or your dependent, according to the Dental Plan.

Copay or Copayment: A specified dollar amount that you are required to pay toward a covered service.

Course of Treatment: Any number of dental procedures or treatments performed by a dentist or physician in a planned series resulting from a dental exam in which the need for such procedures or treatments was determined.

Covered Service: A service and supply specified in the Plan document for which benefits are provided.

Custodial Care: Those services which do not require the technical skills or professional training of medical and/or nursing personnel to be safely and effectively performed. Mostly, these services are furnished to help you in the activities of daily life, such as assistance in walking, bathing or acting as a companion.

Deductible: The amount you pay for covered medical expenses each year before the Plan begins to pay.

Dentist: Dentist means a person practicing dentistry or oral surgery within the scope of his/her license. It also includes a physician operating within the scope of his/her license when the physician performs any of the dental services described in the dental policy.

Diagnostic Service: Tests rendered to diagnose your symptoms to evaluate a condition, disease or injury. Tests include, but are not limited to, x-ray, pathology services, clinical lab tests, pulmonary function studies, electrocardiograms, electroencephalograms, radioisotope tests and electromyograms.
Disability Earnings: Your base salary. For non-exempt employees, your eligible earnings are determined by applying your base hourly rate to your scheduled hours.

Eligible Charge: The charge which a particular hospital or facility usually charges its patients for covered services, or a charge within the range of charges other similar hospitals or facilities in similar geographic areas charge their patients for the same or similar services.

Emergency Medical Care: Services for initial outpatient treatment (including related diagnostic services) of a sudden and unexpected medical condition, where the absence of immediate medical treatment would likely result in serious and permanent medical consequences. Examples of emergency medical conditions are: severe chest pains, convulsions or persistent, severe abdominal pains.

Home Health Care Agency: An agency that:
- Provides mainly skilled nursing and other therapeutic services; and
- Is associated with a professional group (of at least one physician and one RN) that makes policy; and
- Has full-time supervision by a physician or an RN; and
- Keeps complete medical records for each patient; and
- Has an administrator; and
- Meets licensing standards.

Hospice Care: Care provided to a terminally ill person by or under arrangements with a hospice care agency. The care must be part of a hospice care program.

Hospice Care Provider/Agency: An agency or organization that:
- Has hospice care available 24 hours a day;
- Meets any licensing or certification standards established by the jurisdiction where it is located;
- Provides skilled nursing and medical social services as well as psychological and dietary counseling;
- Provides or arranges for physician services, physical and occupational therapy, part-time home health aid services for the care of terminally ill and inpatient care to manage pain control and acute and chronic symptoms.

Hospice Care Program Service: A centrally administered program designed to provide for the physical, psychological, and spiritual care of dying persons and their families. The goal of hospice care is to allow the dying process to proceed with a minimum of patient discomfort while

maintaining dignity and quality of life. Hospice care program service is available in the home, skilled nursing facility, or special hospice care unit.

Hospital: A place that:

- Is a licensed institute which provide services under the care of a Physician including the regular provision of bedside nursing by registered nursed and which is either accredited by the Joint Commission on Accreditation of hospitals or certified by the Social Security Administration as eligible for participation under Title XVIII, Health Insurance for the Aged and Disabled.
- Mainly provides inpatient facilities for the surgical and medical diagnosis, treatment and care of injured and sick persons;
- Is supervised by a staff of physicians;
- Provides 24-hour RN service;
- Is not mainly a place for rest, for the aged, for drug addicts or alcoholics; or a nursing home;
- Charges for services.

Indexed Earnings: For the first 12 months that monthly benefits are payable, your indexed earnings are equal to your covered earnings. After 12 monthly benefits are payable, your indexed earnings are your covered earnings plus an increase applied on each anniversary of the date the monthly benefits became payable. The amount of the increase will be the lesser of:

- 10% of your indexed earnings during your preceding year of disability, or
- The rate of increase in the Consumer Price Index (CPI-W) during the preceding calendar year.

Injury: An accidental loss or bodily harm that results directly and independently from all other causes from an accident.

Investigational/Experimental Services and Supplies: Procedures, drugs, devices, services and/or supplies are considered experimental or investigational if:

- There are insufficient outcomes data available from controlled clinical trials published in peer- reviewed literature to substantiate its safety and effectiveness for the illness or injury involved; or
- It does not have approval required for marketing by the U.S. Food and Drug Administration; or
- A nationally recognized medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational or for research purposes; or
- It is a type of drug, device or treatment that is the subject of a Phase I or Phase II clinical trial of the experimental or research arm of a Phase III clinical trial, using the definition of “phases” indicated in regulations and other official actions and publications of the U.S. Department of Health and Human Services; or
- The written protocol(s) or written informed consent used by the treating facility – or another facility studying the same drug, device, treatment or procedure – states that it is experimental, investigational or for research purposes.

Maximum Reimbursable Charge — Dental: The maximum reimbursable charge is the lesser of the:

- Provider's normal charge for a similar service or supply, or
- 80th percentile of all charges made by providers of such service or supply in the geographic area where it is received.

To determine if a charge exceeds the maximum reimbursable charge, the nature and severity of the injury or sickness may be considered. The insurance carrier uses the Ingenix Prevailing Health Care System database to determine the charges made by providers in an area. The database is updated semiannually. Additional information about the maximum reimbursable charge is available upon request.

Maximum Allowable: The amount determined by the insurance carrier, which participating professional providers have agreed to accept as payment in full for a particular covered service.

Medicaid: Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.

Medically Necessary/Medical Necessity: Health care services and supplies that a physician, other health care provider or dentist, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury or disease. The service or supply must be:

- Provided in accordance with generally accepted standards of medical or dental practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration;
- Considered effective for the patient's illness, injury or disease;
- Not primarily for the convenience of the patient, physician, dentist or other health care provider; and
- Not more costly than an alternative service or sequence of services that would be at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "generally accepted standards of medical or dental practice" means standards that are:

- Based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical or dental community; or
- Otherwise consistent with physician or dental specialty society recommendations and the views of physicians or dentists practicing in relevant clinical areas and any other relevant factors.

Medicare: Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.

Mental Illness: This is a disease commonly understood to be a mental disorder whether or not it has a physiological or organic basis. Treatment for mental disorders is usually provided by or under the direction of a behavioral health provider such as a psychiatrist, psychologist or psychiatric social worker. Mental illness includes, but is not limited to:

- Alcohol and substance abuse
- Schizophrenia
- Bipolar disorder
- Panic disorder
- Major depressive disorder
- Psychotic depression
- Obsessive compulsive disorder

Non Participating Provider / Out of Network Providers– BCBSIL.com Non-participating providers also referred to out of network providers have not signed an agreement with BCBSIL to accept the maximum allowance as payment in full. Therefore, you are responsible to these providers for the difference between BCBSIL's payment and the amount the provider charges.

Occupational Therapy: Constructive therapeutic activity designed and adopted to promote the restoration of useful physical function.

Out-of-Pocket Maximum: This is the most that you will pay toward eligible health care expenses in a calendar year. This protects you from a severe financial loss in the event of a serious illness or injury. Once the out-of-pocket maximum is reached, the CF Industries Medical Plan will pay 100% of eligible expenses for the rest of the year. The out-of-pocket maximum includes the deductible and coinsurance. It does not include prescription drug copays and the portion of charges from an out-of-network provider which exceeds the negotiated in-network rate, or charges for failure to precertify.

Outpatient: Treatment while not admitted to a hospital or inpatient facility.

Participating Providers/ In Network Provider – BCBSIL.com Participating providers also referred to as in-network providers have signed an agreement with BCBS to accept the maximum allowance as payment in full. They have agreed not to bill you for covered service amounts in excess of the maximum allowance. You are only responsible for the difference between the BCBS's payment and the maximum allowance for the covered service – that is, or deductible, copayment and coinsurance amount.

Participating Provider — **CIGNA Dental Preferred Provider**: Participating provider means: a dentist, or a professional corporation, professional association, partnership, or other entity which is entered into a contract with the insurance carrier to provide dental services at predetermined fees. The providers qualifying as participating providers may change from time to time. A list of the current participating providers is available by contacting Cigna at mycigna.com.

Physical Therapy: The treatment of a disease, injury or condition by physical means by a physician or a registered professional physical therapist under the supervision of a physician, which is designed and adapted to promote the restoration of a useful physical function.

Physician: A legally qualified physician.

Physician Assistant: A duly licensed physician assistant performing under the direct supervision of a physician, dentist or podiatrist and billing under such provider.

Primary Care Physician: This is a preferred provider you select from the network and is shown on the plan's record as your primary care physician. Your primary care physician treats all basic illnesses and injuries and coordinates your care by referring you to a specialist when needed.

Private Duty Nursing Service: Skilled nursing service provided on a one-to-one basis by an actively practicing registered nurse or licensed practical nurse who is not providing this service as an employee or agent of a hospital or other health care facility. Private duty nursing service does not include custodial care service.

Provider: Any health care facility or person licensed to render covered services to you. A "Plan provider" means a provider who has a written agreement with the insurance carrier. A "network provider" means a hospital or professional provider with a written agreement with the insurance carrier to provide services to participants.

Psychologist: A registered clinical psychologist registered in his/her state (where statutory licensing exists) and holds a valid credential for such practice. If practicing in a state where statutory licensure does not exist, that person must meet the qualifications specified in the definition of a clinical psychologist. A "clinical psychologist" means a psychologist who specializes in the evaluation and treatment of mental illness and meets the following qualifications: has a doctoral degree from a regionally accredited university, college or professional school, and has two years of supervised experience in health services of which at least one year is post-doctoral and one year is an organized health services program; or is a registered clinical psychologist with a graduate degree from a regionally accredited university or college, and has not less than six years as a psychologist with at least two years of supervised experience in health service.

Recommended Clinical Review

Some services that do not require Prior Authorization may be subject to review for evidence of medical necessity for coverage determinations that may occur prior to services rendered, during the course of care or after care has been completed for a Post-Service Medical Necessity Review.

A Recommended Clinical Review is a Medical Necessity review for a Covered Service that occurs before services are completed and helps limit the situations where you have to pay for a non-approved service. The Claim Administrator will review the request to determine if it meets approved Claim Administrator medical policy and/or level of care review criteria for medical and behavioral health services. Once a decision has been made on the services reviewed as part of the Recommended Clinical Review process, they will not be reviewed for Medical Necessity again on a retrospective basis. Submitted services (subject to Medical Necessity review) not included as part of Recommended Clinical Review may be reviewed retrospectively.

To determine if a Recommended Clinical Review is available for a specific service, visit our website at www.bcbsil.com/find-care/where-you-go-matters/utilization-management.com for the Required Prior Authorization and Recommended Clinical Review list, which is updated when new services are added or when services are removed. You can also call Customer Service at the toll-free telephone number on the back of your Identification Card. You or your Provider may request a Recommended Clinical Review. **Recommended Clinical Review / Predetermination review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions under this Plan. Please coordinate with your Provider to submit a written request for a Recommended Clinical Review**

Regular Occupation: The occupation you routinely perform at the time the disability begins. In evaluating the disability, the insurance carrier considers the duties of the occupation as it is normally performed in the general labor market in the national economy. It is not work tasks that are performed for a specific employer or at a specific location.

Rehabilitation Plan: A written plan designed to enable you to return to work. The rehabilitation plan consists of one or more of the following phases:

- Rehabilitation, under which may provide, arrange or authorize, education, vocational or physical rehabilitation or other appropriate service; and/or
- Work, which may include modified work and work on a part-time basis.

Renal Dialysis Treatment: One unit of service including the equipment, supplies, and administrative service customarily considered necessary to perform the dialysis process.

Respite Care Service: Those services provided at home or in a facility to temporarily relieve the family or other caregivers (non-professional personnel) that usually provide or are able to provide such services for you.

Sickness: Sickness means a physical or mental illness.

Skilled Nursing Facility: An institution that:

- Is licensed or approved under state or local law;
- Qualifies as a skilled nursing facility under Medicare, or as an institution accredited by:
    - The Joint Commission on Accreditation of Health Care Organizations;
    - The Bureau of Hospitals of the American Osteopathic Association; or
    - The Commission on the Accreditation of Rehabilitative Facilities
- Is primarily engaged in providing skilled nursing care and related services for residents who need:
    - Medical or nursing care; or
    - Rehabilitation services because of injury, illness or disability;
- Is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from disease or injury:
    - Professional nursing care by an RN or by an LPN directed by a full-time RN; and
    - Physical restoration services to help patients to meet a goal of self-care in daily living activities;
- Provides 24-hour nursing care by licensed nurses directed by a full-time RN;
- Is supervised full-time by a physician or RN;
- Keeps a complete medical record for each patient;
- Has a utilization review plan;
- Is not mainly a place for rest, the aged, for people who are mentally retarded, or for custodial or educational care;
- Charges for its services.

A skilled nursing facility may be a rehabilitation hospital or a portion of a hospital designated for skilled or rehabilitation services.

Skilled Nursing Service: Those services provided by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) which require the technical skills and professional training of an R.N. or L.P.N. and cannot reasonably be taught to a person who does not have specialized skill and professional training. Skilled nursing service does not include custodial care.

Speech Therapy: The treatment for the correction of a speech impairment resulting from disease, trauma, congenital anomalies or previous therapeutic processes, and which is designed and adapted to promote the restoration of a useful physical function. Speech therapy does not include educational training or services designed and adapted to develop a physical function.

Substance Abuse: The uncontrollable or excessive abuse of addictive substances consisting of alcohol, morphine, cocaine, heroin, opium, cannabis and other barbiturates, amphetamines, tranquilizers and/or hallucinogens, and the resultant physiological and/or psychological dependency which develops with continued use, requiring medical care as determined by a physician or psychologist.

Temporomandibular Joint Dysfunction and Related Disorders: Jaw joint conditions including temporomandibular joint disorders and craniomandibular disorders, and all other conditions of the joint linking the jaw bone and skull and the complex of muscles, nerves and other tissues relating to that joint.

Totally Disabled — **Medical Plan**: An inability of a covered employee, by reason of illness, injury or physical condition, to perform the material duties of any occupation for which he/she is or becomes qualified by reason of experience, education or training or to work for pay or profit. With respect to a covered dependent, totally disabled is the inability by reason of illness, injury or physical condition, to engage in the normal activities of a person of the same age and sex who is in good health.

Utilization Management and Review

The Utilization Management and Review Program assists you in determining the course of treatment that will maximize your benefits under this Health Care Plan. Utilization management may be referred to as Medical Necessity reviews, utilization review (UR) or medical management reviews. Requirements for Medical Necessity may vary based upon a member's plan benefits. A Medical Necessity review for a procedure/service, Inpatient admission, and length of stay is based on the Claim Administrator's Medical Policy and/or level of care review criteria. Medical Necessity reviews may occur when a Provider requests an authorization prior to services rendered, during the course of care, or after care has been completed for a Post-Service Medical Necessity Review. Some services may require a Prior Authorization before the start of services, while other services will be subject to a Post-Service Medical Necessity review. If requested, services normally subject to a Post-Service Medical Necessity review may be reviewed for Medical Necessity prior to the service through a Recommended Clinical Review as defined below.

Please refer to the definition of Medically Necessary under the *Definitions* section for additional information regarding any limitations and/or special conditions pertaining to your benefits.

The Utilization Management and Review Program requires a review of the following Covered Services **before** maximum benefits for such services are available:

- • Inpatient Hospital services
- • Skilled Nursing Facility services
- • Services received in a Coordinated Home Care Program
- • Private Duty Nursing Services
- • Certain Outpatient Procedures