The Mosaic Company

Comprehensive Welfare Benefit Plan - Prescription Drug Coverage

Summary Plan Description

Effective: January 1, 2024

Prescription Drug Coverage Summary Plan Description

The Mosaic Company‘s (the “Plan Sponsor”) Comprehensive Welfare Benefit Plan Prescription Drug Coverage (the “Plan”) is administered by Express Scripts – the Pharmacy Benefit Manager (PBM).

If you enroll in the medical plan, you automatically have prescription drug coverage.

This summary plan description (SPD) outlines the provisions of the Plan in effect as of January 1, 2024. Please read the information in this SPD carefully and share it with your family. Keep this SPD in a convenient location so you can refer to it whenever necessary. You will be notified when changes are made to the benefit plans. Please keep those notifications with this SPD.

All benefits and coverages described in this summary plan description (SPD) are effective as of January 1, 2024 and are subject to the terms of the plan document under which the Plan is provided.

The Mosaic Company reserves the right to amend any of the programs and arrangements described in this SPD (including changing the method of providing benefits and curtailing or reducing future benefits) or to terminate at any time for any reason, any or all the programs and arrangements herein described.

If there is any conflict between this SPD and the plan documents, the plan documents will always govern.

Neither this SPD nor the benefits described herein constitute a contract of employment or a guarantee of employment between The Mosaic Company and any employee.

The Mosaic Company intends to continue this Plan, but reserves the right, in its sole discretion, to change, interpret, withdraw, or add Benefits, or to end the Plan, as permitted by law, without your approval, subject to any collective bargaining agreements, if applicable.

On its effective date, this SPD replaces and overrules any SPD that the Plan Sponsor may have previously issued to you. This SPD will in turn be overruled by any SPD issued to you in the future.

The Plan will take effect on January 1, 2024. Coverage under the Plan starts at 12:01 a.m. and ends at December 31, 2024 12:00 midnight in the time zone of the Plan Sponsor's location.

The Plan is governed by ERISA unless the Plan Sponsor is not a private plan sponsor.

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Who Is Eligible for Coverage?

The plan is offered to you as an employee.

Eligible Person

You will become eligible for insurance on the day you complete the waiting period if:

- You are in a Class of Eligible Employees as determined by your employer; and
- You are an eligible Employee as determined by your Employer; and
- You pay any required contribution.

If you were previously insured and your insurance ceased, you must satisfy the Waiting Period to become insured again. If your insurance ceased because you were no longer employed in a Class of Eligible Employees, you are not required to satisfy any waiting period if you again become a member of a Class of Eligible Employees within one year after your insurance ceased.

You will become eligible for Dependent Insurance on the later of:

- The day you become eligible yourself; or
- The day you acquire your first Dependent.

Eligible Dependent

Dependent generally refers to your lawful spouse, civil union or domestic partner and children. When a Dependent enrolls, the Claims Administrator refers to that person as an Enrolled Dependent.

Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under the Plan.

Your eligible Dependents may also participate in the Plan. An eligible Dependent is considered to be:

- Your Spouse.
- Civil union or domestic partner.
- Your or your Spouse's child who is under age 26, including a natural child, stepchild, a legally adopted child, a child placed for adoption or a child for whom you or your Spouse are the legal guardian.
- An unmarried child age 26 or more years old and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability which arose while the child was

covered as a Dependent under this Plan, or while covered as a dependent under a prior plan with no break in coverage.

To be eligible for coverage under the Plan, a Dependent must reside within the United States.

Note: Your Dependents may not enroll in the Plan unless you are also enrolled. In addition, if you and your Spouse are both covered under the Plan, you may each be enrolled as a Participant or be covered as a Dependent of the other person, but not both. In addition, if you and your Spouse are both covered under the Plan, only one parent may enroll your child as a Dependent.

A Dependent also includes a child for whom health care coverage is required through a Qualified Medical Child Support Order or other court or administrative order.

Domestic Partners

A Domestic Partner is defined as a person of the same or opposite sex who:

- Shares your permanent residence;
- Has resided with you for no less than one year;
- Is no less than 18 years of age;
- Is financially interdependent with you and has proven such interdependence by providing documentation of at least two of the following arrangements: common ownership of real property or a common leasehold interest in such property; community ownership of a motor vehicle; a joint bank account or a joint credit account; designation as a beneficiary for life insurance or retirement benefits or under your partner's will; assignment of a durable power of attorney or health care power of attorney; or such other proof as is considered to be sufficient to establish financial interdependency under the circumstances of you particular case;
- Is not a blood relative any closer than would prohibit legal marriage; and
- Has signed jointly with you, a notarized affidavit attesting to the above which can be made available upon request.

In addition, you and your Domestic Partner will be considered to have met the terms of this definition as long as neither you nor your Domestic Partner:

- Has signed a Domestic Partner affidavit or declaration with any other person within twelve months prior to designating each other as Domestic Partners hereunder;
- Is currently legally married to another person; or
- Has any other Domestic Partner, spouse or spouse equivalent of the same or opposite sex.
- You and your Domestic Partner must have registered as Domestic Partners, if you reside in a state that provides for such registration. The section of this certificate entitled "COBRA Continuation Rights Under Federal Law" will not apply to your Domestic Partner and his or her Dependents.

Effective Date of Coverage

You will become insured on the date you elect the insurance by signing an approved payroll deduction or enrollment form, as applicable, but no earlier than the date you become eligible.

You will become insured on your first day of eligibility, following your election, if you are in Active Service on that date, or if you are not in Active Service on that date due to your health status.

You are a Late Entrant if you elect the insurance more than 30 days after your become eligible; or you again elect it after you cancel your payroll deduction (if required).

Dependent Insurance

For Dependents to be insured, you will have to pay the required contribution, if any, toward the cost of Dependent Insurance.

Insurance for your Dependents will become effective on the date you elect it by signing an approved payroll deduction form (if required), but no earlier than the day you become eligible for Dependent Insurance. All of your Dependents as defined will be included.

Your Dependents will be insured only if you are insured.

You are a Late Entrant for Dependent insurance if you elect that insurance more than 30 days after you become eligible for it; or you again elect it after you cancel your payroll deduction (if required).

Any Dependent child born while you are insured will become insured on the date of his birth if you elect Dependent Insurance no later than 60 days after his birth. If you do not elect to insure your newborn child within such 60 days, no benefits for expenses incurred will be payable for that child.

Special Enrollment Period

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period. A special enrollment period is not available to an Eligible Person and his or her Dependents if coverage under the prior plan ended for cause, or because premiums were not paid on a timely basis.

An Eligible Person and/or Dependent does not need to elect COBRA continuation coverage to preserve special enrollment rights. Special enrollment is available to an Eligible Person and/or Dependent even if COBRA is not elected.

A special enrollment period applies to an Eligible Person and any Dependents when one of the following events occurs:

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage or acquiring a civil union or domestic partner.

A special enrollment period also applies for an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period if any of the following are true:

- The Eligible Person previously declined coverage under the Plan, but the Eligible Person and/or Dependent becomes eligible for a premium assistance subsidy under Medicaid or Children's Health Insurance Program (CHIP). Coverage will begin only if the Plan Sponsor receives the completed enrollment form and any required contribution within 60 days of the date of determination of subsidy eligibility.
- The Eligible Person and/or Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the Initial Enrollment Period or Open Enrollment Period and coverage under the prior plan ended because of any of the following:
  - Loss of eligibility (including legal separation, divorce, or death).
  - The employer stopped paying the contributions. This is true even if the Eligible Person and/or Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer.
  - In the case of COBRA continuation coverage, the coverage ended.
  - The Eligible Person and/or Dependent no longer resides, lives, or works in an HMO service area if no other benefit option is available.
  - The plan no longer offers benefits to a class of individuals that includes the Eligible Person and/or Dependent.
  - The Eligible Person and/or Dependent loses eligibility under Medicaid or Children's Health Insurance Program (CHIP). Coverage will begin only if the Plan Sponsor receives the completed enrollment form and any required contribution within 60 days of the date coverage ended.

When an event takes place (for example, a birth, marriage, or determination of eligibility for state subsidy), coverage begins on the date of the event. The Plan Sponsor must receive the completed enrollment form and any required Premium within 30 days of the event unless otherwise noted above.

For an Eligible Person and/or Dependent who did not enroll because they had existing health coverage under another plan, coverage begins on the day following the day coverage under the prior plan ends. Except as otherwise noted above, coverage will begin only if the Plan Sponsor receives the completed enrollment form and any required contribution within 30 days of the date coverage under the prior plan ended.

Making Changes During the Year

The coverage you elect remains in effect from January 1st (or the date you began participation) through December 31st. Generally, you can make changes only during the open enrollment period; benefit elections made during the open enrollment period are effective January 1st of the following year. However, because your needs may change when you experience certain life events, you may be

allowed to make mid-year enrollment changes in certain situations in accordance with the Internal Revenue Code (IRC) and as permitted by the Plan.

Qualified Status Change

Qualified status changes are as follows:

- Marriage, divorce or annulment
- Entering into or ending a domestic partnership
- Birth or adoption of a child or the assumption of legal guardianship of a child
- A child ceases to be an eligible dependent
- You or your spouse/domestic partner gains or loses group coverage
- A change in your employment status, or the employment status of your spouse[/domestic partner]
- Death of a family member, or
- You or your spouse/domestic partner takes an unpaid leave of absence pursuant to the Family and Medical Leave Act (FMLA).

Keep in mind that any changes you make to your coverage must be consistent with the change in your status.

Special Enrollment Rights

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have special enrollment rights under certain circumstances. If you're declining enrollment for yourself or your eligible dependents because of other health insurance coverage and that coverage ends, you may enroll yourself or your eligible dependents in The Mosaic Company medical and prescription drug benefits, without waiting for the next open enrollment period, provided that you request enrollment within 31 days after your other coverage ends.

If you or your eligible dependents were eligible for The Mosaic Company medical and prescription drug coverage but declined because you had other health insurance coverage, you may enroll in the The Mosaic Company medical and prescription drug benefits if you lose coverage under the other plan because:

- Your eligibility ends.
- Your COBRA coverage is exhausted.
- Employer contributions to the other coverage end.

In addition, if you have a new dependent as the result of marriage, domestic partnership, birth, adoption or placement for adoption, you may enroll yourself and your dependents, provided that you request enrollment within 31 days. Coverage for the new dependent child will be effective from the date of birth,

adoption or placement for adoption. However, if you miss the deadline, you'll have to wait until the next open enrollment period—or for a qualified status change or another special enrollment right—to enroll.

Please Note: Newborns aren't automatically covered by the Plan; you must enroll all dependents for coverage.

Eligibility for Children's Health Insurance Program (CHIP) or Medicaid Coverage

You have a special enrollment opportunity if you or your eligible dependents either:

- Lose Medicaid or CHIP coverage because you are no longer eligible, or
- Become eligible for your state's premium assistance program under Medicaid or CHIP.

The Plan must allow a HIPAA special enrollment for employees and dependents (including domestic partners) who are eligible but not enrolled if they lose Medicaid or CHIP coverage because they are no longer eligible, or they become eligible for a state's premium assistance program. For these enrollment opportunities, you will have 60 days (instead of 31 days) from the date of the Medicaid/CHIP eligibility change to request enrollment in The Mosaic Company medical and prescription drug benefits. This 60-day extension does not apply to enrollment opportunities other than the Medicaid/CHIP eligibility change.

If There Is a Qualified Medical Child Support Orders (QMCSOs)

You may make a change that corresponds to any judgment, decree or order requiring the Plan to provide prescription drug coverage to your dependent child. The required coverage generally must be consistent with Plan provisions. In the case of a child whom you're required to cover pursuant to a Qualified Medical Child Support Order (QMCSO), coverage will begin on the date specified in the order, or if none is specified, the date the order is received. You may decrease your coverage for that child if the court order requires the child's other parent to provide coverage and your spouse's/domestic partner's or former spouse's/domestic partner's plan actually provides that coverage. (See "Qualified Medical Child Support Order").

Cost of Coverage

You and the Plan Sponsor share in the cost of the Plan. Your contribution amount depends on the Plan you select and the family members you choose to enroll.

Your contributions are deducted from your paychecks on a before-tax basis. Before-tax dollars come out of your pay before federal income and Social Security taxes are withheld. In most states, before state and local taxes are withheld. This gives your contributions a special tax advantage and lowers the actual cost to you.

Your contributions are subject to review and the Plan Sponsor reserves the right to change your contribution amount from time to time.

You can obtain current contribution rates by calling the Plan Sponsor.

Value of Domestic Partner Coverage Taxed as Imputed Income

Your contributions to cover a domestic partner are the same as those to cover a legal spouse. However, because of Internal Revenue Code (IRC) restrictions, in most cases, the fair market value of your domestic partner's or domestic partner's children's (if they are not federal tax dependents) health care coverage, which includes Plan coverage, will be taxable to you as imputed income if you are enrolled in the Plan. This imputed income will be included in your paycheck and year-end W-2 statement. You must report this income and may be subject to additional U.S. federal and state income taxes, in most states, as well as Social Security and Medicare taxes. **Please Note:** The IRS restrictions that apply to health care coverage for domestic partners do not apply to legally married, same-sex or opposite-sex spouses.

Coverage While on a Leave of Absence

Family and Medical Leave Act (FMLA) Leave

Under the Family and Medical Leave Act of 1993 (FMLA), you may be eligible for up to 12 weeks of unpaid leave each year if you have a serious illness; adopt or have a child; or need to care for a seriously ill spouse, child or parent.

Your prescription drug coverage will be continued during your FMLA leave, with The Mosaic Company paying the same portion of the costs it normally pays. You will be responsible for paying your portion of the cost of coverage. To continue this coverage, you will be required to make the appropriate contributions.

If you do not continue coverage during the leave, your coverage can be restored to your previous level and type of coverage once you return from your FMLA leave.

Military Leave of Absence

If you are absent from work due to a military service leave qualifying under the Uniformed Services Employment and Reemployment Rights Act (USERRA), you may elect to continue the type of coverage in effect on the day immediately prior to the start of such leave. Such coverage will continue until the earlier of the following occurs: the date you fail to return to active employment as required under USERRA or 24 months.

If the entire length of the leave is 30 days or less, you will not be required to pay any more than the portion you paid for medical coverage before the leave. If the entire length of the leave is 31 days or longer, you may be required to pay up to 102% of the entire cost of coverage for active employees (i.e. your share plus The Mosaic Company's share).

If you decide to waive coverage under the Plan during a military leave qualifying under USERRA and return to employment following the leave (within the time period specified by USERRA), you will be reinstated in the Plan.

If you do not return to work at the end of your military leave, you may be entitled to continue coverage through COBRA. See "Continuation of Coverage Through COBRA" on for more information.

General Information about When Coverage Ends

As permitted by law, the Plan Sponsor may end the Plan and/or all similar benefit plans at any time for the reasons explained in the Plan.

Your right to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, the Claims Administrator will still process Plan payments on claims you received before the date your coverage ended. However, once your coverage ends, the Claims Administrator will not process Plan payments on claims for any health care services received after that date (even if the medical condition that is being treated occurred before the date your coverage ended).

Unless otherwise stated, an Enrolled Dependent's coverage ends on the date the Participant's coverage ends.

What Events End Your Coverage?

Coverage ends on the earliest of the dates specified below:

- The Entire Plan Ends
  - Your coverage ends on the date the Plan ends. In this event, the Plan Sponsor is responsible for notifying you that your coverage has ended.
- You Are No Longer Eligible
  - Your coverage ends on the date you are no longer eligible to be a Participant under this Plan. Coverage for your Enrolled Dependent child ends on the last day of the calendar year your Enrolled Dependent child no longer qualifies as a Dependent under this Plan. The Claims Administrator Receives Notice to End Coverage.
  - The Plan Sponsor is responsible for providing the required notice to the Claims Administrator to end your coverage. Your coverage ends on the date the Claims Administrator receives the required notice from the Plan Sponsor to end your coverage, or on the date requested in the notice, if later.
- Participants Retires or Is Pensioned
  - The Plan Sponsor is responsible for providing the required notice to the Claims Administrator to end your coverage. Your coverage ends the date the Participant is retired or receiving benefits under the Plan Sponsor's pension or retirement plan.

    This provision applies unless there is specific coverage classification for retired or pensioned persons in the Plan, and only if the Participant continues to meet any applicable eligibility requirements. The Plan Sponsor can provide you with specific information about what coverage is available for retirees.

Fraud or Intentional Misrepresentation of a Material Fact

The Plan will provide at least 30 days advance required notice to the Participant that coverage will end on the date identified in the notice because you committed an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact. Examples include knowingly providing incorrect information relating to another person's eligibility or status as a Dependent. You may appeal this decision during the notice period. The notice will contain information on how to appeal the decision.

If the Claims Administrator and the Plan Sponsor find that you have performed an act, practice, or omission that constitutes fraud, or have made an intentional misrepresentation of material fact the Plan Sponsor has the right to demand that you pay back all Benefits the Plan paid to you, or paid in your name, during the time you were incorrectly covered under the Plan.

Continuation of Coverage

If your coverage ends under the Plan, you may have the right to elect continuation coverage (coverage that continues on in some form) in accordance with federal law.

Continuation coverage under COBRA (the federal Consolidated Omnibus Budget Reconciliation Act) is available only to Plan Sponsors that are subject to the terms of COBRA. Contact your plan administrator to find out if your Plan Sponsor is subject to the provisions of COBRA.

If you chose continuation coverage under a prior plan which was then replaced by coverage under the Plan, continuation coverage will end as scheduled under the prior plan or in accordance with federal or state law, whichever is earlier.

The Claims Administrator is not the Plan Sponsor's designated "plan administrator" as that term is used in federal law, and the Claims Administrator does not assume any responsibilities of a "plan administrator" according to federal law.

The Claims Administrator is not obligated to provide continuation coverage to you if the Plan Sponsor or its plan administrator fails to perform its responsibilities under federal law. Examples of the responsibilities of the Plan Sponsor or its plan administrator are:

- Notifying you in a timely manner of the right to elect continuation coverage.
- Notifying the Claims Administrator in a timely manner of your election of continuation coverage.

Your Member Identification Card (ID)

When you enroll in a medical plan, you will automatically receive a separate pharmacy benefit ID card from Express Scripts. You must present your Express Scripts ID card to the network pharmacy every time you get a prescription filled to be eligible for network benefits. The network pharmacy will calculate your claim online. You will pay any Copayment Amount directly to the network Pharmacy. You do not have to complete or submit claim forms. The network pharmacy will take care of claim submission.

The card offers a convenient way of providing important information specific to your coverage including, but not limited to, the following:

- Your Subscriber identification number. This unique number identifies you as a participant in the prescription drug program with Express Scripts.
- The Group number is MOSRX4U
- The BIN number is 610014
- The PCN number A4

The above information identifies your prescription drug program with Express Scripts.

Express Scripts' Customer Service Toll-Free Number is +1 (877) 476-9275.

Any time a change in your family takes place, it may be necessary for a new ID card to be issued to you. Fraudulent, unauthorized, abusive, or intentionally improper use of ID cards by any participant may result in sanctions being applied to all participants covered under your coverage including but not limited to:

- Denial of benefits.
- Cancellation of coverage under the Plan for all participants under your coverage.
- Limitation on the use of the Identification Card to one designated Participating Pharmacy of your choice.
- Recovery from you or any of your covered Dependents of any benefit payments made.
- Prior authorization of drug purchases for all participants receiving benefits under your coverage.
- Notice to proper authorities of potential violations of law or professional ethics.

Fraudulent, unauthorized, abusive or intentionally improper use of ID cards issued to you and your covered Dependents may include: use of the ID card before your effective date (or after your termination of coverage under the Plan); obtaining drugs for resale or use by someone other than the person for whom the Prescription Order is written (even if the person is covered under the Plan); obtaining Covered Drugs without a Prescription Order or through the use of a forged or altered Prescription Order; circumventing the quantity limitations of the Plan; using Prescription Orders for the same drugs from multiple Providers; and using the same Prescription Order at multiple pharmacies.

Your Prescription Drug Coverage

The Plan is managed by Express Scripts and covers prescription drugs that are approved by the U.S. Food and Drug Administration (FDA). When you need to fill a prescription, you can:

- Go to a network pharmacy,
- Use the mail order delivery service.

Below is a summary of the prescription drug coverage under each medical option.

Prescription Drug Plan	Traditional Plan	Consumer Plan[3]
Annual Plan Deductible	$1,000 individual $2,000 family (medical only)	$2,800 individual $3,200 individual + 1 $5,600 family (integrated with medical)
Annual Out-of-Pocket Maximum (integrated with medical)	$5,000 individual $10,000 family	$4,000 individual $8,000 family
Retail from a Network Pharmacy[1] (up to **31**-day supply)	Tier 1: $10 Tier 2: 25% ($20 minimum / $50 maximum) Tier 3: 40% ($40 minimum / $100 maximum)	After meeting the medical plan deductible[3], you pay: Tier 1: 20% Tier 2: 20% Tier 3: 20%
Mail Order Pharmacy[1,2] (up to a 90-day supply)	Tier 1: $25 Tier 2: 25% ($50 minimum / $125 maximum) Tier 3: 25% ($100 minimum / $250 maximum)	After meeting the medical plan deductible[3], you pay: Tier 1: 20% Tier 2: 20% Tier 3: 20%
Specialty Medications (up to 90-day supply)	Tier 1: $25 Tier 2: 25% ($50 minimum / $125 maximum) Tier 3: 25% ($100 minimum / $250 maximum)[4]	20%

1. Maintenance medications have a retail pharmacy refill limit of 1 initial fill plus 1 refill; you pay 100% for any prescriptions filled at a retail pharmacy after the refill limit.
2. 90 day prescriptions may be filled at Express Scripts Mail Order pharmacy.
3. The Consumer Plan includes a “Preventive Drug List,” which is a list of long-term use medications to which the plan’s deductible does not apply.
4. Please see the SaveOnSP program section for additional information.

Medical and prescription drug costs count toward a single out-of-pocket maximum. Once you reach the annual out-of-pocket maximum, you do not have to pay anything further for your covered medications for

the rest of the year. There is one combined annual out-of-pocket maximum for both medical benefits and prescription drug benefits.

Your cost is based on the network-negotiated price for the drug. Prescriptions filled at non-network pharmacies are covered at the network-negotiated price minus your cost-share. You are responsible for your cost-share plus the amount beyond the network-negotiated price.

Brand-Name and Generic Drugs

Generic drugs have the same active ingredients in the same dosage form and strength as their brand-name counterparts. The color and shape may differ between the generic and the brand drug; however, the active ingredients must be the same for both. The U.S. Food and Drug Administration (FDA) approves both brand and generic drugs and requires generics to have the same active ingredients and be absorbed in the body the same way as brand-name drugs. These requirements assure that generic drugs are as safe and effective as brand drugs. The formulary (the list of preferred drugs) chosen by the Plan contains only FDA-approved generic medications.

If you or your doctor specifically requests the brand name medication when a generic is available, you will pay the generic drug copay, plus the difference between the total cost of the brand name drug and the generic drug cost.

Preferred brand and generic drugs, also known as formulary drugs, are medications that have been reviewed and approved by a group of physicians and pharmacists and have been added to the formulary selected by the Plan based on their proven clinical and cost effectiveness.

Non-preferred brand drugs, or non-formulary drugs, are medications that the same team of physicians and pharmacists have not approved for the formulary selected by the Plan. This happens when the team determines that a clinically equivalent and more cost-effective alternative generic or preferred brand drug is available.

The formulary changes from time to time as new clinical information becomes available. To determine the status of any drug on the Plan's formulary, go to www.express-scripts.com or contact customer service at +1 (877) 476-9275. A medication's inclusion on the formulary is no guarantee of effectiveness. Similarly, if a medication is not on the formulary, it does not mean it is not effective, but rather that a clinically equivalent and more cost-effective alternative is available and on the formulary.

Using a Retail Network Pharmacy

Network pharmacies have agreed to accept lower, negotiated fees than non-network pharmacies. When you need to fill a prescription, go to a network pharmacy and present your prescription drug ID card. To find a network pharmacy near you or to see if your pharmacy is part of the network, go to www.express-scripts.com or contact Express Script's customer service at +1 (877) 476-9275.

- Short-term prescriptions are covered through a retail pharmacy. Your retail network purchases are limited to a 31-day supply for each prescription, with the exception of medications packaged in greater than a 31-day supply.

- If a pharmacy's price is less than the coinsurance or copay you would pay for that drug, you'll pay the lower price. For example, if the actual cost of a generic medication is $3.50, but your copay is $10.00, you will pay $3.50.

Filling Long-Term Prescriptions

Some examples of long-term maintenance drugs are those used to control or treat:

- Arthritis
- High cholesterol
- Diabetic conditions, and
- High blood pressure.

Mail Order

With this service, you can order up to a 90-day supply of maintenance drugs and have them delivered to your home.

In order to fill your prescription through Express Scripts Mail Order, mail your prescription, order form and payment in the envelope provided. Order forms and envelopes can be requested by calling Express Scripts at +1 (877) 476-9275. For refills online, visit www.express-scripts.com. Have your member ID number, the prescription number and your credit card ready. For refills by phone, call 1-888-327-9791 to use the automated refill system.

Using a Retail Non-Network Pharmacy

If you purchase your prescription drugs through a non-network pharmacy or do not show your prescription drug identification (ID) card at a network pharmacy, you will have to pay for the prescription and then file a claim form for reimbursement. The Plan will pay benefits based on the amount it would have paid to a network pharmacy. You will pay the difference between what the non-network pharmacy charges and the Plan's benefit payment.

Claim forms are available at www.express-scripts.com. You can mail your completed claim form to the address listed on the form.

If you have any questions about filing a claim, call Member Services at +1 (877) 476-9275 or visit www.express-scripts.com to submit your claim online.

Specialty Pharmacy

Complex conditions, such as anemia, hepatitis C, multiple sclerosis, asthma, cancers and rheumatoid arthritis, are treated with specialty medications. Specialty medications can be injectable medications administered either by you or a healthcare professional and they often require special handling. If you use specialty medications, you'll have access to the services offered by Express Script's Accredo Specialty Pharmacy at +1 (800) 803-2523 or www.accredo.com. Express Scripts Accredo Specialty

Pharmacy provides not only your specialty medicines, but also personalized Pharmacy care management services including:

- Safe, prompt delivery. Accredo will schedule and quickly ship all your specialty medications, including those that require special handling such as refrigeration.
- Personalized care. You'll have access to a team of specialty-trained pharmacists, nurses and patient-care representatives who are trained in your condition.
- Supplies. Most supplies, such as syringes, needles and sharps containers, will be provided with your medication.
- Support – 24/7. Accredo's specialty-trained pharmacists and nurses are available around the clock to answer your questions. The Accredo team can assist in managing side effects.
- Refill reminders. Accredo will contact you regularly to schedule your next refill and see how your therapy is progressing. For convenience, some specialty medication refills can be ordered online, safely and securely, through www.express-scripts.com.
- Drug safety monitoring. As an Express Scripts pharmacy, Accredo can access your prescription information on file at all Express Scripts pharmacies to monitor for potential drug interactions and side effects of your medications.
- Online support and resources through www.accredo.com including condition-specific information and the specialty Pharmacy drug list.

SaveOnSP Program

The plan has a copay assistance program in place for specialty medication users in the Traditional Plan. Certain specialty pharmacy drugs are considered non-essential health benefits under the plan and the cost of such drugs will not be applied toward satisfying the participant's out- of-pocket maximum. Although the cost of the SaveOnSP program drugs will not be applied towards satisfying a participant's out-of-pocket maximum, the cost of the program drugs will be reimbursed by the manufacturer at no cost to you, and copays for certain specialty medications may be set to the max of the current plan design, or any available manufacturer-funded copay assistance, or 30%.

Clinical Coverage Review and Drug Limitations

Prior Authorization

Some drugs may require pre-authorization. If the necessary pre-authorization is not obtained, the drug may not be covered. If a pharmacist tells you that a prescription requires pre-authorization, Express Scripts will need to communicate with the doctor to be sure that the medicine is right and will verify that the Plan covers the drug.

When a prescription requires pre-authorization, the doctor can contact Express Scripts to prescribe a different medicine that is covered by the Plan or start a pre-authorization on your behalf. Only the prescriber can give Express Scripts the information needed to determine if the drug may be covered. If the medicine is approved, you will pay the normal copay. If the medication is not covered but you want to take it, you will pay the full price of the medicine.

Step Therapy

Your plan uses utilization management programs that require you try one or more drugs before another drug will be covered.

Step Therapy is a program for people who take prescription medicine regularly to treat a long-term condition, such as arthritis, asthma or high blood pressure. It lets you get the treatment you need affordably. First-line medicines are the first step.

- First-line medicines are generic and lower-cost brand-name medicines approved by the U.S. Food & Drug Administration (FDA). They are proven to be safe, effective and affordable. Step therapy suggests that a patient try these medicines first because, in most cases, they provide the same health benefit as more expensive drugs, but at a lower cost.
- Second-line medicines are the second and third steps. Second-line drugs typically are brand-name drugs. They are best suited for the few patients who do not respond to first-line medicines. Second-line drugs are the most expensive options.

Quantity Limits

Quantity Limits are in place to make sure that you are getting the right amount of medication and that it is prescribed in the most efficient way. For example, your doctor may say, “take two 20mg pills each morning.” If that medication is also available in 40mg pills, Express Scripts will notify the pharmacy about contacting the prescriber for one 40mg pill a day instead of two 20mg pills. In addition, if your doctor writes the original prescription for 30 pills (a 15-day supply), the new prescription for 30 pills will last a full month — and you will have just one copayment, not two.

Quantity Limits also make sure that your prescriptions do not exceed the amount of medication that the Plan covers. If the prescription is for too large a quantity, the pharmacist can fill the prescription for the amount that the Plan covers or contact the doctor to discuss other options, such as increasing the strength or getting a prior authorization for the quantity originally prescribed.

Opioid Management Program

Express Script’s Advanced Opioid Management Program limits the quantity of opioids, requires step therapy, and is designed to (i) help improve management of opioid use; and (ii) reduce potential misuse/abuse. It is aligned with the Guideline for Prescribing Opioids for Chronic Pain issued by the Centers for Disease Control and Prevention (CDC). The Opioid Management Program uses the CDC criteria of Morphine Milligram Equivalent (MME) to limit the quantity of opioid products. Prior authorization requests can be made if your doctor believes the dose should exceed the MME within the

CDC recommendation. The Advanced Opioid Management Program is not intended to be applicable to cancer treatment or palliative end-of-life care.

Medication Assisted Treatment / Therapy

Medication Assisted Treatment (MAT) Therapy is covered under the plan subject to the limitations of the Advanced Opioid Management Program. Please contact Express Script's customer service at (877) 476-9275 for more information.

Preventive Services

The Patient Protection and Affordable Care Act (PPACA) contains a provision to make certain preventive services available without cost-sharing to the member. Any plan exclusions, formulary, or utilization management status would be overridden by the adoption of one or more of the following categories. The Express Scripts standard drug coverage recommendations include information regarding suggested patient demographics that would be applicable to each drug therapy. The following preventative items and services are covered at no cost to you under your pharmacy plan.

- Aspirin products
- Fluoride products
- Folic acid & prenatal vitamins
- Tobacco smoking cessation products
- Immunizations
- OTC contraceptives
- Prescription contraceptives
- Contraceptive devices – diaphragms, cervical caps, IUD, implants
- Bowel prep agents for colorectal cancer screening
- Breast cancer – primary preventive
- Statins
- Pre-exposure prophylaxis (PrEP) – prevention of HIV infection

What Is Covered?

The Plan covers most prescription drugs approved by the U.S. Food and Drug Administration (FDA) for outpatient care. The following list includes covered prescription drugs. Certain over-the-counter medications may be covered when prescribed by a physician. For the most current information on the types of drugs covered under the Plan, please visit www.express-scripts.com or contact Express Script's customer service at (877) 476-9275.

This list may change at any time:

- Federal legend drugs (other than those identified as not covered).
- State restricted drugs.
- Medications of which at least one ingredient is a legend drug (other than those identified as not covered).
- Insulin.
- Needles and syringes.
- Certain over-the-counter medications and supplies, such as diabetic supplies, fluoride, contraceptives for women, and bowel evacuants when prescribed by a physician.
- Legend and over-the-counter smoking deterrents for participants age 18 and older.
  - Get a prescription for these products from your doctor, even if the products are sold over the counter (OTC).
- Oral contraceptives and devices.
- Contraceptive jellies, creams and foams if FDA-approved and prescribed by your physician.
- Emergency contraceptives.
- Immunization agents and vaccines.
- Certain self-injectables.
- Medications to treat impotency (subject to certain restrictions).

What is Not Covered?

The following are excluded under your pharmacy plan:

- Blood components (Hemophilia and HAE are not included in this category).
- Bulk chemicals.
- Cosmetic alteration drugs (e.g. Botox, Latisse, etc.)
- Diagnostic agents (unless brought in by drug coverage section).
- Digital therapies.
- General anesthetics.
- Multi-vitamins.

- Multi-vitamins with fluoride.
- Multi-vitamins with iron.
- OTC products.
- Repackaged products.
- Surgical supply/medical devices (unless brought in by drug coverage section.
- Oral and injectable fertility medications.
- Homeopathics.
- Electrolyte replacement products.
- Immunizations and vaccines.
- Nutritional supplements.
- Dietary management.

Right of Appeal

Can I appeal this decision?

Yes. You, your provider, or an appointed representative like an attorney or family member can file a standard or urgent appeal within 180 calendar days from the date of this decision. Otherwise, this decision will be final.

To appeal, send written comments, documents or other information to be considered to:

Clinical appeal requests
Express Scripts
Attn: Clinical Appeals Department
P.O. Box 66588
St. Louis, MO 63166-6588
877.852.4070 (fax)

Administrative appeal requests
Express Scripts
Attn: Administrative Appeals Department
P.O. Box 66587
St. Louis, MO 63166-6587
877.328.9660 (fax)

How long does the appeal process take?

Standard appeals can take up to 30 calendar days from when your request is received. You will receive written notice of the decision.

What if my appeal is urgent?

In some cases, urgent appeals can be reviewed, and a decision could be made within 72 hours. Generally, you can request an urgent decision for these reasons:

- Life, health or ability to function would be in jeopardy based on layperson’s judgement.
- You may be subject to severe pain without the treatment or care requested in the opinion of a clinician who is aware of your condition.

You may request an urgent clinical appeal by calling 1-800-753-2851, for urgent administrative appeals call 1-800-946-3979. You do not need to go through the internal appeal review if:

- (a) we fail to meet our internal appeal process timelines, or
- (b) you have an urgent care situation and you have requested an external review, or
- (c) we decide to waive the internal appeal process requirements.

Other Resources

You and your plan may have other ways to get help with, resolve, or dispute this decision.

What if my prescriber wants to discuss this decision with a peer?

Your prescriber may request to discuss this decision with a reviewing physician or other appropriate reviewer by contacting the clinical appeals department at 1-800-753-2851 (phone) or 1-877-852-4070 (fax).

Where can I go for more help or to file a complaint?

U.S. Department of Labor
Employee Benefits Security Administration
200 Constitution Ave., NW Washington, DC 20210

(866) 4-USA-DOL (866-487-2365)
http://www.dol.gov/ebsa/

Can I have an external review of this decision?

You may have the right to have an external (outside 3rd party) review our decision if the denial was due to one of the following:

- Medical necessity.
- Off-label use.
- Health care setting.
- Level of care / effectiveness of health care service or supply.
- Denial because treatment or care was investigational or experimental.
- Off-label use (not using the medication for the condition intended).
- Not on the formulary (list of plan's covered medications).
- Part of a step therapy program.
- Not covered by the plan (also called a plan exclusion).

Urgent external reviews can happen at the same time as an urgent internal appeal.

To submit an external review, the request must be mailed or faxed to MCMC, LLC, an independent third party utilization management company, at:

MCMC LLC
Attn: Express Scripts Appeal Program 300 Crown Colony Drive, Suite 203
Quincy, MA 02169-0929
P: 617.375.7700, ext. 28253, F: 617.375.7683

If You Are Covered by More Than One Plan

If you or a covered dependent has coverage under the Plan and coverage under another prescription drug plan, benefits under the Plan are coordinated with those provided by the other plan so that your combined coverage doesn't exceed the provider's fees for eligible expenses.

Does This Plan Have the Right of Recovery?

Overpayment and Underpayment of Benefits

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that the Plan should have paid. If this occurs, the Plan may pay the other plan the amount owed.

If the Plan pays you more than it owes under this COB provision, you should pay the excess back promptly. Otherwise, the Plan Sponsor may recover the amount in the form of salary, wages, or benefits payable under any Plan Sponsor-funded benefit plans, including this Plan. The Plan Sponsor also reserves the right to recover any overpayment by legal action or offset payments on future Allowed Amounts.

If the Plan overpays a health care provider, the Claims Administrator reserves the right to recover the excess amount from the provider pursuant to Refund of Overpayments, below.

Refund of Overpayments

If the Plan pays for Benefits for expenses incurred on account of a Covered Person, that Covered Person or any other person or organization that was paid, must make a refund to the Plan if:

- The Plan's obligation to pay Benefits was contingent on the expenses incurred being legally owed and paid by you, but all or some of the expenses were not paid by you or did not legally have to be paid by you.
- All or some of the payment the Plan made exceeded the Benefits under the Plan.
- All or some of the payment was made in error.

The amount that must be refunded equals the amount the Plan paid in excess of the amount that should have been paid under the Plan. If the refund is due from another person or organization, you agree to help the Plan get the refund when requested.

If the refund is due from you and you do not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future Benefits for you that are payable under the Plan. If the refund is due from a person or organization other than you, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future Benefits that are payable in connection with services provided to other Covered Persons under the Plan; or (ii) future Benefits that are payment in connection with services provided to persons under other plans for which the Claims Administrator processes payments, pursuant to a transaction in which the Plan's overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment. The reallocated payment amount will either:

- Equal the amount of the required refund, or
- If less than the full amount of the required refund, will be deducted from the amount of refund owed to the Plan.
- The Plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

Continuation of Coverage Through COBRA

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), requires that most employers sponsoring group health plans offer to employees, their spouses and eligible dependents the opportunity for a temporary extension of health coverage (called “continuation coverage”) at group rates in certain instances (called “qualifying events”) where coverage under the plan would otherwise end.

Eligibility to elect COBRA coverage is contingent upon your being enrolled as an active employee prior to the qualifying event.

The following information is intended to inform you of your rights and obligations under the continuation coverage provisions of the law.

You do not have to show that you are insurable to elect continuation coverage. However, continuation coverage under COBRA is provided subject to your eligibility for coverage.

The Mosaic Company reserves the right to terminate your coverage retroactively if you are determined to be ineligible under the terms of the Plan.

You must pay the entire contribution (employee plus employer cost) plus a 2% administration fee for your continuation coverage. A grace period of at least 60 days applies to the payment of the regularly scheduled contribution.

Note: You may have options other than the COBRA continuation of health benefits available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. The day after your employment terminates and you are ineligible for coverage under the Plan, there is a 60 day special enrollment period during which you can enroll for coverage in the Health Insurance Marketplace. If you are considering enrolling for coverage under the Exchange, be mindful of this enrollment deadline.

Who Is Covered under COBRA

You have a right to choose this continuation coverage if:

- You are enrolled in Plan; and
- You lose your group health coverage because of a reduction in your hours of employment or the termination of your employment for reasons other than gross misconduct on your part.

If you terminate employment following a leave of absence qualifying under FMLA the qualifying event that will trigger continuation coverage will be deemed to occur on the earlier of (a) the date that you indicate you will not be returning to work following the leave; (b) the date that you do not return to work after the leave; or (c) the last day of the FMLA leave period.

If you are the spouse of an employee and are covered by Plan and you lose coverage for any of the following four reasons on the day before the qualifying event, you are a qualified beneficiary and have the right to elect continuation coverage for yourself:

- The death of your spouse;
- The termination of your spouse's employment (for reasons other than your spouse's gross misconduct) or a reduction in your spouse's hours of employment;
- Divorce or legal separation from your spouse; or
- Your spouse's entitlement to Medicare.

If you are a covered dependent child of an employee who is covered by the Plan on the day before the qualifying event and you lose coverage under the Plan for any of the following five reasons, you are also a qualified beneficiary and have the right to continuation coverage:

- The death of the employee;
- The termination of the employee's employment (for reasons other than the employee's gross misconduct) or a reduction in the employee's hours of employment;
- The employee's divorce or legal separation;
- The employee's entitlement to Medicare; or
- You cease to be a "dependent child" under the Plan.

If the covered employee elects continuation coverage and then has a child (either by birth, adoption or placement for adoption) during that period of continuation coverage the new child is also eligible to become a qualified beneficiary.

According to the terms of the employer-sponsored group health plans and the requirements of federal law, these qualified beneficiaries can be added to COBRA coverage upon proper notification to The Mosaic Company of the birth or adoption.

If the covered employee fails to notify The Mosaic Company in a timely fashion (according to the terms of the Plan), the covered employee will not be offered the option to elect COBRA coverage for the child. Newly acquired dependents (other than children born to, adopted by or placed for adoption with the employee) will not be considered qualified beneficiaries but may be added to the employee's continuation coverage.

Separate Elections

Each qualified beneficiary has an independent election right for COBRA coverage. For example, if there is a choice among types of coverage, each qualified beneficiary who is eligible for continuation coverage is entitled to make a separate election among the types of coverage. Thus, a spouse or dependent child is entitled to elect continuation coverage even if the covered employee does not make that election. A spouse/partner or dependent child may elect different coverage from that chosen by the employee.

Electing COBRA

You will automatically receive COBRA election information from the COBRA Administrator. The date of the qualifying event is the day your employment terminated or another qualifying event occurred. Under the law, you must elect continuation coverage within 60 days from the date you lost coverage as a result of one of the events described above, or, if later, 60 days after The Mosaic Company provides notice of your right to elect continuation coverage. An employee or family member who does not choose continuation coverage within the time period described above will lose the right to elect continuation coverage.

If you elect continuation coverage, The Mosaic Company is required to give you coverage that, as of the time coverage is being provided, is identical to the coverage provided under the Plan to similarly situated employees or family members. If the coverage for similarly situated employees or family members is modified, your coverage will be modified, too. “Similarly situated” refers to a current employee or dependent who has not had a qualifying event.

To inquire about COBRA coverage, contact your Plan Sponsor at +1 (763) 577-2700.

Duration of COBRA

The law requires that you be provided the opportunity to maintain continuation coverage for up to 18 months if you lose group health coverage because of a termination of employment or a reduction in work hours.

COBRA continuation coverage is available for your spouse/partner and eligible dependents for up to 36 months when the qualifying event is the death of the covered employee, divorce or legal separation, the covered employee becoming entitled to Medicare, or a dependent child’s loss of eligibility as a dependent child.

Additional qualifying events may occur while the continuation coverage is in effect after an initial qualifying event, such as loss of employment. Examples of such events are the death of the covered employee, divorce, legal separation, the covered employee becoming entitled to Medicare, or a dependent child’s loss of dependent status.

If you lose coverage because of a termination of employment or a reduction in hours, these events can, but do not always, result in an extension of an 18-month continuation period to 36 months for your spouse/partner and dependent children. However, in no event will COBRA coverage last beyond 36 months from the date of the event that originally allowed a qualified beneficiary to elect such coverage. You must notify your Plan Sponsor at (763) 577-2700 if a second qualifying event occurs during your continuation coverage period.

When COBRA medical coverage ends, generally you cannot convert your coverage to an individual medical policy.

Special Rules for Disability

The 18 months may be extended to 29 months if the employee or covered family member is determined by the Social Security Administration (SSA) to be disabled at any time during the first 60 days of continuation coverage.

This 11-month extension is available to all family members who are qualified beneficiaries due to termination of employment or reduction in hours of employment, even those who are not disabled. To benefit from the extension, the qualified beneficiary must inform your Plan Sponsor at +1 (763) 577-2700 within 60 days of the SSA determination of disability and before the end of the original 18-month continuation coverage period. If, during continued coverage, the SSA determines that the qualified beneficiary is no longer disabled, the individual must inform your Plan Sponsor at +1 (763) 577-2700 of this redetermination within 30 days of the date it is made, at which time the 11-month extension will end.

If you or a covered family member is disabled and another qualifying event occurs within the 29-month continuation period, then the continuation coverage period for your qualified beneficiaries is 36 months after your termination of employment or reduction in hours.

Medicare

If, within 18 months after becoming entitled to Medicare, you subsequently lose Plan coverage due to your termination of employment or reduction in hours, your eligible dependents' COBRA coverage will not end before 36 months from the date you became entitled to Medicare. However, your eligible dependents' COBRA coverage will not extend beyond 36 months.

The law provides that continuation coverage may be cut short prior to the expiration of the 18-, 29- or 36-month period for any person who elected COBRA for any of the following five reasons:

- The Mosaic Company no longer provides group health coverage to any of its employees;
- The premium for continuation coverage is not paid on time (within the applicable grace period);
- The person who elected COBRA becomes covered — after the date COBRA is elected — under another group health plan (whether or not as an employee) that does not contain any applicable exclusion or limitation for any pre-existing condition of the covered individual;
- The person who elected COBRA becomes entitled to Medicare after the date COBRA is elected; or
- Coverage has been extended for up to 29 months due to disability, and SSA makes a final determination that the individual is no longer disabled.

COBRA and FMLA

A leave that qualifies under the FMLA does not make you eligible for COBRA coverage. However, regardless of whether you lose coverage because of non-payment of premiums during an FMLA leave or

you decide not to return to active employment, you are still eligible for COBRA on the last day of the FMLA leave. Your continuation coverage will begin on the earliest of the following:

- When you definitively inform The Mosaic Company that you are not returning to work at the end of the leave; or
- The end of the leave, and you do not return to work.

For purposes of an FMLA leave, you will be eligible for COBRA, as described above, only if:

- You or your spouse and/or dependent child is covered by the Plan on the day before the leave begins; and
- You do not return to work at the end of the FMLA leave.

Your Duties

Under the law, the employee or a family member is responsible for notifying The Mosaic Company of:

- A divorce or legal separation;
- The loss of a child's dependent status under the Plan;
- An additional qualifying event (such as a death, divorce or legal separation) that occurs during the employee's or family member's initial continuation coverage period of 18 (or 29) months;
- A determination by the SSA that the employee or family member was disabled at some time during the first 60 days of an initial continuation coverage period of 18 months; or
- A subsequent determination by the SSA that the employee or family member is no longer disabled.

This notice must be provided within 60 days from the date of the divorce, legal separation, a child's loss of dependent status or an additional qualifying event. In the case of a disability determination, the notice must be provided within 60 days after the SSA's disability determination and before the end of the initial 18-month continuation coverage.

If the employee or a family member fails to provide this notice to The Mosaic Company during this notice period, any individual(s) who loses coverage will not be offered the option to elect continuation coverage.

The notice may be in writing and must include the following information:

- The applicable plan name;
- The identity of the covered employee and any qualified beneficiaries;
- A description of the qualifying event or disability determination;
- The date on which it occurred; and
- Any related information customarily and consistently requested by the Plan's COBRA Administrator.

Mail this information to the address below if the covered person is an active employee of The Mosaic Company: The Mosaic Company, 13830 Circa Crossing, Lithia, FL 33547.

When The Mosaic Company is notified that one of these events has occurred, The Mosaic Company, in turn, will notify you that you have the right to elect continuation coverage. If you or your family member fails to notify The Mosaic Company and any claims are mistakenly paid for expenses incurred after the date coverage would normally be lost because of the divorce, legal separation or a child's loss of dependent status, you and your family members may be required to reimburse the Plan for any claims mistakenly paid.

The Mosaic Company's Duties

If any of the following events results in a loss of coverage, qualified beneficiaries will be notified of the right to elect continuation coverage automatically without any action required by the employee or a family member:

- The employee's death or termination of employment (for reasons other than gross misconduct); or
- A reduction in the employee's hours of employment.

Cost of COBRA Coverage

Under the law, you may be required to pay up to 102% of the premium for your continuation coverage. If your coverage is extended from 18 to 29 months for disability, you will be required to pay 150% of the premium beginning with the 19th month of continuation coverage.

The cost of group health coverage periodically changes. If you elect continuation coverage, The Mosaic Company will notify you of any changes in the cost. If coverage under the Plan is modified for similarly situated non-COBRA beneficiaries, the coverage made available to you may be modified in the same way. You and your family members will be subject to these changes in the cost of coverage.

The initial payment for continuation coverage is due 60 days from the date of your election. Thereafter, you must pay for coverage on a monthly basis for which you have a grace period of at least 60 days.

If you have any questions about COBRA coverage or the application of the law, contact the COBRA Administrator at the phone number and address below. If the covered person needs to terminate COBRA coverage, your marital status has changed, or you or a qualified beneficiary has changed addresses, or a dependent cease to be a dependent eligible for coverage under the terms of the Plan, you may notify the COBRA Administrator (please include your COBRA member ID) immediately at (855)-671-9395 or Optum Financial, PO Box 2639, Omaha, NE 68103.

For More Information About Your Options Under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is available in the *Medicare & You* handbook. Medicare participants will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. Here's how to get more information about Medicare prescription drug plans:

- Visit www.medicare.gov for personalized help.
- Call your State Health Insurance Assistance Program at the number in the *Medicare & You* handbook.
- Call +1 800 MEDICARE (+1-800-633-4227). TTY users should call +1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov or call +1-800-772-1213 (TTY +1-800-325-0778).

Remember: Keep this notice. If you enroll in a Medicare prescription drug plan after your applicable Medicare enrollment period ends, you may need to provide a copy of this notice when you join a Part D plan to show that you are not required to pay a higher Part D premium amount.

For more information about this notice or your prescription drug coverage, contact your Plan Sponsor at +1 (763) 577-2700.

Plan Documents

Every effort has been made to ensure that the information included is a summary of your benefits. If there is an inconsistency between any of the terms of the official Plan documents or SPD with regard to Plan benefits, the terms of the official Plan document will govern.

All benefits are authorized and subject to federal tax laws, such as the Internal Revenue code and other federal and state laws, which may affect your rights. The provisions of the Plan are subject to revision due to a change in laws or pronouncements by the Internal Revenue Services or other federal agencies.

Copies of all Plan documents are available for review upon written request to the plan administrator. A copy of any of these documents will be furnished to a plan participant or beneficiary (or an authorized representative) upon request. A reasonable fee may be charged for the copies as permitted under the Employee Retirement Income Security Act of 1974 (ERISA).

Your HIPAA Privacy Rights

The privacy rules under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) require employer health plans to maintain the privacy of your health information and to provide you with a notice of the Plan's legal duties and privacy practices with respect to your health information. The notice will describe how the Plan may use or disclose your health information and under what circumstances it may share your health information without your authorization (generally, to carry out treatment, payment or healthcare operations). In addition, the notice will describe your rights with respect to your health information.

As required by law, every three years The Mosaic Company distributes a HIPAA Privacy Notice to you via mail. You should retain this notice with your personal records.

Refer to the Plan's privacy notice for more information. You can obtain a copy of the HIPAA Privacy Notice by contacting your Plan Sponsor at +1 (763) 577-2700.

Non-Assignment of Benefits

Generally, benefits under the Prescription Drug Plan may not be sold, transferred, pledged or assigned except as permitted by law. In certain situations, however, court orders (including qualified medical child support orders and qualified domestic relations orders) may require benefits to be provided for a certain individual or individuals, typically an employee's family member.

Qualified Medical Child Support Order (QMCSO)

A qualified medical child support order, also known as a QMCSO, is any judgment, decree or order, including a court-approved settlement agreement, that is issued by a domestic relations court or other court of competent jurisdiction, or through an administrative process established under state law which has the force and effect of law in that state, and which assigns to a child the right to receive health benefits for which you or your beneficiary is eligible. Federal law provides that a medical child support order must meet certain form and content requirements in order to be a QMCSO. The Plan reviews the

medical child support order to determine whether or not it meets the criteria for a QMCSO. Keep in mind that a medical child support order cannot require the plan to provide coverage it doesn't otherwise offer—for example, children who are no longer eligible due to their age can't be added under a QMCSO.

If a QMCSO affects you, you should notify your Plan Sponsor at so that the order can be handled properly. You and your dependents may obtain a copy of the procedures governing the QMCSO without charge by calling your Plan Sponsor. If The Mosaic Company receives a QMCSO affecting you, you'll be notified. The Plan will comply with all valid QMCSOs.

Change or Termination of the Plan

The Mosaic Company reserves the right to amend, modify, suspend or terminate the Prescription Drug Plan in whole or in part, subject to applicable legal and contractual agreements, at any time and for any reason, regardless of your status at the time of the change.

A decision to terminate, amend or replace the Plan may be due to changes in federal law or state laws governing benefits, the requirements of the Internal Revenue Service (IRS) or ERISA or for any other reason. This may include elimination of or decreases in benefits, changes in Plan networks and/or increases in your required contributions for coverage. If the Plan is terminated or changed, you'll still be paid any benefits you were entitled to receive under the terms of Plan, up to the cancellation date or date of the change.

Employment Rights Not Implied

This summary plan description is for your information only; it is not a binding contract, nor does it impose any legal obligation upon The Mosaic Company The Plan and the benefits described in this summary plan description do not imply or create a contract or guarantee of continued employment between The Mosaic Company and any individual. Employment with The Mosaic Company is "at will" and may be terminated by either party at any time, with or without cause or notice, except as provided by the terms of any applicable collective bargaining agreement. This provision applies to all employees regardless of their hire date.

Participation in The Mosaic Company benefits doesn't give you a right to any benefit to which you're not entitled under the terms of the Plan.

Your Rights under ERISA

As a participant in the Prescription Drug Plan, you're entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants are entitled to each of the rights described here.

Receive Information about Your Plan and Benefits

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites, upon request, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy 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.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The plan administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report, if any is required to be prepared under ERISA.

Continue Group Prescription Drug Plan Coverage

You may continue healthcare coverage for yourself, your spouse/domestic partner or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the summary plan description for the Plan in which you are enrolled and the documents governing the Plan on the rules governing your COBRA coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and don't receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials weren't sent because of reasons beyond the administrator's control. If you have a claim for benefits which is denied or ignored, in whole or in part and you have exhausted the claims procedures available to you under the Plan, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in a federal court, after exhausting the Plan's claim and appeals procedures. If it should happen that Plan fiduciaries misuse the Plan's money, or if you're discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court, after exhausting the Plan's claims and appeals procedures. The court will decide who should pay court costs and legal fees. If you're successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim 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 about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, D.C. 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.