



2027

BENEFIT LEGAL NOTICES & DISCLOSURES



TRINITY INDUSTRIES

Each year, there are legally required notices and disclosures Trinity Industries, Inc. (“Trinity”) is required to provide related to certain benefit plans.

These notices apply to the Trinity Wrap Plan (“Plan”) as required by federal law.

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If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 11 of the Legal Notices and Disclosures section for important information concerning Medicare Part D coverage.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

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

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

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

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2026. Contact your State for more information on eligibility –

U.S. Department of Labor Employee Benefits Security Administration www.dol.gov/agencies/ebsa

1-866-444-EBSA (3272)

**U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services
www.cms.hhs.gov**

1-877-267-2323, Menu Option 4, ext. 61565

ALABAMA - MEDICAID		ALASKA - MEDICAID	
Website: http://myalhipp.com/ Phone: 1-855-692-5447		The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx	
ARKANSAS - MEDICAID		CALIFORNIA - MEDICAID	
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)		Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov	
COLORADO - HEALTH FIRST COLORADO (COLORADO'S MEDICAID PROGRAM) & CHILD HEALTH PLAN PLUS (CHP+)		FLORIDA - MEDICAID	
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442		Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268	
GEORGIA - MEDICAID		ILLINOIS - MEDICAID	
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 , Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162 , Press 2		Illinois Medicaid Premium Assistance Information Medicaid application website: https://abe.illinois.gov HIPP Hotline Number: 217-524-8268 HIPP Email: mhfs.boc.hipp@illinois.gov	
INDIANA - MEDICAID		IOWA - MEDICAID AND CHIP (HAWKI)	
Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfcr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584		Medicaid Website: Iowa Medicaid Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki – Healthy and Well Kids in Iowa Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	

KANSAS – MEDICAID		KENTUCKY – MEDICAID	
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660		Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPPPROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	
LOUISIANA – MEDICAID		MAINE – MEDICAID	
Louisiana Medicaid Website: https://www.ldh.la.gov/healthy-louisiana Medicaid Customer Service Line: 1-888-342-6207 Louisiana Medicaid email: healthy@la.gov Louisiana Health Insurance Premium Program (LaHIPP) Website: https://www.ldh.la.gov/lahipp LaHIPP phone: 1-877-697-6703 LaHIPP email: La.HIPP@la.gov LaHIPP fax: 1-888-716-9787 LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084		Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	
MASSACHUSETTS – MEDICAID AND CHIP		MINNESOTA – MEDICAID	
Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY 711 Email: masspremassistance@accenture.com		Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	
MISSOURI – MEDICAID		MONTANA – MEDICAID	
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005		Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HSHIPPPProgram@mt.gov	
NEBRASKA – MEDICAID		NEVADA – MEDICAID	
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178		Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	
NEW HAMPSHIRE – MEDICAID		NEW JERSEY – MEDICAID AND CHIP	
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345 , ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov		Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	

NEW YORK – MEDICAID		NORTH CAROLINA – MEDICAID	
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831		Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	
NORTH DAKOTA – MEDICAID		OKLAHOMA – MEDICAID AND CHIP	
Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825		Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	
OREGON – MEDICAID AND CHIP		PENNSYLVANIA – MEDICAID AND CHIP	
Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075		Website: https://www.pa.gov/en/services/dhs/apply-for-medicare-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children’s Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	
RHODE ISLAND – MEDICAID AND		SOUTH CAROLINA – MEDICAID	
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347 , or 401-462-0311 (Direct RlTe Share Line)		Website: https://www.scdhhs.gov Phone: 1-888-549-0820	
SOUTH DAKOTA – MEDICAID		TEXAS – MEDICAID	
Website: http://dss.sd.gov Phone: 1-888-828-0059		Website: Health Insurance Premium Payment (HIPP) Program Texas Health and Human Services Phone: 1-800-440-0493	
UTAH – MEDICAID AND CHIP		VERMONT – MEDICAID	
WeUtah’s Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/		Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access Phone: 1-800-250-8427	
VIRGINIA – MEDICAID AND CHIP		WASHINGTON – MEDICAID	
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924		Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	
WEST VIRGINIA – MEDICAID AND CHIP		WISCONSIN – MEDICAID AND CHIP	
Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)		Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	
WYOMING – MEDICAID			
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269			

COBRA RIGHTS NOTICE

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options 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. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

WHEN IS COBRA COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. Notification may be provided by contacting the Trinity Benefits Center at 1-888-765-5367 or Trinity_Benefits@trin.net.

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work.

Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at sometime before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Notice of a disability determination by the Social Security Administration must be made by contacting the Trinity Benefit Center at 1-888-765-5367.

Notice of the disability determination must be provided within 60 days after the later of (1) the date of the disability determination by the Social Security Administration, (2) the date on which the covered employee's employment terminated or

his/her hours were reduced, and (3) the date on which the qualified beneficiary loses (or would lose) coverage under the Plan as a result of the covered employee's termination of employment or reduction in work hours. This notice must also be provided no later than 18 months after the covered employee's termination of employment or reduction in work hours.

If the Plan's notification procedures are not followed or if you do not provide timely notice of the events listed, the affected qualified beneficiaries will lose their rights to extended COBRA coverage.

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event by contacting the Trinity Benefit Center at 1-888-765-5367.

ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA CONTINUATION COVERAGE?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, Children's Health Insurance Program (CHIP) or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period."

Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends? In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period¹ to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit
<https://www.medicare.gov/medicare-and-you>

IF YOU HAVE QUESTIONS

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

PLAN CONTACT INFORMATION

Name of Entity: Trinity Industries, Inc.

Contact: Trinity Industries, Inc.

Attn: HIPAA Privacy Officer

14221 N. Dallas Pkwy, Ste. 1100

Dallas, TX 75254

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This notice describes:

- HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED
- YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION
- HOW TO FILE A COMPLAINT CONCERNING A VIOLATION OF THE PRIVACY OR SECURITY OF YOUR HEALTH INFORMATION, OR OF YOUR RIGHTS CONCERNING YOUR INFORMATION

YOU HAVE A RIGHT TO A COPY OF THIS NOTICE (IN PAPER OR ELECTRONIC FORM) AND TO DISCUSS IT WITH THE BENEFITS DEPARTMENT AT TRINITY_BENEFITS@TRIN.NET IF YOU HAVE ANY QUESTIONS.

Please review it carefully.

YOUR RIGHTS

You have the right to:

- Consent to most uses and disclosures of your health information
- Get a copy of your health and claims records
- Correct your health and claims records

- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Discuss this notice with someone in our program
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

YOUR CHOICES

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

OUR USES AND DISCLOSURES

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions
- In these circumstances, we must protect your information and limit how we use and share it.

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.
- Request confidential communications
- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our health care operations after you have provided consent for all those purposes.
- We are not required to agree to your request, and we may say "no" if, for example, it could affect your care. If we agree to your request, we may still share this information in the event that you need emergency treatment.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any

time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly upon such request.

Discuss this notice with someone in our program

You can ask questions or obtain more information about this notice and our privacy practices by calling or emailing the contact person at the top of this notice.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information

unless you give us written permission:

- Marketing purposes
- Sale of your information

OUR USES AND DISCLOSURES

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Example 2: A doctor treating you for a chronic condition asks a doctor at our program about your health condition and medications you are taking, for example, to avoid complications

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. And in all cases, if we have substance use disorder patient records about you, subject to 42 CFR part 2, we cannot use or share information in those records in civil, criminal, or legislative investigations or proceedings against you without (1) your consent or (2) a court order or subpoena. For more information see: <https://www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html>

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence, only as required by applicable law
- Preventing or reducing a serious threat to anyone's health or safety

For your medical emergencies

We may use or share your health information with health care providers or emergency personnel when needed to provide you with emergency treatment or to respond to a serious and immediate threat to your health or safety, even when you are unable to consent. This is allowed under HIPAA's rules for treatment and emergency disclosures.

Do research

We can use or share your information for health research. Researchers cannot include any patient identifying information in their reports about the research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with

organ procurement organizations.

- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
- Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Legal Proceedings and Lawful Process

We may use or share your health information as permitted or required by law when responding to legal proceedings. This includes disclosures in response to a valid court order, warrant, subpoena, or other lawful process, consistent with HIPAA's rules for judicial and administrative proceedings (45 CFR §164.512(e)) and law enforcement requests (45 CFR §164.512(f)). When responding to legal requests, we disclose only the information required and follow all conditions and limitations imposed by HIPAA.

Communicate within our program and with contractors

We may use and disclose your information within our health plan and with organizations that help us administer our program, including contractors and business associates who perform services for us. These disclosures occur only as permitted by HIPAA for health care operations.

Respond to audits and program oversight

We may use and share your information for health oversight and health care operations. This includes sharing with government agencies that are authorized by law to conduct audits, inspections, and licensure activities, and with accrediting organizations to support accreditation, quality assessment and improvement, and program evaluation of our health plan. We share only the minimum necessary information as required by law.

Disclosure to Law Enforcement

We may disclose information to law enforcement if we believe, in good faith, that it is evidence of a

We may disclose information to law enforcement if we believe, in good faith, that it is evidence of a crime that occurred on our premises, or to report certain crimes during a medical emergency that did not occur on our premises. In these situations, we will disclose only what the law allows in these situations.

OUR RESPONSIBILITIES

- We are required to obtain your consent for most uses and sharing of your information.
- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

With Your Written Consent (42 CFR Part 2)

If you provide written consent, we may use or disclose your Substance Use Disorder (SUD) information in the following ways:

- To the person or organization you name in your consent.
- Part 2 allows you to decide who may receive your SUD information through a written consent.
- To prevent multiple enrollments in withdrawal management or maintenance treatment programs
- Part 2 permits disclosures for this purpose when authorized by your consent or as otherwise allowed by law.
- To report prescribed SUD treatment medications to a state Prescription Drug Monitoring Program when required by law.

Part 2 allows this type of disclosure only when a state statute mandates such reporting.

Additional Protections for SUD Information (42 CFR Part 2)

For records related to Substance Use Disorder (SUD) treatment, we will not disclose your information in any civil, criminal, administrative, or legislative proceeding without your written consent or a court order that meets the requirements of 42 CFR Part 2.

Respond to audits and program oversight

For Substance Use Disorder (SUD) records protected by 42 CFR Part 2, organizations performing audits or evaluations must agree in writing not to redisclose your information and must destroy or return identifying information when the audit or evaluation is complete.

Redisclosure Rules for Substance Use Disorder (SUD) Information

If you authorize us to disclose your SUD records to other health care providers or health plans for treatment, payment, or health care operations, those recipients may redisclose your information as permitted by the HIPAA Privacy Rule. However, your SUD information may not be used or disclosed in any civil, criminal, administrative, or legislative proceeding against you without your written consent or a court order that meets the requirements of 42 CFR Part 2.

We will include the required Part 2 notice prohibiting unauthorized redisclosure with every disclosure of SUD information.

CHANGES TO THE TERMS OF THIS NOTICE

- We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Effective Date: 1/1/2027

Contact: Trinity Industries, Inc.

Attn: HIPAA Privacy Officer

14221 N. Dallas Pkwy, Ste. 1100

Dallas, TX 75254

MEDICARE PART D NOTICE OF CREDITABLE COVERAGE

Important Notice from Trinity about Your Prescription Drug Coverage and Medicare

The key purpose of this notice is to advise you that the prescription drug coverage you have under your Trinity prescription plan is expected to pay out, on average, at least as much as the standard Medicare prescription drug coverage will pay in 2026 (This is known as “creditable coverage.”) The reason this is important is that if you or a covered dependent are or become eligible for Medicare and you decide to enroll in a Medicare prescription drug plan during a subsequent Annual Enrollment Period, you will not be subject to a late enrollment penalty as long as you had creditable coverage within 63 days of your Medicare prescription drug plan enrollment. You should keep this notice with your important records.

Notice of Creditable Coverage

Please read this notice carefully. This notice has information about your current prescription drug coverage with Trinity and prescription drug coverage available for people with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

- 1. Medicare prescription drug coverage is available to everyone with Medicare.**
- 2. Trinity has determined that the prescription drug coverage offered by each medical insurance coverage option is, on average for all Plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay in 2027.**
- 3. Read this notice carefully - it explains the options you have under Medicare's prescription drug coverage, and can help you decide whether or not you want to enroll.**

Prescription drug coverage is available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans will provide at least a standard level of coverage set by Medicare. Some plans might also offer more coverage for a higher monthly premium.

If you are covered under one of the prescription drug plans, your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage in 2027. Therefore, if you are or become eligible for Medicare, you can keep this coverage and not pay extra if you later decide to enroll in a Medicare prescription drug plan.

Medicare participants can enroll in a Medicare prescription drug plan October 15 - December 7.

However, because you have existing prescription drug coverage that, on average, is as good as Medicare coverage, you can choose to keep that coverage and join a Medicare prescription drug plan later. Each year after that, you will have the opportunity to enroll in a Medicare prescription drug plan from October 15th through December 7th.

If you decide to enroll in a Medicare prescription drug plan, you may also continue your coverage under the Plan. The Plan will continue to pay primary or secondary as it had before you enrolled in a Medicare prescription drug plan. You may also drop your Plan coverage, in which case Medicare will be your only payer. You can re-enroll in the Plan during the Annual Enrollment Period or if you have a special enrollment event.

At this time, Trinity is planning to continue, for 2027, its prescription drug plan offerings available to Medicare eligible individuals.

You should know that if you drop or lose your coverage with Trinity and don't promptly enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more to enroll in Medicare prescription drug coverage later. If you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage.

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For example, if you go nineteen months without coverage, your Medicare prescription drug plan premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until next October to enroll. However, if you involuntarily lose credible prescription drug coverage, you will be eligible for a two month Special Enrollment Period (SEP) to enroll in a Part D plan.

For more information about your options under Medicare prescription drug coverage:

More detailed information about Medicare plans that offer prescription drug coverage will be available in the "Medicare & You" handbook. Medicare participants will get a copy of the handbook in the mail from Medicare. You may also be contacted directly by Medicare prescription drug plans.

You can get more information about Medicare prescription drug plans:

- Visit www.medicare.gov for personalized help.
- Call your State Health Insurance Assistance Program (see a copy of the Medicare & You handbook for their telephone number).
- 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 online from the Social Security Administration ("SSA") at www.socialsecurity.gov or call them at 1-800-772-1213 (TTY 1-800-325-0778).

You will get this notice every year, and you will get this notice before the next period you can join a Medicare drug plan, and if this coverage through Trinity changes. You may also request a copy of this notice at any time.

Remember: Keep this notice. If you enroll in one of the plans approved by Medicare, which offer prescription drug coverage, you may need to give a copy of this notice when you join to show that you are not required to pay a higher premium amount.

SOCIAL SECURITY NUMBERS GENERALLY REQUIRED FOR ENROLLMENT

Under Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 ("MMSEA"), the Centers for Medicare and Medicaid Services ("CMS") generally requires Social Security numbers for employees and dependents to assist with reporting under the Medicare Secondary Payer requirements. Accordingly, when you enroll in the Plan, you will be required to provide Social Security numbers for yourself and any dependents you wish to enroll to assist us in complying with this requirement. If Social Security numbers are not available for any of your dependents, you should contact the Trinity Benefits Center for additional instructions.

THE FAMILY AND MEDICAL LEAVE ACT

If you are on a leave of absence covered by the Family and Medical Leave Act of 1993 ("FMLA"), you may continue to participate in and receive health coverage under the Plan during the leave if the following conditions are met:

- Your leave has been approved in writing by the employer, and
- Any required contribution for the cost of your coverage is paid by you when due.
- When you return to work, any arrears for unpaid premiums will be taken out of your paycheck.

You may continue to receive health coverage under the Plan until the end of the leave period required by the FMLA. If you cancel your coverage while you are on an approved FMLA leave and you return to work as an eligible employee immediately following your approved FMLA leave (or your approved leave of absence that includes an approved FMLA leave), you have the right to have your participation reinstated as soon as you return to work for one full day.

If you do not return to work following an approved FMLA leave you (and your spouse and dependent children, if any) may be eligible for COBRA continuation coverage as of the date you terminated employment with Trinity. For more information, contact the Trinity Benefits Center at 1-888-765-5367.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (“USERRA”)

If you voluntarily or involuntarily serve in the uniformed services of the United States for a period of five years or less while an eligible employee, your and covered dependents' medical, dental and/or vision coverage may automatically continue up to 24 months, provided you or your dependents pay the cost of coverage. You may elect to terminate continued coverage at any time. For the first month, the cost is based on the active employee rate and after the first month, it is 102% of the full premium (premium plus 2% administrative fee.)

This provision applies to:

- Employees on active duty in the U.S. Armed Forces,
- Employees on active duty for training in the U.S. Armed Forces,
- Employees on initial active duty for training and inactive duty training in the U.S. Armed Forces (including the Reserve components), the Army or Air National Guard and the commissioned corps of the Public Health Service, and to full-time National Guard duty, and
- Absences needed to determine the employee's fitness for duty in the uniformed service.

If you are still on leave after 24 months, you and your dependents may be eligible to continue coverage under COBRA.

Coverage will end if you are discharged from military service under other than honorable conditions, or if you are dismissed or dropped from the rolls under conditions that result in loss of reemployment rights under the law.

If you or your dependents are covered by TRI-CARE, any plan will not coordinate benefits.

SPECIAL ENROLLMENT RIGHTS

This notice is being provided to make certain that you understand your right to apply for group health coverage. You should read this notice even if you plan to waive health coverage at this time.

LOSS OF OTHER COVERAGE

If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage

(or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Example: You waived coverage under this Plan because you were covered under a plan offered by your spouse's employer. Your spouse terminates employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under this Plan.

MARRIAGE, BIRTH OR ADOPTION

If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, or placement for adoption.

Example: When you were hired, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this Plan. However, you must apply within 30 days from the date of your marriage.

MEDICAID OR CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

Example: When you were hired, your children received health coverage under CHIP and you did not enroll them in this Plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this Plan if you apply within 60 days of the date of their loss of CHIP coverage.

FOR MORE INFORMATION OR ASSISTANCE

To request special enrollment or obtain more information, please contact: Trinity_Benefits@trin.net.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

The Plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related benefits, coverage will be determined in a manner determined in consultation with the attending physician and the patient. This includes all states of reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses, and treatment of physical complications related to all stages of the mastectomy (including lymphedemas). These mastectomy-related benefits are subject to the same annual deductibles and coinsurance rules that apply to other medical and surgical benefits. For more information, call the medical plan carrier for which you are enrolled at the telephone number on your medical plan ID card.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT NOTICE

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

MENTAL HEALTH PARITY

Except in limited circumstances, federal law requires that any mental health care coverage provided by a group health plan generally be comparable to the coverage available for other types of illness or disease. In particular:

- The financial requirements (e.g., deductibles and co-payments) and treatment limitations
- (e.g., number of visits or days of coverage) that apply to mental health and substance abuse benefits must be no more restrictive than the predominant financial requirements or treatment limitations that apply to substantially all medical/surgical benefits;

- Mental health benefits and substance abuse benefits may not be subject to any separate cost-sharing requirements or treatment limitations that only apply to such benefits;
- Out-of-network mental health and substance abuse benefits must generally be made available to covered persons;
- Standards for medical-necessity determinations and reasons for any denial of benefits relating to mental health benefits and substance abuse benefits must be made available upon request to Plan participants; and
- The requirements imposed by the Mental Health Parity Act of 1996 (regarding annual and lifetime dollar limits) will continue and will be extended to substance abuse benefits.

In accordance with the requirements of the Mental Health Parity and Addiction Equity Act of 2008 and its related regulations, upon request, the Plan (or the applicable insurance company) will provide a copy of any criteria used to make medical necessity determinations regarding mental health or substance abuse disorder benefits. In the event your claim for mental health or substance abuse disorder benefits is denied, the Plan or the applicable insurance company will provide you with an explanation for the denial.

QUALIFIED MEDICAL CHILD SUPPORT ORDER ("QMCSO")

Upon receipt of a Qualified Medical Child Support Order ("QMCSO"), Trinity will follow Trinity procedures established for reviewing and implementing such orders with respect to coverage under the Plan.

Upon receiving a properly completed National Medical Support Notice issued by a state child support enforcement agency (Issuing Agency), the notice shall be treated as a QMCSO. If Trinity cannot comply with the notice for one of the permitted reasons, Trinity will complete the Employer Response form included in Part A of the notice specifying the reason(s) that it cannot comply with the notice and advise the Issuing Agency.

If Trinity can comply with the notice, then it will forward a copy of Part B of the notice (Plan Administrator Response form) to the Plan Administrator within 20 business days of the date of the notice. The Plan Administrator will complete the Plan Administrator Response form to inform the employer and the Issuing Agency if the notice is a QMCSO. If the notice is determined not to be a QMCSO, then the Plan Administrator will specify

the reasons and notify the Issuing Agency and the affected parties of that fact. If the notice is determined to be a QMCSO, the Plan Administrator will provide the effective date of enrollment of the child in the health care benefit program, whether any waiting periods apply and what employee contribution is necessary for coverage.

RIGHTS PURSUANT TO GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 (“GINA”)

Trinity complies with GINA and, therefore, does not:

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

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

WELLNESS PROGRAM AND REASONABLE ALTERNATIVE NOTICE

Trinity wellness program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others.

Trinity’s wellness program features three voluntary activities that each target different areas of health improvement and have different rewards for participation. These activities are separate, you (and your spouse, if eligible) can choose which programs you would like to complete.

Activity 1 - Tobacco Cessation Program

The Plan has tobacco and non-tobacco rates, unless prohibited under a collective bargaining agreement. You are considered a tobacco user if you use cigarettes, cigars, chewing tobacco, pipe tobacco, smokeless tobacco, vapor and e-cigarettes or other tobacco products in any amount (including daily and occasional social use).

1. If you certify that you and your spouse (if enrolled) have not used any tobacco products in the last six months, then you will qualify for the non-tobacco user rates for medical coverage.
 - During the Plan year, if you and/or your enrolled spouse begin using tobacco products, you will no longer be eligible for the non-tobacco rates and you must immediately report this change to the Trinity Benefits Center at 1-888-765-5367.
2. If you certify that you or your spouse (if enrolled) have used tobacco products in the last six months, then you will qualify for the tobacco user rates for medical coverage.
 - If you or your spouse successfully stop using tobacco during the Plan year, you will qualify for the non-tobacco user rates retroactive to beginning of the year.
 - Call the Trinity Benefits Center at 1-888-765-5367 and follow the prompts to Payroll and Additional Benefits, then Tobacco Cessation.
 - If you or your spouse are unable to stop using tobacco on your own, you can enroll in the Quit for Life Program for tobacco cessation assistance.
 - Contact a Quit Coach by calling the Trinity Benefits Center at 1-888-765-5367 and follow the prompts to Payroll and Additional Benefits, then Tobacco Cessation.
 - By completing five phone calls with a Quit Coach, you will qualify for the non-tobacco user rates retroactive to beginning of the year. Call the Trinity Benefits Center at 1-888-765-5367 and follow the prompts to Payroll and Additional Benefits, then Tobacco Cessation.

Activity 2 - Biometric Screening and Blood Test

Trinity offers free biometric screenings to all benefit eligible employees, regardless of medical plan enrollment. If you choose to participate, the biometric screening will include a blood test for the Metabolic Syndrome risk factors, including: height, weight, blood pressure, BMI, waist circumference, triglycerides, cholesterol, and glucose. You are not required to participate in the biometric screening or blood test.

Alternative Standard

If you are unable to participate in any of the voluntary health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Trinity Benefit Center at 1-888-765-5367.

Other Services

The information from your preventive care exam and/or screenings and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks and may also be used to offer you services through the wellness program, such as Catapult Health. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

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

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

In addition, all medical information obtained through the wellness program will be maintained separately from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision.

Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

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

Reasonable Alternatives

The Trinity wellness program is committed to helping you achieve your best health. Rewards for participating in one or all health-related activities are available to all eligible employees and spouses. If you think you might be unable to meet a standard for a reward under the Trinity wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact the Trinity Benefit Center at 1-888-765-5367 and we will work with you (and if you wish, with your doctor) to find a wellness program activity with the same reward that is right for you in light of your health status.

If you have questions or concerns regarding this notice, or about protection against discrimination and retaliation, please contact the Trinity Benefits Center at 1-888-765-5367.

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is “balance billing” (sometimes called “surprise billing”)?

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

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

“Surprise billing” is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

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

Certain services at an in-network hospital or ambulatory surgical center

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

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

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

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

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

- Your health plan generally 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.
 - 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've been wrongly billed, you may contact the Federal No Surprises Helpdesk at 1-800-985-3059.

Visit <https://www.cms.gov/nosurprises> for more information about your rights under federal law.

Patient Protection Notice

The Trinity Industries, Inc. medical plans generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members.

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

You do not need prior authorization from BCBS or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Trinity Benefits Department at Trinity_Benefits@trin.net.

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

