

# **TRINITY WRAP PLAN**

## **Summary Plan Description**

Issued January 1, 2024

This Summary Plan Description (“SPD”) is intended to highlight the features of the Trinity Wrap Plan (“Plan”). Each benefit described in this SPD has a legal document, which governs its operation. If there is a conflict between a feature described in this SPD and the Plan document and/or the benefits legal document(s), the provisions of the Plan document and/or the legal document(s) will prevail.

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**TRINITY WRAP PLAN  
SUMMARY PLAN DESCRIPTION**

**(Issued January 1, 2024)**

**INTRODUCTION**

*This Plan summary describes the benefits provided to Eligible Employees, Transitioning Employees and Grandfathered Retirees.*

The Trinity Wrap Plan (effective January 1, 2023) (“Plan”) is maintained by Trinity Industries, Inc., a Delaware corporation (“Company”), to provide comprehensive health and welfare benefits to certain Eligible Employees, Transitioning Employees and Grandfathered Retirees (and, where applicable, their enrolled Dependents) of the Company who participate in the Plan. The Plan was last amended and restated as of January 1, 2023. The Plan incorporates the terms of all welfare benefit plans subject to the ERISA sponsored by the Company (referred to individually throughout this Summary Plan Description (“SPD”) as a “Participating Plan”). Please refer to this SPD for information regarding the Plan.

Terms that have special meaning and are defined in this SPD are capitalized and defined in the **DEFINITIONS** section of this SPD.

*Affordable Care Act Disclosures*

The Participating Medical Plans do not have annual limits on the dollar value of essential health benefits.

The Participating Medical Plans do not have any pre-existing condition exclusions.

The Participating Medical Plans generally do not require the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network for the Participating Medical Plans and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Claims Administrator for your medical plan option. For children, you may designate a pediatrician as the primary care provider, but are not required to do so.

You do not need prior authorization from the Participating Medical Plans 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 Claims Administrator for your medical plan option.

*The Plan offers a broad range of health and welfare benefits to certain Eligible Employees,*

The health and welfare benefits offered under the Plan (referred to collectively throughout this SPD as the “Participating Plans”) are:

- Participating Medical Plans (including prescription drug coverage);

*Transitioning Employees, Grandfathered Retirees (and, where applicable, their enrolled Dependents) of the Company and its Affiliates who participate in the Plan.*

- Participating Dental Plan;
- Participating Vision Plan;
- Participating Life and Accidental Death and Dismemberment Plan (including basic coverage and voluntary supplemental or dependent coverage);
- Participating Long-Term Disability and Short-Term Disability Plans;
- Participating Cafeteria Program;
- Participating Critical Illness, Accident, & Hospital Indemnity Insurance Plan;
- Participating Business Travel Accident Plan;
- Employee Assistance Program;
- Health Savings Account;
- Health Care Flexible Spending Account; and
- Dependent Care Flexible Spending Account.

The medical, dental, vision, voluntary life insurance, critical illness, hospital indemnity and accident insurance plan, flexible spending accounts, health savings account, and short-term disability (for hourly Employees) benefits are “flexible” because they are offered under the Plan which allows you to choose among different benefit options. Each year, you can reconsider your benefit needs and, if they have changed, you can change your coverage election during Annual Enrollment. The basic life, long-term disability and short-term disability benefits (for administrative non-exempt Employees) are provided and funded by contributions made solely by the Company and are not elective. Refer to this SPD and the documents listed in the **PARTICIPATING PLANS SUMMARIES** in this SPD for more specific information on each benefit offered under the Plan. In addition, as to any Participating Plan that is solely paid by you with after-tax dollars you can drop coverage at any time, but you can generally only add coverage during Annual Enrollment or if you experience a Change of Status. See **WHEN CAN I CHANGE MY ELECTIONS DURING A PLAN YEAR?** in this SPD.

*Read this SPD carefully.*

This document, together with the documents listed in the **PARTICIPATING PLANS SUMMARIES** in this SPD, make up this SPD. Together these documents describe the terms and conditions of the Plan and answer the most frequently asked questions about the Plan. Please read this SPD carefully.

The benefit and other principal provisions described in this SPD apply only if you are an Eligible Employee, Transitioning Employee or Grandfathered Retiree,

(and, where applicable, an enrolled Dependent of such) of the Company and its Affiliates who participate in the Plan, and you:

- are eligible to participate in a Participating Plan;
- elect coverage under that Participating Plan, if required;
- remain covered in accordance with the provisions of (i) the Plan and (ii) the applicable Participating Plan.

Additional information regarding the Participating Plans offered under the Plan is set forth in the **PARTICIPATING PLANS SUMMARIES** in this SPD. The **PARTICIPATING PLANS SUMMARIES** may be updated from time to time to reflect changes to the Participating Plans. The Company reserves the right to amend or terminate the Plan and/or any Participating Plan at any time. Any part or all of the Plan and any Participating Plan may be amended by the Company at any time. Any policy providing an insured benefit may be amended by the Company with the agreement of the insurance company at any time, except that no amendment shall reduce the amount of benefits payable for claims incurred prior to the date of amendment, determined in accordance with the terms of the Participating Plan as in effect prior to such date.

The Company shall have the sole authority to terminate part or all of the Plan as to some or all classes of Covered Persons and/or any Participating Plan at any time.

*Different groups of employees may be eligible for different Participating Plans.*

Please note that not all the Participating Plans offered under the Plan are available to every Employee. You should refer to the relevant portions of this SPD and the individual **PARTICIPATING PLANS SUMMARIES** for specific information about each Participating Plan.

Keep in mind that this SPD is based on official legal documents that govern the operation of the Plan. Some features of the Plan, particularly those that apply infrequently, are not included in this SPD. More detailed information is provided in the official Plan documents.

*This SPD is only a summary. The official Plan documents contain the terms of the Plan.*

While every effort has been made to make this SPD as accurate as possible, if there is a benefit discrepancy between this SPD, insurance certificate booklets and/or membership booklets, and the Plan document, the insurance certificate booklets and/or membership booklets shall control. If there is a legal discrepancy between this SPD, insurance certificate booklets and/or membership booklets and the Plan document, the Plan document shall control.

## **DEFINITIONS**

**Affiliate** – Any corporation or other business which is with respect to the Company: (i) a member of a controlled group of corporations (as defined in Code Section 414(b)); (ii) under common control (as defined in Code Section 414(c));

or (iii) any other entity to the extent required to be aggregated under Code Section 414(o). An organization which is an affiliated service group within the meaning of Code Section 414(m) may not participate in the Plan, but may be required to be aggregated with this Plan for testing and Affordable Care Act reporting purposes.

Affordable Care Act – The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, and the regulations and other guidance issued thereunder. References to the Affordable Care Act include any comparable sections of any future legislation which amend, supplement, or supersede said sections of the Affordable Care Act cited here.

Annual Enrollment – The open enrollment period for a Participating Plan designated by the Company during which then currently enrolled Covered Persons may make Participating Plan enrollment elections to be effective the next following Plan Year. Enrolled COBRA qualified beneficiaries and Covered Persons on an authorized leave of absence may also make coverage elections for the following Plan Year during Annual Enrollment.

Claims Administrators and Appeals Fiduciaries – The Claims Administrators and Appeals Fiduciaries appointed by the Company under the various Participating Plans as set forth below under the **MAKING A CLAIM FOR BENEFITS** section.

COBRA – The Consolidated Omnibus Budget Reconciliation Act of 1985.

Code – The Internal Revenue Code of 1986, as amended, and the regulations in effect thereunder.

Company – Trinity Industries, Inc., and any successor or assignee thereof which adopts the Plan by action of its governing body or which contractually assumes the obligations of the Company under the Plan.

Consistency Rule – A regulation stipulating that an Employee may make changes in benefit elections pursuant to a Change of Status during a Plan Year only if the elections are on account of and corresponds with the Change of Status that affects eligibility for coverage under the Plan provided through the Participating Cafeteria Program and/or the Flexible Spending Accounts.

Covered Person – (i) Any Eligible Employee, Transitioning Employee or Grandfathered Retiree who participates in a Participating Plan in accordance with its terms and conditions, and has not for any reason become ineligible to participate further in that Participating Plan, and (ii) any Dependents of the Eligible Employee, Transitioning Employee or Grandfathered Retiree properly enrolled in a Participating Plan under the Plan that provides Dependent coverage. A Covered Person includes each qualified beneficiary who has elected COBRA coverage under the Group Health Plan. With respect to the right to make elections

under the Participating Cafeteria Program, the term “Covered Person” refers to the Eligible Employee only.

Dependent – An Eligible Employee’s, Transitioning Employee’s and Grandfathered Retiree’s Spouse or Child, as defined under the terms of the applicable Participating Plan. In all events, a person of the same sex legally married to the Eligible Employee, Transitioning Employee and Grandfathered Retiree shall be a Spouse.

With respect to the Participating Medical Plans, Dependent shall include any biological or adopted child, stepchild, child placed for adoption, or eligible foster child until the end of the calendar year in which such child reaches twenty-six (26) years of age, without regard to the child’s student status, marital status, financial independence, or place of residence.

The term “Dependent” as it applies to coverage refers only to a person who is dependent on you for more than one-half of his or her financial support. Healthcare benefits provided to your dependent children are tax-free as long as your children qualify as dependents within the meaning of Code Section 152 (this provision defines your tax dependents based on several criteria, including age, relationship, place of residence and source of support). If your children do not qualify as dependents under the Code, the fair market value of the coverage provided to those children (provided after the child attains age twenty-seven (27) with respect to coverage provided under the Participating Medical Plans) is considered taxable income to the Eligible Employee, Transitioning Employee and Grandfathered Retiree.

Eligible Employee – Any Employee who meets the eligibility requirements Participating Plan under the terms of the applicable Participating Plan. An Eligible Employee is an Eligible Employee only to the extent of, and only with respect to participation in, those portions of the Plan with respect to which he meets the eligibility requirements of the applicable Participating Plan.

Employee – The term “Employee” means any individual who is employed by an Employer as an active regular full-time employee regularly scheduled to work at least thirty (30) hours per week. Employee also includes any individual who is on an approved leave of absence (as approved by the Employer or any Affiliate) for the duration of the leave of absence, regardless of the hours per week worked (or not worked) and regardless of the amount of compensation received from the Employer or any Affiliate. Employee does not include any of the following (unless specifically included as an “Employee” under the terms of a Participating Plan):

- Persons classified and treated by an Employer as independent contractors;
- Nonresident aliens who receive no United States source income from an Employer;
- Individuals included in a unit covered by a collective bargaining agreement unless the Employer and the collective bargaining unit have agreed upon coverage under a Participating Plan;
- Individuals characterized as leased employees (as defined by Code Section 414(n)) or any individuals who would be leased employees but for the fact they are common law employees of an Employer; and
- Temporary or seasonal employees classified as such on the Employer's payroll records.

Employer – The term “Employer” means the Company and the Participating Employers.

Grandfathered Retiree – The term “Grandfathered Retiree” means a retiree designated by the Plan Administrator as eligible to participate in the Plan.

Participating Plan – Any of the following health and welfare benefits made available by the Company and described by this SPD; Participating Medical Plans (including prescription drug coverage); Participating Dental Plan; Participating Vision Plan; Participating Life and Accidental Death and Dismemberment Insurance Plan; Participating Long-Term and Short-Term Disability Plans; Participating Critical Illness, Accident, & Hospital Indemnity Insurance Plans; and Participating Cafeteria Program – including Health Savings Account, and Health Care Flexible Spending Account, Dependent Care Flexible Spending Account.

Plan Administrator – The term “Plan Administrator” means the Trinity Industries, Inc. Director of Benefits or in the absence of a Director of Benefits, such individuals, committee, or other entity appointed by the Trinity Industries, Inc. Health and Welfare Plan Committee to serve as Plan Administrator.

Plan Year – January 1 through December 31.

Spouse – An individual who is legally married to a Participant as determined by applicable law, including a legally-recognized common-law spouse, and including legally named same-sex spouses, but excluding domestic partners, or individuals with similar status, whether or not recognized as a “spouse” under federal or state law.

Transitioning Employee – The term “Transitioning Employee” means an employee who is transitioning out of employment with the Company pursuant to the terms of a Transition Agreement entered into by and between the Transitioning

Employee and his Employer and who during such transition period remains eligible for coverage under the medical plan for such period as specified in such applicable Transition Agreement.

## **ELIGIBILITY AND PARTICIPATION**

*Who is eligible to participate in the Plan?*

You are eligible to participate in the Plan if you are an Eligible Employee, Transitioning Employee and Grandfathered Retiree of the Company or an Employer, including eligible Dependents where Dependent coverage is available, and you have satisfied the eligibility and enrollment requirements of the applicable Participating Plan. Some of the Participating Plans may have a waiting period before you are eligible to participate, and some Participating Plans may have broader eligibility rules.

Unless otherwise specified in the **PARTICIPATING PLANS SUMMARIES**, an Employee is eligible to participate in the Plan on the date you become an Eligible Employee, *i.e.* an active, regular full-time Employee of the Company or an Affiliate, scheduled to work at least thirty (30) hours per week and a resident of the United States and on U.S. payroll. Your elections will become effective the first day of the month following your thirty-first (31<sup>st</sup>) day of employment.

*Individuals classified as Eligible Employees are eligible to participate.*

The following are **not** Eligible Employees:

- An individual who has not met the applicable waiting period for coverage under the applicable Participating Plan, if any;
- An individual specifically excluded from the definition of Eligible Employee in the **DEFINITIONS** section of this SPD, above.

When you elect coverage for a Spouse and/or Child, it is your responsibility to make sure the Spouse and/or Child meets the definition of a Dependent under the applicable Participating Plan. In addition, you are responsible for notifying the Plan Administrator when a Spouse and/or Child no longer meets the eligibility criteria. The Plan Administrator reserves the right to audit Dependents for proof of eligibility and to take appropriate actions if it is discovered that an ineligible Spouse and/or Child has been added.

The Plan Administrator has the exclusive right to classify an individual as eligible for participation in the Plan. Classification, reclassification, or retroactive classification of an individual's status with the Employer by any other entity (even a court or government agency) will not cause the individual to become eligible for purposes of the Plan.

*Reemployment as an Employee*

If an Eligible Employee is rehired within thirty (30) days of their last termination date and within the same Plan Year, such Eligible Employee's prior enrollment and contribution elections will be reinstated, including any Flexible Spending Account elections provided still an Eligible Employee. If an Eligible Employee had already met the waiting period for the benefit(s) to be effective, the Eligible

Employee will not have to meet the waiting period again. If an Eligible Employee is rehired after thirty (30) days and within twelve (12) months of their last termination date, such Eligible Employee will need to make new benefit elections within thirty (30) days of their latest hire date. However, such Eligible Employee will not have to meet a new waiting period for any benefit, provided they already met the waiting period during their last employment. The same will apply if an Eligible Employee is rehired within thirty (30) days of their last termination date but not in the same Plan Year.

Employee whose coverage under the Plan ended due to a period of the Eligible Employee's absence for duty in the uniformed services of the United States shall again become covered by the Plan as soon as the Eligible Employee returns to employment at thirty (30) or more hours per week, provided the Eligible Employee returns to, or reapplies for, reemployment within the period of time that the Eligible Employee has reemployment rights under the Uniformed Services Employment and Reemployment Rights Act of 1994.

*When can I participate in the Plan?*

You can participate in the Plan once you meet the eligibility requirements of at least one Participating Plan and enroll in it, if required. Coverage for enrolled Dependents begins on the same day as your coverage. Please refer to the applicable **PARTICIPATING PLANS SUMMARIES** in this SPD to determine if you are eligible for a Participating Plan. Whether or not you are eligible for a Participating Plan may depend on your employment classification.

*After I've enrolled, can I change my elections?*

Generally, your elections under the Plan are effective for the Plan Year and cannot be changed until the next Annual Enrollment. Exceptions to this rule are discussed in the **WHEN CAN I CHANGE MY ELECTIONS DURING A PLAN YEAR?** section of this SPD. If you terminate employment with the Employer and are later reemployed with the Employer, you will generally have to make new elections under the Plan. However, if you terminate employment and are reemployed within thirty (30) days of your termination date, your previous elections under the Plan for the Plan Year will be reinstated.

*Do I have to re-enroll in the Plan each Plan Year?*

You must elect or change your benefit elections in subsequent Plan Years during the Annual Enrollment period before the Plan Year begins.

*When can I change my elections during a Plan Year?*

You may change or revoke your elections in writing (including waiving coverage) if you have a Change of Status. A Change of Status includes:

- Changes in your legal marital status, such as by marriage, divorce, legal separation, death of your Spouse, or annulment;
- Changes in the number of your Dependents, such as the birth, death, adoption, or placement for adoption (as defined in the regulations under Code Section 9801) of a Dependent;

- Changes in your or your Dependent’s employment status if it causes you or your Dependent to become eligible or cease to be eligible under the Plan or another employee benefit plan;
- A change in the eligibility conditions of the Plan, or the employee benefit plan of the employer of your Dependent, affecting the eligibility of that Dependent under the Plan or the other employee benefit plan;
- A change of your or your Dependent’s residence or worksite if it causes you or your Dependent to gain or lose eligibility for insurance;
- Your eligibility for a “Special Enrollment Period to enroll in a Qualified Health Plan through a Marketplace” pursuant to guidance issued by the Department of Health and Human Services and any other applicable guidance, or your seeking to enroll in a Qualified Health Plan (as defined in the Affordable Care Act) through a Marketplace (as established under the Affordable Care Act) during the Marketplace’s annual open enrollment period. In these instances, you may make an election change to revoke your (and your Dependents’) Group Health Plan coverage under the Plan; provided that any such election change corresponds to your (and your Dependents’) enrollment in a Qualified Health Plan through a Marketplace for new coverage that is effective beginning no later than the day immediately following the last day of the revoked coverage under the Plan;
- If you were reasonably expected to work an average of at least thirty (30) hours of service per week and experience a change in employment status resulting in you reasonably being expected to work an average of less than thirty (30) hours of service per week after the change. In this instance, you may make an election change to revoke your (and your Dependents’) Group Health Plan coverage under the Plan, even if your change in employment status does not result in you ceasing to be an Eligible Employee; provided that any such election change corresponds to your (and your Dependents’) enrollment in other group health plan coverage that (i) provides “minimum essential coverage” as defined under the Affordable Care Act and (ii) is effective no later than the first day of the second month following the month that includes the date the coverage under the Plan is revoked;
- An election change under a plan maintained by his or her Spouse’s or Dependent’s employer. In this case, the Plan Administrator may permit the Covered Person to revoke an election under the Plan and make a new election for the balance of the Plan Year that is on account of and corresponds with the election change made by the Eligible Employee’s Spouse or Dependent, if:

- the election change made by the Eligible Employee’s Spouse or Dependent under his or her employer’s plan satisfies the regulations and rulings under Code Section 125; or
- the annual enrollment period under the plan maintained by the employer of the Eligible Employee’s Spouse or Dependent does not correspond with the Annual Enrollment period of the Plan; and
- Your Dependent’s ceasing to be classified as a covered “Dependent” under the terms of the applicable Participating Plan.
- Going on unpaid leave pursuant to the Family and Medical Leave Act (“FMLA”).

*Election changes must be consistent with your Change of Status.*

If you experience a Change of Status, you may change or revoke your elections under the Plan for the remainder of the Plan Year. Your election change, however, must be consistent with your Change of Status. For example, you cannot decrease your Participating Medical Plans coverage after the birth of your Child, because that election change would not be consistent with your Change of Status. You could, however, add your Child as a Dependent under the Participating Medical Plans.

There may be other events that can be a Change of Status under applicable laws or regulations. Please contact the Trinity Benefits Center to report a Change of Status within thirty (30) days of the date of the Change of Status to update your benefits elections.

*You can also change your elections during a Plan Year under certain other special circumstances.*

In addition, you can change or revoke your elections during a Plan Year if the Participating Plan permits and:

- You have special enrollment rights under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time (“HIPAA”) (See the **WHAT ARE MY HIPAA SPECIAL ENROLLMENT RIGHTS?** Section of this SPD); or
- You have special enrollment rights under the State Children’s Health Insurance Program (“SCHIP”) (See the **WHAT SPECIAL ENROLLMENT RIGHTS DO I HAVE AS A RESULT OF SCHIP AND MEDICAID ENROLLMENT EVENTS?** Section of this SPD); or
- You, your Spouse, or your Dependent enroll in or become ineligible for coverage under Medicaid or Medicare.

*You may change your elections by filing a new election form with the Plan Administrator*

Please note that you can change or modify your elections due to an event described above only if you contact the Plan Administrator and request the change within thirty (30) days the Change of Status (or sixty (60) days for an SCHIP or Medicaid Enrollment Event) of the triggering event (e.g., Change of Status). Contact the Trinity Benefits Center at [www.mybenefits.trin.net](http://www.mybenefits.trin.net) or (888) 765-5367.

*within thirty (30), or in some cases sixty (60), days of a Change of Status or other triggering event.*

Your election change will be effective the date you contact the Trinity Benefits Center to request the change, or the effective date of the change for birth or death.

*What are my HIPAA special enrollment rights?*

If you did not elect to participate in the Participating Medical Plans when you first became an Eligible Employee, you may be entitled to enroll before the next Annual Enrollment, if either:

- You previously waived coverage under the Participating Medical Plans because you and/or your Dependents had other medical coverage, and that coverage is later lost, or
- You acquire a new Dependent.

In the event that you and/or your Dependents lose other coverage, the special enrollment period applies if:

- You and/or your Dependents are eligible for the Participating Medical Plans; and
- The other coverage was lost due to (a) exhaustion of COBRA continuation coverage; (b) loss of eligibility as the result of legal separation, divorce, death, termination of employment, or reduction in hours; or (c) termination of the employer contributions for the other coverage.

If you acquire a new Dependent by marriage or through the birth or adoption of a child, the special enrollment period will apply.

You have thirty (30) days from the triggering event (loss of coverage, marriage, birth, adoption, or placement for adoption) to enroll. Coverage will be effective the date you notify the Trinity Benefits Center, or as of the date of the birth, adoption or placement for adoption. Contact the Trinity Benefits Center to update your benefits elections.

For more information about HIPAA special enrollment rights, contact the Trinity Benefits Center at [www.mybenefits.trin.net](http://www.mybenefits.trin.net) or (888) 765-5367.

*What special enrollment rights do I have because of SCHIP and Medicaid Enrollment Events?*

If (i) you or your Dependent(s) lose coverage under SCHIP or Medicaid or (ii) you or your Dependent(s) become eligible for premium assistance from the state toward coverage in the Participating Medical Plans, you have an SCHIP or Medicaid Enrollment Event and are eligible to enroll in the Participating Medical Plans on account of such event. In order to take advantage of this special enrollment you must notify the Plan within sixty (60) days of the date you either lose coverage under SCHIP or Medicaid or you gain eligibility for state premium assistance in the Participating Medical Plans. For further details regarding a loss

of coverage or premium assistance eligibility, contact the Trinity Benefits Center at [www.mybenefits.trin.net](http://www.mybenefits.trin.net) or (888) 765-5367.

*What if my benefit costs change during the Plan Year?*

Your election may automatically be adjusted if the cost of a Participating Plan increases or decreases during a Plan Year or if your contribution amount increases or decreases due to a change in your employment status.

For example, if you elect coverage in a Participating Medical Plan or Participating Dental Plan, and the amount you must pay for that coverage increases, the amount withheld from your paycheck for that coverage will automatically increase to match the new amount you are required to pay for that coverage. Remember, if the cost increases significantly, you can change your election, as explained in the **WHEN CAN I CHANGE MY ELECTIONS DURING A PLAN YEAR?** section of this SPD.

*When does coverage under the Plan end?*

Your coverage under the Plan will end on the earliest of the following to occur:

- The day you terminate employment;
- The day you are no longer eligible for Plan participation; or
- The date the Plan is terminated.

Participation in the Plan may cease retroactively to the date a Covered Person commits fraud or makes an intentional misrepresentation of material fact with regard to coverage under the Plan or Participating Plan. Notwithstanding the foregoing, Covered Persons who otherwise meet the requirements for continuation and reinstatement of coverage under the FMLA; the Uniformed Services Employment and Reemployment Rights Act of 1994 (“USERRA”); and Title X of the COBRA, as amended, shall be offered the right to continue coverage pursuant to the terms and provisions of the applicable statute, the regulations thereunder, and the administrative rules established by the Plan Administrator, in its discretion.

## **HOW THE PLAN WORKS IN GENERAL**

*Do I have to participate in all the Participating Plans?*

No. One of the advantages the Plan offers you is choice – you can elect the Participating Plans that are best for your own individual circumstances. You should note there are Participating Plans under the Plan that are entirely paid for by the Employer. For example, Eligible Employees receive basic coverage under the Participating Life and Death and Dismemberment Plan, Participating Long-Term Disability Plan, and Participating Short-Term Disability Plan (for administrative non-exempt Employees) with no Eligible Employee contribution. See the individual **PARTICIPATING PLANS SUMMARIES** in this SPD for a listing of documents containing more information on the individual Participating Plans.

When you make your benefit choices, you should consider your personal circumstances carefully. Since the Company cannot give you personal tax or financial planning advice, you may want to consult your tax or financial advisor before making benefit elections under the Plan.

*Do I have to contribute to the Plan?*

The Participating Plans that you elect will determine how much you must contribute. For those Participating Plans which require Eligible Employee contributions, a pro-rata portion of the cost for your Participating Plan coverage will be withheld from each of your paychecks on a pre-tax or after-tax basis. Transitioning Employees, including their Dependents where Dependent coverage is available, shall be eligible to participate in the Plan on an after-tax basis solely.

Pro-rata means that the cost for the coverages you selected for the Plan Year is divided by the number of pay periods in the Plan Year. Pre-tax means that your contribution is withheld before your taxes are determined, so that you are taxed on less income (which reduces your income taxes). After-tax means that your pay is first taxed and then your contribution is withheld from your pay.

For example, if you elect Participating Medical Plans coverage, your share of the premiums for that coverage will be withheld from your paycheck before your taxes are determined.

## **PARTICIPATING PLANS SUMMARIES**

*What are the different coverages offered under the Plan?*

Please read the following summaries of the coverages offered under the Plan. Additional details about eligibility and benefits are available in the documents listed in the following individual **PARTICIPATING PLANS SUMMARIES**.

## **PARTICIPATING MEDICAL PLANS**

*Participating Medical Plans*

The Participating Medical Plans provide medical care for you, your Spouse and your eligible Children. The Participating Medical Plans include the following.

- BCBSTX Basic HDHP with Health Savings Account
- BCBSTX Enhanced HDHP with Health Savings Account
- BCBSTX PPO with Health Care Flexible Spending Account

Under the Participating Medical Plans, you will have access to a network of physicians, specialists, and hospitals from which you can choose to receive care. You can receive benefits at a lower cost to you and the Participating Medical Plans by using network providers, or you can go to providers outside of the network and receive care at a higher cost to you and the Participating Medical Plans.

*Deductible and Co-insurance*

There are deductibles and co-insurance under the Participating Medical Plans.

You will be responsible for deductibles and co-insurance if any, which means you must pay the difference in cost between what is paid for by the Participating Medical Plans and what the provider charges for its services, minus any network discounts, if applicable.

You may receive treatment from an in-network provider or out-of-network provider. (See the applicable document listed in this Participating Plan summary for more details).

*Eligibility to Participate*

You may enroll in the Participating Medical Plans during each Annual Enrollment in accordance with instructions provided by the Plan Administrator. If you are a newly hired Eligible Employee, you must enroll within thirty (30) days of your eligibility date in accordance with the provisions of the Participating Medical Plans and in accordance with enrollment instructions provided by the Plan Administrator. Waiting periods may apply. COBRA beneficiaries enroll pursuant to the administrative rules established by the Plan Administrator and the COBRA Administrator, and must pay the COBRA premium for continued coverage.

*Late Enrollment*

If you fail to enroll in the Participating Medical Plans during the thirty (30)-day initial enrollment period, Annual Enrollment, or within thirty (30) days of a Change of Status or other permissible event where you may change your election, (or sixty (60) days for an SCHIP or Medicaid special enrollment event), you and your eligible Dependents must wait until the next Annual Enrollment period to enroll in the Participating Medical Plans (see the **ELIGIBILITY AND PARTICIPATION** section of this SPD for more details).

*Acquiring a New Dependent*

If you acquire a new Dependent through birth, adoption, placement for adoption or marriage and report a Change of Status to the Trinity Benefits Center for this Dependent within thirty (30) days of birth, adoption, placement for adoption or marriage, coverage for the Dependent will become effective on the date of birth, adoption or placement for adoption. Marriage events are effective the date you report the event to the Trinity Benefits Center. If you were not previously enrolled, you and your Spouse may also enroll during this special enrollment period for newly acquired Dependents.

*Funding of  
Participating  
Medical Plans*

You and the Company share the cost of this coverage. You will be required to pay a portion of the cost on a pre-tax basis. The Plan Administrator will notify you annually of the required employee contributions and any surcharge amounts for the Participating Plans.

For more information about benefits, limitations and eligibility for the Participating Medical Plans, see the following documents:

- BCBSTX Open Access Plus Medical Benefits – Basic Plan/Enhanced Plan Summary Plan Description
- BCBSTX Comprehensive Medical Benefits – Retiree Only Plan (Comp 1) Summary Plan Description
- BCBSTX Comprehensive Medical Benefits – Retiree Only Plan (Comp 2) Summary Plan Description
- Employee Benefits Guide

*Tobacco and  
Non-Tobacco  
User Rates*

The Participating Medical Plans have tobacco and non-tobacco rates for the premiums you pay for medical coverage, 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). To qualify for the non-tobacco user rates for the premiums you pay for medical coverage, you must certify that you and your Spouse (if enrolled) have not used any tobacco products, in the last six (6) months. If you and/or your enrolled Spouse begin using tobacco products, you will no longer be eligible for the non-tobacco rates. You must immediately report this to the Trinity Benefits Center. If you stop using tobacco products for at least six (6) consecutive months, then you will be eligible to receive the non-tobacco rate. Contact the Trinity Benefits Center to make this change. False statements regarding the use of tobacco products can result in disciplinary action, up to and including termination.

*Wellness Program  
and Reasonable  
Alternative Notice*

If requesting medical coverage for yourself and/or your Spouse through any of the Participating Medical Plans you are required to complete a Smoker's Attestation online or by phone. ***You must complete this form online or by phone during the Annual Enrollment or upon eligibility to enroll.*** If you certify that you have used tobacco products in the last six (6) months, you may contact the Quit For Life at 888-765-5367 to enroll in the tobacco cessation program (explained in more detail below). By completing the program, you can select "No" to qualify for the non-tobacco user rates retroactive to the beginning of the year.

The Company offers the Quit For Life tobacco cessation program as a voluntary program to all Covered Persons. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health

Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the tobacco cessation program, you will be asked to complete five coaching calls with a Quit for Life coach. You are not required to complete the tobacco cessation program.

However, if you are tobacco users and choose to participate in the tobacco cessation program, you will receive the non-tobacco medical premium rates. Although you are not required to complete the tobacco cessation program, only tobacco users who do so will receive non-tobacco user rates.

The Company also offers free biometric screenings to all benefit eligible employees, regardless of enrollment in Participating Medical Plans. 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.

If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn the non-tobacco user rates including participation in the Quit for Life program or any other wellness program incentive, you may still be entitled to other reasonable accommodations or an alternative standard. In this instance, you may request a reasonable accommodation or an alternative standard by contacting the Trinity Benefit Center.

The information from the wellness program participation will be used to provide you with information to help you understand your current health and potential risks. You also are encouraged to share your results or concerns with your own doctor.

The Participating Medical Plans are committed to helping you achieve your best health. Rewards for participating in the wellness programs are available to all Covered Persons. If you think you might be unable to meet a standard for a reward under the wellness programs, you might qualify for an opportunity to earn the same reward by different means. Contact the Trinity Benefit Center and we will work with you (and if you wish, with your doctor) to find a wellness program 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 protections against discrimination and retaliation, please contact the Trinity Benefit Center .

## **HEALTH SAVINGS ACCOUNT (“HSA”)**

Your medical coverage election may enable you to establish an HSA.

### *Eligibility to Participate*

To be eligible for an HSA, you must:

- Be covered by a high deductible health plan (“HDHP”)
- Not be covered by other health coverage that is not an HDHP (with some limited exceptions)
- Not be enrolled in government sponsored healthcare such as Medicare, Medicaid, TRICARE and certain Veteran’s Administration benefits; and
- Not be eligible to be claimed as a dependent on another person’s tax return.

To establish an HSA, you will need to open an account at an approved financial institution which will be used to pay for current and future health care expenses. Anyone can contribute to your HSA on your behalf, including a family member, your Employer or yourself.

*How Your HSA Works*

An HSA works in conjunction with an HDHP. Your HDHP will cover your eligible health care expenses after you meet your deductible. You can use your HSA to pay for eligible medical expenses until you meet your HDHP’s deductible, or you can use your HSA to pay for qualified medical expenses not covered under your HDHP (for example, dental or vision expenses).

The HSA is not a part of the HDHP and is not sponsored by your Employer. The information in this section is provided only as an overview of the HSA benefit. NOTE: Enrollment in the HSA is the same process as is used for all other Participating Plans offered under the Plan. Your HSA can provide a triple tax advantage—contributions, investment earnings and amounts distributed for qualified medical expenses are all exempt from Federal tax and most state income taxes.

*HSA Contributions*

After you open your account, you (or anyone else on your behalf) can make contributions to your HSA. You fund your HSA through pre-tax salary reduction contributions deducted from your paycheck. All information regarding funding your HSA will be included in your enrollment materials.

Your Employer may also contribute an annual amount (as shown in your enrollment materials) to your HSA. This amount may be a flat dollar amount payable to all participants or it may be based on the coverage you select (for example, self-only or family coverage). Employers are not required to make HSA contributions. If your enrollment materials do not show an Employer contribution, this means that your Employer does not contribute toward your HSA.

Because of an HSA’s powerful tax savings, there are strict limits on how much can be contributed to your HSA each year. The amount you or any other person can contribute to your HSA depends on the type of HDHP coverage you have, your age, the date you become an eligible individual and the date you cease to be an eligible individual. All contributions to your HSA for a calendar year

(including contributions you, your Employer or anyone else makes on your behalf) are counted toward the HSA contribution limit.

In addition, if you are age 55 or older, you are permitted to make a \$1,000 “catch-up” contribution to your HSA each year.

You may wish to discuss your individual tax situation with your tax advisor or obtain IRS Publication 969 - Health Savings Accounts and Other Tax-Favored Health Plans, available at [www.irs.gov](http://www.irs.gov).

### *Using Your HSA*

You can receive tax-free distributions from your HSA to pay (or be reimbursed) for qualified medical expenses you incur after you establish your HSA. You can use your HSA account to pay for current and future qualified health care expenses. These include medical and prescription drug expenses, as well as deductible and coinsurance amounts, for yourself and your eligible dependents. Over-the-counter drugs without a prescription and feminine care products as specified in the Coronavirus Aid, Relief, and Economic Security Act of 2020 (“CARES Act”) are qualified medical expenses. A list of additional qualified medical expenses may be found in IRS Publication 502, available at [www.irs.gov](http://www.irs.gov).

You will receive information about how to use your HSA when you open your account. Depending on where your account is, you may be issued a debit card or checkbook to pay for eligible expenses. It is important for you to keep receipts to document expenses for any tax year that may come under review.

You do not have to make distributions from your HSA each year. Unlike some other types of medical savings accounts, your HSA account balance rolls over from year to year.

If you use the money in your HSA for non-qualified medical expenses, the amount is subject to ordinary income tax, plus a 20-percent tax penalty if you are under age 65. The tax penalty generally does not apply if the distribution occurs after you reach age 65, become disabled or die; however, ordinary income tax will still apply.

### *Important Information About Your HDHP/HSA*

Participation in an HDHP/HSA is subject to the following IRS requirements:

Your medical and prescription drug expenses are combined toward meeting your deductible—there is not a separate deductible for prescription drug expenses. This means that you must pay the full cost for prescriptions, as well as medical expenses, until you have paid the HDHP’s applicable deductible amount (individual or family). Then, the plan starts to pay. However, your HDHP may provide preventive care benefits without a deductible.

You cannot be enrolled in other medical coverage (including a plan through your spouse’s employer) that is not an HDHP, even as a dependent. However, you can

participate in certain permissible types of coverage, such as a limited-purpose HRA that reimburses or pays for dental and vision expenses.

You cannot be enrolled under your spouse's non-HDHP coverage. However, you can still be an eligible individual even if your spouse has non-HDHP coverage, provided you are not covered by that plan.

You cannot be enrolled in Medicare coverage.

For additional information about how an HDHP/HSA works, refer to IRS Publication 969 – Health Savings Accounts and Other Tax-Favored Health Plans.

*When Your HDHP Participation Ends*

Your HSA belongs to you. It stays with you when you change employers or leave the workforce. If your medical coverage under the Plan terminates for any reason, the funds in your HSA account remain yours. Your HSA is also inheritable. What happens to your HSA when you die depends on who you name as your beneficiary. You will need to designate a beneficiary when you open your HSA.

You can make tax-free contributions to your HSA if you participate in another HDHP (and meet the other requirements for HSA eligibility). You may continue to use your HSA to pay for qualified medical expenses, or you may elect to leave the money in your account grow on a tax-free basis to use for future health care expenses. However, once you enroll in Medicare or are no longer covered by an HDHP, you are not permitted to make contributions to your HSA.

You may use your HSA funds to pay Medicare premiums. Payment of Medicare premiums is a qualified expense and a tax-free distribution. If you are 65 or older, HSA distributions used for non-qualified medical expenses will be subject to ordinary income tax but exempt from the additional penalty tax.

**FLEXIBLE SPENDING ACCOUNT PLAN**

*Enrolling*

The Flexible Spending Account Plan includes the following spending accounts:

- Health Care Flexible Spending Account (“HCFSA”)
- Dependent Care Flexible Spending Account (“DCFSA”)
- You must make your elections to contribute to the Flexible Spending Account Plan within thirty (30) days of the date you first become eligible. Thereafter, you may elect to participate in the Flexible Spending Account Plan only:
  - During an Annual Enrollment period; or
  - If you have a Change of Status, as explained below.

During the Annual Enrollment period, you may elect to make contributions to the Flexible Spending Account Plan for the next Plan Year. If you elect to make

contributions to the Plan, you may elect the same or a different contribution amount for each Plan Year. You must make a HCFSA and/or DCFSA election each year during Annual Enrollment to make contributions the following year.

Keep in mind that your elections must remain in effect for the entire Plan Year. You may not change your elections until the next Annual Enrollment period unless you have a Change of Status or are otherwise permitted to change your elections as explained below.

### **No Default Plan Benefits**

There are no default benefits under the Flexible Spending Account Plan if you are a new hire (or newly Eligible Employee) and you fail to timely enroll in the Flexible Spending Account Plan. There also are no default benefits under the Flexible Spending Account Plan if you do not enroll in the Flexible Spending Account Plan during each Annual Enrollment period.

### **Rehired Employee**

If you are rehired and your rehire date is within thirty (30) days of your termination date and within the same Plan Year, you will be reinstated with the same annual contribution amount as you had previously and your Flexible Spending Account deduction will be adjusted.

If you are rehired and your rehire date is thirty (30) days or more from your termination date or in a different Plan Year, you will be treated as a new hire. This means that if you elect a Flexible Spending Account, the amount of your election will be deducted equally from the remaining pay periods in the Plan Year.

### **Change of Status**

Your Flexible Spending Account Plan elections will remain in effect for the entire Plan Year. Changes will be allowed only if you have a Change of Status.

### **Cost or Coverage Changes**

Your Dependent Care Flexible Spending Account election may also be changed during the Plan Year if:

Your cost for your Dependent's care increases or decreases, as long as the caregiver is not a relative of yours or your spouse; or

Your caregiver stops providing dependent care service.

All changes should be made within thirty (30) days of the cost or coverage change. You may report a Change of Status to the Trinity Benefits Center at [www.mybenefits.trinity.com](http://www.mybenefits.trinity.com) or call the Trinity Benefits Center toll free at 888.765.5367 for assistance with your Change of Status. Under IRS rules, any

change must be both on account of and consistent with the Change of Status allowing the mid-year election change.

### **Consistency Rules for Change of Status**

You may make a change to your benefit elections pursuant to a Change of Status during a Plan Year only if the elections satisfy the Consistency Rule. The Plan Administrator will determine whether the Change of Status satisfies the Consistency Rule in accordance with the Code and other guidance issued by the IRS. Only those individuals affected by the change are eligible for new elections. For example, the birth of a child permits you to start or increase contributions to both the Dependent Care Flexible Spending Account and the Health Care Flexible Spending Account.

### **Amount of Your Contributions to a Flexible Spending Account**

The contributions you make under the Flexible Spending Account Plan are credited to your Flexible Spending Account, which allows you to set aside before-tax money through payroll deductions to pay Eligible Expenses. See below for a list of Eligible Expenses that can be reimbursed by the HCFSA and the DCFSA.

During Annual Enrollment, you decide how much to contribute. If you elect to participate, there is a minimum contribution of \$100 for the HCFSA and DCFSA. The maximum contribution for the HCFSA in 2024 is \$3,200.

The IRS limits the maximum amount of reimbursement that you may receive, on a tax-free basis, from the DCFSA for a Calendar Year to the lesser of \$5,000 (\$2,500 if you are a married person filing a separate return) or your “earned income” (as determined by the IRS). You are responsible for determining the maximum amount that you can receive on a tax-free basis from a DCFSA. You may wish to consult a tax adviser before you begin participation.

Your contributions are taken out in equal amounts from your paychecks throughout the Plan Year. Your taxable income is reduced by the contributions described above, reducing the taxes you owe. As a result, your compensation for Social Security purposes may be reduced. This means that your Social Security benefits could be decreased because the amount of compensation that is considered for Social Security purposes is decreased. You may wish to consult a tax adviser before you begin participation in the Flexible Spending Account Plan. The maximum amount that you can be reimbursed at any time is the amount you have elected (subject to the applicable annual limit).

### **Use It or Lose It Rule**

The IRS restricts how you may use the funds in a Flexible Spending Account, so if you decide to contribute to a Flexible Spending Account, you should carefully estimate your Eligible Expenses for the Plan Year. The law requires that a Flexible Spending Account operate on a “use it or lose it” basis. This means you

forfeit any money remaining in your Flexible Spending Account after all Eligible Expenses have been reimbursed according to Flexible Spending Account Plan guidelines. See below section for the Special Rules pertaining to the HCFSA and the DCFSA.

### **Special Rules for the HCFSA**

Generally, you should use the amounts in your HCFSA to reimburse yourself for Eligible Expenses for the current Plan Year. The amount credited to a HCFSA for any Plan Year shall be used only to reimburse Eligible Expenses incurred during such Plan Year, and only if you apply for reimbursement on or before one hundred twenty (120) days following the close of the Plan Year. Notwithstanding the foregoing, if a person ceases to be a participant in the Plan during a Plan Year or becomes a participant other than on the first day of a Plan Year, Eligible Expenses incurred during the Plan Year, but while the person was not a participant in the Plan, shall not be reimbursed under the HCFSA. If any balance remains in a participant's HCFSA for any Plan Year after all reimbursements have been made hereunder, up to the maximum carry-over amount allowed by the IRS, adjusted annually, shall be carried over to reimburse the participant for Eligible Expenses incurred during a subsequent Plan Year. The maximum carry-over for the HCFSA in 2024 is \$640. No additional amount from the Plan Year shall be available to the participant in any other form or manner during a subsequent Plan Year, but shall remain the property of the Company, and the participant shall forfeit all rights with respect to such balance.

### **Special Rules for the DCFSA**

Generally, you should use the amounts in your DCFSA to reimburse yourself for Eligible Expenses for the current Plan Year. The amount credited to a DCFSA for any Plan Year shall be used only to reimburse Eligible Expenses incurred during such Plan Year. Notwithstanding the foregoing, if a person ceases to be a participant in the Plan during a Plan Year or becomes a participant other than on the first day of a Plan Year, Eligible Expenses incurred during the Plan Year, but while the person was not a participant in the Plan, shall not be reimbursed under the DCFSA. If any balance remains in a participant's DCFSA after the end of a Plan Year after all reimbursements have been made hereunder, the participant may use such balance to pay for Eligible Expenses incurred during a grace period of 2.5 months after the end of the Plan Year. No additional amount from the Plan Year shall be available to the participant in any other form or manner during a subsequent Plan Year, but shall remain the property of the Company, and the participant shall forfeit all rights with respect to such balance.

### **Health Care Flexible Spending Account**

#### **Whose Eligible Expenses Can Be Reimbursed by a Health Care Flexible Spending Account**

The HCFSA allows you to receive tax-free reimbursement of health care Eligible Expenses for eligible individuals. You may receive reimbursement for the Eligible Expenses of eligible individuals even if you do not elect medical coverage for these individuals. You may file claims for reimbursement of health care Eligible Expenses incurred by:

- You;
- Your Spouse; and
- Your covered Dependents, which are your dependent children and individuals (such as your elderly or disabled parents) who are considered your tax dependents for health plan purposes according to the IRS.

You can use the HCFSA under the Flexible Spending Account Plan for reimbursement of medical, dental, and vision Eligible Expenses that are not covered by a health plan, subject to IRS guidelines. Eligible Expenses claimed for reimbursement must be for medical care or services you received while you were a covered member during the Plan Year. Eligible Expenses will be paid only up to the amount you elected for the Plan Year.

### **Eligible Expenses**

Examples of Eligible Expenses that can be reimbursed through the HCFSA include, but are not limited to:

- Acupuncture;
- Alcoholism or drug dependency treatment;
- Birth control pills and devices, or sterilization;
- Car controls for the handicapped;
- Charges above reasonable and customary in the medical plan;
- Chiropractors;
- Coinsurance;
- Copays;
- Crutches (purchase or rental);
- Deductibles;
- Dental expenses not covered by another plan, including orthodontia;
- Experimental surgery;
- Health care equipment;
- Hearing expenses, including examinations, hearing aids, and special equipment, training, and dogs for the deaf;
- Home health care, including nurses and attendants;
- Physical and other health
- Prescription drugs, if not on plan;
- Private duty nursing;
- Psychotherapy by a licensed therapist;
- Radial keratotomy surgery;
- Routine medical exams and
- Speech therapy;
- Smoking Cessation treatment;
- Sunscreen SPF 30 or higher;
- Syringes, needles, and insulin;
- Transplants;
- Transportation expenses for medical care, including public transportation, actual out-of-pocket auto mileage at the current IRS rate;
- Vaccinations and immunizations;
- Vision expenses, including ophthalmologist fees,

- Hypnosis for treatment of illness;
- Laboratory tests and x-rays;
- Learning disability tutoring;
- Meals/lodging while receiving medical care if provided by the Hospital;
- Medical care provided while in a skilled nursing facility;
- Nursing service by a registered nurse or licensed practical nurse;
- Over-the-counter drugs such as aspirin and sinus medication only if prescribed by a physician; and
- Oxygen.

- supplies, eyeglasses, exams, a training, and special equipment
- Well baby care;
- Wheelchairs and other necessary the disabled;
- Out-of-pocket expenses that are by any other plan; and
- Other medical expenses (ex premiums), which meet the r reimbursable medical care by th

### **Excluded Expenses**

Expenses that the IRS does not allow you to have reimbursed through the HCFSA include any expenses reimbursed by any other benefit plan as well as:

- Bottled water;
- Cosmetic surgery (except for correction of birth defects and accidental disfigurement);
- Cosmetics, toiletries, and toothpaste;
- Custodial care in an institution, such as a nursing home;
- Electrolysis;
- Funeral and burial expenses;
- Health club dues;
- Household and domestic help;
- Licensed practical nurse (LPN) for the care of a healthy newborn;
- Marriage or family counseling; and
- Maternity clothes and diaper services.
- Over-the-counter drugs physician;
- Premiums for any type of
- Special school tuition for or emotional problems;
- Social activities such as d
- Uniforms;
- Vacation or travel take purposes;
- Vitamins taken for genera
- Weight-loss and fitness health purposes.

### **Continuation of Coverage (COBRA)**

If you are a participant in the HCFSA, you may be able to continue your coverage pursuant to COBRA. If you choose not to participate in COBRA, your benefits under the HCFSA end on the last day of the pay period in which you terminate employment. Generally, if you participated in the HCFSA, you will be entitled to elect COBRA coverage only if you can receive some economic benefit from that election.

In addition, COBRA coverage may not be elected for the years which follow the year in which the Change of Status occurs. Because the Company offers medical coverage under the Participating Medical Plans, coverage under the HCFSA is,

among other reasons, not subject to HIPAA (not subject to HIPAA's rules regarding portability of health coverage). You should check with the Plan Administrator if you need additional information regarding eligibility for COBRA coverage.

### **Dependent Care Flexible Spending Account**

The DCFSA makes it possible for you to pay dependent care Eligible Expenses with tax-free dollars. You can use the DCFSA for reimbursement of Eligible Expenses that you incur for the care for your Children and certain adult dependents while you (and your spouse, if you are married) work. Eligible Expenses claimed for reimbursement must be for dependent care received while you were a covered member during the Plan Year. However, if your employment at the Company ends, the remaining balance of your DCFSA payroll contributions can be used to reimburse the DCFSA expenses you incur through the end of the year.

Whose Eligible Expenses Can Be Reimbursed by a Dependent Care Flexible Spending Account.

The Dependent Care Flexible Spending Account allows you to receive tax-free reimbursement of Eligible Expenses for the care of the following dependents (referred to as "Eligible Dependents"):

- Child(ren) Under Age 13. An individual is a dependent under this section if he or she:
  - Is a child under age thirteen (13);
  - Has the same principal place of abode as you do for more than one-half of the taxable year; and
  - Has not provided over one-half of his or her own support for the Calendar Year.
- Disabled Dependent. An individual is a Dependent under this section if he or she:
  - Is a disabled dependent (your elderly parent, for instance) who is physically or mentally incapable of self-care;
  - Has the same principal place of abode as you do for more than one-half of the taxable year; and
  - Either:
    - Is your dependent for federal income tax purposes and thus can be claimed as your dependent on your federal income tax return; or

- Would be your dependent for federal income tax purposes, except that:
  - He or she received gross income for the taxable year more than the exemption amount defined in Code Section 151(d) (\$4,150 for 2018);
  - He or she filed a joint return; or
  - You, or your spouse if filing jointly, could be claimed as a dependent on someone else's federal income tax return.
- **Disabled Spouse.** An individual is a Dependent under this section if he or she:
    - Is a spouse who is physically or mentally incapable of caring for himself or herself; and
    - Has the same principal place of abode as you for more than one-half of the taxable year.

### **Eligible Expenses**

You may only be reimbursed for Eligible Expenses for day care for your covered Dependents that enables you to work, not for occasional baby-sitters. These day care expenses will be referred to as Eligible Expenses. If you are married, your spouse must also work, be a full-time student, or be disabled. Eligible Expenses paid to the following providers may be reimbursed through your DCFSA if you provide the Social Security or taxpayer identification number:

- A licensed child care center or adult day care center, including a church or non-profit center;
- A private kindergarten if the primary purpose of the school is not for the child's education. For example, your five-year-old child goes to kindergarten in the morning primarily for the education of the child. In the afternoon, she attends an after-school daycare program in the same school. The total cost for sending her to the school is \$3,000, of which \$1,800 is for the after-school program. Only \$1,800 is an Eligible Expense;
- A baby-sitter inside or outside your home if the sitter does not care for more than six children at a time (not including the sitter's own dependents);
- A housekeeper whose duties include dependent care;
- A relative who cares for your dependents but is neither your spouse, your child, nor your dependent;

- Someone who cares for an elderly or disabled dependent inside or outside your home;
- Au pairs (foreign visitors to the United States who perform day care and domestic services in exchange for living expenses), provided the au pair agency is a non-profit organization or the au pair obtains a U.S. Social Security number for tax identification purposes; and
- Costs for facilities away from home, provided your dependent spends at least eight (8) hours per day at home.

### **Excluded Expenses**

Expenses that the IRS does not allow you to have reimbursed through the DCFSA include, but are not limited to:

- Overnight camp;
- Cost of housecleaning services; and
- Cost of care in a convalescent home.

### **When Coverage Ends**

Your coverage will end under the Flexible Spending Account Plan on the earliest of the following to occur:

- The day you terminate employment;
- The day you no longer satisfy the requirements for participation;
- You fail to enroll in the form and manner required by the Plan Administrator during an enrollment period when required; or
- The date the Flexible Spending Account Plan is terminated.

## **PARTICIPATING DENTAL PLAN**

### *Participating Dental Plan*

The Participating Dental Plan provides preventative, basic, and restorative dental care and orthodontic benefits for you and your eligible Dependents. Benefits are provided by Delta Dental.

### *Deductibles and Co-insurance*

There are deductibles and co-insurance under the Participating Dental Plan. You will be responsible for any deductibles and co-insurance, which means you must pay the difference in cost between what is paid for by the Participating Dental Plan and what the provider charges for its services, minus any network discounts, if applicable.

### *Eligibility to Participate*

You enroll in the Participating Dental Plan during each Annual Enrollment in accordance with instructions provided by the Plan Administrator. If you are

newly hired Eligible Employee, you must enroll within thirty (30) days of your eligibility date in accordance with the provisions of the Participating Dental Plan and in accordance with enrollment instructions provided by the Plan Administrator. Waiting periods may apply. COBRA beneficiaries may enroll in the Participating Dental Plan pursuant to the administrative rules established by the Plan Administrator and the COBRA Administrator, and must pay the COBRA premium for continued coverage.

*Late Enrollment*

If you fail to enroll in the Participating Dental Plan during the thirty (30)-day initial enrollment period, Annual Enrollment, or within thirty (30) days of a Change of Status or other permissible event where you may change your election, you and your eligible Dependents must wait until the next Annual Enrollment period to enroll in the Participating Dental Plan unless you have a Change of Status (see the **ELIGIBILITY AND PARTICIPATION** section of this SPD for more details).

*Acquiring a New Dependent*

If you acquire a new Dependent through birth, adoption, placement for adoption, or marriage and submit an enrollment form to the Participating Dental Plan for this Dependent within thirty (30) days of birth, adoption, placement for adoption, or marriage, coverage for the Dependent will become effective on the date of birth, adoption, placement for adoption, or marriage. If you were not previously enrolled, you and your Spouse may also enroll during this special enrollment period for newly acquired Dependents.

*Funding of Participating Dental Plan*

You and the Company share the cost of this coverage. You will be required to pay a portion of the cost on a pre-tax basis. The Plan Administrator will notify you annually of the required employee contributions for the Participating Plans.

For more information about benefits, limitations, and eligibility for the Participating Dental Plan, see the following documents:

- Delta Dental Evidence of Coverage/Summary Plan Description
- Employee Benefits Guide

**PARTICIPATING VISION PLAN**

*Participating Vision Plan*

The Participating Vision Plan, administered by Davis Vision, provides vision care benefits to you your eligible Dependents.

*Deductibles and Co-insurance*

There is co-insurance under the Participating Vision Plan. You will be responsible for any co-insurance, which means you must pay the difference in cost between what is paid for by the Participating Vision Plan and what the provider charges for its services, minus any network discounts, if applicable. You can receive benefits at a lower cost to you and the Participating Vision Plan by using network providers, or you can go to providers outside of the network and receive care at a higher cost to you and the Participating Vision Plan.

*Eligibility to Participate*

You may enroll in the Participating Vision Plan during each Annual Enrollment in accordance with instructions provided by the Plan Administrator. If you are a newly hired Eligible Employee, you must enroll within thirty (30) days of your eligibility date in accordance with the provisions of the Participating Vision Plan and in accordance with enrollment instructions provided by the Plan Administrator. Waiting periods may apply. COBRA beneficiaries enroll pursuant to the administrative rules established by the Plan Administrator and the COBRA Administrator, and must pay the COBRA premium for continued coverage.

*Late Enrollment*

If you fail to enroll in the Participating Vision Plan during the thirty (30)-day initial enrollment period, Annual Enrollment, or within thirty (30) days of a Change of Status or other permissible event where you may change your election, you and your eligible Dependents must wait until the next Annual Enrollment period to enroll in the Participating Vision Plan unless you have a Change of Status (see the **ELIGIBILITY AND PARTICIPATION** section of this SPD for more details).

*Acquiring a New Dependent*

If you acquire a new Dependent through birth, adoption, placement for adoption, or marriage and submit an enrollment form to the Participating Vision Plan for this Dependent within thirty (30) days of birth, adoption, placement for adoption, or marriage, coverage for the Dependent will become effective on the date of birth, adoption, placement for adoption, or marriage. If you were not previously enrolled, you and your Spouse may also enroll during this special enrollment period for newly acquired Dependents.

*Funding of Participating Vision Plan*

You and the Company share the cost of this coverage. You will be required to pay a portion of the cost on a pre-tax basis. The Plan Administrator will notify you annually of the required employee contributions for the Participating Plans.

For more information about benefits, limitations, and eligibility for the Participating Vision Plan, see the following documents:

- Davis Vision – Certificate of Coverage/Summary Plan Description
- Employee Benefits Guide

**PARTICIPATING LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE PLAN**

*Participating Life and Accidental Death and Dismemberment Insurance Plan*

The Participating Life and Accidental Death and Dismemberment Insurance Plan is insured by Standard Insurance Company. In the event of your death, the Participating Life and Accidental Death and Dismemberment Insurance Plan generally provides a basic employee term life insurance benefit of one times your base annual pay, rounded up to the nearest \$1,000, with a minimum amount of \$25,000 and a maximum of \$500,000.

*Eligibility to Participate*

You are automatically enrolled in the basic Company-provided life insurance benefit once you have satisfied any requirements for coverage. If you are a newly hired Eligible Employee, you may enroll in any voluntary supplemental or dependent life insurance coverage at any time once you have satisfied any requirements for coverage in accordance with the provisions of the Participating Life and Accidental Death and Dismemberment Insurance Plan and in accordance with enrollment instructions provided by the Plan Administrator. Waiting periods may apply.

The insurance company may require evidence of insurability. See the **ELIGIBILITY AND PARTICIPATION** section of this SPD for more information.

*When Your Coverage Ends*

Your participation in the Participating Life and Accidental Death and Dismemberment Insurance Plan will end in accordance with the insurance certificate. If your coverage terminates because you are no longer an Eligible Employee, Transitioning Employee and Grandfathered Retiree or because the Employer discontinues this Participating Plan, you may be able to convert your coverage to an individual life insurance contract by paying the required premium within thirty (30) days after your participation in the Participating Plan ends. Your Dependent may also be able to convert his or her insurance to an individual life insurance contract under certain circumstances.

*Beneficiary Designation*

You may designate a beneficiary for your life insurance proceeds by completing a beneficiary designation with the Trinity Benefits Center.

*Funding of Participating Life and AD&D Insurance Plan*

Premiums for the basic life insurance benefit shall be fully paid for by the Employer. If you elect the voluntary supplemental and dependent life insurance options, you will be required to contribute the full cost of the coverage as specified by the Employer on an after-tax basis. If you are an hourly Employee and elect the voluntary supplemental and/or dependent coverage, you will be required to contribute the full cost of the coverage as specified by the Employer on an after-tax basis.

For more information about benefits, limitations, and eligibility for the Participating Life Insurance Plan, please refer to the relevant portions of the following documents:

- Standard Insurance Company – Certificates of Coverage and Summary Plan Description Group Life Insurance Policy Booklet (Non-Union Employee’s, excluding Non-Union Variable Drivers)
- Employee Benefits Guide

**PARTICIPATING LONG-TERM AND SHORT-TERM DISABILITY PLANS**

*Participating Long-Term and Short-*

The Participating Long-Term Disability (“LTD”) Plan and Participating Short-Term Disability (“STD”) Plan are insured by Hartford Life and Accident

*Term Disability  
Plans*

Insurance Company.

The Participating STD Plan provides, for a limited period of time, a benefit if you become disabled from a covered accidental bodily injury, sickness, mental illness, substance abuse, or pregnancy. The Participating LTD Plan provides a benefit if you become disabled from a covered accidental bodily injury, sickness, mental illness, substance abuse, or pregnancy and this disability lasts longer than the amount of days provided for under the Participating STD Plan. The amount of your benefit depends upon a number of factors, including your employment status (hourly, administrative non-exempt, exempt), pre-disability weekly or monthly earnings and any current income or other benefits you may receive. You will generally be required to show proof of your disability in accordance with the procedures provided by the Plan Administrator. You may not receive benefits from the Participating STD Plan and the Participating LTD Plan simultaneously.

*Eligibility to  
Participate*

You are automatically enrolled in the Participating STD Plan (for administrative non-exempt Employees and hourly Employees – as to core benefits) and Participating LTD Plan (for administrative non-exempt Employees and salaried Employees) once you have satisfied any requirements for coverage in accordance with the provisions of the Participating STD Plan and Participating LTD Plan and in accordance with enrollment instructions provided by the Plan Administrator. If you are a newly hired Eligible Employee (hourly Employee), you may enroll in the buy-up short-term disability coverage once you have satisfied any requirements for coverage in accordance with the provisions of the Participating STD Plan and in accordance with enrollment instructions provided by the Plan Administrator. Waiting periods may apply. If you are not actively at work on the date Participating STD Plan or Participating LTD Plan coverage is scheduled to begin, coverage will be postponed until your first day of active employment. Your coverage under the Participating STD Plan and Participating LTD Plan ends on the earlier of (i) the date you are no longer eligible under the terms of the Participating STD Plan and Participating LTD Plan and (ii) the date you terminate employment with the Company.

*Funding of  
Participating LTD  
Plan and STD Plan*

If you are an hourly Employee and elect voluntary buy-up short-term disability coverage, you will be required to contribute the full cost of the coverage as specified by the Employer on an after-tax basis. Because the costs of coverage under the Participating STD Plan (for administrative non-exempt Employees and for hourly Employees as to the core benefits) and Participating LTD Plan (for administrative non-exempt Employees and salaried Employees) are fully paid by the Company the benefits you receive if you become disabled are taxable income when paid and you will have federal income taxes deducted from any benefits received by you from the Participating STD Plan and/or Participating LTD Plan should you become disabled in the future. If you are an hourly Employee and elect the voluntary buy-up Short-Term Disability coverage, you will be required to contribute the full cost of the coverage as specified by the Employer on an after-tax basis.

For more information about benefits, limitations, and eligibility for this Participating Plan, please refer to the relevant portions of the following documents:

- Hartford Life and Accident Insurance Company – Short-Term Disability, Long-Term Disability Booklet and Certificate of Insurance (Non-Union, Variable Drivers)
- Hartford Life and Accident Insurance Company – Short-Term Disability, Long-Term Disability Booklet and Certificate of Insurance (Non-Union, Hourly Employees)
- Hartford Life and Accident Insurance Company – Long-Term Disability Booklet and Certificate of Insurance (Exempt and Administrative Non-Exempt Employees earning less than \$50,000 per year)
- Hartford Life and Accident Insurance Company – Short-Term Disability Booklet and Certificate of Insurance (Administrative Non-Exempt Employees)
- Employee Benefits Guide.

## **PARTICIPATING BUSINESS TRAVEL ACCIDENT PLAN**

### *Participating Business Travel Accident Plan*

The Participating Business Travel Accident Plan is a component plan under the Plan sponsored by the Company.

### *Eligibility to Participate*

You participate in the Participating Business Travel Accident Plan automatically once you are actively employed by a Participating Employer.

### *Funding of Participating Business Travel Accident Plan*

Premiums for the Participating Business Travel Accident Plan shall be fully paid for by the Employer.

For more information about benefits, limitations, and eligibility for the Participating Business Travel Accident Plan, please refer to the relevant portions of the following documents:

- Zurich American Insurance Company Travel Assist Summary
- Employee Benefit Guide

## **PARTICIPATING CRITICAL ILLNESS, HOSPITAL INDEMNITY & ACCIDENT INSURANCE PLAN**

### *Participating Critical Illness, Hospital Indemnity*

The Participating Critical Illness, Hospital Indemnity & Accident Insurance Plan is a component plan under the Plan insured by MetLife.

*& Accident  
Insurance Plan*

*Eligibility to  
Participate*

You participate in the Participating Critical Illness, Hospital Indemnity & Accident Insurance Plan at your election if you are actively employed by a Participating Employer.

*Funding of  
Participating  
Critical Illness &  
Accident Insurance  
Plan*

Premiums for the Participating Critical Illness, Hospital Indemnity & Accident Insurance Plan are fully paid for by you.

For more information about benefits, limitations, and eligibility for the Participating Critical Illness & Accident Insurance Plan, please refer to the relevant portions of the following documents:

- MetLife Critical Illness Insurance Plan Summary
- MetLife Critical Illness Certificate of Insurance
- MetLife Accident Certificate of Insurance
- MetLife Hospital Indemnity Certificate of Insurance
- Employee Benefit Guide

**LEAVES OF ABSENCE**

*What happens if I  
take a military  
leave of absence?*

If you take a leave of absence that qualifies under the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended from time to time (“USERRA”), you will be entitled to continue to participate in the Group Health Plans under the Plan.

For purposes of such leave (so-called “USERRA leave”), the following terms shall have the meanings set forth below:

- “Eligible Person” means a covered Eligible Employee who meets the eligibility requirements for electing USERRA Coverage, or a Dependent of such person.
- “Reemployment Rights” means an Eligible Person’s rights to reemployment with the Employer conferred by USERRA.
- “Uniformed Service” means the performance of duty on a voluntary or involuntary basis under competent authority within the Armed Forces, the Army National Guard and the Air National Guard, including active duty, inactive duty for training, initial active duty for training, inactive duty training, and a period during which a covered Eligible Employee is absent from employment with the Employer for the purpose of an examination to determine the Eligible Employee’s fitness to perform such duty. Uniformed Service also includes service in the commissioned

corps of the Public Health Service and any other category of person designated by the President of the United States in time of war or emergency. In addition, certain types of service in the National Disaster Medical System are considered to be uniformed service covered by USERRA.

- “USERRA Coverage” means the extended Group Health Plan coverage available under the Plan pursuant to the requirements of USERRA.

*What special rights does USERRA give me?*

If you are an Eligible Person and take a leave of absence from employment with the Company or an Employer to perform Uniformed Service for a period of thirty (30) days or less, you shall be treated as an active Eligible Employee during the leave for purposes of continuing Group Health Plan coverage under the Plan. Your coverage will continue as if you were still actively at work, and you must continue to pay for your share of the coverage cost. If you take a leave of absence to perform Uniformed Service for a period of thirty (30) days or more, each Eligible Person can elect USERRA Coverage under the Plan.

Please note that the military leave provisions of the Plan apply only to the extent required under USERRA and are intended and shall be construed to satisfy only the minimum requirements, and do not create any rights in excess of those minimum requirements. The Plan Administrator may adopt such rules for the administration of the military leave provisions of the Plan as it deems necessary and appropriate.

*Who pays for USERRA Coverage?*

For each Eligible Person for whom you elect USERRA Coverage, you must pay the total amount of the cost of the Group Health Plan coverage provided under the Plan during the period of USERRA Coverage, as determined by the Plan Administrator, plus two percent (2%).

*How long does my USERRA Coverage last?*

The period of USERRA Coverage shall begin on the effective date of your leave of absence to perform Uniformed Service and shall end on the earliest of the following dates:

- The last day of the twenty-four (24)-month period beginning on the effective date of your leave of absence;
- The date you do not make a required premium payment; and
- The date your Reemployment Rights expire.

Your coverage may be canceled if you fail to give advance notice of service and fail to elect continuation coverage. However, if you are excused from giving advance notice of service under USERRA’s provisions because of military necessity, impossibility, or unreasonableness, then coverage will be retroactively reinstated upon your election to continue coverage and payment of all amounts due (no administrative reinstatement costs will be charged). In addition, coverage may be canceled if you leave for a period of thirty (30) days or more and give advance notice of service but fail to elect continuation coverage. If you

subsequently elect to continue coverage, the scope of your reinstatement rights depends on the Company's USERRA policy.

*What rights do I have under USERRA when I return to work?*

If you are receiving USERRA Coverage and are reemployed by the Employer before your Reemployment Rights expire, and you are eligible for coverage under the Group Health Plans, your coverage (and that of your Dependents) shall be immediately reinstated when you are reemployed.

*What if I don't return to work before my Reemployment Rights expire?*

If you have maintained USERRA coverage but do not return to work before your Reemployment Rights expire, you and/or your Dependents may be eligible for COBRA continuation coverage. If you are reemployed after your Reemployment Rights expire, you will be treated as a new Eligible Employee for purposes of eligibility under the Group Health Plans.

*What happens if I take a leave of absence for family or medical reasons?*

If you take a paid or unpaid leave, your election will remain in force. Contact the Plan Administrator for more information about your FMLA leave rights.

*What benefit-related rights does FMLA give me?*

Federal law requires the Company to maintain your Group Health Plan coverage during your FMLA leave on the same conditions as coverage would be provided if you were continuously employed during the entire leave period. During your FMLA leave, any change to Group Health Plan coverage will apply to you on the same basis as if you were not on leave, and you shall be given notice of any opportunity to change your Group Health Plan coverage.

If you do not continue your Group Health Plan coverage during an FMLA leave, you are entitled to be reinstated upon your return from leave without any requirements to requalify, such as any waiting period, physical examination. You have no greater right to reinstatement or to other benefits under the Plan than if you had been continuously employed during your FMLA leave.

*How long does my coverage last when I am on FMLA leave?*

The Company's obligation to provide benefit coverage ends on the earlier of the date on which:

- You inform your Employer that you do not intend to return from FMLA leave;
- You do not return from your FMLA leave and terminate employment; or
- You exhaust your FMLA leave entitlement.

*Who pays for my coverage when I am on FMLA leave?*

During FMLA leave, to the extent you are not receiving any pay from the Company, i.e. vacation or sick pay, the Company will pay your share of your any premiums due during your leave and upon return from leave you will be required to repay these amounts via double deduction of your monthly premiums until repaid in full.

If, while on FMLA leave, premiums are raised or lowered for other Eligible Employees, such changes will be applied to you as well.

The Company may also recover from you any premiums paid on your behalf while on unpaid FMLA leave to maintain other benefits if you do not return from FMLA leave. The Company may recover its share of premiums through deductions from any sums due to you. Alternatively, the Company may initiate legal action against you.

Other leaves of absence shall be administered in accordance with the Company's policy on leaves of absence. Please contact the Plan Administrator for more information on continuing coverage under a Participating Plan during a leave of absence.

## **COBRA CONTINUATION COVERAGE**

*What is COBRA continuation coverage?*

This section shall apply to you if you are covered under the Group Health Plan. This section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. Below generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985. COBRA continuation coverage can become available to you when you would otherwise lose your Group Health Plan coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their Group Health Plan coverage.

COBRA continuation coverage is a continuation of Group Health Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You and your Dependents could become qualified beneficiaries if coverage under the Group Health Plan is lost because of a qualifying event. Under the Group Health Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

The COBRA premium may be up to one hundred two percent (102%) of the full

premium.

*What is a COBRA qualifying event?*

A qualifying event is one of the following events that causes either you or a Dependent to lose coverage under a Group Health Plan:

- Your hours of employment are reduced;
- Your employment ends for any reason other than your gross misconduct; or
- You do not return to covered employment at the end of an FMLA leave, even if your coverage lapsed when you were on FMLA leave. (Your maximum coverage period will then be measured from the last day of your FMLA leave unless coverage is actually lost at a later date.)

The following are qualifying events for your Dependent or Spouse:

- Your death;
- Your termination of covered employment (for reasons other than gross misconduct) or reduction in your hours of employment with the Employer;
- Your divorce or legal separation; or
- Your eligibility for Medicare.

The following are qualifying events for your Dependent Children:

- The death of a parent;
- The termination of your covered employment (for reasons other than gross misconduct) or reduction in your hours of employment with the Employer;
- Parents' divorce or legal separation;
- Your eligibility for Medicare; or
- Ceasing to be a Dependent, as defined under the Group Health Plan.

*When is COBRA coverage available?*

The Group Health Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Company has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or your becoming entitled to Medicare benefits (under Part A, Part B, or both), the Company is responsible for notifying the Plan Administrator of the qualifying event.

Continuation coverage will be offered to qualified beneficiaries in accordance with COBRA. If a divorce decree or legal declaration requires the employee to provide continuation coverage in excess of, or contrary to the terms of COBRA

or the Plan, the Plan will only be obligated to comply with the continuation of coverage provisions required by COBRA and the Plan. If a state continuation of coverage law requires the Plan to offer extended coverage beyond the COBRA continuation period, the Plan will comply with that state law.

For the other qualifying events (divorce, or legal separation of you and your Spouse, or your Dependent Child's losing eligibility for coverage as a Dependent Child), you must notify the Trinity Benefits Center at [www.mybenefits.trin.net](http://www.mybenefits.trin.net) or (888) 765-5367.

*How is COBRA coverage provided?*

Once the Company receives timely 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. You may elect COBRA continuation coverage on behalf of your Spouse, and parents may elect COBRA continuation coverage on behalf of their eligible Dependent Children.

COBRA continuation coverage is a temporary continuation of coverage. When you lose coverage due to the qualifying event of death, your entitlement to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a Dependent Child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of thirty-six (36) months. When the qualifying event is the end of your employment or reduction of your hours of employment, and you became entitled to Medicare benefits less than eighteen (18) months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than you lasts until thirty-six (36) months after the date of Medicare entitlement. For example, if you become entitled to Medicare eight (8) months before the date on which your employment terminates, COBRA continuation coverage for your Spouse and children can last up to thirty-six (36) months after the date of Medicare entitlement, which is equal to twenty-eight (28) months after the date of the qualifying event (thirty-six (36) months minus eight (8) months). Otherwise, when the qualifying event is the end of your employment or reduction of your hours of employment, COBRA continuation coverage generally lasts for only up to a total of eighteen (18) months. There are two ways in which this eighteen (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 Group Health Plan is determined by the Social Security Administration ("SSA") to be disabled and you notify the Trinity Benefits Center at (888) 765-5367, in a timely fashion, you and your eligible family members may be entitled to receive up to an additional eleven (11) months of COBRA continuation coverage, for a total maximum period of twenty-nine (29) months if you meet the following requirements:

- The disability must have begun at some time before the sixtieth (60<sup>th</sup>) day of COBRA continuation coverage and must last at least until the end of the eighteen (18)-month period of continuation coverage,

The SSA must determine that the qualified beneficiary was disabled at some time prior to or during the first sixty (60) days of continuation coverage, and

- The qualified beneficiary must notify the Trinity Benefits Center at [www.mybenefits.trin.net](http://www.mybenefits.trin.net) or (888) 765-5367, within the first sixty (60) days of COBRA continuation coverage if Social Security Disability was awarded prior to COBRA continuation coverage and/or within sixty (60) days of the SSA’s determination and before the end of the first eighteen (18) months of continuation coverage.

If the qualified beneficiary is determined by the SSA to no longer be disabled, you must notify the Trinity Benefits Center at [www.mybenefits.trin.net](http://www.mybenefits.trin.net) or (888) 765-5367 of that fact within thirty (30) days of SSA’s determination.

*Second Qualifying Event Extension of 18-Month Period of Continuation Coverage*

If your family experiences another qualifying event while receiving eighteen (18) months of COBRA continuation coverage, your Spouse and Dependent Children can get up to eighteen (18) additional months of COBRA continuation coverage, for a maximum of thirty-six (36) months, if notice of the second qualifying event is properly given to the Plan Administrator. This extension may be available to your Spouse and any Dependent Children receiving continuation coverage if you die, become entitled to Medicare benefits (under Part A, Part B, or both), or get divorced, or legally separated, or if the Dependent Child stops being eligible under the Group Health Plan as a Dependent Child, but only if the event would have caused your Spouse or Dependent Child to lose coverage under the Plan had the first qualifying event not occurred.

*Military Service Extension of 18-Month Period of Continuation Coverage*

If you lose Group Health Plan coverage under the Plan due to active military duty, you may be eligible for special health care continuation coverage rights under USERRA, including the ability to continue Group Health Plan coverage under the Plan for you and your Dependents for a total maximum period of up to twenty-four (24) months. See the **LEAVES OF ABSENCE** section of this SPD for more information.

*Other Additional Beneficiaries*

Any additional beneficiary (as defined below) is eligible to continue Group Health Plan coverage under terms similar to those applicable to qualified beneficiaries. An “additional beneficiary” is any Dependent who is not a qualified beneficiary but who, on the day before a qualifying event, is covered under the Group Health Plan and loses coverage under the Group Health Plan on account of such qualifying event. Qualifying events for additional beneficiaries are the same as those listed above, except that (a) dissolution of a Domestic Partner relationship shall be treated as equivalent to a divorce or legal separation, and (b) coverage of the additional beneficiary will terminate in accordance with the terms of the Group Health Plan when the additional beneficiary no longer qualifies as a Dependent.

An additional beneficiary will not be eligible for continued coverage on account of the dissolution of a Domestic Partner relationship or the cessation of Dependent status under the Group Health Plan unless the additional beneficiary (or someone acting on his behalf) notifies the Plan Administrator (or its delegate) within sixty (60) days following the later of the qualifying event or the date the additional beneficiary would lose coverage on account of the qualifying event. Continuation coverage will not be extended beyond the initial continuation period if an additional beneficiary experiences a subsequent qualifying event during the initial continuation period.

*If You Have Questions*

Questions concerning your Plan or your COBRA continuation coverage rights, contact the Trinity Benefits Center at [www.mybenefits.trin.net](http://www.mybenefits.trin.net) or (888) 765-5367. For more information about your rights under ERISA, including COBRA, HIPAA, and other laws affecting your 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 the EBSA website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa). (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

*Keep Your Plan Informed of Address Changes*

In order to protect your family's rights, you should keep the Plan Administrator informed of 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.

*You are responsible for making timely COBRA coverage payments. You will not be billed.*

If you or your eligible covered Dependent(s) elect continuation coverage after the qualifying event, then you or your eligible covered Dependent(s) will have forty-five (45) days from the date of that election to make the required initial premium contribution. That initial contribution must cover the entire period, from the date of the qualifying event to the date of your payment. There is no grace period for the initial contribution. Each other contribution payment is due within thirty (30) days after the first day of each month of continuation coverage.

**OTHER IMPORTANT INFORMATION ABOUT THE PLAN**

*Name of Plan*

The official name of the Plan is the Trinity Wrap Plan.

*Plan Type*

The Plan is an employee welfare benefit plan offering you and your eligible Dependents: Participating Medical Plans (including prescription drug coverage); Participating Dental Plan ; Participating Vision Plan ; Participating Life and Accidental Death and Dismemberment Insurance Plan; Participating LTD Plan and STD Plan; Participating Critical Illness, Hospital Indemnity & Accident Insurance Plan; Health Savings Account; Limited Purpose Health Reimbursement Account; Dependent Care Flexible Spending Account; Health Care Flexible Spending Account; and a Participating Cafeteria Program.

The Plan is a "welfare benefit plan" under Section 3(1) of the Employee Retirement Income Security Act of 1974, and a "cafeteria plan" under Code Section 125. The Pre-Tax Premium Option is not an ERISA covered plans.

*Plan Number* The Plan number is 609.

*Plan Year* As to all benefits other than benefits under the Participating Medical Plans, January 1 through December 31.

*Plan Sponsor* The Plan Sponsor is: Trinity Industries, Inc.

*Plan Sponsor's EIN* 75-0225040

*Employers* Affiliates of Trinity Industries, Inc. may elect to participate in some or all of the Participating Plans under the Plan. The following are Employers who have elected to participate in the Participating Plans under the Plan.

CJB Prime Property LLC	Trinity Logistics Group, Inc.
FreightLucid LLC	Trinity North American Freight Car Inc.
Ramptech LLC	Trinity Parts & Components, LLC
Trinity Central Maintenance, LLC	Trinity Rail Leasing Management, Inc
Trinity Heads, Inc.	TrinityRail Maintenance Services, Inc.
Trinity Industries Leasing Co.	Vigilant Systems, Inc.

*Claims Administrators and Appeals Fiduciaries* There is a Claims Administrator or Appeals Fiduciary for each Participating Plan. See the **MAKING A CLAIM FOR BENEFITS** section of this SPD, and the documents listed in the **PARTICIPATING PLANS SUMMARIES** in this SPD for more information.

*Source of Contributions* Some Participating Plans are paid for entirely by the Company or Employer(s), but you must contribute to others.

*Plan Administrator and Agent for Legal Process* You can request information about the Plan or serve legal process on the Plan Administrator at the following address:

Director of Benefits  
Trinity Industries, Inc.  
14221 N. Dallas Parkway, Suite 1100  
Dallas, TX 75254  
(214) 631-4420

*Plan Administration* The Plan Administrator is the Company or any other person, entity or committee designated by the Company. The Plan Administrator is appointed by the Company. The Plan Administrator shall be the named fiduciary of the Plan for purposes of ERISA unless specific fiduciary functions have been delegated to other parties.

The Plan Administrator has the discretionary authority to determine all issues arising under the Plan, including issues of eligibility, Plan interpretation and coverage. Benefits under the Plan will be paid only if the Plan Administrator decides, in its sole discretion, that the applicant is entitled to them. An insurance

company or other party that has contracted with the Company to provide administrative services to a Participating Plan may be responsible for determining whether a particular claim is covered by a Participating Plan or if a particular benefit is provided under a Participating Plan. Such an insurance company is a fiduciary of the Plan (called a “Claims Administrator”) or an “Appeals Fiduciary” if that entity has final discretionary authority to determine whether a claims appeal should be granted or denied. The Plan Administrator and Appeals Fiduciaries may delegate some of their administrative duties to agents.

*Representations  
Contrary to The  
Plan*

No employee, officer, or director of the Company or an Employer has the authority to alter, vary or modify the terms of the Plan or any Participating Plan except by means of an authorized written amendment to the Plan. No verbal or written representations contrary to the terms of the Plan or a Participating Plan, or its written amendments, shall be binding upon the Plan, the Plan Administrator, or any Employer.

*Plan Amendment  
and Termination*

The Company reserves the right to amend or terminate the Plan at any time, and the right to decrease or eliminate its contributions for Participating Plan premiums with or without advance notice to Covered Persons. No consent of any Covered Person or other person shall be necessary for the Company to amend or terminate the Plan. Any such amendment or termination may be made by proper action of the board of directors of the Company or their delegate. Alternatively, in certain instances, the Plan Administrator may amend the Plan through the issuance of revised **PARTICIPATING PLAN SUMMARIES** or certificates of coverage.

In the event of the Plan’s termination, the rights of all persons covered by the Plan at the time shall be limited to claims incurred as of the date of the termination. Benefits provided under the Plan are not vested benefits.

*Limitation of Rights*

No Covered Person, beneficiary, or other person shall acquire, by reason of the Plan, this SPD, or any other Participating Plan or Plan document, any right in or title to any assets, funds or property of the Company or an Employer. No employee, officer, director or agent of the Company guarantees in any manner the payment of Plan benefits.

*Assignment of  
Benefits /  
Authorized  
Representative*

To the extent permitted by law, no Covered Person’s rights, interests or benefits under this Plan or the Participating Plans will be subject in any way to alienation, sale, transfer, assignment, pledge, attachment, garnishment, execution, levy, lien or encumbrance of any kind, either voluntary or involuntary, and any attempt to accomplish the same shall be void.

Notwithstanding the foregoing, the Plan Administrator will provide benefits to the extent required by a QMCSO. The Plan Administrator also shall have the right, in its sole discretion, to accept a valid assignment for payment of Plan benefits made by a Covered Person to a company, doctor, dentist or other provider. If the Plan Administrator does not accept your assignment to a health care provider, any benefits due will be paid directly to you. Payments made in accordance with a

valid assignment are made in good faith and discharge the Plan's payment obligation. To authorize a personal representative to act on your behalf with respect to a benefit claim, you must submit a signed written request on a form approved by the Plan Administrator, which authorizes the representative to act on your behalf with respect to the benefit claim. You must sign and submit the approved form to the Plan Administrator and have such request approved prior to the authorized representative taking any action on behalf of your benefit claim. If a party is not properly designated as an authorized personal representative under the Plan, the Plan Administrator will not communicate with that party with respect to any benefit claim or other exercise of your rights under the Plan. With respect to any urgent, pre-service, or concurrent care claim, your treating physician or other health care professional may act as an authorized representative in exercising your rights under the Plan. The Plan will also recognize a court order giving a person authority to submit claims on your behalf. Your assignment of benefits to a health care provider does not constitute a designation of an authorized personal representative for purposes of the Plan. The Company shall not be in any manner liable for or subject to the debts, contract, liabilities or torts of any person entitled to benefits under the Plan.

*Payment to  
Guardian or  
Custodian*

If the Plan Sponsor, Plan Administrator or an Claims Administrator finds that any person entitled to receive benefits under the Plan is unable to care for his or her financial affairs due to physical illness, infirmity, or mental incompetence, or because the person is a minor, any benefits or payments owed to such person may be paid to the person's legal representative or custodian, or to a Spouse, Child, parent, or other relative for such person. Any payments made in accordance with this provision will be a full and complete discharge of any liability for such payment under this Plan and the Participating Plans.

*Certain Judgments  
and Orders*

To the extent required by a QMCSO, and subject to procedures established by the Plan Administrator, your election may be changed by the Plan Administrator to provide coverage to a Dependent in accordance with the terms of a QMCSO. If a QMCSO requires your Spouse, your former Spouse, or another individual to provide coverage for your Dependent Child, and that coverage is, in fact, provided, you may cancel coverage under the Plan for that Child within thirty (30) days following the effective date of the other coverage by contacting the Trinity Benefits Center at (888) 765-5367.

The Plan Administrator or its designee, in its sole discretion, shall determine whether an order or notice qualifies as a QMCSO in accordance with the procedures established for such purpose.

*No Employment  
Rights*

The Plan does not confer employment rights on any person. No person shall be entitled, by virtue of the Plan, to become or to remain in the employ of the Company or an Employer, and nothing in the Plan shall restrict the right of the Company or an Employer to terminate the employment of any Eligible Employee or Transitioning Employee or other person at any time.

*Subrogation/  
Reimbursement*

If you have a claim to recover money from a third party due to an injury and you have received or will receive benefits from the Plan in connection with that injury, the applicable Participating Plan will be subrogated to your rights with respect to that third party. If you receive any payment from any potentially responsible third parties as a result of an injury or illness, the applicable Participating Plan has the right to recover from, and be reimbursed by you for all amounts the Plan has paid and will pay as a result of that injury or illness, up to and including the full amount you received from all potentially responsible parties. In addition, as a condition of paying benefits, a Participating Plan may be entitled to reimbursement out of any money recovered by you from a third party for benefits paid to you by such Participating Plan. The Plan's right to recover these amounts take priority over your right to be made whole. Any settlement proceeds or assets collected from judgments are subject to the imposition of a constructive trust.

Whenever the Plan pays welfare benefits in excess of the maximum amount of payment required under an applicable Participating Plan, the Plan Administrator, its delegate(s) or a Claims Administrator will have the right to recover any such excess payments and associated earnings from any person who received the excess payments.

Please refer to the individual **PARTICIPATING PLANS SUMMARIES** for additional information. If you are injured and are considering making a claim against a third party, you may contact the Claims Administrators for the Participating Plans and ask if any subrogation or reimbursement provisions apply to you.

*Governing Law and  
Venue*

Any lawsuits brought under this Plan pursuant to ERISA shall be filed and litigated in the U.S. District Court for the Northern District of Texas. The Plan will be construed in accordance with the laws of the state of Texas (determined without regard to any conflicts of law provisions), to the extent not preempted by federal law, except that any interpretation of the arbitration provisions herein shall also be governed by the Federal Arbitration Act ("FAA"). In the event of conflict between Texas law and the FAA, the FAA shall control.

*Coordination of  
Benefits*

Coordination of benefits, if applicable, shall be administered in accordance with the terms of the documents listed in the **PARTICIPATING PLANS SUMMARIES** in this SPD.

*Errors*

Any administrative or clerical error when determining eligibility or benefits or maintaining Plan records shall not place in effect any Plan coverage or benefits not provided under the terms of the Plan, void any valid coverage or benefits provided under the Plan, or extend any coverage or benefits that have otherwise terminated. When an administrative or clerical error becomes known (including an error relating to mistaken contributions), the Plan Administrator shall cause all proper and equitable adjustments to be made, including any adjustment to any required contributions as necessary to correct the error (to the extent permitted by law). In no event shall the Employer, Plan Administrator, or any Plan fiduciary be

liable in any manner for any administrative or clerical error, or for any other determination of fact that is made in good faith.

*Misstatement and Misrepresentations*

In the event of a misstatement of any fact affecting your coverage under this Plan, the true facts will be used to determine the coverage in force.

If you or your Dependent(s) receive benefits under the Plan as a result of false, incomplete, or incorrect information or a misleading or fraudulent representation, you may be required to repay all amounts paid by the Plan and may be liable for all costs of collection, including attorney's fees and court costs. If you make any intentional misrepresentation or use fraudulent means concerning eligibility for coverage, changing your existing coverage, or benefits under the Plan, your coverage (and your dependents' coverage) may be terminated irrevocably (retroactively to the extent permitted by law), and could be grounds for discipline up to and including termination. Failure to provide timely notice of loss of eligibility will be considered intentional misrepresentation.

## **CLAIMS PROCEDURES**

*Eligibility*

The Plan Administrator has the authority to decide any and all appeals relating to eligibility and enrollment. In connection with deciding such appeals, the Plan Administrator has the authority to interpret the applicable Plan provision, decide eligibility and enrollment related questions and make factual determinations, each in its sole discretion. Such interpretations, decisions, and factual determinations shall be controlling.

- *Eligibility Determinations that do not Involve Claims for Benefits.* For any Participating Plan subject to ERISA, the Plan Administrator will make any determinations related to eligibility and notify the participant orally or in writing of that determination within thirty (30) days after receipt of the request for an eligibility determination.
- *Adverse Determinations.* If the initial benefit eligibility determination is an adverse determination, the Plan Administrator will orally or in writing explain the Plan's review procedures and the time limits applicable.
- *Initial Appeal of an Adverse Eligibility Determination.* To appeal an initial adverse eligibility determination, a participant must, within one hundred eighty (180) days of receiving the determination, notify the Plan Administrator. The participant may submit written comments, documents, records, and other information relevant to the eligibility determination, and will be given reasonable access to, and copies of, all relevant documents, records, and other information. The Plan Administrator's review will take into account all comments, documents, records, and other information the participant submits relating to the determination, without regard to whether the information was submitted or considered in the initial determination.

- *Notice of Decision on Initial Appeal.* The Plan Administrator will notify the participant of the decision on appeal within thirty (30) days of the Plan Administrator's receipt of the appeal, unless special circumstances require an extension of time of up to thirty (30) days for processing the appeal. If an extension is required, the Plan Administrator will notify the participant before the expiration of the initial thirty (30)-day period, explaining the special circumstances that require an extension of time and including the date by which the Plan Administrator expects to issue its determination on the appeal. If the decision on appeal is an adverse eligibility determination, the Plan Administrator will provide the participant with a notice of the adverse eligibility determination that will: (1) be written in a manner designed to be understood by the participant; (2) include the specific reasons for the adverse eligibility determination; (3) refer to the Plan provisions on which the determination was based; (4) inform the participant that, upon request and free of charge, he or she is entitled to reasonable access to and copies of all relevant documents, records, and other information; and (5) notify the participant of the right to bring legal action within one hundred twenty (120) days after receipt of final notice on appeal.
- *Final Appeal of Adverse Benefit Determination.* To appeal an adverse eligibility determination, a participant must, within one hundred eighty (180) days of receiving the determination, notify the Plan Administrator. The participant may submit written comments, documents, records, and other information relevant to the eligibility determination, and will be given reasonable access to, and copies of, all relevant documents, records, and other information. The Plan Administrator's review will take into account all comments, documents, records, and other information the participant submits relating to the determination, without regard to whether the information was submitted or considered in the initial determination.
- *Notice of Decision on Final Appeal.* The Plan Administrator will notify the participant of the decision on appeal within thirty (30) days of the Eligibility Appeals Administrator's receipt of the appeal, unless special circumstances require an extension of time of up to thirty (30) days for processing the appeal. If an extension is required, the Plan Administrator will notify the participant before the expiration of the initial thirty (30)-day period explaining the special circumstances that require an extension of time and including the date by which the Plan Administrator expects to issue its determination on appeal. If the decision on appeal is an adverse eligibility determination, the Plan Administrator will provide the participant with a notice that will: (1) be written in a manner designed to be understood by the participant; (2) include the specific reasons for the determination; (3) refer to the Plan provisions on which the determination was based; (4) inform the participant that, upon request and free of charge, he or she is entitled to reasonable access to and copies

of all relevant documents, records, and other information; and (5) notify the participant of the right to bring legal action within one hundred twenty (120) days after receipt of notice on final appeal.

The Plan Administrator’s address is:

Trinity Industries, Inc.  
 14221 N. Dallas Parkway, Suite 1100  
 Dallas, TX 75254  
 (214) 631-4420

In most cases, it is the Plan Administrator’s responsibility to operate the Plan and make final decisions on such issues as eligibility and other responsibilities not delegated to a Claims Administrator.

*Making a Claim for Benefits*

Claim decisions are made by a Claims Administrator or Appeals Fiduciary as set forth below. Do not send benefit claims to the Plan Administrator unless the Plan Administrator is listed as the Claims Administrator or Appeals Fiduciary below. If you need a claim form, or if you need to know who and where to send your claims for benefits please see below:

*Always send your claim for benefits to the appropriate Claims Administrator or Appeals Fiduciary.*

PARTICIPATING PLAN	SEND CLAIMS FOR BENEFITS TO
Medical Plan	<p><u>Claims Administrator and Appeals Fiduciary:</u></p> <p>BCBSTX                      Basic HDHP Policy # 369880                      Enhanced HDHP Policy # 369881                      PPO Policy # 369879</p> <p>Blue Cross and Blue Shield of Texas                      P.O. Box 660044                      Dallas, Texas 75266-0044                      877-278-5205  <a href="http://www.bcbstx.com">www.bcbstx.com</a></p>
Grandfathered Medical Plan      Retiree	<p><u>Claims Administrator and Appeals Fiduciary:</u></p> <p>BCBSTX                      Basic HDHP Policy # 369880                      Enhanced HDHP Policy # 369881                      PPO Policy # 369879</p> <p>Blue Cross and Blue Shield of Texas                      P.O. Box 660044                      Dallas, Texas 75266-0044                      877-278-5205</p>

[www.bcbstx.com](http://www.bcbstx.com)

Prescription Drug

CVS  
PO Box 659541  
San Antonio, TX 78265-9541  
833-826-6859  
[www.caremark.com](http://www.caremark.com)

Dental Plan

Claims Administrator and Appeals Fiduciary:

Delta Dental  
Policy #17965  
1-800-521-2651  
P.O. Box 1809  
Alpharetta, GA 30023-1809

Long-Term Disability

Claims Administrator and Appeals Fiduciary:

Hartford Life and Accident Insurance Company  
Policy #681438  
One Hartford Plaza  
Hartford, CT 06155

Short-Term Disability

Claims Administrator and Appeals Fiduciary:

Hartford Life and Accident Insurance Company  
Policy #681438  
One Hartford Plaza  
Hartford, CT 06155

Vision Plan

Claims Administrator and Appeals Fiduciary:

Davis Vision  
c/o Guardian  
Policy #500765  
Attn: Claims  
3333 Quality Drive  
Rancho Cordova, CA 95670-7985

Life and Accidental  
Death and  
Dismemberment  
Insurance

Claims Administrator and Appeals Fiduciary:

Standard Insurance Company  
Policy #758182-A  
1100 SW 6<sup>th</sup> Avenue  
Portland, OR 97204-1093

Critical Illness, Hospital  
Indemnity & Accident  
Insurance Plan

Claims Administrator and Appeals Fiduciary:

MetLife  
Policy #0140956

1-800-438-6388

Business Travel Accident Claims Administrator and Appeals Fiduciary:  
Plan Zurich  
1-800-263-0261  
[www.zurichna.com/travelassist](http://www.zurichna.com/travelassist)

You should first file a claim with the appropriate Claims Administrator listed above and in accordance with the procedures required by that Claims Administrator. If your claim is denied, or if you believe that you are entitled to a larger benefit, then you may file an appeal with the Appeals Fiduciary. Claims procedures are explained in detail below. Please note that **you will not be entitled to challenge a claim decision made by the Claims Administrator or Appeals Fiduciary in federal or state court or in any other administrative proceeding unless and until the claims procedures described below have been complied with and exhausted. In addition, all such appeals must be brought within the timeframe mentioned below under *Action After Exhausting Appeal Rights*.**

*You must follow these claims procedures before you can bring an action for benefits in court.*

The Plan Administrator has delegated claims and appeals responsibilities to Claims Administrators and Appeals Fiduciaries. The Claims Administrator or Appeals Fiduciary has discretionary authority to grant or deny benefits under the Plan. Benefits under the Plan will be paid only if the Claims Administrator or Appeals Fiduciary determines, in its discretion, that the applicant is entitled to them. Nevertheless, medical care providers are responsible for the services they provide and for their decisions regarding the care provided. Neither the Plan Administrator nor the Company or Employers assume responsibility for, nor do they make any express or implied warranties concerning, the outcome of any covered or non-covered services or supplies.

*Claims Procedures for Group Health Plans*

The following shall apply to claims for benefits filed under the Group Health Plan.

Initial claims for benefits will be decided by the Claims Administrator in the timeframe specified below under the **DENIAL OF A GROUP HEALTH PLAN CLAIM** section, and in accordance with the documents listed in the **PARTICIPATING PLANS SUMMARIES** in this SPD and the U.S. Department of Labor's ("DOL") procedures.

For purposes of this section, an "urgent care claim" is a claim where the application of non-urgent care time frames could seriously jeopardize your life, health or ability to regain maximum function, or, in the opinion of a licensed physician with knowledge of your medical condition, would subject you to severe pain without the care or treatment that is the subject of the claim.

A "pre-service claim" is a claim that requires you to obtain approval of the benefit in advance of obtaining care.

A "post-service claim" is a claim that does not require prior approval.

A “concurrent care claim” is a claim relating to an ongoing course of treatment provided over a period of time or number of treatments.

If a claimant fails to follow the Participating Plan’s procedures for filing a pre-service claim, the claimant will be notified within five (5) days (or within twenty-four (24) hours in the case of a failure regarding an urgent care claim). Notification may be oral unless the claimant requests written notification.

*Denial of a Group Health Plan Claim*

If a Group Health Plan claim is denied, in whole or in part, the Claims Administrator shall notify you in writing:

- For urgent care claims, within seventy-two (72) hours after receipt by the Claims Administrator of the correctly and completely filed claim.
- For concurrent care claims (A) that are also urgent care claims, within twenty-four (24) hours after receipt of a claim to extend a course of treatment (provided the claim is filed at least twenty-four (24) hours prior to the expiration of the prescribed period or number of treatments), or (B) within sufficient time to appeal an adverse decision in the case of the reduction or termination of a course of treatment.
- For all pre-service claims, within fifteen (15) days after receipt of the claim by the Claims Administrator.
- For post-service claims, within thirty (30) days after receipt of the claim by the Claims Administrator.

If the Claims Administrator determines that special circumstances require an extension of time for processing the claim:

- For urgent care claims, the Claims Administrator will notify the claimant within twenty-four (24) hours if additional information is needed from the claimant, and the claimant shall have at least forty-eight (48) hours from receipt of the notice within which to provide the requested information.
- For pre-service and post-service claims, the Claims Administrator shall notify the claimant in writing of the need for an extension, the reason for the extension, and the expected date of decision within the initial period. In no event shall such extension exceed fifteen (15) days from the end of such initial period. If an extension is necessary because additional information is needed from the claimant, the notice of extension shall also specifically describe the missing information, and the claimant shall have at least forty-five (45) days from receipt of the notice within which to provide the requested information.

If your claim is denied again, in whole or in part, the Claims Administrator shall notify you in writing within the following timeframes:

- For urgent care claims, within seventy-two (72) hours after receipt by the Claims Administrator of the correctly and completely filed claim.
- For concurrent care claims (a) that are also urgent care claims, within twenty-four (24) hours after receipt of a claim to extend a course of treatment (provided the claim is filed at least twenty-four (24) hours prior to the expiration of the prescribed period or number of treatments), or (b) within sufficient time to appeal an adverse decision in the case of the reduction or termination of a course of treatment.
- For all pre-service claims, within thirty (30) days (fifteen (15) days if the Claims Administrator utilizes two levels of appeal) after receipt of the claim by the Claims Administrator.
- For post-service claims, within sixty (60) days (thirty (30) days if the Claims Administrator utilizes two levels of appeal) after receipt of the claim by the Claims Administrator.

Your claim denial will include the following:

- The specific reason(s) for the denial, and reference to the pertinent Participating Plan provisions upon which the denial is based;
- A description of any additional material or information you need to submit to perfect your claim and the reasons why such material or information is necessary;
- An explanation of the Participating Plan’s claims appeal procedures, including any applicable time limits;
- A statement of your right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974 (“ERISA”) if the claim is denied on review; and
- In the case of a denial of an urgent care claim, a description of the expedited review procedure applicable to such claims. An urgent care claim decision may be provided orally, so long as written notice is furnished to the claimant within three (3) days of oral notification.

Upon request you may also receive:

- Reasonable access to and copies of all documents, records and other information relevant to the claim for benefits;
- Any internal rule, guideline, protocol or other similar criterion relied on in the determination, or a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge; and

- An explanation of the scientific or clinical judgment relied on in the determination, or a statement that such explanation will be provided free of charge.

*If your claim is denied, you may appeal the decision.*

If your claim is denied, you or your authorized representative may, within one hundred eighty (180) days after receiving the written notice of denial, file a written appeal. The decision on appeal usually will be made within the timeframe specified above, unless special circumstances require an extension. You may submit additional information or documents and written issues and comments relating to the claim. On second review, the Appeals Fiduciary will take into account all comments, documents, records and other information submitted by you, without regard to whether such information was considered in the initial determination. No deference will be given to the initial adverse benefit determination or the first level appeal.

You will receive notice of the decision of the second appeal in writing. If your claim is denied on appeal, the written decision will include:

- The specific reason(s) for the denial, and reference to the pertinent Participating Plan provisions upon which the denial is based;
- A statement that you (or your authorized representative) are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim;
- An explanation of the scientific or clinical judgment relied on in the determination, or a statement that such explanation will be provided free of charge upon request; and
- A statement of your right to bring a civil action under Section 502(a) of ERISA if the claim is denied on final review, and the deadline for filing such action.

*External Review*

The Plan Administrator will provide foreign language assistance as requested by federal law.

If your claim is denied based on an internal rule, guideline, protocol, or other similar criterion, then in addition to the items listed above, each notice of denial will set forth the international guideline, protocol or other similar criterion or include a statement that such criteria do not exist and will also include a statement that you may obtain a copy of such rule, guideline, protocol, or other criterion free of charge upon request.

*Claim Procedures for Disability Plans*

If a claim under the Participating Medical Plans is denied on appeal, you have the right to external review as described in applicable Participating Medical Plans documents.

*Denial of a  
Disability Claim*

The following shall apply to claims for benefits filed under the Participating LTD Plan and Participating STD Plan, and any disability determinations under the Participating Life and Accidental Death and Dismemberment Insurance Plan.

Initial claims for benefits will be decided by the Claims Administrator in the timeframe specified below in the **DENIAL OF A DISABILITY CLAIM** section, and in accordance with the documents listed in the **PARTICIPATING PLANS SUMMARIES** in this SPD and the DOL procedures.

If a claim is denied, in whole or in part, the Claims Administrator shall notify the claimant in writing within forty-five (45) days after receipt of the claim by the Claims Administrator. If the Claims Administrator determines that special circumstances require an extension of time for processing the claim, the Claims Administrator shall notify the claimant in writing of the need for extension, the reason for the extension, and the expected date of decision within the initial forty-five (45) day period. In no event shall such extension exceed a period of thirty (30) days from the end of such initial period. If the Claims Administrator determines that an additional extension is needed, the Claims Administrator shall notify the claimant in writing within the first thirty (30) day extension period. If an extension is necessary because additional information is needed from the claimant, the notice of extension shall also specifically describe the missing information, and the claimant shall have at least forty-five (45) days from receipt of the notice within which to provide the requested information.

The decision will be made in writing. Your claim denial will include the following:

- The specific reason(s) for the denial, and reference to the pertinent Participating Plan provisions upon which the denial is based;
- A discussion of the decision, including a discussion of the reasons why the Plan Administrator agreed or disagreed with the views presented by relevant health care professionals, vocational professionals, a disability determination made by the Social Security Administration, medical experts, and vocational experts;
- A description of any additional material or information you need to submit to perfect your claim and the reasons why such material or information is necessary;
- An explanation of the Participating Plan's claims appeal procedures, including any applicable time limits;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim; and

- A statement of your right to bring a civil action under Section 502(a) of ERISA if the claim is denied on review, and the deadline for filing such action.

Upon request you may also receive:

- Reasonable access to and copies of all documents, records and other information relevant to the claim for benefits; and
- Any internal rule, guideline, protocol or other similar criterion relied on in the determination, or a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge.

The Plan Administrator will provide foreign language assistance as requested by federal law.

If your claim is denied based on an internal rule, guideline, protocol, or other similar criterion, then in addition to the items listed above, each notice of denial will set forth the internal guideline, protocol or other similar criterion or include a statement that such criteria do not exist and will also include a statement that you may obtain a copy of such rule, guideline, protocol, or other criterion free of charge upon request.

*If your disability claim is denied, you may appeal the decision.*

If your disability claim is denied, you or your authorized representative may file a written appeal within one hundred eighty (180) days after receiving the notice of the denial. The decision on appeal usually will be made within forty-five (45) days after the receipt of your appeal, unless special circumstances require an extension of up to an additional forty-five (45) days. If the period is extended, the Appeals Fiduciary will notify you in writing of the need for extension and the expected date of decision within forty-five (45) days of receiving your appeal. You may submit additional information or documents and written issues and comments relating to the claim. On second review, the Appeals Fiduciary will take into account all comments, documents, records and other information submitted by you, without regard to whether such information was considered in the initial determination. No deference will be given to the initial adverse benefit determination or the first level appeal.

You will receive notice of the decision of the second appeal in writing. If your claim is denied on appeal, the written decision will include:

- The specific reason(s) for the denial, and reference to the pertinent Participating Plan provisions upon which the denial is based;
- A statement that you (or your authorized representative) are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim; and

- A statement of your right to bring a civil action under Section 502(a) of ERISA, and the deadline for filing such action.

The Plan Administrator will provide foreign language assistance as requested by federal law. If your claim is denied based on an internal rule, guideline, protocol, or other similar criterion, then in addition to the items listed above, each notice of denial will set forth the international guideline, protocol or other similar criterion or include a statement that such criteria do not exist and will also include a statement that you may obtain a copy of such rule, guideline, protocol, or other criterion free of charge upon request.

If your disability claim is denied based on an internal rule, guideline, protocol, or other similar criterion, then in addition to the items listed above, each notice of denial will also include a statement that you may obtain a copy of such rule, guideline, protocol, or other criterion free of charge upon request.

If the appeal is denied based on new or additional evidence or rationale not presented during the initial claim process, the Plan Administrator will disclose the new evidence or rationale (as applicable) and provide you with a reasonable time to respond.

*Claims Procedures  
for Other ERISA  
Covered Plans*

Other than disability determinations, the following shall apply to claims for benefits filed under the Participating Life and Accidental Death and Dismemberment Insurance Plan.

Claims for benefits will be decided by the Claims Administrator in the timeframe specified below in the **DENIAL OF A CLAIM** section, and in accordance with the documents listed in the **PARTICIPATING PLANS SUMMARIES** in this SPD and the DOL procedures.

*Denial of a Claim*

If your claim is denied, in whole or in part, the Claims Administrator shall notify you in writing within ninety (90) days after receipt of the claim by the Claims Administrator. If the Claims Administrator determines that special circumstances require an extension of time for processing the claim, the Claims Administrator shall notify you in writing of the need for extension, the reason for the extension, and the expected date of decision within the initial ninety (90)-day period. In no event shall such extension exceed a period of ninety (90) days from the end of such initial period.

The decision will be made in writing. Your claim denial will include the following:

- The specific reason(s) for the denial, and reference to the pertinent Participating Plan provisions upon which the denial is based;

- A description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; and
- A statement of your right to bring a civil action under Section 502(a) of the ERISA.

Upon request you may also receive:

- Reasonable access to and copies of all documents, records and other information relevant to the claim for benefits; and
- Any internal rule, guideline, protocol or other similar criterion relied on in the determination, or a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge.

*If your claim is denied, you may appeal the decision.*

A claimant must file an appeal of an adverse decision with the Appeals Fiduciary within sixty (60) days following receipt of the written notice of denial. In connection with any review on appeal by the Appeals Fiduciary, the claimant may submit additional information or documents and written issues and comments relating to the claim. You may submit additional information or documents and written issues and comments relating to the claim. On second review, the Appeals Fiduciary will take into account all comments, documents, records and other information submitted by you, without regard to whether such information was considered in the initial determination. No deference will be given to the initial adverse benefit determination or the first level appeal.

You will receive notice of the decision of the second appeal in writing. If your claim is denied on appeal, the written decision will include:

- The specific reason or reasons for such denial;
- Specific references to the provisions of the Participating Plan upon which such denial is based; and
- The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits; and
- An explanation of the Participating Plan's voluntary appeal procedures, if any, and a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA.

*Claims Procedures for Non-ERISA Covered Plans*

The following shall apply to claims for benefits filed under the Pre-Tax Premium Option. Claims for benefits will be reviewed by the Claims Administrator and decided in a uniform and non-discriminatory manner. The claimant will be notified of the decision and will have an opportunity to appeal the decision to the Appeals Fiduciary in accordance with reasonable procedures established by the Claims Administrator and Appeals Fiduciary for that purpose.

*Action After  
Exhausting Appeal  
Rights*

You are not permitted to file a civil action under Section 502(a) of ERISA unless you have exhausted the Plan's claims procedures. However, if the Plan Administrator fails to abide by the claims procedures set forth in this section, you will be deemed to have exhausted these claims procedures.

No action at law or in equity shall be brought to recover under the Plan until the appeal rights herein provided have been exercised and the Plan benefits requested in such appeal have been denied in whole or in part. If any judicial proceeding is undertaken to challenge a claim denial or if a Covered Person seeks to bring any other action under ERISA other than a breach of fiduciary duty claim, the evidence presented shall be strictly limited to the evidence timely presented to the Plan Administrator or the person or entity delegated with discretionary authority to make final claim determinations. In addition, any such judicial proceeding must be filed by the earliest of: (i) sixty (60) days after the final decision on the benefit claim under the Participating Plan's claims procedures; or (ii) two (2) years after the date that the medical or dental treatment at issue in the legal action was provided by a physician or other medical provider, or in the case of benefits other than medical or dental benefits, the date that the proof of loss is submitted to the Plan Administrator related to the benefit at issue in the legal action. In no case may a suit or legal action be brought if the claim for benefits was not made within the time period prescribed in the claims procedures of the applicable Participating Plan. This limitation on suits for benefits applies in any forum where a Covered Person initiates a suit or legal action.

## **SPECIFIC RIGHTS AND NOTICES REGARDING THE PLAN**

*Women's Health  
and Cancer Rights  
Act Notice*

In 1998, Congress passed the Women's Health and Cancer Rights Act. This federal law requires group health plans that provide medical benefits for a mastectomy to also provide coverage for breast reconstruction for patients.

Specifically, any patient whose mastectomy is covered under a group health plan must also be covered for:

Reconstruction of the breast on which the mastectomy has been performed;

Reconstruction of the other breast to achieve symmetry; and

Prostheses and physical complications of all stages of a mastectomy, including lymphedemas.

Decisions about these medical procedures will be determined in consultation with you and your attending physician. This coverage is subject to applicable deductibles and co-insurance payments, and to the terms and provisions of the Participating Medical Plans. Please refer to the applicable Participating Benefit summary or contact your health plan for more information.

*Newborns' and  
Mothers' Health*

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth

*Protection Act  
Disclosure*

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

*Privacy Rights*

The Department of Health and Human Services ("HHS") has issued a series of regulations under HIPAA designed to protect the privacy of health information and to establish standards for its electronic transmission. For more information, see the HIPAA Privacy Notice for the Trinity Wrap Plan.

The Plan is considered a "hybrid entity" under HIPAA. The Group Health Plan constitutes the covered components of the hybrid entity and is subject to the requirements of the HIPAA privacy rule.

The privacy regulations govern how the Group Health Plan and the business associates with whom they contract handle protected health information ("PHI"). PHI includes health information that could identify an individual. It is created or received by a health care provider, health plan, employer, or life insurer, and either relates to the physical or mental health of an individual, the provision of health care to an individual, or the payment for the provision of health care to an individual. PHI can be in an electronic, paper, or oral format.

In order for a number of entities, including a health plan, insurer, or provider ("Covered Entities"), to use an individual's PHI for purposes other than treatment, payment or health care operations, that Covered Entity must obtain an authorization from the individual. The authorization must specify who will have access to the PHI, when that access expires, and the individual's right to revoke the authorization.

As a Covered Person in the Plan, you are entitled to receive a privacy notice from any Group Health Plan insurers and from the Plan for self-insured Group Health Plan benefits. This privacy notice describes your rights under HIPAA, including standards and procedures for the exercise of those rights. You may also request the right to inspect or make copies of your PHI. The Group Health Plan must act on your request to inspect your PHI within thirty (30) days, or sixty (60) days if the PHI is not on-site; however, the Group Health Plan may receive a thirty (30) day extension as long as it notifies you. The Group Health Plan may deny access under certain circumstances. You will have the right to request an amendment or correction of your PHI, and you will be able to request that the Group Health Plan restrict the use and disclosure of your PHI. You will also have the right to request

an accounting of the disclosure of your PHI by a Covered Entity to another Covered Entity or business associate for purposes other than treatment, payment or health care operations. Amendments, corrections, and accountings must be acted upon by the Covered Entity within sixty (60) days; however, the Covered Entity may receive a thirty (30) day extension with notice to the individual.

If you have questions regarding your privacy rights, you may contact the Plan Administrator or log onto <http://www.cms.hhs.gov> and search for “HIPAA”.

If you have complaints about the handling of your PHI, you may contact the insurance carrier.

*Information You  
Must Provide*

You must provide the Plan Administrator with such documents, data or other information as the Plan Administrator considers necessary or desirable for administering the Plan. You may also be required to fully complete forms, releases or documents as necessary. The benefits payable under the Plan to you or on your behalf are conditioned on furnishing full, true and complete documents, data or other information reasonably related to the administration of the Plan requested by the Plan Administrator. If you commit fraud, misrepresentation or deceit or omit a material fact on an enrollment form, in a claim or appeal for benefits, or in response to any request for information by the Plan Administrator, a Claims Administrator, an Appeals Fiduciary, or an Employer, the Plan Administrator may terminate your coverage retroactively, in accordance with the rules governing rescission of coverage under the Affordable Care Act. The Plan Administrator will provide at least thirty (30) days advance written notice to you (and your covered Dependents, if applicable) before Participating Medical Plans coverage is rescinded. A rescission or cancellation of coverage is treated as an adverse benefit determination for purposes of applying the Plan’s claims procedures.

*No Guarantee of  
Employment*

Participation in the Plan does not guarantee your employment with the Company. Nor does it guarantee your right to any benefit under a Participating Plan.

*No Vesting*

No person shall have any guaranteed or vested right to receive or continue to receive any benefits provided under the Plan.

*Your Rights Under  
ERISA*

As a Covered Person in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan Covered Persons shall be entitled to:

Examine without charge at the Plan Administrator’s office and at other specified locations all documents governing the Plan, including insurance contracts, 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.

*Receive Information About Your Plan and Benefits* Obtain, upon written request, copies of documents governing operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated SPD. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

*Continue Group Health Plan Coverage* Continue health care coverage for yourself, your Spouse or Dependent Children 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 this SPD and the documents governing the Plan on the rules governing your COBRA continuation 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 the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other participants and beneficiaries. No one, including the Company, your Employer, or any other person, 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 Plan 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 the 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 Administrator and do not receive them within thirty (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 per day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous. Any lawsuit brought against the Plan, the Company, the Plan Administrator, or a Participating

Plan must be filed by the earliest of: (i) sixty (60) days after the final decision on the benefit claim under the Participating Plan's claims procedures; or (ii) two (2) years after the date that the medical or dental treatment at issue in the legal action was provided by a physician or other medical provider, or in the case of benefits other than medical or dental benefits, the date that the proof of loss is submitted to the Plan Administrator related to the benefit at issue in the legal action.

*Assistance with  
Your Questions*

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the 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.

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