DISCOVERY BENEFITS, INC.

HEALTH REIMBURSEMENT ARRANGEMENT

Certificate of Coverage

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ABOUT THIS CERTIFICATE OF COVERAGE

The rules and operation of your group health plan are described in this Certificate of Coverage as clearly as possible with minimal use of the technical terms appearing in the official legal documents (including applicable insurance contracts). However, the official legal documents remain the final authority and, in the event of a conflict with this Certificate of Coverage, shall govern in all cases. You may request a copy of the official legal documents from the Plan Administrator.

This Certificate may only be used when your Employer has contracted with Discovery Benefits to be the Claims Administrator of your Plan. Once Discovery Benefits is no longer the Claims Administrator, this document shall be void with respect to any term, condition or requirement of Discovery Benefits.

ELIGIBILITY AND PARTICIPATION

ELIGIBLE EMPLOYEES

You are eligible for the Plan if you are a full-time or part-time employee scheduled to work 20 hours or more per week. Further you must be enrolled in the Medical Premier CDHP or Medical Basic CDHP.

INELIGIBLE PERSONS

The following employees or individuals are ***not*** eligible to participate in the Plan:

- Any employee who is paid from a non-U.S. payroll, either entirely or partly.
- Any employee who is classified by your Employer as an intern or as an on-call or temporary employee.
- Any individual who is classified by your Employer as an independent contractor (without regard to how the individual may be classified by a court or administrative agency).
- Union Employees
- Non-Resident aliens
- Leased Employees
- Part-time employees scheduled to work less than 20 hours per week.

It is expressly intended that individuals not treated as eligible employees by your Employer are to be excluded from participation in the Plan under all circumstances until your Employer changes their classification. Therefore, an independent contractor or any other ineligible individual who is reclassified by a court, administrative agency or other party, as an eligible employee will not be considered an eligible employee for periods before your Employer implements the reclassification decision, even if the decision applies retroactively.

RETURN FROM MILITARY SERVICE

If an employee returns to active employment in a position as an eligible employee following active military duty, any minimum age and service requirements and any waiting period applicable to new eligible employees will not apply. All benefits provided by the Plan will be restored to their status as of the eligible employee's last day worked provided the employee applies for reinstatement within the time period required by the Uniform Services Employment and Reemployment Rights Act (USERRA). Plan coverage will be effective on the date the employee returns to active employment in a position as an eligible employee.

SPOUSE AND DEPENDENT COVERAGE

As a Plan participant you can receive reimbursement for eligible claims for your eligible spouse and eligible children who qualify as your Federal income tax dependent and are covered as dependents in your medical plan. In addition, you can receive reimbursement for eligible claims for a child who is covered by a qualified medical child support order (QMCSO) under ERISA Section 609. A child of a participant (e.g., biological, adopted, step and eligible foster children) shall be a dependent hereunder up to his or her 26th birthday.

Your eligible spouse includes your spouse to whom you are legally married, common law spouse where applicable and domestic partner in all states that don't recognize common law marriage.

A medical child support order is a judgment, decree or order (including approval of a property settlement) made under state law that provides for child support or health coverage for the child of a participant. The child becomes an "alternate recipient" and can receive benefits under the Plan, if the order is determined to be "qualified." You may obtain, without charge, a copy of the procedures governing the determination of qualified medical child support orders from the Plan Administrator.

COMMENCEMENT OF PARTICIPATION

If you are eligible for participation in the Plan, the effective date of your coverage will be the same as your Premier CDHP medical plan or Basic CDHP medical plan coverage start date. Your enrollment rights are also subject to the following waiting periods. If you are a weekly paid employee you are eligible for benefits on your 31st day of employment. If you are a semi-monthly paid employee you are eligible for benefits on your first day of employment.
Leaves of Absence

LEAVE OF ABSENCE

When you apply for an authorized leave of absence (including a leave pursuant to the Family and Medical Leave Act of 1993) you will be advised of the specific requirements regarding the continuation of your participation in Plan coverage. You will also be advised of the requirements to resume your participation should your participation terminate while you are on leave. The following rules will apply to your leave of absence.
Your Employer will provide up to 12 weeks of unpaid, job-protected leave during any 12-month period to eligible employees for certain family and medical reasons. Please contact your

Employer to see if you are covered by FMLA. In general, an Employer will be subject to FMLA rules, if your Employer employs 50 or more employees for each working day during each of 20 or more calendar workweeks in the current or preceding calendar year.

In general, if your Employer is subject to FMLA you will be eligible to take FMLA leave if:

- You have worked for your Employer at least 12 months before the leave;
- You have worked at least 1,250 hours during the 12 months immediately before the leave.

If you take a leave of absence pursuant to FMLA, your group health plan coverage will continue, if you continue to pay your portion of the premiums during your FMLA leave period. If you fail to pay the premiums as they become due, your Employer may choose to either pay them on your behalf, or to terminate your coverage after written notice.

If your Employer pays your premiums, your Employer may recover them from any sum (such as from your unpaid wages) due you after your return to work, or after you provide notice that you will not return after the end of the FMLA leave period. You may also revoke your group health plan coverage for the period of your FMLA leave. Upon returning from FMLA leave you will resume participation in group health plan coverage, whether you voluntarily revoked your participation or your participation was cancelled due to non-payment of the premiums.

TERMINATION OF PARTICIPATION

Your Plan coverage will terminate at the time when you no longer meet the criteria to be an eligible employee. For example, your Plan coverage will terminate based on certain events, including:

- Termination of employment, including retirement, layoff and otherwise;
- When you are no longer considered an eligible employee.

In addition, your dependent children and spouse will cease to have Plan coverage when your participation as an employee terminates or earlier if your dependent children or spouse fail to satisfy the criteria as set forth above.

Upon termination of employment you will still be able to request reimbursement for qualifying expenses incurred during plan participation from the balance remaining in your account at the time of termination. You must submit claims within 89 days of termination.

RESCISSION OF COVERAGE

The Plan shall not rescind coverage for a participant or qualifying dependent, unless the participant or dependent performs an act, practice, or omission that constitutes fraud or unless the participant or dependent makes an intentional misrepresentation of a material fact with respect to the Plan. If coverage may be rescinded under the foregoing provisions, the participant or dependent shall be provided with at least 30 days advance written notice of such rescission. A rescission is subject to the claims procedures.

A rescission of Plan coverage is a cancellation or discontinuance of such coverage that has retroactive effect. A cancellation or discontinuance of coverage is not a rescission (and not subject to the rescission of coverage rules) if:

- The participant or dependent voluntarily requests such cancellation or discontinuance with a retroactive effective date;
- The cancellation or discontinuance of coverage has only prospective effect;
- The cancellation or discontinuance of coverage results from a participant's termination of employment from an Employer; or
- The cancellation or discontinuance of coverage of a dependent resulting from such dependent's failing to satisfy the applicable eligibility requirements to be a dependent.

BENEFITS

REIMBURSEMENTS

The plan allows you to be reimbursed for all medical expenses under IRC 213(d), excluding insurance premiums. Some examples of eligible expenses are:

Co-pay and Coinsurance Amounts
Deductibles
Hospital Services
Physical Therapy
Radiation Therapy
Durable Medical Equipment
Dialysis

For a complete list of eligible 213(d) expenses you can contact Discovery Benefits, Inc. at 866.451.3399 or visit www.DiscoveryBenefits.com.

CODE SECTION 213(D) EXPENSES

Your HRA includes reimbursements for any Code Section 213(d) expense, the IRS requires that the expense is:

- For the diagnosis, cure, mitigation, treatment or prevention of disease and for treatments affecting any part or function of the body, and
- Primarily to alleviate or prevent a physical or mental defect or illness.

Expenses NOT generally eligible for reimbursement are those:

- Solely for cosmetic reasons, or
- Merely beneficial to one's general health (for example, health spas, vacations)

If you have any questions as to whether an expense satisfies the Code Section 213(d) requirements, please review the rules set forth on the Claims Administrator's website at www.DiscoveryBenefits.com, or contact Participant Services at 1-866-451-3399 or via email at customerservice@discoverybenefits.com.

SPECIAL REIMBURSEMENT RULES

The following includes other special rules regarding Plan reimbursements and benefits –

- Any expense submitted for reimbursement under the Plan cannot also be reimbursed or paid by any other health plan.

- You must file any claims for eligible expenses within one year following the end of the plan year in which the eligible expense incurred. Claims filed after will not be paid. Expenses incurred prior to the effective date of the Plan or before you began Plan participation are not eligible for reimbursement. Expenses incurred after you end plan participation will not be eligible for reimbursement.

- Eligible expenses incurred for yourself may be reimbursed from the HRA Account. Expenses incurred for your spouse, your child or other dependent will only be reimbursed if your spouse, child or other dependent satisfies the provisions to be eligible for the Plan.

- Any money you don't use in a particular Plan Year will carry over to the following Plan Year as long as you remain a participant in the Premier CDHP or Basic CDHP. You will be allowed to carry over unused money until you reach that plans annual family deductible, if applicable, based on your coverage selection. For example; employee only, employee plus spouse, employee plus child(ren), employee plus family.

- If you leave the Employer or otherwise terminate Plan participation, you have until the end of the period outlined below to file claims for eligible expenses incurred prior to your end in plan participation. If your employment ends you have 89 days from your date of separation to submit claims for eligible expenses incurred while you were a plan participant. See comment above regarding the deadline to file claims. You may be able to file claims for eligible expenses incurred after your termination, if you continue active coverage under COBRA.

- If you die while employed by the Employer, your eligible spouse and eligible dependents can continue to use the HRA Account for their eligible expenses incurred both before and after your death by continuing plan participation under COBRA.

Participants may be provided with a debit card by the Claims Administrator to pay for Qualifying Medical Expenses. Any debit card shall be subject to the debit card's terms of use and any other requirements established by the Claims Administrator for this purpose. If a debit card is used to pay for an expense that is not a Qualifying Medical Expense, the Claims Administrator shall apply correction procedures as set forth in guidance promulgated pursuant to Section 125 of the Internal Revenue Code.

MAXIMUM REIMBURSEMENTS

The amount that your Employer will credit to your HRA Account will be based on the medical plan elected and the coverage tier. Reference the table below for the amounts. Keep in mind that if your coverage under the plan starts after January of that plan year then you will receive a prorated amount based on the number of full months remaining is that plan year. Unused amounts from the prior calendar year may be carried forward to subsequent calendar years as long as you remain a participant in the Premier CDHP or Basic CDHP. Unused money will cease to carry forward to subsequent years if you discontinue participation in the Premier CDHP or Basic CDHP or have reached your annual family deductible amount, if applicable based on the plan and coverage tier you participate in.

	Premier CDHP	Basic CDHP
Employee Only	$750	$500
Employee + Spouse	$1,000	$750
Employee + Child(ren)	$1,000	$750
Employee + Family	$1,500	$1,000

REIMBURSEMENT REQUESTS

During the course of the calendar year, you may submit requests for reimbursement of expenses you have incurred. However, you must make your requests for reimbursements no later than the end of the period outlined in the 'Special Reimbursement Rules' section of this Certificate of Coverage. The Claims Administrator will provide you with acceptable forms for submitting these requests for reimbursement. In addition, you must submit to the Claims Administrator proof of the expenses you have incurred and that they have not been paid by any other health plan coverage. If the request qualifies as a benefit or expense that the Plan has agreed to pay, you will receive a reimbursement payment soon thereafter.

CLAIM AND APPEALS

When you have a claim to submit for reimbursement, you must:

(1) Obtain a claim form from the Claim Administrator;

(2) Complete the Employee portion of the form; and

(3) Attach copies of all bills from the service provider for which you are requesting reimbursement.

(4) Submit the completed form with supporting documentation to Discovery Benefits.
Mail: PO Box 2926; Fargo, ND 58108-2926
Fax: 1-866-451-3245

A claim is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant that complies with the Plan's reasonable procedure for making benefit claims. The times listed are maximum times only. A period of time begins at the time the claim is filed. Decisions will be made within a reasonable period of time appropriate to the circumstances but no later than the time periods set forth below. "Days" means calendar days.

Notification of whether claim is accepted or denied	30 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information on the claim:	
Notification of insufficient information	15 days
Required Response by Participant	45 days

The Claim or Plan Administrator will provide written or electronic notification of any claim denial. The notice will state:

(1) The specific reason or reasons for the denial.

(2) Reference to the specific Plan provisions on which the denial was based.

(3) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.

(4) A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of your right to bring a civil action under Section 502 of ERISA following a denial on review.

(5) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim; and

(6) If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a

rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to the claimant upon request.

When you receive a denial, you will have 180 days following receipt of the notification in which to appeal the decision. You may submit written comments, documents, records, and other information relating to the claim. The appeal would need to be mailed to PO Box 2926; Fargo, ND 58108-2926. If you request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

Once an appeal is filed, the Claim or Plan Administrator will notify you within 60 days thereafter.

A document, record, or other information shall be considered relevant to a claim if it:

(1) was relied upon in making the claim determination;

(2) was submitted, considered, or generated in the course of making the claim determination, without regard to whether it was relied upon in making the claim determination;

(3) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that claim determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants;

(4) or constituted a statement of policy or guidance with respect to the Plan concerning the denied claim.

The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial claim determination. The review will not afford deference to the initial denial and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

EXTERNAL REVIEW

External review of denied appeals may be available once you complete the regular claims and appeal process noted above. However, external review is limited to only the following types of claims and appeals –

- Medical Judgment Claims and Appeals: External review procedures apply to adverse benefit determinations that involve medical judgments (including those based on medical necessity, appropriateness, health care setting, level of care, effectiveness of a benefit or experimental or investigational determinations).
- Rescissions of Coverage: External review procedures apply to rescissions of coverage and whether a rescission has any effect on a particular benefit at the time of a rescission.

(Subject to certain exceptions, generally a rescission is a retroactive termination of coverage.)

External review procedures do not apply to any other adverse determination (other than medical judgment and rescissions as set forth above), including eligibility appeals.

COBRA COVERAGE

General Explanation of COBRA Rights

You and your dependents have the option to extend your Plan coverage at group rates in certain instances when coverage would otherwise end (or the cost of coverage would increase). This is called COBRA coverage. COBRA stands for the Consolidated Omnibus Budget Reconciliation Act of 1985. This section gives you a general description of your rights under COBRA.

COBRA Participation

If one of the circumstances listed in the COBRA continuation chart below causes you or a dependent to lose health coverage, you may continue group health plan coverage for yourself and your dependents if you pay the entire cost of coverage, with an additional 2 percent to cover administrative expenses.

Continued coverage is available for a maximum of 18, 29, or 36 months, depending on the circumstances outlined in the chart. The maximum continuation period if multiple circumstances should occur during the 18-month COBRA period is a total of 36 months. For example, if you terminate your employment and then die, your dependents' coverage may continue for 36 months, as long as COBRA was elected at termination and in effect at your death.

It is the responsibility of you, your spouse, or your dependent children to contact your Employer within 60 days of the event to request an application to continue participation due to your divorce or legal separation, death, or a child no longer qualifying as a dependent. Also, to extend coverage beyond 18 months because of disability, you or your covered dependent must become disabled for Social Security purposes within 60 days of the qualifying event, and notice of the Social Security Administration's determination must be provided both within the initial 18-month period and within 60 days of when the determination is made.

If the disability ceases, notice should be provided within 30 days of the final determination that the disability has ended. You or your dependents must pay the full group rate for continued coverage, with an additional 2 percent for administrative expenses. In addition, if you (or a dependent) are disabled and coverage continues for 29 months, during the 19th through 29th month of COBRA participation, the cost for coverage will be greater than that usually charged for COBRA coverage.

If COBRA is elected, the coverage previously in effect will generally be continued. From time to time, some changes in coverage are possible. For example, coverage and cost will be modified as the Employer makes regular changes to the programs, and you will be given the opportunity to make a new election during annual enrollment or when you have a change in

family status (if applicable). Any newly eligible dependents you may have may be covered under the same rules that apply to active employees.

You or your eligible dependents will have 60 days from the date the COBRA notice is mailed to elect continued participation under COBRA. An election by you or your spouse to continue coverage will apply to all the qualified beneficiaries losing coverage in the same qualifying event, unless the election specifies otherwise. You will continue participation in the HRA plan if you continue coverage under the Medical Premier CDHP or Medical Basic CDHP, whichever of the two plans was in effect at the time of the COBRA qualifying event. Once you make your election, you will have up to 45 days to pay any make-up premiums you missed and the monthly premium for the current month. COBRA coverage will be effective the day after the qualifying event.

TERMINATION OF COBRA

COBRA coverage will terminate before the end of the indicated time period if:

- You or your dependent becomes covered under another group healthcare plan after electing COBRA (provided the plan does not have pre-existing condition exclusions affecting the covered individuals).
- You or your dependents become entitled to Medicare after electing COBRA continuation coverage.
- The first required premium is not paid within 45 days or any subsequent premium is not paid within 30 days of the due date.
- If coverage is extended beyond 18 months because of disability, the date a final determination is made that the individual is no longer disabled.
- All health plans for active employees are terminated by your Employer.

COBRA CONTINUATION CHART

CIRCUMSTANCES	MAXIMUM CONTINUATION PERIOD		
	EMPLOYEE	SPOUSE	CHILD
Employee loses coverage because of reduced work hours	18 months	18 months	18 months
Employee terminates for any reason (except gross misconduct)	18 months	18 months	18 months
Employee or covered dependent is disabled (as defined by Title II or XVI of the Social Security Act) during the first 60 days of COBRA coverage	29 months	29 months	29 months
Employee dies	N/A	36 months	36 months
Employee and spouse legally separate or divorce	N/A	36 months	36 months
Employee becomes entitled to	N/A	36 months	36 months

CIRCUMSTANCES	MAXIMUM CONTINUATION PERIOD		
	EMPLOYEE	SPOUSE	CHILD
Medicare			
Child no longer qualifies as dependent	N/A	N/A	36 months

USERRA

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) established requirements that Employers must meet for certain employees who are involved in the uniformed services. If your coverage under the Plan terminates due to your service in the uniformed services, you may elect special continuation coverage under USERRA for yourself and your covered dependents. Please contact your Employer for additional information if you think these special rules apply to you.

AMENDMENT AND TERMINATION

Your Employer reserves the right to discontinue or terminate the Plan, or to reduce, amend or modify coverage in whole or in part and in any respect. The Claims Administrator also has the right to amend and revise certain provisions of the Plan document. This may be done at any time and without advance notice. Benefits for claims occurring after the effective date of a modification or termination are payable in accordance with the revised provisions of the Plan.

All statements in this Certificate of Coverage and all representations by your Employer, the Claims Administrator and their personnel are subject to this right of amendment and termination. This right applies without limitation even after an individual's circumstances have changed by retirement, termination or otherwise. Benefits do not become vested at any time.

MISCELLANEOUS

OFFICIAL PLAN INFORMATION

Your Plan coverage is an employee welfare benefit plan under the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

The official name of the Plan and other related information is located in the Powell Industries, Inc. Welfare Benefit Plan & Summary Plan Description plan document.

The financial and other records for the Plan are kept on a plan year basis. The Plan Year ends on each December 31.

PLAN SPONSOR AND PLAN ADMINISTRATOR

The plan sponsor is your Employer. Identifying and contact information for your Employer is located in the Adoption Agreement. The plan administrator is your Employer or other entity as

identified in the Powell Industries, Inc. Welfare Benefit Plan & Summary Plan Description plan document. Contact information for the plan administrator is located in the Powell Industries, Inc. Welfare Benefit Plan & Summary Plan Description plan document.

AGENT FOR SERVICE OF LEGAL PROCESS

Legal process may be served on your Employer. Identifying and contact information is located in the Powell Industries, Inc. Welfare Benefit Plan & Summary Plan Description plan document.

THIRD-PARTY ADMINISTRATOR / CLAIMS ADMINISTRATOR

Discovery Benefits, Inc. provides certain third-party administration services related to the Plan. Contact information is as follows –

Discovery Benefits, Inc.
3216 13th Avenue South
Fargo, ND 58103
Phone: (866) 451-3399
Fax: (866) 451-3245
www.discoverybenefits.com

PLAN FUNDING

Contributions for Plan coverage are made by your Employer. Benefits are self-insured and paid out of general assets of your Employer. The Claims Administrator is not responsible for funding or insuring Plan benefits.

NO GUARANTEE OF EMPLOYMENT

Nothing in the Plan or this Certificate of Coverage may or can be interpreted as a guarantee of future employment or continued employment for any duration.

YOUR RIGHTS UNDER ERISA

The following statement is required by federal law. As a participant in the group health plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to the following rights:

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

You may examine, without charge, at the Employer's office and at other specified locations, such as worksites, all documents governing the plans, 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.

You may obtain, upon written request to the Employer, copies of documents governing the operation of the plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary plan descriptions. The Employer may make a reasonable charge for the copies.

You will receive a summary of the plan's annual financial reports. The Employer is required by law to furnish each participant with a copy of this summary annual report.

CONTINUE GROUP HEALTH PLAN COVERAGE

You may continue coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Certificate of Coverage 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 employee benefit plans. The people who operate your plans, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a plan 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 any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the plan documents and/or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Employer to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Employer. 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 a 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 if, for example, it finds your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about a plan, you should contact your Employer. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in

obtaining documents from your Employer, you should contact the nearest 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.