## CERTIFICATE OF COVERAGE

The Certificate of Coverage found in the following pages comprises the Certificate Holder section of the Policy.

For purposes of this Certificate, “we, “us,” and “our” means Reliance Standard Life Insurance Company and “you,” “your,” and “yours” refers to an Eligible Person.

RELIANCE STANDARD
LIFE INSURANCE COMPANY

Home Office: Schaumburg, Illinois• Administrative Office: Philadelphia, Pennsylvania

**GROUP HOSPITAL INDEMNITY**
**CERTIFICATE OF INSURANCE**

Group Policy No. VHI 862429 ("the Policy") has been issued to Youth and Shelter Services DBA YSS which we will refer to as the Policyholder.

The Policy was delivered in Iowa and will be governed by the laws thereof and, to the extent applicable, the Employee Retirement Income Security Act of 1974 (ERISA) and any of its amendments.

This Certificate of Insurance is evidence of the Insured's insurance under the Policy and of its benefits. Everything contained in this Certificate of Insurance is subject to the provisions, definitions, and exceptions in the Policy. The Policy is on file with the Policyholder and may be examined at any reasonable time. Only one of our Executive Officers can authorize a change to the Policy.

This Certificate of Insurance replaces all Certificates and Certificate Riders, if any, previously issued to the Insured under the Policy.

READ THIS CERTIFICATE CAREFULLY

PRE-EXISTING CONDITIONS LIMITATIONS
ARE APPLICABLE TO COVERAGE UNDER THE POLICY.

**THIS POLICY PROVIDES LIMITED INJURY & SICKNESS COVERAGE. IT IS NOT A SUBSTITUTE FOR COMPREHENSIVE HEALTH INSURANCE COVERAGE AND DOES NOT QUALIFY AS MINIMUM ESSENTIAL HEALTH COVERAGE UNDER THE AFFORDABLE CARE ACT.**

This Certificate contains the major terms of insurance coverage and payment of benefits under the Policy. Coverage is subject to the terms and conditions of the Policy.

Receipt of benefits under the Policy may be taxable. We recommend that you contact your personal tax advisor.

Secretary

President

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## SCHEDULE OF BENEFITS

**EFFECTIVE DATE:** January 1, 2022

**ELIGIBLE CLASSES:** Each Active Full-time employee, except any person employed on a temporary or seasonal basis.

**BENEFIT WAITING PERIOD – LATE APPLICANT/BENEFIT INCREASE:** 30 days.

**INDIVIDUAL EFFECTIVE DATE:** Subject to payment of premium, the first day of the month coinciding with or next following the latest of:

1. The date an employee becomes part of an Eligible Class; and
2. The date an employee completes his/her enrollment form.

**INDIVIDUAL REINSTATEMENT:** 6 months

**PLAN YEAR:** Begins on January 1st and continues for the next 12 consecutive months and ends on December 31st.

**COVERAGE TYPE:** On and Off-the-Job (24 hour coverage)

**EMPLOYEE AND SPOUSE ELIGIBLE AGE:** You and your Dependent spouse must be under age 70 to enroll for insurance coverage. For purposes of eligibility, your Dependent spouse's age will be considered to be the same age as you. Throughout the Policy and this Certificate, your Dependent spouse's age will be considered the same age as you.

**CHANGES IN BENEFITS:** Increases in Benefit Amounts can be made during an approved enrollment period or within 31 days of a qualifying life event (such as marriage, birth, or specific changes in employment status). Any increase in Benefit Amounts made outside of an approved enrollment period or after 31 days following a qualified life event, will be subject to the limitations set forth in the Limitations – Late Application/Benefit Increase section.

Increases in Benefit Amounts are effective on the January 1st coinciding with or next following the date of the change, provided you are Actively at Work on the effective date of the change. If you are not Actively at Work when the change would otherwise take effect, the change will take effect on the day after you have returned to Active Work in an Eligible Class for one full day.

Decreases in the Benefit Amounts are effective on the January 1st coinciding with or next following the date of the change.

**CONTRIBUTIONS:** You are required to contribute towards the cost of your insurance. You are required to contribute towards the cost of your Dependent insurance.

## TYPE OF BENEFITS AND BENEFIT AMOUNTS:

**Maximum Benefit per Plan Year** Unlimited

The Maximum Benefit includes all benefits paid under this Policy, excluding any attached riders (if riders are included) and applies separately to each Insured.

| **Type of Benefits** | **Benefit Amount** |
|---|---|
| ***Hospital Admission Benefits*** | |
| Hospital Admission Benefit | $1000 per Admission |
| Plan Year Maximum | 1 benefit(s) |
| Hospital Admission Benefit – Nursery Care | $1000 per Admission |
| Plan Year Maximum | 1 benefit(s) |
| ***Hospital Confinement Benefits*** | |
| Hospital Confinement Benefit | $100 per day |
| Plan Year Maximum | 180 daily benefit(s) |
| Hospital Confinement Benefit– Nursery Care | $100 per day |
| Plan Year Maximum | 10 daily benefit(s) |

## DEFINITIONS

“Admission” or “Admitted” means an Insured receiving treatment for a Sickness or Injury in a Hospital, including and observation room or ICU, for a period of more than 23 hours.

"Actively at Work" and "Active Work" means you are actually performing on a Full-time basis each and every duty pertaining to your job in the place where and the manner in which the job is normally performed. This includes approved time off for vacation, jury duty and funeral leave, but does not include time off as a result of injury or sickness.

“Complications of Pregnancy” means:

(1) conditions requiring a Confinement whose diagnoses are distinct from pregnancy but are adversely affected or caused by pregnancy. Such conditions include:
    (a) Acute nephritis; or
    (b) Nephrosis; or
    (c) Cardiac decompensation; or
    (d) Pre-Eclampsia; or
    (e) Eclampsia; or
    (f) Puerperal Infection; or
    (g) Hyperemesis gravidarum; or
    (h) Other conditions of comparable severity;
(2) termination of ectopic pregnancy; or
(3) dilation curettage (D&C) or other miscarriage-related procedures; or
(4) non-elective cesarean section; or
(5) spontaneous end of pregnancy that occurs during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy does not include:
(1) elective cesarean section; or
(2) false labor; or
(3) morning sickness; or
(4) multiple gestation pregnancy; or
(5) occasional spotting; or
(6) rest during pregnancy prescribed by a Physician; or
(7) other conditions associated with pregnancy that are not diagnosed as a complication of pregnancy as defined above.

“Confinement” and “Confined” means the period of time that an Insured is Admitted into a Hospital and a bed is assigned. Confinement does not include any period of time during which an Insured is in observation, an Emergency Room less than 23 hours, recovery room, freestanding surgical facility or an outpatient surgery facility. If an Insured is transferred from one Hospital to another during Confinement, we will treat the transfer as a continuation of the first Confinement.

“Covered Event" means the Sickness or Injury for which benefits under the Policy are payable. For a Sickness to be considered as a Covered Event, the Confinement must begin while the Policy is in force.

“Dependent” means:

(1) your legal spouse; and
(2) your child(ren), birth to 26 years, including natural children, legally adopted children, children who are dependent on you during the waiting period before adoption, stepchildren, and foster children. Foster children must be in your custody to be considered a Dependent; and
(3) your child(ren) beyond the limiting age who is incapable of self-sustaining employment by reason of intellectual disability or physical handicap and who is chiefly dependent on you for support and maintenance.

“Eligible Person” means a person who meets the eligibility requirements of this Policy, as stated in the Eligible Classes.

"Full-time" means working for the Policyholder for a minimum of 30 hours during a regularly scheduled workweek.

“Hospital" means a legally operated institution for the care and treatment of injured or sick persons that has organized facilities for diagnosis and surgery or has a contract with another hospital for these facilities and has 24-

hour nursing service. Hospital excludes any institution that is primarily a rest home, nursing home, convalescent home, or a home for the aged, a facility for treatment of alcoholism or drug addiction, or a facility for treatment of mental disorders.

“Immediate Family” means your parents, siblings, spouse (or civil union or domestic partner) or children.

"Injury" means a sudden, unforeseeable event that causes bodily injury to an Insured resulting directly from an accident independent of all other causes, which occurs while the Insured’s coverage under the Policy is in force.

“Inpatient” means an Insured who is Confined.

“Insured Person” means a person who meets the eligibility requirements of the Policy, as stated in the Eligible Classes, and is enrolled for this insurance, and whose insurance under the Policy is in effect.

“Insured Dependent" means a "Dependent" as defined, whose insurance under the Policy is in effect.

"Insured" means a person whose insurance under the Policy is in effect.

“Intensive Care Unit (ICU)” means a pre-designated and fixed medical/surgical care area within a Hospital that:

(1) is utilized exclusively for the treatment of patients who are there because of their acute and serious condition; and
(2) provides continuous 24-hour monitoring of each patient’s vital physiological responses; and
(3) has emergency life-saving equipment and supplies that are immediately accessible; and
(4) is staffed with nurses specially trained for duty in such an area; and
(5) is not primarily a post-operative or post-anesthesia area.

“Medically Necessary” means the care, treatment or supply is:

(1) rendered for the diagnosis, treatment, care or relief of a health condition, Sickness, Injury, or their symptoms; and
(2) necessary for and appropriate to the diagnosis or treatment according to the attending medical care provider.

“Nursery Care” means routine well baby care provided to an Insured Person’s newborn baby while the baby is Confined from birth.

“Outpatient” means an Insured who receives treatment or services at a Hospital, freestanding surgical facility, laboratory, medical clinic, Physician’s office/clinic, radiologic center or other licensed medical facility and is neither Confined nor charged for room and board.

“Physician” means a duly licensed:

(1) medical or osteopathic doctor; or
(2) medical practitioner who is recognized by the law of the jurisdiction in which treatment is provided as qualified to treat the type of Injury or Sickness for which treatment is sought.

Physician may not be you or a member of your Immediate Family.

“Pre-Existing Condition” means any medical condition, whether specifically diagnosed or not, for which an Insured received medical treatment, consultation, care or services, including diagnostic procedures, or took prescribed drugs or medicines, during the twelve (12) months immediately prior to the Insured’s effective date of insurance.

“Sickness” means a physical or mental disease or disorder, including pregnancy and Complications of Pregnancy.

“Urgent Care Facility” means a licensed, free-standing medical center that provides urgent or immediate short-term medical care without an appointment, other than a Hospital, any outpatient department within a Hospital, emergency room or Physician office or clinic that must be supervised by a Physician and provide treatment by Physicians.

## GENERAL PROVISIONS

**INCONTESTABILITY:** Any statement made by you or your Dependent(s) to persuade us to provide coverage, will be deemed a representation, not a warranty. This provision limits our use of these statements in contesting the Benefit Amounts for which the Insured is covered. The following rules apply to each statement:

(1) No statement will be used in a contest unless:
    (a) it is in written form signed by the Insured; and
    (b) a copy of such written instrument is, or has been, furnished to the Insured's beneficiary or legal representative.
(2) If the statement relates to your or your Dependents' insurability, it will not be used to contest the validity of insurance that has been in force, before the contest, for at least two years during the Insured's lifetime. In addition, we will not use such statements to contest a benefit increase after such benefit increase has been in force for two years during the Insured's lifetime.

**CLERICAL ERROR:** Clerical errors in connection with the Policy or delays in keeping records for the Policy, whether by the Policyholder, us, or the plan administrator:

(1) will not terminate insurance that would otherwise have been effective; and
(2) will not continue insurance that would otherwise have ceased or should not have been in effect.

If appropriate, a fair adjustment of premium will be made to correct a clerical error.

Clerical Errors include (but are not limited to) the payment of premium for coverage not provided by the Policy. If appropriate, a fair adjustment of premium will be made to correct a clerical error. Such adjustments will be limited to the 6 month period preceding the date we receive proof from you that an adjustment due to overpayment of premium should be made or the date we discover that premium has been underpaid.

**MISSTATEMENT OF FACTS:** If relevant facts about any person were misstated:

(1) an adjustment of the premium will be made; and
(2) the true facts will decide what amount of insurance is valid under the Policy.

If any misstated fact impacts the amount of premium that should have been paid, any benefit payable shall be in the amount the paid premium would have purchased based on the correct fact(s).

**ASSIGNMENT:** The benefits under the Policy may not be assigned, except as required by law.

**NOT IN LIEU OF WORKERS' COMPENSATION:** The Policy is not a Workers' Compensation Policy. It does not provide Workers' Compensation benefits.

## INDIVIDUAL ELIGIBILITY, EFFECTIVE DATE AND TERMINATION

**ELIGIBLE CLASSES:** The eligible classes will be those persons described on the Schedule of Benefits.

**ELIGIBILITY REQUIREMENTS:** You are eligible for insurance under the Policy if you are a member of an Eligible Class, as shown on the Schedule of Benefits page.

**EFFECTIVE DATE OF INDIVIDUAL INSURANCE:** The insurance of an Eligible Person will go into effect on the date stated on the Schedule of Benefits. If you, as an Eligible Person, pay any part of the premium, you must apply within 31 days from the date you first met the eligibility requirements for the insurance to go effect. If you do not apply within that period, you will not be able to apply until an approved enrollment period or within 31 days of a qualifying life event. If you do not apply within that period of time, during an approved enrollment period, or within 31 days of a qualifying life event, you may still apply but will be subject to the limitations set forth in the Limitations -Late Enrollment/Benefit increase section.

**TERMINATION OF INDIVIDUAL INSURANCE:** An Insured Person's coverage will terminate on the first of the following to occur:

(1) the date the Policy terminates; or
(2) the date you cease to be in a class eligible for this insurance; or
(3) the end of the period for which premium has been paid; or
(4) the date you enter military service on active duty (not including Reserve or National Guard).

**INDIVIDUAL REINSTATEMENT:** Insurance may be reinstated if you, as a former Insured Person, have been:

(1) on an approved leave of absence; or
(2) on temporary lay-off.

You, as the former Insured Person, must return to Active Work with the Policyholder within the period of time shown on the Schedule of Benefits. You must also be a member of a class eligible for this insurance.

The insurance will go into effect on the day you return to Active Work for one full day. However, if you return after having resigned or having been discharged, you will be required to fulfill the eligibility requirements of the Policy again.

## DEPENDENT INSURANCE

Nothing in this section will change or affect any of the terms of the Policy other than as specifically set out in this section. All the Policy provisions not in conflict with these provisions shall apply to this section.

Only dependents that meet the definition of Dependent can be insured for this benefit.

A person may not have coverage under the Policy both as an Insured Person and as an Insured Dependent. Only one eligible spouse may cover the eligible children as Insured Dependents. The spouse may be covered as a Dependent if not covered as an Insured. If insurance is in force for one Insured Dependent child, any newly eligible Dependent child(ren) will be automatically insured.

**ELIGIBILITY:** You, as an Eligible Person, may enroll your Dependent(s) on the date you become an Insured Person.

**EFFECTIVE DATE OF DEPENDENT INSURANCE:** If the Policyholder pays the entire premium for Dependent(s), an Insured Dependent's insurance will become effective on the later of:

(1) the first day of the month coinciding with or next following the date you become eligible for Dependent Insurance; or
(2) the first day of the month coinciding with or next following the date your dependent meets the definition of Dependent.

If you pay any portion of the Dependent premium for Dependent insurance, you may insure your Dependent(s) by applying for the insurance. In this case, the insurance for Dependent(s) will take effect on the later of:

(1) the first day of the month coinciding with or next following the date you become eligible for Dependent insurance; or
(2) the first day of the month coinciding with or next following the date the dependent meets the definition of Dependent, if application is made on or before that date; or
(3) the first day of the month coinciding with or next following the date of application if application is made within 31 days from the date your Dependent first becomes eligible for this insurance.

Changes in your Insured Dependent's benefits are effective as shown on the Schedule of Benefits.

**DEPENDENT SPOUSE:** For a Dependent spouse who is confined in a Hospital or medical facility or at home on the date on which she/he would otherwise become insured, insurance will be effective as of the date of the confinement ends. This requirement does not apply to newborns of the Insured Person.

**NEWLYWED:** If an Insured Person gets married and had not previously elected Dependent spouse coverage, his/her new spouse shall automatically become an Insured Dependent spouse provided that the spouse is not confined in a Hospital or medical facility or confined at home due to a medical condition.

The spouse shall be an Insured Dependent spouse for 31 days. He/she shall then cease to be an Insured Dependent spouse unless:
(1) the Insured Person requests continuation of such Dependent spouse coverage within the 31 day period; and
(2) the additional premium is paid for such coverage.

**NEWBORN CHILD:** An Insured Person's child born while the Policy is in force is provided coverage for benefits under the Policy for the first 31 days. He/she shall then cease to be an Insured Dependent child unless:
(1) the Insured Person requests continuation of such Dependent child(ren) coverage within 31 day period; and
(2) the additional premium is paid for such coverage.

The above coverage will also be extended to newly adopted, foster or stepchildren, as of the date they become financially dependent on the Insured Person for support, provided they otherwise meet the definition of Dependent.

**TERMINATION OF DEPENDENT INSURANCE:** The insurance for Insured Dependent(s) will terminate on the first of the following dates:

(1) the date this Section of the Certificate terminates;
(2) the end of the period for which premium for the Dependent insurance has been paid;
(3) the date the Insured Person's insurance terminates; or
(4) the date the dependent is no longer a Dependent as defined in this Certificate

## CONTINUATION OF INDIVIDUAL INSURANCE

**TEMPORARY CONTINUATION OF INDIVIDUAL INSURANCE:** An Insured Person no longer eligible for coverage may continue his/her coverage and that of his/her Insured Dependent's coverage by payment of premium, beyond the date the Insured Person ceases to be eligible for insurance, but not longer than:

(1) 12 months, if due to Sickness or Injury; or
(2) 1 month, if due to temporary lay-off; or
(3) 1 month, if due to approved leave of absence.

**EXTENSION OF BENEFITS:** If an Insured is Confined on the date his/her insurance ends and his/her Confinement continues beyond the end date, and coverage is not continued under the Temporary Continuation of Individual Insurance provision or Portability provision we will pay the following benefits, subject to the terms and conditions of this Certificate:

(1) Hospital Confinement; and
(2) Hospital Confinement – Nursery Care.

However, these benefits will not be available to the Insured under this provision if:

(1) the Insured's insurance ends due to non-payment of premium; or
(2) coverage ended as a result of the Insured's voluntary termination of coverage; or
(3) benefits are not related to the same Covered Event as that which caused the Confinement.

If the benefits under this provision are payable, the benefits will end on the earlier of:

(1) the date the Insured is no longer Confined; or
(2) 90 days after the date the Insured's coverage under the Policy ends; or
(3) the date the Insured reaches the Plan Maximum for the Confinement benefits.

If the Insured is Confined again at any time after discharge, no further benefits will be payable.

**PORTABILITY:** An Insured Person may continue coverage and that of his/her Insured Dependent(s) under the Policy if coverage would otherwise terminate because the Insured Person ceases to be an Eligible Person, for reasons other than the termination of the Policy, or the Insured Person's retirement, provided the former Insured Person:

(1) notifies us within 31 days from the date he/she ceases to be eligible; and

(2) remits the necessary premiums when due.

The benefits available under this provision will be the current benefits that the Insured Person is and his/her Insured Dependents are insured for under the Policy on the last day the Insured Person was Actively at Work.

The premium charged to continue coverage will be based on the prevailing rate charged to all Insureds who choose to continue coverage under this provision. Such premium will be billed directly to the Insured Person on a monthly basis.

Insurance coverage continued under this provision will terminate on the first of the following to occur:

(1) the end of the period for which premium has been paid; or
(2) the date the Insured Person attains age 70; or
(3) at any time coverage would normally terminate according to the terms of the Policy had the Insured Person continued to be an Eligible Person.

If the Policy terminates subsequent to an Insured Person's election to continue coverage in accordance with this provision, such coverage will be continued in accordance with the provisions of the Certificate.

## BENEFIT PROVISIONS

The following provisions describe the benefits we will pay as set forth on the Schedule of Benefits. Except as described in the Extension of Benefit provision, we will pay benefits only while an Insured is covered under the Policy.

***HOSPITAL ADMISSION BENEFITS*:**

If more than one type of Hospital Admission occurs during the same Confinement, only the highest Hospital Admission Benefit is payable.

If the Insured is admitted to a Hospital within 90 days after being discharged from a preceding Hospital Admission for the same or related cause, the second admission will be considered part of the first Hospital Admission.

**Hospital Admission Benefit:** We will pay the applicable Benefit Amount shown on the Schedule of Benefits for the day an Insured is Admitted to a Hospital if:

(1) the Admission is Medically Necessary; and
(2) the Insured is under a Physician's care.

This benefit does not apply to treatment received in an Emergency Room or observation room or for newborn Nursery Care.

This benefit is payable at most once per period of Confinement.

**Hospital Admission Benefit – Nursery Care:** We will pay the applicable Benefit Amount as shown on the Schedule of Benefits if, after delivery, an Insured Person's newborn stays in the Hospital for Nursery Care.

This benefit is payable at most once for the duration of the newborn's stay in Nursery Care.

***HOSPITAL CONFINEMENT BENEFITS*:**

If more than one type of Hospital Confinement occurs on the same day, only the highest Hospital Confinement Benefit is payable.

**Hospital Confinement Benefit:** We will pay the applicable daily Benefit Amount shown on the Schedule of Benefits for each day an Insured is Confined in a Hospital if:

(1) the Hospital Confinement is Medically Necessary; and
(2) the Insured is under a Physician's care.

Payment of the applicable daily benefit will start on the first day of Confinement.

This benefit is payable at most once per day.

This benefit does not apply to newborn Nursery Care.

**Hospital Confinement Benefit – Nursery Care:** We will pay the applicable daily Benefit Amount shown on the Schedule of Benefits for each day after delivery that an Insured Person's newborn is Confined in the Hospital for Nursery Care until discharge.

This benefit is payable at most once per day.

## CLAIM PROVISIONS

**NOTICE OF CLAIM:** Written notice must be given to us within 31 days after the service or event occurs for which claim may be made, or as soon as reasonably possible. The notice must be sent to us at our Administrative Offices or to our authorized agent. The notice should include the Insured's name and the Policy Number.

**CLAIM FORMS:** When we receive notice of a claim, we will send claim forms to the claimant within 15 days. If we do not, the claimant will satisfy the requirements of written proof of loss by sending us written proof as shown below. The proof must describe the occurrence, extent and nature of the claim.

**PROOF OF CLAIM:** Written proof must be sent to us within 90 days after the date of services or the occurrence of an event, or as soon as reasonably possible thereafter. In any event, proof must be given within one year, unless the claimant is legally incapable of doing so.

Proof of claim must include:

(1) the nature and date of the claim and reason claim is being made; and
(2) a description of the event and/or services provided; and
(3) proof that the services or event occurred. Such proof may take the form of a receipt for services or some other official documentation supporting the claim and which is acceptable to us; and
(4) an Explanation of Benefits (EOB) or other proof of payment from Prior Plan, when applicable.

Within 15 days after receiving the first proof of claim, we may send a written acknowledgment. Such acknowledgment may request any missing information or other items we need in order to adjudicate the claim.
Such information or items we may request may include, but are not limited to:

(1) copies of x-rays or any other diagnostic tests performed; or
(2) copies of medical records or charts; or
(3) any other information we may reasonably require.

**TIME OF PAYMENT OF CLAIMS:** When we receive satisfactory written proof of loss, we will pay any benefits due.

**PAYMENT OF CLAIMS:** All benefits will be paid to the Insured, if living. If the Insured dies, we will pay any accrued benefits to the first of the following classes to survive the Insured:

(1) legal spouse;
(2) surviving children (including legally adopted children), in equal shares;
(3) surviving parents, in equal shares;
(4) surviving siblings, in equal shares; or if no one of the above,
(5) the Insured’s estate.

We will not be liable for any payment we have made in good faith.

Reliance Standard Life Insurance Company shall serve as the claims review fiduciary with respect to the insurance policy and the Plan. The claims review fiduciary has the discretionary authority to interpret the Plan and the insurance policy and to determine eligibility for benefits. Decisions by the claims review fiduciary shall be complete, final and binding on all parties.

**PHYSICAL EXAMINATIONAND AUTOPSY:** At our own expense, we will have the right to have the Insured examined as often as reasonably necessary when a claim is pending. We can also have an autopsy performed unless prohibited by law.

**LEGAL ACTION:** No legal action may be brought against us to recover on the Policy within sixty (60) days after written proof of claim has been given as required by the Policy. No action may be brought after three (3) years (Kansas, five (5) years; South Carolina, six (6) years) from the time written proof of claim is required to be submitted.

## EXTENSION OF COVERAGE UNDER THE FAMILY AND MEDICAL LEAVE ACT AND UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

**Family and Medical Leave of Absence:**

We will continue an Insured's, if applicable, in accordance with the Policyholder's policies regarding leave under the Family and Medical Leave Act of 1993, as amended, or any similar state law, as amended, if:

(1) the premium for the Insured, if applicable, continues to be paid during the leave; and
(2) the Policyholder has approved the Insured Person's leave in writing and the Policyholder provides a copy of such approval within thirty-one (31) days of our request.

As long as the above requirements are satisfied, we will continue coverage until the later of:

(1) the end of the leave period required by the Family and Medical Leave Act of 1993, as amended; or
(2) the end of the leave period required by any similar state law, as amended.

**Military Services Leave of Absence:**

We will continue an Insured's coverage, if applicable, in accordance with the Policyholder's policies regarding Military Services Leave of Absence under USERRA if the premium for the Insured, if applicable, continues to be paid during the leave.

As long as the above requirement is satisfied, we will continue coverage until the end of the period required by USERRA.

The Policy, while coverage is being continued under this Military Services Leave of Absence extension, does not cover any loss which occurs while on active duty in the military if such loss is caused by or arises out of such military service, including but not limited to war or any act of war, whether declared or undeclared.

While you are on a Family and Medical Leave of Absence for any reason other than your own illness or injury, or Military Services Leave of Absence, you will be considered Actively at Work. Any changes such as revisions to coverage due to change in class will apply during the leave except that increases in your Benefit Amounts, whether automatic or subject to election, will not be effective for you if you are not considered Actively at Work until you have returned to Active Work in an eligible class for one (1) full day.

A leave of absence taken in accordance with the Family and Medical Leave Act of 1993 or USERRA will run concurrently with any other applicable continuation of insurance provision in the Policy.

An Insured's coverage will cease under this extension on the earliest of:

(1) the date the Policy terminates; or
(2) the end of the period for which premium has been paid for the Insured; or
(3) the date such leave should end in accordance with the Policyholder's policies regarding Family and Medical Leave of Absence and Military Services Leave of Absence in compliance with the Family and Medical Leave Act of 1993, as amended and USERRA.

Should the Policyholder choose not to continue your coverage during a Family and Medical Leave of Absence and/or Military Services Leave of Absence, your coverage as well as any Dependent coverage, if applicable, will be reinstated in accordance with the Family and Medical Leave Act and USERRA.

## LIMITATIONS – LATE APPLICANT/BENEFIT INCREASE

For this section only, “benefits” will refer to the entire Benefit Amount, when requested by a late applicant.

**BENEFIT WAITING PERIOD LATE APPLICANT/BENEFIT INCREASE:** The period of time, shown on the Schedule of Benefits page, an Insured must be covered under the Policy before benefits are payable. If a Confinement begins during the Benefit Waiting Period Late Applicant/Benefit Increase, benefits will be payable for services rendered after the Benefit Waiting Period Late Applicant/Benefit Increase has been fulfilled. The Benefit Waiting Period Late Applicant/Benefit Increase is not applicable for a Covered Event that results from an Injury.

**PRE-EXISTING CONDITION LIMITATION:** We will not pay any benefits for any treatment or services received as a result of a Covered Event that began during the first twelve (12) months after an Insured’s Effective Date of insurance or Effective Date of Benefit Amount increase that is caused or contributed to by a Pre-Existing Condition.

## EXCLUSIONS

The Policy does not cover any Sickness or Injury:

(1) caused by committing or attempting to commit suicide, while sane or insane, or intentionally self-inflicted injuries; or

(2) caused by or resulting from war or any act of war, declared or undeclared; or

(3) caused by or resulting from riding in, getting into or out of any aircraft unless:

(a) an Insured is a passenger (not a pilot or crew member) in a tested and approved civilian aircraft being operated as passenger transport in compliance with the then current rules of the authority having jurisdiction over its operation; and

(b) the aircraft is not owned, leased or operated by or on behalf of the the Policyholder, an Insured, or any other employer of the Insured, unless a specific written agreement has been obtained from us; or

(4) sustained during an Insured's commission or attempted commission of an assault or felony; or

(5) caused by elective surgery, except when required for appropriate care as determined by a Physician as a result of an Insured’s Injury or Sickness.

In addition to the above exclusions, no benefits will be paid for care, treatment or supplies rendered to an Insured while outside of the United States of America.

**NOTICE OF PROTECTION PROVIDED BY**
**IOWA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION**

This notice provides a brief summary of the Iowa Life and Health Insurance Guaranty Association (the "Association") and the protection it provides for policyholders. This safety net was created under Iowa law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Iowa law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

Life Insurance
- $300,000 in death benefits
- $100,000 in cash surrender and withdrawal values

Health Insurance
- $500,000 in basic hospital, medical-surgical or major medical insurance benefits
- $300,000 in disability income protection insurance benefits
- $300,000 in long-term care insurance benefits
- $100,000 in other types of health insurance benefits

Annuities
- $250,000 in annuity benefits, cash surrender and withdrawal values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $350,000. Special rules may apply with regard to hospital, medical-surgical and major medical insurance benefits.

**Note: Certain policies and contracts may not be covered or fully covered.** If coverage is available, it will be subject to substantial limitations and exclusions. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements under Iowa law.

To learn more about the Association and the protections it provides, as well as those relating to group contracts or retirement plans, please visit the Association's website at www.ialifega.org, or contact:

Iowa Life and Health Insurance
Guaranty Association
700 Walnut Street, Suite 1600
Des Moines, IA 50309
(515) 248-5712

Iowa Insurance Division
330 Maple Street
Des Moines, IA 50319
(515) 281-5705

Information about the financial condition of insurers is available from a variety of sources, including financial rating agencies such as AM Best Company, Fitch Inc., Moody's Investors Service, Inc., and Standard & Poor's. That information may be accessed from the "Helpful Links & Information" page located on the website of the Iowa Insurance Division at www.iid.state.ia.us.

The Association is subject to supervision and regulation by the Commissioner of the Iowa Insurance Division. Persons who desire to file a complaint to allege a violation of the laws governing the Association may contact the Iowa Insurance Division. State law provides that any suit against the Association shall be brought in the Iowa District Court in Polk County, Iowa.

**Insurance companies and agents are not allowed by Iowa law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Iowa law, then Iowa law will control.**

# Claim Procedures and ERISA Statement of Rights

**CLAIM PROCEDURES FOR CLAIMS FILED WITH**
**RELIANCE STANDARD LIFE INSURANCE COMPANY**
**ON OR AFTER APRIL 1, 2018**

## CLAIMS FOR BENEFITS

Claims may be submitted by mailing the completed form along with any requested information to:

Reliance Standard Life Insurance Company
Claims Department
P.O. Box 8330
Philadelphia, PA 19101-8330

Claim forms are available from your benefits representative or may be requested by writing to the above address or by calling 1-800-644-1103.

In the event of any *Adverse Benefit Determination* (defined below), the claimant (or their authorized representative) may appeal that *Adverse Benefit Determination* in accordance with the following procedures. This opportunity to appeal exists without regard to the applicability of the Employee Retirement Income Security Act of 1974 as amended ("ERISA"), 29 U.S.C. 1001 *et seq.*

## TIMING OF NOTIFICATION OF BENEFIT DETERMINATION

Non-Disability Benefit Claims
If a non-disability claim is wholly or partially denied, the claimant shall be notified of the Adverse Benefit Determination within a reasonable period of time, but not later than 90 days after our receipt of the claim, unless it is determined that special circumstances require an extension of time for processing the claim. If it is determined that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the benefit determination is expected to be rendered.

Calculating time periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is filed, without regard to whether all the information necessary to make a benefit determination accompanies the filing.

Disability Benefit Claims
In the case of a claim for disability benefits, the claimant shall be notified of the Adverse Benefit Determination within a reasonable period of time, but not later than 45 days after our receipt of the claim. This period may be extended for up to 30 days, provided that it is determined that such an extension is necessary due to matters beyond our control and that notification is provided to the claimant, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered. If, prior to the end of the first 30-day extension period, it is determined that, due to matters beyond our control, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the claimant is notified, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date by which a decision is expected to be rendered. In the case of any such extension, the notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the claimant shall be afforded at least 45 days within which to provide the specified information.

Calculating time periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is filed, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event that a period of time is extended due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

**MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION**

Non-Disability Benefit Claims
A Claimant shall be provided with written notification of any Adverse Benefit Determination. The notification shall set forth, in a manner calculated to be understood by the claimant, the following:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific plan/policy provisions on which the determination is 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; and
4. A description of the review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974 as amended ("ERISA") (where applicable), following an Adverse Benefit Determination on Review.

Disability Benefit Claims
A claimant shall be provided with written notification of any Adverse Benefit Determination. The notification shall be set forth, in a manner calculated to be understood by the claimant, the following:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific plan/policy provisions on which the determination is 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 review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974 as amended ("ERISA") (where applicable), following an Adverse Benefit Determination on Review; and
5. A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
   a) The views presented by the claimant to the plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;
   b) The views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination; and
   c) A disability determination regarding the claimant presented by the claimant to the plan made by the Social Security Administration;
6. Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making the adverse determination, or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist;
7. 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 (defined below) to a claim for benefits; and
8. The notification shall be provided in a Culturally and Linguistically Appropriate (defined below) manner.

**APPEALS OF ADVERSE BENEFIT DETERMINATIONS**

Appeals of Adverse Benefit Determinations may be submitted in accordance with the following procedures to:

Reliance Standard Life Insurance Company
Quality Review Unit
P.O. Box 8330
Philadelphia, PA 19101-8330

Non-Disability Benefit Claims
1. Claimants (or their authorized representatives) must appeal within 60 days following their receipt of a notification of an Adverse Benefit Determination, and only one appeal is allowed;
2. Claimants shall be provided with the opportunity to submit written comments, documents, records, and/or other information relating to the claim for benefits in conjunction with their timely appeal;
3. Claimants shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;
4. The review on (timely) appeal shall 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 benefit determination;
5. No deference to the initial Adverse Benefit Determination shall be afforded upon appeal;

6. The appeal shall be conducted by an individual who is neither the individual who made the (underlying) Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual; and
7. Any medical or vocational expert(s) whose advice was obtained in connection with a claimant's Adverse Benefit Determination shall be identified, without regard to whether the advice was relied upon in making the benefit determination.

Disability Benefit Claims

1. Claimants (or their authorized representatives) must appeal within 180 days following their receipt of a notification of an Adverse Benefit Determination, and only one appeal is allowed;
2. Claimants shall be provided with the opportunity to submit written comments, documents, records, and/or other information relating to the claim for benefits in conjunction with their timely appeal;
3. Claimants shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information Relevant (defined below) to the claimant's claim for benefits;
4. The review on (timely) appeal shall 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 benefit determination;
5. No deference to the initial Adverse Benefit Determination shall be afforded upon appeal;
6. The appeal shall be conducted by an individual who is neither the individual who made the (underlying) Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;
7. Any medical or vocational expert(s) whose advice was obtained in connection with a claimant's Adverse Benefit Determination shall be identified, without regard to whether the advice was relied upon in making the benefit determination;
8. In deciding the appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, the individual conducting the appeal shall consult with a health care professional:

   (a) who has appropriate training and experience in the field of medicine involved in the medical judgment; and
   (b) who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal; nor the subordinate of any such individual.

**TIMING OF NOTIFICATION OF BENEFIT DETERMINATION ON REVIEW**

Non-Disability Benefit Claims

The claimant (or their authorized representative) shall be notified of the benefit determination on review within a reasonable period of time, but not later than 60 days after receipt of the claimant's timely request for review, unless it is determined that special circumstances require an extension of time for processing the appeal. If it is determined that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 60-day period. In no event shall such extension exceed a period of 60 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the determination on review is expected to be rendered.

Calculating time periods. The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is timely filed, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as above due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

Disability Benefit Claims

The claimant (or their authorized representative) shall be notified of the benefit determination on review within a reasonable period of time, but not later than 45 days after receipt of the claimant's timely request for review, unless it is determined that special circumstances require an extension of time for processing the appeal. If it is determined that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 45-day period. In no event shall such extension exceed a period of 45 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the determination on review is expected to be rendered.

Calculating time periods. The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is timely filed, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as above due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination on

review shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

**MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION ON REVIEW**

Non-Disability Benefit Claims

A claimant shall be provided with written notification of the benefit determination on review. In the case of an Adverse Benefit Determination on Review, the notification shall set forth, in a manner calculated to be understood by the claimant, the following:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific plan/policy provisions on which the determination is based;
3. 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 (defined below) to the claimant's claim for benefits; and
4. A statement of the claimant's right to bring an action under section 502(a) of ERISA (where applicable).

Disability Benefit Claims

A claimant must be provided with written notification of the determination on review. In the case of Adverse Benefit Determination on Review, the notification shall set forth, in a manner calculated to be understood by the claimant, the following:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific plan/policy provisions on which the determination is based;
3. 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 (defined below) to the claimant's claim for benefits;
4. A statement of the claimant's right to bring an action under section 502(a) of ERISA (where applicable) as well as a description of any applicable contractual limitations period that applies to the claimant's right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim;
5. A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
   a) The views presented by the claimant to the plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;
   b) The views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination; and
   c) A disability determination regarding the claimant presented by the claimant to the plan made by the Social Security Administration;
6. Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making the adverse determination, or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist;
7. 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 (defined below) to a claim for benefits; and
8. The notification shall be provided in a Culturally and Linguistically Appropriate (defined below) manner.

**REQUESTS CONCERNING ALLEGED VIOLATION OF THESE PROCEDURES**

In the event that a claimant requests a written explanation of any alleged violation of these procedures, such explanation should be provided within 10 days, including a specific description of any basis for asserting that any violation should not cause any administrative remedies available under the plan to be exhausted (where applicable).

**DEFINITIONS**

The term "Adverse Benefit Determination" means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan.

The term "Culturally and Linguistically Appropriate Manner" means:

- Oral language services (such as telephone customer assistance hotline) that includes answering questions in any Applicable Non-English Language and providing assistance with filing claims and appeals in any Applicable Non-English Language must be provided;
- A notice in any Applicable Non-English Language must be provided upon request; and
- A statement prominently displayed in any Applicable Non-English Language clearly indicating how to access the language services provided must be included in the English versions of all notices.

The term "Applicable Non-English Language" means:
With respect to an address in any United States county to which a notice is sent, a non-English language is an Applicable Non-English Language if ten percent or more of the population residing in the county is literate only in the same non-English language as determined in guidance published by the United States Secretary of Health and Human Services.

The term "us" or "our" refers to Reliance Standard Life Insurance Company.

The term "Relevant" means:

A document, record, or other information shall be considered relevant to a claimant's claim if such document, record or other information:

- Was relied upon in making the benefit determination;
- Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination;
- Demonstrates compliance with administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with governing plan documents and that, where appropriate, the plan provisions have been applied consistently with respect to similarly situated claimants; or
- In the case of a plan providing disability benefits, constitutes a statement of policy or guidance with respect to the plan concerning the denied benefit of the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

The term "Reliance Standard Life Insurance Company" means Reliance Standard Life Insurance Company and/or its authorized claim administrators.

## ERISA STATEMENT OF RIGHTS

As a participant in the Group Insurance Plan, you may be entitled to certain rights and protections in the event that the Employee Retirement Income Security Act of 1974 (ERISA) applies. ERISA provides that all Plan Participants shall be entitled to:

**Receive Information About Your Plan and Benefits**

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including

insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The 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.

**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 benefits plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interests of you and other Plan Participants and Beneficiaries. No one, including your employer, your union, 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.

Reliance Standard Life Insurance Company shall serve as the claims review fiduciary with respect to the insurance policy and the Plan. The claims review fiduciary has the discretionary authority to interpret the Plan and the insurance policy and to determine eligibility for benefits. Decisions by the claims review fiduciary shall be complete, final and binding on all parties.

**Enforce Your Rights**

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Plan documents 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 Plan Administrator 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 Administrator. If you have a claim for benefits which is denied or ignored, in whole or 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 domestic relations order or 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.

**Assistance with Your Questions**

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