Pension and Health Care Coverage...

Questions and Answers for Dislocated Workers

U.S. Department of Labor
Employee Benefits Security Administration

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The Employee Benefits Security Administration (EBSA) was formerly known as the Pension and Welfare Benefits Administration (PWBA).

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Introduction

Plant and business closings, downsizings, and reductions in hours affect employees in numerous adverse ways. Workers lose income, the security of a steady job and, often, the health and other benefits that go along with working full time. As a dislocated worker, you may have many questions, some of them concerning your health and pension benefits. For instance, *Do I have access to my retirement funds? What happens to my health insurance coverage? Can I continue health benefits until I get another job?*

You may have rights to certain pension protections and health benefits even if you lose your job. If your company provided a group health insurance plan, you may be entitled to continued health benefits for a period of time. When you find a new job, you may have fewer barriers to health care coverage. And with a change in employment, you should understand how your pension benefits are affected. Knowing your rights can help you protect yourself and your family until you are working full time again.

This booklet addresses some of the common questions dislocated workers ask. In addition, there is a brief guide to additional resources at the back. Together, they can help you in making critical decisions about continued health care coverage and about your pension benefits.

Protecting Your Pension and Health Benefits

The Employee Benefits Security Administration (EBSA) enforces and administers the Employee Retirement Income Security Act of 1974 (ERISA), the nation's major pension law. This piece of legislation provides a number of rights and protections for private-sector pension and health benefit plan participants and their beneficiaries.

There have been a number of amendments to ERISA, expanding the protections available to pension and health benefit plan participants and beneficiaries. One important amendment, the Consolidated Omnibus Budget and Reconciliation Act of 1986 (COBRA), provides some workers with the right to continue their health benefit coverage for a limited time after they lose their jobs.

A more recent amendment to ERISA is the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This piece of legislation includes important new protections for millions of working Americans and their families who have preexisting medical conditions or who might otherwise suffer discrimination in health coverage based on factors that relate to an individual's health.

The following questions and answers pertain to these laws and how they may affect you.

COBRA - Health Benefits

One of the first questions dislocated workers ask is: What happens to my health insurance?

While dislocated workers may lose health insurance from their former employer, they may have the right to continue health coverage under certain conditions. Health continuation rules enacted under COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1986) apply to dislocated workers and their families as well as to workers who change jobs or workers whose work hours have been reduced, thus causing them to lose eligibility for health insurance. This coverage is temporary, however, and the cost is borne by the employee.

To be eligible for COBRA coverage, you must have been enrolled in your employer's health plan when you worked and the health plan must continue to be in effect for active employees. In addition, you must take steps to enroll for COBRA continuation benefits.

Q ***Which employers are required to offer COBRA coverage?***

A Employers with 20 or more employees are usually required to offer COBRA coverage and to notify their employees of the availability of such coverage. COBRA applies to private-sector employees and to most State and local government workers. In addition, many States have laws similar to COBRA. Check with your State insurance commissioner's office to see if such coverage is available to you.

Q ***What if the company closed or went bankrupt and there is no health plan?***

A If there is no longer a health plan, there is no COBRA coverage available. If, however, there is another plan offered by the company, you **may** be covered under that plan. Union members who are covered by a collective bargaining agreement that provides for a medical plan also may be entitled to continued coverage.

Q ***How do I find out about COBRA coverage and how do I elect to take it?***

A Employers or health plan administrators must provide an initial *general notice* if you are entitled to COBRA benefits. You probably received the initial notice about COBRA coverage when you were hired.

When you are no longer eligible for health coverage, your employer has to provide you with a *specific notice* regarding your rights to COBRA continuation benefits. Here is the sequence of events: First, employers must notify their plan administrators **within 30 days** after an employee's termination or after a reduction in hours that causes an employee to lose health benefits.

Next, the plan administrator must provide notice to individual employees of their right to elect COBRA coverage **within 14 days** after the administrator has received notice from the employer.

Finally, you **must** respond to this notice and elect COBRA coverage **by the 60th day after the written notice is sent or the day health care coverage ceased, whichever is later.** Otherwise, you will lose

all rights to COBRA benefits. Spouses and dependent children covered under your health plan have an independent right to elect COBRA coverage upon your termination or reduction in hours. If, for instance, you have a family member with an illness at the time you are laid off, that person alone can elect coverage.

Q ***If I elect COBRA, how much do I pay?***

A When you were an active employee, your employer may have paid all or part of your group health premiums. Under COBRA, as a former employee no longer receiving benefits, you will usually pay the entire premium amount—that is, the premium that you paid as an active employee **plus** the amount of the contribution made by your employer. In addition, there may be a 2 percent administrative fee.

While COBRA rates may seem high, you will be paying group premium rates, which are usually lower than individual rates.

Since it is likely that there will be a lapse of a month or more between the date of layoff and the time you make the COBRA election decision, you may have to pay health premiums retroactively—from the time of separation from the company. The first premium, for instance, will cover the entire time since your last day of employment with your former employer.

You should also be aware that it is your responsibility to pay for COBRA coverage even if you do not receive a monthly statement.

Although they are not required to do so, some employers may subsidize COBRA coverage.

Q ***When does COBRA coverage begin?***

A Once you elect coverage and pay for it, COBRA coverage begins on the date that health care coverage ceased. It is, essentially, retroactive. In addition, the health care coverage you receive is the same as it is for active employees.

Q ***How long does COBRA coverage last?***

A Generally, individuals who qualify initially are covered for a maximum of 18 months, but coverage may end earlier under certain circumstances. Those circumstances include:

- Premiums are not paid on time;
- Your former employer decides to discontinue a health plan altogether;
- You obtain coverage with another employer's group health plan; (There may be some exception if your new employer's health plan excludes or limits benefits for a "preexisting" condition—basically a medical condition present before you enrolled in the plan. Please see the discussion on HIPAA on page 11.)
- You become entitled to Medicare benefits.

Employers may offer longer periods of COBRA coverage but are only required to do so under special circumstances, such as disability (yours or a family member's), your death or divorce, or when your child ceases to meet the definition of a dependent child under the health plan.

Q ***Who can answer other COBRA questions?***

A COBRA administration is shared by three Federal agencies. The Department of Labor (DOL) handles questions about notification rights under COBRA for private-sector employees. The Department of Health and Human Services (HHS) handles questions relating to State and local government workers. The Internal Revenue Service (IRS), Department of the Treasury, has other COBRA jurisdiction.

More details about COBRA coverage are included in the booklet **Health Benefits under the Consolidated Omnibus Budget Reconciliation Act - COBRA**. To receive a copy, call 1-866-444-EBSA. You can also be connected to the EBSA office nearest you at this number. For telephone numbers of the nearest HHS and IRS, call the Federal Information Center at: **1-800-688-9889**.

Possible benefits under the Trade Act of 2002

The Trade Act of 2002 (TAA) created new programs that can assist certain dislocated workers. TAA provides assistance to two groups: **(1)** workers who lose their jobs due to the effects of international trade (TAA-eligible individuals) and **(2)** retirees who are receiving benefit payments from the Pension Benefit Guaranty Corporation because it has taken over their pension plan (PBGC-eligible individuals).

Through grants to states, TAA-eligible individuals may be eligible for training, job search, and relocation allowances, and income support while in training. TAA funds are allocated to States throughout the year. To check on the status of TAA in your state, visit

www.doleta.gov/tradeact or call the Department of Labor TAA Call Center at **1-877-US2-JOBS**.

In addition, TAA created the Health Coverage Tax Credit (HCTC), an advanceable tax credit of up to 65 percent of the premiums paid for certain types of health insurance coverage (including COBRA coverage). The HCTC may be available both to TAA-eligible individuals and to PBGC-eligible individuals who are at least 55 years old, but not yet eligible for Medicare.

Individuals who are eligible for the HCTC may choose to have the amount of the credit paid on a monthly basis to their health coverage provider as it becomes due or may claim the tax credit on their income tax returns after the end of the year.

For questions about eligibility for the TAA tax credit for qualified health insurance coverage, call the HCTC Customer Contact Center at **1-866-628-HCTC** (TDD/TTY: 1-866-626-HCTC (4282)). You may also visit the HCTC Web site on-line at **www.irs.gov** by entering the keyword "HCTC."

HIPAA - Health Insurance Portability

HIPAA—the Health Insurance Portability and Accountability Act of 1996—amended the Employee Retirement Income Security Act to provide new rights and protections for participants and beneficiaries in group health plans. Understanding this amendment is important to your decisions about future health coverage. HIPAA contains protections both for health coverage offered in connection with employment ("group health plans") and for individual insurance policies sold by insurance companies ("individual policies").

If you find a new job that offers health coverage, or if you are eligible for coverage under a family member's employment-based plan, HIPAA includes protections for coverage under group health plans that:

- limit the exclusion period for preexisting conditions;
- prohibit discrimination against employees and dependents based on their health status; and
- allow a special opportunity to enroll in a new plan to individuals in certain circumstances.

If you choose to apply for an individual policy for yourself or your family, HIPAA includes protections for individual policies that:

- guarantee access to individual policies for people who qualify; and
- guarantee renewability of individual policies.

Q ***What is a "preexisting" condition?***

A A "preexisting condition" is a condition present before your enrollment date in any new group health plan. An exclusion from enrollment in a new group health plan is sometimes applied to, those with preexisting conditions.

Under HIPAA, the only preexisting conditions that may be excluded under a preexisting condition exclusion are those for which medical advise, diagnosis, care or treatment was recommended or received within the 6-month period before your enrollment date. (Your enrollment date is your first day of coverage, or if there is a waiting period to get into the plan, the first day of the waiting period.)

If you had a medical condition in the past, but have not received any medical advise, diagnosis, care or treatment within the 6 months prior to your enrollment date in the plan, your old condition is not a "preexisting condition" to which an exclusion can be applied. Moreover, under HIPAA, preexisting condition exclusions cannot be applied to pregnancy, regardless of whether the woman had previous health coverage.

Finally, a preexisting condition exclusion cannot be applied to a newborn, adopted child, or child placed for adoption as long as the child enrolls for health coverage within 30 days of the birth, adoption, or placement for adoption and provided that the child does not incur a subsequent 63-day break in coverage.

Q ***I have a preexisting condition that may be excluded under HIPAA. How does my new plan determine the length of my preexisting condition exclusion period?***

A The maximum length of a preexisting condition exclusion period is 12 months after your enrollment date (18 months in the case of a "late enrollee"). A late enrollee is an individual who enrolls in a plan other than on the earliest date on which coverage can become effective under the terms of the plan and other than on a "special enrollment date" (see below).

A plan must reduce an individual's preexisting condition exclusion period by the number of days of an individual's "creditable coverage." Most health coverage is creditable coverage, such as coverage under a group health plan (including COBRA continuation coverage), HMO, individual insurance policy, Medicaid, or Medicare. However, a plan is not required to take into account any days of creditable coverage that precede a significant break in coverage (generally, a break in coverage of 63 days or more).

A plan generally receives information about an individual's creditable coverage from a certificate furnished by a prior plan or health insurance issuer (e.g., an insurance company or HMO). You should receive a certificate of creditable coverage automatically when you lose coverage under your old plan, or when you become entitled to COBRA continuation coverage, and when your COBRA continuation coverage ceases. You also have a right to receive a certificate when you request one from your previous plan or issuer within 24 months of when your

coverage ceases (including before your coverage ceases).

Q ***I received my certificate from my former plan. What do I do now?***

A You should:

— ensure that the information is accurate; (Contact the plan administrator of your former plan if any information is wrong.)

— keep the certificate in case you need it. (You will need the certificate if you enroll in a new group health plan that applies a preexisting condition exclusion period or if you purchase an individual policy from an insurance company.)

Q ***What if I have trouble getting a certificate from my former employer's group health plan?***

A Under HIPAA, group health plans and health insurance issuers are required to provide documentation that certifies the creditable coverage you have earned. Plans and issuers that fail or refuse to provide such certificates are subject to penalties under HIPAA.

However, if you have trouble obtaining a certificate, your new group health plan is required to accept other evidence of creditable coverage, if you have it. It is important, therefore, to keep accurate records (e.g., pay stubs that reflect a deduction for health insurance, explanation of benefits forms (EOBs), or verification by a doctor or your former health care

benefits provider that you had prior health insurance coverage) that can be used to establish periods of creditable coverage in the event a certification cannot be obtained.

Q ***When I enroll in a new group health plan that contains a preexisting condition exclusion period, how does "crediting" for prior coverage work under HIPAA?***

A Most plans will use what is known as the "standard method" of crediting coverage. Under this method, you will receive credit for your previous coverage that occurred without a break in coverage of 63 days or more. Any coverage you had prior to a break in coverage of 63 days or more may not be credited against a preexisting condition period. However, if your health coverage is offered through an HMO or an insurance policy issued by an insurance company, you should check with your State insurance commissioner's office to find out if this break in coverage period is longer in your State.

To illustrate: Suppose an individual had health insurance coverage for 2 years followed by a break in coverage of 70 days and then resumed coverage for 8 months. That individual would only receive credit for 8 months of coverage. No credit would be given for the 2 years of coverage prior to the break in coverage of 70 days.

HIPAA also permits an "alternative method" for crediting coverage for all employees. Under the alternative method of calculating creditable coverage, the plan or issuer separately determines the amount of an individual's creditable coverage for

any of the five following categories of benefits: mental health, substance abuse treatment, prescription drugs, dental care and vision care. Your new plan must notify you if it is using the alternative method for any of these benefits.

Q ***What are my new group health plan's obligations with respect to "special enrollment opportunities"?***

A A group health plan is required to allow special enrollment for certain individuals to enroll in the plan without having to wait until the plan's next regular enrollment season.

A special enrollment opportunity occurs if an individual with other health insurance loses that coverage. A special enrollment opportunity also occurs if a person has (or becomes) a new dependent through marriage, birth, adoption, or placement for adoption. However, you must notify the plan of your request for special enrollment within 30 days after losing your other coverage or within 30 days of having (or becoming) a new dependent.

If you enroll as a special enrollee, you may not be treated as a late enrollee for purposes of any preexisting condition exclusion period. Therefore, the maximum preexisting condition exclusion period that may be applied is 12 months, reduced by your creditable coverage (rather than 18 months, reduced by creditable coverage).

Q ***Can I be denied coverage or charged more for coverage by my new group health plan based on my health status?***

A No. First, group health plans and health insurance issuers may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan based on "health status related factors." These factors include: health status, medical condition (physical or mental), claims experience, receipt of health care, medical history, genetic information, evidence of insurability, and disability. However, plans may establish limits or restrictions on benefits or coverage for all similarly situated individuals.

Second, plans generally may not require an individual to pay a premium or contribution that is greater than that for a similarly situated individual based on a health status related factor.

Q ***What if I am unable to obtain new group health plan coverage?***

A You may be able to purchase an individual insurance policy. HIPAA guarantees access to individual policies to "eligible individuals." Eligible individuals are those who:

- have had coverage for at least 18 months where the most recent period of coverage was under a group health plan;
- did not have their group coverage terminated because of fraud or nonpayment of premiums;
- are ineligible for COBRA continuation coverage or have exhausted their COBRA benefits (or continuation coverage under a similar State provision); and

— are not eligible for coverage under another group health plan, Medicare, or Medicaid or have any other health insurance coverage.

The chance to buy an individual policy is the same, whether you are laid off, fired, or quit your job. However, the type of coverage you are guaranteed may differ across States. Therefore, it is important to check with your State insurance commissioner's office if you are interested in obtaining individual insurance coverage.

In addition, children in families who do not have health coverage due to a temporary reduction in income (for instance, due to job loss) may be eligible for the Children's Health Insurance Program (CHIP). CHIP is a Federal/State partnership that is helping to provide children with health coverage.

States have flexibility in administering programs under CHIP. State agencies may choose to expand their Medicaid programs, design new child health insurance programs, or create a combination of both. To find out more about the program in your State, call **1-877-KIDS NOW (1-877-543-7669)** or visit **www.insurekidsnow.gov** on the Web.

ERISA - Pension Benefits

The Employee Retirement Income Security Act of 1974, or ERISA, protects the assets of millions of Americans so that funds placed in retirement plans during their working lives will be there when they retire.

ERISA does not require that pension benefits be disbursed before normal retirement age, usually age 65. By that age an employee is usually "vested" in a retirement plan—that is, the employee has earned the years of service credit required to retire with a pension.

Dislocated workers face two important issues when they leave employment: access to pension funds and the continued safety of their pension benefit investments.

Q ***Can I get my pension money if I am laid off?***

A Generally, if you are enrolled in a 401(k), profit sharing, or other type of **defined contribution plan** (a plan in which you have an individual account), your plan may provide for a lump sum distribution of your retirement money when you leave the company.

However, if you are in a **defined benefit plan** (a plan in which you receive a fixed, pre-established benefit) your benefits begin at retirement age. These types of plans are less likely to contain a provision that enables you to withdraw money early.

Whether you have a defined contribution or a defined benefit plan, the form of your pension

distribution (lump sum, annuity, etc.) and the date your pension money will be available to you depend upon the provisions contained in your plan documents. Some plans do not permit distribution until you reach a specified age. Other plans do not permit distribution until you have been separated from employment for a certain period of time. In addition, some plans process distributions throughout the year and others only process them once a year. You should contact your pension plan administrator regarding the rules that govern the distribution of your pension money.

One of the most important documents defining your benefits is the summary plan description (SPD). It outlines what your benefits are and how they are calculated. A copy of the SPD is available from your employer or pension plan administrator.

In addition to the SPD, your employer also may give you—or you may request—an individual benefit statement showing the value of your pension benefits— the amount you have actually earned to date and your vesting status. These documents contain important information for you, whether you withdraw your money now or later.

Q ***Is my plan required to give me a lump-sum distribution?***

A ERISA does not require pension and profit-sharing plans to provide for lump-sum distributions. Lump-sum distributions are possible only if the plan specifically provides for them and only if you meet the plan's eligibility requirements.

Q ***If I withdraw retirement money, are there potential adverse effects?***

A Yes. Receiving a lump sum or other distribution from your pension plan may affect your ability to receive unemployment compensation. You should check with your State unemployment office.

In addition, receiving money from your pension plan may result in additional income tax. You can defer these taxes, however, if you keep the money in your plan or if you "roll over" the money into a qualified pension plan or Individual Retirement Account (IRA). There are provisions in the Internal Revenue Code that allow these rollovers.

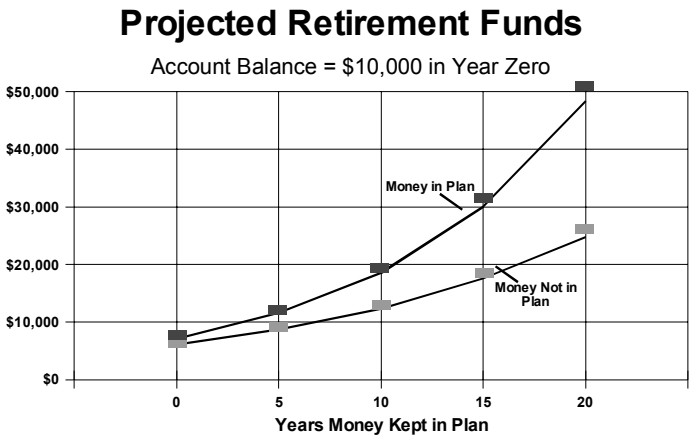
Generally, your plan is required to withhold 20 percent of an eligible rollover distribution unless you elect to have the distribution paid directly to an eligible retirement plan, including an IRA. This is known as a "direct rollover." If there is no direct rollover, you will have to make up the 20 percent withholding to avoid tax consequences on the full rollover amount. The IRS does not require 20 percent withholding of an eligible rollover distribution that, when added to other rollover distributions made to you during the year, is less than $200.

Under IRS rules, and in order to avoid certain tax consequences, you have 60 days to roll over the distribution you received to another qualified plan or IRA if you wish to avoid the tax consequences.

If you have a choice between leaving the money in your current pension plan or depositing it in an

IRA, you should carefully evaluate the investments available through each option.

Withdrawing money from your retirement plan before retirement age also affects the amount of money you will accumulate over time. The graph below shows the consequences of withdrawing money from your pension plan and not depositing it in another qualified plan within the required time limit.



Note: **The retirement funds available are less than account balances due to subtraction of taxes.**

As the graph shows, your pension keeps the full amount it earns through investments because its earnings are not fully taxed (until you receive a distribution). As a result, pension accounts can grow faster than comparable taxable accounts (see graph). Let's say, for instance, that you have $10,000 in a pension account or IRA, and it earns an average return on investment of 10 percent. In 20 years it will grow, with compounding, to $67,300. If you withdraw this amount after you reach age 59 ½ (the age at which you can withdraw money

without a 10 percent penalty) and pay 28 percent income tax on your withdrawal, you will keep $48,400.

On the other hand, if you close your pension account before age 59½, taxes will claim a portion of the funds you receive and will reduce your return every year thereafter. As a result, the value of your account after 20 years will be approximately $24,900, assuming the same rate of return and tax bracket. As shown in the graph, the tax consequences of early withdrawal will cost you 45 percent of your account balance at retirement.

Before you withdraw retirement funds, you may want to talk to your employer, bank, union or a financial advisor for practical advice about the long-term and the tax consequences.

Q ***If I am laid off, are my retirement funds safe?***

A Generally, your pension funds should not be at risk even if a plant or business closes. Employers must comply with Federal laws when establishing and running pension plans, and the consequences of not prudently managing pension plan assets are serious.

In addition, your pension benefits may be protected by the Federal government. Traditional plans (**defined benefit plans)** are insured by the Pension Benefit Guaranty Corporation (PBGC), a Federal government corporation. If an employer has financial difficulty and cannot fund the plan, and the plan does not have enough money to pay the promised benefits, the PBGC will assume responsibility as trustee of the plan. The PBGC pays benefits up to a certain maximum guaranteed amount.

Defined contribution plans, on the other hand, are not insured by the PBGC.

To help employees monitor their retirement plans and thus ensure retirement security, EBSA has issued a list of 10 warning signs that may indicate your pension plan has financial problems. They are included in the publication **Protect Your Pension**, listed at the end of this booklet. (See "For More Information" at the back of this booklet to obtain a copy.)

If, for any reason, you suspect your pension benefits are not safe or are not prudently invested, you should pursue the issue with an EBSA regional office. Call 1-866-EBSA (3272) to be connected to the office nearest you.

Q ***What if my company goes out of business and the pension plan terminates?***

A In a defined contribution plan, the plan administrator generally gathers certain pension plan and tax-related information and submits it to the IRS. This process may delay plan termination and subsequent payment of any benefits. You should contact your pension plan administrator for information on status and length of time before you receive your money.

In a defined benefit plan, the plan administrator generally files certain documents with the IRS and the PBGC. Once PBGC approves the termination, benefits are generally distributed in a lump sum or as an annuity within 1 year of termination.

Regardless of the type of benefit plan, you should know the name of the plan administrator. This information is contained in the latest copy of your summary plan description. If you can't find the name of your plan administrator, you may wish to contact your company's personnel department, your union representative (if there is a union) or the IRS or PBGC (in the case of most defined benefits plans).

If you do decide to contact one of these agencies, you may need to know your employer's identification number, or EIN, a 9-digit number used for tax purposes. The EIN can be found on last year's wage tax form (Form W-2). An EBSA regional office may be able to help you obtain this information.

Q ***What if the company declared bankruptcy?***

A If an employer declares bankruptcy, there are a number of choices as to what form the bankruptcy takes. A Chapter 11 (reorganization) bankruptcy may not have any effect on your pension plan and the plan may continue to exist. A Chapter 7 (final) bankruptcy, where the employer's company ceases to exist, is a more complicated matter.

Because each bankruptcy is unique, you should contact your pension plan administrator, your union representative or the bankruptcy trustee and request an explanation of the status of your pension plan.

In summary:

Know in advance the plan rules that govern the way your pension assets and health care benefits are treated if you are laid off. The following documents contain valuable information about your health care and pension plans and should be helpful to you as a dislocated worker. You should be able to obtain most of them from your plan administrator, union representative, or human resource coordinator.

- Summary plan description - A brief description of your pension or health plan;
- Summary annual report - A summary of the plan's annual finances. The summary may contain names and addresses you may need to know;
- Enrollment forms listing you and/or your family members as participants in a plan;
- Earnings and leave statements;
- A certificate of creditable coverage (furnished by your former employer) - Informs your new employer that you had health coverage;
- Statements showing how much money is in your pension account or the value of your pension benefit.

Save these documents. In addition, save any documents, such as memos or letters from your company, union, or bank, that relate to your pension or health plans. They may prove valuable in protecting your pension and health benefit rights.

For More Information

The Employee Benefits Security Administration offers more information on ERISA, COBRA, and HIPAA. The following booklets, available the agency's toll-free number, may be particularly useful:

- **Health Benefits under the Consolidated Omnibus Budget Reconciliation Act (COBRA)**
- **Questions and Answers: Recent Changes in Health Care Law (HIPAA)**
- **What You Should Know About Your Pension Rights (ERISA)**
- **Protect Your Pension - A Quick Reference Guide**
- **Work Changes Require Health Choices...Protect Your Rights**
- **Your Guaranteed Pension (PBGC)**

For copies of the above publications, please visit:
www.dol.gov/ebsa

Or call our toll-free number:
1- 866-444-EBSA (3272)

Your Guaranteed Pension and other information on terminated pension plans are available on the Pension Benefit Guaranty Corporation Web site at:

www.pbgc.gov

Or call PBGC at:

(202) 326-4000

For specific questions pertaining to your rights to pension or health benefits under COBRA, HIPAA, or ERISA, please contact the EBSA regional office nearest you. To locate regional offices, call 1-866-444-EBSA or visit the following Web site:

www.dol.gov/ebsa