Retirement and Health Care Coverage...

Questions and Answers for Dislocated Workers

U.S. Department of Labor
Employee Benefits Security Administration

This publication has been developed by the U.S. Department of Labor, Employee Benefits Security Administration (EBSA).

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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 retirement benefits that go along with working full time. As a dislocated worker, you may have many questions, some of them concerning your health and retirement benefits. For instance, *Do I have access to my retirement funds? What happens to my health benefits? Can I continue health coverage until I get another job?*

You may have rights to certain retirement protections and health benefits even if you lose your job. If your company provided a group health plan, you may be entitled to continued health benefits for a period of time if you cannot find a job immediately. 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 retirement 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 your health care coverage and your retirement benefits.

Protecting Your Retirement and Health Benefits

The Employee Benefits Security Administration (EBSA) enforces and administers the Employee Retirement Income Security Act of 1974 (ERISA), which provides a number of rights and protections for private-sector retirement and health plan participants and their beneficiaries.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides important protections for millions of working Americans and their families who need to maintain health coverage between jobs or limit exclusions for preexisting conditions under a new health plan.

The Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) provides workers with the right to continue their health coverage for a limited time after they lose their jobs.

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

Maintaining Your Health Coverage

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

HIPAA and COBRA both may provide a way to continue coverage. Remember, you, your spouse, and your dependents each have the right to decide among various options for continuing health coverage. For instance, you may enroll in your spouse's plan while one of your dependents may elect COBRA coverage through your former employer's plan.

By acquainting yourself with HIPAA and COBRA, you can make informed decisions that will keep you and your family covered.

HIPAA - Enrolling in Another Plan

HIPAA – the Health Insurance Portability and Accountability Act of 1996 – offers protections for people who lose their jobs and their health coverage. And, when you find a new job that offers health benefits, HIPAA will allow you to enroll in the plan with fewer restrictions. The law's umbrella of protection:

- Provides additional opportunities to enroll in a group health plan if you lose other coverage or experience certain life events;

- Limits the ability of a new employer's plan to exclude coverage for preexisting conditions;

- Prohibits discrimination against employees and their dependents based on any health factors they may have, including prior medical conditions, previous claims experience, and genetic information; and

- Guarantees that certain individuals will have access to, and can renew, individual health insurance policies.

For health coverage that is insured, HIPAA may be complemented by State laws that offer additional protections. Check your plan documents or ask your plan administrator to see if your plan is insured. If it is, contact your State insurance commissioner's office to see what your State law provides.

The following questions explain how HIPAA can help you.

Q ***I've lost my job. Is there any way I can get health coverage for me and my family?***

A Often, the most cost-effective option for maintaining health coverage is special enrollment. If other group health coverage is available (for example, through a spouse's employer provided plan), special enrollment in that plan should be considered. It allows the individual and his/her family an opportunity to enroll in a plan for which they are otherwise eligible, regardless of enrollment periods. However, to qualify, enrollment must be requested within 30 days of losing eligibility for other coverage.

After you request special enrollment due to your loss of eligibility for other coverage, your coverage will begin on the first day of the next month.

You and your family each have an independent right to choose special enrollment. A description of special enrollment rights should be included in the plan materials you received when initially offered the opportunity to sign up for the plan.

Special enrollment rights also arise in the event of a marriage, birth, adoption, or placement for adoption. You have to request enrollment within 30 days of the event. In special enrollment as a result of birth, adoption, or placement for adoption, coverage is retroactive to the day of the event. In case of marriage, coverage begins on the first day of the next month.

Q ***What coverage will I get when I take advantage of a special enrollment opportunity?***

A Special enrollees must be offered the same benefits that would be available if you were enrolling for the first time. You cannot be required to pay more for the same coverage or have longer preexisting condition exclusion periods than other individuals who enrolled when first eligible for the plan.

Q ***What is a preexisting condition exclusion period?***

A One of the most important things HIPAA does is help those people with preexisting conditions get health coverage. Under HIPAA, a plan can look back only 6 months for a condition that was present before the start of coverage in a group health plan. If medical advice, diagnosis, care, or treatment was recommended or received during that time for a condition, the plan can impose a preexisting condition exclusion period. This means that the condition may not be covered for a certain period of time. However, you will still be eligible for the plan's other benefits.

For example, you may have had arthritis for many years before you came to your current job. If you did not have medical advice, diagnosis, care, or treatment – recommended or received – in the 6 months before you enrolled in the plan, then the prior condition cannot be subject to an exclusion period. If you did receive medical advice, diagnosis, care, or treatment within the past 6 months, then the plan may impose a preexisting condition exclusion for arthritis.

However, plans cannot apply preexisting condition exclusion periods to pregnancy, genetic information, or conditions that are present in children who are enrolled in health coverage within 30 days after birth, adoption, or placement for adoption.

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 if you are a late enrollee, who does not sign up with the employer's health plan at the first opportunity or through special enrollment). Be aware that some plans may have a shorter exclusion period or none at all.

Generally, you can reduce the length of a preexisting condition exclusion period by proving you had prior health coverage, or "creditable coverage." Most types of coverage can be used as creditable coverage, such as participation in a group health plan, HMO, COBRA, Medicare, Medicaid, or an individual insurance policy.

The maximum preexisting condition exclusion period under the plan is offset and can be eliminated by the amount of your creditable coverage. As long as you do not have a break in coverage of 63 days or more, your creditable coverage can be used to reduce your preexisting condition exclusion period. Any coverage you had prior to a break of 63 days or more will not count as creditable coverage.

For example, if you had 9 months of creditable coverage and did not have a break in coverage of 63 days or more before enrolling in a new plan, your preexisting condition exclusion period would be reduced from the maximum 12 months to 3 months. If, instead, you had 15 months of creditable coverage without a break of 63 days or more, you could fully offset and eliminate the exclusion period.

Q ***How long can I go without coverage between jobs if I want to reduce the length of a preexisting condition exclusion period?***

A If you are between jobs and do not have health coverage for 63 days or more, then you may lose the ability to use the coverage you had before the break to offset a preexisting condition exclusion period in a new health plan.

As long as any break is no longer than 63 days, you will not have a significant break. You can count different periods of prior coverage you had to accumulate 12 months of creditable coverage (18 months for late enrollees). For instance, if you had 6 months of group health plan coverage and a 30-day break in coverage, followed by 8 more months of coverage, both periods of prior health coverage can be added together and counted. In this example you would have 14 months of creditable coverage to offset a preexisting condition exclusion period.

Q ***How can I avoid this 63-day significant break?***

A There are several ways. You can:

- Special enroll in your spouse's group plan if it allows family members to join.

- Sign up for COBRA continuation coverage. You probably will have to pay for this temporary coverage for yourself and any family members who were part of your previous plan, but COBRA can prevent or reduce a break in coverage. To learn more, see the chapter on COBRA on page 15.

- Buy an individual health insurance policy. See page 21.

- Contact your State insurance commissioner's office to find out whether your State has a high-risk pool for people who cannot otherwise get health benefits.

Q ***How do I prove I have creditable coverage?***

A You can offer proof through a "certificate of creditable coverage." This is a document that shows your prior periods of coverage, the dates on which they began and ended, contact information for your old plan, and information about your HIPAA rights. Upon losing health coverage, you should automatically receive a certificate from your health plan, HMO, or health insurance company. You can also request a certificate before you lose your coverage. HIPAA requires that

health plans issue certificates even if they do not exclude coverage for preexisting conditions.

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

A You should:

- Make sure the information is accurate. Contact the administrator of your former plan if anything on the certificate is wrong.

- Keep the certificate in a safe place in case you need it. It will be necessary if your new group health plan imposes preexisting condition exclusion periods or if you purchase an individual insurance policy.

Q ***What if I have trouble getting a certificate from my (soon-to-be) former employer's group health plan?***

A If you have trouble obtaining a certificate, your new group health plan must accept other evidence of creditable coverage, if you have it. It is important, therefore, to keep accurate records that can be used to establish periods of creditable coverage. That evidence can include:

- Pay stubs that reflect a deduction for health coverage premiums;

- Explanation of benefits forms (EOBs);

- Copies of premium payments or other documents showing evidence of coverage; and

- Verification by a doctor or your former plan.

Q ***Can my new group health plan deny or charge me more for coverage based on my health status?***

A No. A health plan cannot deny you and your family eligibility or benefits because of certain health factors. These health factors include: health status, physical and mental medical conditions, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, and disability.

The plan also cannot charge you more than similarly situated individuals because of these health factors. However, the plan can distinguish among employees based on bona fide employment-based classifications, such as those who work part time or in another geographic area, and establish different benefits or premiums for those different groups.

COBRA - Continuing in Your Old Plan

Another way to maintain health coverage between jobs is to elect COBRA continuation coverage.

While dislocated workers may lose health coverage from their former employer, they may have the right to continue 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 coverage. This coverage is temporary, however, and the cost may be 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 eligible to 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 *and their covered dependents* 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 — 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 of HIPAA on page 9.)

- 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), as part of the Department of the Treasury, has other COBRA jurisdiction.

More details about COBRA coverage are included in the booklet **An Employee's Guide to Health Benefits Under COBRA**. To receive a copy, call 1-866-444-EBSA (3272). You can also be connected to the EBSA office nearest you at this number. For telephone numbers of the nearest HHS and IRS offices, call the Federal Information Center at **1-800-FED-INFO (1-800-333-4636)** or visit **www.usa.gov**.

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 (4282)** (TDD/TTY: 1-866-626-HCTC (4282)). You may also visit the HCTC Web site online at **www.irs.gov** by entering the keyword "HCTC."

Q ***What if I cannot obtain new group health coverage?***

A You can buy your own individual health insurance policy whether you quit your job, were fired, or were laid off. HIPAA guarantees access to individual insurance policies and State high-risk pools for eligible individuals. You must meet all of the following criteria:

- Had coverage for at least 18 months, most recently in a group health plan, without a significant break;
- Lost group coverage, but not because of fraud or non-payment of premiums;
- Are not eligible for COBRA continuation coverage or have exhausted COBRA benefits; and
- Are not eligible for coverage under another group health plan, Medicare, or Medicaid, or have any other health coverage.

The type of health coverage you are guaranteed may differ from State to State. Check with your State insurance commissioner's office if you are interested in obtaining individual 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 State Children's Health Insurance

Program (S-CHIP), a Federal/State partnership that helps provide children with health coverage.

States have flexibility in administering S-CHIP programs. They 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 - Protecting Your Retirement Assets

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 retirement 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 right to retire with benefits which cannot be forfeited.

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

Q ***Can I get my retirement 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 allow you to receive money early.

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

plan distribution (lump sum, annuity, etc.) and the date your benefits 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 plan administrator regarding the rules that govern the distribution of your benefits.

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 retirement plan administrator.

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

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

A ERISA does not require that retirement plans provide lump sum distributions. Lump sum distributions are possible only if the plan documents specifically provide for them.

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

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

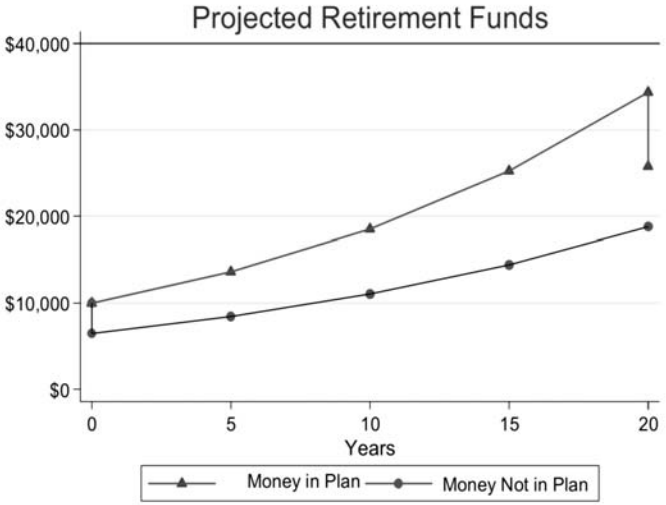
In addition, withdrawing money from your retirement plan may result in additional income tax. You can defer these taxes, however, if you keep the money in your plan or if you "roll over" the money into a qualified retirement plan or Individual Retirement Account (IRA). There are provisions in the Internal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

Generally, your plan must withhold 20 percent of an eligible rollover distribution for tax purposes. However, in the case of a "direct rollover" where you elect to have the distribution paid directly to an eligible retirement plan, including an IRA, there is no tax withholding, and the full amount of your eligible rollover distribution is paid into the new eligible retirement plan. If you do not elect a direct rollover, you will have to make up the 20 percent withholding to avoid tax consequences on the full rollover amount. The Internal Revenue Service does not require a 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 have a choice between leaving the money in your current retirement plan or depositing it in an IRA, you should carefully evaluate the investments available through each option.

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



As the graph shows, if your money is left in the plan, it grows tax free until it is distributed, after 20 years in this example. At that point, when the money is distributed to you, you pay taxes on it so your account balance decreases (see lower starting point in graph). On the other hand, if you remove

your money from the plan initially, and do not roll it over into an IRA, then your account balance decreases during that initial year (see lower starting point in graph), as you pay taxes and a 10 percent penalty for withdrawing the money before age 59½. After that, your account grows for the next 20 years but at a lower rate of growth, because you are paying taxes on your investment earnings.

Let's say, for instance, that you have $10,000 in a retirement plan account or IRA. Your money is invested in a mix of stocks and bonds that earns an average return on investment of 6.4 percent. In 20 years, your account will grow, with compounding, to $34,400. If you withdraw this amount after you reach age 59½ (the age at which you can receive money without a 10 percent penalty) and pay 25 percent income tax on that amount, you will keep nearly $25,800.

However, if you close your retirement plan account before age 59½, your account balance will decrease from $10,000 to $6,500 after paying the 10 percent penalty and 25 percent income tax. In addition, your account grows for the next 20 years but at a lower rate of growth, because you are paying taxes on your investment earnings. As a result, the value of your account after 20 years will be approximately $18,800, assuming the same rate of return and tax bracket. As shown in the graph, the tax consequences of early withdrawal will cost you 27 percent of your account balance at retirement.

Before you request retirement funds from the plan, you should talk to your employer, bank, union, or

financial adviser for practical advice about the long-term and tax consequences.

If you receive retirement funds, you may want to hire someone to manage your money. The law generally requires money managers to be clear and open about their fees and charges and to explain whether they are paid by commissions or for the sales of financial products, such as annuities and mutual funds. Ask questions, get references, and avoid anyone who guarantees good investment performance.

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

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

In addition, your benefits may be protected by the Federal government. Traditional pension plans (**defined benefit plans)** are insured by the Pension Benefit Guaranty Corporation (PBGC), a Federal government corporation. If an employer 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.

If your retirement benefit remains with your former employer, keep current on any changes your former employer makes, including changes of address, mergers, and employer name. If you move, give the plan your new contact information.

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 plan has financial problems. They are included in the guide **Ten Warning Signs That Your 401(k) Contributions Are Being Misused**, available at www.dol.gov/ebsa.

If, for any reason, you suspect your retirement benefits are not safe or are not prudently invested, you should pursue the issue with an EBSA regional office. Call 1-866-444-EBSA (3272) to be connected to the office nearest you.

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

A In a defined contribution plan, the plan administrator generally gathers certain retirement 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 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 the 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 benefit 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 declares 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 retirement 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 plan administrator, your union representative, or the bankruptcy trustee and request an explanation of the status of your plan.

In summary:

Know in advance the plan rules that govern the way your retirement plan assets and health care benefits are treated if you are laid off. The following documents contain valuable information about your health care and retirement 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 retirement or health plan;
- Summary Annual Report -- A summary of the plan's annual finances. The summary should 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;
- Certificates of creditable coverage (furnished by your former employer(s)) -- Informs your new employer that you had health coverage;
- Statements showing how much money is in your retirement plan account or the value of your retirement benefits.

Save these documents, as well as memos or letters from your company, union, or bank, that relate to your retirement or health plans. They may prove valuable in protecting your retirement and health benefit rights.

For More Information

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

- **Your Health Plan and HIPAA...Making the Law Work for You**
- **An Employee's Guide to Health Benefits Under COBRA**
- **Work Changes Require Health Choices...Protect Your Rights**
- **What You Should Know About Your Retirement Plan**
- **Your Guaranteed Pension (PBGC)**

For copies of the above publications, call our toll-free number **1-866-444-EBSA (3272)** or visit **www.dol.gov/ebsa**.

If you have specific questions pertaining to your retirement or health benefits you should speak to one of our Benefits Advisors by calling toll-free **1-866-444-EBSA (3272)** or contact us electronically at **www.askebsa.dol.gov**.

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:

1-800-400-7242