2017 BENEFITS DECISION GUIDE

Lewis & Clark College

Open Enrollment Schedule

Begins:	**Ends:**	**Effective:**
Friday February 17, 2017	Monday March 6, 2017	Saturday April 1, 2017

Lewis & Clark College – Office of Human Resources 503-768-6235

0615 SW Palatine Hill Road, MSC 72, Portland, OR 97219

Dear Colleagues:

You are encouraged to give your benefits a ‘check-up’ at least once per year, and Open Enrollment is the perfect opportunity to do so. This guide has all the information you will need for Open Enrollment and throughout the year so you can make educated decisions that are right for you and your family.

If you make no changes during Open Enrollment, your current benefit elections will remain in place throughout 2017 – except for flexible spending accounts (FSA). FSA elections do not carry over from year-to-year. **If you want an FSA, you must actively enroll in one during Open Enrollment**.

All benefit changes during Open Enrollment will be done online in Workday. You will receive an email notification and an item in your Workday inbox to start the process on Friday, February 17.

Questions? We are here to help!

- Visit our 2017 Benefits & Wellness Fair to speak to benefit vendors on Tuesday, February 21, 2017 from 10 a.m. to 1:30 p.m. in Stamm – Templeton Student Center.
- Contact our Benefits Analyst, Helen DeVol, in Human Resources any time by email helen@lclark.edu or by phone at 503-768-6234.
- Use our Benefit Vendor Contact Sheet (on page 14 of this guide) to get in touch with plan administrators.

We look forward to helping you with any of your benefit needs.

Human Resources

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BENEFITS CHECKLIST

Open Enrollment is a great time to review your existing benefit plans, evaluate any anticipated needs, learn more about available benefits, and adjust for the upcoming plan year.

Review…

- ✓ Your benefits in Workday.
  - Sign in to Workday
  - Click on the Benefits Worklet on your home screen
  - View Benefits Elections under VIEW
- ✓ This 2017 Open Enrollment Guide.
- ✓ Your beneficiary designations. Are there any updates to make?

Get Informed…

- ✓ Attend the Benefits & Wellness Fair on Tuesday, February 21, 2017 from 10 a.m. to 1:30 p.m. in Stamm – Templeton Student Center.
- ✓ Visit the Human Resources Benefits Open Enrollment webpage https://go.lclark.edu/open_enrollment
- ✓ Contact the Office of Human Resources with questions: 503.768.6235 or HR@lclark.edu.
- ✓ Review the tools & resources available through our health and dental insurance providers. See the contact sheet on page 14 of this booklet for more information.

Make Changes…

- ✓ Change your medical or dental plan enrollment.
- ✓ Add or remove spouse/domestic partner and dependents.
- ✓ Sign up for Flexible Spending Account(s).

No Changes?

- ✓ Do nothing – If you do not make enrollment changes during Open Enrollment, your participation in your medical and dental insurance will remain the same but at the new contribution rates. **If you do not enroll in the Allegiance Flexible Spending Account, you will not be a participant in 2017-18**.

IMPORTANT DATES

2/17 (F) - Open Enrollment starts in Workday at 9:00

- You will receive an email and a task in your Workday inbox

2/21 (T) - Benefits and Wellness Fair in Stamm from 10:00 - 1:30

- Over 30 amazing exhibitors such as : The Portland Clinic, Chiropractic, Acupuncture, Turtles Yoga Studio, Columbia Sportswear, doTerra Essential Oils, Thrive Life Foods, and more!
- Connect with your benefit providers and learn how you can use online tools, find providers, and get the most out of your enrollment choices
- Cooking demonstrations by the exclusive Chef Steven Hazell
- Don’t miss the raffle of prizes generously donated by our plan representatives
- Drop by the Fair and sign up for the drawings. Bring your postcard invitation to enroll in the grand prize drawing for a Garmin fitness tracker!

3/1 (W) - Drop in enrollment assistance 11:00 - 1:00 in Mac Lab, Templeton

3/2 (Th) - Presentation in Council Chambers by our benefit vendors 12:00 - 1:30

3/6 (M) - Open House at the HR office 10:00 - 3:00

- Come enjoy a treat, and get assistance with your Open Enrollment elections

3/6 (M) - Open Enrollment closes in Workday 4:00

4/1 (Sa) - Plan year begins and new benefits are effective

- New rates are effective on March payroll

PLAN CHANGES

1. Healthcare Flexible Spending annual limit will increase to $2,600.

2. PEHT/Regence and Kaiser will both include alternative care in the next plan year.

2017 Alternative Care Coverage		
	Kaiser HMO	**Regence PPO**
Network	CHP	Regence
Annual Maximum	$1,500 / calendar year	24 visits / calendar year
Chiropractic	$15 copay	20% of allowed amount (spinal manipulations only)
Acupuncture	$15 copay	20% of allowed amount
Naturopath	$15 copay	$25 copay (as a PCP practicing within scope of license)
Therapeutic Massage	$25 copay	20% of allowed amount

Do I need a referral to see these providers?

Kaiser - No, this is a self-referred benefit.

Regence PPO - No, you do not need to a referral for alternative care benefits.

What if I get a referral from a Kaiser provider? Will those services count towards the $1,500 max?

Kaiser - No, only the self-referred services count toward the $1,500 max.

Regence PPO - N/A

How is the $1,500 maximum with Kaiser determined?

Kaiser - This is the max amount that Kaiser pays out in claims in a calendar year, per covered person.

Regence PPO - N/A

Are there restrictions on the type of visit I see these providers for?

Kaiser - Coverage is limited to chiropractic, acupuncture, naturopathic and massage therapy.

Regence PPO - Chiropractic care includes spinal manipulations. Massage must be coded as therapeutic.

Where will I find the providers that are participating?

Kaiser - The providers must be participating in the CHP network

Regence PPO - Create an account on www.regence.com and to access “Find A Doctor”

Are there out of network benefits for Alternative care?

Kaiser - Services outside of the CHP network are not covered.

Regence PPO - Same benefit available for in network and out of network. You may be subject to balance billing with out of network providers.

Medical Plan Comparison 2017-2018			
	Pioneer Educators Health Trust (PEHT) Regence BlueCross/BlueShield PPO		**Kaiser HMO**
	In-Network	Out-of-Network	In-Network Only
Monthly Employee Premium	Employee Only: $114.15 Employee + 1: $442.41 Family: $637.32		Employee Only: $82.90 Employee + 1: $321.18 Family: $464.17
Annual Deductible	Individual $1,500 Family $4,500	Individual $3,000 Family $9,000	None
Annual Out-of-Pocket Maximum	Individual $4,000 Family $12,000	Individual $8,000 Family $24,000	Individual $1,250 Family $2,500
Primary Care	$25 Copay*	40%	$15 Copay
Specialty Care	$50 Copay*	40%	$15 Copay
Diagnostic Lab & X-ray	20%*	40%	No Charge
Inpatient Stay/Surgery	20%	40%	$250 per admission
Outpatient Surgery	20%	40%	$15 Copay
Urgent Care	$25 Copay*	40%	$35 Copay
Emergency Room	$250 Copay*, then 20%		$75 Copay + normal applicable charges
Ambulance Services	20%		$75 Copay
Alternative Care	24 Visit Max per Calendar Year 20% of allowed amount Chiropractic, Acupuncture & Massage (Naturopathic services are covered under Primary Care if provider is practicing within the scope of their license)		$1,500 Max / Calendar Year $15 Copay Chiropractic, Acupuncture & Naturopath $25 Copay Massage (massage max is 12 per year)
Prescription Retail (up to 30-day supply)	$20 Generic* $40 Preferred* $60 Non-Preferred*		$15 Generic $30 Preferred $50 Non-Preferred
Mail Order Rx (up to 90-day supply)	1.5 x Retail		2 x Retail
Vision Benefits	$0 Exam* $250 Hardware allowance per calendar year maximum benefit. No vision network required.		$15 Exam Copay Up to $150 Hardware allowance every 24 months.
Please note: This summary provides a brief description of the Plan benefits. It is not meant to address all covered services, nor does it address all limitations, exclusions, or instances where prior authorization may be required. Please refer to the Summary Plan Document as it is the binding contract in the event of a discrepancy. * Deductible Waived			

Dental Plan Comparison 2017 - 2018			
	Pioneer Dental	**Kaiser Dental**	**Willamette Dental**
Monthly Premium	Employee Only: $13.85 Employee + 1: $58.48 Family: $115.44	Employee Only: $15.35 Employee + 1: $62.73 Family: $103.16	Employee Only: $11.98 Employee + 1: $43.93 Family: $86.53
Annual Deductible	Individual - $50 Family - $150	None	None
Annual Maximum Benefit	$1,500 per person	$1,500 per person	None
Office Visits	None	$15 copay	$10 copay
Preventive Services: Exams, Cleanings, X-rays, Fluoride	Employee pays 0% (deductible waived)	Fully covered after office visit charge	Fully covered after office visit charge
Basic Services: Fillings, Simple Extractions	Employee pays 20% after deductible	Fully covered after office visit charge	Fully covered after office visit charge
Major Services: Crowns, Bridges, Dentures	Employee pays 50% after deductible	Employee pays 20% Coinsurance	Office visit charge plus: Crown $50 each Bridge $50 per tooth Dentures $100 each
Emergency	Employee pays 20% after deductible	$25 copay in-network Plan pays up to $100 for out-of-area emergency	$50 copay in-network. Plan pays up to $100 for out-of-area emergency
Orthodontia	Employee pays 50% after deductible	Employee pays 50% up to $1,500; 100% thereafter	Pre-orthodontic visit $150, $1,200 treatment co-pay
Orthodontia Lifetime Max	$1,500	$1,500	None
Please note: This summary provides a brief description of the Plan benefits. It is not meant to address all covered services, nor does it address all limitations, exclusions, or instances where prior authorization may be required. Please refer to the Summary Plan Document as it is the binding contract in the event of a discrepancy.			

MEDICAL AND DENTAL RATES

Effective March 31, 2017

When will the new rates appear on my paycheck?

- New insurance premiums will appear on your March 2017 paycheck.
- Flexible spending account deductions will begin on your April 2017 paycheck.
- Medical, dental, vision and FSA contributions are deducted from your pay on a pre-tax basis.
- Employees with domestic partners should carefully read the information available through Human Resources regarding the IRS guidelines for premiums the College pays for domestic partner coverage.

Lewis & Clark pays a large percentage of the monthly medical and dental premiums costs for all medical and dental participants. This is in addition to the full premiums for the group Life and AD&D, Long-term Disability, Employee Assistance Plan (Cascade Centers), and 9% of each employee's base salary towards their retirement plan (TIAA).

2017 Benefit Rates					
	Total Premium	**College Cost**	**College Increase**	**Employee Cost**	**Employee Increase**
PEHT/Regence Medical					
Employee Only	$708.57	$594.42	$26.41	**$114.15**	$5.06
Two Party	$1,417.28	$974.87	$41.25	**$442.41**	$19.62
Family	$1,978.29	$1,340.97	$57.10	**$637.32**	$28.26
Kaiser Medical					
Employee Only	$564.00	$481.10	$72.65	**$82.90**	$8.88
Two Party	$1,128.00	$806.82	$128.66	**$321.18**	$34.41
Family	$1,579.20	$1,115.03	$178.57	**$464.17**	$49.73
PEHT/Regence Dental					
Employee Only	$60.46	$46.61	$3.15	**$13.85**	$0.93
Two Party	$120.97	$62.49	$4.23	**$58.48**	$3.93
Family	$169.35	$53.91	$3.68	**$115.44**	$7.75
Kaiser Dental					
Employee Only	$58.60	$43.25	$0.00	**$15.35**	$0.00
Two Party	$117.21	$54.48	$0.00	**$62.73**	$0.00
Family	$164.08	$60.92	$0.00	**$103.16**	$0.00
Willamette Dental					
Employee Only	$40.70	$28.72	$0.00	**$11.98**	$0.00
Two Party	$81.40	$37.47	$0.00	**$43.93**	$0.00
Family	$122.45	$35.92	$0.00	**$86.53**	$0.00

Note: Employees with domestic partners should carefully read the information available through Human Resources regarding the IRS guidelines for premiums the College pays for domestic partner coverage

FLEXIBLE SPENDING ACCOUNTS (FSA)

A Flexible Spending Account enables you to set aside pretax income to pay for health and dependent care expenses. The Plan Year for this benefit is April 1, 2017 through March 31, 2018. There are two Flexible Spending Accounts available: Health Care and Dependent Care. **If you wish to participate in a Flexible Spending Account in 2017, you must complete Workday Open Enrollment.**

Health Care Spending Account

- Pay for medical, dental, vision, and alternative care expenses by setting aside a monthly portion of your pre-tax salary into the Allegiance Flex Advantage account for future use. When you incur an applicable expense, you can use your Benefits Debit Card ***or*** you can submit a simple claim form to Allegiance and they will mail you a check to reimburse the claim amount. **The IRS requires an annual re-enrollment for the Health Care Spending account during the annual Open Enrollment period.** The amount allowed this year is $2,600.
- Up to $500 of unused funds can be rolled over and utilized for purchasing of authorized expenses. Any funds above and beyond $500 that is not used will be lost. All expenses and claims for the 2016-17 benefits year must be submitted by June 30, 2017.

Dependent Care Spending Account

- When you enroll in a Dependent Care Spending account, you are instructing the College to set aside a specific monthly portion of your pre-tax salary into the Allegiance Flex Advantage account for dependent care expenses. Please be advised that IRS regulations do not allow refunds for unused contributions; therefore, this is a “use it or lose it” account. **The IRS requires an annual re-enrollment for the Dependent Care spending account during the annual Open Enrollment period.** The amount allowed this year remains at $5,000 per family. There is no rollover for Dependent Care Flexible Spending.

OTHER LEWIS & CLARK BENEFITS

Employee Assistance Program

Cascade Centers provides individuals with no-cost, private, and confidential short-term counseling and referrals to assist with stresses and problems faced in day-to-day life. Participants may receive up to four sessions, for each issue or situation, in a 12-month period. You may access an immediate and confidential consultation 24 hours a day, seven days a week by calling 1-800-433-2320. You may also e-mail Cascade Centers at info@cascadecenters.com. Visit www.cascadecenters.com for more information. This program is available to employees, their families, and significant others.

Basic Life & Accidental Death and Dismemberment (AD&D)

A College paid group term life insurance plan through LifeMap is available for benefit eligible employees. The college contributes the entire cost for the basic coverage for employees. This basic policy provides you with the security of life insurance and accidental death and dismemberment insurance coverage at 150% of your annual base salary. You can also sign up for voluntary life/accidental death & dismemberment/buy-ups at any time of the year, but a health statement (EOI) will be required if you are past the first 31 days of hire.

Basic Long-Term Disability Coverage

Long-term disability insurance (LTD) replaces up to 60% of your pre-disability income if you are unable to work due to a disability. The college contributes the entire cost for the basic coverage for employees. There is a 180-day waiting period for benefits on approved claims.

TIAA RETIREMENT PLAN

- How much does the College contribute towards my retirement?
    - 9% of your monthly base salary with no employee match required. Even more amazing is that your retirement contributions are immediately fully vested.
- Who is eligible for the College's contribution?
    - You must be 21 years or older and a regular faculty or staff member (not adjunct, temporary, or student), who works at least 1000 hours or more per year.
- When do I start receiving the College's contribution?
    - If you are a new employee, the College will make its first contribution toward your Group Retirement Annuity (GRA) plan on the first day of the month following a year of service. For example, if your hire date is on September 8th, the College's retirement contributions will begin on October 1st of the following year. However, if you can prove that you have completed 12 months of service in which you worked at least 1,000 hours with another institution of higher education within 6 months of starting your employment with Lewis & Clark College and were not adjunct, temporary, or student status, you may be eligible to waive the one-year waiting period. A letter from your former employer is required to document employment.
- When can I start contributing toward my retirement?
    - You can start contributing toward your retirement the first of the month following your hire date. All of our employees are welcome to participate, including our adjunct faculty and temporary employees. All new employees who are not adjunct or temporary are auto-enrolled at 3%, which can be changed or opted out of at any time.
- How do I make changes to my retirement contributions?
    - You can change, start, or stop your contribution at any time in Workday. You are not limited to making changes during the Open Enrollment period. Please keep in mind that your changes may be delayed by one month when changes are submitted in Workday after payroll has been run (it is best to make a change by the 15th of the month to be effective in the month the change is made).

Benefit Contact Sheet

2017 Benefit Provider Contact Sheet			
	Group/Policy Number	**Phone**	**Hours**
Kaiser Medical	1495-001	(800) 813.2000	8am – 6pm
PEHT / Regence Medical	60026055	(866) 240.9580	7am – 6pm
Kaiser Dental	1495-006	(800) 813.2000	8am – 6pm
PEHT / Regence Dental	60026055	(866) 240.9580	7am – 6pm
Willamette Dental	Z908A	(855) 433.6825	8am – 5pm
TIAA (Retirement Savings)	GRA: 101700 GSRA: 101701	(800) 842.2776	5am – 7pm (M–F) 6am – 3pm (Sat)
LifeMap • **Life Insurance** • **AD&D** • **LTD**	OR300475	contact HR x6234	8:30am – 4:30pm
Allegiance • **Healthcare FSA** • **Dependent Care FSA**	503711	(877) 424.3570	7am – 5pm
Cascade Centers, EAP	N/A	(800) 433.2320	always open

Important Legal Notices Affecting Your Health Plan Coverage

The Women's Health Cancer Rights Act of 1998 (WHCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

Newborns Act Disclosure – Federal

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

Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- coverage is lost under Medicaid or a State CHIP program; or
- you or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within 60 days from the loss of coverage or the date you become eligible for premium assistance.

To request special enrollment or obtain more information, contact person listed at the end of this summary.

Notice of patient protections that require designation of a PCP

Kaiser HMO and POS group health plans generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Kaiser Customer Service.

For children, you may designate a pediatrician as the primary care provider.

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free Or Low-Cost Health Coverage To Children And Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. You should contact your State for further information on eligibility –

OREGON – Medicaid and CHIP	WASHINGTON – Medicaid

Medicaid & CHIP Website: http://www.oregonhealthykids.gov Medicaid & CHIP Phone: 1-877-314-5678	Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: 1-800-562-3022 (toll free) ext 15473

Statement of ERISA Rights

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all 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, the Plan and Plan documents, including the insurance contract and copies of all documents filed by the Plan with the U.S. Department of Labor, if any, such as annual reports and Plan descriptions.
Obtain copies of the Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
Receive a summary of the Plan's annual financial report, if required to be furnished under ERISA. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if any.

Continue Group Health Plan Coverage

If applicable, you may continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the Plan for the rules on COBRA continuation of coverage rights.
If you have creditable coverage from another plan, you may be entitled to a reduction or elimination of exclusionary periods (if applicable) of coverage for preexisting conditions under your group health plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to COBRA continuation of coverage, when COBRA continuation of coverage ceases, if you request before losing coverage or if you request it up to 24 months after losing coverage. Without evidence of prior creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for operation of the Plan. These people, called "fiduciaries" of the Plan, have a duty to operate the Plan prudently and in the interest of you and other Plan participants.
No one, including the Company or any other person, may fire you or discriminate against you in any way to prevent you from obtaining welfare benefits or exercising your rights under ERISA.

Enforce your Rights

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in 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 due to reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you have exhausted the available claims procedures under the Plan, you may file suit in a state or 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 (for example, if the court finds your claim is frivolous) the court may order you to pay these costs and fees.

Assistance with your Questions

If you have any questions about your Plan, this statement, or your rights under ERISA, you should contact the nearest office of the Employee Benefits and Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits and Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.