

**MEDICAL AND DENTAL
INSURANCE**

HMSA

TYPES OF PLANS

HRP offers eligible employees two medical and dental benefit plan options: one indemnity (HMSA Preferred Provider Plan) and one Health Maintenance Organization (Health Plan Hawaii Plus).

This is only a summary of the main features of the Plan. The Plan Document is available for review during office hours at the Administration office. **IN CASE OF ANY CONFLICT BETWEEN THIS SUMMARY AND THE ACTUAL PROVISIONS OF THE PLAN DOCUMENT, THE WORDING OF THE PLAN DOCUMENT WILL GOVERN.**

ELIGIBILITY

EMPLOYEES

You are eligible for medical and dental benefits on the first of the month following your date of hire if you are an HRP employee working 20 or more hours per week.

DEPENDENTS

Your dependents become eligible for coverage when you first become eligible for coverage or when they first qualify as eligible dependents.

An eligible dependent is your legal spouse or unmarried children:

- until their 19th birthday. This includes natural and adopted children as well as stepchildren and children under legal guardianship who are wholly dependent on you or living with you in a parent-child relationship.
- after age 19 if incapable of self-support. You must provide proof of incapacity within 31 days of attaining age 19.
- your child may qualify through age 22 if enrolled as a full-time student at an accredited school, college or university.

HOW TO ENROLL

To enroll you must complete the enrollment form and return it to your individual Program's benefits administrator before your effective date of coverage (first scheduled work shift).

EFFECTIVE DATES

Membership will be effective on the first day of the month following your date of hire, providing you have submitted a completed enrollment form.

LATE ENROLLMENT

If you do not enroll yourself or your dependents by the first day of the month following your date of hire, you will not be allowed to enroll until the next announced open enrollment period.

CHANGES IN YOUR ENROLLMENT

You may change your health care elections under the benefit program during HRP's annual open enrollment. Changes take effect on July 1 following open enrollment and apply for that insurance contract year.

MID-YEAR CHANGES

Mid-year changes in your enrollment are limited to the following circumstances:

- If you have new dependents (through marriage, birth, adoption), you may add them to the plan in which you are enrolled.
- If you lose eligible dependents (through divorce, death, or because the dependents no longer qualify due to their age), you may drop coverage for the dependent(s). A signed Payroll Deduction Authorization Form will allow an adjustment to your monthly medical premiums for the balance of the plan year.
- If your spouse involuntarily loses health care coverage through another job -- that is, because of termination of employment or cancellation of a benefit plan, and you had elected not to enroll you or your dependents in the benefit program because you had coverage through your spouse's plan, you may enroll in the HRP plan.
- If you or your spouse's employment status changes -- that is, your spouse goes to work or stops working or you or your spouse switch from part-time to full-time working status, you may be able to change your election. In this instance please contact Administration's HR Generalist for assistance at (808) 528-1495.
- If you move outside the HMO's service area, you may transfer to the other plan.

In any of these circumstances, your request for change, or enrollment, application must be submitted to your program's benefits administrator during the 30-day period after the change occurs. ***Changes submitted past the 30-day period will be disallowed until the next open enrollment.***

TERMINATION OF COVERAGE

Your coverage under the medical and dental plans stops on the earliest of the following days:

- The last day of the month when you leave active employment (unless you are disabled or taking a paid, or unpaid, leave of absence).
- You stop making any required contributions for coverage or cancel your coverage.
- You no longer meet the plan's eligibility requirements, or
- The plan or the insurance contract terminates.

CONTINUATION OF BENEFIT COVERAGE

COBRA PROGRAM

COBRA Continuation Coverage in General

1. In 1986, Congress passed the Consolidated Omnibus Budget Reconciliation Act, commonly called COBRA. This law generally requires that most employers with group health plans offer employees and their covered Dependents the opportunity to temporarily continue their health care coverage at group rates when coverage under the plan would otherwise end.
2. If you or your Spouse and/or Dependent Child(ren) are covered under the medical plan, you and/or your Dependents can continue coverage for a time if coverage ends for one of several reasons.

Qualifying Events and Maximum Periods of Continuation of Coverage

<u>Qualifying Event</u>	<u>Employee</u>	<u>Spouse</u>	<u>Dependent Child(ren)</u>
Employee terminated (for other than gross misconduct)	18 months	18 months	18 months
Reduction in hours worked (making employee ineligible for the same coverage)	18 months	18 months	18 months
Employee dies	N/A	36 months	36 months
Employees becomes divorced or legally separated	N/A	36 months	36 months
Employee becomes entitled to Medicare	N/A	36 months	36 months

<u>Qualifying Event</u>	<u>Employee</u>	<u>Spouse</u>	<u>Dependent Child(ren)</u>
Dependent Child ceases to be eligible as a Dependent	N/A	N/A	36 months

When the Plan Must Be Notified of a Qualifying Event

In order for a Spouse or Dependent Child to be entitled to continue coverage, the employee, Spouse, or Dependent Child must notify the Plan of:

1. The death of the employee;
2. The divorce or legal separation from the employee; or
3. The event under which a Dependent Child loses Dependent status **within 60 days after the event occurs. If the plan does not receive written notice of any such event within that 60-day period, the Spouse and/or Dependent Child(ren) will not be eligible for COBRA continuation coverage.** This notification is also necessary so that the Plan Administrator may provide you, your Spouse and/or Dependent Child(ren) with a Certification of Creditable Coverage in the event COBRA Continuation Coverage is not elected. Your notice should be sent to the Plan Administrator at the address shown under the heading of Plan Administrator in the Other Information section of this document.

Notice of Entitlement to COBRA Continuation Coverage

When your employment terminates or your hours are reduced so that you are no longer entitled to coverage under the Plan, or the Plan is notified on a timely basis that you died, divorced or were legally separated, became entitled to Medicare, or that a Dependent Child lost Dependent status, you and/or your Dependent(s) will be notified that you and/or they have the right to continue their health care coverage(s). You and/or your Dependent(s) will then have 60 days to apply for COBRA continuation coverage. **If you and/or they do not apply within that time, health care coverage will end as of the last day of the calendar month in which the qualifying event occurs.**

Coverage Provided When COBRA Continuation Coverage Is Elected

1. If you and/or your Dependent(s) choose COBRA Continuation Coverage, the Plan provides coverage that is identical to the current coverage that is provided for similarly situated employees or family members.
2. If, during the period of COBRA Continuation Coverage, you marry, have a newborn child, or have a child placed with you for adoption, that Spouse

or Dependent Child may be enrolled for coverage for the balance of the period of COBRA Continuation Coverage on the same terms available to active employees. Enrollment must occur no later than 30 days after the marriage, birth or placement for adoption. A child born or placed for adoption while you are on COBRA Continuation Coverage (but not a spouse you marry while you are on COBRA Continuation Coverage) will have all the same COBRA rights as your Spouse or Dependent Children who were covered by the Plan before the event that resulted in your loss of coverage. Otherwise, the same rules about Dependent status and qualifying changes in family status that apply to active employees will apply to those Dependents. Adding a Spouse or Dependent Child may cause an increase in the amount you must pay for COBRA Continuation Coverage.

3. If, during the period of COBRA continuation coverage, the Plan's benefits change for active employees, the same changes will apply to you and/or your Dependent(s).

Changes to Maximum Period of COBRA Continuation Coverage

1. Multiple Qualifying Events

- If your continuation coverage (according to the table above) is for a maximum period of 18 months, and during that period, another qualifying event takes place that would otherwise entitle a Spouse or Dependent Child to a 36-month period of continuation coverage, the 18-month period will be extended for that Spouse or Dependent Child. The total period of coverage for any Spouse or Dependent Child will never exceed 36 months from the date of the **first** qualifying event. For example, if you terminated employment and elected COBRA continuation coverage for 18 months for you and your covered Spouse and/or Dependent Child(ren), and died during that 18-month period, the continuation coverage for your Spouse and/or Dependent Child(ren) could be extended for the balance of 36 months from the date your employment terminated.
- However, if you become entitled to COBRA continuation coverage because of termination of employment or reduction in hours worked that occurred less than 18 months after the date you became entitled to Medicare, your Spouse and/or Dependent Child(ren) would be entitled to a 36-month period of COBRA continuation coverage beginning on the date you became entitled to Medicare.

2. **Entitlement to Social Security Disability Income Benefits**

If you, your Spouse or any of your covered Dependent Child(ren) are entitled to COBRA continuation coverage for an 18-month period, that period can be extended for the Covered Individual who is determined to be entitled to Social Security disability income benefits, and for any other covered family members, for up to 11 additional months if all of the following conditions are satisfied:

- The **disability occurred** on or before the start of COBRA continuation coverage, or within the first 60 days of COBRA continuation coverage; and
- The disabled Covered Individual **receives a determination** of entitlement to Social Security disability income benefits from the Social Security Administration; and
- The Plan **must be notified** by you or the disabled Covered Individual that the determination was received:
 - **no later than 60 days after it was received; and**
 - **before the 18-month COBRA continuation period ends.**

This extended period of COBRA continuation coverage will end at the earlier of the end of 29 months from the date of the qualifying event or the date the disabled individual becomes entitled to Medicare.

Cost to You for COBRA Continuation Coverage

1. You, your covered Spouse and/or your covered Dependent Child(ren) will have to pay 102% of the full cost of the coverage during the COBRA continuation period. However, any individual or whose coverage is extended beyond 18 months because of entitlement to Social Security disability income benefits must pay 150% of the full cost of coverage during the 11-month extension of COBRA continuation coverage.
2. The amount you, your covered Spouse and/or your covered Dependent Child(ren) must pay for your COBRA continuation coverage will be payable monthly. There will be an initial grace period of 45 days to pay the first amounts due starting with the date continuation coverage was elected. There will then be a grace period of 30 days to pay any subsequent amounts due. If payment of the amounts due is not received by the end of the applicable grace period, the COBRA continuation coverage will terminate.

3 If:

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under the Plan. If, within 62 days after your coverage under this Plan ends, you and/or your covered Dependents become eligible for coverage under another group health plan, or if you buy, for yourself and/or your covered Dependents, a health insurance policy, this certificate may be necessary to reduce any exclusion for Pre-Existing Conditions that may apply to you and/or your covered Dependents in that group health plan or health insurance policy. The certificate will indicate the period of time you and/or they were covered under this Plan, and certain additional information that is required by law.

- B. The certificate will be sent to you (or to any of your covered Dependents) by first class mail shortly after your (or their) coverage under this Plan ends. If you or any of your covered Dependents elect COBRA Continuation Coverage, another certificate will be sent to you (or if COBRA Continuation Coverage is provided only to your covered Dependent(s), to the Dependent(s)) by first class mail after the COBRA Continuation Coverage ends for any reason.
- C. In addition, a certificate will be provided to you and/or any covered Dependent upon receipt of a request for such a certificate if that request is received by the Plan Administrator within two years after the later of the date your coverage under this Plan ended or the date COBRA Continuation Coverage ended.

LEAVE OF ABSENCE

You may continue your health care coverage until the end of the month during an approved leave of absence **by paying your full share of the premium (if applicable)**. Should the leave of absence fall under The Family and Medical Leave Act of 1993, HRP provides up to a total of 12 weeks of unpaid, job-protected leave during any 12 month period to eligible employees for certain family and medical reasons. Contact the Human Resources Generalist for further details.

MILITARY LEAVE OF ABSENCE

If you go on active duty in the U.S. armed forces, you will cease to be covered under the regular group health plan as of the end of the month in which you enter active military service. However, you have the following rights to continue coverage:

1. If your military leave period is for 30 days or less, you have the right to continue medical coverage for yourself and dependents that were covered under our group medical plan for up to 31 days, your cost is the same as when active.

2. If the military leave period is for 31 days or more, you have the right to elect COBRA coverage for yourself and your dependents who were covered under the group medical plan and you will be responsible for 100% of the premiums plus a 2% administrative cost.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO)

The Omnibus Budget Reconciliation Act of 1993 requires all employers to honor Qualified Medical Child Support Orders (QMCSOs) by providing group health plan benefits for children whose parents are divorced or separated. When the company, as plan sponsor, receives a QMCSO, we must promptly notify the employee and the child that the order has been received and what procedures we will use to determine if the order is “qualified”. If we determine the order is “qualified” we will deduct from the employee’s paycheck the amount necessary to pay for such coverage. We will notify the affected employee once we determine whether or not the order is qualified. Participants and beneficiaries can obtain a copy of the procedures governing QMCSO determinations from the Plan Administrator without charge.

COST TO YOU

HRP pays the entire cost of medical and dental coverage *for you* if you enroll in the available HMO. If you enroll in the available HMO for two-party or family coverage, HRP pays 90% of the cost of medical, drug, vision, and dental coverage. The remaining cost (10%) for providing coverage to your dependents will be deducted from your earnings each pay period. Alternatively, if you select medical and dental coverage under the Preferred Provider Plan, you will be required to pay an additional amount for covering yourself or your dependents.

Costs of this plan will be automatically deducted from your earnings each pay period on a **pre-tax basis**. If you wish to have your cost/premiums deducted *after-tax*, contact your Program’s benefits administrator or Human Resources to sign a declination form.

WAIVING MEDICAL AND DENTAL INSURANCE

If you have health insurance coverage through another source and decide to voluntarily waive your coverage, HRP will directly pay you a cash incentive in addition to your regular wages on an after tax basis. The current incentive is \$100 per month (less applicable taxes); amount is subject to change every July 1.

Should you lose coverage, you are entitled to enroll in the HRP health plan on the first day of the month following such loss. For information on how to enroll, see first page of this section.

OTHER INFORMATION YOU SHOULD KNOW

Under ERISA, you have the right to know certain information about your benefits. This includes descriptions of the benefits, eligibility and claims information, and the specific plan information outlined below:

Employer	Hawaii Residency Programs, Inc. 1356 Lusitana Street, Rm. 510 Honolulu, HI 96813-2478 Tel No. (808) 528-1495
Employer Identification Number	99-0215841
Plan Name	Hawaii Residency Programs Employee Benefit Program
Plan Number	501

Type of Plan	Welfare Benefit Plan providing Medical and Dental benefits
Plan Year	July 1 To June 30
Type Of Administration	Contract Administration
Plan Administrator	Executive Director Hawaii Residency Programs, Inc. 1356 Lusitana Street, Rm. 510 Honolulu, HI 96813-2478 Tel. No. (808) 528-1495
Plan Agent for Legal Process	Legal process may be served on the Plan Administrator at the following address: Executive Director Hawaii Residency Programs, Inc. 1356 Lusitana Street, Rm. 510 Honolulu, HI 96813-2478
Plan Funding	The plans are funded by a combination of employee contributions and Hawaii Residency Programs, Inc.
Labor Organizations	None

NO EMPLOYMENT CONTRACT

Nothing in the welfare plans sponsored by HRP shall confer any rights of continued employment or in any way prohibit changes in the terms of employment of any employee covered under these plans.

WOMEN'S HEALTH CANCER RIGHT ACT

The Women's Health and Cancer Act of 1998 requires that the following benefits are offered under this Plan:

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and physical complications in all stages of mastectomy, including lymphedemas.

Coverage may be subject to annual deductibles and co-insurance provisions under a plan.

MENTAL HEALTH PARITY ACT

Mental health and substance abuse services are provided according to an individual treatment plan that is approved by HMSA. Benefit limitations are listed in the Guide to Benefits except for serious mental illness as defined by Hawaii law.

MINIMUM MATERNITY STAY

The Newborns' and Mothers' Health Protection Act covers maternity length of stay for up to:

- 48 hours from time of delivery for normal labor and delivery: or
- 96 hours from time of delivery for a cesarean birth.

However, Federal law does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or the newborn earlier than 48 hours (or 96 hours as applicable).

CLAIMS PROCEDURES

A. Your Request for an Appeal

If you wish to dispute a determination made by HMSA related to coverage, reimbursement, or any other matter related to this Agreement, you must request an appeal. Your request must be in writing unless you are requesting an expedited appeal. We must receive it within one year from the date we first informed you of the denial or limitation of your claim, or of the denial of coverage for any requested service or supply.

Address written requests to: HMSA
 Attn: Appeals Coordinator
 P.O. Box 1958
 Honolulu, HI 96805-1958

Or, send us a fax at (808) 952-7546

And, provide the information described in the section below labeled, "What Your Request Must Include". Requests which do not comply with the requirements of this chapter will not be recognized or treated as an appeal by us.

If you have any questions regarding appeals, you can call us at (808) 948-5090, or toll free at 1-800-462-2085.

B. Appeal or Our Precertification Decision

HMSA will respond to your appeal as soon as possible given the medical circumstances of your case but not later than 30 days after receipt of your appeal.

C. Appeal of Any Other Decision

HMSA will respond to your appeal within 45 calendar days of receipt of your appeal.

D. Expedited Appeal

You may request expedited appeal if application of the time periods for appeals above may:

- Seriously jeopardize your life or health,
- Seriously jeopardize your ability to gain maximum functioning, or

- Subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal.

You may request an expedited appeal by calling HMSA at (808) 948-5090, or toll free at 1-800-462-2085.

HMSA will respond to your request for expedited appeal as soon as possible taking into account your medical condition but not later than 72 hour so receipt of your request.

E. Who Can Request an Appeal

Either you or your authorized representative may request an appeal. Authorized representatives include:

- Any person you authorize to act on your behalf provided you follow our procedures which include filing a form with HMSA. To obtain a form to authorize a person to act on your behalf, call HMSA at (808) 948-5090, or toll free at 1-800-462-2085. (Requests for appeal from an authorized representative who is a physician or practitioner must be in writing unless requesting expedited appeal.)
- A court appointed guardian or an agent under a health care proxy.

F. What Your Request Must Include

To be recognized as an appeal, your request must include all of the following information:

- The date of your request.
- Your name.
- The date of the service we denied (or in the case of precertification for a service or supply, the date of our denial of coverage for such service or supply).
- The subscriber number from you member card.
- The provider name.
- A description of facts related to your request and why you believe the decision was in error.
- Any other information relating to the claim for benefits including written comments, documents, and records you would like us to review.

You should keep a copy of the request for your records. It will not be returned to you.

If You Disagree with HMSA's Appeal Decision

If you disagree with HMSA's decision, you must either 1) request arbitration before a mutually selected arbitrator, or 2) file a lawsuit against HMSA. If you are not enrolled in an employer sponsored group plan subject to ERISA, you have the additional option of requesting a review by a panel appointed by the Hawaii State Insurance Commissioner.

A. Request for Arbitration

You may request arbitration by submitting a written request for arbitration to HMSA, Legal Services, P.O. Box 860, Honolulu, Hawaii 96808-0860. Your request for arbitration will not affect your rights to any other benefits under this plan. You must have fully complied with HMSA's appeals procedures described above and we must receive your request for arbitration within one year of the decision of your appeal. In arbitration, one person (the arbitrator) reviews the positions of both parties and makes the final decision to resolve the disagreement. The arbitration is binding and the parties waive their right to a court trial and jury.

Before arbitration actually starts, both parties (you and HMSA) must agree on the person to be the arbitrator. If both cannot agree within 30 days of your request for arbitration, either party may ask the First Circuit Court of the State of Hawaii to appoint an arbitrator.

The arbitration hearing shall be in Hawaii. The questions for the arbitrator shall be whether HMSA was in violation of law, or acted arbitrarily, capriciously, or in abuse of discretion.

The arbitrator will make a decision as quickly as possible and will give both parties a copy of this decision. The decision of the arbitrator is final and binding and no further appeal or court action can be taken.

HMSA will pay the arbitrator's fee. You must pay your attorney's or witness's fees, if you have any, and HMSA must pay for their own. The arbitrator will decide who will pay all other costs of the arbitration.

HMSA waives any right to assert that you have failed to exhaust administrative remedies because you did not select arbitration.

B. Request for Review by Insurance Commissioner

If you are not in an employer sponsored group plan subject to ERISA, you may request review by a panel selected by the Hawaii Insurance Commissioner by submitting a request for review within 60 days of the date of our decision to the Insurance Commissioner at:

Hawaii Insurance Division
Attn: Health Insurance Branch – External Appeals
250 South King Street, Fifth Floor
Honolulu, HI 96813
Telephone: (808) 586-2804

If your request for review is accepted by the Commissioner, the Commissioner will appoint a three member panel composed of a representative from another health plan, a provider not involved in your care, and a representative from the Commissioner's office. A hearing will be conducted within 60 days and the panel will issue a decision within 30 days of the hearing.

You may request expedited review by the Insurance Commissioner if application of the above time frames may:

- Seriously jeopardize your life or health,
- Seriously jeopardize your ability to gain maximum functioning, or
- Subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal.

STATEMENT OF ERISA RIGHTS

As a participant in the HRP medical and dental plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the plan administrator's office, all documents governing the plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefits Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and copies of the latest annual report (From 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

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 or your dependents may

have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another 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 elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of 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 plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

