FOCUS On Benefits

September, 2005

In This Issue

Applying for Medicare Part D Subsidy

The *Medicare Modernization Act of 2003* created Medicare Part D — the prescription drug benefit effective in 2006. It also formed the Retiree Drug Subsidy (RDS) Center of the Centers for Medicare and Medicaid Services (CMS). At a recent RDS conference, we heard about how to apply for one of several incentives to encourage employers to continue retiree medical plans with prescription drug coverage. Specifically, the RDS conference focused on a non-taxable individual subsidy of 28 percent of the value of the drug benefits provided by the employer plan — provided they are at least as valuable as those under Part D.

More than 800 plan sponsors, service providers and consultants were given information about the application process. There is a very short window this year — August 1 through September 30 — and RDS has clearly communicated that incomplete applications are treated as not filed. Many of the steps will take several days for CMS to validate so waiting too long to apply can result in forfeiting the subsidy for 2006.

There are five essential elements to the application process:

1. Apply by September 30, 2005 to qualify for the 2006 subsidy.
2. Attach an actuarial certification.
3. Certify that the creditable coverage status of the plan will be disclosed to plan participants and CMS.
4. Electronically submit enrollment information for retirees.
5. Electronically submit aggregate data about drug costs and reconcile at the end of the year.

All plans must appoint an authorized representative, an account manager, an actuary, and designees to go through the process. Each person can only perform one job on the Web site. An authorized representative must be someone from the employer with authority, such as the chief executive officer or chief financial officer. The account manager can be an employee or outside consultant, and will also be the individual to complete the information in the online application.

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Each appointment must be submitted via the RDS Web site. Validation of those appointments will take a few days, it is best to designate those positions as soon as possible.

Submitting Information

There are three ways to submit information about retirees for whom the employer will be claiming a subsidy: mainframe-to-mainframe via AT&T Global Network Services (AGNS), upload to RDS Web site, or voluntary data sharing agreements (VDSA). Presumably third party administrators, pharmacy benefit managers, and the carriers will have most of the information already and they will provide most of the heavy lifting in the application process.

Actuarial Certification

Actuaries must certify that the employer's plan provides a drug benefit that is at least actuarially equivalent to the Medicare Part D plan. Actuaries will not have to submit work papers, but will need to maintain them for audit purposes. Please contact your Willis representative for help with any related actuarial work.

Payment Schedule

Employers may be paid monthly, quarterly, interim annual, or annually. For an annual payment, the employer will wait to submit the request for payment until the amount of actual annual drug expenses net of rebates is available. For all other payment schedules, the employer will submit estimated net annual drug expenses and must reconcile with actual drug cost and rebate data within 15 months of the close of the plan year. Payment frequency cannot be changed for a current year, but the payment frequency could be changed in future years.

Payment and Reconciliation

CMS is still developing the payment process and more information is expected. What is clear is that the subsidy is paid to the plan sponsor. It is not a plan asset, and the plan sponsor has complete freedom in deciding what to do with the subsidy. Payments will be made within 30 days after a request for payment and perhaps earlier. The RDS Center plans to process payments once a week.

For a self-funded plan, the employer must submit the following data for the month in which drug costs were paid:

- Gross Rx costs paid
- Threshold reduction ($250 per participant)
- Limit reduction ($5,000 per participant)
- Estimated cost adjustment (for rebates, etc.)

Fully insured plans may submit premium information after which an actuary would need to allocate the portion of the premium amount between the cost threshold and cost limit. The employer would then follow the same format for reconciliation as self-funded plans (e.g., provide actual drug cost and rebate data). If premiums include rebates, the employer will not need to submit other rebate data.

The employer or a plan administrator may submit cost data. Using the online application, the account manager will designate a benefit option administrator (BOA)

for each benefit option. The BOA will submit the claims data. Claims data must be submitted at the benefit option level. CMS is considering whether this will be true even if the benefit options are aggregated. Even if an employer is required to submit data quarterly or annually (based on payment frequency selected), data must be reported based upon monthly figures.

Questions

Conference materials are available at http://rds.cms.hhs.gov/events/presentations.html. Starting on August 1, 2005 employers may also use this Web site to apply for the subsidy for the January 1, 2006 plan year.

Employers may submit questions about RDS operations through the Web site: http://rds.cms.hhs.gov/. The RDS Center has a goal of responding to all questions within 48 hours. Finally, a help line is also available by calling 1-877-RDS-HELP and the Web site offers contact via e-mail.

Electronic Transmission of Employee Benefit Information

In 2000, Congress enacted a law making electronic signatures as valid as ink signatures. Called the *Electronic Signatures in Global and National Commerce Act*, Public Law 106-229 (E-SIGN), this bill allowed electronic documents and signatures that otherwise met applicable legal requirements, to have the same legal force as those handwritten on paper. Under the law, no contract, signature, or record could be denied legal effect solely because it was in electronic form.

On July 13, 2005, the Treasury Department and the Internal Revenue Service issued proposed regulations entitled *Use of Electronic Technologies for Providing Employee Benefit Notices and Transmitting Employee Benefit Elections and Consents*. These proposed regulations address the use of electronic media to provide communication between a plan and its participants, and coordinate with the existing E-SIGN statute from the year 2000. Ultimately, the proposed regulations allow a plan to use electronic media either under the E-SIGN statute or under an alternative electronic communication method that is as protective of participant rights.

Effective Date

These proposed regulations will apply prospectively and will apply no earlier than the date of the publication of final regulations in the *Federal Register*. Although these rules offer an interesting glimpse of what lies ahead, until final regulations are issued plan sponsors should not rely upon these proposed regulations. Meanwhile, plan sponsors should continue to follow existing IRS guidance regarding electronic communications.

Two Methods of Electronic Communications

The proposed regulations recognize two methods of communicating through electronic media, and compliance with either will satisfy compliance standards in the proposed regulations.

The first acceptable method of electronic communication requires a plan to obtain the recipient's consent before sending a notice or communication by electronic means. The consent must demonstrate that the recipient can retrieve the com-

munication in electronic form.

Before a participant agrees to the electronic delivery, the participant must receive a disclosure statement that contains the following:

- Scope of the consent
- Participant's right to withdraw his consent to receive the communication electronically (including a description of conditions, consequences, or associated fees)
- Right to receive the communication in paper form
- A description of the hardware and software requirements used in accessing the electronic media, and
- Procedures for updating information to contact the participant electronically

The second acceptable method of electronic communication has guidelines that were issued before the E-SIGN statute was created. Under the alternate rules for electronic distribution, recipients:

- Must have the effective ability to access the electronic medium being used to provide the notice
- Must be advised that they can request a paper version of the notice at no charge

The IRS stresses that the information should be provided to the recipient in a manner no less understandable to the recipient than if provided on a written paper document. Additionally, the electronic transmission must alert the recipient to the significance of the transmittal and tell how to access the notice.

Administering Elections and Consents

Most importantly, the participant must be able to access the electronic system that is used. The system must also preclude anyone other than the participant from making elections or providing consent. To accomplish this, plans should consider using electronic identifiers such as personal identification numbers. The plan must provide a reasonable opportunity to "review, confirm, modify, or rescind" any election choice that is made as long as the participant takes action before the election becomes effective.

Finally, the participant making the election must, within a reasonable time period, receive a confirmation of the election through either a paper document or an electronic confirmation.

The proposed regulations would also permit electronic notarization of a signature. The rules, however, require that the signature must be witnessed in the presence of a plan representative or notary public whether the signature is on paper or through an electronic format. Plans can expect further guidance on this issue because the IRS has requested formal public comment.

Plans Affected

Some of the plans that may use electronic media communications include the following:

- 401(k)
- 403(b)

- Accident and health plan
- Cafeteria plan
- Health savings account

Summary Plan Descriptions, Summaries of Material Modifications, Summary Annual Reports, and COBRA notices may all be distributed electronically since those key disclosures were not exempted by the proposed regulations. Specifically exempt from the proposed regulations are items like tax reporting, tax records, or substantiation of expenses and the proposed regulations generally do not apply to any notices, elections, consents, or disclosures required that are regulated by the Department of Labor's Pension Benefit Guaranty Corporation.

Patient Safety Debated

Nearly 100,000 Americans die every year as a result of preventable medical errors. Health care officials say increased reporting of such errors would make it easier to spot harmful practices and to implement safeguards. A key problem associated with the current healthcare system is that it penalizes honesty. Why? Reporting such errors often leads to the loss of a medical license or a lawsuit.

The Leapfrog Group boasts more than 170 members (including many Fortune 500 companies) that provide health benefits for their employees. It was started several years ago as an employer initiative to address medical errors and enhance patient safety. The group's stated mission is the pursuit of healthcare safety, quality and affordability. Taken together, Leapfrog members spend about $67 billion annually on health care benefits for 36 million Americans. Living up to their name, the group has made a huge leap toward making healthcare safer.

Last month Congress forwarded a bill designed to increase reporting of medical mistakes to President Bush. This legislation is aimed at creating a national database of hospital and medical errors through a network of patient safety organizations. These organizations would receive voluntary information from health care providers. The system, once in place, would evaluate the data and offer solutions to common medical errors in an attempt to improve medical care in the United States. According to the Congressional Budget Office (CBO), legislators hope that although this is voluntary, health care providers will participate to reduce the number of patients who die due to medical error. The next five years of set up and implementation of the database system could cost $58 million.

Similar legislation passed both chambers of Congress last year, but the session ended before a final agreement was reached. The House and Senate bills are virtually identical, so the bill only needs the signature of President Bush before becoming law.

Critics are already attacking the proposal as far more expensive than the CBO projects. Some studies suggest that costs would run closer to $150 billion in startup expenses and $40 billion in annual operating costs. The private sector is expected to bear these costs. The private sector would likely also benefit from use of archived database information.

IRS Issues Priority Guidance for 2005-2006

The U.S. Department of Treasury and IRS have released their 2005-2006 Priority

Guidance Plan listing those issues that will be the subject of formal guidance during the next year. The government also promised to issue "increased and timelier published guidance" in the future. They also state that "the published guidance process can only be fully successful if [the agencies] have the benefit of the insight and experience of taxpayers and practitioners who must apply the rules." Individuals should submit comments and suggestions throughout the year as the agencies work on their guidance.

The plan includes at least 250 projects dealing with tax topics that affect individuals, corporations, charities, international transactions, and employee benefit plans. The following are a few of the projects affecting retirement, health, and executive compensation programs:

- Final regulations on electronic notices;
- Additional guidance on debit cards in employer-provided medical reimbursement arrangements;
- Guidance on the impact of providing a two-and-a-half month grace period for dependent care assistance plans and health flexible spending arrangements;
- Proposed regulations on cafeteria plans;
- Guidance on the tax treatment of distributions from Roth 401(k) plans and final Roth 401(k) regulations;
- Final regulations concerning in-service distributions under phased retirement arrangements;
- Proposed regulations updating mortality tables;
- Final regulations under Section 417 on the relative value of optional forms of benefit;
- Guidance examining the impact of the Medicare prescription drug subsidy and its minimum cost requirement;
- Proposed regulations addressing numerous issues with respect to the taxation of nonqualified deferred compensation under Section 409A; and
- Final regulations on a flat rate supplemental wage withholding.

Survey: Grace Period Proves Popular

Findings of a recent national study indicate that about half of those employers surveyed plan to allow employees to take advantage of new federal tax rules that permit them to carry over unused flexible health care spending accounts for two and a half months into a new year. The same study shows that only 34 percent of respondents plan to extend the grace period to allow participants in both the health care and dependent care flexible spending accounts (FSA) to carry over unused money. In another key finding, an astonishing 97 percent of the companies surveyed offered some form of flexible spending account.

Last May, the IRS issued guidance allowing employers to amend plans to give health and dependent care FSA participants a grace period of up to two and a half months to incur eligible expenses that can be paid from the previous year's salary contributions. The grace period is designed to provide some relief from the use-it-or-lose-it rule, which requires employees to forfeit any money remaining in their FSAs at the end of the plan year. However, unanswered questions remain. (For additional information about the grace period and for sample materials, please see *Willis EB Alert* #37.)

The survey also asked respondents for other reasons for not offering the grace period. Several respondents said they were planning to implement consumer-

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driven health plans with health savings accounts (HSAs) in 2006, and individuals participating in the health FSA this year would not be eligible to fund HSAs during the grace period. Others cited various administrative problems, and some expressed doubts whether the grace period would change employee behavior.

Pregnancy Discrimination Growing?

The SHRM organization (Society for Human Resource Management) notes that the number of employees filing pregnancy-discrimination suits has increased dramatically over the last decade. SHRM observations also claim that with passage of the Family Medical Leave Act (FMLA) and similar anti-discrimination laws, pregnant workers have become more aware of their legal rights. Also, pregnant women are far more likely to want to remain on the job after giving birth than they were in the past. As a result, discriminatory behavior towards pregnant workers is more often reported and employers should take steps to prevent inadvertent discrimination.

The best way to make sure that an employer does not discriminate is to implement a policy that treats pregnant workers exactly the same as any other worker who has a temporary disability. Employers should provide information about pregnant workers' rights under the FMLA and be sure that employees understand standards of appropriate communication regarding pregnancy. In addition, providing the appropriate training to employees and educating them about the non-discrimination rules will help ensure that they follow the rules; and support good faith efforts if a complaint does arise. Employers who can demonstrate that they maintain a process in which workers can direct discrimination complaints may also mitigate the effects of complaints. Please contact your Willis representative if you want to review and develop policies to help maintain compliance.

Companies Facing Pension Shortfalls

Airlines aren't the only ones struggling with their pension plan obligations, so too are companies in the manufacturing, trade, agriculture, finance, and insurance industries. According to the *Wall Street Journal*, the four major airlines only account for $13 billion in underfunding, while firms in other sectors have pension plans that are underfunded by $60 billion.

Critics are calling for legislative reform now more than ever. The House Education and Workforce Affairs Committee recently passed reforms that would require firms to contribute more cash to their retirement plans and prevent them from projecting long-term health of the plan when it is presently struggling. The provisions will be woven into other legislation and face a full House vote in the near future. Lawmakers are eager to close loopholes in pension accounting that sometimes enable plans to appear healthier than they are. The time period companies use to calculate future pension returns could be reduced from five years to as little as 90 days. Other changes are likely to increase payments for companies with a 40 percent or higher shortfall in their pension plans.

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Chop Pharmacy Costs by "Pill Splitting"

According to several news sources, insurers are encouraging "pill splitting." The patient must split the pill in half to acquire the appropriate dosage. The practice is intended to save patients a copayment and save plan sponsors prescription costs. Last month, UnitedHealthcare and ConnectiCare both launched pill-splitting programs, and the Regence Group (a health insurer operating in Oregon) says it saves $5 million a year through pill splitting, which it has been actively promoting for nearly two years. The design of pill-splitting programs offered by insurers come in several variations, but their goal is all the same: target "flat-priced" prescription drugs and encourage members to ask their doctors to write higher-dose scripts for those drugs.

On June 1, 2005, UnitedHealthcare began promoting pill splitting in Wisconsin and has plans to offer the program to its 12.5 million nationwide drug-benefit subscribers by the end of this year. The program encourages the splitting of certain antidepressants, cholesterol drugs and hypertension medications.

UnitedHealthcare and ConnectiCare use voluntary programs and encourage members to obtain a 15-tablet prescription from their physician so they can pay only half the copay at the pharmacy. Although the option is there for them to get a 30-tablet prescription and pay one copay for a 60-day supply, they recommend starting with a 15-tablet prescription in case they're not happy with splitting.

The Regence Group first piloted a pill-splitting program two years ago in Washington and has since rolled out the program to almost all of its clients. It, too, is a voluntary program and features flat-priced pills — but it encourages patients to obtain a 30-tablet prescription from their physicians instead of 15 tablets.

A spokesman for the Pharmaceutical Research and Manufacturers of America (PhRMA) expressed concerns about accurate dosing; indicating that if a pill is not split accurately a patient can receive too much or too little medicine. The insurers contend that the medications they have selected for pill splitting are all standard immediate-release tablets and are effective even if they are split unevenly, meaning that cutting them in half does not affect drug absorption.

Issue Spotlight: Cafeteria Plans and the FMLA

A cornerstone of cafeteria plans is the irrevocability of plan elections. The IRS does recognize exceptions to this rule and will permit revocations due to changes in family status. The IRS does not require plan sponsors to allow cafeteria plan election revocations. Instead, plan sponsors are permitted to allow changes. Some plan sponsors, for a variety of reasons, refuse to permit an employee to revoke an election for any reason. IRS regulations recognize, however, that the FMLA gives an employee the independent right to revoke a group health plan coverage election, including health spending account elections. This right is distinct from any change in family status provision in the cafeteria plan document. The regulations also give an employee the right to reinstate an election upon return from FMLA leave.

IRS regulations cover arrangements for payment of health insurance costs and health care spending account contributions while an employee is on unpaid FMLA leave. These regulations apply to both insured and self-funded plans. (The regulations do not apply when an employee takes paid FMLA leave. During paid

leave, the employee's share of the premiums would be paid by the method normally used during any paid leave.)

The regulations authorize ways to make employee contributions to a cafeteria plan while on unpaid leave. A cafeteria plan may — on a nondiscriminatory basis — offer the following payment options: pre-pay, pay-as-you-go, or catch-up.

Pre-pay: With pre-pay, a cafeteria plan allows an employee to pay, before beginning the FMLA leave, the amounts that will be due for the FMLA leave period. An employer may not require that an employee pre-pay the amounts due for the leave period. The regulations also state that the pre-pay option can never be the only option available. However, the cafeteria plan may limit the availability of the pre-pay option to an employee on FMLA leave.

Under the pre-pay option, contributions may be made on a pre-tax salary reduction basis from any taxable compensation. As an example of taxable compensation, the IRS cites the "cashing-out" of unused sick pay or vacation time (when permitted by the employer) as an appropriate way to pre-pay group health plan premiums or health care spending account contributions. In addition, the rules permit the pre-payment of these amounts on an after-tax basis.

If an employee's FMLA leave spans two different plan years, the cafeteria plan cannot allow an employee to defer compensation from one cafeteria plan year to the next. Although the regulations do not directly mention it, an employee whose FMLA leave overlaps two plan years could choose to pay for benefits on an after-tax basis. This practice would not violate cafeteria plan rules because this option would not defer income.

Pay-as-you-go: Under this option, an employee on FMLA leave may pay using the same schedule in effect before the employee took leave. The IRS regulations also approve of the other payment schedules permitted by DOL's FMLA regulations (such as payment schedules for COBRA participants). An employer also may use premium schedules already in place that apply to contributions by an employee in an unpaid leave situation. Generally, any other voluntary system that is consistent with applicable regulations is also okay.

Contributions under the pay-as-you-go system are usually made on an after-tax basis. However, pre-tax payments are permitted when the contributions are made from taxable compensation that is payable to an employee during the leave period (such as cashing out unused sick pay or vacation pay). This allowance assumes all cafeteria plan requirements are satisfied.

If the pay-as-you-go option is offered to an employee on non-FMLA unpaid leave, a cafeteria plan cannot offer an employee on FMLA leave a choice of either the pre-pay option or the catch-up option without also offering the pay-as-you-go option.

Catch-up: With the catch-up option, an employee repays the required share of the premium payments after returning from FMLA leave. This method generally applies to two situations. First, an employee may elect to use this alternative to fund cafeteria plan payments while on FMLA leave. Secondly, an employer may use this method to recoup premium payments made on behalf of an employee. An employer is never required to implement this option, even if an employee requests this alternative.
Under IRS rules, when an employee elects to use the catch-up method, the em-

ployer and employee must agree in advance of the coverage period that the employee elected to continue health coverage while on unpaid FMLA leave. An employer will then assume responsibility for advancing payment of the premium on the employee's behalf during the FMLA leave. This agreement is based on the mutual understanding that advanced amounts must be repaid by the employee upon return from the FMLA leave. Although IRS regulations provide for a catch-up payment arrangement, some employers choose not to permit them in their plans due to the increased risk of loss for those amounts.

An employer also may use the catch-up method to recoup payments advanced without employee consent. Although an employer is not required to continue the health coverage for an employee who fails to make the required premium payments while on FMLA leave, an employer must reinstate an employee to exactly the same level of benefits enjoyed before FMLA leave. An employer may be caught in the untenable position of persuading an insurance carrier to restore coverage to original levels after a lapse in coverage. As a result, an employer will often pay for the continuation of benefits during the leave period while an employee fails to make required contributions.

Contributions under the catch-up option may be made on a pre-tax, salary reduction basis when the employee returns from FMLA leave. Contributions under the catch-up option also may be made on an after-tax basis.

The regulations also permit an employer to voluntarily waive, on a non-discriminatory basis, the requirement that an employee pay for continuing health coverage while on FMLA leave.

Health Care Spending Accounts

The regulations require that cafeteria plans with health care spending accounts generally conform to the same FMLA rules as those addressing health care coverage. The FMLA requires that an employee taking authorized leave must be permitted to:

- Continue coverage under a health care spending account while on FMLA leave.
- Revoke an existing health care spending account election under the cafeteria plan for the remainder of the coverage period.
- Be reinstated in a health care spending account upon return from FMLA leave under the same terms in effect prior to the leave.

Uniform Coverage Rule – An employee participating in health care spending accounts while on FMLA leave is entitled to the full amount of the elected coverage (less any reimbursements) at all times, as long as the employee continues payments. This IRS rule applies regardless of the contribution method selected.

An exception to the uniform coverage rule applies if coverage has lapsed. If an employee's coverage under the health care spending account terminates while on FMLA leave, the employee is not entitled to receive reimbursements for claims incurred during the period after the coverage ended. An employee returning from FMLA leave can be reinstated to the health care spending account for the balance of the plan year.

Reinstatement in Health Care Spending Accounts – Under FMLA regulations, reinstatement to a health care spending account upon return from FMLA leave is entirely at the employee's discretion. Under no circumstances may an employer require an employee whose coverage terminated during FMLA leave to reinstate coverage.

The effect of a reinstatement will differ, based on whether an employer's cafeteria plan allows participants to change their elections due to status changes. In many cases, cafeteria plans do not allow an election change in the event of a status change. In such a case, an employee electing to be reinstated in a health care spending account upon return from FMLA leave receives coverage equal to the coverage selected prior to leave. This coverage will be prorated for the period during FMLA leave when no premiums were paid. The coverage is also reduced by any reimbursements.

Consider the following:

> Dennis elects $1,200 worth of coverage ($100 per month) under a health care spending account. On April 1 (after Dennis has contributed $300, or three months worth of premiums), Dennis takes FMLA leave. As permitted by the FMLA, Dennis terminates his health care spending account participation. Upon his return to work on July 1, Dennis has the choice of reinstating his health care spending account participation, or of forgoing it entirely for that year. Dennis decides to renew his participation, but under IRS regulations he must then choose whether he will continue his participation at the same $100 per month level as before his leave or whether he will make up the contributions that were missed during his FMLA leave.
>
> Because Dennis chose not to participate during his FMLA leave period, expenses incurred during that time are not covered, reducing his overall annual contribution upon reinstatement to $900. The $900 level reflects Dennis' original participation level, minus the three-month period he chose not to participate in the health care spending account.
>
> In contrast, Dennis could have continued his participation during his FMLA leave and elected to use the catch-up method to fund his contributions (plan permitting). Upon his return, Dennis would be required to repay the additional $300 during the balance of the year. If Dennis returned to work on July 1, his six remaining payments would be $150 per month ($100 covering the original health care spending account contribution, plus six, $50 monthly payments).

IRS regulations address election changes for cafeteria plans that treat non-FMLA leaves as approved status changes. Such plans must give those returning from FMLA leave the opportunity to make health care spending account elections identical to those offered to a participant returning from non-FMLA leaves.

A cafeteria plan sponsor should review the terms of its plan and evaluate its strategy for implementing IRS requirements. Making the necessary modifications to the cafeteria plan document and related materials should help ensure compliance with both DOL and IRS regulations.

U.S. Benefit Office Locations

Anchorage, AK (907) 562-2266	Atlanta, GA (404) 224-5000	Austin, TX (800) 861-9851	Baltimore, MD (410) 527-1200
Bethesda, MD (301) 530-5050	Birmingham, AL (205) 871-3871	Boston, MA (617) 437-6900	Cary, NC (919) 459-3000
Charlotte, NC (704) 376-9161	Chicago, IL (312) 621-4700	Cleveland, OH (216) 861-9100	Columbus, OH (614) 766-8900
Dallas, TX (972) 385-9800	Denver, CO (303) 218-4020	Detroit, MI (248) 735-7580	Eugene, OR (541) 687-2222
Farmington, CT (860) 284-6137	Florham Park, NJ (973) 410-1022	Ft. Worth, TX (817) 335-2115	Grand Rapids, MI (616) 954-7829
Greenville, SC (864) 232-9999	Houston, TX (713) 625-1023	Jacksonville, FL (904) 355-4600	Knoxville, TN (865) 588-8101
Lake Mary, FL (407) 805-3005	Lexington, KY (859) 223-1925	Long Island, NY (516) 941-0260	Los Angeles, CA (213) 607-6300
Louisville, KY (502) 499-1891	Malvern, PA (610) 889-9100	Memphis, TN (901) 818-3263	Miami, FL (305) 373-8460
Milwaukee, WI (414) 271-9800	Minneapolis, MN (763) 302-7100	Mobile, AL (251) 433-0441	Montgomery, AL (334) 264-8282
Mountain View, CA (650) 944-7000	Naples, FL (239) 514-2542	Nashville, TN (615) 872-3700	New Orleans, LA (504) 581-6151
New York, NY (212) 344-8888	Omaha, NE (402) 778-4851	Orange County, CA (714) 953-9521	Philadelphia, PA (610) 964-8700
Phoenix, AZ (602) 787-6000	Pittsburgh, PA (412) 586-1400	Plainview, NY (516) 941-0260	Portland, OR (503) 224-4155
Raleigh, NC (919) 459-3000	Rochester, NH (603) 332-5800	Roswell, NM (505) 317-3397	St. Louis, MO (314) 721-8400
San Diego, CA (858) 455-4888	San Francisco, CA (415) 981-0600	San Juan, PR (787) 756-5880	Seattle, WA (206) 386-7400
Tampa, FL (813) 281-2095	Washington, DC (301) 530-5050	Wilmington, DE (302) 477-9640	

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