

LEGAL & COMPLIANCE

FEDERAL EXTERNAL REVIEW PROCESS RULES AND MODEL NOTICES RELEASED

The federal agencies responsible for implementation of the insurance reform provisions of the Patient Protection and Affordable Care Act (PPACA) released interim final regulations regarding standards for internal claims and appeals procedures and external review of denied claims. At the time that guidance was issued, the agencies adopted transition rules with respect to external review requirements and promised to establish a federal external review process at a later date. The agencies have recently issued additional guidance (Technical Release 2010-01) regarding the interim federal external review process. In addition, the agencies have issued model notices for use in connection with the review procedures.

The requirement for both internal and external review processes is described in Willis Human Capital Practice *Alert*, Vol.3, No. 3, “**First Things First: Health Care Reform in 2010 and 2011.**” The internal and external review requirements do not apply to grandfathered plans (for additional information regarding grandfathered plan rules, see Willis Human Capital Practice *Alert*, Vol. 3, No. 12, “**Regulations on Grandfathered Plans**”).

Willis’ National Legal & Research Group (NLRG) will provide analysis on the new guidance, the interim final regulations and the model notices as well as suggested compliance strategies in a separate Willis publication. The following are some highlights from the new guidance.

- Technical Release 2010-01 provides an interim enforcement safe harbor for non-grandfathered self-insured group health plans that are not subject to a state external review process. This means that the agencies (the Department of Labor (DOL) and the Internal Revenue Service (IRS)) will not take any enforcement action against a self-insured group health plan that complies with either the compliance procedure outlined in Technical Release 2010-01 or voluntarily complies with state external

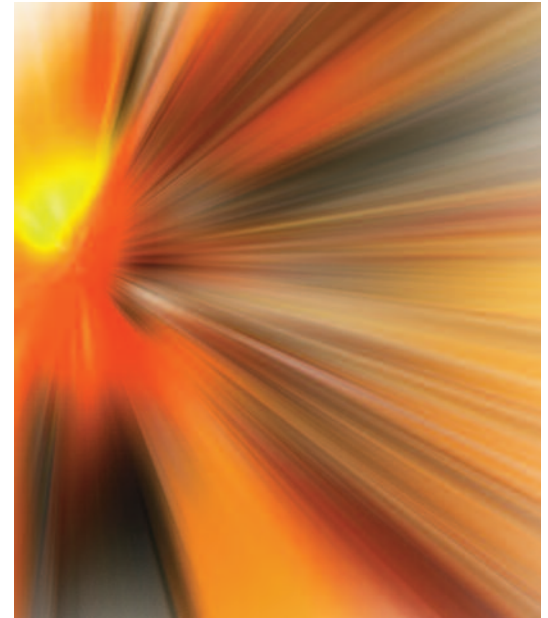


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review processes, if available (and the plan sponsor would not be responsible for reporting any excise tax liability in regard to requirements under the external review process on IRS Form 8928).

- The interim guidance and safe harbor for self-funded group health plans applies for plan years on or after September 23, 2010 and will be replaced by the agencies by July 1, 2011.
- The new guidance provides procedures for both standard and expedited external reviews.
- The external appeals procedures do NOT apply to eligibility determinations, only to the determination of whether benefits are payable under the plan.
- An interim enforcement safe harbor has also been established for issuers in the individual and small and large group health insurance markets. The agencies will not take any enforcement action against an issuer who complies with an interim compliance method that is yet to be determined. The method will either involve the use of a state external appeals process or a temporary process that the Department of Health and Human Services (HHS) establishes. This interim guidance and safe harbor is also expected to be replaced by July 1, 2011.

MODEL NOTICES

The agencies have also released model notices that can be used to satisfy the rule's disclosure requirements. These notices include:

- A notice of **adverse benefit determination**
- A notice of **final internal adverse benefit determination**
- A notice of **final external review decision**

The agencies further indicate that model language for a description of the internal claim and appeals and external review procedures to be included in the group health plan's summary plan description (SPD) that is distributed to participants will be made available at a later date.

CONCLUSION

Compliance with the internal and external claim review process rules will be burdensome and likely result in additional expenses for the plan and plan sponsor. However, these requirements do not apply to grandfathered

plans. While retaining and/or maintaining grandfathered plan status may prove to be too difficult or financially impractical for some employers (particularly for any significant length of time), employers need to carefully consider what the loss of grandfathered plan status will mean for them and their group health plans.

HHS RELEASES PROCESS FOR OBTAINING ANNUAL LIMIT WAIVER

The Department of Health and Human Services (HHS) has released instructions for applying for a waiver from the Patient Protection and Affordable Care Act's (PPACA) restrictions on annual dollar limits. PPACA generally prohibits employer-sponsored health plans and other health programs from imposing annual dollar limits on essential health benefits. However, the interim final regulations released earlier this summer granted some leeway for restricted annual limits until 2014. The regulations also allowed for HHS to institute a process for waiving restricted annual limits in order to avoid a significant decrease in access to benefits or a significant increase in premiums. (For more information on the restricted annual dollar limits that are permitted until 2014, see Willis Human Capital Practice *Alert*, Vol. 3, No. 13, "**Patient's Bill of Rights Guidance Issued.**")

The waiver process and information is included in the **OCIIO Sub-Regulatory Guidance (OCIIO 2010 - 1): Process for Obtaining Waivers of the Annual Limits Requirements of PHS Act Section 2711**. The process will be available for insurance companies who can apply on behalf of all the company's policy holders (so employers maintaining insured benefits are not required to file for individual waivers) as well as for any employers who have self-funded medical benefits plans.

THE WAIVER PROCESS

For those employers who maintain self-funded medical plans, a summary of the process appears below.

When Must Applications Be Filed?

A group health plan may apply for a waiver from the restricted annual limits if the plan was offered prior to September 23, 2010 for the plan or policy year beginning between September 23, 2010 and September 23, 2011. The plan must submit an application at least 30 days before the beginning of such plan year (but, for any plan year that begins before November 2, 2010 the application must be submitted at least 10 days before the beginning of such plan year).

The waiver only applies for the plan year that starts between September 23, 2010 and September 23, 2011. However, the plan may reapply for a waiver for any subsequent plan year prior to January 1, 2014 when this waiver process expires in accordance with future guidance from HHS. HHS indicates that the waiver approval process may be modified after reviewing the information provided in connection with the waiver process set forth in the current guidance and other relevant information.

Applications Must Include

1. The terms of the plan for which a waiver is sought
2. The number of individuals covered by the plan submitted
3. The annual limit(s) and rates applicable to the plan submitted
4. A brief description of why compliance with the interim final regulations would result in a significant decrease in access to benefits for those currently covered by such plans or policies, or a significant increase in premiums paid by those covered by such plans or policies, along with any supporting documentation
5. An attestation, signed by the plan administrator, certifying that:
 - The plan was in force prior to September 23, 2010
 - The application of restricted annual limits to such plans would result in a significant decrease in access to benefits for those currently covered by such plans, or a significant increase in premiums paid by those covered by such plans

The plan administrator or chief executive officer should retain documents in support of this application for potential examination by the secretary of HHS.

When Will Plans Hear Whether Their Applications Have Been Accepted?

HHS will process complete waiver applications within 30 days of receipt, except that complete applications submitted for plan or policy years beginning before November 2, 2010 will be processed no later than five days in advance of such plan or policy year.

Where Do I Send My Application?

A group health plan should send its waiver application to:

HHS, Office of Consumer Information and Insurance Oversight, Office of Oversight, attention James Mayhew, Room 737-F-04, 200 Independence Ave. SW, Washington, DC 20201; or email the items to healthinsurance@hhs.gov (use "waiver" as the subject of the email).

CONCLUSION

While the waiver program is only of limited duration (beginning with the first plan year on or after January 1, 2014, annual dollar limits are no longer permitted), this is good news for employers currently offering limited medical plans (also known as mini-med plans) as the jump from current annual limits to the minimum annual limits allowed during the phase-in was likely to significantly affect both access and premiums. If the employer receives a waiver from the annual limits requirement, this will give the employer additional time in which to decide what to do in regard to its benefits plans, and employees will continue to have access to their current coverage.

HHS RELEASES LIST OF APPROVED ERRP APPLICANTS

HHS has approved almost 2,000 plan sponsors for participation in the Early Retiree Reinsurance Program (ERRP) and released a **fact sheet** and **list of approved plan sponsors**. Under the ERRP, employer health plan sponsors whose applications are approved may file for partial reimbursement of certain early retiree health care expenses (for more information on the ERRP, see Willis Human Capital Practice *Alert*, Vol. 3, No. 7, “**It’s a Start: Guidance on the Early Retiree Reinsurance Program.**”) The agency began accepting ERRP applications on June 29 and continues to accept and review applications on a daily basis. Employers whose applications are approved will receive notification.

HHS has also launched an ERRP secure website and provided **details on registration to use the site**. As stated in **HHS’ announcement** of the secure site: “Plan Sponsors whose application(s) have been approved will be able to use this new secure website to view and change application information; submit summary cost data, claims line-item data, and other information; and request ERRP reimbursement for a portion of the costs of health benefits for early retirees and their spouses, surviving spouses, and dependents.” Once a plan sponsor’s ERRP application has been approved, HHS will send an e-mail to the plan sponsor’s account manager and authorized representative inviting them to register for the ERRP Secure Website.

The first reimbursements to approved sponsors are expected to be deposited in October.

FORM 1099 REPORTING REQUIREMENTS MODIFIED BY PPACA

Under § 6041 of the Internal Revenue Code (IRC), persons engaged in a trade or business who make payments totaling at least \$600 to another person in a single year are required to file an information return (typically a Form 1099) with the Internal Revenue Service (IRS) and to provide the payee with a copy. However, there is a provision in the Patient Protection and Affordable Care Act (PPACA § 9006) which greatly expands this information reporting. The new mandate will require businesses to use Form 1099 to report to the IRS all payments to “persons engaged in a trade or business” in excess of \$600 for goods and services. For purposes of this provision, a “person” is deemed to include any corporation that is not an organization exempt from tax under IRC § 501(a). This new reporting requirement is applicable to any payments made after December 31, 2011.

Under the amended provision, most payments to corporations will no longer be exempt from reporting. Types of payments that can trigger the reporting requirement will include gross proceeds and amounts received by a payee in consideration for property. Categories of payments that can give rise to the information reporting requirements, which were previously not subject to reporting, include payments for merchandise, telegrams, telephone, freight and storage.

Failure of a payer to file a timely and accurate information return with the IRS can result in monetary fines; willful failure may also result in criminal sanctions being applicable. Payers may be penalized for failing to provide a timely and accurate copy of an information return to their payees.

This new reporting requirement will likely place an expensive paperwork burden on small businesses and possibly further curtail revenue as clients of small businesses will consider consolidating purchases. Already, several bills and amendments have been introduced that would repeal the modifications made to IRC § 6041 by PPACA § 9006. Willis will continue to keep you up to date on any actions taken regarding this health care reform provision.

CHANGES TO ADOPTION ASSISTANCE PROGRAMS

The many changes legislated under The Patient Protection and Affordable Care Act (PPACA) affect a variety of different employee benefits plans, including adoption assistance programs. PPACA also made changes to the adoption tax credit.

Under PPACA, the maximum income exclusion for employer-provided adoption assistance and the maximum amount of the adoption tax credit for 2010 increased to \$13,170 (a \$1,000 increase from the 2010 limit previously announced). For future years, the amount will be indexed for inflation.

For tax years beginning on or after January 1, 2010, the adoption tax credit is made refundable. For individuals taking the tax credit, this means that if the taxpayer owes less in federal taxes than the amount of the credit, the taxpayer can get the remaining credit amount in the form of a tax refund.

Under the Economic Growth and Tax Relief Reconciliation Act (EGTRRA), the adoption tax credit and the exclusion for employer-provided adoption benefits were to expire at the end of 2010. PPACA has extended the EGTRRA sunset date by one year and, absent any further extensions, will sunset on December 31, 2011.

BACKGROUND

An “adoption assistance” program is a separate written plan of an employer, for the exclusive benefit of its employees, which: (1) provides adoption assistance and (2) meets requirements similar to those that apply to educational assistance programs under the tax code regarding eligibility, principal shareholders or owners, funding and notification of employees. Applicable rules are governed by § 137 of the IRC.

Favorable tax treatment is not available unless, before adoption expenses are incurred by either the employer or employee, the written plan is in existence and the employee receives notification of the existence of the plan. An adoption assistance program may be part of a more comprehensive benefits plan and is not required to be funded. An employer is not required to apply to the IRS for a determination that the plan is a qualified program, and the program can be offered through a cafeteria plan.

The IRS requires that the employer’s adoption assistance program not pay more than 5% of its payments during the year to shareholders or owners, or their spouses or dependents. In addition to any job-based benefits, adoptive parents may also receive a significant federal tax credit. States also may provide tax incentives for adoption.

For additional information about adoption assistance programs and the adoption assistance tax credit, please see Chapter 3 of the Willis Online *Compliance Manual*.

For tax years beginning on or after January 1, 2010, the adoption tax credit is made refundable. For individuals taking the tax credit, this means that if the taxpayer owes less in federal taxes than the amount of the credit, the taxpayer can get the remaining credit amount in the form of a tax refund.

SINCE YOU ASKED:

HIPAA SPECIAL ENROLLMENTS AND ADOPTION

An *HR FOCUS* reader recently posed an interesting question that we suspect might be fairly common. The reader represented an organization with a worker who was headed to Guatemala to adopt a child. The employee asked when she could enroll the child under her employer-sponsored plan. A Guatemalan adoption would be followed by a second adoption in the U.S. In the meantime, the employee wondered if the child could be covered under the employer's plan BEFORE either adoption.

HIPAA provides special enrollment rights for new dependents and makes provision for the addition of the new dependent (and even includes the parents of the new dependent, as well) under the employer's benefits plan. Employer plans must provide a special enrollment right for the new dependent provided the plan is informed of the new dependent within the deadline established by the plan (the plan must provide an enrollment period of at least 30 days in length; we typically see 30 or 31 days). If the plan is not informed by the employee within the deadline, there is no requirement that it permit the special enrollment. Accordingly, if the child is not added to the plan within the required time, the new dependent will have to wait until the next open enrollment to join the plan.

NOTE: While a plan may permit a more lenient HIPAA special enrollment notification deadline than 30 days, the issue then will become whether the participant can change an election under the *cafeteria plan rules* on a pre-tax basis. If the plan has a 30-day cafeteria plan election requirement written into the document, then a change (due to a HIPAA special enrollment) after 30 days cannot be made on a pre-tax basis, although the HIPAA special enrollment election can still take place.

When a dependent is added through adoption, the key question is: when will the 30 days begin to run? Since the child might be "placed for adoption" before the actual adoption, the 30 days might start to run at that time. The regulations define placement for adoption as follows:

"Placement, or being placed, for adoption means the assumption and retention of a legal obligation for total or partial support of a child by a person with whom the child has been placed in anticipation of the child's adoption. The child's placement for adoption with such person terminates upon the termination of such legal obligation."

Therefore, if the adoptive parents have a legal obligation to provide for the support of the child even before the legal adoption, the



parents could add the child to the plan as of the placement date and the plan would have to provide coverage from that date.

Employees should take care to then consider that date as the trigger for the HIPAA special enrollment period.

The cafeteria plan rules and the HIPAA special enrollment rules require prospective elections; the ONLY exception to that rule is where coverage is granted back to the date of birth or adoption or placement for adoption for a new dependent (as long as the dependent is added to the plan within the required time period). With any other change in status event or HIPAA special enrollment, the coverage may NOT be put in place retroactive to the date of the event.

In order to comply with the HIPAA special enrollment rules, plan sponsors should make sure that their plan documents do not allow retroactive election changes except in the case of birth, adoption or placement for adoption. Questions frequently arise with regard to marriages, and clients often want to retroactively apply election changes to add the new spouse. Because marriages fall outside of the special treatment given to birth, adoption or placement for adoption, plans cannot grant coverage as of the date of the marriage unless the employee completes the required enrollment change form in advance of the marriage.

In order to comply with the cafeteria plan and HIPAA special enrollment rules, plans typically provide that coverage will be effective on the first day of the payroll period (or the first of the month) following the completion of an enrollment change form.

WELLNESS

CREATING A CULTURE OF HEALTH

Organizations are implementing wellness programs at a record pace. However, producing sustainable and effective worksite wellness programs takes a long-term commitment and often proves challenging. A critical and sometimes overlooked piece of the puzzle is creating an organizational culture that supports your health promotion program.

We know it takes more than providing educational opportunities to bring about desired and ongoing changes in personal health behaviors – it takes an environment and culture that supports health.

Employers are uniquely positioned to positively affect the health of their employee population for many reasons, which include:

- The majority of the American population is currently in the workforce
- The majority of our waking hours are spent in the workplace
- The workplace offers informal peer support networks that can encourage (or discourage) healthy behaviors
- Due to the current economic climate, many people are staying in the workforce longer, delaying retirement plans and will experience increased health risks with increasing age while still employed

The term *culture* describes the norms, values and ideals of a group or a place. Culture can be something of which you are consciously aware or something implied and unspoken. Think about the culture of your worksite. Is it normal in your worksite to have long, stressful days or do employees have a positive work-life balance? Do people work through their lunch hour or take regular breaks throughout the day? Are there internal cheerleaders or champions for safety, wellness or other corporate goals?

One of the most common ways to describe or define worksite culture is, “The way we do things around here.” The way goals are set and accomplished, how projects get done and how progress is made in your organization is often very telling of your culture.

Think about the ways your organization may be making it easier – or harder – for your employees to make healthy choices and stick with them.

Creating a culture of health is a best practice, vital component of a successful worksite wellness program. So how does an employer go about creating a culture of health? Below are three key areas to consider when integrating health and wellness into your organization’s culture.

LEADERSHIP SUPPORT

Based on the Willis 2009 Health and Productivity Survey, management support was rated as the most important factor in achieving success with a wellness program. Employees can see when senior leaders in the organization demonstrate their support for the program.

So where is the worksite culture found?

- During the new hire tour: What is highlighted or pointed out?
- In the break room: What is posted? What foods do people bring? What choices are available from vending machines?
- In the cafeteria: What are the specials? Are there healthy food choices? Do you encourage your employees to take the time it takes for a healthy lunch rather than grabbing fast food on the run?
- Outside the building: Are people smoking? Are there bike racks?

Elements that show leadership support include a clear articulation of their vision and goals for worksite wellness, involvement in program communications, active participation in program events and driving the engagement of other leaders in the organization.

ENVIRONMENTAL CHANGES

Assess your physical environment for opportunities to promote health. Consider what types of onsite foodservice or vending is provided, if the workplace encourages physical activity, such as stairwell use, and if the workplace can eventually be tobacco-free. Looking at the physical environment through a wellness lens may reveal areas of opportunity for change.

HEALTH SUPPORTING POLICIES

Worksite policies can be one of the most effective ways to impact systematic change throughout the organization. Policies can help shape your culture, but also to some extent, formally outline expectations of behavior. Review and update policies with the goal of making it easier for employees to make healthy decisions. A few common areas that often are reviewed relate to policies regarding

tobacco use, ergonomics, physical activity during work hours and availability of healthy food choices.

In today's economic climate, many organizations are realizing that a culture of health can be a competitive advantage to retaining and attracting productive, engaged employees. In the words of Dr. Dee Edington, Director of the University of Michigan's Health Research Center and one of the foremost researchers and advocates for managing the health and well-being of the U.S. workforce: "By promoting behavior change without cultivating the culture, most employees will fail miserably."

To learn more about creating a culture of health in your organization or to obtain a quick cultural health audit tool, contact one of your Willis Associates.

HR CORNER

TOP WORKPLACES MASTER SIX DRIVERS OF EMPLOYEE ENGAGEMENT

As employees' feelings of uncertainty about their future grew during the recession, employee engagement scores across the country dropped, says Leigh Branham, SPHR. However, some employers were actually able to increase employee engagement.

The most common strategy used by those employers was openly sharing information with employees, states Branham, founder and principal of Keeping the People, Inc., a talent management consulting firm. "They had a plan for how they were going to survive," and they communicated that plan and asked employees for their help and ideas in implementing it.

In companies where engagement scores declined, senior leaders tended to develop a "hunker-down mentality" by withholding information from employees, says Branham.

BENEFITS OF ENGAGEMENT

Engaged employees are willing "to give a little more effort than they might ordinarily give," to show more initiative than unengaged employees do, and to do things that need to be done—without being told, says Branham. Not surprisingly, numerous studies have linked high employee engagement with better business results.

In *Re-Engage: How America's Best Places to Work Inspire Extra Effort in Extraordinary Times*, Branham and co-author Mark Hirschfeld identify six universal drivers of employee engagement

1. Caring, competent, and engaging senior leaders
2. Effective managers who keep employees aligned and engaged
3. Effective teamwork at all levels
4. Job enrichment and professional growth
5. Valuing employee contributions
6. Concern for employee well-being

'SIGNATURE' DRIVERS

Branham says all six of the universal drivers must be present for an organization to attain high employee engagement. "They're all tied together," but certain drivers are more important to certain organizations, departments, and individuals. That is, one or two drivers typically become "signature" drivers for an organization.

Signature drivers might change as business objectives change, and current events can result in certain drivers becoming more important than others to a particular organization or industry. For example, given the events of the last decade, "people are hyper aware now of senior leader behavior," Branham says.

GETTING STARTED

Branham says companies that want to improve employee engagement should conduct an engagement survey to assess the level of engagement—or disengagement—among their workers.

However, he cautions that an organization should conduct a survey only if it is willing to take action based on the survey's results. "Ask, 'are we prepared to have a different kind of culture here?' If your heart is not in it, it won't work."

Employers that conduct engagement surveys, but do not implement changes based on survey results, run the risk of employees becoming more disengaged, he says. "That's something I've seen too often. You need to be committed." He also says HR professionals should:

- Be strategic partners for senior leaders and show them the link between business objectives and attracting, retaining, and engaging talent.
- Be as transparent as possible with employees. "Feed them information. In the absence of information, employees create their own" in the form of rumors," Branham says.
- Involve employees in solutions to business challenges, recognize and reward their contributions, and challenge them to keep themselves engaged.

To complete surveys on your own level of engagement and on engagement at your organization, visit <http://www.re-engagebook.com/>.

You can also read the **free** white paper **Want Engaged Employees? Help Them Get Their 'Mojo' Back**, available on HR.BLR.com.

This article is provided by BLR.



WEBCASTS

WELLNESS: BEST PRACTICES IN WORKSITE WELLNESS

OCTOBER 19, 2010
2:00 PM EASTERN TIME

Presented by Cheryl A. Mealey, CHES
National Practice Leader
Wellness Consulting,
Human Capital Practice

What are the secrets to success in worksite health promotion programs? What common elements turn up time and time again in programs we consider to be “Best in Class?” This presentation will cover the essential elements you need to know to maximize the results of your worksite wellness program and will feature representatives from client organizations with award winning programs who will share their secrets of success with you.

PARTICIPANT ACCESS

Advance reservations are required to participate. [Click here](#) to RSVP for this call.

HR FOCUS READERS' TOP RANKED TOPIC

NOVEMBER 16, 2010
2:00 PM EASTERN TIME

Presented by HR Partner

For the November educational webcast, *HR Focus* readers will pick the topic of their choice. You may choose between Employee Engagement and Compensation Basics for the HR Generalist. To cast your vote, complete the October poll question. The winning topic will be chosen at the end of the month and will be announced in the November issue of *HR Focus*.

PARTICIPANT ACCESS

Advance reservations are required to participate. [Click here](#) to RSVP for this call.

KEY CONTACTS

U.S. HUMAN CAPITAL PRACTICE OFFICE LOCATIONS

NEW ENGLAND

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207 783 2211

Bangor, ME
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Boston, MA
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973 829 6465

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Memphis, TN
901 248 3103

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Reston, VA
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352 378 2511

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704 344 4856

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904 355 4600

Marietta, GA
770 425 6700

Miami, FL
305 421 6208

Mobile, AL
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813 289 7996

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312 621 4843
312 348 7678

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614 326 4722

East Lansing, MI
517 349 3226

Grand Rapids, MI

248 735 7249

Green Bay, WI

414 259 8837

Milwaukee, WI

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414 259 8837

Minneapolis, MN

763 302 7131

763 302 7209

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Pittsburgh, PA

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412 586 3524

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972 715 6272

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713 625 1082

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602 787 6078

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602 787 6078

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858 678 2000

858 678 2132

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800 456 1415

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