ALSTON & BIRD

WWW.ALSTON.COM

Employee Benefits & Executive Compensation ADVISORY ■

APRIL 20, 2023

Breaking Up Is Hard to Do: The End of the COVID Mandates and Outbreak Period Extensions

On March 29, 2023, the U.S. Departments of Labor (DOL), Health and Human Services (HHS), and Treasury issued FAQs Part 58 as a follow up to the January 30, 2023 announcement from the Biden Administration and the February 9, 2023 announcement from HHS Secretary Xavier Becerra of the intent to end the COVID-19 National Emergency and the Public Health Emergency as of the end of the day on May 11, 2023. For group health plans, this means an end to several temporary changes that plan sponsors and group health plans were required to make in response to the COVID-19 pandemic and the beginning of a transition back to pre-pandemic benefits and administration.

Generally, there are two sets of issues that plan sponsors and TPAs need to address to prepare for the transition. The first issue involves continuation of certain benefits, including mandatory benefits like COVID-19 diagnostic testing and vaccines and optional benefits like telehealth and employee assistance programs (EAPs). The second issue involves the tolling period, known as the "Outbreak Period," for certain deadlines under all ERISA and Internal Revenue Code covered plans (not just group health plans). We look at each in turn, as relevant for group health plans, with added practice pointers to assist with planning.

Mandates and Relief That End May 11, 2023

Mandatory and optional benefits

After the end of the Public Health Emergency on May 11, 2023, group health plans and health insurance issuers, including grandfathered health plans, will no longer be required to cover COVID-19 diagnostic tests (both over-the-counter and prescribed) and out-of-network COVID-19 vaccines. FAQ Q1 clarifies that if the earliest date of an episode of a multistep COVID-19 test occurs on or before May 11, 2023, the entire episode of care should be treated as having occurred during the Public Health Emergency, even if another part of the episode occurs after May 11.

The departments encourage plans and issuers to continue covering COVID-19 diagnostic tests. Coverage can continue without the restrictions on cost-sharing, prior authorization, and other medical management requirements imposed during the Public Health Emergency. In the case of over-the-counter COVID-19 diagnostic tests, plans and issuers that continue such coverage no longer need to satisfy the direct coverage safe harbor in order to apply a cost-sharing cap for tests purchased at non-preferred providers. Also, the eight tests per person/per month limit can be adjusted for over-the-counter COVID-19 diagnostic tests.

> ***Practice Pointer:*** For plans and issuers that make changes to how COVID-19 diagnostic tests are covered after May 11, 2023, attention must be paid to whether a particular claim involved more than one date for the entire episode of care. If, for example, a specimen for a COVID-19 diagnostic test was collected in a provider's office on or before May 11, 2023, and the laboratory analysis occurred after May 11, 2023, the laboratory analysis must be processed as if it occurred on or before May 11, 2023.

Providers of COVID-19 diagnostic tests were required to post the cash price for such tests on their website in order to set reimbursement rates for plans and issuers that did not have any negotiated rate in place with the provider. Although this requirement also ends on May 11, 2023, the departments encourage providers to keep this posting on their public websites in order to accommodate the processing of claims for tests furnished on or before May 11, 2023.

A few changes to health plan coverage will remain even after the end of the Public Health Emergency. Coverage for in-network, approved COVID-19 vaccines must continue without cost-sharing for non-grandfathered plans under the Affordable Care Act (ACA) preventive services requirements. FAQ Q4 clarified that the rapid coverage requirement for COVID-19 vaccines remains after the end of the Public Health Emergency, meaning that such coverage must be provided within 15 business days after the date an applicable recommendation is made by the Advisory Committee on Immunization Practices. Also, the IRS will continue to recognize personal protective equipment (PPE) as a qualified medical expense, so health flexible spending accounts (FSAs) and health reimbursement accounts (HRAs) that allow reimbursement for all qualifying §213(d) medical expenses will continue to reimburse claims for PPE.

Relief from most ACA mandates for stand-alone telehealth for employees who are not eligible for the major medical group health plan of their large employer will continue, but only until the end of any plan year that begins on or before May 11, 2023. What is not clear is whether the relief extended to EAPs to maintain their status as an "excepted benefit" even if providing COVID-19 diagnosing, testing, and vaccines will extend beyond May 11, 2023. In the absence of further guidance, plan sponsors will need to weigh the risk of noncompliance with continuing to provide this benefit through the EAP until the end of the plan year.

Relief for advance notice of coverage reversal

Plans are generally required to provide 60 days' advance notice of any material midyear changes in the plan that would affect the content of the summary of benefits and coverage (SBC). Plan sponsors that do not continue coverage of formerly mandated benefits after May 11, 2023 may not have time to provide the 60-day advance notice. In Q2 of the FAQs, the departments acknowledge that the previous guidance issued in FAQs Part 43 generally still applies. Under that guidance, once the federal emergencies end, plan sponsors and issuers that choose to reverse these changes will be considered to have satisfied the advance notice obligation for material modifications if the plan sponsor or issuer either:

- Previously notified participants of the general duration of the additional benefits coverage or reduced cost-sharing.
- Notified participants within a reasonable time before the reversal of the changes.

In order for a previous notification to satisfy the requirement for notice of a reversal, the previous notification must apply to the current plan year. A plan sponsor or issuer cannot rely on a notice that was issued in a previous plan year, even if the notice included the duration of the additional benefit.

The departments provided no relief in the FAQs for plan sponsors that choose to continue, but alter, the additional benefits or coverage (e.g., adding a copay to COVID-19 diagnostic testing). Any midyear material modification that would affect the content of the SBC is still subject to the 60-day advance notice rule.

Practice Pointer: Plan sponsors opting for a reversal of the additional previously mandated benefits should review all plan communications related to announcements about coverage for COVID-19 diagnosis, treatment, and preventive services to confirm: (1) whether the duration of the expanded benefit (i.e., until the end of the Public Health Emergency) was clearly communicated; and (2) that the notice was issued in the current plan year. If duration was not communicated, or if the notice was issued in an earlier plan year, then the participants need to be notified within a "reasonable time" in advance of the reversal. Plan sponsors intending for a reversal to take effect immediately after the expiration of the Public Health Emergency on May 11, 2023 will need to evaluate the reasonableness of providing a notice that is less than 60 days in advance of the reversal. Plan sponsors that decide to delay the reversal until after May 11, 2023 in order to provide the full 60-day advanced notice (or some other period it deems reasonable) will need to confer with their insurance carriers (if applicable) and stop-loss carriers. A plan amendment may also be needed.

Special issues for HSAs and HDHPs

Health savings accounts (HSAs) will also encounter transition issues, although these issues are not as closely tied to the expiration of the National Emergency or Public Health Emergency. Generally, pre-deductible coverage under a high-deductible health plan (HDHP) can disqualify a person from being eligible to participate in an HSA, but IRS guidance and legislation provided in response to the pandemic provided some relief. IRS Notice 2020-15 allows HDHPs to cover COVID-19 testing and treatment before the deductible without disqualifying HSA eligibility. This relief remains in effect until the IRS modifies or updates this guidance, regardless of the date that the emergency periods end. The IRS confirmed in the FAQs that although the appropriateness of this relief in light of the end of the Public Health Emergency is currently under review, any future modification to Notice 2020-15 "will not generally require HDHPs to make changes in the middle of a plan year in order for covered individuals to remain eligible to contribute to an HSA."

Also, the Coronavirus Aid, Relief, and Economic Security (CARES) Act permitted HDHPs to cover pre-deductible telehealth and other remote services offered through the HDHP without disqualifying a person from HSA participation. This original relief expired December 31, 2022, regardless of plan year. Although the relief was most recently extended in December 2022 by the Consolidated Appropriations Act, 2023, this extension applies only to *plan years* starting on or after January 1, 2023 and before January 1, 2025. Relief for non-calendar-year plans expired on December 31, 2022, and no relief is available in 2023 for non-calendar-year plans until the beginning of the 2023 plan year. Note, however, that even without this relief, pre-deductible benefits for services that qualify as preventive care, including certain telehealth services, do not disqualify individuals from HSA eligibility. Also, pre-deductible telehealth services for COVID-19 testing and treatment are allowed under Notice 2020-15.

Special issues for MHPAEA QTLs

In light of the mandates on group health plans to cover COVID-19 diagnostic testing, the departments announced enforcement relief in FAQs Part 43 for the quantitative treatment limitation (QTL) requirements under the Mental Health Parity and Addiction Equity Act (MHPAEA). For purposes of compliance with the "substantially all" and "predominant" tests for financial requirements and QTLs, no enforcement action will be taken against any plan or insurer that disregards benefits for the items and services that are covered without cost-sharing as required by the Families First Coronavirus Response Act (FFCRA). The relief was intended to be temporary and applies to the COVID-19 diagnostic testing mandated by the FFCRA, which is tied to the Public Health Emergency. Presumably this non-enforcement protection also ends on May 11, 2023, and while (depending on QTL testing results) plan changes may not generally be required, any non-mandated COVID-19 coverage must be taken into account for QTL testing.

Outbreak Period Transition

During the National Emergency, certain timeframes for action by plan sponsors and participants were suspended by disregarding the Outbreak Period, subject to the statutory duration limitation in ERISA §518 and Code §7508. The Outbreak Period applies to plans covered by ERISA or the Code, including church plans (which are covered by the Code but not ERISA). HHS encouraged non-federal governmental plans to apply the Outbreak period as well, although it was not mandatory.

The Outbreak Period began on March 1, 2020 and ends either (1) 60 days after the end of the National Emergency; or (2) *on such other date announced by the agencies (i.e., EBSA and IRS) in a future notification*. The departments stated in Q5 of the FAQs that the anticipated end of the Outbreak Period is July 10, 2023, 60 days after May 11, 2023. Accordingly, the suspended period for any applicable timeframe ends on the earlier of (1) one year after the otherwise-applicable triggering event date (the "one-year rule"); or (2) July 10, 2023. A "triggering event date" means the date relief was first available. For example, if a participant receives a COBRA election notice on March 1, normally that person has 60 days to make a COBRA election, or until April 30. This 60-day period was tolled during the Outbreak Period as of the date relief was first available, which was March 1 (not April 30).

> ***Practice Pointer:*** On April 10, 2023, President Biden signed legislation ending the National Emergency on that date. DOL and IRS officials have confirmed in informal conversations that this legislation does not impact their announcement that for Outbreak Period purposes the National Emergency ends on May 11 and the Outbreak Period ends on July 10. We note that the legislation ended only the National Emergency declaration under the National Emergencies Act and not any declaration made pursuant to the Stafford Act (or the Public Health Emergency declaration by HHS). The Outbreak Period is a function of ERISA §518 and Code §7508, each of which grants authority to the agencies following certain declarations made pursuant to the Stafford Act and/or Public Health Emergency declaration by HHS.

The Outbreak Period rules apply to:

- The 30-day period (or 60-day period for CHIP and Medicaid beneficiaries) to request HIPAA special enrollment.
- The 60-day election period for COBRA continuation coverage.
- The date for making COBRA premium payments (the 45-day grace period for the initial payment and the 30-day grace period for subsequent monthly payments).
- The date for individuals to notify a plan of a COBRA qualifying event or determination of disability.
- The date by which individuals may file a benefit claim under a plan's claims procedure (applicable to both health and welfare plans and retirement plans covered by ERISA or the Code).
- The date by which claimants may file an appeal of an adverse benefit determination under the plan's claims procedure (applicable to both health and welfare plans and retirement plans covered by ERISA or the Code).
- The date by which claimants may file a request for an external review after receipt of certain group health plan adverse benefit determinations or final internal adverse benefit determinations.
- The date by which a claimant may file information to perfect a request for external review upon a finding that the request was not complete.
- Furnishing COBRA election notices.

Calculating the tolling period: a simplified method

Before the announcement of the end of the Outbreak Period, the one-year rule was the only rule that needed to be applied. Now that we know that July 10, 2023 is the end of the Outbreak Period, a very simple general rule can be applied:

The tolling period for events occurring on or before July 10, 2022 will be subject to the one-year rule, and the tolling period for events occurring on or after July 11, 2022 and before July 11, 2023 will universally end as of July 10, 2023. For this later group, July 11, 2023 will generally be "day 1" for purposes of starting the clock on the applicable time period.

The following examples illustrate the difference in the one-year rule and the simplified rule:

Example 1: Special enrollment. An event entitling an individual to a HIPAA special enrollment right, such as the birth of a child or marriage, triggers a 30-day notice period (or 60-day notice period for loss of coverage under CHIP or Medicaid). An individual must provide proper notice by the end of the 30-day (or 60-day) period in order to exercise the enrollment right.

- For a special enrollment event occurring before July 11, 2022, the clock for counting the 30-day (or 60-day) period does not begin until one year after the triggering event. The deadline for notice is one year and 30 days after the special enrollment event (or one year and 60 days for Medicare or CHIP).
- For a special enrollment event occurring on or after July 11, 2022, the clock for counting the 30-day period begins after July 10, 2023. The deadline for notice is August 9, 2023. Or, for loss of eligibility under Medicaid or CHIP, 60 days after July 10, 2023, or September 8, 2023.

Example 2: COBRA election period. Receipt of a COBRA election notice triggers the 60-day period for making a COBRA election.

- For a COBRA election notice received before July 11, 2022, the clock for counting the 60-day notice period does not begin until one year after the date the election notice is received. The deadline for making a COBRA election is one year and 60 days from receipt of the notice.
- For a COBRA election notice received on or after July 11, 2022, the clock for counting the 60-day election period begins after July 10, 2023. The election deadline is September 8, 2023.

Example 3: COBRA premiums. A missed monthly COBRA premium payment that was not made by the monthly due date (after an initial COBRA premium payment) triggers a 30-day grace period for making the payment.

- For a missed payment with a due date before July 11, 2022, the clock for counting the 30-day grace period does not begin until one year after the due date. The end of the 30-day grace period is one year and 30 days from the monthly due date that was missed.
- For a missed payment with a due date on or after July 11, 2022, the clock for counting the 30-day grace period begins after July 10, 2023. The end of the 30-day grace period is August 9, 2023.

Example 4: Adverse benefit determination. Generally, ERISA requires a group health plan to allow at least 180 days after an adverse benefit determination for participants to file an appeal.

- For an adverse benefit determination made before July 11, 2022, the clock for counting the 180-day appeal period does not begin until one year after the adverse benefit determination was made. The deadline for filing an appeal is one year and 180 days from the adverse benefit determination.

- For an adverse benefit determination made on or after July 11, 2022, the clock for counting the 180-day appeal period begins after July 10, 2023. The deadline for filing an appeal is January 6, 2024.

Example 5: Run-out periods for health flexible spending accounts. Assume a health FSA for a calendar year plan has a 90-day run-out period beginning on January 1 and ending on March 31.

- For plan year 2021, the run-out period would ordinarily begin January 1, 2022 (before July 11, 2022) and end March 31, 2022. Due to the Outbreak Period, the end of the run-out period for the 2021 plan year is one year and 90 days after January 31, 2022, or March 31, 2023.
- For plan year 2022, the run-out period would ordinarily begin January 1, 2023 (after July 11, 2022) and end March 31, 2023. Due to the Outbreak Period, the clock for counting the 90-day run-out period begins after July 10, 2023. The deadline for submitting a health FSA claim for reimbursement for the 2022 plan year is October 8, 2023.

COBRA: special cases

COBRA creates some special cases. Although the FAQs addressed one of those special cases, transitioning out of the Outbreak Period for other potential situations remains unclear. The issue that the departments addressed in the FAQs involves the initial COBRA premium payment and subsequent monthly payments. The initial COBRA premium payment has a 45-day grace period, but a monthly COBRA premium payment has a 30-day grace period. The initial payment is triggered by the actual COBRA election. If a COBRA election is made on or after July 11, 2022, and an initial COBRA premium payment has not yet been made as of July 10, 2023, the individual presumably still has 45 days after July 10 to make the initial payment. Before the release of the FAQs, there was a question about when the monthly premium payments, which are subject to a 30-day grace period deadline, would be due. With the following example, the departments clarified that the monthly payments will be due with the initial COBRA premium payment:

> ***Facts:*** Individual B participates in Employer Y's group health plan. Individual B has a qualifying event and receives a COBRA election notice on October 1, 2022. Individual B elects COBRA continuation coverage on October 15, 2022, retroactive to October 1, 2022.
>
> When must Individual B make the initial COBRA premium payment and subsequent monthly COBRA premium payments?
>
> ***Conclusion:*** Individual B has until 45 days after July 10, 2023 (the end of the Outbreak Period), which is August 24, 2023, to make the initial COBRA premium payment. *The initial COBRA premium payment would include the monthly premium payments for October 2022 through July 2023*. [emphasis added] The premium payment for August 2023 must be paid by [the end of August] 2023 (the last day of the 30-day grace period for the August 2023 premium payment). Subsequent monthly COBRA premium payments would be due the first of each month, subject to a 30-day grace period.

Although not highlighted by the departments, one important fact in the example is that the individual made the COBRA election within the standard 60-day COBRA election period. During the Outbreak Period the time for making the COBRA election was also tolled, but there are no examples in the FAQs illustrating when the initial COBRA premium payment is due for elections made *outside* the standard 60-day election period, even though a special rule for such situations had been issued. On October 6, 2021, the IRS issued Notice 2021-58, which clarified application of the Outbreak Period to initial and subsequent COBRA premium payments when the COBRA election is made outside the standard 60-day COBRA election period. There, under the one-year rule, the time for making the initial COBRA premium was one year and 105 days from receipt of the COBRA *election notice* (not the actual election of COBRA).

Because the departments did not address this special rule for COBRA elections made outside the standard 60-day election period, it is unclear how to treat these situations during the transition period.

Plan sponsors also received some relief during the Outbreak Period for furnishing COBRA election notices within the standard timeframe; however, for plan sponsors that did not provide the COBRA election notice to qualified beneficiaries within the standard timeframe, calculating deadlines for COBRA elections will be even more complicated.

Extending the timeframes beyond the end of the Outbreak Period

The end of the Outbreak Period could present systems and communications challenges. In Example 5, regarding the end of the health FSA run-out period for the 2022 plan year, October 8, 2023 would be the run-out period deadline. This may create administrative problems because this date does not align with any other standard plan deadlines. In the FAQs, plan sponsors are encouraged to extend timeframes for participants, employees, and beneficiaries even further for a smoother transition. In conjunction with the FAQs, the DOL also published a blog post that appears to encourage extending timeframes beyond what is required by the Outbreak Period: "Employers should consider making reasonable accommodations to existing timeframes by amending the deadlines in their plans to minimize the possibility of individuals losing their benefits because of a failure to comply with one of these deadlines."

The post raises a question of whether a plan amendment is necessary to extend timeframes beyond what is required by the Outbreak Period. This would include when claims and appeals procedures or COBRA deadlines are in plan documents. The DOL has not issued definitive guidance on this.

> ***Practice Pointer:*** Plan sponsors that are considering extending deadlines beyond what is required by the end of the Outbreak Period should discuss with insurers and stop-loss carriers. It would be prudent to obtain a written agreement of these extensions with applicable parties to avoid plan liability for a large health, life insurance, or other claim.

Participant communications about the end of the Outbreak Period

Another open question is communications to participants and beneficiaries on the end of the Outbreak Period. The departments address notice for reversing or making material changes to the additional benefits mandated during the Public Health Emergency, but the FAQs are silent on notice about the Outbreak Period. The DOL blog post, however, states: "Plans need to communicate key deadlines to impacted individuals in advance." The post does not state what form that communication should take, which key deadlines need to be communicated, and who would be considered an impacted individual. Is a notice on a website enough or should there be individual communications? We think the facts and circumstances for each plan or employer may vary.

Earlier guidance on the Outbreak Period (EBSA Disaster Relief Notice 2021-01) stated the following on communications:

> For example, where the plan administrator or other responsible plan fiduciary knows, or should reasonably know, that the end of the relief period for an individual action is exposing a participant or beneficiary to a risk of losing protections, benefits, or rights under the plan, the administrator or other fiduciary should consider affirmatively sending a notice regarding the end of the relief period.

It is likely that participants and beneficiaries will be unaware of the end to the Outbreak Period, which is compounded by the confusion created by the National Emergency ending earlier than originally anticipated. While the DOL had never specifically stated that individual notice is required when a plan is aware that the deadline for a participant or beneficiary impacted by the Outbreak Period is approaching, individual notice would be the safer course, but it may be impractical for some.

Practice Pointer: As a best practice, plan sponsors and third-party administrators (TPAs) should prepare reminder communications to explain deadlines to prevent employees, participants, and enrollees from missing crucial deadlines. Situations may differ dramatically among plans based on the content of prior communications. Plan sponsors should consult with their vendors and legal counsel for guidance.

Action Items

Plan sponsors and TPAs should prepare for the transition by:

- Determining whether to continue providing benefits that are no longer mandatory after May 11, 2023.
- Reviewing COVID communications to determine whether the duration of increased benefits was clearly stated.
- Preparing reminders for end dates of certain benefits (if applicable).
- Communicating upcoming deadlines related to the end of the Outbreak Period to participants and enrollees.
- Updating summary plan descriptions and amending plan documents (if applicable).

You can subscribe to future ***Employee Benefits & Executive Compensation*** advisories and other Alston & Bird publications by completing our **publications subscription form**.

If you have any questions or would like additional information, please contact your Alston & Bird attorney or any of the following:

Members of Alston & Bird's Employee Benefits & Executive Compensation Group

Emily Seymour Costin
202.239.3695
emily.costin@alston.com

R. Blake Crohan
404.881.4625
blake.crohan@alston.com

Meredith Gage
404.881.7953
meredith.gage@alston.com

Ashley Gillihan
404.881.7390
ashley.gillihan@alston.com

David R. Godofsky
202.239.3392
david.godofsky@alston.com

Amy Heppner
404.881.7846
amy.heppner@alston.com

John R. Hickman
404.881.7885
john.hickman@alston.com

H. Douglas Hinson
404.881.7590
doug.hinson@alston.com

James S. Hutchinson
212.210.9552
jamie.hutchinson@alston.com

Michelle Jackson
404.881.7870
michelle.jackson@alston.com

Kenneth M. Johnson
919.862.2290
kenneth.johnson@alston.com

Edward T. Kang
202.239.3728
edward.kang@alston.com

Laurie Kirkwood
404.881.7814
laurie.kirkwood@alston.com

Blake Calvin MacKay
404.881.4982
blake.mackay@alston.com

Earl Pomeroy
202.239.3835
earl.pomeroy@alston.com

Cremeithius M. Riggins
404.881.4595
cremeithius.riggins@alston.com

Jonathan G. Rose
202.239.3693
jonathan.rose@alston.com

Syed Fahad Saghir
202.239.3220
fahad.saghir@alston.com

John B. Shannon
404.881.7466
john.shannon@alston.com

Carolyn E. Smith
202.239.3566
carolyn.smith@alston.com

Michael L. Stevens
404.881.7970
mike.stevens@alston.com

Ellie Studdard
404.881.7291
ellie.studdard@alston.com

Courtney E. Walter
202.239.3165
courtney.walter@alston.com

Kerry T. Wenzel
404.881.4983
kerry.wenzel@alston.com

Kyle R. Woods
404.881.7525
kyle.woods@alston.com

ALSTON & BIRD

WWW.ALSTON.COM

ATLANTA: One Atlantic Center ■ 1201 West Peachtree Street ■ Atlanta, Georgia, USA, 30309-3424 ■ 404.881.7000 ■ Fax: 404.881.7777
BEIJING: Hanwei Plaza West Wing ■ Suite 21B2 ■ No. 7 Guanghua Road ■ Chaoyang District ■ Beijing, 100004 CN ■ +86 10 8592 7500
BRUSSELS: Rue Guimard 9 et Rue du Commerce 87 ■ 3rd Floor ■ 1000 Brussels ■ Brussels, 1000, BE ■ +32.2.550.3700 ■ Fax: +32.2.550.3719
CHARLOTTE: One South at The Plaza ■ 101 South Tryon Street ■ Suite 4000 ■ Charlotte, North Carolina, USA, 28280-4000 ■ 704.444.1000 ■ Fax: 704.444.111
DALLAS: Chase Tower ■ 2200 Ross Avenue ■ Suite 2300 ■ Dallas, Texas, USA, 75201 ■ 214.922.3400 ■ Fax: 214.922.3899
FORT WORTH: Bank of America Tower ■ 301 Commerce ■ Suite 3635 ■ Fort Worth, Texas, USA, 76102 ■ 214.922.3400 ■ Fax: 214.922.3899
LONDON: 4th Floor, Octagon Point, St. Paul's ■ 5 Cheapside ■ London, EC2V 6AA, UK ■ +44.0.20.3823.2225
LOS ANGELES: 333 South Hope Street ■ 16th Floor ■ Los Angeles, California, USA, 90071-3004 ■ 213.576.1000 ■ Fax: 213.576.1100
NEW YORK: 90 Park Avenue ■ 15th Floor ■ New York, New York, USA, 10016-1387 ■ 212.210.9400 ■ Fax: 212.210.9444
RALEIGH: 555 Fayetteville Street ■ Suite 600 ■ Raleigh, North Carolina, USA, 27601-3034 ■ 919.862.2200 ■ Fax: 919.862.2260
SAN FRANCISCO: 560 Mission Street ■ Suite 2100 ■ San Francisco, California, USA, 94105-0912 ■ 415.243.1000 ■ Fax: 415.243.1001
SILICON VALLEY: 755 Page Mill Road ■ Building C - Suite 200 ■ Palo Alto, California, USA 94304-1012 ■ 650.838.2000 ■ Fax: 650.838.2001
WASHINGTON, DC: The Atlantic Building ■ 950 F Street, NW ■ Washington, DC, USA, 20004-1404 ■ 202.239.3300 ■ Fax: 202.239.3333