



BENEFIT *Advisor*

In This Issue

In this final issue of our Benefit Advisor for 2006, we will review the important developments that affected employee benefit programs this year. We also review the year-end housekeeping issues that organizations should revisit annually.

We welcome your comments and suggestions regarding this issue of our technical bulletin. For more information on this Benefit Advisor, please contact your Account Manager or visit the McGrawWentworth web site at www.mcgrawwentworth.com.

“2006 Year-End Review”

Fortunately, the government spared health and welfare plans from major legislative activity in 2006. For the most part, the guidance issued this year clarified previous legislation. Below is a summary of the key clarifications and reminders for 2006:

- Small group health plans needed to comply with the Security Rule by April 21, 2006.
- New USERRA regulations were effective mid-January of 2006.
- The government issued technical corrections to WFTRA that affect the definition of a qualified tax-favored dependent under various sections of the Internal Revenue Code.
- The IRS released additional guidelines on using debit cards to process claims under medical Flexible Spending Accounts (FSAs) and Health Reimbursement Arrangements (HRAs).
- The government issued new guidelines on the Medicare Part D notice requirements that apply to group health plans. The new rules cover notices that employers must issue not only to Medicare-eligible participants but also to the Centers for



Medicare and Medicaid Services (CMS).

- The IRS detailed the comparability requirements for employer contributions to Health Savings Accounts (HSAs).
- The Department of Labor issued guidelines requiring employers to submit Form 5500 electronically for plan years beginning on or after January 1, 2008.
- Group health plans need to comply with an important requirement of

HIPAA’s Privacy Rule: the three-year reminder notice.

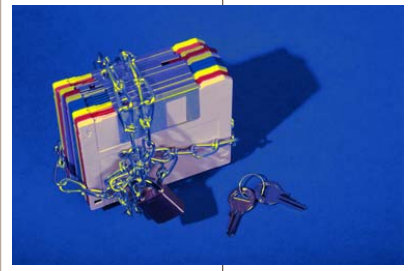
This year-end checklist *Advisor* briefly overviews these legislative issues for 2006 and also reminds your organization of important annual housekeeping issues.

The Security Rule

The Security Rule is the final part of the HIPAA Administrative Simplification Provisions to affect group health plans. The rule requires covered entities to safeguard health information transmitted or maintained electronically. Small group health plans had to meet the Security Rule requirements by April 21 of this year.

The Security Rule affects many entities, including health care providers, health care information clearinghouses and group health plans. All group health plans are now required to comply with the Security Rule in order to protect the integrity, confidentiality and availability of Electronic Protected Health Information (EPHI).

EPHI is individually identifiable information addressing an individual's past, present, or future physical or mental condition or



information relating to the payment for care, that is stored or transmitted electronically. To determine whether PHI is electronic, look at the original format. For example, paper faxes are not considered electronic, because the original format is paper. The same information faxed from a desktop computer is considered electronic, because it is in an electronic format initially.

In general, the rule requires covered entities to:

1. Ensure the confidentiality, integrity and availability of the EPHI they create, receive, maintain or transmit.
2. Protect EPHI against any threats to security.
3. Protect against any uses or disclosures not permitted.
4. Ensure employees comply with procedures.

The rule presents a series of standards covered entities must meet. Once an organization meets these standards it automatically achieves the four global goals listed above.

Your IT and HR departments share responsibility for complying with this rule. To determine how to meet the requirements, consider your organization's size, capabilities and complexity, technical infrastructure, cost of proposed measures and the potential risk to EPHI. The Department of Health and Human Services recognizes that for the rule to

remain current and apply to the wide range of entities it encompasses, it should be flexible, scalable and technologically neutral.

Details on implementing the standards can be found on our website at http://www.mcwent.com/Benefit_Advisor/2003/Issue%20Six.pdf.

To ensure you comply with these standards, take these ten key action steps:

1. **Appoint a Security Officer:** Formally appoint a security officer responsible for complying with Security Rule standards. Give the officer the authority to implement the necessary measures.
2. **Map your Plan's EPHI:** Identify where EPHI is housed on your system and how it is accessed. The Security Rule does not apply to *all* the information you maintain electronically. It applies only to EPHI.
3. **Conduct a Risk Analysis:** Review your current security measures and determine whether they meet the requirements. During this process, you may identify potential weaknesses in your current set-up.

4. **Strengthen your Position:** Design policies and procedures or implement new technology and procedures to strengthen your weak areas.

5. **Implementation Specifications:** Review all the implementation specifications. Again, focus on offering better security for your EPHI.

6. **Security Awareness Training:** Inform your employees of your security policies and procedures and explain how these provisions affect them. Also, you must periodically update your employees on any new threats to EPHI security.

7. **Amend your Business Associate Contracts:** Ensure your business associate contracts comply with the Security Rule. These contracts need to be amended only if the business associate uses EPHI.

8. **Amend Plan Documents:** State in your plan document how your organization will use EPHI and describe the measures your plan has taken to comply with the Security Rule.

9. **Establish a Discipline Policy:** Discipline employees that don't follow your security measures.

10. **Schedule a Compliance Review:** Review your compliance plans periodically to make sure your system is still secure. It makes tremendous sense to do the review whenever technology changes to make sure you are still in compliance.

The Security Rule affects all covered entities, including your group health plan. If your organization does not have a security compliance action plan, developing one should be a priority in 2007.

Final USERRA Regulations

USERRA prohibits discrimination in reemployment, retention, or any other employment-based benefit for employees in the United States military. It also protects employment privileges and benefits for employees called to "active duty in the uniform services." The final USERRA regulations, effective January 18, 2006, include many of the legislation changes that have been made over the last decade.

USERRA has anti-discrimination and anti-retaliation provisions, as well as return to work requirements. It also spells out the requirements for employers when employees are called to active duty.

Employers offering health coverage need to meet two specific USERRA requirements for any employees called to active duty:

1. Post a Notice of USERRA Rights
2. Offer health plan continuation coverage for up to 24 months

The notice of USERRA rights was easy to overlook. The government released two model notices, one for private sector and state governments and another for the federal government. If you have not posted a USERRA notice, you should make this a priority. It is a simple requirement to meet.

For more information on the required notice or continuing health plan coverage, please read our Spe-

cial Alert at http://www.mcwent.com/Special_Alert/2006/Special_Alert_Issue_2.pdf.

Technical Corrections to WFTRA

The Working Family Tax Relief Act redefined *eligible tax dependent* for several sections of the Internal Revenue Code as of January 1, 2005. The change directly affected Section 152.

In its attempt to create a more uniform definition of *dependent* throughout the Internal Revenue Code, the IRS created a great deal of confusion on how various plans should define an *eligible tax dependent*. Because several sections of the Internal Revenue Code refer to Section 152 to define *eligible dependent*, the changes affected many different employee benefit plans.

The Gulf Opportunity Zone Act of 2005 included the following technical corrections:

- It defined *dependent* for Dependent Care Flexible Spending Accounts.
- It changed the definition of *dependent* for Health Savings Accounts.

For more information on eligible tax dependents under WFTRA, please read our *Advisor* at http://www.mcwent.com/Benefit_Advisor/2004/BA_Issue14.pdf.

The new dependent definitions of WFTRA added a minimum income requirement for a qualifying relative to be considered a tax depen-

dent. In many cases, this impacted an employee's ability to use Dependent Care Flexible Spending Account funds for elder care. The addition of the income requirement disqualified the tax dependent status of some parents that live with their adult children. Social security income benefits are considered income for the purposes of meeting the qualifying relative requirements.

The new technical corrections allow individuals to disregard the income limit for Dependent Care Flexible Spending Accounts. This means if a dependent meets all the requirements of a qualifying relative other than the income limit, an employee can use a dependent care spending account to pay for dependent day care. The age limit of 13 for any eligible dependent children for the

Dependent Care Account remains the same. However, employees can use FSA funds to pay medically necessary elder care expenses for a dependent parent.



The technical corrections also corrected an oversight of a previous clarification. The provisions of WFTRA apply age limits to dependents that can be considered eligible tax-dependents for the purposes of tax-favored health benefits. The dependent child must be under age 19 or under age 24 if a full-time student. These age limits were more restrictive than some employer sponsored plans' definitions of eligible dependent children. In some cases, the child might have been able to be considered a qualifying relative, except there is an income limit that is applied in determining a qualifying relative. Many children

in that age range would be disqualified by virtue of the income limit.

Recognizing this was an issue with the tax-favored nature of employer-sponsored health plan coverage, the government immediately released a clarification that stated the income requirement for a qualifying relative would not be used in determining the tax-favored status of employer-sponsored health benefits. This meant if children could not meet the age requirements of a qualifying child under WFTRA, they could definitely be considered a qualifying relative with the income requirement removed. The end result was the differing age requirements did not impact the tax-favored status of employer-sponsored health coverage.

Originally this technical correction did not apply to Section 223. Section 223 governs Health Savings Accounts or HSAs. Thus a child might have qualified for a tax-favored benefit under an employer-sponsored health plan but might not have qualified for tax-favored distributions from an HSA for medical expenses. The income restriction for qualifying relatives under Section 223 has now been removed. Employers offering tax-favored benefits for dependents need to make sure their definition of dependent coincides with the WFTRA definition.

Debit Card Guidance for HRAs and FSAs

This year's IRS Notice 2006-69 clarified rules for substantiating Health Reimbursement Arrangement (HRA) and Flexible Spending Account (FSA) claims.

The notice covers three key topics:

1. Automatically substantiating claims paid by debit card.
2. Using a debit card to pay for dependent care expenses under an FSA.
3. Substantiating all claims under HRAs and FSAs.

The guidance allows for auto-adjudication; in other words, processing certain transactions without follow-up paperwork.

Initially, the IRS allowed a plan to auto-substantiate any of the following debit card transactions:

- The payment is to a health care provider and the dollar amount matches exactly a copayment amount of the plan.
- A participant has a previously substantiated recurring expense; for example, a \$40 copay for a weekly visit to a counselor. Once the initial claim is substantiated, the matching recurring copayment is auto-substantiated.
- A provider verifies the charge is for a medical expense at the time of the service.

All claims paid with either HRA or FSA funds must be substantiated. If a claim satisfies the above requirements and is paid by debit card, no additional documentation is necessary. The new guidelines present additional situations where the information collected with the debit card transaction is enough to substantiate the claim.

Under the new guidelines, certain debit card transactions involving multiple co-payments to either merchants or service providers with health-care-related merchant codes can be automatically substantiated. To qualify, the transaction amount must be an exact multiple of the co-payment but no more than five times the amount the plan allows for that specific service (for example, a prescription drug co-payment). A third party claim payer must independently verify the plan's co-payment schedule with the employer. It is not sufficient to have the employee verify the copayment schedule.



Also, the new guidance offers a method to automatically substantiate debit card purchases of qualifying over-the-counter (OTC) drugs and prescriptions even when the merchant has no health care related merchant code. These claims may be paid if the merchant has an inventory information approval system that ensures the debit cards are used only for eligible medical care expenses. The merchant must have the SKU (stock keeping unit) technology, and your debit card vendor must be able to read the bar code to verify the expense is a qualified medical expense.

If your health FSA or HRA debit cards are programmed to work with such an inventory system, you must be able to produce auditable records of all transactions. Therefore, your organization should verify with your claims payer and debit card vendor that you can access records of transactions if you are ever audited.

In some cases, employees can use debit cards to pay dependent care expenses. However, debit cards do have some limitations. For example, not all day-care vendors can process debit card transactions. Also, while most dependent care expenses are paid a week or two in advance, your plan cannot reimburse an expense until the expense is incurred. The employee would have to pay for two weeks of day care and when the next two week payment is due, the employee can now pay with the debit card and report the dates of service as the previous two weeks to meet this requirement. Another issue is that only funds already deposited into the account can be reimbursed. The debit card vendor may decline a claim if there are not enough funds in the account to cover the charge submitted.

Finally, the guidance clarified two additional problem areas in substantiating claims with or without using a debit card:

1. If an employer receives an explanation of benefits (EOB) or similar information from an insurer or other independent third party indicating the date of a Code Section 213(d) medical care expense and the employee's responsibility to pay for the expense (that is, as co-insurance or to satisfy a deductible), the claim is fully substantiated.



2. Expenses cannot be reimbursed based on an employee's self-substantiation.

For more details regarding this guidance on substantiating claims, please read our Special Alert at http://www.mcwent.com/Special_Alert/2006/Special_Alert_Issue_5.pdf.

Medicare Part D Notice Requirements

Employers need to comply with two Medicare Part D notice requirements.

One notice must be distributed to the Medicare eligible beneficiaries your health plan covers. This notice informs the Medicare beneficiary whether or not your health plan is considered creditable. Your plan is creditable if your benefits are as good as the standard Medicare Part D benefits. Your plan is not-creditable if your benefits are not as good as the standard Medicare Part D benefits.

Employers can determine whether their prescription drug benefits satisfy creditable coverage requirements in one of

two ways. The first way is to meet the simplified determination requirements. The second way is to perform a "gross test" on claim data to determine whether your benefits are more favorable than Medicare Part D benefits. The good news is, McGraw Wentworth and a number of insurance carriers have hired actuaries to perform the gross tests for various prescription drug plan designs. Employers can use these matrixes to determine whether your plan design is creditable.

This notice to Medicare beneficiaries serves an important purpose. Medicare Part D assesses a late enrollment penalty if beneficiaries do not apply for Medicare Part D when they initially become eligible. If a Medicare beneficiary has creditable prescription coverage and enrolls in Medicare Part D within 63 days after losing that coverage, the late enrollment penalty will not apply. However, if the prescription coverage is not creditable, a substantial late enrollment penalty applies. This information is included in the Notice of Creditable and Not-Creditable Coverage.

The government has released several pieces of guidance on these notice requirements. Guidance issued this past spring details timing and delivery requirements. It also includes model notice language. Our Benefit Advisor discusses this guidance at length in at http://www.mcwent.com/Benefit_Advisor/2006/BA_Issue_5.pdf. The government released proposed model notice wording in September and requested comments on the proposed changes. Until the final changes are made to the model language, employers can use the wording released in the spring.

Employers also need to notify the Centers for Medicare and Medicaid Services (CMS) whether or not their plan is creditable.

Employers must send this notice to CMS every year and when any changes in coverage affect creditable status. Initially, CMS had to receive the notice by March 31 this year.

However, the notice is an ongoing requirement and must also be issued at the following times:

- Within 60 days after the beginning date of the plan year for plan years that end in 2007 and beyond.
- Within 30 days after the prescription drug coverage ends.
- Within 30 days after any change in creditable coverage for the prescription drug plan.

The notice must be made electronically at the government URL, <http://www.cms.hhs.gov/creditablecoverage>. Also, employers need to examine any prescription drug plan changes to ensure the coverage remains creditable. For more information on informing CMS, please read our Special Alert at http://www.mcwent.com/Special_Alert/2006/Special_Alert_Issue_1.pdf.

More Guidance on Health Savings Accounts (HSAs)

Over the last few years the government has attempted to clarify Health Savings Account requirements. This year the government provided more information on comparability requirements for employers that contribute to HSAs.

The government does not require employers to contribute to employees' HSAs; however, if employers do contribute to any employee's HSA, they must contribute to all other "comparable" employees HSAs.

These comparability requirements are fairly complicated, but the new guidance did clarify some important issues:

- Employers could vary contributions depending on the number of people covered (employee, employee +1, and so on). However, the funding for employee only cannot be more than the funding for employee + 1.
- Employer contributions to the HSA of an independent contractor, a self-employed individual or a partner in a partnership are not subject to the comparability requirements because these individuals are not considered employees.
- Separate comparability requirements tests apply depending on whether the employee is a current full-time employee, a current part-time employee or a former employee (this category does not include COBRA continuation).
- Collectively bargained employees are excluded from the comparability requirements. If a collective bargaining agreement dictates employer HSA contributions, those contributions do not have to meet the comparability requirements.
- The new guidance also discusses a time frame for employers to contribute to the HSAs. All the comparability requirements are pro-rated by the number of months an individual is qualified to contribute during the plan year. Employers must contribute on a regular schedule. Although employers can contribute the entire amount



at the beginning of the plan year, this approach carries some risk. If the employee quits during the year, the employer cannot recover the contribution. Contributions can be made at year-end and reflect the number of months each employee was covered by the high deductible health plan.

The only exception to the comparability requirements are contributions made through a Section 125 plan. Employers need to make sure their plan docu-

ment allows the participants to choose between cash and benefits.

For more information on the new comparable contributions guidance, please see our Special Alert at http://www.mcwent.com/Special_Alert/2006/Special_Alert_Issue_6.pdf.

Electronic 5500 Filing

Form 5500 must be filed electronically for plan years beginning on or after January 1, 2008. The Form 5500 must be filed within 210 days following the close of the plan year. For calendar year plans, this means the Form 5500 filed in July of 2009 will be the first one that must be filed electronically.

The government hopes mandatory electronic filing will save money and time. The goal is to allow plans two options when they submit Form 5500 electronically:

- Employers may file electronically using a system called EFAST. Employers can choose from a number of EFAST software programs available. The DOL currently has a request for proposal out to update the EFAST software. The software may change but employers will still have the option to use an approved software vendor to file the Form 5500 electronically.
- Employers may submit Form 5500 information electronically via the Internet. The government is working on building the technology and security systems to make this Internet option available.



Although electronic filing is still several years away, we know it's coming. Expect more details as systems to manage the electronic 5500 process are developed.

Privacy Notice Reminder

Just three short years ago, large group health plans were struggling to get through their HIPAA Privacy Rule compliance steps. Most organizations won't remember the requirement to remind their health plan participants that the privacy notice is available. Health plan participants must receive the Privacy Notice as follows:

- When they enroll in the plan
- Within 60 days after an important change in the notice

- A reminder notice every three years

Group health plans are not required to re-issue the entire

notice every three years, they merely need to notify the participants the notice is available. The plan may simply send a memo to all plan participants with the following message:

The ABC Company maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) is used or maintained by our group health plan. If you would like a copy of our plan's Notice of Privacy Practice, it can be found on our website at *(address where notice can be accessed)*. You may also contact *(contact name)* at *(contact phone number)* to request a copy.

Large group health plans should have sent the reminder notice out in April of 2006. Small group health plans will need to send the reminder before April 2007.

Annual Reminders and Updates

- 2007 Medicare Information**
The Department of Health and Human Services released the Medicare information for 2007:

Medicare Information

Medicare Part A Annual Deductible \$992.00

Hospital Per Day Copay

60 to 90 day stays \$248.00
90+ day stays \$496.00

Skilled Nursing Facility
Per Day Copay (after 20 days) \$124.00

Medicare Part B Monthly Premiums \$ 93.50

Medicare Part B Annual Deductible \$124.00

	2007
Annual Deductible (amount the beneficiary pays before benefits are payable)	\$265
Initial Coverage Limit (once the beneficiary meets the deductible, the plan pays 75% and the beneficiary pays 25% until the total prescription expense - paid by plan and beneficiary - reaches the initial coverage limit)	\$2,400
True Out-of-Pocket Maximum (Once the beneficiary has paid the true out-of-pocket cost, Medicare catastrophic coverage will pay the majority of prescription drug cost). The standard plan pays no part of expenses after initial coverage limit is met until the True Out-of-Pocket Maximum is reached.	\$3,850
Total Covered Part D Expenses before Catastrophic Coverage (if the beneficiary has no coverage other than the Medicare Part D plan)	\$5,451.25
Catastrophic Coverage (Medicare pays most of the prescription drug expense once the catastrophic coverage level is reached.) The Medicare beneficiary pays the greater of 5% of drug cost or a \$2.15 generic or \$5.35 brand name copay.	

Launched in January 1, 2006, Medicare Part D is Medicare outpatient prescription drug coverage offered through approved private insurance carriers. The coverage has cost-sharing features indexed every year. The standard benefit plan provisions for 2007 are listed in the table on page 7.

Approved prescription drug plans may either provide benefits that mirror the standard benefit plan design, offer an actuarially equivalent plan or offer an enhanced benefit plan design. Most plans do not offer benefits that mirror the standard plan design, instead, they often integrate some of the standard plan parameters. For example, a plan may require a deductible and then offer a copay for generic, brand and preferred brand drugs. In many of these copay plan designs, once beneficiaries have reached the initial \$2,400 coverage limit, the plan offers no coverage until they meet the true out of pocket cost limit. For this reason, Medicare beneficiaries must understand how this indexing affects their specific Medicare Part D plan.

Medicare Part D also affected employers sponsoring retiree drug plans. Employers could choose to work with Medicare Part D in a number of ways.

Health Saving Account Limits	2005	2006	2007
HDHP Minimum Deductible			
Self Only Coverage	\$1,000	\$1,050	\$1,100
Family Coverage	\$2,000	\$2,100	\$2,200
HDHP Maximum Out-of-Pocket			
Self Only Coverage	\$5,100	\$5,250	\$5,500
Family Coverage	\$10,200	\$10,500	\$11,000
HSA Statutory Contribution Maximum			
Self Only Coverage	\$2,650	\$2,700	\$2,850
Family Coverage	\$5,250	\$5,450	\$5,650
Catch-Up Contribution (age 55 and older)	\$600	\$700	\$800

One option was to apply for a government-paid subsidy based on a percentage of claims paid. The subsidy equals roughly 28% of prescription claims for Medicare Part D covered medications that fall between the cost threshold and cost limit.

The cost threshold and cost limit are also indexed and the 2007 amounts are as follows:

2007

Cost Threshold \$265
Cost Limit \$5,350

- **Group Term Life Insurance: Section 79**
 Each year, employers need to review their employer-provided life coverage to determine whether their employees' group term life coverage is taxable.

Employers have to impute

income for the value of the life insurance plan in only a few instances:

- The employer-paid life insurance exceeds \$50,000.
- The life plan favors key employees.
- The employee-paid optional life plan rate table straddle Table 1 rates.

The most recent *Benefit Advisor*, available on our website, explains when and how to calculate imputed income.

- **W-2 Forms for STD Benefits**
 At year-end organizations need to account for any disability benefits or earnings they paid to disabled employees during the year. Although in many cases, disability carriers pay the benefits, employers need to make sure these benefits are accounted for on the employee's W-2. All employees who received short-term disability benefits under your short-term disability (STD) plan in 2006 need W-2s.

NOTABLE THOUGHTS

LEADERSHIP IS PRACTICED NOT SO MUCH IN WORDS AS IN ATTITUDE AND ACTION.

HAROLD S. GENEEN (1910-1997)

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The income is generally reported in one of two ways:

- Disability carriers or third party administrators may issue W-2s directly to participants who received benefits during the year.
- Carriers or administrators may send you a quarterly or annual report with the information you must include on each employee's W-2.

Your STD insurer or STD administrator may issue W-2s for your employees. If the insurer issues the W-2 separately, it is wise to let employees who had claims in 2006 know that they will receive a separate W-2 from the disability vendor. More often, disability vendors inform employers of the amount paid in disability benefits and then employers add the benefit income to the employee's W-2.

If your organization self-funds STD benefits, you will need to include those benefits in the employee's 2006 W-2. If you use a payroll service to issue W-2s, your payroll vendor must include the additional compensation on the employee's W-2.

- **2007 Indexed HSA Limits** - see table at the top of page 8.
- **2007 Indexed Plan Limits**
The Table to the right summarizes the 2007 indexed plan limits

Conclusion

Year-end is a hectic time, professionally and personally. It makes sense to review this checklist to make sure your organization accounts for new legislation as well as run-of-the-mill housekeeping issues. If your organization has missed a key notice or legislative requirement, make that issue a priority in 2007.

Good luck in handling the year-end compliance issues that affect your organization's benefit plans. The McGraw Wentworth staff wishes you and your family a happy, healthy and prosperous 2007! **MW**

Indexed Plan Limits		
Plan Limits	2006	2007
Section 401(k) or SAR-SEP	\$15,000	\$15,500
Section 402(g) maximum pre-tax contribution by employees for elective deferrals	\$15,000	\$15,500
Age 50+ Catch-Up Deferral Limit	\$5,000	\$5,000
Section 403(b) Plan	\$15,000	\$15,500
Section 408(p)(2)(A) SIMPLE Plan Contributions	\$10,000	\$10,500
Section 457(b)(2) Limit	\$15,000	\$15,500
Key Employee Determination - Officers' Earnings Threshold	\$140,000	\$145,000
Section 415 Limit for: Defined Contribution Plans (calendar year) Defined Benefit Plans	\$44,000 \$175,000	\$100,000
Highly Compensated Employees Section 414(g)	\$100,000	\$100,000
Includible Compensation - Section 401(a)(17)	\$220,000	\$225,000
FICA Taxable Wage Base: Social Security (Tax Rates 6.2%) Medicare (Tax Rate 1.45%)	\$94,200 No limit	\$97,500 No limit

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