Vision Plan

Administrative Guide

Plan Administered by CompBenefits

www.compbenefits.com

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introduction

Welcome to the CompBenefits family of clients. We are pleased that you have chosen VisionCare Plan to provide and administer vision benefits for your employees. We take our responsibility seriously and will do everything in our power to ensure that service levels meet your expectations.

This guide is designed to assist you in the administration of the benefit program by providing a handy reference to procedures and contacts in our company. We have kept it as brief as possible to enable you to have a quick reference. Please note that this guide is for reference and guidance only and may be amended from time to time. All administrative policies are established by CompBenefits and can only be changed with written permission from CompBenefits. The information in this guide does not in any way change or alter the provisions or benefits contained in the policy, certificates or benefit schedules.

contact numbers

VisionCare Plan Home Office

Phone: (800) 749-5855 or (813) 289-2020

Fax: (813) 349-5588

Address: 1511 N. Westshore Blvd. Suite 1000, Tampa, FL 33607

Non–Network Claims can be mailed to

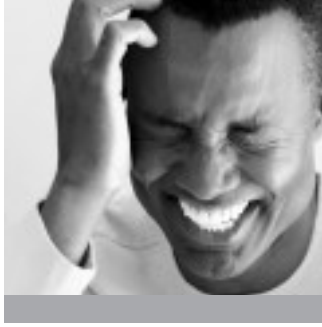
VisionCare Plan – VCP Claims
1511 N. Westshore Blvd. Suite 1000
Tampa, FL 33607

Administration/Operations for Group Administrators

(800) 749-5855

Member Services for Employees

(800) 865-3676



enrollment procedures

Initial Enrollment

During the initial enrollment process all eligible employees and their dependents may enroll in the plan. The effective date of their coverage will be the effective date of your plan.

Eligible employees may enroll after the initial enrollment period only for the following reasons:

1. New employees upon satisfying eligibility requirements defined by the Employer;
2. Newly acquired dependent(s) [spouse or child(ren)];
3. Individuals who become eligible due to a qualifying event;
4. Change of status (divorce, etc.); or
5. Annual open enrollment.

All employees will become effective on the first day of the next month.

Terms of Enrollment

All members must remain enrolled in the plan until an open enrollment period, except in the following situations:

1. The subscriber voluntarily or involuntarily terminates employment with the employer;
2. The subscriber's employment status changes to such an extent that he/she is no longer eligible for benefit coverage as determined by the Employer's eligibility rules;
3. The dependent reaches the limited age (Please refer to the group policy/ certificate for the dependent age limit) or
4. The member experiences a qualifying event.

Open Enrollment

Open enrollment is conducted annually, prior to the anniversary date of the contract. VisionCare Plan will notify you 2-3 months prior to the contract anniversary date of the renewal terms for your policy. The open enrollment should be held at this time. The following changes are allowed during open enrollment and are effective on the plan's renewal date:

1. New enrollment for eligible employees not previously enrolled;
2. Enrollment for dependents not previously enrolled; or
3. Termination of coverage for subscribers and/or their dependents.

enrollment procedures

Employee / Subscriber Change Form

The following actions require completion of an employee/subscriber change form*:

1. Employee name change;
2. Add dependent coverage;
3. Add dependent child(ren);
4. Terminate dependent spouse;
5. Terminate dependent child(ren);
6. Terminate all coverage;
7. Address change; or
8. Changing plans during an open enrollment.

* Signature by employee and date required.

Change forms should be submitted to VisionCare Plan no later than the 15th day of each month to be effective on the 1st day of the next month. Changes that are made after the 15th of the month will be processed as soon as possible but may not be effective the 1st of the next month. Example: A change made on the 20th of April would become effective on the 1st of June.

New Employees

New employees may be added to the group once they become eligible. Eligibility will be based on the criteria that we have agreed upon. Applications received on or before the 15th of the month will be processed to appear in our system by the 1st of the next month. Employees must enroll within 30 days of becoming eligible or wait until your next group open enrollment period.

Renewals

Coverage for employees and their dependents is automatically renewed upon each annual open enrollment period unless a written request for termination is submitted to VisionCare Plan.

enrollment procedures

Enrollment Materials

Please contact your local Account Manager for the following materials:

1. Enrollment Packets;
2. Updated Provider Directories;
3. Enrollment Forms;
4. Employee/Subscriber Change Forms;
5. Claim Forms;
6. Benefit Plan Design; or
7. Certificates of Coverage.

Enrollment packets containing an application, Schedule of Benefits, and updated Provider Directory are available. Requests may be made through your local Account Manager.

termination of coverage

Coverage must remain in-force for the full month, with termination being the last day of the month. VisionCare Plan must be notified of the termination by the 15th of the month for coverage to terminate at the end of the month. At no time will VisionCare Plan provide more than 60 days back credit for retroactive terminations submitted in the current month.

Consolidated Omnibus Reconciliation ACT (COBRA)

VisionCare Plan will continue benefits in accordance with COBRA requirements as administered by your company.

Once COBRA coverage is elected, the Administrator must collect the monthly premiums from the individual and remit to VisionCare Plan. Upon receipt of the premiums, VisionCare Plan will reinstate the individual back to the date of termination and continue coverage as stipulated by COBRA requirements. Reinstatement will only be allowed up to 180 days from the date of the qualifying event.

billing procedures

Invoices are mailed no later than the last day of each month. Included will be:

- An original copy of the invoice;
- A bar coded return envelope.

It is important to review the first invoice to confirm the accuracy. Listed below for your convenience is an explanation for each item on the invoice.

1. Your group account number
2. Coverage month for the current invoice
3. Your group's name and address
4. Certificate number for each covered subscriber
5. Names of each covered subscriber
6. Coverage period for each covered subscriber
7. Premium amount for each covered subscriber
8. Type of plan for covered subscriber
9. Original effective date of coverage for each covered subscriber
10. Total premium for current invoice
11. Adjustments made to current invoice, if any
12. Current monthly premium due after adjustments
13. Total premium due. This includes the monthly adjusted premium, past due premium and pending payments
14. Total number of subscribers on your group account
15. Due date for premium payment
16. Mailing address to send the premium remittance

See sample invoice on next page with above numbers referenced.

sample invoice

compbenefits

ABC COMPANY, INC. (3)
ATTN: JOHN MANSELL
4100 SMITH ROAD
FRIENDLY, GEORGIA 30076

invoice

(1) Group Number 3639
Desk Code P
(2) For Month of July, 2003
Invoice Number 000895136
Payment Due 06/15/03
Agent # 99179
Agent Name Broker, Julia A.

Cobra	Certificate	Subscriber or Buyer	Cvrg Prd	Prem Amt	Plan	Eff Date
	(4) 000-00-0001	(5) SUBSCRIBER NAME	(6) 7/03	(7) 24.70	(8) PP	(9) 04/97
	000-00-0002	SUBSCRIBER NAME	7/03	10.50	PP	04/97
	000-00-0003	SUBSCRIBER NAME	7/03	10.50	PP	08/97
	000-00-0004	SUBSCRIBER NAME	7/03	10.50	PP	08/98
	000-00-0005	SUBSCRIBER NAME	7/03	24.70	PP	04/98
	000-00-0006	SUBSCRIBER NAME	7/03	18.00	PP	08/97
C	000-00-0007	SUBSCRIBER NAME	7/03	18.00	PP	04/99
	000-00-0008	SUBSCRIBER NAME	7/03	10.50	PP	08/99
	000-00-0009	SUBSCRIBER NAME	7/03	10.50	PP	04/00
	000-00-0010	SUBSCRIBER NAME	7/03	10.50	PP	04/99
	000-00-0011	SUBSCRIBER NAME	7/03	10.50	PP	11/01
	000-00-0012	SUBSCRIBER NAME	7/03	10.50	PP	04/00
	000-00-0013	SUBSCRIBER NAME	7/03	18.00	PP	04/02
C	000-00-0014	SUBSCRIBER NAME	7/03	10.50	PP	04/02
	000-00-0015	SUBSCRIBER NAME	7/03	24.70	PP	04/02
	000-00-0016	SUBSCRIBER NAME	7/03	10.50	PP	04/02
	000-00-0017	SUBSCRIBER NAME	7/03	10.50	PP	11/98

Previous Balance		EE Only	11
Unreconciled Cash		EE+1	3
Balance		Family	3
Current Month Premium	(10) 243.60		
Current Adjustments	(11)	Total (14)	17
Administrative Fee			
Current Total Due	(12) 243.60		
Please Pay this amount	(13) 243.60		

how you can reach us

For benefit questions, please call Member Services at (800) 865-3676.

For billing questions, please call Account Services at (800) 865-3676.

If you have special needs, please call your billing representative, John Doe at (800) 865-3676.

If no changes, detach and return bottom portion of invoice with your remittance. If changes shown, adjust the total premium and mail this entire form back to CompBenefits with your remittance.
Check here if changes are shown on the back of this form. ☐

ABC COMPANY, INC.
ATTN: JOHN MANSELL
4100 SMITH ROAD
FRIENDLY, GEORGIA 30076

MAKE CHECK PAYABLE TO:

CompBenefits (16)
PO Box 769849
Roswell, GA 30076-8230

Group Number 3639
Desk Code P
For Month of July, 2003
Invoice Number 000895136
Payment Due 06/15/03 (15)

Check Amount

Check Number

reconciling your payment

To cancel any employee on the invoice:

1. Complete the membership changes section found on the back of page one of your invoice;
2. Strike through the individual's name with a single line; and
3. Note the date the certificate is to be cancelled (always on 1st day of the month).

To add new employees:

1. New applications for the month should be noted in the membership changes section on the back of the invoice. Please include the additional amount in your premium check.

Overpayments and credits should be noted on the invoice when you return it and you will receive credit on the next invoice.

All refund requests must be submitted in writing listing the employee name and premium amount to be refunded.

A copy of the invoice must accompany the premium payment.

member access

To access care, plan members are required to:

1. Request and obtain a personalized benefit form called VisionPass from VisionCare Plan;
2. Choose either a network or non-network doctor and set up an appointment for an examination. (Members may only choose a non-network doctor if your plan includes coverage for doctors outside the VisionCare Plan network. Members may only receive partial reimbursement for expenses incurred from a non-network doctor.); and
3. Deliver the VisionPass to the network doctor and pay any plan co-payment at the time of the initial visit.

OR

Pay a non-network doctor's fees at the time of their visit and send the VisionPass to VisionCare Plan along with an itemized receipt for services rendered.

The following steps outline the way to access your VisionCare Plan.

VisionPass

Plan members must request and obtain a VisionPass prior to making an appointment for their eye exam. To request a VisionPass, plan members may call Member Services at (800) 865-3676, access the VisionCare Plan web-site at www.compbenefits.com, fax in a request to (800) 421-0100 or mail a request card to VisionCare Plan at 1511 N. Westshore Blvd. Ste 1000 Tampa FL 33607. At the time eligibility is verified, the Member Services Representative will also verify past services to ensure the member is covered for current services. Upon confirmation of eligibility a VisionPass will be issued and mailed directly to the plan member.

Upon request, a current network provider directory will be included with the VisionPass. This VisionPass is valid for 60 days. Should the form expire prior to usage, the plan member may request a replacement by returning the expired VisionPass to VisionCare Plan. If the VisionPass is misplaced or destroyed the plan member must forward a brief explanation of its disposition along with the request for a replacement. A replacement VisionPass will be issued promptly by Member Services after re-verifying eligibility.

member access

Eligibility

If an employee does not appear on the eligibility roster, Enrollment Services will attempt to verify coverage through the member's employer. In the case where an employee is determined to be ineligible, a notice will be sent to the member informing them of his or her ineligibility. A VisionPass can be issued when the employee becomes eligible and again requests a form through Member Services.

The VisionPass must be presented at the time of the initial visit. Upon failure to do so, the member will be considered a private patient and may be charged the provider's usual and customary fees. The member will be required to pay the full fee at the time of service and submit an itemized receipt for reimbursement according to the non-network schedule of reimbursement for your plan. The difference in the VisionCare Plan network provider fees and the private pay fees charged by the physician will not be reimbursed. Any exam or material co-payment applicable to the plan will be deducted from the reimbursement. (If your plan does not include non-network reimbursements, no payment will be made to the member.)

Network Doctors

By choosing a network doctor, members are assured of quality care through a doctor that has been approved by the VisionCare Plan Credentialing Committee. Network doctors must abide by stringent criteria and agree to ongoing evaluations. After the examination, the member simply signs the VisionPass acknowledging services and materials received. That is the only paperwork the member will encounter. The network doctor's office will file the claim for payment.

ID Card

An alternative to the VisionPass system. This system alleviates the need for the VisionPass prior to making an appointment with the doctor. Upon enrolling in VisionCare Plan, the member will receive their Certificate of Coverage and Member ID card. This card will not only serve as identification but also describes how to access benefits as a member in six easy steps.

1. Before scheduling an appointment for eye care, the member would choose a doctor from the list of doctors. This can be done from the list of doctors or from the list of active doctors available on the VisionCare Plan website. Call the selected doctor and make an appointment.

member access

2. When setting the appointment the member should identify themselves as a VisionCare Plan member and provide the following information:

- The subscriber's name;
- The patient's name;
- The subscriber's ID number;
- Policy number (group number); and
- Name of the subscriber's employer.

3. The doctor will schedule the appointment and verify eligibility and benefits before the visit.
4. Upon your visit, show your ID card and sign the VisionCare Plan form provided by the doctor at your initial visit. You'll pay any co-payments and/or the cost of any upgrades at that time.
5. The doctor will provide you with a complete eye exam, and when necessary, order prescribed eyeglasses or contact lenses from a VisionCare Plan approved lab. The doctor also checks for accuracy and fit.
6. VisionCare Plan pays the doctor directly for his or her professional services. It's that easy!

Non-Network Doctors

Because VisionCare Plan offers the members a choice, members may opt to see a non-network doctor if they prefer. Not all plans include coverage for non-network doctors. The member must obtain a VisionPass in the standard manner. When visiting a non-network doctor, the member will pay the full amount of the doctor's regular charges for services and materials. The member will then submit the VisionPass along with the doctor's itemized receipt to VisionCare Plan for reimbursement. Benefits are paid according to the plan's out-of-network schedule allowances. VisionCare Plan sends reimbursement payments directly to the member.

member access

Co-payments

Many of VisionCare Plan's contracts include a co-payment that the plan member is responsible for paying. Co-payment amounts are stated in the contract. The co-payment amount will also appear on the benefit form issued to the plan member at the time they seek service. When a plan member sees a network doctor and pays the co-payments, the plan member will carry no further financial obligation unless they choose upgrades or cosmetic options that are not included in the plan benefits (sales tax may apply). Any applicable co-payments will be deducted from the member's reimbursement for all non-network claims as well.

Extra Charges

If a plan member chooses any of the following options for which the network doctor has not received authorization from VisionCare Plan, the plan member will be responsible for the extra charges. These charges will, however, be provided at a reduced cost. At the time of the visit, the network doctor will explain the specific charges that may be incurred for these items, which include:

- Oversized, coated or faceted lenses;
- Blended or progressive lenses;
- Tinted or photochromic lenses (except pink #1 & # 2);
- A frame that exceeds the contracted plan wholesale allowance; or
- Other cosmetic items.

plan benefits

The plan provides a complete analysis of the eyes and related structures to determine vision problems other than abnormalities.

A vision exam typically includes:

- Patient's history;
- Visual acuity;
- External examination;
- Pupillary examination;
- Visual field testing;
- Internal examination;
- Biomicroscopy;
- Tonometry;
- Refraction;
- Extra ocular muscle balance assessment; and
- Diagnosis and treatment plan

Frames

VisionCare Plan covers a wide range of frames, with an allowance designed to include the most popular styles. VisionCare Plan encompasses a wholesale frame allowance. For example, if your plan includes a frame allowance of $40.00, it typically retails from $80.00 to $100.00. Plan members may also choose frames that exceed the limit and pay the difference on a wholesale cost basis (the difference between wholesale allowance and actual wholesale cost multiplied by two) making virtually every frame on the market available to VisionCare Plan members at a reduced cost.

Lenses

The plan covers any lenses needed for patient's visual welfare as determined by the network doctor. Certain lenses such as those described in the "Limitations" are cosmetic in nature, and not necessary for the visual welfare of the patient and are not covered. The extra cost of these cosmetic options must be paid by the patient.

plan benefits

Contact lenses when elective

We will cover the combined cost of an annual exam and contact lenses up to a maximum of your contracted "Elective Contact Lens Allowance." Payment will be in lieu of the lens and frame benefits.

Contact lenses when necessary

VisionCare Plan will pay for one pair of contact lenses under the following circumstances and only if prior authorization from VisionCare Plan has been obtained:

- Following cataract surgery without intraocular lens;
- Correction of extreme visual acuity problems not correctable with glasses;
- Anisometropia greater than 5.0 diopters and aesthenopia or diplopia, with spectacles; Keratoconus; or
- Monocular aphakia and/or binocular aphakia where the doctor certifies contact lenses are medically necessary for safety and rehabilitation to a productive life.

Replacement will not be more often than once in any 12-month period and only if prior authorization is obtained from VisionCare Plan. The co-payment is waived.

limitations and exclusions

Limitations

In no event will coverage exceed the lesser of:

- The actual cost of covered services or materials;
- The limits of the policy, shown in the Schedule of Benefits; or
- The allowance as shown in the Schedule of Benefits.

Materials covered by the policy that are lost or broken will only be replaced at normal intervals as provided for in the Schedule of Benefits.

limitations and exclusions

We will pay only the cost for lenses and frames covered by the policy. The insured is responsible for extras selected including, but not limited to, the following unless otherwise specifically listed as a covered benefit in the schedule of benefits:

- Blended lenses;
- Progressive multi-focal lenses;
- Photochromic lenses, tinted lenses, sunglasses, prescription and plano;
- Laminating of lens or lenses; or
- Groove, drill or notch, and roll and polish.

Exclusions

We will not cover:

- Orthoptic or vision training and any associated supplemental testing;
- Two pair of glasses, in lieu of bifocals or trifocals;
- Medical or surgical treatment to eyes;
- Any services and/or materials required by an employer as a condition of employment;
- Any injury or illness covered under any Workers Compensation or similar law;
- Sub-normal vision aids, aniseikonic lenses or non-prescription lenses;
- Charges incurred after:
    - The policy ends
    - The insured's coverage under the policy ends; except as stated in the policy;
- Experimental or non-conventional treatment or device;
- Contact lenses except as specifically covered by the policy;
- Hi Index, aspheric and non-aspheric style;
- Oversized 61 and above lens or lenses; or
- Cosmetic items, unless otherwise specifically listed as a covered benefit in the schedule of benefits.

important HIPAA information for groups and benefits administrators

The following information is provided as a courtesy to our groups to address frequently asked questions about HIPAA and is not intended as interpretive or legal advice.

The new privacy protections required by the Health Insurance Portability and Accountability Act ("HIPAA") is changing the way health plans manage, use and disclose an individual's health-related information. These changes will affect the availability and amount of information that groups and group benefits administrators will be able to receive from health carriers, such as CompBenefits. The information provided below will help you better understand what these changes will be and how they may affect you and your ability to receive certain kinds of information.

The HIPAA privacy rule provides the first comprehensive federal protection for the privacy of an individual's health information. You will hear this referred to as the individual's "Protected Health Information" or "PHI." The privacy rule gives individuals more control over their PHI and it sets boundaries on the use and disclosure of their PHI. Additionally, it establishes safeguards that must be achieved to protect the privacy of protected health information and it holds violators accountable with civil and criminal penalties that can be imposed if they violate an individual's privacy rights.

Depending on the type of information you request from us, certain certifications or authorizations may be required under HIPAA before we can release such information to you. As a general rule, when you request information from us that contains an individual's PHI, you will be required to provide us with some type of certification or authorization depending on the type of request. Whether or not your request will require you to provide a certification or authorization will depend upon whether your request is for summary information, plan administration functions, or other type of request.

(NOTE: Information regarding enrollment, disenrollment or participation is not subject to these requirements.)

You may receive "summary information" from us for the purpose of obtaining premium bids or when modifying, amending, or terminating the group health plan, without any type of authorization or certification. HIPAA defines "summary information" as information that summarizes claims history, claims expenses, or types of claims experienced by individuals for whom the plan sponsor has provided health benefits under a group health plan, provided that specified identifiers (i.e. those identifiers that could identify an individual, including, but not limited to, name, address, social security number, etc.) are omitted.

If you request an individual's PHI for the purposes of "plan administration functions" that you perform as the plan sponsor, we can provide you with such PHI without authorization from the individual, if, and only if, you provide us with written certification that your plan documents have been amended as required under HIPAA. If you wish to receive an individual's PHI from us for plan administration functions, your written certification to us must state that your plan documents have been amended to incorporate the following provisions and that you agree to:

a) not use or further disclose PHI other than as permitted or required by the plan documents or as required by law;

b) ensure that any subcontractors or agents to whom the plan sponsor provides PHI agree to the same restrictions;

c) not use or disclose the PHI for employment-related actions;

d) report to group health plan any use or disclosure that is inconsistent with the plan documents or HIPAA regulation;

e) make the individual's PHI accessible to the individual;

f) allow individuals to amend their information;

g) provide an accounting of its disclosures;

h) make its practices available to the Secretary of HHS for determining compliance;

i) return and destroy all PHI when no longer needed, if feasible; and

j.) ensure that firewalls have been established. (Note: the firewalls must identify the employees or classes of employees or other persons under the plan sponsor's control who will have access to PHI.)

It is important to note that "plan administration functions" are defined by HIPAA to only include quality assurance, claims processing, auditing, monitoring, and management of carve-out plans. Plan administration functions do not include any employment-related functions or functions in connection with any other benefits or benefit plans, and we are not permitted under HIPAA to disclose information for such purposes absent an authorization from the individual.

All other requests for an individual's PHI will require that you provide us with written authorization from the individual prior to release of such PHI. This includes instances where the individual has asked you to advocate on his/her behalf in benefit disputes,

claims issues and grievances and appeals. In order for an authorization to be a valid authorization, it must be written in plain language and must contain the following core elements:

1) a description of the information to be used or disclosed that identifies the information in a specific and meaningful fashion;
2) the name or other specific identification of the person(s) or class of persons authorized to make the use/disclosure;
3) the name or other specific identification of the person(s) or class of persons to whom the covered entity may make the requested use/disclosure;
4) a description of each purpose of the requested use or disclosure. (The statement "at the request of the individual" is a sufficient description of the purpose when an individual initiates the authorization and does not, or elects not to, provide a statement of purpose.)
5) the authorization's expiration date or an expiration event that relates to the individual or to the purpose or use of the requested disclosure;
6) a statement of the individual's right to revoke the authorization in writing and exceptions to the right, along with a description of how the individual may revoke;
7) a statement that information used or disclosed under the authorization may be subject to re-disclosure by the recipient and no longer protected;
8) the signature of the individual and the date signed; and
9) a description of the personal representative's authority to sign, if applicable.

Further, a copy of the signed authorization must be given to the individual. An authorization is not valid if: 1) the expiration date has passed or the expiration event has occurred; 2) the authorization was not filled out completely; 3) the authorization was revoked; 4) the authorization lacks a required element; or 5) any material information in the authorization is known to be false.

We appreciate your business and hope that this information has been helpful in your understanding of the additional measures that are being put into place as part of our commitment to ensuring the privacy and confidentiality of your group members' protected health information in compliance with HIPAA requirements.

If you should have any questions, please do not hesitate to contact our Privacy Officer at (770) 998-8936 or e-mail at PrivacyOfficer@CompBenefits.com.

frequently asked questions

Q. *What do I do if my bill is wrong?*

A. Contact your Billing Representative. His or her name and extension are listed on your bill.

Q. *Who do I call if an employee did not receive his or her VisionPass?*

A. Contact Member Services at (800) 865-3676.

Q. *I need enrollment materials. How do I get them?*

A. Contact your local Account Manager.

Q. *Who do I call if I have questions about my plan?*

A. Your primary contact should be your Account Manager, however you can always contact Administration Operations in our Tampa office at (800) 749-5855. Just follow the prompts.

Q. *I changed brokers. Do I need to do anything?*

A. Yes. Anytime you make a change to your agent, you need to supply a letter to your Account Manager on your company's letterhead advising us of the date the change will take effect and who your new agent will be.

Q. *How do I add and terminate employees from VisionCare Plan?*

A. You have several options:

- Make the corrections directly on your bill and send them in with your payment; or
- Fax them to our Premium Administration Department at (813) 281-0554.

Q. *I am having an enrollment fair and would like a representative from VisionCare to be there. Who do I call?*

A. Contact your Account Manager in advance to see if he/she will be available to attend. The more advance notice the better the chance that his or her schedule will be free.

Q. *What is the address to which I send my payment and what do you need me to send with my check?*

A. The mailing address is P.O Box 769209 – Roswell, GA 30076. Please include a detailed explanation of your payment. If you receive a bill from VisionCare Plan, you can include a copy with any necessary changes made on the back. If you do not receive a bill and "self-bill," please include backup for payment by member and premiums paid for each.

regional sales offices

Alabama

2204 Lakeshore Drive
Suite 100
Birmingham, AL 35209
Ph.: 205-879-7374 / 888-879-7374
Fax: 205-879-5307

Florida

5775 Blue Lagoon
Suite 400
Miami, FL 33126-2034
Ph.: 305-262-1333 / 800-223-6447
Fax: 305-262-6119 / 305-269-2106

Citadel International Building
5950 Hazeltine National Dr.
Suite 520
Orlando, FL 32822
Ph.: 407-240-0540 / 800-893-2981
Fax: 407-240-5452

1511 North Westshore Blvd.
Suite 1000
Tampa, FL 33607
Ph.: 813-289-2020 / 800-749-5855
Fax 813-281-0916

Georgia

100 Mansell Court East
Suite 125
Roswell, GA 30076
Ph.: 404-365-0074 / 800-411-6725
Fax: 404-233-2366

Illinois

200 W. Jackson Boulevard
9th Floor
Chicago, IL 60606
Ph.: 312-261-6200 / 800-888-0221
Fax: 312-427-9665

Indiana

3850 Priority Way S. Drive
Suite 222
Indianapolis, IN 46240
Ph.: 317-581-7081 / 800-456-1625
Fax: 317-581-7080

Kansas

7450 West 130th Street
Suite 320, Bldg. 10
Overland Park, KS 66213-2665
Ph.: 913-851-9532 / 800-456-1629
Fax: 913-851-4563

Kentucky

9300 Shelbyville Rd.
Suite 703
Louisville, KY 40222
Ph.: 502-412-0522 / 800-999-3900
Fax: 502-394-9138

Ohio

8180 Corporate Park Drive
Suite 202
Cincinnati, OH 45242
Ph.: 513-489-6550 / 800-456-1635
Fax: 513-489-7003

Rockside Square Two
6133 Rockside Road
Suite 304
Independence, OH 44131
Ph.: 216-520-1555 / 800-903-1555
Fax: 216-520-1559

Tennessee

105 Westpark Drive
Suite 450
Brentwood, TN 37027
Ph.: 615-371-5881 / 800-261-5881
Fax: 615-371-5445

Texas

14160 Dallas Parkway
Suite 725
Dallas, TX 75254
Ph.: 972-385-3710 / 800-275-2584
Fax: 972-385-3791

2929 Briarpark
Suite 314
Houston, TX 77042
Ph.: 713-784-7011 / 800-679-7883
Fax: 713-784-9440

85 N.E. Loop 410
Koger Atrium Bldg.
Suite 603
San Antonio, TX 78216
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