

GOVERNMENT HEALTH CARE PROGRAM FUNDAMENTALS

Guidelines for Making Well-Informed Decisions

There's Wealth in Our Approach.™



RBC Wealth Management

When it comes to preparing for your financial future, it's natural to focus on retirement income planning. After all, we all want the security of knowing we'll be able to afford the retirement lifestyle we each envision for ourselves.

But don't overlook the importance of retirement health care planning. As people age, they tend to need more medications and doctor visits to continue leading healthy, active lives. Furthermore, with people now living longer, on average, than previous generations — and with health care costs generally increasing faster than inflation — many of us need to be prepared to spend more on health care than our parents.

The result? Determining how you will pay medical bills while you are enjoying a long, healthy retirement is an important part of preparing for your financial future.

Like your Social Security, the choices you make about retirement health care funding will depend a lot on your personal situation. And although you'll need to carefully consider how each option available relates to you personally, the "relative" nature of your options is actually a benefit to you, because it allows you to select the payment strategies that best fit your health care needs and your financial situation.

Essentially, you may have three government-sponsored health care programs to choose from.

- Medicare
- Department of Veterans Affairs
- Medicaid

In addition, you may choose to:

- buy health insurance directly from an insurance company,
- pay premiums to continue your health insurance through your employer (if you work for a company with 20 or more employees),
- pay COBRA premiums to extend your employer's health insurance coverage for up to 18 months, or
- elect to work during retirement to participate in an employer's health insurance plan.

As you make decisions about your retirement health care plan, talk with your employer's benefits administrator, your health insurance agent and your RBC Wealth Management® financial advisor. They can help you make well-informed choices.

Regardless of when you plan to begin taking Social Security benefits and how you plan to pay for health care, remember to sign up for Medicare three months before you turn 65.

Health Care Reform

Recent changes in health care legislation are not government or national health care, but should be reviewed along with your health care options as you make decisions. The Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010, seeks to provide all Americans with access to quality, affordable health care and reduce long-term health care costs. A summary of the 2010 legislation is on pages 14.

MEDICARE ESSENTIALS

WHAT IS MEDICARE?

Medicare is a federal government-sponsored health insurance program intended to help people 65 or older pay their medical bills. (People younger than 65 who have certain disabilities may also be eligible.) The program covers some, but not all, medical expenses; and it is important to know that Medicare does not cover most long-term care costs.

Medicare is a “pay as you go” system similar to Social Security that is financed by a 2.9% payroll tax, half (1.45%) paid by workers and half by their employers, as well as by monthly premiums deducted from Social Security checks. Unlike Social Security, however, there is no upper income limit above which earnings are not taxed for Medicare.

While you apply for Medicare through the Social Security Administration, it is run by the Centers for Medicare and Medicaid Services, a division of the U.S. Department of Health and Human Services. As a beneficiary, however, you deal mostly with the private insurance companies that actually handle the claims at your local level.

The amount Medicare pays is based on the average “reasonable and necessary” cost for the specific care you need — in the area of the country where you receive it. So Medicare benefits are not based on your financial resources or ability to pay.

Key take away — Like Social Security, Medicare is an earned benefit that many qualifying retirees depend on to help pay for at least a portion of their health care.

MEDICARE COVERAGE CHOICES

Most people get their Medicare health care coverage in one of two ways.

1. *Original Medicare Plan* — Choose Part A (hospital), Part B (medical) and Part D (prescription drug) coverage from the government and buy a Medigap insurance policy from a private provider. This strategy offers you greater choice of doctors, however costs may be higher than in Medicare Advantage Plans.
2. *Medicare Advantage Plan* — Choose Part C (which includes Part A and Part B coverage) from a private provider like a HMO or PPO. Many of these plans also include Part D, but if your provider’s plan does not, you may choose to receive Part D from the government. Generally you must see doctors in the plan, however your costs may be lower than in the Original Medicare Plan, and you may get extra benefits.

Key take away — Your costs vary depending on your plan, coverage and the services you use.

MORE ABOUT THE FOUR PARTS OF MEDICARE

For optimum flexibility, choose one or more coverage options.

MEDICARE PART A (HOSPITAL INSURANCE)

Helps you pay for the services associated with inpatient care — such as your meals, hospital room and nursing services — received at a hospital, skilled nursing facility or psychiatric hospital. Some home health care and hospice care may also be covered. Insurance companies that handle Part A claims are called “fiscal intermediaries.”

It is important to know that not all hospital services are covered by Part A. For example, private duty nursing, a television or telephone and a private room (unless medically necessary) are not covered under Part A.

Features: The portion of hospitalization costs Medicare Part A pays for depends on the length of your hospital stay. In 2014, there is a \$1,216 deductible for each hospitalization.

| Length of Hospitalization | What You Pay (2014) | What Medicare Part A Pays (2014) |
|---------------------------|--|--|
| 1-60 | \$1,216 deductible | All covered costs, after deductible is met |
| 61-90 | Coinsurance payment of \$304/day per benefit period | All covered costs, after daily coinsurance payment |
| 91-150* | Coinsurance payment of \$608/day per “lifetime reserve” day used | All covered costs, after daily coinsurance payment |

* Lifetime reserve days are 60 extra days that Medicare will pay for when you are in a hospital more than 90 days during a benefit period. Once these 60 reserve days are used, you don’t get any more extra days during your lifetime. Medicare Part A pays nothing after 150 days of hospitalization.

Costs: There is no premium for Medicare Part A if you are age 65 or older and you are eligible for Social Security benefits. People with certain disabilities who are younger than 65, as well as dependents and some survivors of a person who is entitled to Social Security retirement benefits, may also qualify for free Medicare Part A.

If you are 65, but not eligible for Social Security, you may still buy Medicare Part A.

| Total Social Security Credits | What You Pay (2014) |
|---|---------------------|
| 40 or more quarters of full-time employment | Nothing |
| Less than 40 quarters of full time employment | Up to \$426/month |

In most cases, if you choose to purchase Part A coverage, you must also have Part B and pay monthly premiums for both.

MEDICARE PART B (MEDICAL INSURANCE)

Helps you pay for other medical care — including physician care, regardless of where it is received — and other medical services and supplies not covered by hospital insurance, such as ambulance service, laboratory tests and physical therapy or rehabilitation services. Insurance companies that handle Part B claims are called “Medicare carriers.”

It is important to know that not all medical services and supplies are covered by Part B. For example, hearing aids, eye glasses and most annual physical exams are not covered under Part B.

Features: In 2014, there is an annual deductible of \$147 and you are also required to pay a portion of covered costs, usually 20% of the medicare-approved amount.

Costs: Anyone who is eligible for Medicare Part A can enroll in Part B by paying a monthly premium. Citizens of the United States and certain long-term lawfully admitted non-citizens who are not eligible for free Medicare Part A can buy Part B medical insurance without having to buy Part A.

Single beneficiaries with Adjusted Gross Income greater than \$85,000 and married beneficiaries with Adjusted Gross Income greater than \$170,000 are required to pay a greater percentage of the program’s cost.

| Medicare Part B Monthly Premium (adjusted for income) | | |
|---|------------------------|----------|
| Individual | Joint | 2014 |
| Less than \$85,001 | Less than \$170,001 | \$104.90 |
| \$85,001 - 107,000 | \$170,001 - 214,000 | \$146.90 |
| \$170,001 - 160,000 | \$214,001 - 320,000 | \$209.80 |
| \$160,001 - 214,000 | \$320,001 - 428,000 | \$272.70 |
| Greater than \$214,000 | Greater than \$428,000 | \$335.70 |

Higher income beneficiaries will pay a monthly premium equal to 35, 50, 65 or 80 percent of the total program cost, depending on income level and tax filing status.

Although the same insurance company may handle Part A and Part B claims, the two parts are different in administration and there is little overlap between the two. So it is like having two distinctly different health insurance policies.

MEDICARE PART C (MEDICARE ADVANTAGE PLAN, FORMERLY KNOWN AS “MEDICARE + CHOICE”)

In many areas, private health care plans like managed care plans, preferred provider organizations, medical savings accounts and private fee-for-service plans are authorized to offer Medicare benefits. People with Medicare Parts A & B may choose to receive all their health care services through one of these plans using Medicare Part C.

Features: With one of these plans, you may not need a Medigap policy (a special supplemental insurance policy designed to help cover deductibles, coinsurance and other “gaps” in your Medicare coverage).

Costs: Your managed care plan will likely charge a monthly premium, along with associated costs. What you pay may vary, depending on the scope of coverage you choose.

MEDICARE PART D (PRESCRIPTION DRUG COVERAGE)

Helps you pay for medications doctors prescribe for treatment.

Features: If you currently do not have prescription drug coverage, enrolling in Part D may be a wise health care investment, even if you currently do not take many prescription drugs. If you have prescription drug coverage through a current or former employer or union — or through the Department of Veterans Affairs or the Federal Employees Health Benefits program — check with your benefits administrator to discuss your options before enrolling in Part D.

Costs: Anyone who has Medicare Parts A and B or Medicare Part C is eligible for prescription drug coverage (Part D). Participation in Part D is voluntary. You will be charged an additional monthly premium for the benefit, and what you pay may vary, depending on your financial situation and the scope of coverage you choose.

Medicare Part D pays a variable amount, depending on your total annual prescription costs. Note the “donut hole” in coverage where Medicare Part D pays nothing.

| Total Prescription Costs in 2014 | What You Pay | What Medicare Pays Part D | Out of Pocket | Total Out of Pocket |
|----------------------------------|---|---|---------------------------|---------------------|
| From \$0 to \$310 | You pay deductible of up to \$310 (some plans may offer lower deductible) | Medicare pays nothing until the deductible is satisfied | \$310.00 | \$310.00 |
| From \$310 to \$2,850 | You pay 25% of these costs | Medicare Part D pays 75% of these costs | \$635 | \$945 |
| From \$2,850 to \$6,455 | You pay 100% of these costs until you have spent \$4,750 out of pocket for the year | Medicare Part D pays none of these costs | \$3,605 | \$4,550 |
| Over \$6,455 | You pay 5% of these costs | Medicare Part D pays 95% of these costs | 5% of amount over \$6,455 | \$4,550 + 5% |

Key take away — If you are 65 or older and qualify for Social Security, enrolling in Part A costs you nothing and enrolling in Part B may be a practical health care investment. Whether you should enroll in Parts C and/or D depend on your personal situation.

WHEN TO ENROLL

The initial enrollment period for Medicare Parts A, B, C and D begins three months before you turn 65, includes the month you turn 65 and ends three months after the month you turn 65. Should you fail to enroll during the initial enrollment period, you can still apply for benefits. However, if you don't sign up for Part B when you are first eligible, you may pay a higher monthly premium.

Key take away — Contact the Social Security Administration three months before your 65th birthday to sign up for Medicare, even if you do not plan to retire or begin taking Social Security benefits at 65.

GENERAL AND SPECIAL ENROLLMENT

If you miss the initial enrollment period, change your mind about the Medicare coverage you wish to receive or your other health insurance circumstances change, there are general and special enrollment periods. However, some penalties may apply.

Late enrollment windows and penalties (if any)

| | Jan. | Feb. | Mar. | Apr. | May | Jun. | Jul. | Aug. | Sep. | Oct. | Nov. | Dec. |
|--------|---|------|------|------|-----|------|-----------------|------|------|------|---|------|
| Part A | Annual general enrollment Jan. 1-Mar. 31 with no penalty | | | | | | Coverage begins | | | | | |
| Part B | Annual general enrollment Jan. 1-Mar. 31 <i>with 10% penalty for each 12-month period you were eligible for, but did not enroll in, Medicare Part B — unless covered by a current employer's health care plan (either your employer or your spouse's)*</i> | | | | | | Coverage begins | | | | | |
| Part C | | | | | | | | | | | Annual coordinated election period Oct. 15-Dec. 7 with no penalty | |
| Part D | | | | | | | | | | | Annual coordinated election period Oct. 15-Dec. 7 <i>with penalty for as long as you have coverage</i> | |

* If you qualify, you may delay enrolling in Medicare Part B without waiting for the next general enrollment period and paying the 10 percent premium surcharge per year of late enrollment. You can take advantage of this special enrollment period any time while you are covered under the current employer's group health plan or within an eight-month period that begins with the month your group health coverage or employment ends, whichever comes first.

Key take away — There are no penalties for late enrollment in Medicare Parts A and C, however you may pay more for Medicare Parts B and D if you miss your initial enrollment period during the three months immediately before and after the month you turn 65.

HOW TO ENROLL

Call 1-800-772-1213 to locate the Social Security Administration office nearest you. You may be able to enroll over the phone.

When you enroll, you will be required to opt in to Part A and you will need to choose whether or not you want to enroll in Parts B, C and D. Once you are enrolled, you will receive a red, white and blue Medicare card showing the Parts you have elected. You will also receive a copy of “Medicare and You,” a handbook that describes your Medicare benefits and Medicare Plan choices in more detail.

Keep your Medicare card in a safe place, so you have it when you need it. If it gets lost or stolen, you will need to apply for a replacement card.

Key take away — Enrolling in Medicare is relatively easy once you’ve decided which Parts are right for you.

For more information about your Medicare options or to order a free handbook, “Medicare & You” (Publication No. CMS-10050), go to www.medicare.gov or call 1-800-MEDICARE (1-800-633-4227).

DEPARTMENT OF VETERANS AFFAIRS HEALTH CARE BENEFITS ESSENTIALS

WHAT IS AVAILABLE?

The United States Department of Veterans Affairs provides eligible military veterans and certain survivors or dependents with a standard health benefits plan that emphasizes preventive and primary care. This standard plan also offers a full range of outpatient and inpatient services within the Veterans Affairs health care system. Disability benefits and long-term care benefits are available for qualifying veterans.

It's important to know that not all health care services are available. For example, drugs or medical devices not approved by the Federal Drug Administration are not covered by Veterans Affairs.

Key take away — The U.S. Department of Veterans Affairs health care system is designed to meet the essential medical and health needs of our nation's military veterans.

WHO IS ELIGIBLE?

Eligibility for most veterans' health care benefits is based on active military service in the Army, Navy, Air Force, Marines, or Coast Guard (or Merchant Marines during World War II) with discharge under other than dishonorable conditions. Health care eligibility is not only for combat veterans.

To prevent demand for services from outstripping the resources available — thus preserving the quality of medical care and treatment provided — a priority system helps ensure that veterans with service-connected disabilities and those below a certain income level are able to be enrolled in the Veterans Affairs health care system.

Key take away — Providing health care to veterans with service-connected disabilities and/or the ability to demonstrate financial need is the top priority of Veterans Affairs.

WHAT ARE THE COSTS?

There is no monthly premium for Veterans Affairs health care benefits. However, co-payments are required for non-service connected and zero % non-compensable veterans whose income is above the established threshold that is set annually by Veterans Affairs.

Co-payment costs for qualified veterans for outpatient services.

- \$15 for basic care
- \$50 for specialty care
- \$8 per 30 days or less supply of prescription medicine
- Zero co-payment for preventive care

Key take away — Eligible veterans pay no premium for health care provided by Veterans Affairs. However, there are nominal co-pays, and prescription drugs are available for a highly competitive price.

HOW TO ENROLL

There are three ways to enroll:

1. In person at any Veterans Affairs Medical Center or Clinic
2. On-line at: www.va.gov/1010EZ.htm
3. By mailing completed Form 10-10EZ to the Veterans Affairs Medical Center of your choice

Once your application is processed, the Veterans Affairs Health Eligibility Center will send you a letter with your enrollment priority group assignment and instructions to contact the local Veterans Affairs health care facility for an appointment. You should receive the appropriate enrollment letter within 7 to 14 days. If the Health Eligibility Center determines you are not eligible to enroll, the letter will give you instructions on how to appeal the decision if you do not agree with it.

Key take away — Enrolling is easy, there are no initial, general or special enrollment periods and Veterans Affairs will notify you promptly if coverage is available for you.

If you are a military veteran, to learn more about your U.S. Department of Veterans Affairs health care benefits, go to www.va.gov or call 1-877-222-8387.

MEDICAID ESSENTIALS

WHAT IS MEDICAID?

Medicaid is a state-run program intended to provide medical treatment and health care services to people who may not otherwise be able to afford the essential care they need. There are broad federal guidelines. However, each state determines the amount, duration and types of benefits Medicaid will provide. Typical Medicaid programs cover inpatient and outpatient hospital services, physician and surgical services, diagnostic services, family planning services and prenatal/delivery services for pregnant women.

It's important to know not all health care services are available. For example, elective procedures (such as cosmetic surgery, orthodontics or surgical vision correction) not deemed a medical necessity generally are not covered. Seniors considering Medicaid should also be reminded that they will frequently have limited or no choice in the doctors, hospitals and nursing homes they go to for care.

Key take away — Medicaid and Medicare are two different government programs. Unlike Medicare, which offers the beneficiary a higher degree of control over health care decisions, Medicaid is a social safety net designed to catch people who may not have the means to pay for essential care on their own.

WHO IS ELIGIBLE?

Medicaid rules require an applicant's financial records to be reviewed as far as five years back to ensure his or her income and total net worth are lower than statutory maximum thresholds. Applicants must generally meet three fundamental definitions of neediness to receive Medicaid benefits.

1. *Categorical Need Test* — Applicants must be at least one of the following:
 - Age 65 or older
 - Disabled
 - Blind
2. *Income Test* — In “spend-down” states, the applicant must spend all of his or her monthly income (minus a very small personal needs allowance) on medical or nursing home expenses. In “income-cap” states, personal income greater than the generally low monthly income cap allowed by the state will disqualify the applicant from receiving Medicaid.
3. *Asset Test* — The applicant is allowed to own only minimal assets (generally up to \$2,000 for an individual or \$3,000 for a married couple, if they are both applying).

While it is possible to plan for Medicaid by using tools such as trusts, transfers of the family home, purchase of exempt assets, purchase of long-term care insurance and other strategies, it is critical for you and your family to consult a knowledgeable elder law attorney before you take any steps toward trying to qualify for Medicaid.

Key take away — Qualifying is not easy. To receive Medicaid, you must demonstrate a categorical need and a financial need that may be extremely difficult for someone not living in poverty. Some people may qualify for both Medicare and Medicaid.

WHAT ARE THE COSTS?

You do not pay any premium for Medicaid coverage and Medicaid does not pay money to you. Instead, it sends payments directly to your health care providers. Depending on your state's rules, you may be required to make a nominal co-payment for some medical services.

Key take away — There is no monthly premium for Medicaid, however you may still be financially responsible for a small portion of the care and services you receive.

HOW TO ENROLL

You can apply for Medicaid benefits at your local Medicaid office. Most states have a toll-free number to help answer your questions. If you are not sure whether you qualify, you can apply for Medicaid and have a caseworker in your state evaluate your situation.

You will usually need to bring the following documents with you when you apply:

- Proof of who you are (such as a birth certificate)
- Proof of where you live (such as a lease, utility bills)
- Proof of your income (such as pay stubs, last five years' tax returns, letter from Social Security)
- Proof of what you own (such as bank account statements from past five years, car registration)
- Your medical bills

In many states, if you are eligible for Supplemental Security Income (SSI), you are automatically eligible for Medicaid. To get Medicaid benefits by applying for SSI, call the Social Security Administration at 1-800-772-1213.

Key take away — Applying for Medicaid is fairly easy. However, you will need to provide some personal information about your health and finances in order to be accepted.

If you do not believe you will have the income or assets in retirement to afford to pay for the health care services and medical treatments you need, go to www.cms.hhs.gov/home/medicaid.asp or call the toll free number for your state listed at www.cms.hhs.gov/apps/contacts/ (select "State Medical Assistance Office" for Organization Type) to learn about Medicaid. If you do not have internet access, look under "State Department of Human Services" in the government section of your phone book, call your local Social Security office or call Medicare at 1-800-633-4227 for a voice-automated system to help you find the number for the Medicaid office nearest you.

SUMMARY OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010

| | |
|----------------------------|---|
| Coverage | Provide coverage to 32 million Americans who are currently uninsured. |
| Cost | \$940 billion over ten years. |
| Deficit Impact | According to the latest estimate from the Congressional Budget Office (CBO), the Bill would reduce the deficit by \$143 billion over the first ten years. The first preliminary estimate said it would reduce the deficit by \$130 billion over ten years and reduce the deficit by \$1.2 trillion dollars in the second ten years. |
| Individual Mandate | In 2014, everyone must purchase health insurance or face an annual penalty. The flat dollar amount starts at \$95 in 2014, rises to \$325 in 2015 and increases to \$695 in 2016. After 2016 the amount is indexed for inflation. There are some exceptions for low-income people. |
| Insurance Reforms | <ul style="list-style-type: none"> ■ Six months after enactment, insurance companies can no longer deny children coverage based on a preexisting condition. ■ Starting in 2014, insurance companies cannot deny coverage to anyone with preexisting conditions. ■ Insurance companies must allow children to stay on their parent's insurance plans until age 26. ■ No lifetime limits on coverage. |
| Health Insurance Exchanges | <ul style="list-style-type: none"> ■ The uninsured and self-employed would be able to purchase insurance through state-based exchanges with subsidies available to individuals and families with income between the 133 percent and 400 percent of poverty level. ■ Effective 2014, separate exchanges would be created for small businesses to purchase coverage. ■ Funding will be available to states to establish exchanges within one year of enactment and until January 1, 2015. |
| Subsidies | Individuals and families who make between 100 - 400 percent of the Federal Poverty Level (FPL) and want to purchase their own health insurance on an exchange are eligible for subsidies. They cannot be eligible for Medicare, Medicaid and cannot be covered by an employer. Eligible buyers receive premium credits and there is a cap for how much they have to contribute to their premiums on a sliding scale. <i>2010 Federal Poverty Level for family of four is \$22,050</i> |
| Funding the Plan | <ul style="list-style-type: none"> ■ The Medicare Tax Base is broadened by (1) Additional 0.9 percent hospital insurance on earned income in excess of \$200,000 for single tax payers and \$250,000 for married couples filing jointly, and (2) A 3.8 percent "unearned income Medicare contributions" tax on higher income tax payers. The 3.8 percent is imposed on the lesser of net investment income or excess MAGI over a threshold amount (\$200,000 for single individuals or the head of a household; \$250,000 for married couples filing jointly; \$125,000 for married couples filing separate returns). ■ Beginning in 2013 the threshold for the itemized deduction for unreimbursed medical expenses is increased from 7.5 percent to 10 percent of AGI. ■ <i>Excise Tax</i> — Beginning in 2018, insurance companies will pay a 40 percent excise tax on so-called "Cadillac" high-end insurance plans with an annual premium in excess of an inflation-adjusted \$27,500 for families (\$10,200 for individuals). Dental and vision plans are exempt and will not be counted in the total cost of a family's plan. ■ <i>Tanning Tax</i> — 10 percent excise tax on indoor tanning services beginning in 2010. |
| Medicare Impact | <ul style="list-style-type: none"> ■ Closes the Medicare prescription drug "donut hole" by 2020. Medicare Part D enrollees who hit the donut hole by 2010 will receive a one time \$250 rebate in 2010. ■ Beginning in 2011, seniors in the gap will receive a 50 percent discount on brand name drugs. |
| Medicaid Impact | <ul style="list-style-type: none"> ■ Expands Medicaid to include 133 percent of federal poverty level, which is \$29,327 for a family of four. ■ Requires states to expand Medicaid to include childless adults starting in 2014. ■ Federal Government pays 100 percent of costs for covering newly eligible individuals through 2016. ■ Illegal immigrants are not eligible for Medicaid. |
| Employer Mandate | Technically, there is no employer mandate. Employers with more than 50 employees must provide health insurance or pay a fine of \$2,000 per worker each year if any worker receives federal subsidies to purchase health insurance. Exemption allowed for first 30 employees when calculating the penalty. |
| Immigration | Illegal immigrants will not be allowed to buy health insurance in the exchanges — even if they pay completely with their own money. |



Sources:

- Social Security Administration Publication No. 05-10043, September 2009
- “Medicare and You: 2010” (CMS Publication No. 10050), January 2010
- Social Security Administration website: www.ssa.gov
- Medicare website: www.medicare.gov
- U.S. Department of Veterans Affairs website: www.va.gov
- Centers for Medicare and Medicaid Services website: www.cms.gov/home/medicaid.asp
- American Association of Retired People website: www.aarp.org

This material is based on data obtained from sources we consider to be reliable; however, it is not guaranteed to accuracy and does not purport to be complete. This information is not intended to be used as the primary basis of investment decisions. Because of individual client requirements, it should not be construed as advice designed to meet the particular investment needs of any investor.

RBC Wealth Management does not provide tax or legal advice. All decisions regarding the tax or legal implications of your investments should be made in connection with your independent tax or legal advisor.

© 2013 RBC Capital Markets, LLC. All rights reserved.

6891 (12/13)

