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Insurance Law Alert

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"A very, very impressive team which is completely hands-on in terms of shaping the issues, and dealing with other parties and the judge."

–Chambers USA 2015, quoting a client

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Second Circuit Rules That Physicians and Medical Associations Lack Standing To Sue Health Insurers

The Second Circuit ruled that psychiatrists and professional medical associations lacked standing to bring claims against health insurers based on allegedly discriminatory reimbursement practices. *American Psychiatric Assoc. v. Anthem Health Plans, Inc.*, 2016 WL 2772853 (2d Cir. May 13, 2016). (Click here for full article)

U.S. Supreme Court Reverses Ninth Circuit on Standing Issue, Ruling That Statutory Violation Does Not Automatically Satisfy Injury-in-Fact Requirement

The United States Supreme Court reversed a Ninth Circuit decision holding that an individual plaintiff had standing to sue Spokeo, a search engine company, under the Fair Credit Reporting Act. *Spokeo, Inc. v. Robins*, No. 13-1339 (U.S. May 16, 2016). (Click here for full article)

Allocation Alert:

New York Court of Appeals Applies "All Sums" Allocation and Vertical Exhaustion to Determine Excess Coverage

The New York Court of Appeals ruled that under the applicable policy language, all sums allocation and vertical exhaustion governed excess insurers' coverage obligations for long-tail asbestos injuries. *Viking Pump, Inc. v. TIG Ins. Co.*, 2016 WL 1735790 (N.Y. May 3, 2016).

Viking Pump sued excess insurers seeking coverage for asbestos-related injury claims. In 2009, relying upon "non-cumulation" and "prior insurance" provisions in the policies at issue, the Delaware Court of Chancery ruled that coverage for injuries spanning multiple years should be allocated on an "all sums" basis, under which the policyholder can designate a single policy year to bear the responsibility for a covered loss that spans multiple policy periods. *Viking Pump, Inc. v. Century Indem. Co.*, 2 A.3d 76 (Del. Ch. 2009) (*see* December 2009 Alert). The Chancery Court thereafter transferred the case to the Delaware Superior Court for trial.

In 2013, the Superior Court ruled that, under New York law, horizontal exhaustion applies, such that all policies of a layer of coverage must be exhausted before any policies of a higher layer of coverage are triggered. In a subsequent decision, the court clarified its ruling, predicting that New York's highest court would rule that horizontal exhaustion would apply in continuous injury cases only to the primary and umbrella layers, but would not govern payment among excess tiers of coverage. *Viking Pump, Inc. v. Century Indem. Co.*, 2014 WL 1305003 (Del. Super. Ct. New Castle Cnty. Feb. 28, 2014) (*see* April 2014 Alert).

In 2015, the Delaware Supreme Court concluded that resolution of these matters depended on "significant and unsettled questions of New York law," and certified the following questions to the New York Court of Appeals:

> (1) Under New York law, is the proper method of allocation to be used all sums or pro rata when there are non-cumulation and prior insurance provisions? (2) Given the Court's answer to Question #1, under New York law and based on the policy language at issue here, when the underlying primary and umbrella insurance in the same policy period has been exhausted, does vertical or horizontal exhaustion apply to determine when a policyholder may access its excess insurance?

In a unanimous opinion issued this month, the New York Court of Appeals ruled that under the applicable policy language, all sums allocation and vertical exhaustion governed the excess insurers' coverage obligations. The court reasoned that non-cumulation clauses and prior insurance provisions in the excess policies compelled all sums allocation. The court explained:

> [I]t would be inconsistent with the language of the non-cumulation clauses to use pro rata allocation here. Such policy provisions plainly contemplate that multiple successive insurance policies can indemnify the insured for the same loss or occurrence by acknowledging that a covered loss or occurrence may "also [be] covered in whole or in part under any other excess [p]olicy issued to the [Insured] prior to the inception date" of the instant policy. By contrast, the very essence of pro rata allocation is that the insurance policy language limits indemnification to losses and occurrences during the policy period. . . .

The court distinguished *Consolidated Edison Co. of N.Y. v. Allstate Ins. Co.*, 98 N.Y.2d 208 (2002), which applied pro rata allocation to long-tail environmental contamination claims, based on the policy language. In *Consolidated Edison*, the court's decision turned upon interpretation of the same "all sums" and "during the policy period" language at issue in *Viking Pump*, but did not address non-cumulation or prior insurance provisions.

The court also concluded that the policy language required vertical exhaustion (under which an insured need only exhaust the primary and umbrella policies immediately underlying an excess policy, rather than all triggered policies in underlying layers). In so ruling, the court explained that the excess policies at issue "primarily hinge[d] their attachment on the exhaustion of underlying

policies that cover the same policy period as the overlying excess policy, and that are identified by either name, policy number or policy limit." Finally, the court held that vertical exhaustion was "conceptually consistent" with an all sums allocation, allowing a policyholder to "seek coverage through the layers of insurance available for a specific year."

Subrogation Alert:

New York Court of Appeals Rules That Anti-Subrogation Rule Does Not Bar Insurers' Claims Against Liable Party

The New York Court of Appeals ruled that the anti-subrogation rule did not bar insurers' claims against a party who was not an insured under the applicable policy. *Millennium Holdings LLC v. The Glidden Co.*, 2016 WL 2350158 (N.Y. May 5, 2016).

The coverage dispute arose from paint and pigment manufacturer Glidden Company's complex corporate history, which involved numerous corporate purchases, transfers and takeovers. Ultimately, Glidden's pigment and paint businesses were divided and became separately owned entities. Akzo Nobel Paints ("ANP") is the successor company of the paint business, and Millennium is the successor company of the pigment business. ANP's predecessor agreed to indemnify Millennium's predecessor.

Various London insurers and Northern Assurance Company provided primary and excess coverage to one of Millennium's corporate predecessors. The insurers funded the defense of lead paint/pigment claims asserted against Millennium and ANP under those policies. In the present action, the insurers, as Millennium's subrogee, sought indemnification from ANP for the defense costs based on a judicial ruling that ANP's predecessors were not insured under the policies issued to Millennium's predecessor. *See The Glidden Co. v. Lumbermens Mutual Casualty Co.*, 112 Ohio St. 3d 470 (2006).

A New York trial court found that ANP was required to indemnify Millennium under the predecessors' agreement but that the anti-subrogation doctrine precluded the insurers' subrogation claim against ANP. *Millennium Holdings LLC v. The Glidden Co.*, 2013 WL 6182552 (N.Y. Sup. Ct. New York Cnty. Nov. 25, 2013) (*see* December 2013 Alert). Under the anti-subrogation rule, "an insurer has no right of subrogation against its own insured for a claim arising from the very risk for which the insured was covered even where the insured has expressly agreed to indemnify the party from whom the insurer's rights are derived." Even though ANP was not insured under the subject policies (either by name or by operation of law), the trial court concluded that the anti-subrogation rule applied because the insurers sought "to recover for the very risk [they] insured when [they] originally issued the policies." More specifically, the trial court reasoned that the reimbursement the insurers sought from ANP—relating to defense costs for lead paint/pigment claims—was the same risk the insurers covered under policies issued to Millennium's predecessor. Therefore, the court dismissed the insurers' claims. An intermediate appellate court affirmed. The New York Court of Appeals reversed, applying a literal reading of the policies at issue.

The New York Court of Appeals ruled that the anti-subrogation rule applies only where "the party the insurer is seeking to enforce its right of subrogation against is its insured, an additional insured, or a party who is intended to be covered by the insurance policy in some other way." Here, because it was determined that ANP and its predecessor were not insured under the applicable policies, the anti-subrogation rule did not apply. The court distinguished *Jefferson Ins. Co. of N.Y. v. Travelers Indem. Co.*, 92 N.Y.2d 363 (1998), which held that the anti-subrogation rule barred an insurer's claim against a non-insured party. In *Jefferson*, the non-insured party was covered under the policy as a "permissive user" of the insured vehicle and was thus "a party who was intended to be covered by the insurance policy in some other way." The court also distinguished cases in which lower courts have extended the anti-subrogation rule to third parties who are not covered by the applicable policies as "limited and distinguishable" and based on public policy grounds not applicable here.

Advertising Injury Alerts:

Sale of Counterfeit Goods with Infringing Trademark Does Not Constitute Advertising Injury, Says Second Circuit

The Second Circuit ruled that an insurer had no duty to defend or indemnify trademark infringement claims arising out of the policyholder's sale of counterfeit products, finding that the allegations did not constitute covered advertising injury. *United States Fidelity & Guaranty Co. v. Fendi Adele S.R.L.*, 2016 WL 2865578 (2d Cir. May 17, 2016).

The coverage dispute arose out of trademark infringement suits in which Ashely Reed was found liable for its role in transactions involving counterfeit Fendi products. During the relevant time frame, Ashley Reed was insured under liability policies issued by USF&G. The policies covered damages caused by "advertising injury," defined to include injury resulting from the "use of another's advertising idea in your 'advertising.'" USF&G sought a declaration that its policies did not cover the underlying suits because the claims were based on the sale, not the advertising, of counterfeit products. A New York federal district court agreed and granted USF&G's summary judgment motion. The Second Circuit affirmed.

The Second Circuit ruled that there was no coverage under the advertising injury provision because Ashley Reed did not engage in any advertising of the counterfeit products, and in the underlying suits, Fendi did not allege any injuries based on advertising activities. The court rejected an argument frequently asserted by policyholders in this context—namely, that the use of another company's trademark constitutes "advertising" because it "attract[s] the attention of others by any means for the purpose of seeking customers or supporters or increasing sales or business." The court explained that reasonable parties would not expect advertising injury coverage to extend to the sale of infringing goods where the insured engaged in no advertising. Emphasizing the difference between the "placement of a counterfeit brand label" on a product and the "act of soliciting customers through printed advertisements or other media," the court held that mere product identification (or misidentification) is not equivalent to advertising activity.

Michigan Court Rejects Policyholder's Implicit Disparagement Argument for Advertising Injury Coverage

A Michigan federal district court ruled that an insurer had no duty to defend or indemnify infringement and false advertising claims because they did not allege disparagement within the scope of advertising injury coverage. *Vitamin Health, Inc. v. Hartford Cas. Ins. Co.*, 2016 WL 2622353 (E.D. Mich. May 9, 2016).

Bausch & Lomb sued Vitamin Health alleging patent infringement and false advertising based on Vitamin Health's advertisements for vision-related supplements. Vitamin Health's insurer, Hartford, refused to defend or indemnify, arguing that the underlying complaint did not state a claim for product disparagement. The court agreed and granted Hartford's summary judgment motion.

The court ruled that the underlying complaint could not be read to allege that Vitamin Health disparaged Bausch & Lomb's products. The complaint alleged that Vitamin Health misrepresented the content of its own products, not its competitors' products. The court rejected the notion that Vitamin Health "implicitly disparaged" Bausch & Lomb's products by creating a false comparison between the two companies' products. In so ruling, the court distinguished cases in which false advertising claims were held to allege disparagement because they contained assertions of product superiority, and therefore implied that competitors' products were inferior. The court also held that even assuming the claims were within the scope of advertising injury, coverage was barred by intellectual property and failure to conform exclusions.

Coverage Alerts:

Ohio Supreme Court Rules That Abuse Exclusion Bars Coverage for Direct and Vicarious Liability

The Ohio Supreme Court ruled that an abuse and molestation exclusion barred coverage for damages based on the insured entity's vicarious liability and that its application was not limited to damages arising directly from its employee's abuse of a minor. *World Harvest Church v. Grange Mutual Cas. Co.*, 2016 WL 2754889 (Ohio May 12, 2016).

In an underlying abuse suit, a church and its employee were found liable for assault and battery, negligence, and intentional infliction of emotional distress, among other claims. Grange, the church's general liability insurer, refused to indemnify based on an exclusion that precluded coverage for the "actual or threatened abuse or molestation by anyone of any person while in the care, custody or control of any insured." The church argued that the exclusion barred coverage only for damages arising from an insured's direct liability for abuse, and did not extend to damages based on vicarious liability. The Ohio Supreme Court disagreed and ruled in the insurer's favor. The court reasoned that the abuse exclusion was broadly worded, and did not contain any language limiting its application to damages based on an insured's direct liability.

The court also ruled that post-judgment interest is based only on the portion of the judgment that reflects covered injury, not the entire underlying judgment. Because the underlying suit did not allege any covered injuries, the court held that Grange was not obligated to pay any post-judgment interest.

Seventh Circuit Rejects Policyholder's Attempt to Recast Contract Claims as Negligence Claims For Coverage Purposes

The Seventh Circuit ruled that an insurer had no duty to defend a suit alleging that a law firm had failed to pay certain benefits to a retired employee, finding that the suit alleged only uncovered breach of contract. *Hartford Casualty Ins. Co. v. Karlin, Fleisher & Falkenberg, LLC*, 2016 WL 2849449 (7th Cir. May 16, 2016).

A retired attorney sued his former employer alleging that it had failed to compensate him for unused vacation time and sick leave in violation of his employment contract and applicable law. Hartford denied coverage on the basis that the claims did not allege any covered acts of negligence. An Illinois federal district court agreed and granted Hartford's summary judgment motion. The Seventh Circuit affirmed.

The law firm argued that the attorney's claims, although sounding in contract, were actually based on negligent acts—namely, the firm's failure to maintain accurate records and/or properly administer employee benefits. The Seventh Circuit rejected this argument, holding that the underlying claims were based on money owed by virtue of the employment contract. The court further held that Hartford was not estopped from denying coverage notwithstanding a seven-month delay in disclaiming coverage. The court found that a delay cannot create coverage that does not exist and that, in any event, the law firm should have reasonably known that a breach of the employment contract was not covered by the policy.

Bad Faith Alert:

Wisconsin Appellate Court Affirms Dismissal of Bad Faith Claim Against Property Insurer

A Wisconsin appellate court ruled that a trial court did not err in granting summary judgment to an insurer on a first-party bad faith claim on the basis that coverage was "fairly debatable." *Tripalin v. American Family Mutual Ins. Co.*, 2016 WL 1370129 (Wis. Ct. App. Apr. 7, 2016).

Tripalin filed a claim with American Family for roof damage allegedly caused by hail. American Family denied coverage based on an adjuster's report concluding that the damage was caused by defective shingles rather than hail. Tripalin submitted a report from a local contractor opining that the damage was caused by hail and requested that American Family reconsider its coverage denial. American Family denied the request. Thereafter, Tripalin sued for bad faith. A trial court granted American Family's summary judgment motion, finding that bad faith

was not established because the cause of damage was "fairly debatable." The appellate court affirmed.

The appellate court set forth the stringent standard for withstanding summary judgment on a bad faith claim:

> It is not enough to point to evidence supporting or undermining an expert's opinion in a bad faith case. Rather, to establish a bad faith denial of coverage, Tripalin would need to show that the opposing expert was so obviously wrong in his opinion that American Family could not have reasonably relied on his opinion in its decision to deny coverage.

The court concluded that no such showing had been made because at most, the two conflicting opinions as to the cause of roof damage supported the argument that coverage was "fairly debatable."

Affordable Care Act Alert:

D.C. Court Rules That Government Wrongly Reimbursed Health Insurers

A Washington, D.C. federal district court ruled that the government unlawfully paid billions of dollars to insurance providers under the Affordable Care Act ("ACA") without a funding appropriation from Congress. *U.S. House of Representatives v. Burwell*, 2016 WL 2750934 (D.D.C. May 12, 2016).

The House of Representatives filed suit alleging that the Secretary of the Department of Health and Human Services and other federal agencies spent unappropriated funds in order to reimburse health insurers for discounts given to low-income consumers pursuant to the ACA. More specifically, the suit alleged that insurers were improperly reimbursed for discounts they provided pursuant to Section 1402 of the ACA (in the form of "cost sharing reductions," such as reduced deductibles, coinsurance and copayments) because funds for such reimbursements were never appropriated by Congress. The court explained:

> Paying out Section 1402 reimbursements without an appropriation thus violates the Constitution. Congress authorized reduced cost sharing but did not appropriate monies for it, in the FY 2014 budget or since. Congress is the only source for such an appropriation, and no public money can be spent without one.

The court rejected the argument that the funds were available through a related ACA provision that provides funds for subsidies that reduce the cost of health insurance premiums (Section 1401), noting that "[s]uch an appropriation cannot be inferred, no matter how programmatically aligned the Secretaries may view Sections 1401 and 1402."

Although the court issued an injunction enjoining the use of unappropriated monies to fund reimbursements to health insurers under Section 1402, the ruling will not take immediate effect because the court issued a stay of the injunction pending any appeal.

Jurisdictional Alerts:

Second Circuit Rules That Physicians and Medical Associations Lack Standing To Sue Health Insurers

The Second Circuit ruled that psychiatrists and professional medical associations lacked standing to bring claims against health insurers based on allegedly discriminatory reimbursement practices. *American Psychiatric Assoc. v. Anthem Health Plans, Inc.*, 2016 WL 2772853 (2d Cir. May 13, 2016).

Two psychiatrists and three professional organizations sued health insurance companies alleging that the insurers' reimbursement practices discriminate against patients with mental health and substance abuse disorders in violation of ERISA and the Mental Health Parity and Addition Equity Act ("MHPAEA"). The psychiatrists brought suit on behalf of themselves and their patients, while the associations sued on behalf of their members and their members' patients. A Connecticut federal district court dismissed the suit on several bases, including lack of standing. The Second Circuit affirmed.

The Second Circuit held that the psychiatrists did not have a cause of action under ERISA based on the health insurers' alleged MHPAEA violations. The court explained that ERISA unambiguously provides that civil actions may be brought by a "participant, beneficiary or fiduciary." Because the psychiatrists did not fall within any of these categories, they did not have standing to sue. The court rejected the psychiatrists' assertion that they were entitled to "stand in the shoes of their patients" for the purposes of bringing suit. The court acknowledged that policy reasons might support allowing physicians to sue on behalf of patients with mental disorders, but concluded that it was not authorized to apply its own judgment to recognize a cause of action that Congress has denied. The court also rejected the psychiatrist's standing argument based on the principle of assignment (*i.e.,* that patients had assigned their right to sue to the psychiatrist). In order to confer an ERISA cause of action upon a provider, an assignment must be made in exchange for consideration, in the form of the provision of health care services. Because such consideration did not exist here, there was no valid assignment of the right to sue. Finally, the court held that the associations lacked constitutional standing because their individual members lacked standing.

U.S. Supreme Court Reverses Ninth Circuit on Standing Issue, Ruling That Statutory Violation Does Not Automatically Satisfy Injury-in-Fact Requirement

The United States Supreme Court reversed a Ninth Circuit decision holding that an individual plaintiff had standing to sue Spokeo, a search engine company, under the Fair Credit Reporting Act of 1970 ("FCRA"). *Spokeo, Inc. v. Robins*, No. 13-1339 (U.S. May 16, 2016).

The putative class action suit was based on incorrect personal information disseminated by Spokeo on its website. A California federal district court dismissed the complaint, holding that the plaintiff had not properly pleaded injury in fact as required by Article III of the Constitution. The Ninth Circuit reversed, reasoning that the plaintiff had adequately alleged injury in fact because he alleged that Spokeo violated his statutory rights (not just the rights of other people) and because the plaintiff's "personal interests in the handling of his credit information are personalized." The Supreme Court vacated the decision.

The Supreme Court ruled that the Ninth's Circuit's analysis was incomplete because a plaintiff must allege injury that is both "concrete and personalized" in order to establish injury in fact. The Ninth Circuit focused only on particularity and did not address concreteness. In remanding the matter to the Circuit court, the Court noted that the term "concrete" is not necessarily synonymous with "tangible," and that intangible injuries can, in some instances, be concrete. However, the Court cautioned that a plaintiff does not automatically satisfy the injury-in-fact requirement simply by alleging a violation of a statutory right.

Simpson Thacher

Simpson Thacher has been an international leader in the practice of insurance and reinsurance law for more than a quarter of a century. Our insurance litigation team practices worldwide.

David J. Woll
+1-212-455-3136
dwoll@stblaw.com

Mary Beth Forshaw
+1-212-455-2846
mforshaw@stblaw.com

Andrew T. Frankel
+1-212-455-3073
afrankel@stblaw.com

Lynn K. Neuner
+1-212-455-2696
lneuner@stblaw.com

Chet A. Kronenberg
+1-310-407-7557
ckronenberg@stblaw.com

Bryce L. Friedman
+1-212-455-2235
bfriedman@stblaw.com

Michael D. Kibler
+1-310-407-7515
mkibler@stblaw.com

Michael J. Garvey
+1-212-455-7358
mgarvey@stblaw.com

Tyler B. Robinson
+44-(0)20-7275-6118
trobinson@stblaw.com

George S. Wang
+1-212-455-2228
gwang@stblaw.com

Deborah L. Stein
+1-310-407-7525
dstein@stblaw.com

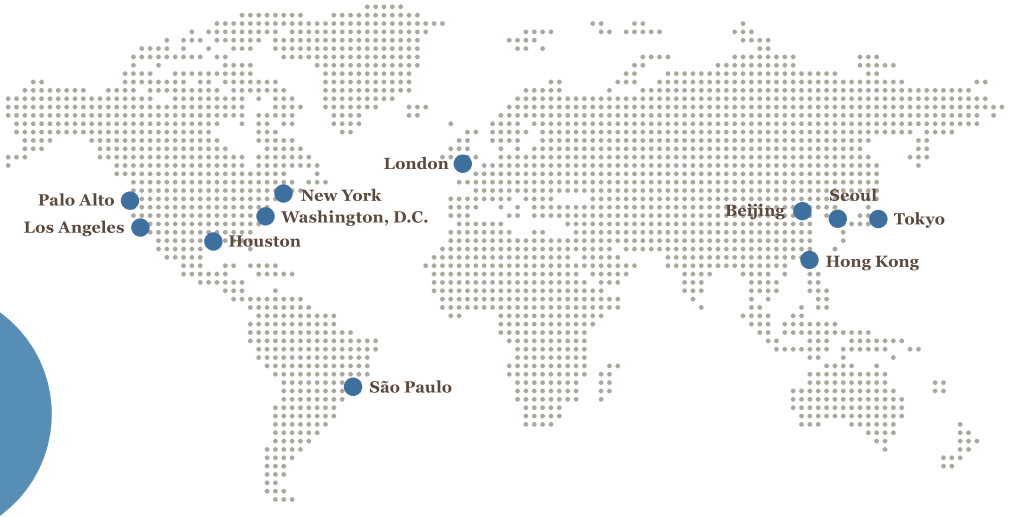
Craig S. Waldman
+1-212-455-2881
cwaldman@stblaw.com

Susannah S. Geltman
+1-212-455-2762
sgeltman@stblaw.com

Elisa Alcabes
+1-212-455-3133
ealcabes@stblaw.com

Summer Craig
+1-212-455-3881
scraig@stblaw.com

This edition of the Insurance Law Alert was prepared by Mary Beth Forshaw mforshaw@stblaw.com /+1-212-455-2846 and Bryce L. Friedman bfriedman@stblaw.com /+1-212-455-2235 with contributions by Karen Cestari kcestari@stblaw.com.



Simpson Thacher Worldwide

UNITED STATES

New York
425 Lexington Avenue
New York, NY 10017
+1-212-455-2000

Houston
600 Travis Street, Suite 5400
Houston, TX 77002
+1-713-821-5650

Los Angeles
1999 Avenue of the Stars
Los Angeles, CA 90067
+1-310-407-7500

Palo Alto
2475 Hanover Street
Palo Alto, CA 94304
+1-650-251-5000

Washington, D.C.
900 G Street, NW
Washington, D.C. 20001
+1-202-636-5500

EUROPE

London
CityPoint
One Ropemaker Street
London EC2Y 9HU
England
+44-(0)20-7275-6500

ASIA

Beijing
3901 China World Tower
1 Jian Guo Men Wai Avenue
Beijing 100004
China
+86-10-5965-2999

Hong Kong
ICBC Tower
3 Garden Road, Central
Hong Kong
+852-2514-7600

Seoul
25th Floor, West Tower
Mirae Asset Center 1
26 Eulji-ro 5-gil, Jung-gu
Seoul 100-210
Korea
+82-2-6030-3800

Tokyo
Ark Hills Sengokuyama Mori Tower
9-10, Roppongi 1-Chome
Minato-Ku, Tokyo 106-0032
Japan
+81-3-5562-6200

SOUTH AMERICA

São Paulo
Av. Presidente Juscelino
Kubitschek, 1455
São Paulo, SP 04543-011
Brazil
+55-11-3546-1000