A. Documents, data compilations and tangible things in the possession, custody or control of Defendants.

In addition to those documents listed in Defendants' Initial Disclosures, Defendants hereby supplements their document list pursuant to the Discovery Commissioner's Report and Recommendation entered on March 13, 2015. Defendants reserve the right to amend this list as necessary if it discovers additional information about documents relevant to this matter.

1. Redacted spreadsheet with individual identification numbers that verifies the rate of pay for all 2,100 employees identified in Defendant MDC Restaurants, LLC's Supplemental Response to Interrogatory No. 5 (MDC000843 – MDC000992);

2. Redacted spreadsheet with individual identification numbers that verifies the rate of pay for all 426 employees identified in Defendant Inka, LLC's Supplemental Response to Interrogatory No. 5 (MDC000843 – MDC000992);

3. Report representing the number of employees enrolled in Defendants' insurance plans in January 2013 (MDC000993 – MDC000995));

4. Report representing the number of employees enrolled in Defendants' insurance plans in December 2013 (MDC000996 – MDC001001);

5. Report representing the number of employees enrolled in Defendants' insurance plans in December 2014 (MDC001002 – MDC001004);

6. Report representing the number of employees enrolled in Defendants' insurance plans in March 2015 (MDC001005).

LITTLER MENDELSON, P.C.
ATTORNEYS AT LAW
3960 Howard Hughes Parkway
Suite 300
Las Vegas, NV 89169-5937
702 862 8800

March 26, 2015

Respectfully submitted,

RICK D. ROSKELLEY, ESQ.
ROGER L. GRANDGENETT II, ESQ.
KATHRYN BLAKEY, ESQ.
LITTLER MENDELSON, P.C.

Attorneys for Defendants

LITTLER MENDELSON, P.C.
ATTORNEYS AT LAW
3960 Howard Hughes Parkway
Suite 300
Las Vegas, NV 89169-5937
702 862 8800

PROOF OF SERVICE

I am a resident of the State of Nevada, over the age of eighteen years, and not a party to the within action. My business address is 3960 Howard Hughes Parkway, Suite 300, Las Vegas, Nevada 89169-5937. On March 26, 2015, I served the within document:

DEFENDANTS MDC RESTAURANTS, LLC'S, LAGUNA RESTAURANTS, LLC'S, AND INKA, LLC'S FIFTH SUPPLEMENTAL DISCLOSURE STATEMENT

☒ By CM/ECF Filing – Pursuant to Administrative Order 14-2 and Rule 9 of the N.E.F.C.R. the above-referenced document was electronically filed and served upon the parties listed below through the Court's Case Management and Electronic Case Filing (Wiznet) System:

Don Springmeyer, Esq.
Bradley Schrager, Esq.
Daniel Bravo, Esq.
Royi Moas, Esq.
Wolf Rifkin Shapiro Schulman Rabkin, LLP
3556 East Russell Road, Second Floor
Las Vegas, Nevada 89120

I declare under penalty of perjury that the foregoing is true and correct. Executed on March 26, 2015, at Las Vegas, Nevada.

Debra Perkins

Firmwide:132447313.1 081404.1002

JITTLER MENDELSON, P.C.
ATTORNEYS AT LAW
3960 Howard Hughes Parkway
Suite 300
Las Vegas, NV 89169-5937
702 862 8800

	A	B	C	D	E	F	G	H	I	J	K	L	M	N
1	**Company**	**Store #**	**SS#**	**Empl ID**	**Name**	**Hrly Rate**	**Last Name**	**First Name**	**Org Hire Date**	**Term Date**	**Rehire Date**	**EE Type**	**Status**	**DOB**
2	MD4		Redacted			**7.25**	Redacted							
3	MD4					**8.00**								
4	MD4					**8.00**								
5	MD4					**8.00**								
6	MD4					**8.00**								
7	MD4					**7.25**								
8	MD4					**7.55**								
9	MD4					**7.25**								
10	MD4					**7.55**								
11	MD4					**7.25**								
12	MD4					**8.00**								
13	MD4					**8.00**								
14	MD4					**8.00**								
15	MD4					**7.25**								
16	MD4					**7.55**								
17	MD4					**7.25**								
18	MD4					**8.00**								
19	MD4					**7.25**								
20	MD4					**8.00**								
21	MD4					**8.00**								
22	MD4					**7.25**								
23	MD4					**7.55**								
24	MD4					**7.55**								
25	MD4					**7.75**								
26	MD4					**7.55**								
27	MD4					**7.25**								
28	MD4					**8.00**								
29	MD4					**7.55**								
30	MD4					**7.25**								
31	MD4					**7.55**								
32	MD4					**7.55**								
33	MD4					**8.00**								
34	MD4					**8.00**								

	A	B	C	D	E	F	G	H	I	J	K	L	M	N
2517	VMX	Redacted				7.55	Redacted							
2518	VMX					7.25								
2519	VMX					7.75								
2520	VMX					7.55								
2521	VMX					7.25								
2522	VMX					7.25								
2523	VMX					7.55								
2524	VMX					7.25								
2525	VMX					7.25								
2526	VMX					7.55								
2527	VMX					7.75								
2528	VMX					7.55								
2529	**VMX - INKA Count**						426							
2530	**Grand Count**						2526							

Exhibit 13

Exhibit 13

INTG
RICK D. ROSKELLEY, ESQ., Bar # 3192
ROGER L. GRANDGENETT II, ESQ., Bar # 6323
KATIE BLAKEY, ESQ., Bar # 12701
LITTLER MENDELSON, P.C.
3960 Howard Hughes Parkway
Suite 300
Las Vegas, NV 89169-5937
Telephone: 702.862.8800
Fax No.: 702.862.8811

Attorneys for Defendants

DISTRICT COURT

CLARK COUNTY, NEVADA

PAULETTE DIAZ, an individual; and LAWANDA GAIL WILBANKS, an individual; SHANNON OLSZYNSKI, and individual; CHARITY FITZLAFF, an individual, on behalf of themselves and all similarly-situated individuals, Plaintiffs, vs. MDC RESTAURANTS, LLC, a Nevada limited liability company; LAGUNA RESTAURANTS, LLC, a Nevada limited liability company; INKA, LLC, a Nevada limited liability company and DOES 1 through 100, Inclusive, Defendants.	Case No. A-14-701633-C Dept. No. XVI **DEFENDANT INKA, LLC'S RESPONSES TO SECOND SET OF INTERROGATORIES BY PLAINTIFFS, ON BEHALF OF THE PUTATIVE CLASS**

PROPOUNDING PARTY: PLAINTIFFS, ON BEHALF OF PUTATIVE CLASS

RESPONDING PARTY: DEFENDANT INKA, LLC

SET NO.: TWO (2)

Defendant INKA Restaurants, LLC ("Defendant" or "INKA") hereby submits its Responses to Second Set of Interrogatories by Plaintiffs, on Behalf of the Putative Class as follows:

///

///

PRELIMINARY STATEMENT

The information contained in the responses set forth below is based only upon the information and documents currently available to Defendant. Defendant's investigation and discovery in preparation for trial has not been completed. Additional investigation may disclose further information and documents relevant to these responses, as could information and documents obtained by Defendant from Plaintiff or third parties through additional discovery procedures. Therefore, Defendant expressly reserves the right to alter, amend, supplement, modify or otherwise revise its responses if, for any reason, such alterations, amendments, supplements, modifications or revisions become appropriate or warranted or as may be required by Rule 33 of the Nevada Rules of Civil Procedure.

All of Defendant's responses are made subject to this preliminary statement.

INTERROGATORIES

INTERROGATORY NO. 19:

Describe with specificity what administrative services Mancha Development Company, a California corporation, provide to INKA with regard to choosing or offering health care.

RESPONSE TO INTERROGATORY NO 19:

Objection. This interrogatory is overly broad, unduly burdensome, vague and ambiguous and not likely to lead to the discovery of admissible evidence. Under the Nevada Rules of Civil Procedure, the scope of discovery is limited to matters that are relevant to a party's claim or defense. Nev. R. Civ. P. 26(b)(1). This lawsuit is limited to and only relates to health insurance plans offered to Defendant's hourly employees from May 30, 2012 to present. Therefore, any and all information about health insurance plans offered to non-hourly employees and health insurance plans offered before May 30, 2012 has no relevance to this matter and is outside the scope of this litigation. Subject to and without waiving these objections, Defendant responds that during the relevant statute of limitations, Mancha Development Company used an insurance broker who presented plans to the Director of Human Resources. The HR Director and CFO in turn jointly make decision on a plan. As part of its administrative services, Mancha Development Company provides plans to Defendant which then offers the selected plan to its hourly employees.

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Attorneys At Law
3960 Howard Hughes Parkway
Suite 300
Las Vegas, NV 89169-5937
702.862.8800

RESPONSE TO INTERROGATORY NO 37:

Objection. Defendant incorporates its response to Interrogatory No. 20.

Dated: December 29, 2014

Respectfully submitted,

RICK D. ROSKELLEY, ESQ.
ROGER L. GRANDGENETT II, ESQ.
KATIE BLAKEY, ESQ.
LITTLER MENDELSON, P.C.

Attorneys for Defendants

LITTLER MENDELSON, P.C.
Attorneys At Law
3960 Howard Hughes Parkway
Sixth Floor
Las Vegas, NV 89169-5937
702.862.8800

VERIFICATION

I, TERRY TIGIAMARINO, declare:

I am the Payroll Administrator/Benefits Manager of Mancha Development Companies, which is the Defendant in the above-entitled action, and I have been authorized to make this verification on its behalf.

I have read the foregoing Defendant INKA, LLC's Responses to Second Set of Interrogatories by Plaintiffs, on Behalf of the Putative Class, on file herein and know the contents thereof. The same is true of my own knowledge, except as to those matters which are therein stated on information and belief, and, as to those matters, I believe them to be true.

I declare under penalty of perjury under the laws of the United States and the State of California that the foregoing is true and correct.

Executed at Corona, California on this 29th day of December, 2014.

TERRY TIGIAMARINO

LITTLER MENDELSON, P.C.
Attorneys At Law
3960 Howard Hughes Parkway
Suite 300
Las Vegas, NV 89169-5937
702.862.8800

PROOF OF SERVICE

I am a resident of the State of Nevada, over the age of eighteen years, and not a party to the within action. My business address is 3960 Howard Hughes Parkway, Suite 300, Las Vegas, Nevada 89169. On December 29, 2014, I served the within document:

DEFENDANT INKA, LLC'S RESPONSES TO SECOND SET OF INTERROGATORIES BY PLAINTIFFS, ON BEHALF OF THE PUTATIVE CLASS

☒ by placing a true copy of the document listed above for collection and mailing following the firm's ordinary business practice in a sealed envelope with postage thereon fully prepaid for deposit in the United States mail at Las Vegas, Nevada addressed as set forth below:

Don Springmeyer, Esq.
Bradley Schrager, Esq.
Daniel Bravo, Esq.
Wolf, Rifkin, Shapiro, Schulman & Rabkin, LLP
3556 East Russell Road, Second Floor
Las Vegas, Nevada 89120

I am readily familiar with the firm's practice of collection and processing correspondence for mailing and for shipping via overnight delivery service. Under that practice it would be deposited with the U.S. Postal Service or if an overnight delivery service shipment, deposited in an overnight delivery service pick-up box or office on the same day with postage or fees thereon fully prepaid in the ordinary course of business.

I declare under penalty of perjury that the foregoing is true and correct. Executed on December 29, 2014, at Las Vegas, Nevada.

Debra Perkins

Firmwide:130429494.1 081404.1002

Exhibit 14

Exhibit 14

INTG
RICK D. ROSKELLEY, ESQ., Bar # 3192
ROGER L. GRANDGENETT II, ESQ., Bar # 6323
KATIE BLAKEY, ESQ., Bar # 12701
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Telephone: 702.862.8800
Fax No.: 702.862.8811

Attorneys for Defendants

DISTRICT COURT

CLARK COUNTY, NEVADA

PAULETTE DIAZ, an individual; and LAWANDA GAIL WILBANKS, an individual; SHANNON OLSZYNSKI, and individual; CHARITY FITZLAFF, an individual, on behalf of themselves and all similarly-situated individuals, Plaintiffs, vs. MDC RESTAURANTS, LLC, a Nevada limited liability company; LAGUNA RESTAURANTS, LLC, a Nevada limited liability company; INKA, LLC, a Nevada limited liability company and DOES 1 through 100, Inclusive, Defendants.	Case No. A-14-701633-C Dept. No. XVI **DEFENDANT MDC RESTAURANTS, LLC'S RESPONSES TO SECOND SET OF INTERROGATORIES BY PLAINTIFFS, ON BEHALF OF THE PUTATIVE CLASS**

PROPOUNDING PARTY: PLAINTIFFS, ON BEHALF OF PUTATIVE CLASS

RESPONDING PARTY: DEFENDANT MDC RESTAURANTS, LLC

SET NO.: TWO (2)

Defendant MDC Restaurants, LLC ("Defendant" or "MDC") hereby submits its Responses to Second Set of Interrogatories by Plaintiffs, on Behalf of the Putative Class as follows:

///

PRELIMINARY STATEMENT

The information contained in the responses set forth below is based only upon the information and documents currently available to Defendant. Defendant's investigation and discovery in preparation for trial has not been completed. Additional investigation may disclose further information and documents relevant to these responses, as could information and documents obtained by Defendant from Plaintiff or third parties through additional discovery procedures. Therefore, Defendant expressly reserves the right to alter, amend, supplement, modify or otherwise revise its responses if, for any reason, such alterations, amendments, supplements, modifications or revisions become appropriate or warranted or as may be required by Rule 33 of the Nevada Rules of Civil Procedure.

All of Defendant's responses are made subject to this preliminary statement.

INTERROGATORIES

INTERROGATORY NO. 19:

Describe with specificity what administrative services MANCHA DEVELOPMENT COMPANY, a California corporation, provided to MDC with regard to choosing or offering health care.

RESPONSE TO INTERROGATORY NO. 19:

Objection. This interrogatory is overly broad, unduly burdensome, vague and ambiguous and not likely to lead to the discovery of admissible evidence. Under the Nevada Rules of Civil Procedure, the scope of discovery is limited to matters that are relevant to a party's claim or defense. Nev. R. Civ. P. 26(b)(1). This lawsuit is limited to and only relates to health insurance plans offered to Defendant's hourly employees from May 30, 2012 to present. Therefore, any and all information about health insurance plans offered to non-hourly employees and health insurance plans offered before May 30, 2012 has no relevance to this matter and is outside the scope of this litigation. Subject to and without waiving these objections, Defendant responds that during the relevant statute of limitations, Mancha Development Company used an insurance broker who presented plans to the Director of Human Resources. The HR Director and CFO in turn jointly make decision on a plan. As

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part of its administrative services, Mancha Development Company provides plans to Defendant which then offers the selected plan to its hourly employees.

INTERROGATORY NO. 20:

State the total number of hours paid less than $8.25 per hour as a regular hourly wage rate, excluding any tips, gratuities, or bonuses between July 1, 2010, and the present, for employees employed at all restaurants owned or operated by MDC in Nevada.

RESPONSE TO INTERROGATORY NO. 20:

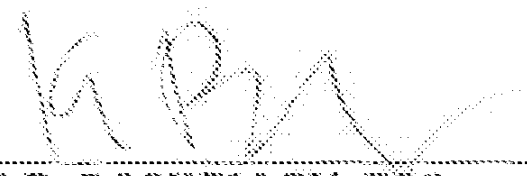
Objection. This interrogatory is overly broad, unduly burdensome, vague and ambiguous and not likely to lead to the discovery of admissible evidence. Under the Nevada Rules of Civil Procedure, the scope of discovery is limited to matters that are relevant to a party's claim or defense. Nev. R. Civ. P. 26(b)(1). This interrogatory relates solely to the issue of liability and claims for alleged minimum wage violations before May 30, 2012 are barred by the statute of limitations. Therefore, information about hours worked prior to May 30, 2012 is not likely to lead to the discovery of admissible evidence because any hour worked prior to May 30, 2012 has no bearing on liability in this matter.

Defendant further objects that the reference to a "regular hourly rate" is vague and ambiguous. Each employee's rate of pay can vary throughout their period of employment. Moreover, this request is unduly burdensome as the rate of pay varies by individual. To the extent this interrogatory seeks information about individual employees' rates of pay, it is premature. Specifically, Courts have held that certain discovery is premature when the Court has yet to rule on class action certification. *See, e.g., Doninger v. Pac. Northwest Bell, Inc.*, 564 F.2d 1304, 1307, 1313 (9th Cir. 1977) (noting discovery of personnel information could become appropriate only after class certification); *Eisen v. Carlisle & Jacquelin*, 417 U.S. 156, 177-78, 94 S. Ct. 2140 (1974) (indicating inquiry into the merits at the pre-certification stage is inappropriate because a defendant may be substantially prejudiced and it contravenes the rules governing class actions); *McPhail v. First Command Financial Planning, Inc.* 251 F.R.D. 514, 517 (S.D. Cal. Apr. 3, 2008) (finding prior to class certification, discovery should be conducted on a class wide level only in the "rarest of cases").

LITTLER MENDELSON, P.C.
Attorneys at Law
3960 Howard Hughes Parkway
Suite 300
Las Vegas, NV 89169-5937
702.862.8800

Dated: December 29, 2014

Respectfully submitted,



RICK D. ROSKELLEY, ESQ.
ROGER L. GRANDGENETT II, ESQ.
KATIE BLAKEY, ESQ.
LITTLER MENDELSON, P.C.

Attorneys for Defendants

LITTLER MENDELSON, P.C.
Attorneys At Law
3960 Howard Hughes Parkway
Suite 300
Las Vegas, NV 89169-5937
702.862.8800

VERIFICATION

I, TERRY TIGIAMARINO, declare:

I am the Payroll Administrator/Benefits Manager of Mancha Development Companies, which is the Defendant in the above-entitled action, and I have been authorized to make this verification on its behalf.

I have read the foregoing Defendant MDC Restaurants, LLC's Responses to Second Set of Interrogatories by Plaintiffs, on Behalf of the Putative Class, on file herein and know the contents thereof. The same is true of my own knowledge, except as to those matters which are therein stated on information and belief, and, as to those matters, I believe them to be true.

I declare under penalty of perjury under the laws of the United States and the State of California that the foregoing is true and correct.

Executed at Corona, California on this 31st day of December, 2014.

TERRY TIGIAMARINO

LITTLER MENDELSON, P.C.
Attorneys at Law
3960 Howard Hughes Parkway
Suite 300
Las Vegas, NV 89169-5937
702.862.8800

PROOF OF SERVICE

I am a resident of the State of Nevada, over the age of eighteen years, and not a party to the within action. My business address is 3960 Howard Hughes Parkway, Suite 300, Las Vegas, Nevada 89169. On December 29, 2014, I served the within document:

DEFENDANT MDC RESTAURANTS, LLC'S RESPONSES TO SECOND SET OF INTERROGATORIES BY PLAINTIFFS, ON BEHALF OF THE PUTATIVE CLASS

☒ by placing a true copy of the document listed above for collection and mailing following the firm's ordinary business practice in a sealed envelope with postage thereon fully prepaid for deposit in the United States mail at Las Vegas, Nevada addressed as set forth below:

Don Springmeyer, Esq.
Bradley Schrager, Esq.
Daniel Bravo, Esq.
Wolf, Rifkin, Shapiro, Schulman & Rabkin, LLP
3556 East Russell Road, Second Floor
Las Vegas, Nevada 89120

I am readily familiar with the firm's practice of collection and processing correspondence for mailing and for shipping via overnight delivery service. Under that practice it would be deposited with the U.S. Postal Service or if an overnight delivery service shipment, deposited in an overnight delivery service pick-up box or office on the same day with postage or fees thereon fully prepaid in the ordinary course of business.

I declare under penalty of perjury that the foregoing is true and correct. Executed on December 29, 2014, at Las Vegas, Nevada.

Debra Perkins

Firmwide:130463463.1 081404.1002

Exhibit 15

Exhibit 15

Starbridge
Limited-benefit health plan

CIGNA

SUMMARY PLAN DESCRIPTION

LIMITED-BENEFIT SICKNESS and ACCIDENT PLAN

Underwritten by Connecticut General Life Insurance Company

for the Employees of

Mancha Development Company

ID Cards and Getting Started Information were mailed separately.

This document is required by and subject to Department of Labor Laws related to ERISA.

This plan does not have Grandfathered Status under PPACA.
The insurance coverage described includes annual limits. These annual limits have been approved by the Department of Health and Human Services for the current policy year under the waiver process described in the interim final rules to the Patient Protection and Affordable Care Act (PPACA).

For customer service or benefits info, call 1-800-859-0086.

www.starbridge.com

SBCB-102-9499 10710

Your Plan Information

Plan Name:	CIGNA Starbridge Choices
Plan Type:	LIMITED-BENEFIT SICKNESS and ACCIDENT PLAN
Plan ID Number:	EIN: 33-0974550 PN: 551
Policy Number:	Trust: ST-0100-3449 Direct Issues: ST-1097-3449
Plan Administrator/Sponsor:	Mancha Development Company 2275 Simpson Ave, #201 Corona, CA 92879 (951) 271-4100
Type of Administration:	Insurer Administration
Program Administrator:	Connecticut General Life Insurance Company 2222 West Dunlap Avenue, Suite 350 Phoenix, AZ 85021-2866
Agent for Service of Legal Process:	Employer named above
Claims Administrator:	Connecticut General Life Insurance Company P.O. Box 55270 Phoenix, AZ 85078-5270 800-859-0086
Sources and Methods of Contributions to the Plan:	Employer contribution (if applicable) from general assets and Employee contribution through payroll deductions
Funding:	This Plan is underwritten by Connecticut General Life Insurance Company
Date of the Plan's Fiscal Year:	January 1 - December 31

Commonly Used Telephone Numbers:

Customer Service/Benefits/Enrollment	800-859-0086
Claims Inquiries	800-859-0086
Provider Discount Networks	
Medical Plan - Cigna HealthCare PPO Network	800-859-0086
Discount Programs within the Plan	
Medimpact	800-788-2949
CIGNA 24-Hour Employee Assistance Program℠	866-909-3461
Healthy Rewards®	800-854-7308

Although the Company presently intends to continue this Plan, it reserves the right to amend or terminate the Plan at its sole discretion at any time with or without notice.

This document is intended to confirm enrollment and to authorize your employer to deduct or reduce your pay for any contributions required by the plan.

This Summary Plan Description is a brief summary of the Plan. The insurance certificate, the group master policy, and state specific variations are the official documents governing the provisions of this plan. In the event there is a conflict with the terms of this SPD, the official plan documents remain the final authority and will govern in all cases, unless superceded by applicable law.

PRIVACY POLICY

We know that your privacy is important and we protect the confidentiality of your personal information. We do not disclose any non-public personal information about our existing or former customers to anyone; except as permitted or required by law. We maintain appropriate physical, electronic, and procedural safeguards to ensure the security of your information. A detailed copy of our privacy policy is contained in this booklet.

Important Notice Regarding Your Benefits

Who is eligible?
All Employees with 90 days of employment

When does my coverage begin?
Your coverage will begin the 1st of the month following 90 days.

Member Year Accumulation -
Your plan offers an individual benefit year feature. This means that your annual deductible and annual benefit maximums begin to accumulate on your individual effective date and last through your individual anniversary date one year later, minus one day. This is true even if your Plan Sponsor has a different anniversary date for its overall policy. Your benefits will not start over until YOUR individual anniversary date and you will not be required to pay another annual deductible until YOUR individual anniversary date.* For example, if you enroll on September 1, 2009, your annual deductible and annual benefit maximums will accumulate until August 31, 2010 (even though your Plan Sponsor's overall policy may have a January 1, 2010 anniversary date and requires you to participate in annual open enrollment). **Provided you don't move to a plan that requires a higher deductible during your Plan Sponsor's open enrollment period.*

This Summary Plan Description contains a summary in English of your plan rights and benefits under The CIGNA Starbridge Choices Sickness and Accident Plan. If you have difficulty understanding any part of this Summary Plan Description, contact Connecticut General Life Insurance Company at 1-800-859-0825. Office hours are from 5 AM to 6 PM Mountain Standard Time, Monday through Friday.

Esta Descripción resumida del plan contiene un resumen en inglés de sus derechos y beneficios bajo el Plan CIGNA Starbridge Choices para enfermedades y accidentes de Starbride Select. Si tiene dificultades para comprender cualquier parte de esta Descripción resumida del plan, comuníquese con Connecticut General Life Insurance Company al 1-800-859-0825. El horario de atención es de 5 AM a 6 PM, Hora estándar de la montaña (MST), de lunes a viernes.

Benefit Table

Doctor Office Visit *		
Copay	$15	Visit a doctor and pay only the copay listed.
Plan Pays	100%	
Outpatient Care		
Deductible	$100 per Year	Common procedures such as Lab Fees, X-Ray, Diagnostic Testing as well as other outpatient services.
Plan Pays / You Pay	80% / 20%	
Maximum Amount Paid by Plan	$1,250 per Year	
Non-Emergency Care in Emergency Room *		
Deductible	$100 per Occurrence	Coverage when you cannot get in to see a doctor and must use the Emergency Room.
Plan Pays / You Pay	50% / 50%	
Maximum Amount Paid by Plan	$500 per Year	
Wellness Benefit		
Copay	$20	Can be used for Well Child Care, osteoporosis screenings, general health exams.
Plan Pays	100%	
Maximum Visits	1 per Year	
Maximum Amount Paid by Plan	$100 per Year	
Prescription Benefit		
	See Prescription Information page in this booklet.	Savings on prescription drug purchases.
Accidental Death Benefit		
Plan Pays	$15,000	Amount paid to beneficiary in the event of loss of life due to an accident.
Inpatient Care (Illness)		
Deductible	$0	Coverage for inpatient expenses incurred due to a covered illness
Plan Pays / You Pay	100% / 0%	
Maximum Amount Paid by Plan	$3,000	
In-Hospital Surgery		
Deductible	$0	Surgical expenses such as operating and recovery room, doctor fees, and anesthesiology.
Plan Pays / You Pay	100% / 0%	
Number of Occurrences per Year	No maximum	
Maximum Benefit per Occurrence	$1,500/Occurrence	
Maximum Amount Paid by Plan	No maximum	
Maternity Benefit		
Deductible	$0	Inpatient expenses related to the birth of a child.
Plan Pays / You Pay	100% / 0%	
Maximum Amount Paid by Plan	$1,500/Occurrence	
Accident Coverage (Injury)		
Deductible/Occurrence	$50 per Occurrence	Outpatient and Inpatient charges for injuries suffered as the result of a covered accident.
Plan Pays / You Pay	80% / 20%	
Number of Occurrences/Year	2 per Year	
Maximum Amount Paid/Occurrence	$2,500 per Occurrence	

The benefits above are provided by policy form SBCB-GHP-02. All yearly benefits are paid per coverage year.

* The total amount paid by the plan will count toward your Outpatient Care yearly maximum.

Doctor Office Visits

Each insured person is responsible for the Doctor Office Visit Copay listed in the Benefit Chart. The plan will pay 100% of the remaining service charge made by the Doctor up to the usual and customary amount. In addition, Related Charges in connection with the office visit are paid at 80% once the individual insured coverage year deductible is met. Related Charges include, but are not limited to the following: Injections, laboratory, pathology, radiology, diagnostic testing and venipuncture. Any Doctor Office Visit benefit amount, whether paid to the insured or Doctor, will count towards the Outpatient Care Maximum Benefit per Coverage Year.

Outpatient Care

Each insured person will receive coverage for outpatient medical expenses incurred as the result of a Covered Sickness. Once the individual insured coverage year deductible is satisfied, the plan will pay 80% of the remaining expenses up to the usual and customary amount for each covered expense. This will continue until the Outpatient Care Maximum Benefit per Coverage Year is reached (listed in the Benefit Chart).

List of Covered Expenses for Outpatient Care

1. Charges for Doctor's Office Visit (as shown above);
2. Emergency Room Services;
3. Urgent Care Facility services;
4. Charges made for diagnostic tests;
5. Charges made for radiation and chemotherapy treatment;
6. Charges made for the cost of giving an anesthetic;
7. Charges for rental of durable medical equipment used in the patient's home. If purchase would cost less, then that is the amount allowed;
8. Charges for artificial limbs, eyes and other prosthetic devices (except for replacement);
9. Charges for casts, splints, trusses, crutches and braces (except dental braces);
10. Charges for oxygen and rental of equipment for the giving of oxygen;
11. Charges for physical therapy prescribed by a Doctor;
12. Charges for services by and supplies received for use in an Outpatient Surgery Facility;
13. Charges for ambulance service to and from a local Hospital (a licensed ambulance must be used);
14. Miscellaneous Outpatient charges;
15. Charges for expenses incurred for a postpartum visit. The visit must occur within 48 hours of the early discharge from a Hospital or birthing center and be performed by a licensed health care provider whose scope of practice includes postpartum home care. This coverage includes:
    a. physical assessment of the covered mother and newborn child;
    b. parent education;
    c. training or assistance with breast or bottle feeding; and
    d. the performance of any appropriate clinical tests. At the covered mother's discretion, the visit may occur at the health care provider's facility or Hospital.

Covered Expenses will be considered to be incurred when the services are performed or the purchases are made.

Limitation for Pre-Existing Condition - The Preexisting Condition Limitation provision described below does not apply to anyone who is under 19 years of age.

Pre-Existing Condition means a condition for which a Covered Person has been medically diagnosed, treated by, or sought advice from, or consulted with, a Doctor during the 6 months before his effective date of coverage (or waiting period start date) under this Policy.

Benefits for this coverage shall not be payable for a Pre-Existing Condition as defined herein. This provision will cease to apply to any expenses incurred in connection with a Pre-Existing Condition after 12 months of continuous coverage (or 12 months from your waiting period start date).

The Pre-Existing Condition Limitation above does not apply to newborn or adopted children, or to any pregnancy. Pregnancy, and genetic information with no related treatment, will not be considered Pre-Existing Conditions. Any Pre-Existing Condition limitation can be reduced by that period of time the Covered Person was previously covered for the condition causing claim; provided, such Covered Person:

1. Was validly covered under his prior plan with Creditable Coverage, within 63 days prior to becoming insured under this policy; and
2. Became insured under this policy within 63 days after termination of his prior coverage exclusive of any waiting period.

Benefit Limitations for Outpatient Care

Coverage is not provided for services, supplies or equipment for which a charge is not customarily made in the absence of insurance.

No coverage is provided for loss caused by or resulting from:

1. Injury or Sickness arising out of or in the course of employment; or which is compensable under any Worker's Compensation or Occupational Disease Act or Law;
2. Declared or undeclared war; or act of war;
3. Expenses which are not ordered or under the written direction of a Physician;
4. Cosmetic surgery. This does not apply to:
   a. Reconstructive surgery incidental to or following surgery resulting from trauma, infection, or other diseases of the involved part; or
   b. Reconstructive surgery because of a congenital disease or anomaly of a covered Dependent newborn or adopted infant; or
   c. Reconstructive surgery on a non-diseased breast to restore and achieve symmetry between two breasts following a mastectomy.
5. Hearing examinations or hearing aids;
6. Vision services and supplies related to eye refractions or eye examinations, eyeglasses or contact lenses or prescriptions or fitting of eyeglasses other than for a disease process, and radial keratotomy, keratomileusis or excimer laser photo refractive keratectomy or similar type procedures or services;
7. Charges made by a health care provider if such person is a member of the Covered Person's Immediate Family or is living with the Covered Person;
8. The Covered Person's commission of a felony;
9. Charges in connection with manipulations of the musculoskeletal system, which includes manipulation of the muscles, joints, soft tissue, bone, spine, as well as traction and massage and applications of heat and cold;
10. The treatment of mental or nervous disorders, alcoholism, or any form of substance abuse, except as specifically provided; **Where treatment of mental or nervous disorders, alcoholism, or substance abuse coverage is mandated, program complies with the federal mental health and substance abuse parity requirements.**
11. Intentionally self-inflicted injury, or for attempted suicide whether sane or insane except when the injury results from a physical or mental medical condition covered under the health plan;
12. Dental care and treatment, except that required by injury and rendered within 6 months of injury;
13. Treatment which is determined to be Experimental or Investigational;
14. Treatment or service(s) that are not considered Necessary Treatment.
15. Custodial Care confinement in a Hospital or Skilled Nursing Facility;
16. Home Health Care Services, unless provided in place of a Hospital confinement;

No benefits will be paid for any expense incurred after the date the policy terminates.

Necessary Treatment means medical or dental treatment necessary to treat a covered Sickness or Injury and which is consistent with currently accepted medical or dental practice. Any:
1. Medical device;
2. Drug or pharmaceutical agent;
3. Procedure or treatment; or confinement or expense in connection therewith which is Experimental/Investigational in nature is not considered ***Necessary Treatment***.

If services are not considered to be:
1. Medically necessary; or
2. Consistent with professionally recognized standards of care with respect to quality, frequency or duration; expenses related to those services will not be deemed ***Necessary Treatment***.

Non-Emergency Care in Emergency Room
The plan reimburses covered outpatient medical expenses incurred for non-emergency care received in an Emergency Room (ER) subject to the following limits: After a $100 Deductible per occurrence, the plan will reimburse 50% of all covered expenses up to $500 per coverage year. The paid benefit amount will count towards the Outpatient Care or Basic Medical Expense coverage year benefit maximum. Once the $500 maximum per coverage year limit is reached, no additional non-emergency care provided in the ER will be paid under the plan.

Emergency Care means medical care and treatment provided after the sudden onset of a medical condition manifesting itself by acute symptoms, including severe pain that is severe enough that the lack of immediate medical attention could reasonably be expected to result in any of the following:
1. The patient's health would be placed in serious jeopardy;
2. Bodily function would be seriously impaired;
3. There would be serious dysfunction of a bodily organ or part.

Outpatient Wellness Benefit

The plan will pay this benefit if any Covered Person incurs charges for a Doctor office visit for preventive care.

Benefits are payable for:
- Well Child Care - Visits, Labs and Immunizations;
- Osteoporosis screenings;
- Routine gynecological exams;
- Routine prostate exams;
- General health exams;
- Colorectal cancer screening;
- Lead poisoning screening;
- Cancer screenings; and
- Adult immunizations.

This benefit is payable:
- while the coverage is in force; and
- after the waiting period (if applicable).

This benefit is subject to the Co-Payment and Maximums shown in the Benefit Table. There is no limit to the number of years a Covered Person can receive this benefit.

This benefit is not subject to any limitation that requires treatment or services to be considered Necessary Treatment.

Inpatient Care (Illness)

Each Covered Person will receive coverage for medical expenses incurred for a covered illness. The plan will pay 100% of the covered inpatient medical expenses up to the Maximum listed in the Benefit Chart per Coverage Year.

Confined or **Confinement** means the assignment to a bed as a resident inpatient in a Hospital for a period of no less than 20 continuous hours on the advice of a Doctor.

Hospital means an establishment that:
1. Holds a license as a Hospital (if required in the state);
2. Operates primarily for the reception, care and treatment of sick or injured persons as inpatients;
3. Provides around the clock nursing service;
4. Has a staff of one or more Doctors available at all times;
5. Provides organized facilities for diagnosis and surgery;
6. Is not primarily a clinic, nursing, rest or convalescent home or a Skilled Nursing Facility or a similar establishment; and
7. Is not, other than incidentally, a place for treatment of drug addiction.

The nursing service must be by registered or graduate nurses on duty or call. The surgical facilities may be either at the Hospital or at a facility with which it has a formal arrangement. Confinement in a special unit of a Hospital used primarily as a nursing, rest or convalescent home or skilled nursing facility will not be deemed to be confinement in a Hospital.

Hospital also includes a licensed emergency treatment center. The center must have permanent facilities and:
1. A Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) present at all times;
2. An M.D. specialist representing each of the major specialties available within minutes;
3. Ancillary services, including laboratory and X-ray, staffed at all times; and
4. A pharmacy staffed, or on call, at all times.

In-Hospital Surgery & Maternity Benefit

Each insured person will receive coverage for inpatient medical expenses incurred for surgery due to a covered sickness, and for inpatient medical expenses incurred due to maternity. To be eligible, the insured person must be confined in a hospital and incur a room and board charge. The plan will pay 100% of the covered inpatient medical expenses for surgery and maternity up to the Maximum Benefit per Occurrence amount listed in the Benefit Chart.

List of Covered Expenses - Inpatient Care
The covered expenses listed below are payable while a Covered Person is Confined to a Hospital.
1. Hospital room, board and general nursing services;
2. Charges made by a Hospital for medical services and supplies, including emergency room services if it leads to a hospitalization;
3. Inpatient operating and recovery room charges;
4. Inpatient charges made by a Doctor for medical care, treatment or for performing a surgical procedure;
5. Inpatient charges made for diagnostic tests;
6. Inpatient charges made for radiation and chemotherapy treatment;
7. Inpatient charges made for the cost of giving an anesthetic;
8. Charges for private duty nursing by an R.N. or L.P.N. while Hospital confined and when ordered by a Doctor;
9. Inpatient charges for drugs and medicines requiring the written prescription of a Doctor and dispensed by a licensed pharmacist;
10. Inpatient charges for casts, splints, trusses, crutches and braces (except dental braces);
11. Inpatient charges for oxygen and the giving of oxygen;
12. Inpatient charges for physical therapy prescribed by a Doctor;

13. Inpatient charges for a minimum of forty-eight hours of inpatient care following a vaginal delivery and a minimum of ninety-six hours of inpatient care following delivery by caesarean section for a mother and her newborn in a Hospital or birthing center. Shorter Hospital stays are allowed if recommended by the attending health care provider in consultation with the mother and one postpartum visit is performed within 48 hours of discharge. (Note: the postpartum visit will be covered under the Outpatient Care Benefit.)
14. Inpatient charges for reconstructive breast surgery, including augmentation mammoplasty, reduction mammoplasty and mastoplexy resulting from a mastectomy. Coverage is also provided for all stages of reconstructive breast surgery performed on a non-diseased breast to establish symmetry with the diseased breast and for prostheses and physical complication at all stages of the mastectomy, including lymphedemas.
15. Miscellaneous In-patient Expenses.

Covered Expenses will be considered to be incurred when the services are performed.

Benefit Limitations Inpatient Care
Coverage is not provided for services, supplies or equipment for which a charge is not customarily made in the absence of insurance.
In addition to the Benefit Limitations listed under the Outpatient Care, no coverage is provided for loss caused by or resulting from:

1. Any period of Custodial Care confinement in a Hospital or Skilled Nursing Facility;
2. Charges for home health care services, unless provided in lieu of a Hospital confinement;

No benefits will be paid for any expense incurred after the date the policy terminates.

Accident Medical Benefit

Accident means an unintended or unforeseen bodily injury sustained by a Covered Person, wholly independent of disease, bodily infirmity, illness, infection, or any other abnormal physical condition.
Each insured person will receive coverage for outpatient and inpatient medical expenses incurred for injuries due to a covered accident. This supplemental coverage is for accidents only and does not cover sickness.

The plan will pay for such Usual and Customary expenses which constitute Necessary Treatment and are incurred:

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Medical Benefits Chart (applies to each covered individual)

	Level 1 (Plan 370)	Level 2 (Plan 371)
Illness		
Outpatient Care deductible Starbridge pays maximum amount paid by plan	$100 per coverage year 80% $1,000 per coverage year	$100 per coverage year 80% $1,250 per coverage year
Doctor Office Visits [1] copay Starbridge pays	$15 100%	$15 100%
Inpatient Care Starbridge pays maximum amount paid by plan	100% $2,000 per coverage year	100% $3,000 per coverage year
Additional In-Hospital Surgery Starbridge pays maximum amount paid by plan	covered in Inpatient Care	100% $1,500 per occurrence
Additional Maternity Benefit Starbridge pays maximum amount paid by plan	covered in Inpatient Care	100% $1,500 per occurrence
Wellness		
Wellness Benefit [3] copay Starbridge pays number of occurrences maximum amount paid by plan	not covered	$20 100% 1 per coverage year $100 per coverage year
Pharmacy		
Prescription Benefit copay Starbridge pays maximum amount paid by plan	discount program included[2]	discount program included[2] $15/generic, $30/pref. brand 100% $300 per coverage year
Injury		
Accident Coverage[4] deductible Starbridge pays number of occurrences maximum per occurrence maximum amount paid by plan	$50 per occurrence 80% 2 per coverage year $1,000 $2,000 per coverage year	$50 per occurrence 80% 2 per coverage year $2,500 $5,000 per coverage year
Accidental Death Benefit Starbridge pays	$10,000	$15,000

PLEASE NOTE: If visiting the ER for a true emergency, your benefits may come out of Outpatient, Inpatient, and/or Accident Coverage. If you receive non-emergency treatment in the Emergency Room[1] (care you could receive in a doctor's office), your coverage is reduced to: $100 deductible per occurrence, the plan pays 50% of total bill with a $300 maximum per year. You will be responsible for the remaining balance.

More valuable services that are included in your plan:

Online Tools

CIGNA provides a variety of online tools available only to our members. You'll be able to locate network doctors or pharmacies that provide discounts to our members. You can also track the status of claims that have been submitted.

CIGNA 24-Hour EAP

The CIGNA 24-Hour Employee Assistance Program℠ is available day or night for helpful information on a range of health topics. The EAP Program includes access to: a 24-hour nurse line, mental health assistance (includes 3 in-person consultations per year per condition), and a health information library.

Healthy Rewards®

Healthy Rewards® offers you discounts on health products and services such as: weight loss programs, vitamins, and dental products. You'll receive discounts of up to 60% on brand names like Weight Watchers, Jenny Craig® and much more.

Healthy Rewards® is not available in all states, and is not insurance.

[1] The total amount Starbridge pays will count toward your Outpatient Care Maximum. [2] The prescription discount program is not insurance.
[3] Provision varies by state. [4] Work related injuries are not covered. The benefits above are provided by policy form SBC8-GMP-02.

Questions? Call a Starbridge Benefits Specialist: 1-877-209-7098 • www.starbridge.com

MDC000098

SPECIAL ENROLLMENT

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, placement for adoption, or Qualified Medical Child Support Order you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Loss of coverage (non-COBRA) that can qualify for Special Enrollment includes, but is not limited to:

Loss of eligibility for coverage as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of an employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage when a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual.

To request special enrollment or obtain more information, contact a Customer Service representative at 1-877-209-7095. Representatives are available Monday through Friday, 5 AM to 6 PM, Mountain Standard time.

LIMITATION FOR PRE-EXISTING CONDITION [1] -- Pre-Existing Condition means a condition for which a Covered Person has been medically diagnosed, treated by, or sought advice from, or consulted with, a Doctor during the 6 months before his effective date of coverage (or waiting period start date) under this Policy.

Benefits for this coverage shall not be payable for a Pre-Existing Condition as defined herein. This provision will cease to apply to any expenses incurred in connection with a Pre-Existing Condition after 12 months of continuous coverage (or 12 months from your waiting period start date).

The Pre-Existing Condition Limitation above does not apply to newborn or adopted children, or to any pregnancy. Pregnancy, and genetic information with no related treatment, will not be considered Pre-Existing Conditions. Any Pre-Existing Condition limitation can be reduced by that period of time the Covered Person was previously covered for the condition causing claim; provided, such Covered Person:

1. Was validly covered under his prior plan with Creditable Coverage, within 63 days prior to becoming insured under this policy; and
2. Became insured under this policy within 63 days after termination of his prior coverage exclusive of any waiting period.

BENEFIT LIMITATIONS [1] -- Coverage is not provided for services, supplies or equipment when a charge is not usually made in the absence of insurance.

No coverage is provided for loss caused by or resulting from:

1. Injury or sickness arising out of or in the course of employment;
2. War or act of war
3. Expenses which are not ordered by a Physician;
4. Cosmetic surgery. This does not apply to reconstructive surgery due to:
   a. trauma, infection, or other disease; or
   b. congenital disease or anomaly of a covered dependent newborn or adopted infant; or
   c. surgery on a non-diseased breast to restore and achieve symmetry between two breasts following a mastectomy.
5. Hearing examinations or hearing aids;
6. Vision services and supplies other than for a disease process, radial keratotomy, keratomileusis or excimer laser photo refractive keratectomy or similar type procedures or services;
7. Charges made by a health care provider who is a member of your family or who is living with you;
8. Custodial Care confinement in a Hospital or Skilled Nursing Facility;
9. Home Health Care Services, unless provided in place of a Hospital confinement.
10. Commission of a felony;
11. Manipulations of the musculoskeletal system;
12. The treatment of mental or nervous disorders, alcoholism, or any form of substance abuse, except as specifically provided;
13. Intentionally self-inflicted injury or suicide attempt;
14. Dental care and treatment, except that required by injury and rendered within 6 months of the injury;
15. Treatment which is experimental or investigational.
16. Any expense incurred after the date the policy terminates.

DEFINITION OF DEPENDENT [1] -- Your Dependent is:

1. Your spouse,
2. Your children up to age 26,

who are not eligible for coverage under another employer-sponsored health plan.

ACCIDENTAL DEATH -- No coverage is provided by death caused by:

1. War or act of war
2. Suicide within 2 years of your effective date,
3. Medical or surgical treatment of sickness of disease, or
4. Flight except as a passenger in a commercial airline.

TERMINATION

A Covered Person's coverage will terminate at 12:01 a.m Standard Time at Your home on the earliest of the following:

1. The date the Policy terminates;
2. The date this Certificate terminates;
3. The date coverage is terminated by Us for all certificate holders in Your state;
4. The date we receive a written request to terminate coverage.
5. The end of the period for which premium is paid, subject to the Grace Period.
6. The date a Covered Person enters the armed forces of any country. Membership in the reserves or in the National Guard is not deemed entry into the armed forces. Active duty service in the reserves or National Guard for a period of 31 consecutive days or more will be deemed entry into the armed forces.
7. With respect to a Dependent spouse, the date the spouse no longer qualifies as a Dependent, unless coverage is continued as stated in the Continuation of Coverage provision.
8. With respect to a Dependent child, the date that child no longer qualifies as a Dependent, unless coverage is continued as stated in the Continuation of Coverage provision.

At least 60 days prior written notice will be given to You if We terminate Your coverage for any reason, except for nonpayment premium.

FOOTNOTES

[1] Provisions, Limitations & Exclusions may vary where required by state law.

Exhibit 16

Exhibit 16

Annual Limit Waiver Notice

Please read the special notice below that explains the annual limits for coverage options.

The Affordable Care Act prohibits health plans from applying dollar limits below a specific amount on coverage for certain benefits. This year, if a plan applies a dollar limit on the coverage it provides for certain benefits in a year, that limit must be at least $2.0 million.

Your health coverage, offered by Connecticut General Life Insurance Company, does not meet the minimum standards required by the Affordable Care Act described above. Your coverage has an annual limit of:

- **Outpatient Care: $1,000 per coverage**
- **Inpatient Care: $2,000 per coverage**
- **Prescription Coverage: Discount Only program, limits do not apply**
- **Accident Medical Coverage: $1,000 per accident (2 accidents per coverage year)**

This means that your health coverage might not pay for all of the health care expenses you incur. For example, a stay in the hospital costs around $1,853 per day. At this cost, your insurance would only pay for 1.07 days.

Note: If you seek care at a network hospital, additional time may be covered because the network discount may result in a lower cost per day. If you are hospitalized for surgery or maternity care, your coverage may also pay for additional hospital services as described in your benefit booklet.

Your health plan has requested that the U.S. Department of Health and Human Services waive the requirement to provide coverage for certain key benefits of at least $2.0 million this year. Your health plan has stated that meeting this minimum dollar limit this year would result in a significant increase in your premiums or a significant decrease in your access to benefits. Based on this representation, the U.S. Department of Health and Human Services has waived the requirement for your plan until 12/31/2013.

If you are concerned about your plan's lower dollar limits on key benefits, you and your family may have other options for health care coverage. For more information, go to: www.HealthCare.gov.
If you have any questions or concerns about this notice, contact Cigna at 1-800-420-6308.
In addition, you can contact your state's Consumer Assistance Program.

State	Primary #	State	Primary #	State	Primary #	State	Primary #
AL	*	IL	(877) 527-9431	MT	*	RI	(855) 747-3224
AK	*	IN	*	NE	*	SC	*
AZ	*	IA	*	NV	(888) 333-1507	SD	*
AR	(855) 332-2227	KS	(800) 432-2484	NH	*	TN	*
CA	(888) 466-2219	KY	*	NJ	*	TX	*
CO	*	LA	*	NM	(888) 427-5772	UT	*
CT	(866) 466-4446	ME	(800) 965-7476	NY	(888) 614-5400	VT	(800) 917-7787
DE	*	MD	(877) 261-8807	NC	(877) 885-0231	VI	(340) 773-6459
DC	(877) 685-6391	MA	(800) 272-4232	ND	*	VA	*
FL	*	MI	(877) 999-6442	OH	*	WA	*
GA	(800) 656-2298	MN	*	OK	(800) 522-0071	WV	(888) 879-9842
HI	*	MS	(877) 314-3843	OR	(855) 999-3210	WI	*
ID	*	MO	(800) 726-7390	PA	(877) 881-6388	WY	*

*For states that do not have a Consumer Assistance Program, please visit www.healthcare.gov/using-insurance/managing/consumer-help/index.html for other consumer resources and links to your state's Department of Insurance.

This plan does not have "Grandfathered Status" under PPACA. In addition to any other preventive care services described in the plan documents, no deductible, copayment, or coinsurance shall apply to the following Covered Services. (1) evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force; (2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Covered Person involved; (3) for infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; (4) for women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Starbridge
Limited-benefit health plan

Cigna.

SUMMARY PLAN DESCRIPTION

LIMITED-BENEFIT SICKNESS and ACCIDENT PLAN ("Plan")

Underwritten by Connecticut General Life Insurance Company

for the Employees of

Mancha Development Company-NV Hourly

ID Cards and Getting Started Information were mailed separately.

This Summary Plan Description is required by and subject to Department of Labor Laws related to ERISA.

Notice of Grandfathered Plan Status

The Plan is being treated as a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your coverage may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the program administrator at the phone number or address provided on your ID card or an explanation can be found on CIGNA's website at http://www.cigna.com/sites/healthcare_reform/customer.html.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

For customer service or benefits info, call 1-800-859-0086,www.starbridge.com

Your Plan Information

Plan Name:	CIGNA Scarbridge Choices
Plan Type:	LIMITED-BENEFIT SICKNESS and ACCIDENT PLAN ("Plan")
Plan ID Number:	EIN: 33-0974550 PN: 551
Policy Number:	Trust: ST-0100-4584
Plan Administrator/Plan Sponsor:	Mancha Development Company-NV Hourly 2275 Simpson Ave, #201 Corona, CA 92879 (951) 271-4100
Type of Administration:	Insurer Administration
Program Administrator:	Connecticut General Life Insurance Company 2222 West Dunlap Avenue, Suite 350 Phoenix, AZ 85021-2866
Agent for Service of Legal Process:	Employer named above
Claims Administrator:	Connecticut General Life Insurance Company P.O. Box 55270 Phoenix, AZ 85078-5270 800-859-0086
Sources and Methods of Contributions to the Plan:	Employer contribution (if applicable) from general assets and Employee contribution through payroll deductions
Funding:	This Plan is underwritten by Connecticut General Life Insurance Company
Plan Fiscal Year End:	December 31

Commonly Used Telephone Numbers:

Customer Service/Benefits/Enrollment	800-859-0086
Claims Inquiries	800-859-0086
Provider Discount Networks	
Medical Plan - Cigna HealthCare PPO Network	800-859-0086
Discount Programs within the Plan	
Scriptsave Select	866-315-8008

Although the Company presently intends to continue the Plan, it reserves the right to amend or terminate the Plan at its sole discretion at any time with or without notice.

This Summary Plan Description ("SPD") is intended to confirm enrollment and to authorize your employer to deduct or reduce your pay for any contributions required by the Plan.

This Summary Plan Description is a brief summary of the Plan. The insurance certificate, the group master policy, and state specific variations are the official documents governing the provisions of the Plan. In the event there is a conflict with the terms of this SPD, the official Plan documents remain the final authority and will govern in all cases, unless superseded by applicable law.

We know that your privacy is important and we protect the confidentiality of your personal information. We do not disclose any non-public personal information about our existing or former customers to anyone; except as permitted or required by law. We maintain appropriate physical, electronic, and procedural safeguards to ensure the security of your information. A detailed copy of our privacy policy is contained in this booklet.

Important Notice Regarding Your Benefits

Who is eligible?
NV hourly Employees are eligible upon date of hire. This plan is only available to hourly employees residing in NV.

When does my coverage begin?
Your coverage will begin the 1st day of employment.

Member Year Accumulation -
Your Plan offers an individual benefit year feature. This means that your annual deductible and annual benefit maximums begin to accumulate on your individual effective date and last through your individual anniversary date one year later, minus one day. This is true even if your Plan Sponsor has a different anniversary date for its overall policy. Your benefits will not start over until YOUR individual anniversary date and you will not be required to pay another annual deductible until YOUR individual anniversary date.* For example, if you enroll on September 1, 2011, your annual deductible and annual benefit maximums will accumulate until August 31, 2012 (even though your Plan Sponsor's overall policy may have a January 1, 2012 anniversary date and requires you to participate in annual open enrollment). **Provided you don't move to a plan that requires a higher deductible during your Plan Sponsor's open enrollment period.*

This Summary Plan Description contains a summary in English of your plan rights and benefits under The CIGNA Starbridge Choices Sickness and Accident Plan. If you have difficulty understanding any part of this Summary Plan Description, contact Connecticut General Life Insurance Company at 1-800-882-0088. Office hours are from 5 AM to 6 PM Mountain Standard Time, Monday through Friday.

Esta Descripción resumida del plan contiene un resumen en inglés de los derechos y los beneficios que le otorga el plan según el Plan para Enfermedades y Accidentes de CIGNA Starbridge Choices. Si tiene problemas para entender alguna parte de la Descripción resumida del plan, póngase en contacto con Connecticut General Life Insurance Company al 1-800-882-0088. El horario de oficina es de las 5 a.m. a las 6 p.m. hora estándar de montaña, de lunes a viernes.

Benefit Table

Doctor Office Visit *		
Copay	$15	Visit a doctor and pay only the copay listed.
Plan Pays	100%	
Outpatient Care		
Deductible	$100 per Year	Common procedures such as Lab Fees, X-Ray, Diagnostic Testing as well as other outpatient services.
Plan Pays / You Pay	80% / 20%	
Maximum Amount Paid by Plan	$1,000 per Year	
Non-Emergency Care in Emergency Room *		
Deductible	$100 per Occurrence	Coverage when you cannot get in to see a doctor and must use the Emergency Room.
Plan Pays / You Pay	50% / 50%	
Maximum Amount Paid by Plan	$500 per Year	
Prescription Benefit		
	See Prescription Information page in this booklet.	Savings on prescription drug purchases.
Accidental Death Benefit		
Plan Pays	$10,000	Amount paid to beneficiary in the event of loss of life due to an accident.
Inpatient Care (Illness)		
Deductible	$0	Coverage for inpatient expenses incurred due to a covered illness
Plan Pays / You Pay	100% / 0%	
Maximum Amount Paid by Plan	$2,000 per Year	
Accident Coverage (Injury)		
Deductible/Occurrence	$50 per Occurrence	Outpatient and Inpatient charges for injuries suffered as the result of a covered accident.
Plan Pays / You Pay	80% / 20%	
Number of Occurrences/Year	2 per Year	
Maximum Amount Paid/Occurrence	$1,000 per Occurrence	

This benefits above are provided by policy form SBCR-CMP-02. All yearly benefits are paid per coverage year.

* The total amount paid by the Policy will count toward your Outpatient Care yearly maximum.

Doctor Office Visits

Each insured person is responsible for the Doctor Office Visit Copay listed in the Benefit Chart. The Policy will pay 100% of the remaining service charge made by the Doctor up to the usual and customary amount. In addition, Related Charges in connection with the office visit are paid at 80% once the individual insured coverage year deductible is met. Related Charges include, but are not limited to the following: Injections, laboratory, pathology, radiology, diagnostic testing and venipuncture. Any Doctor Office Visit benefit amount, whether paid to the insured or Doctor, will count towards the Outpatient Care Maximum Benefit per Coverage Year.

Outpatient Care

Each insured person will receive coverage for outpatient medical expenses incurred as the result of a Covered Sickness. Once the individual insured coverage year deductible is satisfied, the Policy will pay 80% of the remaining expenses up to the usual and customary amount for each covered expense. This will continue until the Outpatient Care Maximum Benefit per Coverage Year is reached (listed in the Benefit Chart).

List of Covered Expenses for Outpatient Care

1. Charges for Doctor's Office Visit (as shown above);
2. Emergency Room Services;
3. Urgent Care Facility services;
4. Charges made for diagnostic tests;
5. Charges made for radiation and chemotherapy treatment;
6. Charges made for the cost of giving an anesthetic;
7. Charges for rental of durable medical equipment used in the patient's home. If purchase would cost less, then that is the amount allowed;
8. Charges for artificial limbs, eyes and other prosthetic devices (except for replacement);
9. Charges for casts, splints, trusses, crutches and braces (except dental braces);
10. Charges for oxygen and rental of equipment for the giving of oxygen;
11. Charges for physical therapy prescribed by a Doctor;
12. Charges for services by and supplies received for use in an Outpatient Surgery Facility;
13. Charges for ambulance service to and from a local Hospital (a licensed ambulance must be used);
14. Miscellaneous Outpatient charges;
15. Charges for expenses incurred for a postpartum visit. The visit must occur within 48 hours of the early discharge from a Hospital or birthing center and be performed by a licensed health care provider whose scope of practice includes postpartum home care. This coverage includes:
    a. physical assessment of the covered mother and newborn child;
    b. parent education;
    c. training or assistance with breast or bottle feeding; and
    d. the performance of any appropriate clinical tests. At the covered mother's discretion, the visit may occur at the health care provider's facility or Hospital.

Covered Expenses will be considered to be incurred when the services are performed or the purchases are made.

Limitation for Pre-Existing Condition - The Preexisting Condition Limitation provision described below does not apply to anyone who is under 19 years of age.

Pre-Existing Condition means a condition for which a Covered Person has been medically diagnosed, treated by, or sought advice from, or consulted with, a Doctor during the 6 months before his effective date of coverage (or waiting period start date) under this Policy.

Benefits for this coverage shall not be payable for a Pre-Existing Condition as defined herein. This provision will cease to apply to any expenses incurred in connection with a Pre-Existing Condition after 12 months of continuous coverage (or 12 months from your waiting period start date).

The Pre-Existing Condition Limitation above does not apply to newborn or adopted children, or to any pregnancy. Pregnancy, and genetic information with no related treatment, will not be considered Pre-Existing Conditions. Any Pre-Existing Condition limitation can be reduced by that period of time the Covered Person was previously covered for the condition causing claim; provided, such Covered Person:

1. Was validly covered under his prior plan with Creditable Coverage, within 63 days prior to becoming insured under this policy; and
2. Became insured under this policy within 63 days after termination of his prior coverage exclusive of any waiting period.

Benefit Limitations for Outpatient Care

Coverage is not provided for services, supplies or equipment for which a charge is not customarily made in the absence of insurance.

No coverage is provided for loss caused by or resulting from:

1. Injury or Sickness arising out of or in the course of employment; or which is compensable under any Worker's Compensation or Occupational Disease Act or Law;
2. Declared or undeclared war; or act of war;
3. Expenses which are not ordered or under the written direction of a Physician;
4. Cosmetic surgery. This does not apply to:
    a. Reconstructive surgery incidental to or following surgery resulting from trauma, infection, or other diseases of the involved part; or
    b. Reconstructive surgery because of a congenital disease or anomaly of a covered Dependent newborn or adopted infant; or
    c. Reconstructive surgery on a non-diseased breast to restore and achieve symmetry between two breasts following a mastectomy.
5. Hearing examinations or hearing aids;
6. Vision services and supplies related to eye refractions or eye examinations, eyeglasses or contact lenses or prescriptions or fitting of eyeglasses other than for a disease process, and radial keratotomy, keratomileusis or excimer laser photo refractive keratectomy or similar type procedures or services;
7. Charges made by a health care provider if such person is a member of the Covered Person's Immediate Family or is living with the Covered Person;
8. The Covered Person's commission of a felony;
9. Charges in connection with manipulations of the musculoskeletal system, which includes manipulation of the muscles, joints, soft tissue, bone, spine, as well as traction and massage and applications of heat and cold;
10. The treatment of mental or nervous disorders, alcoholism, or any form of substance abuse, except as specifically provided; **Where treatment of mental or nervous disorders, alcoholism, or substance abuse coverage is mandated, program complies with the federal mental health and substance abuse parity requirements.**
11. Intentionally self-inflicted injury, or for attempted suicide whether sane or insane except when the injury results from a physical or mental medical condition covered under the health Policy;
12. Dental care and treatment, except that required by injury and rendered within 5 months of injury;
13. Treatment which is determined to be Experimental or Investigational;
14. Treatment or service(s) that are not considered Necessary Treatment.
15. Custodial Care confinement in a Hospital or Skilled Nursing Facility;

16. Home Health Care Services, unless provided in place of a Hospital confinement;

No benefits will be paid for any expense incurred after the date the policy terminates.

Necessary Treatment means medical or dental treatment necessary to treat a covered Sickness or Injury and which is consistent with currently accepted medical or dental practice. Any:

1. Medical device;
2. Drug or pharmaceutical agent;
3. Procedure or treatment; or confinement or expense in connection therewith which is Experimental/Investigational in nature is not considered ***Necessary Treatment***.

If services are not considered to be:

1. Medically necessary; or
2. Consistent with professionally recognized standards of care with respect to quality, frequency or duration; expenses related to those services will not be deemed ***Necessary Treatment***.

Non-Emergency Care in Emergency Room

The Policy reimburses covered outpatient medical expenses incurred for non-emergency care received in an Emergency Room (ER) subject to the following limits: After a $100 Deductible per occurrence, the Policy will reimburse 50% of all covered expenses up to $500 per coverage year. The paid benefit amount will count towards the Outpatient Care or Basic Medical Expense coverage year benefit maximum. Once the $500 maximum per coverage year limit is reached, no additional non-emergency care provided in the ER will be paid under the Policy.

Emergency Care means medical care and treatment provided after the sudden onset of a medical condition manifesting itself by acute symptoms, including severe pain that is severe enough that the lack of immediate medical attention could reasonably be expected to result in any of the following:

1. The patient's health would be placed in serious jeopardy;
2. Bodily function would be seriously impaired;
3. There would be serious dysfunction of a bodily organ or part.

Inpatient Care (Illness)

Each Covered Person will receive coverage for medical expenses incurred for a covered illness. The Policy will pay 100% of the covered inpatient medical expenses up to the Maximum listed in the Benefit Chart per Coverage Year.

Confined or ***Confinement*** means the assignment to a bed as a resident inpatient in a Hospital for a period of no less than 20 continuous hours on the advice of a Doctor.

Hospital means an establishment that:

1. Holds a license as a Hospital (if required in the state);
2. Operates primarily for the reception, care and treatment of sick or injured persons as inpatients;
3. Provides around the clock nursing service;
4. Has a staff of one or more Doctors available at all times;
5. Provides organized facilities for diagnosis and surgery;
6. Is not primarily a clinic, nursing, rest or convalescent home or a Skilled Nursing Facility or a similar establishment; and
7. Is not, other than incidentally, a place for treatment of drug addiction.

The nursing service must be by registered or graduate nurses on duty or call. The surgical facilities may be either at the Hospital or at a facility with which it has a formal arrangement.

Confinement in a special unit of a Hospital used primarily as a nursing, rest or convalescent home or skilled nursing facility will not be deemed to be confinement in a Hospital.

Hospital also includes a licensed emergency treatment center. The center must have permanent facilities and:

1. A Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) present at all times;
2. An M.D. specialist representing each of the major specialties available within minutes;
3. Ancillary services, including laboratory and X-ray, staffed at all times; and
4. A pharmacy staffed, or on call, at all times.

List of Covered Expenses - Inpatient Care

The covered expenses listed below are payable while a Covered Person is Confined to a Hospital.

1. Hospital room, board and general nursing services;
2. Charges made by a Hospital for medical services and supplies, including emergency room services if it leads to a hospitalization;
3. Inpatient operating and recovery room charges;
4. Inpatient charges made by a Doctor for medical care, treatment or for performing a surgical procedure;
5. Inpatient charges made for diagnostic tests;
6. Inpatient charges made for radiation and chemotherapy treatment;
7. Inpatient charges made for the cost of giving an anesthetic;
8. Charges for private duty nursing by an R.N. or L.P.N. while Hospital confined and when ordered by a Doctor;
9. Inpatient charges for drugs and medicines requiring the written prescription of a Doctor and dispensed by a licensed pharmacist;
10. Inpatient charges for casts, splints, trusses, crutches and braces (except dental braces);
11. Inpatient charges for oxygen and the giving of oxygen;
12. Inpatient charges for physical therapy prescribed by a Doctor;
13. Inpatient charges for a minimum of forty-eight hours of inpatient care following a vaginal delivery and a minimum of ninety-six hours of inpatient care following delivery by cassarean section for a mother and her newborn in a Hospital or birthing center. Shorter Hospital stays are allowed if recommended by the attending health care provider in consultation with the mother and one postpartum visit is performed within 48 hours of discharge. (Note: the postpartum visit will be covered under the Outpatient Care Benefit.)
14. Inpatient charges for reconstructive breast surgery, including augmentation mammoplasty, reduction mammoplasty and mastopexy resulting from a mastectomy.
    Coverage is also provided for all stages of reconstructive breast surgery performed on a non-diseased breast to establish symmetry with the diseased breast and for prostheses and physical complication at all stages of the mastectomy, including lymphedemas.
15. Miscellaneous In-patient Expenses.

Covered Expenses will be considered to be incurred when the services are performed.

Benefit Limitations Inpatient Care

Coverage is not provided for services, supplies or equipment for which a charge is not customarily made in the absence of insurance.

In addition to the Benefit Limitations listed under the Outpatient Care, no coverage is provided for loss caused by or resulting from:

1. Any period of Custodial Care confinement in a Hospital or Skilled Nursing Facility;
2. Charges for home health care services, unless provided in lieu of a Hospital confinement;

No benefits will be paid for any expense incurred after the date the policy terminates.

Accident Medical Benefit

Accident means an unintended or unforeseen bodily injury sustained by a Covered Person, wholly independent of disease, bodily infirmity, illness, infection, or any other abnormal physical condition.

Each insured person will receive coverage for outpatient and inpatient medical expenses incurred for injuries due to a covered accident. This supplemental coverage is for accidents only and does not cover sickness.

The Policy will pay for such Usual and Customary expenses which constitute Necessary Treatment and are incurred:

- as the result of an injury;
- while insured for this benefit; and
- within 90 days from the date of the Covered Accident.

The Policy will pay 80% for each covered expense, until it has paid the Maximum Amount per Occurrence, and the number of occurrences per coverage year, as listed in the Benefit Chart.
Covered charges for this benefit are:

- Hospital room and board and general nursing services;
- Hospital miscellaneous expense for medical services and supplies including emergency services;
- operating and recovery room;
- Physician charges for medical treatment including performing a surgical procedure;
- diagnostic tests performed by a Physician including laboratory fees and x-rays;
- the cost of giving an anesthetic;
- a private duty nurse;
- prescription drugs;
- rental of durable medical equipment (if the purchase price is less than the rental, the maximum amount payable will be the purchase price);
- artificial limbs, eyes and other prosthetic devices, except replacement;
- casts, splints, trusses, crutches and braces, except dental braces;
- oxygen and rental of equipment for the administration of oxygen;
- physiotherapy given by licensed physical therapist acting within the scope of his license.
- Dental care and treatment required by injury to the sound and natural teeth and rendered within 6 months of the Injury.

Benefit Limitations for Accident Coverage
Coverage is not provided for services, supplies or equipment for which a charge is not customarily made in the absence of insurance.
The Benefit Limitations for the Accident Coverage are the same as listed in the Outpatient Care or Basic Medical Expense section.

Accidental Death Benefit

If a Covered Person suffers a loss of life due to an Accident, We will pay the amount shown in the Benefit Table, provided such loss:

1. Is incurred within 365 days after the Accident; and
2. Is the result of an injury sustained in such Accident.

Beneficiary means the person, persons or entity the Covered Person names to receive the Accidental Death Benefit.

Change of Beneficiary
The Covered Person may name a new beneficiary at any time by filing with Us a written request on forms furnished by Us. When We receive the request, the change will relate back to and take effect as of the date it was signed. This is the case whether the Covered Person is alive or not when We receive the request. Even though the change of beneficiary will relate back to the date it was signed, it will be without prejudice to Us on account of any payment We have already made.

Benefit Limitations for Accidental Death
No coverage is provided for loss caused by or resulting from:

1. Declared or undeclared war; or any act of war;
2. Death within 2 years from the Covered Person's effective date of coverage as a result of suicide, while sane or insane;
3. Medical or surgical treatment of Sickness or disease; or
4. Flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline.

Conversion Privilege
The right to convert the medical insurance to conversion coverage is available to any Covered Person whose insurance under the Policy ceases for any reason except:
a. Termination of the Policy;
b. Termination of the class of Covered Persons; or
c. Non-Payment of premium.

The conversion coverage will be issued subject to the following:
a. Written application must be made to Us at our home office within 31 days after the insurance under the group policy ceases. Premium payment must be made within the 31-day period.
b. Our underwriting rules and standards with respect to over insurance.
c. Conversion coverage will be on the form We then issue to Covered Persons whose coverage under the group policy ceased.

The effective date of the conversion coverage will be the day following the date insurance under the group policy ceased.

How to File a Medical Claim
There are two ways to file a claim:

1. Through your provider
2. By mailing the forms yourself

ALL CLAIMS MUST BE FILED WITHIN 90 DAYS OF THE DATE OF SERVICE

Provider Medical Claims
During your office or hospital visit, ask your provider to submit an itemized bill to Connecticut General Life Insurance Claim Department at the address listed on the back of your ID card.
If more information is needed, have your provider call the toll-free number on your ID card.

Do It Yourself
When you are finished seeing your provider and have paid for the services, ask for an itemized medical receipt and follow these four simple steps:

1. Fill out the Claim Form enclosed in the back of this booklet. Additional claim forms are available at www.cignavoluntary.com or by calling the customer service phone number listed on the front of your ID card.
2. Make copies of your Claim Form and receipt(s)
3. Attach ORIGINAL receipt(s) to your Claim Form
4. Mail ORIGINAL receipt(s) and Claim Form to the address listed on the back of your ID card

We cannot accept photocopies or fax copies of claims receipts. You must mail the original documents.

CIGNA HealthCare PPO Network*

Quality, Convenience and Cost Savings
Using our network relationships will allow you to save money the next time you visit the doctor. These networks are just another way we are working to help members maximize their health care benefits. Our Preferred Provider Organization (PPO) network offers referral-free access to more than 500,000 credentialed primary and specialty care physicians and facilities nationwide. Members may visit any licensed provider although in-network Providers offer discounted fee-for-service rates for the best cost savings.

*This Policy is not a PPO product. The reference to PPO is solely a description of the network available with this limited-benefit product.

Prescription Savings Program

SCRIPTSAVE® SELECT

1-866-315-8008
www.starbridge.com

You and your family are automatically enrolled in the ScriptSave® Select Prescription Savings Program. This program provides instant savings for your entire household on brand name and generic prescriptions. Over 62,000 pharmacies nationwide participate in the program, including both chain and independents. The ScriptSave® Select program is most likely accepted at the neighborhood pharmacy you currently use.

The ScriptSave® Select program also offers:

- Average savings of 36%, with potential savings up to 75% (based on 2012 national program savings data). All prescriptions are eligible for savings.
- No limits or caps on usage
- An easy-to-use program with no paperwork to complete
- Savings for everyone in the household regardless of age

Find a Participating Pharmacy

Visit www.starbridge.com and click on the "Login" link. First time users will need to register first: visit www.starbridge.com, click Login, then click Register Now. Once registered, you can now login. Once logged in, click on the link "Find A Pharmacy" and click on the link provided to access the ScriptSave® Select Prescription Savings Network. Enter the Group number that appears on your Prescription ID card along with a zip code to receive a list of all participating pharmacies within that zip code.

Plan Your Prescription Purchases

You can plan your prescription purchases before you go to the pharmacy. Simply visit www.starbridge.com and click on the ScriptSave® link. Log in with your Group #. Enter the name of the prescription medication you wish to price in the Drug Price Look Up Tool. Follow the steps indicated to receive the price for that specific medication at the pharmacy of your choice. When pricing a brand name drug, you will also be provided the name of other generic prescriptions you can consider to help save you money. You will need to talk to your doctor to see if any of the lower cost prescriptions are right for you.

Please note that prescription prices vary from pharmacy to pharmacy and are subject to change. Pricing is based on the most recent information available and may change based on when you actually fill your prescription at the pharmacy. With the ScriptSave® Select Best Price Advantage, if a drug is ever "on sale," or if the pharmacy price is less than the discounted price, you will pay the lower of the two prices on your retail prescription purchases.

DISCOUNT ONLY – NOT INSURANCE. Discounts are available exclusively through participating pharmacies. The range of the discounts will vary depending on the type of provider and services rendered. This program does not make payments directly to providers. Members are required to pay for all health care services. You may cancel your registration at any time or file a complaint by contacting Customer Care at 1-866-315-8008. This program is administered by Medical Security Card Company, LLC (MSC) of Tucson, AZ.

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Claims Procedures

Claims Timeline
A claims administrator will process your claim within 30 days of receipt (or within the timeframe mandated by your State). You will be notified in writing during the initial 30-day period if more time is needed. Benefits will be paid within 60 days after receipt of acceptable documents and information.

The Policy requires that you file your claim within 90 days of the date of service. If this is not reasonably possible, you will be allowed to submit your claim, along with the reason for delay, as soon as it is reasonably possible to do so.

Your benefits will not be affected if your claim, along with any additional requested information, is received in our office within one year from the date of service. If you were legally incapacitated and unable to file your claim within one year from the date of service, you may request a special review.

Appeal of a Claim that has been denied
Any denial of a claim for benefits will be provided by the Claims Administrator and consist of a written explanation which will include (i) the specific reasons for the denial, (ii) reference to the pertinent plan provisions upon which the denial is based, (iii) a description of any additional information you might be required to provide and explanation of why it is needed, and (iv) an explanation of the Plan's claim review procedure. You, your beneficiary (when an appropriate claimant), or a duly authorized representative may appeal any denial of a claim for benefits by filing a written request for a full and fair review to the Program Administrator. In connection with such a request, documents pertinent to the administration of the Plan may be reviewed, and comments and issues outlining the basis of the appeal may be submitted in writing. You may have representation throughout the review procedure. A request for a review must be filed by 180 days after receipt of the written notice of denial of a claim. All information that you submit will be considered, even if you did not provide it when your claim was first decided. The full and fair review will be held and a decision rendered by the Program Administrator, no later than 60 days after receipt of the request for review. The decision after your review will be in writing and will include specific reasons for the decision as well as specific references to the pertinent plan provisions on which the decision is based. You will have the right to bring a legal action under section 502(a) of ERISA.

Physical Examination (and Autopsy)
We have the right to have a Physician examine a Covered Person at Our expense, as often as it is reasonably required while the claim is pending. We also have the right to have an autopsy performed at Our expense where it is not forbidden by law.

Legal Actions
You cannot bring legal action until 60 days after the date you've notified us of a loss in writing. No legal action can be brought after 3 years from the date that written proof was required.

Subrogation
This plan does not subrogate.

NOTE: <u>We cannot accept photocopies or faxes for any claim. You must mail the original documents.</u>

Important Information

Effect of Section 125 Tax Regulation on this Plan
Your employer has chosen to administer this plan in accordance with Section 125 regulations of the Internal Revenue Code. Per this regulation, you may agree to a pre-tax salary reduction put toward the cost of your benefits. Otherwise, you will receive your taxable earnings as cash (salary).

A. Coverage Elections
Per Section 125 regulations, you are generally allowed to enroll for or change coverage only before each annual benefit period.
However, exceptions are allowed if your employer agrees and you enroll for or change coverage within 31 days of the following (or 60 days for Section D below):

1. The date you meet the Special Enrollment criteria described above; or
2. The date you meet the criteria shown in the following Sections B through F.

B. Change in Status
A change in status is defined as:

1. Change in legal marital status due to marriage, death of a spouse, divorce, annulment or legal separation;
2. Change in the number of dependents due to birth, adoption, placement for adoption, or death of a dependent;
3. Change in employment status of employee, spouse or dependent due to termination or start of employment, strike, lockout, beginning or end of unpaid leave of absence, including under the Family and Medical Leave Act (FMLA), or change in worksite;
4. Changes in employment status of employee, spouse or dependent resulting in eligibility or ineligibility for coverage;
5. Change in residence of employee, spouse or dependent to a location outside of the employer's network service area; and
6. Changes which cause a dependent to become eligible or ineligible for coverage.

C. Court Order
A change in coverage due to and consistent with a court order issued to the employee or other person to cover a dependent.

D. Medicare or Medicaid Eligibility/Entitlement
The employee, spouse or dependent cancels or reduces coverage due to entitlement to Medicare or Medicaid, or enrolls or increases coverage due to loss of Medicare or Medicaid eligibility.

E. Change in Cost of Coverage
If the cost of benefits increase or decrease during a benefit period, your employer may, in accordance with plan terms, automatically change your elective contribution. When the change in cost is significant, you may either increase your contribution or elect less-costly coverage. When a significant overall reduction is made to the benefit option you have elected, you may elect another available benefit option. When a new benefit option is added, you may change your election to the new benefit option.

F. Changes in Coverage of Spouse or Dependent Under Another Employer's Plan
You may make a coverage election change if the plan of your spouse or dependent:

1. incurs a change such as adding or deleting a benefit option;
2. allows election changes due to Special Enrollment, Change in Status, Court Order, or Medicare or Medicaid Eligibility/Entitlement; or3. this plan and the other plan have different periods of coverage or open enrollment periods.

Statement of ERISA Rights
As a participant in the plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all plan participants shall be entitled to:

1. Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
2. Obtain upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
3. Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report if the plan is required to file an annual report.
4. Continue health care coverage (for the participant or the participants spouse or dependents) if there is a loss of coverage under the plan as a result of a qualifying event. The participant may have to pay for such coverage. Participants should review this summary plan description and the documents governing the plan on the rules governing their COBRA continuation coverage rights.
5. Receive a reduction or elimination of exclusionary periods of coverage for preexisting conditions if there is creditable coverage from another plan. Participants should be provided a certificate of creditable coverage, free of charge, from their group health plan or health insurance issuer when they lose coverage under the plan, when they become entitled to elect COBRA continuation coverage, when their COBRA continuation coverage ceases, if they request it before losing coverage, or if they request it up to 24 months after losing coverage. Without evidence of creditable coverage, participants may be subject to a preexisting condition exclusion for 12 months after enrollment.
6. In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a (pension, welfare) benefit or exercising your rights under ERISA.
7. If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order or domestic relations order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plans money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay

these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA)
The Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and re-employment in regard to military leaves of absence. These requirements apply to medical and dental coverage for you and your covered dependents. The requirements do not apply to Term Life Insurance, Short-Term Disability or Accidental Death coverage you may have.

A. Continuation of Coverage
For leaves of less than 31 days, coverage will continue as described in the Termination section regarding Leave of Absence.

For leaves of 31 days or more, you may continue coverage for yourself and your covered dependents as follows:

You may continue benefits by paying the required premium to your employer, until the earliest of:

1. 24 months from the last day of employment with the employer
2. the day after you fail to return to work; and
3. the date the policy cancels

Your employer may charge you and your covered dependents up to 102% of the total premium.

Following the continuation of health coverage per USERRA requirements, you may convert to a plan of individual coverage according to the Conversion Privilege list in the certificate.

B. Reinstatement of Benefits (applicable to all coverages)
If your coverage ends during the leave of absence because you did not elect USERRA or an available conversion plan at the expiration of USERRA, and you are reemployed by your current employer, coverage for you and your covered dependents may be reinstated if (a) you gave your employer advance written or verbal notice of your military service leave, and (b) the duration of all military leaves while you are employed with your current employer does not exceed 5 years.

You and your covered dependents will be subject to only the balance of a Pre-Existing Condition Limitation or waiting period that was not yet satisfied before the leave began. However, if an injury or sickness occurs or is aggravated during the military leave, full plan limitations will apply.

Any 63 day break in coverage rule regarding credit time accrued toward a Pre-Existing Condition limitation waiting period will be waived.

Dependent Coverage
Your Dependent is:

1. Your spouse,
2. Your children up to age 26,

Provisions may vary where required by state law.

Coverage of Students on Medically Necessary Leave of Absence
Provision varies by state law and only applies in states that mandate extended dependent coverage including and beyond age 26.

If your state requires Student Status of your dependent child/ren, coverage will remain active for that child if the child is on a medically necessary leave of absence from a postsecondary educational institution (such as a college, university or trade school.)

Coverage will terminate on the earlier of:

a. The date that is one year after the first day of the medically necessary leave of absence; or
b. The date on which coverage would otherwise terminate under the terms of the plan.

The child must be a Dependent under the terms of the plan and must have been enrolled in the plan on the basis of being a student at a postsecondary educational institution immediately before the first day of the medically necessary leave of absence.

The plan must receive written certification from the treating physician that the child is suffering from a serious illness or injury and that the leave of absence (or other change in enrollment) is medically necessary.

A "medically necessary leave of absence" is a leave of absence from a postsecondary educational institution, or any other change in enrollment of the child at the institution that: (1) starts while the child is suffering from a serious illness or condition; (2) is medically necessary; and (3) causes the child to lose student status under the terms of the plan.

Family and Medical Leave Act of 1993 (FMLA)
The federal Family and Medical Leave Act of 1993 (FMLA) provides for continuation of insurance during a leave of absence, and reinstatement of insurance following a return to active service.

A. Continuation of Health Insurance During Leave
Your health insurance will be continued during a leave of absence if:

1. That leave qualifies as a leave of absence under the Family and Medical Leave Act of 1993; and
2. You are an eligible employee under the terms of the Act.

The cost of your health insurance during such leave must be paid, whether by you or your employer entirely or in part by you and your employer.

B. Reinstatement of Canceled Insurance Following Leave
Upon your return to active service following a leave of absence that qualifies under the Family and Medical Leave Act of 1993, any canceled insurance (health, life, disability) will be reinstated as of the date of your return.
You will not be required to satisfy any eligibility or benefit waiting period or the requirements of any Pre-Existing Condition Limitation to the extent that they had been satisfied prior to the start of such leave of absence.

You employer will provide detailed information about the Family and Medical Leave Act of 1993.

Qualified Medical Child Support Order (QMCSO)
A medical child support order is a judgment, decree or order that:

1. Is made pursuant to State domestic relations law (including a community property law) or certain other State laws relating to medical child support; and
2. Provides for child support or health benefit coverage for a child of a participant under a group health plan and relates to benefits under the plan

If a qualified Medical Child Support Order is issued for your child, that child will be eligible for coverage as required by the order.

You must notify your employer and elect coverage for that child and yourself, if you are not already enrolled, within 31 days of the QMCSO being issued.

You may request a free copy of the plan's QMCSO procedures from the Plan Administrator.

Newborns' and Mothers' Health Protection Act (NMHPA) - Special Rights upon Childbirth
Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section.

However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

This Act does not change the benefit limits or deductible of the Plan.

Effective Date of Insurance for Newborn or Adopted Children
We will cover the Named Insured's newborn children by this Policy if the Named Insured's Spouse or another child is covered by the Policy. These children must be born to the Named Insured or to his Spouse while this Policy is in force. We will cover each newborn child from the moment of live birth. For each newborn child, you must:

- notify Us within 31 days of his birth; and
- complete the required application for him; and
- pay the required premium for him, if any.

If notice is given within the 31-day period, no additional premium will be charged for the notice period. If notice is not given within the 31-day period, premium will be charged from the date of birth. We may not deny coverage for a child due to the Named Insured's failure to timely notify us of the birth of the child.

We will cover the Named Insured's adopted children or foster children who are placed in the Named Insured's custody prior to the child's eighteenth birthday from the time of placement in the Named Insured's residence. Coverage is not excluded for any Pre-existing Condition of the Named Insured's adopted children only.

In the case of a newborn, coverage will begin from the moment of birth if the written agreement to adopt is entered into prior to the birth of the child, whether or not the agreement is enforceable. If the child is not ultimately placed in the Named Insured's residence, coverage will not be effective.

For each adopted child, you must:

- notify Us of his birth or placement in Your residence within 31 days of this occurrence;
- complete the required application for him; and
- pay the required premium for him, if any.

If notice is given within the 31-day period, no additional premium for the coverage of the child will be charged for the notice period. If the notice is not given within the 31- day period, premium will be charged from the date of birth.

Reconstructive Surgery after Mastectomies
Effective October 21, 1998, Congress enacted the Women's Health and Cancer Rights Act. The Act stipulates that any health plan that provides medical benefits for a mastectomy must also provide coverage for breast reconstruction if you chose to receive it. Specifically, any patient who is covered for mastectomy is also covered for:

1. Reconstruction of the breast on which the mastectomy was performed;
2. Reconstruction of the other breast to achieve symmetry
3. Prostheses and physical complications of all stages of mastectomy including lymphedema

This Act does not change the benefit limits or deductible of the Plan.

Special Enrollment
If you declined enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). You and your dependents may qualify for special enrollment if the COBRA continuation coverage has been exhausted, or if your health benefits with the current carrier have met or exceeded the lifetime maximum. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Loss of coverage (non-COBRA) that can qualify for Special Enrollment includes, but is not limited to:

- Loss of eligibility for coverage as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of an employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;
- Loss of eligibility for State Medicaid or Children's Health Insurance Program (CHIP). If you and/or your Dependent(s) were covered under a state Medicaid or CHIP plan and the coverage is terminated due to a loss of eligibility, you may request special enrollment for yourself and any affected Dependent(s) who are not already enrolled in the Plan. You must request enrollment within 60 days after termination of Medicaid or CHIP coverage.
- Eligibility for employment assistance under State Medicaid or Children's Health Insurance Program (CHIP). If you and/or your Dependent(s) become eligible for assistance with group health plan premium payments under a state Medicaid or CHIP plan, you may request special enrollment for yourself and any affected Dependent(s) who are not already enrolled in the Plan. You must request enrollment within 60 days after the date you are determined to be eligible for assistance.
- A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual.

To request special enrollment or obtain more information, contact a Customer Service representative at the phone number listed on the front of your ID cards.

Circumstances Causing Your Coverage to End
The date on which your insurance will terminate is the earliest of:

1. The date ending the last period for which You made any required premium contribution;
2. The date you enter the armed forces of any country and do not elect to invoke rights under USERRA (membership in the reserves is not deemed entry into the armed forces);
3. The date You are no longer a member of a class eligible for insurance;
4. With respect to a coverage, the date on which that coverage is cancelled;
5. The date the policy is terminated or
6. The date your Employer ceases to provide the plan

The date on which the insurance of a covered Dependent will terminate is the earliest of:

1. The date Your insurance terminates;
2. The date he/she enters the armed forces of any country (membership in the reserves is not deemed entry into the armed forces);
3. The date he/she ceases to be a Dependent

Once your coverage terminates, you are entitled to a Certificate of Creditable Coverage. To request a copy of your HIPAA Certificate of

Creditable Coverage or for more information, call a Customer Service representative at the phone number listed on the front of your ID card.

State Laws
Any provision of the Policy that, on the effective date, does not agree with state laws where the Named Insured lives will be amended to conform to the minimum requirements of those laws.

Notice to Texas Residents of Coverage for Acquired Brain Injury
Your health benefit plan coverage for an acquired brain injury includes the following services:

1. cognitive rehabilitation therapy;
2. cognitive communication therapy;
3. neurocognitive therapy and rehabilitation;
4. neurobehavioral, neurophysiological, neuropsychological and psychophysiological testing and treatment;
5. neurofeedback therapy and remediation;
6. post acute transition services and community reintegration services, including outpatient day treatment services or other post acute care treatment services, and
7. reasonable expenses related to periodic reevaluation of the care of an individual covered under the plan who has incurred an acquired brain injury, has been unresponsive to treatment, and becomes responsive to treatment at a later date, at which time the cognitive rehabilitation services would be a covered benefit.

The fact that acquired brain injury does not result in hospitalization or acute care treatment does not affect the right of the insured or the enrollee to receive the preceding treatments or services commensurate with their condition. Post acute care treatment or services may be obtained in any facility where such services may legally be provided, including acute or post acute rehabilitation hospitals and assisted living facilities regulated under the Health and Safety code.

Please refer to your plan materials for benefit limitations and plan maximums.

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Important Information – COBRA and Continuation of Coverage

CONTINUATION COVERAGE RIGHTS UNDER COBRA

You are receiving this notice because you have recently become covered or renewed your coverage under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of medical and/or dental coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Program Administrator.

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

Note that your employer's withdrawal from the Plan will not constitute a qualifying event. This means that even if you and/or your covered dependents lose Plan coverage because your employer withdrew from this plan (or stopped making contributions to the Plan), you and your dependents will not be eligible for COBRA continuation coverage.

When Is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Program Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Program Administrator of the qualifying event.

You may elect COBRA if you are covered under the plan on the day prior to a qualifying event and would otherwise lose coverage as a result of that event. If, however, you are the spouse or dependent child of an employee and the employee drops your coverage in anticipation of a divorce, legal separation or annulment (such as at open enrollment), you may still be entitled to elect COBRA following the date of the divorce, legal separation or annulment. The Program Administrator must determine that the employee dropped your coverage in anticipation of the qualifying event. In this case, COBRA coverage would be offered only from the date of the qualifying event. COBRA coverage would not be available from the date coverage was dropped to the date of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Program Administrator, in writing, within 60 days after the qualifying event occurs. To receive the form for reporting a qualifying event change, you must contact the Program Administrator for a qualifying event form. The completed form, along with any required documentation, must be received by the Program Administrator within 60 days of the qualifying event.

How Is COBRA Coverage Provided?

Once the Program Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months from the date of the qualifying event. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries, other than the employee, lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months from the date of the qualifying event. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration ("SSA") to be disabled and you notify the Program Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months from the date of the qualifying event. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must provide this notice, in writing, to the Program Administrator within 60 days after the later of: the date qualifying event occurs and the date of the Social Security

Administration disability determination. To receive the form for requesting a disability extension, you must contact the Program Administrator for a qualifying event form, complete the form, and return it with the appropriate documentation, as requested on the form. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the Program Administrator by filling out and submitting the form required by the Program Administrator within 30 days after SSA's determination.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months from the date of the original qualifying event, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. You must provide this notice, in writing, to the Program Administrator within 60 days after the qualifying event occurs. To receive the form for requesting an extension, you must contact the Program Administrator for a qualifying event form, complete the form, and return it with the appropriate documentation, as requested on the form.

How can you elect COBRA continuation coverage?

Upon receipt of notice of the qualifying event, the Program Administrator generally has 14 days to provide each qualified beneficiary with a COBRA election notice. You or your eligible family member(s) have 60 days after the date coverage is lost or the date the election notice is sent, if later, to submit a completed election form to the Program Administrator. Failure to timely submit a completed election form will result in loss of your (and your family's) rights to COBRA continuation coverage. To elect continuation coverage, you must complete an election form and return it according to the directions on the form. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The employee or the employee's spouse can elect continuation coverage on behalf of all of the qualified beneficiaries. In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

How much does COBRA continuation coverage cost?

Each qualified beneficiary will be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. The required payment for each continuation coverage period for each option is described in this notice.

When and how must payment for COBRA continuation coverage be made?

First payment for continuation coverage

If you elect continuation coverage, you do not have to send any payment with the election form. However, you must make your first payment for continuation coverage not later than 45 days after the date of your election. (This is the date the election notice is post-marked, if mailed.) If you do not make your first payment for continuation coverage in full not later than 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact the Program Administrator to confirm the correct amount of your first payment.

Periodic payments for continuation coverage

After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The amount due for each coverage period for each qualified beneficiary is shown in the election notice. The periodic payments can be made on a monthly basis. Under the Plan, each of these periodic payments for continuation coverage is due on the specified day of the month for that coverage period. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break. The Plan will not send periodic notices of payments due for these coverage periods.

Grace periods for periodic payments

Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, your coverage under the Plan will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to continuation coverage under the Plan.

All payments for continuation coverage should be sent to: Connecticut General Life Insurance Company - P.O. Box 202362 Dallas, TX 75320-2362

Termination of COBRA Coverage

Continuation coverage will be terminated before the end of the maximum period if:

- any required premium is not paid in full on time,
- a qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary (if the plan does apply an exclusion or limitation for a preexisting condition, COBRA continuation coverage will terminate at the end of the pre-existing condition exclusion or limitation period),

Important Information – COBRA and Continuation of Coverage Continued

- a qualified beneficiary becomes enrolled in Medicare benefits(under Part A, Part B, or both) after electing continuation coverage, or
- your employer ceases to provide any group health plan for its employees.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

If You Have Questions
Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes
In order to protect your family's rights, you should keep the Program Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Program Administrator.

Program Administrator Information
If you have any questions, please contact:
Connecticut General Life Insurance Company
P.O. Box 55279
Phoenix, Arizona 85078
or call 1-800-859-0086

Notice of Privacy Practices

Si desea recibir este Aviso Sobre Practicas de Privacidad en español, por favor llame a Servicios a Clientes en el número que se encuentra en su tarjeta de identificación de CIGNA HealthCare.

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice is effective on July 1, 2004.

CIGNA HealthCare® is committed to maintaining and protecting the confidentiality of our members' personal information. We are required by federal and state law to protect the privacy of your personal health information and other personal information about you. In this Notice, we will refer to this information as "confidential information." We also are required to send you this Notice about our policies, safeguards and practices. When we use or disclose your confidential information, we are bound by the terms of this Notice or our revised notice, if we revise it.

How We Protect Your Privacy

To provide you with health insurance benefits, CIGNA HealthCare receives confidential information from you and from other sources such as your health care providers, insurers and your employer. The information we receive includes personal health information as well as your name and address. CIGNA HealthCare will not disclose confidential information without your authorization unless it is necessary to provide your health benefits, administer your benefit plan, to support CIGNA HealthCare programs or services, or as otherwise required or permitted by law. When we need to disclose your confidential information, we will follow the policies described in this Notice to protect your privacy.

CIGNA HealthCare locations that maintain confidential information have procedures for accessing, labeling and storing confidential records. Access to our facilities is limited to authorized personnel. We restrict internal access to your confidential information to CIGNA HealthCare employees who need to know that information to conduct our business. CIGNA HealthCare trains its employees on policies and procedures designed to protect your privacy. Our Privacy Office monitors how we follow those policies and procedures and educates our organization on this important topic.

How We Use and Disclose Your Confidential Information

We will not use your confidential information or disclose it to others without your authorization, except for the following purposes:

- **Treatment.** We may disclose your confidential information to your doctors, hospitals and other health care providers for their provision, coordination or management of your health care and related services - for example, for coordinating your health care with us or for referring you to another provider for care.
- **Payment.** We may use and disclose your confidential information to obtain payment of premiums for your coverage and to determine and fulfill our responsibility to provide your health plan benefits - for example, to make coverage determinations, administer claims and coordinate benefits with other coverage you may have. We also may disclose your confidential information to another health plan or a health care provider for its payment activities - for example, for the other health plan to determine your eligibility or coverage, or for the health care provider to obtain payment for health care services provided to you.
- **Health Care Operations.** We may use and disclose your confidential information for our health care operations - for example, to provide customer service and conduct quality assessment and improvement activities. Other health operations may include providing appointment reminders or sending you information about treatment alternatives or other health-related benefits and services. We also may disclose your confidential information to another health plan or a provider who has a relationship with you, so that it can conduct quality assessment and improvement activities - for example, to perform case management.
- **Disclosure to Persons Involved in Your Care.** We may disclose confidential information about you or your child to persons who are involved in your or your child's care or payment for that care. For example, we might disclose confidential information about you to your spouse or confidential information about your child to your former spouse who is the parent of your child. We will disclose only the information that is relevant to the care or payment. Callers will be asked to provide identifying information and, if they are asking about a claim, they will have to show knowledge of that claim before we will answer their questions. You have the right to stop or limit this kind of disclosure by requesting a restriction on the disclosure of your confidential information as described below under "Right to Request Additional Restrictions."
- **Disclosures to your Employer as Sponsor of Your Health Plan.** We may disclose your confidential information to your employer or to a company acting on your employer's behalf, so that it can monitor, audit and otherwise administer the employee health benefit plan in which you participate. Your employer is not permitted to use the confidential information we disclose for any purpose other than administration of your health benefit plan. See your employer's health benefit plan documents for information on whether your employer receives confidential information and the identity of the employees who are authorized to receive your confidential information.
- **Disclosures to CIGNA HealthCare Vendors and Accreditation Organizations.** We may disclose your confidential information to companies with whom we contract if they need it to perform the services we've requested -- for example, vendors who help us provide important information and guidance to members with chronic conditions like diabetes and asthma. CIGNA HealthCare also discloses confidential information to accreditation organizations such as the National Committee for Quality Assurance (NCQA) when the NCQA auditors collect Health Plan Employer Data and Information Set (HEDIS®)** data for quality measurement purposes. When we enter into these types of arrangements, we obtain a written agreement to protect your confidential information.
- **Promotional Gifts.** We may use your confidential information or disclose it to a mailing vendor so that we may provide you with a promotional gift of nominal value such as a pen or a calendar. We will not disclose your confidential information to other companies for their marketing purposes.
- **Public Health Activities.** We may disclose your confidential information for the following public health activities and purposes: (1) to report health information to public health authorities that are authorized by law to receive such information for the purpose of preventing or controlling disease, injury or disability; (2) to report child abuse or neglect to a government authority that is authorized by law to receive such reports; (3) to report information about a product or activity that is regulated by the U.S. Food and Drug Administration (FDA) to a person responsible for the quality, safety or effectiveness of the product or activity; and (4) to alert a person who may have been exposed to a communicable disease, if we are authorized by law to give this notice.
- **Health Oversight Activities.** We may disclose your confidential information to a government agency that is legally responsible for oversight of the health care system or for ensuring compliance with the rules of government benefit programs, such as Medicare or Medicaid, or other regulatory programs that need health information to determine compliance.
- **For Research.** Under very limited circumstances, your confidential information may be used and disclosed for research without an authorization - for example, an authorization would not be necessary if your name, street address and other identifying information were removed.
- **To Comply with the Law.** We may use and disclose your confidential information to comply with the law.

- **Judicial and Administrative Proceedings.** We may disclose your confidential information in a judicial or administrative proceeding or in response to a legal order.
- **Law Enforcement Officials.** We may disclose your confidential information to the police or other law enforcement officials, as required by law or in compliance with a court order or other processes authorized by law.
- **Health or Safety.** We may disclose your confidential information to prevent or lessen a serious and imminent threat to your health or safety or the health and safety of the general public.
- **Government Functions.** We may disclose your confidential information to the U.S. military or to authorized federal officials for purposes specified by federal law.
- **Workers' Compensation.** We may disclose your confidential information when necessary to comply with workers' compensation laws.

Please note that should your coverage with CIGNA HealthCare terminate, we will continue to protect your confidential information. It will be used and disclosed only for the purposes described above and in accordance with the policies and procedures described in this Notice.

Uses and Disclosures With Your Written Authorization

We will not use or disclose your confidential information for any purpose other than the purposes described in this Notice without your written authorization. For example, we will not supply confidential information to another company for its marketing purposes or to a potential employer with whom you are seeking employment without your signed authorization. You may revoke an authorization that you previously have given by sending a written request to our Privacy Office, but not with respect to any actions we already have taken.

CIGNA HealthCare complies with state laws that place further restrictions on the disclosure of your personal health information without your authorization. For example, many states have laws that do not permit us to disclose a diagnosis of AIDS or mental illness. These laws have some limited exceptions.

Your Individual Rights

- **Right to Request Additional Restrictions.** You may request restrictions on our use and disclosure of your confidential information for the treatment, payment and health care operations purposes explained in this Notice. While we will consider all requests for restrictions carefully, we are not required to agree to a requested restriction.
- **Right to Receive Confidential Communications.** You may ask to receive communications of your confidential information from us by alternative means of communication or at alternative locations. While we will consider reasonable requests carefully, we are not required to agree to all requests.
- **Right to Inspect and Copy your Confidential Information.** You may ask to inspect or to obtain a copy of your confidential information that is included in certain records we maintain. Under limited circumstances, we may deny you access to all or a portion of your records. If you request copies, we may charge you copying and mailing costs.
- **Right to Amend your Records.** You have the right to ask us to amend your confidential information that is contained in certain records we maintain. If we determine that the record is inaccurate, and the law permits us to amend it, we will correct it. If your doctor or another person created the information that you want to change, you should ask that person to amend the information.
- **Right to Receive an Accounting of Disclosures.** Upon request, you may obtain an accounting of disclosures we have made of your confidential information. The accounting that we provide will not include disclosures made before April 14, 2003, disclosures made for treatment, payment or health care operations, disclosures made earlier than six years before the date of your request, and certain other disclosures that are excepted by law. If you request an accounting more than once during any 12-month period, we will charge you a reasonable fee for each accounting statement after the first one.
- **Right to Receive Paper Copy of this Notice.** You may call Member Services at the toll-free number on your ID card to obtain a paper copy of this Notice, even if you previously agreed to receive this Notice electronically.

If you wish to make any of the requests listed above under "Individual Rights," you must complete and mail us the appropriate form. To obtain forms, please call Member Services at the toll-free number on your ID card to request the appropriate form. Completed forms should be mailed to the address printed on the forms. After we receive your signed, completed form, we will respond to your request.

- **For More Information or Complaints.** If you want more information about your privacy rights, do not understand your privacy rights, are concerned that we have violated your privacy rights or disagree with a decision that we made about access to your confidential information, you may contact our Privacy Office. You may also file written complaints with the Secretary of the U.S. Department of Health and Human Services. Please call our Privacy Office to obtain the correct address for the Secretary. We will not take any action against you if you file a complaint with the Secretary or us.

You may contact our Privacy Office at:

Privacy Office - CIGNA Healthcare
PO Box 188014
Chattanooga, TN 37422
Telephone Number: 800.762.9940
Fax Number: 860.226.9513

We may change the terms of this Notice at any time. If we change this Notice, we may make the new notice terms effective for all of your confidential information that we maintain, including any information we created or received before we issued the new notice. If we change this Notice, we will send you the new notice if you are enrolled in a benefit plan at that time. In addition, we will post any new notice on our Web site at http:// www.cigna.com/general/misc/privacy.html. You also may obtain any new notice by calling Member Services at the toll-free number on your ID card.

STATE DISCLOSURES

Some states have specific disclosure that must be disclosed in materials to inform the consumer of state specific mandates. Please read below if the state you reside in is listed below.

Connecticut

THIS LIMITED HEALTH BENEFITS PLAN DOES NOT PROVIDE COMPREHENSIVE MEDICAL COVERAGE. IT IS A BASIC OR LIMITED BENEFITS POLICY AND IS NOT INTENDED TO COVER ALL MEDICAL EXPENSES. THIS PLAN IS NOT DESIGNED TO COVER THE COST OF SERIOUS OR CHRONIC ILLNESS. IT CONTAINS SPECIFIC DOLLAR LIMITS THAT WILL BE PAID FOR MEDICAL SERVICES WHICH MAY NOT BE EXCEEDED. IF THE COST OF SERVICES EXCEEDS THOSE LIMITS, THE BENEFICIARY AND NOT THE INSURER IS RESPONSIBLE FOR PAYMENT OF THE EXCESS AMOUNTS. PLEASE REFER TO THE MEDICAL BENEFIT CHART INCLUDED IN THIS ENROLLMENT CARD.

Hawaii

In Hawaii, the Cigna Voluntary Limited Benefit Medical option is not available.

Massachusetts

As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL or visit the Connector website www.mahealthconnector.org.

The Cigna Voluntary Limited Benefit Plan has overall **benefit maximums** that do not meet the **Creditable Coverage standard**. If you purchase this health plan only, you will not satisfy the statutory requirement that you have health insurance meeting these standards.

Montana

The Cigna Voluntary Limited Benefit Insurance Plan is not available to residents of Montana.

New Hampshire

The Cigna Voluntary Limited Benefit Insurance Plan is not available to residents of New Hampshire.

North Dakota

The Cigna Voluntary Limited Benefit Insurance Plan is not available to residents of North Dakota.

Puerto Rico

The Cigna Voluntary Limited Benefit Insurance Plan is not available to residents of Puerto Rico.

Vermont

The Cigna Voluntary Limited Benefit Insurance Plan is not available to residents of Vermont.

Washington

The Cigna Voluntary Limited Benefit Insurance Plan is not available to residents of Washington.

Claim Identification Form

We can't process claims we can't identify. To help us identify your claim faster, you must complete this Claim Identification Form. Please follow the instructions below.

1. Complete This Claim Identification Form (Claim ID Forms may be photocopied).
2. Attach original bills (bills may NOT be photocopied).
3. Attach copy of "Certificate of Creditable Coverage" from your prior insurer with your first claim.
4. Mail to the address below. (Facsimile documents CANNOT be accepted.)

Please submit your claim within 90 days of the date of service.

CIGNA HealthCare
P.O. Box 188004
Chattanooga, TN 37422
1-800-859-6086

Employee Name		Member ID
Home Address		Employee Birth Date
City & State	Zip	Telephone No.
Name of Employer	Mancha Development Company-NV Hourly	Has Employment Terminated? Yes ☐ No ☐
City & State		If Yes, Date
Patient Name (if other than Employee)		Male ☐ Female ☐
Patient Relationship to Employee	Patient Birth Date	Is Patient Married? Yes ☐ No ☐
Nature of Sickness, Injury, Diagnosis or Medical Visit		

This authorization is valid for the term of the policy or contract under which a claim has been submitted.

Signed (Employee, All Claims) X _____ Date _____

Patient or Parent (if minor) X _____ Date _____

Any person who knowingly (with intent to injure, defraud, or deceive the insurance company) files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a crime and maybe subject to fines and confinement in prison.

I certify that each of the statements made as part of this claim are complete and true to the best of my knowledge and belief.

Employee Signature _____

CIGNA HealthCare refers to Connecticut General Life Insurance Company and CIGNA Health and Life Insurance Company, both subsidiaries of CIGNA Corporation. Products and services are provided or arranged by these subsidiaries and not by CIGNA Corporation.

CIF_PPO_1110A

SPD

Mancha Development Company-NV Hourly
2275 Simpson Ave, #201
Corona, CA 92879

INSURANCE DOCUMENT ENCLOSED

050505 144933_SampleOrder.pdf 000001 000001 012
<Mailing_Name>
<Address>
<CITY>, <STATE> <Zip Code>

BACK 07066A

MDC000120

Exhibit 17

Exhibit 17

TransChoice® Advance hospital indemnity insurance

[illegible]			[illegible]	[illegible]	[illegible]
Daily In-Hospital Indemnity Benefit	Pays benefits per day of hospital confinement, up to the annual maximum.		$ 100 31 Days per confinement	$ 300 31 Days per confinement	$ 300 31 Days per confinement
[illegible]					
Outpatient Physician Office Visit Indemnity Benefit	Pays each day a covered person receives outpatient treatment in a physician's office or at an urgent care facility as the result of a covered accident or sickness, up to the annual maximum days listed.		$ 30 6 Days	$ 70 6 Days	$ 70 8 Days
Outpatient Diagnostic Laboratory Test Indemnity Benefit	Pays each day a covered person undergoes an outpatient lab test performed for the purpose of diagnosis for a covered accident or sickness, up to the annual maximum days listed. Does not include tests covered under any other rider.		$ 10 2 Days	$ 15 4 Days	$ 15 4 Days
Outpatient Select Diagnostic Test Indemnity Benefit	Pays each day a covered person undergoes an outpatient X-ray, ultrasound, EEG or sleep study performed for the purpose of diagnosis for a covered accident or sickness, up to the annual maximum days listed.		$ 60 1 Day	$ 75 2 Days	$ 75 2 Days
Outpatient Advanced Studies Diagnostic Test Indemnity Benefit	Pays each day a covered person undergoes an outpatient CT scan, MRI, myelogram, PET, angiogram, arteriogram or thallium stress test performed for the purpose of diagnosis for a covered accident or sickness, up to the annual maximum days listed.		$ 200 1 Day	$ 300 2 Days	$ 300 2 Days
Hospital Confinement Indemnity Benefit	Pays each day over 23 hours a covered person is confined to a hospital (not emergency room, outpatient stay or stay in an observation unit) as the result of a covered accident or sickness, maximum of 1 day per confinement, up to the annual maximum days listed.		$ 500 2 Days	$ 1,000 2 Days	$ 1,000 2 Days
Surgical and Anesthesia Indemnity Benefit	Pays each day a covered person undergoes surgery. The percentage listed is also paid if anesthesia is administered.	Inpatient surgery	$ 500	$ 1,000	$ 1,000
		Outpatient surgery	$ 250	$ 500	$ 500
		Outpatient minor surgery	$ 50	$ 100	$ 100
		Anesthesia percentage	20%	20%	20%
Off-the-Job Accidental Injury Indemnity Benefit	Pays each day a covered person requires x-rays or receives treatment by a physician within 96 hours of a covered accident.		No Coverage	No Coverage	$700
Prescription Drug Indemnity Benefit	Pays each day a covered person fills a prescription as the result of a covered accident or sickness.	Generic prescription	$ 10	$ 15	$25
		Name brand prescription	$ 20	$ 30	$50
		Annual maximum	12 Days per Year	12 Days per Year	36 Days per Year
Critical Illness Indemnity Benefit	Pays once when diagnosed with invasive cancer, heart attack, stroke, end-stage renal failure or major organ failure. A subsequent benefit is payable if diagnosed more than 60 days later with a different critical illness. *Dependent percentage*		No Coverage	No Coverage	$5,000 50%
Wellness Indemnity Benefit	Pays each day a covered person undergoes a physical exam or stress test or specific health screening tests as defined in the policy, up to the annual maximum days listed. Includes four days for children 0-12 mos. and two days for children 12- 24 mos for well baby exams.		$100 1 Day	$100 1 Day	$100 1 Day
Inpatient Mental and Nervous Disorder Indemnity Benefit	Pays each day a covered person is confined on an inpatient basis to a hospital or mental health facility as the result of a mental or nervous disorder. Annual maximum of 31 Days, lifetime maximum 60 Days.		$ 100	$ 100	$ 100

THIS IS NOT MAJOR MEDICAL INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL INSURANCE.
IT DOES NOT QUALIFY AS MINIMUM ESSENTIAL HEALTH COVERAGE UNDER THE FEDERAL AFFORDABLE CARE ACT.

This is a brief summary of TransChoice® Advance Hospital Indemnity Insurance underwritten by Transamerica Life Insurance Company, Cedar Rapids, Iowa. Policy Form Series CFGH500 and CCGH500. Forms and form numbers may vary. Coverage may not be available in all jurisdictions. Limitations and exclusions apply. Refer to the policy, certificate and riders for complete details.

Issue State: *NY* Lives: *1500* Calculator: *Ver. 14.A0.3.00* SIC: *5812* Pay type: *Voluntary* Multi-Sit: *No*

MOC000129

Inpatient Drug and Alcohol Addiction Indemnity Benefit	Pays each day a covered person is confined on an inpatient basis to a hospital or residential treatment facility as the result of drug or alcohol addiction. Annual maximum of 31 Days, lifetime maximum 93 Days.	$ 100	$ 100	$ 100
Ambulance Indemnity Benefit	Pays each day a covered person receives licensed ambulance transportation within 90 hours of a covered accident or onset of sickness. Air ambulance pays three times the amount.	No Coverage	$ 200	$ 330
[illegible]				
Group Term Life Policy with Accidental Death and Dismemberment Rider	Employee	$ 10,000	$ 10,000	$ 10,000
	Spouse	$ 5,000	$ 5,000	$ 5,000
	Children) *Accidental Death and Dismemberment Rider not available to dependent children*	$ 2,500	$ 2,500	$ 2,500
[illegible]				
Prescription Drug Discount Card *offered by ProCare*	By presenting the prescription drug discount card to one of the participating providers, an insured can receive a savings of at least 14% on retail pharmacy prices for brand-name drugs and up to 60% for generic drugs.	Included	Included	Included
Telemedicine Option	Around the clock telephone, video or e-mail access to a board-certified physician.	No Coverage	Healthiestyou	Healthiestyou
Employee Discount Card *offered by New Benefits, Ltd.*	Provides access to a discount vision plan, nurses' hotline, counseling services and discounts for hearing aids.	Included	Included	Included
PPO Network *offered by WebIPA*	Employee and covered dependents will receive contracted savings from the normal fees charged by network physicians, hospitals and outpatient X-ray and laboratory providers.	No Coverage	Included	Included

Employee per pay check	Employee	Employee + Spouse	Employee + Children	Family
Plan I	19.08	38.74	39.62	62.22
Plan II	41.64	93.83	75.34	115.51
Plan III	51.36	114.80	93.70	142.82

Non-Insurance Benefits

Telemedicine

Healthiestyou provides insureds with telemedicine access to consult with a doctor by telephone, video chat or secure e-mail 24/7/365.

Prescription Drug Discount Card (provided by ProCare)

By presenting the prescription drug discount card to one of the participating providers, an insured can receive a savings of at least 14% on retail pharmacy prices for brand-name drugs and up to 60% for generic drugs. The insured will continue to receive the savings even after his or her TransChoice Advance benefit has been used for the year.

Employee Discount Card (provided by New Benefits Ltd.)

The employee discount card offers access to a discount vision plan, a nurses' hotline, counseling services and benefits for hearing aids. This is not an insurance plan.

The discount vision plan's coast-to-coast network allows the employee to receive savings of 20-60% on eyeglasses, contact lenses and frames from more than 12,000 participating retail optical locations. Providers include independent practitioners, regional chains, department store opticals and the largest chains in the United States, like LensCrafters®, Pearle Vision®, Sears® Optical and JCPenney® Optical.*

A nurses' hotline allows telephone access to experienced, registered nurses 24 hours a day, 7 days a week, 365 days a year. These nurses are an immediate, reliable and caring source of health information, education and support. Services provided by this plan include:

- general information on all types of health concerns,
- information based on physician-approved guidelines,

TRANSAMERICA
LIFE INSURANCE COMPANY

Transamerica Life Insurance Company *(Insurer)*
Home Office: Cedar Rapids, IA
Administrative Office: Web-TPA
P.O. Box 310, Grapevine, TX 76099-0310

Hospital Indemnity Enrollment Form

☐ First Application ☐ Add Dependents – Policy # _____ ☐ Change Coverage – Policy # _____

Group Name | Group Number | Location

Applicant (Last, First, M.I.) ☐ Male ☐ Female		Social Security No.	Date of birth	Date of marriage
Spouse[1] (Last, First, M.I.) ☐ Male ☐ Female		Social Security No.	Date of birth	
Email Address	Do you agree to receive correspondence about your coverage electronically? ☐ Yes ☐ No		Work phone/ext.	Home phone
Date of hire	Avg hours worked per week	Occupation		Applicant ID
Home address				
City		State		Zip code

Child(ren) name	Social Security No.	Date of birth	Child(ren) name	Social Security No.	Date of birth

Primary Beneficiary: (Last, First, M.I.)	Relationship:
Contingent Beneficiary: (Last, First, M.I.)	Relationship:

Applicant will be the beneficiary for any dependent coverage

[1] *Spouse includes your legally married spouse, common law spouse, civil union partner, or domestic partner, if legally recognized in the governing jurisdiction.*

Premium Mode: ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly ☐ Other

I Am Applying For: ☐ Individual ☐ Individual & Spouse ☐ Individual & Children ☐ Individual & Family

		Premium per Mode
Hospital Indemnity Coverage	Plan _____	$

Eligibility Questions

1.	Are you actively at work on a full time basis and able to perform the regular duties of your occupation? If "No", you and your dependents are not eligible for coverage.	☐ Yes ☐ No
2.	If applying for dependent coverage, is any proposed insured currently disabled? If "Yes", List name(s) _____, who will be excluded from coverage, unless included by special endorsement.	☐ Yes ☐ No
3.	Is anyone proposed for coverage covered by any Title XIX program (e.g. Medicaid)? If "Yes", List name(s) _____, who will be excluded from coverage, unless included by special endorsement.	☐ Yes ☐ No

STATEMENTS AND AGREEMENTS:

I have read or had read to me the completed enrollment form. I represent *(Residents of NW and VA:* I certify*)* that all statements and answers made on or attached to this enrollment form are true to the best of my knowledge and belief. I realize that any false statements herein which materially affect the acceptance of the risk or the hazard assumed may result in loss of coverage under the policy/certificate.

I have read the Fraud Warning for my state shown on the back of this form.

I understand that completion of this enrollment form in no way implies that I will be accepted for insurance coverage. I understand that coverage will take effect only if this enrollment form is approved by the Insurer and the first month's premium has been received by the Insurer, provided that I meet any eligibility or coverage effective date requirements listed in the policy/certificate.

The policy/certificate provides limited benefits. Review your policy/certificate carefully.

Signed in (City/State) _____ This _____ Day of (Month/Year) _____

Applicant's Signature _____ Spouse's Signature (if applicable) _____

AGENT'S STATEMENTS AND AGREEMENTS:

I hereby certify that I have accurately recorded in this enrollment form all of the information supplied by the enrollee. The enrollee has read or had read to him/her the completed enrollment form.

Licensed Agent/Representative's Name _____ Licensed Agent/Representative's Signature _____ Agent # _____

Fraud Warning

CA: I understand that any false statement made with actual intent to deceive or which materially affects either the acceptance of the risk or the hazard assumed could bar the right to receive benefits under the policy to which this application is attached.

AL, DC, LA, MN, & RI: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

FL: I understand that any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

KS: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may be guilty of insurance fraud as determined by a court of law.

KY: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, any information concerning any fact material thereto, commits a fraudulent insurance act which is a crime.

MA, NC & OR: I understand that any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, any information concerning any fact material thereto, commits a fraudulent insurance act which may be a crime and may subject such person to criminal and civil penalties.

MD: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NJ: I understand that any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

OK: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

TN & WA: It is a crime to knowingly present false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

VA: I understand that any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

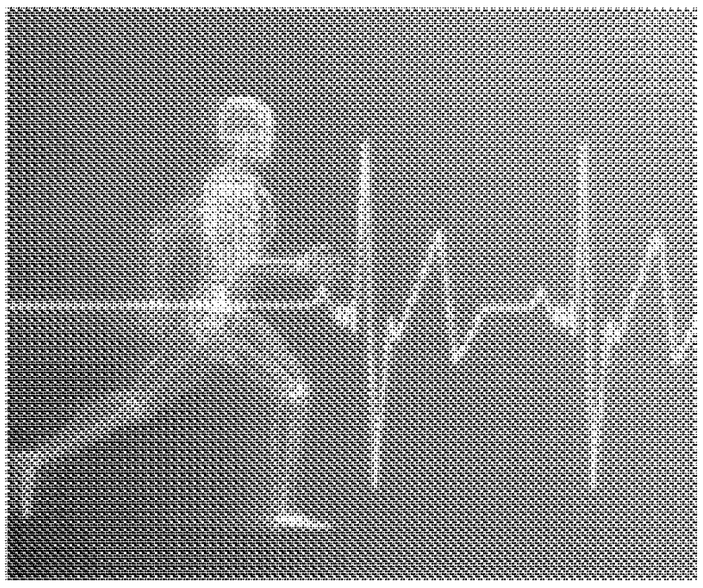
VT: I understand that any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, any information concerning any fact material thereto, may be committing a fraudulent insurance act which may be a crime subject to criminal and civil penalties.

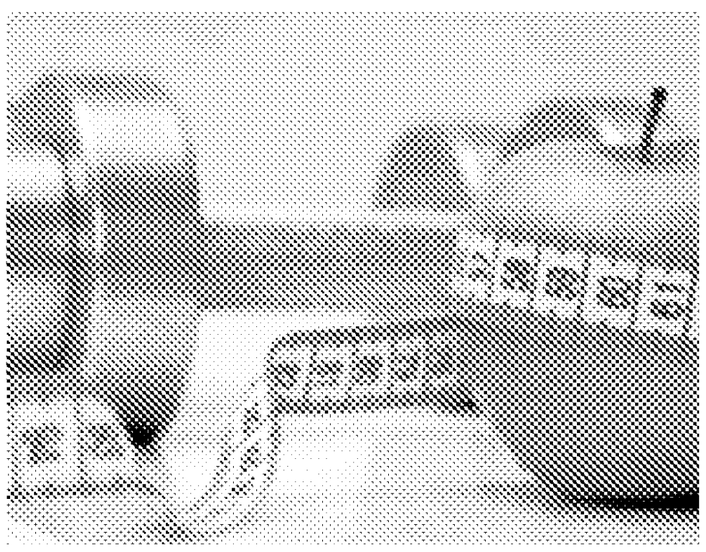
ME and all other states: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Exhibit 18

Exhibit 18

Mancha Companies





2015 Employee Benefit Guide

January 1, 2015 – December 31, 2015

MDC000770

CONTACT INFORMATION

Refer to this list when you need to contact one of your benefit vendors.
For general information contact Human Resources.

CUSTOMER SERVICE: KEY BENEFITS ADMINISTRATION

Member Services: (877) 851-0906

Hours: 8:00 am to 7:00 pm (EST)

PROVIDER NETWORK: MULTIPLAN

Member Services: (888) 342-7427

On-Line Services: www.multiplan.com

This guide is intended as only a summary of the benefit plans offered as of January 1, 2015, and is not meant to be a complete plan document.

Complete description of plan specifications, coverage, limitations and exclusions are provided in the appropriate summary plan description and/or plan document.

All plans are subject to policy provisions and limitations and may be amended, modified or terminated at any time with or without notice. Applicable federal, state and local laws govern all plans.

Participation in the employee benefit programs is in no way to be considered a contract of employment, implied or otherwise.

In case of discrepancy between the 2015 Benefit Guide and the actual plan documents, the actual plan documents will prevail.

MVP Plan

Full-time employees of Mancha Companies have the option to enroll in the ACA Minimum Value Plan.

Benefits	In-Network	Non-Network
Deductible	None	$500 Individual $1,000 Family
Maximum Out-of-Pocket	$1,850 Individual $12,700 Family	None
Office Visit Copay (Primary / Specialist)	$15 / $25 Copay	40% After Deductible
Preventative Care	No Charge	40% After Deductible
Basic X-Ray/Lab Work	$50 Copay	40% After Deductible
Complex X-Ray/Lab Work	$400 Copay	40% After Deductible
Emergency Room	$400 Copay	$400 Copay
Prescription Deductible	None	Plan Deductible
Prescription Copay (Generic / Brand / Non-Formulary)	$15 / $25 / $75	40% After Deductible

Plan Exclusions:

1) **Hospital inpatient services are not covered by the plan.** This means any inpatient service billed by the hospital.

2) Outpatient Surgery Physician/Surgical and Ambulatory Surgical Center services are not covered.

3) Specialty drugs are not covered.

4) Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services are not covered with the exception of services covered under the MEC benefits.

5) Rehabilitative Speech, Rehabilitative Occupational and Rehabilitative Physical Therapy services are not covered.

6) Skilled Nursing Facility services are not covered.

MDC000772

FREQUENTLY ASKED QUESTIONS:

What is covered in an emergency room visit?

Includes all services done in emergency room. Emergency room services will not be covered if admitted to hospital (stay over 24 hours). Emergency Room services are covered at the same rate for in and out of network providers.

Are services rendered in an urgent care facility covered?

Urgent Care is covered the same as the physician visit benefit. The exam and lab/x-ray benefit will be a separate copay as listed in the schedule of benefits. All surgeries including stitches, setting of broken bones, etc. are not covered.

Are maternity services covered? Pre-Post Natal Care? Ultrasound? Delivery?

Services for pregnancy and pre-natal care are covered. The pregnancy services listed under preventive care will be covered at the preventive benefit. Preventive care for maternity would include (but not limited to) pre-natal care, breastfeeding support and supplies, folic acid supplements and gestational diabetes screening. Ultrasounds and non-routine pregnancy services will be covered the same as any other illness. Delivery and inpatient charges including nursery are not covered.

Are mental health and substance abuse services covered?

Mental health and substance abuse services are not covered under the plan unless listed in the preventive care schedule (example, screenings for depression over age 12 are covered but treatment for depression is not covered).

Are contraceptives covered?

Approved contraceptives would be covered in-network at 100% at the pharmacy, as they are considered part of the preventive/wellness benefit.

Is surgery covered?

Surgery, whether inpatient, outpatient or in the office, is not covered under the plan unless it is listed under the preventive/wellness benefit, such as a routine colonoscopy. This includes stitches, removal of moles, setting of bones, etc.

How are MRI, CAT/CT, PET scans covered?

MRI, CAT/CT and PET scans are covered with a $400 copay and then at 100% per service. If rendered in an emergency room (ER) these would be covered under the ER copay and benefit. The $400 copay will cover the physician and facility charge when rendered on an outpatient basis in a hospital, independent clinic or office setting. The inpatient facility charge of an MRI, CT, PET scans is not covered.

What is covered when I go to the doctor's office?

If it is an illness or injury visit, the exam would be covered under the physician benefit after a copay. There is a difference between Primary Care Physician or Specialist exam copays (see summary below or plan document). Lab and x-ray's done in the office, again for illness or injury, are a separate benefit and copay for each service line billed. Wellness exams are covered under the preventive care/wellness benefit at 100% in network. Some lab and x-rays related to wellness may also be considered under this benefit. Surgery will not be covered.

FREQUENTLY ASKED QUESTIONS:

Is durable medical equipment and prosthetics covered?
All medical supplies, durable medical equipment and prosthetics are not covered under the plan.

Are biotechs/specialty medication covered?
All biotechs and specialty medications through either the pharmacy or other setting/place are not covered under the plan. This includes specialty medications given through infusion.

Are ambulance services covered?
Ambulance services are not covered. This includes ground, air, sea, etc.

Is chiropractic care covered?
Chiropractic care is not covered. This includes exam and all services rendered by a chiropractic provider.

Is infusion therapy, chemotherapy, or radiation covered?
Infusion, chemotherapy and radiation are not covered.

What preventive/routine services are covered?
Preventive care/wellness services will be covered in-network at 100% based on the 63 CMS mandated preventive care listing. Please see the plan document for the complete listing.

Are domestic partners covered?
Yes as long as the requirements stated in the plan document are met.

What is the benefit period?
The benefit period runs from January to December.

Are injections or shots covered?
Injections, whether inpatient, outpatient or in the office, are not covered under the plan unless it is listed under the preventive/wellness benefit, such as a routine immunization. This includes antibiotics, steroids, allergy injections, etc.

How is a healthcare provider defined?
Healthcare providers are defined as physicians or licensed healthcare professionals that are acting within the scope of their license. This includes physician assistants, nurse practitioners, licensed clinical social workers, etc.

How is the allowed amount for out of network claims determined?
The 90th percentile of usual and customary will be used.

Are inpatient services covered?
Inpatient facility services are not covered. Physician visits performed while inpatient will be covered under the physician benefit with the copay stated in the schedule of benefits.

Deductible

Type	Network	Non-Network	Limitations
Individual	$0 – No deductible	$500	Not applicable

Coinsurance

	100%	40%	Not applicable

Out-of-Pocket Maximums

Individual Maximum	$1,850 per covered person, per plan year	No maximum	Copays apply to out-of-pocket. When the out-of-pocket per plan year has been reached, no additional copays will be applied. In-network out-of-pocket separate from non-network out-of-pocket.
Family Maximum	$12,700 Per covered family, per plan year	No maximum	

Hospital Services

All Inpatient Hospital Services	Not Covered	Not Covered	Includes all services billed by any facility when admitted (stay over 24 hours)
Miscellaneous Charges	Not Covered	Not Covered	Includes inpatient and outpatient miscellaneous services, including but not limited to chemotherapy and infusion.
Outpatient Surgery	Not Covered	Not Covered	Not applicable
Emergency Room (ER)	$400 copay, then paid at 100%	$400 copay, then paid at 100%	Copays apply to the network out-of-pocket maximum. Includes all services done in ER. ER services will not be covered if admitted to hospital. One copay for physician and facility per ER visit.
Lab & X-ray: outpatient facility	$50 copay, then paid at 100%	40% after deductible	Copay will apply per service line billed. Copay applies to the out-of-pocket maximum. Does not include inpatient facility charges. Does not include CT/PET Scan and MRIs.

Physician Services

Primary Care Physician (PCP)	$15 copay, then paid at 100%	40% after deductible	Allowed with copay only for visit for illness or injury. Visit will be allowed for any place of service or location. This benefit does not include services other than visit/exam. Copay applies to the out-of-pocket maximum.
Specialist	$25 copay, then paid at 100%	40% after deductible	Allowed with copay only for visit for illness or injury. Visit will be allowed for any place of service or location. This benefit does not include services other than visit/exam. Copay applies to the out-of-pocket maximum.
Surgery – in office, outpatient facility, inpatient facility	Not Covered	Not Covered	Not applicable
Medical equipment & supplies	Not Covered	Not Covered	Includes durable medical equipment, prosthetics and general supplies.
Lab & X-ray: in office & non-office outpatient facility	$50 copay, then paid at 100%	40% after deductible	Copay will apply per service line billed. Copay applies to the out-of-pocket maximum. Does not include inpatient facility charges. Does not include CT/PET Scan and MRIs.
Imaging: CT/PET scan and MRIs	$400 copay, then paid at 100%	40% after deductible	Copay will apply per service line billed. Copay applies to the out-of-pocket maximum. Does not include inpatient facility charges.
Emergency Room (ER) physician visit	$400 copay, then paid at 100%	$400 copay, then paid at 100%	Copays apply to the network out-of-pocket maximum. One copay for physician and facility per ER visit.
Preventive/Wellness	100%	40% after deductible	Limited only to CMS mandated preventive services – See separate plan document for complete listing.

Unless covered under Preventive/Wellness or CDM benefit excludes (but not limited to) services for: maternity care, medical or allergy injections, mental health, substance abuse, durable medical equipment, prosthetics, home health care, hospice, TMJ, specialty/biotech medications, physical therapy, occupational therapy, speech therapy, chiropractic care, infusion therapy, radiation and chemotherapy. See exclusions for complete list.

Prescription Drugs – copays apply toward the medical out-of-pocket

Service	Benefit	Limitations
Generic Drugs	$15 copay per prescription or refill	Limited to a 34-day supply
Preferred Drugs	$25 copay per prescription or refill	Limited to a 34-day supply
Non-Preferred Drugs	$75 copay per prescription or refill	Limited to a 34-day supply
Mail-In Generic Drugs	$37.50 copay per prescription or refill	Limited to a 90-day supply
Mail-In Preferred Drugs	$62.50 copay per prescription or refill	Limited to a 90-day supply
Mail-In Non-Preferred Drugs	$187.50 copay per prescription or refill	Limited to a 90-day supply
Biotech/Specialty Drugs	Not Covered	Not Covered

Chronic Disease Management (CDM) Benefits

The listed chronic diseases below shall have the listed services (service details listed in full plan document) rendered by a network provider payable at 100% and not subject to the copay. Non-network services shall be payable according to the standard plan benefits. Once the service maximum benefit has been met, eligible charges shall be payable according to the standard plan benefits.

The provider must provide the appropriate billing including diagnosis code and procedure/CPT code for the Chronic Disease Management benefit to apply. If a covered person has more than one CDM diagnosis, the primary diagnosis billed will determine the benefit payable.

*The services listed below are the standard laboratory and diagnostic procedure for each disease.

Asthma	2 Office exams per plan year *Spirometry
Atherosclerosis (Peripheral Vascular Disease)	1 Office exam per plan year *Lipid panel
Atrial Fibrillation	1 Office exam per plan year *EKG *Prothrombin times
Chronic Obstructive Pulmonary Disease	2 Office exam per plan year *Spirometry
Chronic Renal Insufficiency	2 Office exam per plan year * Creatinine *Completed blood count (CBC) *Electrolytes *Urine protein *Serum calcium *Serum phosphorus *Lipid panel
Congestive Heart Failure	2 Office exams per plan year *BUN *Creatinine *Potassium
Coronary Artery Disease	1 Office exam per plan year *Lipid panel *EKG *Cholesterol
Diabetes	2 Office exams per plan year *Glycohemoglobins *Microalbumin *Lipid panel
Epilepsy	1 Office exam per plan year
Human Immunodeficiency Virus Infection	1 Office exams per plan year *T-Cell/CD-4 counts *HIV quantifications *Pap smear (women only) *PPD *Complete blood count (CBC)
Hyperlipidemia	1 Office exam per plan year *Lipid panel *Cholesterol

Hypertension	2 Office exams per plan year
Hyperthyroidism	1 Office exam per plan year *Thyroid stimulating hormone (TSH) *Thyroxine (T4)
Hypothyroidism	1 Office exam per plan year *Thyroid stimulating hormone (TSH) *Thyroxine (T4)
Metabolic Syndrome	1 Office exam per plan year *Lipid panel *Glucose FBS or Hemoglobin A1c (HgbA1c)
Multiple Sclerosis	2 Office exams per plan year
Parkinson's Disease	2 Office exams per plan year
Pre-diabetes	1 Office exam per plan year *Lipid panel *Glucose FBS or Hemoglobin A1c (HgbA1c)
Polymyalgia Rheumatica	2 Office exams per plan year *Erythrocyte sedimentation rate (ESR) or C-reactive protein (CRP) *Complete blood count (CBC)
Pulmonary Hypertension (unrelated to COPD)	2 Office exams per plan year
COPD with Pulmonary Hypertenstion/COR Pulmonale	2 Office exams per plan year *Spirometry *12 months of supplemental 02 Tx
Rheumatoid Arthritis	1 Office exams per plan year *Complete blood count (CBC)
Sleep Apnea	1 Office exam per plan year
Chronic Venous Thrombotic Disease	2 Office exams per plan year
Ulcerative Colitis (Inflammatory Bowel Disease)	1 Office exam per plan year *Complete blood count *LFT

KEY BENEFIT ADMINISTRATORS

KEYSOLUTION

Minimum Value Plan (MVP) Enrollment Form

1. Enrollee Information

Group Name:		Employee's Original Start Date:	
Last Name:		Date you became a Full time Employee:	
First Name:		Date of Birth (DOB):	
Sex: ☐M ☐F	SS #:	No. Hours Work/per week:	
Home Phone #:		Work Phone #:	
Street Address:	City:	State:	Zip:
Please check one of the following: ☐New employee OR ☐ Current employee newly eligible for benefits OR ☐New Group Enrollment			
Plan Selection:			
Beneficiary of Life Insurance	Full name, address and phone number:	Relationship:	

2. Dependent Information

I would like to be covered under this plan along with the following dependents:					
❑Spouse ❑Domestic Partner	Last Name:	First:	SS#:	DOB:	❑Male ❑Female
Last Name:		First:	SS#:	DOB:	❑Male ❑Female
❑Child ❑Disabled[1] ❑Court Ordered[2]					
Last Name:		First:	SS#:	DOB:	❑Male ❑Female
❑Child ❑Disabled[1] ❑Court Ordered[2]					
Last Name:		First:	SS#:	DOB:	❑Male ❑Female
❑Child ❑Disabled[1] ❑Court Ordered[2]					
Last Name:		First:	SS#:	DOB:	❑Male ❑Female
❑Child ❑Disabled[1] ❑Court Ordered[2]					
Last Name:		First:	SS#:	DOB:	❑Male ❑Female
❑Child ❑Disabled[1] ❑Court Ordered[2]					
Last Name:		First:	SS#:	DOB:	❑Male ❑Female
❑Child ❑Disabled[1] ❑Court Ordered[2]					

[1]For disabled dependents; SUBMIT appropriate documentation as proof of disabled status with this enrollment form.
[2]If a court decree requires you to cover your dependent under this plan, SUBMIT that portion of the court decree with this enrollment form.

I hereby apply for participation in my Minimum Value Benefit Plan for myself and/or my dependents listed above and agree to abide by the terms, provisions and limitations as outlined by the Plan Sponsor in the issuance of the Summary Plan Description. I declare all statements contained in this entire form are true and correct and that no material information has been withheld or omitted. I agree that no benefits will be effective until the date specified by Key Benefit Administrators. I agree a photographic copy of this authorization shall be as valid as the original and that said authorization shall be valid for the maximum length of time permitted by law. I understand that I have the right to receive a copy of this authorization upon request. I authorize my employer to deduct from earnings the contributions (if any) required toward the benefits.

☐ I am waiving/declining coverage for myself and all dependents

Employee (print name): ______________________ **Employee Signature:** ______________________Date:_________

Revised 7-15-14

MDC000777

Exhibit 19

Exhibit 19

EIGHTH JUDICIAL DISTRICT COURT

IN AND FOR CLARK COUNTY, STATE OF NEVADA

PAULETTE DIAZ, an individual; LAWANDA GAIL WILBANKS, an individual; SHANNON OLSZYNSKI, an individual; and CHARITY FITZLAFF, an individual, on behalf of themselves and all similarly-situated individuals,

Plaintiffs,

vs. No. A-14-701633-C

MDC RESTAURANTS, LLC, a Nevada limited liability company; LAGUNA RESTAURANTS, LLC, a Nevada limited liability company; INKA, LLC, a Nevada limited liability company, and DOES 1 through 100, Inclusive,

Defendants.

DEPOSITION OF TERRY DIGIAMARINO

Irvine, California

Thursday, March 12, 2015

Reported by:

CARA JACOBSEN

CSR NO. 13053

Job No. 2022661

Pages 1 - 109

EIGHTH JUDICIAL DISTRICT COURT

IN AND FOR CLARK COUNTY, STATE OF NEVADA

PAULETTE DIAZ, an individual; LAWANDA GAIL WILBANKS, an individual; SHANNON OLSZYNSKI, an individual; and CHARITY FITZLAFF, an individual, on behalf of themselves and all similarly-situated individuals,

Plaintiffs,

vs. No. A-14-701633-C

MDC RESTAURANTS, LLC, a Nevada limited liability company; LAGUNA RESTAURANTS, LLC, a Nevada limited liability company; INKA, LLC, a Nevada limited liability company, and DOES 1 through 100, Inclusive,

Defendants.

Deposition of TERRY DIGIAMARINO, taken on behalf of Defendant, at 2050 Main Street, Suite 900, Irvine, California, beginning at 9:06 a.m. and ending at 12:51 p.m. on Thursday, March 12, 2015, before CARA JACOBSEN, Certified Shorthand Reporter No. 13053.

APPEARANCES:

For the Defendant:

LITTLER MENDELSON
BY: RODGER L. GRANDGENETT II
Attorney at Law
3960 Howard Hughes Parkway
Las Vegas, Nevada 89169
702.862.8800

For the Plaintiff:

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Irvine, California, Thursday, March 12, 2015

9:06 a.m. - 12:51 p.m.

TERRY DIGIAMARINO,

having been first placed under oath,

was examined and testified as follows:

EXAMINATION

BY MR. BRAVO:

Q We've met, but may you please state your name for the record.

A It's --

Q And spell it.

A And spell it? It's Terry Digiamarino. And it's T-e-r-r-y, D-i-g-i-a-m-a-r-i-n-o.

Q May I call you Terry?

A Yes, please.

Q My name is Daniel Bravo. I'm an attorney at Wolf Rifkin in Las Vegas. And we are here today for your deposition pursuant to a notice of taking a deposition in the case of Diaz, et al, versus MDC Restaurants LLC, Laguna Restaurants LLC and Inka LLC.

Terry, where do you currently reside?

A My full address?

policy for the hourly employees in Nevada, do you have any role in providing the information to employees?

A Not as a responsibility. But I pitch in and do help out if they call in and need information. Or send out -- you know, if the manager asks, I can send out the summary to them or the rates. Because I have all that because I need to know for payroll purposes.

Q Okay. Do you know what the current plan is for 2015 for insurance in Nevada?

A For hourly, it's called an MVP.

Q Prior to MVP, do you know what plan was in place for hourly employees in Nevada?

A Transamerica.

Q And prior to Transamerica, do you know what plan was in place for Nevada hourly employees during your tenure?

A Starbridge. Cigna. Starbridge.

Q Presently, every hourly employee in Nevada is offered the same MVP plan?

A Every hourly employee that's offered insurance is offered the same plan, yes.

Q Does the MVP plan provide dental?

A Separate. Totally separate.

Q Does the MVP plan provide vision?

A It's totally separate.

Q Do you know what the MVP plan provides Nevada hourly employees?
A No.
Q Prior to the MVP plan, was the Transamerica or TransChoice plan provided to all Nevada hourly employees?
A Yes.
Q Prior to Transamerica/TransChoice plan, was the Starbridge offered to all hourly employees?
A Yes.
Q Has the dental plan changed from Guardian? To Guardian? Excuse me. Was there -- was there a dental plan prior to Guardian?
A Yes.
Q What was that?
A Assurant.
Q Were Nevada hourly employees offered Assurant?
A Yes.
Q Was every hourly employee offered Assurant?
A Yes.
Q And was there a different vision plan prior to VSP?
A Not since I've been there, no.
Q Okay. The -- do you know if the VSP plan was always offered to hourly employees since you began?

I, the undersigned, a Certified Shorthand Reporter of the State of California, Registered Professional Reporter, do hereby certify:

That the foregoing proceedings were taken before me at the time and place herein set forth; that any witnesses in the foregoing proceedings, prior to testifying, were duly sworn; that a record of the proceedings was made by me using machine shorthand which was thereafter transcribed under my direction; that the foregoing transcript is a true record of the testimony given.

Further, that if the foregoing pertains to the original transcript of a deposition in a Federal Case, before completion of the proceedings, review of the transcript [ ] was [ ] was not requested.

I further certify I am neither financially interested in the action nor a relative or employee of any attorney or party to this action.

IN WITNESS WHEREOF, I have this date subscribed my name.

Dated: 03/26/2015

<%signature%>

CARA JACOBSEN

CSR No. 13053

Exhibit 20

Exhibit 20

Wolf, Rifkin, Shapiro, Schulman & Rabkin, LLP

LOS ANGELES

LAS VEGAS

RENO

With offices in California and Nevada, Wolf Rifkin Shapiro Schulman & Rabkin, LLP has been a leader in the Community Association Industry for over 25 years. The firm currently represents over 3,500 associations. The firm's association clients range from two units to 18,000 units, and include all types of multi-family housing, high rise luxury developments, planned unit developments (attached and stand-alone), condominiums and cooperatives.

Wolf Rifkin Shapiro Schulman & Rabkin, LLP is recognized for its superior representation in all aspects of the law including:

- Arbitration of Owner Disputes
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- Drafting, Interpretation and Enforcement of Bylaws and CC&Rs
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- Participation in Homeowner Meetings and Elections
- Regulatory Compliance Training and Advice

Education and training are fundamentals of the firm's commitment to its clients and the industry. Wolf Rifkin Shapiro Schulman & Rabkin attorneys and staff are active in community association trade organizations and present seminars and classes in association law and management. The firm has not only developed and provided State certification training for the industry, but has dedicated staff to offer and further those efforts.

The firm is dedicated to helping the industry deal with the complexity of the legislation that surrounds the industry in California and Nevada. Our staff actively works, by serving on legislative action committees, to help provide wording for changes and/or defeating legislation that would adversely affect all owners who live in a common interest community.

Meeting day-to-day association concerns is an integral part of our service to our community association clients. The firm recognizes the need for rapid responses to difficult business, homeowner and compliance issues facing the community association on a daily basis. Wolf Rifkin Shapiro Schulman & Rabkin, LLP takes pride in our knowledge of, and experience in, every facet of community association law and its ability to be available for our clients when the need arises.

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Document title: Plaintiffs' Motion for Class Certification Pursuant to N.R.C. P. 23
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VOLUME 3

IN THE SUPREME COURT OF THE STATE OF NEVADA

MDC RESTAURANTS, LLC, a Nevada limited liability company; LAGUNA RESTAURANTS, LLC, a Nevada limited liability company; INKA, LLC, a Nevada limited liability company, Petitioners, vs. THE EIGHTH JUDICIAL DISTRICT COURT OF THE STATE OF NEVADA in and for the County of Clark and THE HONORABLE TIMOTHY C. WILLIAMS, District Court Judge, Respondents, vs. PAULETTE DIAZ, an individual; LAWANDA GAIL WILBANKS, an individual; SHANNON OLSZYNSKI, an individual; and CHARITY FITZLAFF, an individual, on behalf of themselves and all similarly-situated individuals, Real Parties in Interest.	**Case No.** District Court Case No. A-14-701633-C District Court Dept. No. XVI

PETITIONERS' APPENDIX

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July 16, 2015 Supplemental Brief in Support of Plaintiffs' Motion for Class Certification Pursuant to N.R.C.P. 23	Vol. 5	770-819

PROOF OF SERVICE

I am a resident of the State of Nevada, over the age of eighteen years, and not a party to the within action. My business address is 3960 Howard Hughes Parkway, Suite 300, Las Vegas, Nevada 89169. On July 30, 2015, I served the within document:

PETITIONERS APPENDIX

☒ Via **Electronic Service** - pursuant to N.E.F.C.R Administrative Order: 14-2.

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Bradley Schrager, Esq.
Daniel Bravo, Esq.
Wolf, Rifkin, Shapiro, Schulman & Rabkin, LLP
3556 E. Russell Road, 2nd Floor
Las Vegas, NV 89120-2234
Attorneys for Real Party in Interest

Honorable Timothy C. Williams
Eighth Judicial District Court, Dept. 16
200 Lewis Avenue
Las Vegas, NV 89155
Respondents

I declare under penalty of perjury that the foregoing is true and correct. Executed on July 30, 2015, at Las Vegas, Nevada.

/s/ Erin J. Melwak
Erin J. Melwak

Firmwide:135026506.1 081404.1002

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EIGHTH JUDICIAL DISTRICT COURT

IN AND FOR CLARK COUNTY, STATE OF NEVADA

PAULETTE DIAZ; LAWANDA GAIL WILBANKS; SHANNON OLSZYNSKI; and CHARITY FITZLAFF, all on behalf of themselves and all similarly-situated individuals,

Plaintiffs,

vs.

MDC RESTAURANTS, LLC; LAGUNA RESTAURANTS, LLC; INKA, LLC; and DOES 1 through 100, Inclusive,

Defendants.

Case No.: A701633
Dept. No.: XVI

PLAINTIFFS' MOTION FOR CLASS CERTIFICATION PURSUANT TO N.R.C.P. 23

Hearing Date: 7/9/15
Hearing Time: 9:00am

COME NOW Plaintiffs, by and through her attorneys of record, and hereby move for an order certifying this action as a class action pursuant to N.R.C.P. 23. The motion is based on the Memorandum of Points and Authorities below, the papers and exhibits on file, the declarations of Plaintiffs Paulette Diaz (**Exhibit 1**), Shannon Olszynski (**Exhibit 2**), Lawanda Wilbanks (**Exhibit 3**), and Charity Fitzlaff (**Exhibit 4**), and attorneys Bradley Schrager, Esq. (**Exhibit 5**) and Don Springmeyer, Esq. (**Exhibit 6**), and any oral argument this Court sees fit to allow at hearing on this matter.

NOTICE OF MOTION

TO: ALL PARTIES AND THEIR COUNSEL OF RECORD:

Please take notice that the undersigned will bring **PLAINTIFFS' MOTION FOR CLASS CERTIFICATION PURSUANT TO N.R.C.P. 23** on for hearing before this Court at the Eighth Judicial District Court, 200 Lewis Avenue, Las Vegas, Nevada 89155, on 7/9/15 at 9:00 a.m./~~p.m.~~ in Dept. XVI or as soon thereafter as counsel can be heard.

DATED this 8th day of June, 2015.

WOLF, RIFKIN, SHAPIRO, SCHULMAN & RABKIN, LLP

By: */s/ Bradley Schrager*

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MEMORANDUM OF POINTS AND AUTHORITIES

I. INTRODUCTION

Since the passage by Nevada voters of Question 6 in November of 2006, workers in this State have been subject to a two-tiered minimum hourly wage requirement. Nev. Const. art. XV, § 16 (the "Minimum Wage Amendment" or the "Amendment"). Employers must pay their employees at the upper-tier hourly level, but may qualify for the privilege of paying between the lower and upper-tier if they provide comprehensive, low-cost health insurance benefits to their workers. Currently, the wage-tiers are $7.25 and $8.25 per hour.[1] Defendants here did not provide Plaintiffs or members of the putative Class with qualifying health insurance benefits, yet paid those employees below the mandated upper-tier minimum hourly wage.

The questions concerning Plaintiffs and the proposed Class are straightforward. Did Defendants pay Class members below the upper-tier hourly wage? If so, they had to meet the constitutional mandate regarding provision of benefits. If they did not qualify to pay a lower wage—either by offering a health insurance benefits plan that did not meet coverage requirements, by offering a plan where employee premium costs exceeded legal limits, or by not offering a qualifying plan at all—then Defendants are liable to Plaintiffs and the Class for back pay, damages, and other associated relief. All employees paid below the upper-tier minimum hourly wage are necessarily similarly situated because Defendants would have had to arrange for health insurance benefits coverage common to all Plaintiffs and Class members in order to pay any of them less than $8.25 per hour. *See* N.A.C. 608.102(2)(a).

The proposed Class definition encompasses all of Defendants' employees paid below the upper-tier minimum hourly wage level pursuant to the Minimum Wage Amendment during the

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[1] Since November 28, 2006, the Minimum Wage Amendment has been subject to an indexing mechanism, and the state minimum wage rate has interacted with the federal minimum wage rate over the last nine years. *See* Nev. Const. art. XV, § 16(A). On July 1, 2010, the upper-tier rate for employees who are not provided qualifying health insurance benefits was raised to $8.25 per hour, and the lower-tier rate for employees who are provided qualifying health insurance benefits was raised to $7.25 per hour. *See* Nevada Minimum Wage Announcement, Office of the Nevada Labor Commissioner, 2010-2015. The upper-tier and lower-tier rates have remained unchanged since that time. *Id.*

appropriate limitations period. Defendants procure, and procured, health insurance benefit plans they purported to offer to all of their minimum wage employees. The plans Defendants purportedly offered to Plaintiffs were the same plans Defendants claimed to have made available to every hourly employee paid below the upper-tier minimum hourly wage. The Class mechanism, therefore, is perfectly suited to this action because the same question can be answered on a class-wide basis: whether Defendants claimed provision of health insurance supports Defendants eligibility to pay below the upper-tier minimum wage rate. Put simply: If Defendants claimed the privilege to pay any employee less than the upper-tier minimum wage, it has to be for the same reasons as for all others—that they claimed to have provided qualifying health insurance benefits to all of them.

The allegations in the Amended Complaint are clear: Each of the Plaintiffs alleges that she was paid below the upper-tier minimum wage by Defendants, and that they each have not been provided qualifying health insurance benefit plans by Defendants. The proposed Class is comprised of those employees of Defendants who are similarly-situated: like Plaintiffs, paid below the upper-tier minimum hourly wage level and not provided with qualifying health insurance plan benefits.

The proposed Class is numerous, counting in the thousands, which Defendants have confirmed in discovery responses, disclosures, and deposition testimony. The questions of law and fact regarding Defendants' eligibility to pay below the upper-tier hourly wage are clearly common to all employees paid below that level. Plaintiffs, as current and former employees of Defendants paid at the lower hourly minimum wage and alleging they were not provided or offered qualifying benefits plans, are typical of the Class they seek to represent, and suffered the same injuries as the Class due to Defendants' conduct in underpaying on the basis of non-qualifying health insurance benefit plans. Plaintiffs are adequate representatives of the Class, as no conflicts among them arise from their common effort to recover years of lost wages as well as appropriate damages. Further, the common questions among Plaintiffs and all Class members predominate entirely, and a class action is superior to any other method of adjudicating the claims made herein. Class certification, therefore, is appropriate and necessary to redress the injuries alleged in the Amended Complaint.

II. THE PROPOSED CLASS

Plaintiffs move for certification of the following proposed Class:

> **All current and former employees of Defendants at all Nevada locations at any time during the applicable period of limitation who were compensated at less than the upper-tier hourly minimum wage set forth in Nev. Const. art XV, § 16.**

The proposed Class is easily ascertainable, identifiable, and manageable from employment records necessarily kept by Defendants, and encompasses the community of interest sought to be protected by the passage by Nevada voters of the Minimum Wage Amendment. The named Plaintiffs seek appointment as representatives of the Class.

This motion is made on the grounds that the proposed Class is sufficiently numerous such that joinder is impracticable; there are questions of law and fact common to the Class; the respective named Plaintiffs' claims are typical of the Class' claims; and the respective named Plaintiffs will adequately represent the Class. *See* N.R.C.P. 23(a). Certification of the Class is appropriate under N.R.C.P. 23(b)(3) because common questions predominate over any questions affecting only individual Class members, and class resolution is superior to other available methods for the fair and efficient adjudication of the controversy. *See id*.

III. FACTUAL BACKGROUND

A. Plaintiffs

Plaintiffs are all current or former employees of Defendants in Nevada at Denny's or Coco's restaurants (the "Restaurants"). *See* Amend. Compl. ¶¶ 14-17, 24, 27, 30, 33. All of them were paid by Defendants below the upper-tier minimum hourly rate set pursuant to the Minimum Wage Amendment. *See id*. All of them allege that Defendant have not provided them with qualifying health insurance plan benefits such that wage payments below the upper-tier level are permissible. *See id*. ¶¶ 25, 28, 31, 34; *see also* Diaz Decl. ¶¶ 7-8 (**Ex. 1**); Olszynski Decl. ¶ 7 (**Ex. 2**); Wilbanks Decl. ¶¶ 8-9 (**Ex. 3**); Fitzlaff Decl. ¶ 7 (**Ex. 4**).

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B. Defendants

Defendant MDC Restaurants, LLC owns and operates approximately twenty-two (22) Denny's restaurants (the "MDC Restaurants") in Nevada at which Plaintiffs Diaz and Wilbanks and Class members work or did work.[2] *See* Defs.' Ans. ¶¶ 14-15. Defendant INKA, LLC owns and operates approximately four (4) Denny's restaurants (the "INKA Restaurants") in Nevada at which Plaintiffs Olszynski and Fitzlaff and Class members work or did work.[3] *See id*. ¶¶ 16-17. Defendant Laguna Restaurants, LLC owns and operates approximately two (2) Denny's or other-branded restaurants (the "Laguna Restaurants") in Nevada at which Class members work or did work.[4] Defendants, through Mancha Development Co., create and impose uniform wage and benefit policies and practices at all the Restaurants, and maintain centralized human resource functions to implement those policies and practices at the Restaurants, and contract and arrange for the same health insurance benefits policies that each Defendant claims as the basis for paying Plaintiffs and Class members less than the upper-tier hourly minimum wage rate. *See* Amend. Compl. ¶¶ 36-38.

II. PROCEDURAL BACKGROUND

Plaintiffs filed their initial Complaint on May 30, 2014, and the Amended Complaint on June 5, 2014. *See* Pls.' Compl.; Pls.' Amend. Compl. Defendants answered the Amended Complaint on July 22, 2014. *See* Defs.' Ans. A number of motions for partial summary judgment or judgment on the pleadings on discrete issues have also been filed by the parties, including: Defendants' Motion for Judgment on the Pleadings with Respect to All Claim for Damages Outside

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[2] Asked in Class Interrogatory No. 9 to list its Denny's or Coco's restaurant locations in Nevada, Defendant MDC provided a list of twenty-two (22) separate stores in operation during the appropriate limitations period. *See* document produced as MDC000158, offered in response to propounded interrogatories, an accurate copy of which is attached as **Exhibit 7**.

[3] Asked in Class Interrogatory No. 9 to list its Denny's or Coco's restaurant locations in Nevada, Defendant INKA provided a list of four (4) separate stores in operation during the appropriate limitations period. *See* Defendant INKA's Response to Class Interrogatory No. 9, an accurate copy of which is attached as **Exhibit 8**.

[4] Asked in Class Interrogatory No. 39 to list its Denny's or Coco's restaurant locations in Nevada, Defendant Laguna provided a list of two (2) separate stores in operation during the appropriate limitations period. *See* Defendant Laguna's Response to Third Set of Interrogatories, an accurate copy of which is attached as **Exhibit 9**.

the Two-Year Statute of Limitations; Plaintiffs' Countermotion for Partial Summary Judgment Regarding Limitation of the Action; and Plaintiff Diaz's Motion For Partial Summary Judgment on Liability to Plaintiff Diaz's First Claim for Relief.

III. ARGUMENT

The language of Rule 23 of the Nevada Rules of Civil Procedure is similar to its federal counterpart. *Compare* N.R.C.P. 23 *with* F.R.C.P. 23. Nevada courts therefore routinely look to federal case law for guidance on class certification issues. See *Beazer Homes Holding Corp. v. Dist. Ct.*, 128 Nev. Adv. Op. 66, 291 P.3d 128, 135 n. 4 (2012) (citing approvingly federal precedent on Rule 23); *Shuette v. Beazer Homes Holdings Corp.*, 121 Nev. 837, 847, 124 P.3d 530, 537-38 (2005) (citing approvingly "analogous" Sixth Circuit analysis of F.R.C.P. 23).

"[T]he determination to use the class action is a discretionary function wherein the district court must pragmatically determine whether it is better to proceed as a single action, or many individual actions in order to redress a single fundamental wrong." *Deal v. 999 Lakeshore Ass'n*, 94 Nev. 301, 306, 579 P.2d 775, 778-79 (1978). Class actions serve three essential purposes: (1) to facilitate judicial economy by the avoidance of multiple suits on the same subject matter; (2) to provide a feasible means for asserting the rights of those who would have no realistic day in court if a class action were not available; and (3) to deter inconsistent results, assuring a uniform, singular determination of rights and liabilities. *American Pipe and Constr. Co. v. Utah*, 414 U.S. 538, 550, 94 S. Ct. 756, 764-65 (1974); *In re Syncor Erisa Litig.*, 227 F.R.D. 338, 343 (C.D. Cal. 2005).

N.R.C.P. 23 should be given a liberal rather than a restrictive interpretation. "[I]f there is to be an error made, let it be in favor and not against the maintenance of the class action." *Esplin v. Hirschi*, 402 F.2d 94, 99 (10th Cir. 1968), *cert. denied*, 394 U.S. 928 (1969); *see also Joseph v. Gen. Motors Corp.*, 109 F.R.D. 635, 638 (D. Colo. 1986) (noting that any doubts should be resolved in favor of class certification). Most importantly, Nevada has a strong public policy in favor of class actions in order to provide multiple plaintiffs who individually may have a valid but small claim, an adequate remedy at law. *Picardi v. Eighth Judicial Dist. Court of State, ex rel. County of Clark*, 127 Nev. Adv. Op. 9, 251 P.3d 723, 727 (2011).

Here, certification is appropriate under Rule 23(b)(3) because "questions of law or fact common to class members predominate over any questions affecting only individual members, and that a class action is superior to other available methods for fairly and efficiently adjudicating the controversy." *See* N.R.C.P. 23(b)(3). In determining whether class certification is appropriate, the Court need not—and, where possible, should not—reach resolution of the substantive merits of the claims. The trial court "should generally accept the allegations of the complaint as true; an extensive evidentiary showing is not required." *Meyer v. Eighth Judicial Dist. Court*, 110 Nev. 1357, 1363-64, 885 P.2d 622, 626 (1994). Rule 23(b)(3) requires only "a showing that questions common to the class predominate, not that those questions will be answered, on the merits, in favor of the class." *Abdullah v. U.S. Sec. Associates, Inc.*, 731 F.3d 952, 964 (9th Cir. 2013) (internal quotations and citations omitted). Applying these principles, class certification is appropriate in this action.

A. Class Certification Is Appropriate Under N.R.C.P. 23(a)

Under N.R.C.P. 23(a), plaintiffs seeking to certify a case as a class action must establish four prerequisites. *See Shuette*, 121 Nev. at 846; *Staton v. Boeing Co.*, 327 F.3d 938, 953 (9th Cir. 2003); *Amchem Products, Inc. v. Windsor*, 521 U.S. 591, 117 S. Ct. 2231 (1997). First, the *numerosity* prerequisite requires that the members of a proposed class be so numerous that separate joinder of each member is impracticable. N.R.C.P. 23(a)(1). Second, the *commonality* prerequisite requires questions of law or fact common to each member of the class. N.R.C.P. 23(a)(2). Third, *typicality* demands a showing that the representative parties' claims or defenses are typical of the class's claims or defenses. N.R.C.P. 23(a)(3). Finally, under the *adequacy* prerequisite, the parties must be able to fairly and adequately protect and represent each class member's interests. N.R.C.P. 23(a)(4).

Plaintiffs address each requirement of N.R.C.P. 23(a) in turn below, and demonstrate that all four are met in this instance.

1. The Proposed Class Satisfies the Numerosity Requirement of Rule 23(a)(1)

It must be shown that the putative class has so many members that joinder of all members is

impracticable. The United States Supreme Court has cautioned that "[t]he numerosity requirement requires examination of the specific facts of each case and imposes no absolute limitations." *General Tel. Co. of the Northwest, Inc. v. Equal Employment Opportunity Comm'n*, 446 U.S. 318, 330, 100 S. Ct. 1698 (1980). Although courts agree that numerosity mandates no minimum number of individual members, a putative class of forty or more generally will be found to satisfy this requirement. *See Shuette*, 121 Nev. at 847 (holding that numerosity is generally satisfied when there are at least 40 or more class members); *Mazza v. AM. Honda Motor Co.*, 254 F.R.D. 610, 617 (C.D. Cal. 2008) ("As a general rule, classes of forty or more are considered sufficiently numerous."). Plaintiffs need not state exact figures of total potential Class members; instead, they can satisfy the numerosity requirement by providing reasonable estimates. *See Sobel v. Hertz Corp.*, 291 F.R.D. 525, 541 (D. Nev. 2013). Plaintiffs need only demonstrate that the Class "is so large that proceedings as a class action is the only manageable method of resolving the controversy." *Cummings v. Charter Hosp. of Las Vegas, Inc.*, 111 Nev. 639, 643-44, 896 P.2d 1137, 1140 (1995).

Here, Defendants have stated in depositions and in discovery responses that, apart from the named Plaintiffs whom have alleged payments at less than the upper-tier minimum wage under the Nevada Constitution, Defendant MDC paid **2,100** employees below the upper-tier during the period between July 1, 2010 and March 26, 2015. *See* Defendant MDC's Supplemental Response to Class Interrogatory No. 5, an accurate copy of which is attached as **Exhibit 10**. Defendant INKA, responding to the same query, enumerated **426** employees that it paid less than $8.25 during that same period. *See* Defendant INKA's Supplemental Response to Class Interrogatory No. 5, an accurate copy of which is attached as **Exhibit 11**. Defendant Laguna, also responding, stated that it paid less than $8.25 to **19** employees between May 30, 2012 and January 20, 2015. *See* **Ex. 9** (Defendant Laguna's Response to Class Interrogatory No. 38).[5] Laguna refused to provide information on the number of employees paid at that level between 2010 and 2012, during peak

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[5] Each set of interrogatory responses by each Defendant was verified by Ms. Terry DiGiamarino, the current Payroll Manager for Mancha Development Co., Defendants' parent corporation.

months of its operations, and so the number of Laguna employees expected to be contained in the Class is significantly higher than 19. Furthermore, in documents produced in response to the Discovery Commissioner's Report and Recommendation on Plaintiffs' Motion to Compel, Defendants indicated—without specifically identifying members of the putative Class and in the form demonstrated here by document MDC000843 and MDC000917, accurate copies of which are attached as **Exhibit 12**—a total of **2,526** employees of Defendants were paid less than $8.25 between May of 2010 and March of 2015.

Plaintiffs have developed sufficient evidence, therefore, to establish the necessary numbers of putative Class members. *See e.g., Rannis v. Recchia*, 380 F. Appx. 646, 651 (9th Cir. 2010) (approving district court's finding that class of 20 satisfied numerosity requirement). The precise number of Class members will be calculable from a further review of Defendants' personnel, payroll, and benefits records, but the Class size is large enough to make joinder of all members impracticable. *See Rainero v. Archon Corp.*, 2011 WL 167278 at *2 (D. Nev. Jan. 19, 2011) ("Joinder of over 500 putative plaintiffs is impracticable.").

2. The Proposed Class Satisfies the Commonality Requirement of Rule 23(a)(2)

Under the commonality requirement, class action certification is proper when there are questions of law or fact common to the class. See *Shuette*, 121 Nev. at 848. "Commonality requires the plaintiff to demonstrate that the class members have suffered the same injury, and the plaintiff's common contention must be of such a nature that it is capable of class-wide resolution—which means that determination of its truth or falsity will resolve an issue that is central to the validity of each one of the claims in one stroke." *Hester v. Vision Airlines, Inc.*, 2014 WL 1366550 (D. Nev. Apr. 7, 2014) (approving class settlement agreement; citing *Wal-Mart Stores, Inc. v. Dukes*, 131 S. Ct. 2541, 2551 (2011)). Commonality assesses "the capacity of a class-wide proceeding to generate common answers apt to drive the resolution of the litigation." *Wal-Mart Stores, Inc.*, 131 S. Ct. at 2551.

As the Ninth Circuit stated, "Rule 23(a)(2) has been construed permissively, and all questions of fact and law need not be common to satisfy the rule." *Hanlon v. Chrysler Corp.*, 150

F.3d 1011, 1019 (9th Cir. 1998). "The existence of shared legal issues with divergent factual predicates is sufficient, as is a common core of salient facts coupled with disparate legal remedies within the class." *Id.* This prerequisite may be satisfied by a single common question of law or fact. *See Shuette*, 121 Nev. at 848; *see also Wal-Mart Stores, Inc.*, 131 S. Ct. at 2556.

Here, the major common questions are simple, and are of both fact and law. First, Plaintiffs and proposed Class members share the common question of whether they were paid less than the upper-tier minimum hourly wage, a clear mutual question of fact which Defendants' discovery responses and deposition testimony answer in the affirmative. *See* **Exs. 9-11** (where Defendants enumerate totals figures of employees paid less than $8.25 per hour since 2010); *see also* Defs.' Ans. ¶¶ 11, 14, 15, 16, 17, 24, 27, 30, 33 (where Defendants "admit that some employees are paid an hourly rate less than $8.25 per hour[,]" and where Defendants admit they paid each named Plaintiff below $8.25 per hour).

Second, given that Defendants procure and offer only a single series of successive, annual plans to Plaintiffs and members of the putative Class as the basis for paying them below the upper-tier minimum wage, the commonality requirement is satisfied. Both Defendant INKA and Defendant MDC responded to interrogatories regarding provision of human resources and benefits services by stating that "[a]s part of its administrative services, Mancha Development Company provides plans to Defendant (INKA, or MDC) which then offers the selected plan to its hourly employees." *See* Defendant INKA's Response to Interrogatory No. 19 and Defendant MDC's Response to Interrogatory No. 19, accurate copies of which are here attached as **Exhibit 13** and **14**, respectively.

Defendants all offered the following benefits plans, in annual succession, in their attempt to justify paying Plaintiffs and the Class less than $8.25, pursuant to the Minimum Wage Amendment:

2010 – 2012: Starbridge Limited-Benefit Sickness and Accident Plan, an accurate copy of which is attached as **Exhibit 15** (produced by Defendants as MDC000087-000096).

2013: Starbridge Limited-Benefit Sickness and Accident Plan, an accurate copy of which is attached as **Exhibit 16** (MDC000097-000120).

2014: Transamerica TransChoice Advance Hospital Indemnity Insurance Plan, an accurate copy of which is attached as **Exhibit 17** (MDC000129-000132).

2015: Key Benefit Minimum Value Plan (MVP Plan), an accurate copy of which is attached as **Exhibit 18** (MDC000770-000777).

Furthermore, Ms. DiGiamarino testified thusly at her recent deposition, regarding these successive plans:

> Q. Presently, every hourly employee in Nevada is offered the same MVP plan?
> A. Every employee that's offered insurance is offered the same plan, yes.
>
> . . .
>
> Q. Prior to the MVP Plan, was the Transamerica or TransChoice Plan provided to all Nevada hourly employees?
> A. Yes.
> Q. Prior to TransAmerica/TransChoice plan, was the Starbridge offered to all hourly employees?
> A. Yes.

See Transcr. Depo. Terry DiGiamarino at 42:18-21, 44:4-9 (Mar. 12, 2015). The pertinent excerpts of Ms. DiGiamarino's deposition testimony are here attached as **Exhibit 19**. The shared nature of the question regarding whether Defendants paid these employees lawfully, after purporting to offer—not provide, but merely to offer—all their hourly crew members the plans in question here, is manifest.

There are other common questions, certainly: Did Defendants' health insurance benefit plans, if they were provided by Defendants to Plaintiffs and members of the proposed Class, meet legal requirement as comprehensive, low-cost insurance permitting payment below the upper-tier wage rate? Did Defendants appropriately and lawfully calculate the premium costs to Plaintiffs and members of the proposed Class in offering or providing health insurance benefit plans? The answers to these questions will determine "the validity of [this claim] in one stroke." *Wal-Mart Stores, Inc.*, 131 S. Ct. at 2551. The simple, overarching legal question, however, is whether Defendants were eligible to pay Plaintiffs and proposed Class members below the upper-tier minimum wage rate. They paid all these employees less than the upper-tier wage, and they offered all of them the same benefits plans. The contentions by Plaintiffs are common to the proposed Class and are capable of class-wide determination and resolution, and because the Class members'

claims arise from Defendants' standard and uniform practices, the commonality requirement of N.R.C.P. 23(a)(2) is satisfied.

3. The Proposed Class Representatives Satisfy the Typicality Requirement of Rule 23(a)(3)

Typicality demands that the claims or defenses of the representative parties be typical of those of the class. *See Shuette*, 121 Nev. at 848. Generally, typicality exists where the claims of the named plaintiffs arise from the same event that gives rise to the claims of the other class members, and the named plaintiffs' claims are based on the same legal theories as the other class members' claims. *Rosario v. Livaditis*, 963 F.2d 1013, 1018 (7th Cir. 1992); *see also Alpern v. UtiliCorp United, Inc.*, 84 F.3d 1525, 1540 (8th Cir. 1996) ("Factual variations in the individual claims will not normally preclude class certification if the claim arises from the same event or course of conduct as the class claims, and gives rise to the same legal or remedial theory.").

Typicality "is satisfied when each class member's claim arises from the same course of events, and each class member makes similar legal arguments to prove the defendant's liability." *Rodriguez v. Hayes*, 591 F.3d 1105, 1124 (9th Cir. 2009) (internal quotations and citation omitted). "Under the [Rule 23]'s permissive standards, representative claims are 'typical' if they are reasonably co-extensive with those of absent class members; they need not be substantially identical." *Hanlon*, 150 F.3d at 1020; *see also Kristensen v. Credit Payment Services*, 12 F. Supp. 3d 1292, 1305 (D. Nev. 2014). The typicality prerequisite concentrates on the defendants' actions, not on the plaintiffs' conduct. *See Rosario*, 963 F.2d at 1018. If the class representatives and members of the class "share a common issue of law or fact" and "are sufficiently parallel to insure a vigorous and full presentation of all claims for relief" then the typicality requirement is satisfied. *California Rural Legal Assistance v. Legal Services Corp.*, 917 F.2d 1171, 1175 (9th Cir. 1990).

Here, all Plaintiffs were paid below the upper-tier minimum wage. *See* Amend. Compl. ¶¶ 14-17, 24, 27, 30, 33; *see also* Diaz Decl. ¶ 6 (**Ex. 1**); Olszynski Decl. ¶ 6 (**Ex. 2**); Wilbanks Decl. ¶ 7 (**Ex. 3**); Fitzlaff Decl. ¶ 6 (**Ex. 4**); Defs.' Ans. ¶¶ 14, 15, 16, 17, 24, 27, 30, 33. Plaintiffs allege that they were not provided with qualifying health benefits, per the Minimum Wage Amendment, that would permit Defendants to pay below the upper-tier wage. *See* Amend. Compl.

¶¶ 25, 28, 31, 34; *see also* Diaz Decl. ¶¶ 7-8 (**Ex. 1**); Olszynski Decl. ¶ 7 (**Ex. 2**); Wilbanks Decl. ¶¶ 8-9 (**Ex. 3**); Fitzlaff Decl. ¶ 7 (**Ex. 4**). Defendants, for their part, admit that they paid a sizable number of their employees below the upper-tier wage, and did so on the basis of having offered the health benefits plans in question, for every year noted herein during the Class period. *See* **Exs. 9-11**.

Plaintiffs' claims, therefore, are typical of those of the proposed Class, and the relief sought is typical of the relief which would be sought by each member of the Class in separate actions—back pay for underpayment of the minimum wage, and damages associated with the constitutional violations of Defendants. Plaintiffs and all other proposed Class members sustained similar losses of back pay, and for the very same reasons: Defendants' unlawful minimum wage underpayments and failure to provide qualifying health benefits. Plaintiffs' and the Class' injuries and damages are all a direct and proximate result of Defendants' unlawful conduct, policies, and practices. Defendants' failure to provide qualifying health benefits affected Plaintiffs and all Class members similarly, and Defendants benefited from their conduct in the same way—unlawful retention of up to a dollar an hour for every hour worked—relative to every member of the putative Class, including Plaintiffs. Plaintiffs are thus typical of the putative Class they seek to represent.

4. The Proposed Class Representatives Satisfy the Adequacy Requirement of Rule 23(a)(4)

A class action may proceed when it is shown that plaintiffs can fairly and adequately protect the interest of the class. *See* N.R.C.P. 23(a)(4). This inquiry "serves to uncover conflicts of interest between named parties and the class they seek to represent." *Amchem*, 521 U.S. at 625. Resolution of two questions determines legal adequacy: "(1) do the named plaintiffs and their counsel have any conflicts of interest with other class members and (2) will the named plaintiffs and their counsel prosecute the action vigorously on behalf of the class?" *Hanlon*, 150 F.3d at 1020; *see also Lerwill v. Inflight Motion Pictures, Inc.*, 582 F.2d 507, 512 (9th Cir. 1978).

Adequate representation is usually presumed in the absence of contrary evidence. *Newberg on Class Actions* § 7:24 (4th ed. 2002). Additionally, "precise alignment of the representative's interest in the case with those of putative class members is not required; what matters is sufficient

co-extensiveness of interests and the representative's abilit[y] to pursue the class claims vigorously and represent the interests of the absentee class members." *Santoro v. Aargon Agency, Inc.*, 252 F.R.D. 675, 683 (D. Nev. 2008) (internal quotations omitted).

Plaintiffs here are adequate representatives of the proposed Class, because Plaintiffs are members of the proposed Class they seek to represent and their interests do not conflict with the interests of the other members of the proposed Class that Plaintiffs seek to represent. Plaintiffs will vigorously prosecute this case on behalf of the entire Class. Plaintiffs have retained counsel that is competent and experienced in complex class action litigation, and Plaintiffs intend to prosecute this action vigorously. *See* Wolf, Rifkin, Shapiro, Schulman & Rabkin LLP Firm Resume, here attached as **Exhibit 20**. The interests of members of the proposed Class will be fairly and adequately protected by Plaintiffs and their counsel. Neither Plaintiffs nor their counsel have any interests that are contrary to, or in any way conflict with, the interests of the proposed Class.

B. Class Certification Is Appropriate Under N.R.C.P. 23(b)(3)

In addition to meeting the requirements of N.R.C.P. 23(a), parties seeking to certify a class action also must meet one of the conditions set forth in N.R.C.P. 23(b): (1) that separate litigation by individuals in the class would create a risk that the opposing party would be held to inconsistent standards of conduct or that nonparty members' interests might be unfairly impacted by the other members' individual litigation; (2) that the party opposing the class has acted or refused to act against the class in a manner making appropriate class-wide injunctive or declaratory relief; or (3) that common questions of law or fact predominate over individual questions, and a class action is superior to other methods of adjudication. *See* N.R.C.P. 23(b); *Shuette*, 121 Nev. at 850. Plaintiffs here concentrate upon N.R.C.P. 23(b)(3), which itself has two prongs: *predominance* and *superiority*. *See* N.R.C.P. 23(b)(3). Plaintiffs take these requirements in turn below, and demonstrate fulfillment of their prerequisites.

1. Common Questions of Law and Fact Predominate

Predominance "asks whether proposed classes are sufficiently cohesive to warrant adjudication by representation … [and focuses] on the relationship between the common and individual issues." *Stearns v. Ticketmaster Corp.*, 655 F.3d 1013, 1019 (9th Cir. 2011); *see also*

Amchem, 521 U.S. at 623. In contrast to Rule 23(a)(2)'s commonality analysis, Rule 23(b)(3) tests the interplay between the common and individual issues and determines their relative importance within the action. "When common questions present a significant aspect of the case and they can be resolved for all members of the class in a single adjudication, there is clear justification for handling the dispute on a representative rather than on an individual basis." *Hanlon*, 150 F.3d at 1022.

Here, the legal and factual issues common to the Plaintiffs and the Class dominate the litigation and will determine its outcome. In fact, the major common questions utterly control this action. The questions of employee pay levels, Defendants' eligibility to pay at reduced hourly minimum wage rates, and the recompense Defendants must make to Plaintiffs and the Class through back pay and a damages award essentially describe the entirety of the suit. If Defendants are liable to any one Plaintiff or member of the Class because they did not qualify to pay below the upper-tier minimum wage, they are liable to all Plaintiffs and members of the Class to whom a sub-minimum wage was paid and to whom Defendants purported to provide that health benefit plan. Defendants do not purchase, maintain, or offer individualized insurance benefit plans for each individual employee; they contract with an insurer for a single plan annually that they offer to hourly Nevada employees, and have done so for the entirety of the period covered by this lawsuit. *See* **Exs. 15-18** (the summaries of Defendants' annual Plans from 2010 through 2015). Either those plans were compliant with Nevada constitution, or they were not. Defendants were either eligible to pay below the upper-tier minimum wage, or they were not. The answer will be the same for any employee covered by the Class definition. All of these question are common to the whole Class and, therefore, the predominance requirement of N.R.C.P. 23(b)(3) is met.

2. A Class Action is Superior to Other Methods of Adjudication

The second requirement of N.R.C.P. Rule 23(b) is a determination whether a class action is the superior method for adjudicating the claims. In evaluating superiority, Rule 23(b) directs the court to consider (A) the class members' interests in individually controlling the prosecution or defense of separate actions; (B) the extent and nature of any litigation concerning the controversy already begun by or against class members; (C) the desirability or undesirability of concentrating

the litigation of the claims in the particular forum; and (D) the likely difficulties in managing the class action. *See Shuette*, 121 Nev. at 852; *Sobel*, 291 F.R.D. at 544. The Ninth Circuit, for its part, has held that superiority is established where the small size of individual claims effectively precludes individual action. *Local Joint Executive Bd. of Culinary/Bartender Trust Fund v. Las Vegas Sands, Inc.*, 244 F.3d 1152 (9th Cir. 2001).

Here, a class action is superior to other available methods for the fair and efficient adjudication of the controversy, because, *inter alia*, as minimum wage employees it is economically infeasible for proposed Class members to prosecute individual actions of their own given the relatively small amount of damages at stake for each individual. Plaintiffs seek the difference in wages actually paid by Defendants and the wages as ought to have been paid pursuant to the Minimum Wage Amendment, as well as appropriate damages available under law. *See* Pls.' Amend. Compl.

The class action mechanism is particularly appropriate where, as here, the alternative is class members "filing hundreds of individual lawsuits that could involve duplicating discovery and costs that exceed the extent of the proposed class members' individual injuries." *Wolin v. Jaguar Land Rover North America, LLC*, 617 F.3d 1168, 1176 (9th Cir. 2010). In this instance, the number of individual actions would be in the thousands. The cost to the court system and the public for the adjudication of individual litigation and claims would be substantially more than if the claims were to be treated as a class action. Furthermore, prosecution of separate actions by individual Class members would create the real but unnecessary risk of inconsistent and/or varying adjudications with respect to the individual Class members, establishing incompatible standards of conduct for Defendants and resulting in the impairment of Class members' rights and the disposition of their interests through actions to which they were not parties. Plaintiffs and their counsel know of no unusual difficulties in the case, and Defendants have advanced network computer, payroll, and benefit systems that will allow the Class, wage, benefits, and damages issues in the case to be resolved with relative ease.

C. Undersigned Counsel Are Appropriate Class Counsel

Plaintiffs request appointment of undersigned counsel as class counsel. A court may

consider "any other matter pertinent to counsel's ability to fairly and adequately represent the interests of the class." *In re Cathode Ray Tube (CRT) Antitrust Litig.*, 2008 WL 2024957 at *1 (N.D. Cal. May 9, 2008). As is demonstrated in the declaration of Don Springmeyer, Esq. (**Ex. 6**), and the firm resume of Wolf, Rifkin, Shapiro, Schulman & Rabkin LLP (**Ex. 20**), and as evidenced by the present motion and supporting papers, proposed class counsel have thoroughly investigated the claims in this action; have extensive experience handling class actions, and deep knowledge of the applicable law; and, have adequate resources to litigate this action.

IV. CONCLUSION

Based upon the foregoing, the requirements of Rules 23(a) and 23(b)(3) are satisfied. Plaintiffs request that the Court grant their Motion for Class Certification and certify the case as a class action; with Plaintiffs to serve as representatives of that Class; and, designate their attorneys and firm as class counsel.

DATED this 8th day of June, 2015.

WOLF, RIFKIN, SHAPIRO,
SCHULMAN & RABKIN, LLP

By: */s/ Bradley Schrager*

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CERTIFICATE OF SERVICE

I hereby certify that on this 8th day of June, 2015, a true and correct copy of **PLAINTIFFS' MOTION FOR CLASS CERTIFICATION PURSUANT TO N.R.C.P. 23** was served by electronically filing with the Clerk of the Court using the Wiznet Electronic Service system and serving all parties with an email-address on record, pursuant to Administrative Order 14-2 and Rule 9 of the N.E.F.C.R.

By: */s/ Dannielle Fresquez*
Dannielle Fresquez, an Employee of
WOLF, RIFKIN, SHAPIRO, SCHULMAN &
RABKIN, LLP

Exhibit 1

Exhibit 1

DON SPRINGMEYER, ESQ.
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EIGHTH JUDICIAL DISTRICT COURT

IN AND FOR CLARK COUNTY, STATE OF NEVADA

PAULETTE DIAZ, an individual; and LAWANDA GAIL WILBANKS, an individual; SHANNON OLSZYNSKI, an individual; CHARITY FITZLAFF, an individual, on behalf of themselves and all similarly-situated individuals,

Plaintiffs,

vs.

MDC RESTAURANTS, LLC, a Nevada limited liability company; LAGUNA RESTAURANTS, LLC, a Nevada limited liability company; INKA, LLC, a Nevada limited liability company, and DOES 1 through 100, Inclusive,

Defendants.

Case No: A-14-701633-C
Dept. No.: XVI

DECLARATION OF PAULETTE DIAZ

DECLARATION OF PAULETTE DIAZ

I, Paulette Diaz, under penalty of perjury, hereby declare as follows:

1. I am over eighteen years of age and I am a Plaintiff in the present case. I have personal knowledge of the facts set forth herein, except as to those stated on information and belief and, as to those, I am informed and believe them to be true. If called upon to testify before this Court I would do so to the same effect.

2. I am currently a resident of the State of Oregon.

3. Upon information and belief, I worked as an hourly, non-exempt employee at several Coco's and Denny's restaurants owned and operated by Defendants.

4. I worked at the Coco's and Denny's restaurants from April 2010 through August 2013.

5. I held various positions, including server, hostess, and person in charge, when I worked at the Coco's and Denny's restaurants.

6. Upon information and belief, my hourly wage varied when I worked at the Coco's and Denny's restaurants as follows:

a. From April 2010 to September 2010, I was paid $8.25 an hour;

b. From September 2010 to October 2010, I was paid $7.25 an hour;

c. From October 2010 to November 2010, I was paid $10 an hour;

d. From December 2010 to February 2011, I was paid $11.00 an hour; and

e. From March 2011 to August 2013, I was paid $7.25 an hour.

7. When I was initially hired, I was not offered health insurance by Defendants.

8. During my employment at the Coco's and Denny's restaurants, I was never enrolled in nor accepted a health insurance plan offered or provide by Defendants.

9. When I worked at the Coco's and Denny's restaurants, I had one dependent.

Under penalties of perjury under the laws of the United States of America and the State of Nevada, I declare that the foregoing is true and correct to my own knowledge, except as to those matters stated on information and belief, and that as to such matters I believe to be true.

DATED this 19 day of May, 2015.

By: _____
PAULETTE DIAZ

Exhibit 2

Exhibit 2

DON SPRINGMEYER, ESQ.
Nevada State Bar No. 1021
BRADLEY SCHRAGER, ESQ.
Nevada State Bar No. 10217
DANIEL BRAVO, ESQ.
Nevada State Bar No. 13078
WOLF, RIFKIN, SHAPIRO, SCHULMAN & RABKIN, LLP
3556 E. Russell Road, 2nd Floor
Las Vegas, Nevada 89120-2234
Telephone: (702) 341-5200/Fax: (702) 341-5300
Email: dspringmeyer@wrslawyers.com
Email: bschrager@wrslawyers.com
Email: dbravo@wrslawyers.com
Attorneys for Plaintiffs

EIGHTH JUDICIAL DISTRICT COURT

IN AND FOR CLARK COUNTY, STATE OF NEVADA

PAULETTE DIAZ, an individual; and LAWANDA GAIL WILBANKS, an individual; SHANNON OLSZYNSKI, an individual; CHARITY FITZLAFF, an individual, on behalf of themselves and all similarly-situated individuals,

Plaintiffs,

vs.

MDC RESTAURANTS, LLC, a Nevada limited liability company; LAGUNA RESTAURANTS, LLC, a Nevada limited liability company; INKA, LLC, a Nevada limited liability company, and DOES 1 through 100, Inclusive,

Defendants.

Case No: A-14-701633-C
Dept. No.: XVI

DECLARATION OF SHANNON OLSZYNSKI

DECLARATION OF SHANNON OLSZYNSKI

I, Shannon Olszynski, under penalty of perjury, hereby declare as follows:

1. I am over eighteen years of age and I am a Plaintiff in the present case. I have personal knowledge of the facts set forth herein, except as to those stated on information and belief and, as to those, I am informed and believe them to be true. If called upon to testify before this Court I would do so to the same effect.

2. I am currently a resident of the State of Colorado.

3. Upon information and belief, I worked as an hourly, non-exempt employee at Denny's Restaurant Store #8758 in Elko, NV ("Denny's), owned and operated by Defendants.

4. I worked at Denny's from May 20, 2014 through November 19, 2014.

5. I held the position of server when I worked at Denny's.

6. My hourly wage while working at Denny's was $7.25/hr.

7. During my employment at Denny's, I was never enrolled in nor accepted a health insurance plan offered or provided by Defendants.

Under penalties of perjury under the laws of the United States of America and the State of Nevada, I declare that the foregoing is true and correct to my own knowledge, except as to those matters stated on information and belief, and that as to such matters I believe to be true.

DATED this 19th day of May, 2015.

By: _____
SHANNON OLSZYNSKI

Exhibit 3

Exhibit 3

DON SPRINGMEYER, ESQ.
Nevada State Bar No. 1021
BRADLEY SCHRAGER, ESQ.
Nevada State Bar No. 10217
DANIEL BRAVO, ESQ.
Nevada State Bar No. 13078
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Email: bschrager@wrslawyers.com
Email: dbravo@wrslawyers.com
Attorneys for Plaintiffs

EIGHTH JUDICIAL DISTRICT COURT

IN AND FOR CLARK COUNTY, STATE OF NEVADA

PAULETTE DIAZ, an individual; and LAWANDA GAIL WILBANKS, an individual; SHANNON OLSZYNSKI, an individual; CHARITY FITZLAFF, an individual, on behalf of themselves and all similarly-situated individuals,

Plaintiffs,

vs.

MDC RESTAURANTS, LLC, a Nevada limited liability company; LAGUNA RESTAURANTS, LLC, a Nevada limited liability company; INKA, LLC, a Nevada limited liability company, and DOES 1 through 100, Inclusive,

Defendants.

Case No: A-14-701633-C
Dept. No.: XVI

DECLARATION OF LAWANDA GAIL WILBANKS

DECLARATION OF LAWANDA GAIL WILBANKS

I, Lawanda Gail Wilbanks, under penalty of perjury, hereby declare as follows:

1. I am over eighteen years of age and I am a Plaintiff in the present case. I have personal knowledge of the facts set forth herein, except as to those stated on information and belief and, as to those, I am informed and believe them to be true. If called upon to testify before this Court I would do so to the same effect.

2. I am currently a resident of the State of Nevada.

3. I have one dependent child, a seventeen year old daughter.

4. Upon information and belief, I worked as an hourly, non-exempt employee at a Denny's restaurant owned and operated by Defendant MDC Restaurants, LLC. The Denny's restaurant was located at 5318 Boulder Highway, Las Vegas, Nevada 89122.

5. I worked at the Denny's restaurant from June 2011 through January 2013.

6. I held the position of server at the Denny's restaurant.

7. Upon information and belief, my hourly wage was $7.45 at the Denny's restaurant.

8. When I was initially hired, I was not offered health insurance by Defendants.

9. During my employment at the Denny's restaurant, I was never enrolled in nor accepted a health insurance plan offered or provide by Defendants.

Under penalties of perjury under the laws of the United States of America and the State of Nevada, I declare that the foregoing is true and correct to my own knowledge, except as to those matters stated on information and belief, and that as to such matters I believe to be true.

DATED this 18th day of May, 2015.

By: Lawanda Gail Wilbanks
LAWANDA GAIL WILBANKS

Exhibit 4

Exhibit 4

DON SPRINGMEYER, ESQ.
Nevada State Bar No. 1021
BRADLEY SCHRAGER, ESQ.
Nevada State Bar No. 10217
DANIEL BRAVO, ESQ.
Nevada State Bar No. 13078
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Email: bschrager@wrslawyers.com
Email: dbravo@wrslawyers.com
Attorneys for Plaintiffs

EIGHTH JUDICIAL DISTRICT COURT

IN AND FOR CLARK COUNTY, STATE OF NEVADA

PAULETTE DIAZ, an individual; and LAWANDA GAIL WILBANKS, an individual; SHANNON OLSZYNSKI, an individual; CHARITY FITZLAFF, an individual, on behalf of themselves and all similarly-situated individuals,

Plaintiffs,

vs.

MDC RESTAURANTS, LLC, a Nevada limited liability company; LAGUNA RESTAURANTS, LLC, a Nevada limited liability company; INKA, LLC, a Nevada limited liability company, and DOES 1 through 100, Inclusive,

Defendants.

Case No: A-14-701633-C
Dept. No.: XVI

DECLARATION OF CHARITY FITZLAFF

DECLARATION OF CHARITY FITZLAFF

I, Charity Fitzlaff, under penalty of perjury, hereby declare as follows:

1. I am over eighteen years of age and I am a Plaintiff in the present case. I have personal knowledge of the facts set forth herein, except as to those stated on information and belief and, as to those, I am informed and believe them to be true. If called upon to testify before this Court I would do so to the same effect.

2. I am currently a resident of the State of Nevada.

3. Upon information and belief, I worked as an hourly, non-exempt employee at Denny's Restaurant Store #8758 in Elko, Nevada ("Denny's), owned and operated by Defendants.

4. I worked at Denny's from July 20, 2012 through October 2013.

5. I held the position of server when I worked at Denny's.

6. My hourly wage while working at Denny's was $7.25/hr, unless I had supervisory duties, in which case I was paid $10.00/hr.

7. Upon being hired at Denny's, the store manager, Lazaro, instructed me to decline the insurance.

8. To the best of my knowledge, hourly employees are paid less than $8.25 per hour by Denny's.

9. To the best of my knowledge, hourly employees are offered the same health insurance by Denny's.

10. To the best of my knowledge, my experience was similar to other Denny's employees.

Under penalties of perjury under the laws of the United States of America and the State of Nevada, I declare that the foregoing is true and correct to my own knowledge, except as to those matters stated on information and belief, and that as to such matters I believe to be true.

DATED this 8 day of June, 2015.

By: _____
CHARITY FITZLAFF

Exhibit 5

Exhibit 5

DON SPRINGMEYER, ESQ.
Nevada State Bar No. 1021
BRADLEY SCHRAGER, ESQ.
Nevada State Bar No. 10217
DANIEL BRAVO, ESQ.
Nevada State Bar No. 13078
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Email: dbravo@wrslawyers.com
Attorneys for Plaintiffs

EIGHTH JUDICIAL DISTRICT COURT

IN AND FOR CLARK COUNTY, STATE OF NEVADA

PAULETTE DIAZ; LAWANDA GAIL WILBANKS; SHANNON OLSZYNSKI; and CHARITY FITZLAFF, all on behalf of themselves and all similarly-situated individuals,

Plaintiffs,

vs.

MDC RESTAURANTS, LLC; LAGUNA RESTAURANTS, LLC; INKA, LLC; and DOES 1 through 100, Inclusive,

Defendants.

Case No.: A701633
Dept. No.: XVI

DECLARATION OF BRADLEY SCHRAGER, ESQ. IN SUPPORT OF PLAINTIFFS' MOTION FOR CLASS CERTIFICATION PURSUANT TO N.R.C.P. 23

DECLARATION OF BRADLEY SCHRAGER, ESQ.

I, Bradley Schrager, Esq., under penalty of perjury, declare as follows:

1. I am an attorney with the law firm Wolf, Rifkin, Shapiro, Schulman & Rabkin, LLP, duly admitted to practice law in the state of Nevada, and counsel for Plaintiffs in the above-captioned action. I make this declaration of personal, firsthand knowledge and, if called and sworn as a witness, I could and would testify competently thereto. I have personal knowledge of the facts stated herein and submit this Declaration in support of Plaintiffs' Motion for Class Certification Pursuant to N.R.C.P. 23.

2. Attached, as **Exhibit 1**, is a true and accurate copy of the declaration of Plaintiff Paulette Diaz.

3. Attached, as **Exhibit 2**, is a true and accurate copy of the declaration of Plaintiff Shannon Olszynski.

4. Attached, as **Exhibit 3**, is a true and accurate copy of the declaration of Plaintiff Lawanda Wilbanks.

5. Attached, as **Exhibit 4**, is a true and accurate copy of the declaration of Plaintiff Charity Fitzlaff.

6. Attached, as **Exhibit 6**, is a true and accurate copy of the declaration of Don Springmeyer, Esq.

7. Attached, as **Exhibit 7**, is a true and accurate copy of the document produced by Defendants as MDC000158, offered in response to propounded interrogatories.

8. Attached, as **Exhibit 8**, is a true and accurate copy of Defendant INKA's Response to Class Interrogatory No. 9.

9. Attached, as **Exhibit 9**, is a true and accurate copy of Defendant Laguna's Response to Third Set of Interrogatories.

10. Attached, as **Exhibit 10**, is a true and accurate copy of Defendant MDC's Supplemental Response to Class Interrogatory No. 5.

11. Attached, as **Exhibit 11**, is a true and accurate copy of Defendant INKA's Supplemental Response to Class Interrogatory No. 5.

12. Attached, as **Exhibit 12**, are true and accurate copies of documents produced by Defendants as MDC000843 and MDC000917.

13. Attached, as **Exhibit 13**, is a true and accurate copy of Defendant INKA's Response to Interrogatory No. 19.

14. Attached, as **Exhibit 14**, is a true and accurate copy of Defendant MDC's Response to Interrogatory No. 19.

15. Attached, as **Exhibit 15**, is a true and accurate copy of Defendants' 2010-2012 Starbridge Limited-Benefit Sickness and Accident Plan and produced by Defendants as

MDC000087-000096.

16. Attached, as **Exhibit 16**, is a true and accurate copy of Defendants' 2013 Starbridge Limited-Benefit Sickness and Accident Plan and produced by Defendants as MDC000097-000120.

17. Attached, as **Exhibit 17**, is a true and accurate copy of Defendants' 2014 Transamerica TransChoice Advance Hospital Indemnity Insurance Plan and produced by Defendants as MDC000129-000132.

18. Attached, as **Exhibit 18**, is a true and accurate copy of Defendants' 2015 Key Benefit Minimum Value Plan (MVP Plan) and produced by Defendants as MDC000770-000777.

19. Attached, as **Exhibit 19**, is a true and accurate copy of the pertinent portions of Terry DiGiamarino's deposition transcript.

20. Attached, as **Exhibit 20**, is a true and accurate copy of Wolf, Rifkin, Shapiro, Schulman & Rabkin LLP Firm Resume.

Under penalties of perjury under the laws of the United States of America and the State of Nevada, I declare that the foregoing is true and correct to my own knowledge, except as to those matters stated on information and belief, and that as to such matters I believe to be true.

DATED this 8th day of June, 2015.

/s/ Bradley Schrager
BRADLEY SCHRAGER, ESQ.

Exhibit 6

Exhibit 6

DON SPRINGMEYER, ESQ.
Nevada State Bar No. 1021
BRADLEY SCHRAGER, ESQ.
Nevada State Bar No. 10217
DANIEL BRAVO, ESQ.
Nevada State Bar No. 13078
WOLF, RIFKIN, SHAPIRO, SCHULMAN & RABKIN, LLP
3556 E. Russell Road, 2nd Floor
Las Vegas, Nevada 89120-2234
Telephone: (702) 341-5200/Fax: (702) 341-5300
Email: dspringmeyer@wrslawyers.com
Email: bschrager@wrslawyers.com
Email: dbravo@wrslawyers.com
Attorneys for Plaintiffs

EIGHTH JUDICIAL DISTRICT COURT

IN AND FOR CLARK COUNTY, STATE OF NEVADA

PAULETTE DIAZ; LAWANDA GAIL WILBANKS; SHANNON OLSZYNSKI; and CHARITY FITZLAFF, all on behalf of themselves and all similarly-situated individuals,

Plaintiffs,

vs.

MDC RESTAURANTS, LLC; LAGUNA RESTAURANTS, LLC; INKA, LLC; and DOES 1 through 100, Inclusive,

Defendants.

Case No.: A701633
Dept. No.: XVI

DECLARATION OF DON SPRINGMEYER, ESQ. IN SUPPORT OF PLAINTIFFS' MOTION FOR CLASS CERTIFICATION PURSUANT TO N.R.C.P. 23

DECLARATION OF DON SPRINGMEYER, ESQ.

I, Don Springmeyer, Esq., under penalty of perjury, declare as follows:

1. I am over eighteen years of age. I am a member in good standing of the Bar of the State of Nevada, and am a partner of Wolf, Rifkin, Shapiro, Schulman & Rabkin LLP ("Wolf, Rifkin" or the "Firm"), attorneys for Plaintiffs in this action. I make this declaration of personal, firsthand knowledge and, if called and sworn as a witness, I could and would testify competently thereto. I have personal knowledge of the facts stated herein and submit this Declaration in support of Plaintiffs' Motion for Class Certification Pursuant to N.R.C.P. 23.

2. Wolf, Rifkin has expended significant resources to date investigating and analyzing the claims detailed in the First Amended Complaint in this action. Wolf, Rifkin's work to date includes conducting numerous client interviews, extensive legal research, document review, drafting and filing the original Complaint and Amended Complaint in this action, appearing at numerous hearings and preparing for, taking and defending multiple depositions to date. As a result of the work done developing this action, we have been retained by the four named Plaintiffs in this action and have interviewed numerous other putative class members who, together with the named Plaintiffs, have worked at numerous Denny's and Coco's restaurants located throughout Clark County, Nevada. Wolf, Rifkin has also spent considerable amounts of time preparing the instant motion for class action certification.

3. Wolf, Rifkin is eminently qualified to act as class counsel in this action. Wolf, Rifkin was founded 1977 and is comprised of a team of over 40 attorneys who handle cases in all areas of law, with offices in Los Angeles, Las Vegas, and Reno. The Firm's clientele includes individuals and community associations as well as businesses ranging from fledgling firms to Fortune 500 companies. I am the litigation partner in charge of class action and complex high damages litigation for Wolf, Rifkin. I am headquartered in the Firm's Las Vegas office. I have 33 years of experience in high stakes litigation including class actions of all types, mass torts ranging from medical device and pharmaceutical products to components of home building construction, residential and commercial construction defects, real estate and condominium litigation, water rights/environmental, and insurance bad faith. Within the last three years I have been designated as lead counsel for class actions pending in six separate states, aside from Nevada. Within the last year here in Nevada, I and the Firm have been designated as co-lead class counsel by Hon. Jennifer Dorsey in the conditionally certified FLSA collective and class action entitled *Cardoza v. Bloomin' Brands, Inc.*, 2:13-cv-01820-JAD-NJK—a case involving a putative class of approximately 135,000 hourly employees at Outback Steakhouse restaurants.

4. I was named to "2012 Top Lawyers: 100 top lawyers in Southern Nevada" by the business weekly Vegas Inc. I was honored as the first Trial Lawyer of the Year by the Nevada Trial Lawyers Association in 1997, in recognition of my work on the infant formula price-fixing class

actions, and my pro bono work on health insurance coverage cases for breast cancer victims. I have been AV® Peer Review Rated 5.0 through Martindale-Hubble for 18 years. I have received a National Community Service Award for my pro bono work. I also conduct an extensive appellate practice, appearing in multiple cases before the Nevada Supreme Court, and the United States Courts of Appeal for the Ninth, Fourth, Seventh, Sixth, and Eleventh Circuits.

5. Here, there should be no doubt proposed counsel are, and will continue to be, committed to this case. This litigation team has the experience and skill capable of seeing complex litigation through from beginning to end. Counsel will continue to commit all the resources necessary to effectively represent the Class here.

6. Wolf, Rifkin is, and will continue to be, fully committed to this case. We have also advanced all costs incurred in pursuing this case to date, and will continue to advance costs incurred in the litigation of this action, and to commit all the resources necessary to effectively represent the Class in this action until the conclusion of this action.

Under penalties of perjury under the laws of the United States of America and the State of Nevada, I declare that the foregoing is true and correct to my own knowledge, except as to those matters stated on information and belief, and that as to such matters I believe to be true.

DATED this 8th day of June, 2015.

/s/ Don Springmeyer
DON SPRINGMEYER, ESQ.

Exhibit 7

Exhibit 7

dba Denny's Restaurant Franchise				
7242	5045 W. Tropicana Ave. Las Vegas, NV 89103	(702) 967-5280 (702) 967-5283	Fax	December, 1999
7243	9320 S. Eastern Ave. Las Vegas, NV 89123	(702) 990-4560 (702) 990-4565	Fax	December, 1999
7518	4280 W. Craig Rd., Ste. 103 N. Las Vegas, NV 89031	(702) 947-0457 (702) 947-0461	Fax	November, 2000
7632	310 N. Nellis Blvd. Las Vegas, NV 89110	(702) 452-5885 (702) 452-1918	Fax	June, 2002
7633	7071 W. Craig Rd., Ste. 101 Las Vegas, NV 89129	(702) 395-9116 (702) 395-8376	Fax	March, 2002
7671	3230 Losee Rd. N. Las Vegas, NV 89030	(702) 649-7671 (702) 649-1767	Fax	September, 2002
7674	8000 W. Sahara Ave., Ste. 109 Las Vegas, NV 89117	(702) 948-8382 (702) 948-8387	Fax	August, 2001
7764	1201 W. Warm Springs Rd. Henderson, NV 89014	(702) 454-7818 (702) 454-5247	Fax	August, 2003
7765	6300 W. Charleston Blvd. #110 Las Vegas, NV 89102	(702) 309-0622 (702) 309-1218	Fax	Sept, 2006
7825	7341 W. Lake Mead Blvd. Las Vegas, NV 89128	(702) 240-6015 (702) 240-9078	Fax	December, 2005
7828	5585 Simmons St. Ste #5 North Las Vegas, NV 89031	(702) 631-0024 (702) 631-0047	Fax	May, 2006
7914	2380 E. Tropicana Ave. Las Vegas, NV 89119	(702) 739-7001 (702) 739-9925	Fax	October, 2007
7998	9310 W. Tropicana Ave. Las Vegas, NV 89123	(702) 868-3558 (702) 227-7343	Fax	July, 2008
8061	Boomtown Hotel & Casino 2100 Garson Rd., Verdi, NV 89439	(775) 636-9358 (775) 345-6000 Casino		22-Jun-09 **CLOSED 6/27/2012**
8096	Fiesta Rancho Casino Hotel 2400 North Fiesta Rancho Dr. Las Vegas, NV 89130	(702) 636-4100 (702) 636-4102	Fax	October, 2008
8185	Fiesta Henderson Casino Hotel 777 W Lake Mead Pkwy Henderson, NV 89015	(702) 495-3816 (702) 495-3817		4-May-09 **CLOSED 1/12/2013**
8187	Wildfire Rancho Casino 1901 N. Rancho Rd. Henderson, NV 89106	(702) 636-8013 (702) 636-8014	Fax	13-Feb-09
8188	Wildfire Lanes Casino 4451 E. Sunset Rd. Henderson, NV 89014	(702) 495-3810 (702) 495-3811	Fax	8-Feb-09
8189	Wild Wild West 3330 W Tropicana Ave Las Vegas, NV 89103	(702) 495-3814 (702) 495-3815	Fax	24-Apr-09
8563	5318 Boulder Hwy. Las Vegas NV 89122	(702) 333-2185 (702) 333-2187	Fax	29-Sep-10
8648	31700 S. Las Vegas Blvd. Jean, NV 98019	(702) 679-7577 (702)386-7867 Casino		22-Dec-10
8687	River Palms Casino 2700 S. Casino Drive Laughlin, NV 89029	(702) 298-0524 (702) 298-0935	Fax	19-Jan-10

Exhibit 8

Exhibit 8

ELECTRONICALLY SERVED
11/05/2014 11:26:54 AM

INTG
RICK D. ROSKELLEY, ESQ., Bar # 3192
ROGER L. GRANDGENETT II, ESQ., Bar # 6323
KATIE BLAKEY, ESQ., Bar # 12701
LITTLER MENDELSON, P.C.
3960 Howard Hughes Parkway
Suite 300
Las Vegas, NV 89169-5937
Telephone: 702.862.8800
Fax No.: 702.862.8811

Attorneys for Defendants

EIGHTH JUDICIAL DISTRICT COURT

CLARK COUNTY, NEVADA

PAULETTE DIAZ, an individual; and LAWANDA GAIL WILBANKS, an individual; SHANNON OLSZYNSKI, and individual; CHARITY FITZLAFF, an individual, on behalf of themselves and all similarly-situated individuals, Plaintiffs, vs. MDC RESTAURANTS, LLC, a Nevada limited liability company; LAGUNA RESTAURANTS, LLC, a Nevada limited liability company; INKA, LLC, a Nevada limited liability company and DOES 1 through 100, Inclusive, Defendants.	Case No. A701633 Dept. No. XV **DEFENDANT INKA, LLC'S RESPONSE TO FIRST SET OF INTERROGATORIES BY PLAINTIFFS, ON BEHALF OF THE PUTATIVE CLASS**

PROPOUNDING PARTY: PLAINTIFFS, ON BEHALF OF PUTATIVE CLASS

RESPONDING PARTY: DEFENDANT INKA, LLC

SET NO.: ONE

Defendant INKA Restaurants, LLC ("Defendant" or "INKA") hereby submits its Response to First Set of Interrogatories by Plaintiffs, on Behalf of the Putative Class as follows:

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///

PRELIMINARY STATEMENT

The information contained in the responses set forth below is based only upon the information and documents currently available to Defendant. Defendant's investigation and discovery in preparation for trial has not been completed. Additional investigation may disclose further information and documents relevant to these responses, as could information and documents obtained by Defendant from Plaintiff or third parties through additional discovery procedures. Therefore, Defendant expressly reserves the right to alter, amend, supplement, modify or otherwise revise its responses if, for any reason, such alterations, amendments, supplements, modifications or revisions become appropriate or warranted or as may be required by Rule 33 of the Nevada Rules of Civil Procedure.

All of Defendant's responses are made subject to this preliminary statement.

INTERROGATORIES

INTERROGATORY NO. 1:

State the number of employees employed at all Denny's between November 28, 2006, and June 30, 2007, that were paid less than $6.15 per hour as a regular hourly wage rate, excluding any tips, gratuities, or bonuses.

RESPONSE 1:

Objection. Interrogatory No. 1 is overly broad, unduly burdensome, and not likely to lead to the discovery of admissible evidence. Claims for alleged minimum wage violations before May 30, 2012 are barred by the statute of limitations and, therefore, information about employees prior to May 30, 2012 is not likely to lead to the discovery of admissible evidence. Moreover, any employee whose employment with Denny's terminated prior to May 30, 2012 cannot be a part of the alleged class. Accordingly, this request seeks information outside the scope of this litigation that would be burdensome to retrieve and not likely to lead to the discovery of admissible evidence. Subject to and without waiving these objections, Defendant responds that all INKA employees were paid at least $7.55 per hour prior to July 2010.

///

///

LITTLER MENDELSON, P.C.
ATTORNEYS AT LAW
3960 Howard Hughes Parkway
Suite 300
Las Vegas, NV 89169-5937
702 862 8800

INTERROGATORY NO. 2:

State the number of employees employed at all Denny's between July 1, 2007, and June 30, 2008, that were paid less than $6.33 per hour as a regular hourly wage rate, excluding any tips, gratuities, or bonuses.

RESPONSE 2:

Defendant incorporates its Response to Interrogatory No. 1.

INTERROGATORY NO. 3:

State the number of employees employed at all Denny's between July 1, 2008, and June 30, 2009, for which employees were paid less than $6.85 per hour as a regular hourly wage rate, excluding any tips, gratuities, or bonuses.

RESPONSE 3:

Defendant incorporates its Response to Interrogatory No. 1.

INTERROGATORY NO. 4:

State the number of employees employed at all Denny's between July 1, 2009, and June 30, 2010, that were paid less than $7.55 per hour as a regular hourly wage rate, excluding any tips, gratuities or bonuses.

RESPONSE 4:

Defendant incorporates its Response to Interrogatory No. 1.

INTERROGATORY NO. 5:

State the number of employees employed at all Denny's between July 1, 2010, and the present that were paid less than $8.25 per hour as a regular hourly wage rate, excluding any tips, gratuities, or bonuses.

RESPONSE 5:

Defendant incorporates its response to Interrogatory No. 1. Subject to and without waiving these objections, Defendant responds that it paid less than $8.25 per hour as a regular hourly wage rate to the following number of Denny's employees during the below listed dates:

///

LITTLER MENDELSON, P.C.
ATTORNEYS AT LAW
3960 Howard Hughes Parkway
Suite 300
Las Vegas, NV 89169-5937
702 862 8800

Dates	Total Number of INKA Denny's employees
May 30, 2012 to June 30, 2012	63
July 1, 2012 to June 30, 2013	97
July 1, 2013 to June 30, 2014	124
July 1, 2014 to October 31, 2014	123

INTERROGATORY NO. 6:

Describe with specificity all payroll and/or timekeeping software and hardware that has been used to keep track of hours worked and/or wages owed to hourly employees at any and all Denny's from November 28, 2006, until the present.

RESPONSE 6:

Objection. Interrogatory No. 6 is overly broad, unduly burdensome, and not likely to lead to the discovery of admissible evidence. Plaintiffs make no allegations related to the payroll and/or timekeeping systems and there is no indication whatsoever that the payroll/timekeeping systems used by Denny's are inaccurate or require inspection. Subject to and without waiving these objections, Defendant responds that All Denny's Restaurant's operated by Defendant uses Timesaver ADP Payroll/Timekeeping.

INTERROGATORY NO. 7:

Identify any and all payroll administrator(s) with responsibility for each and every Denny's at all times from November 28, 2006, until the present time. "Identify" with regard to a person shall mean to state that person's name, last known physical address, last known email address, and last known telephone number.

RESPONSE 7:

Objection. Interrogatory No. 7 is overly broad, unduly burdensome, and not likely to lead to the discovery of admissible evidence. Plaintiffs make no allegations related to the payroll and/or timekeeping practices and procedures and there is no indication whatsoever that the payroll/timekeeping systems used by Denny's are inaccurate or require inspection. Subject to and

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Attorneys At Law
3960 Howard Hughes Parkway
Suite 300
Las Vegas, NV 89169-5937
702 862 8800

without waiving these objections, Defendant responds that Terry Digiamarino has been the Payroll Manager from 2007 – 2010 and 2012 to present. Her contact information is as follows:

Terry Digiamarino
Payroll Manager/Benefits Representative
c/o Littler Mendelson
3960 Howard Hughes Parkway, Suite 300
Las Vegas, NV 89169

INTERROGATORY NO. 8:

Identify each and every member of INKA Restaurant Group, LLC, from November 28, 2006, until the present time. "Identify" with regard to a person shall mean to state that person's name, last known physical address, last known email address, and last known telephone number.

RESPONSE 8:

Objection. Interrogatory No. 8 is overly broad, unduly burdensome, and not likely to lead to the discovery of admissible evidence. Plaintiffs make no allegations related to any member of INKA, LLC.

INTERROGATORY NO. 9:

Identify each and every Denny's owned and/or operated by INKA, and the dates of operation, since November 28, 2006, whether currently in operation or not. "Identify" with regard to a restaurant shall mean to state the restaurant's name or identification number, address, telephone number, form of business entity, owner(s) and their respective ownership interest, and current manager if still in operation.

RESPONSE 9:

Objection. Interrogatory No. 9 is overly broad, unduly burdensome, and not likely to lead to the discovery of admissible evidence. Claims for alleged minimum wage violations before May 30, 2012 are barred by the statute of limitations and, therefore, information about stores prior to May 30, 2012 is not likely to lead to the discovery of admissible evidence. Moreover, any store which closed prior to May 30, 2012 is beyond the scope of this lawsuit. Subject to and without waiving these objections, Defendant responds as follows:

Unit	Address	City	State	Zip Code	Phone	Fax
8685	900 Highway 95 N.	Beatty	NV	89003	775-553-9942	775-553-9956
8560	240 S. Highway 160	Pahrump	NV	89003	775-751-3828	775-751-3834
8659	3081 S. Maryland Parkway	Las Vegas	NV	89109	702-734-1295	702-892-3579
8758	2405 Mountain City Hwy.	Elko	NV	89801	775-777-0810	775-777-1515

INTERROGATORY NO. 10:

Describe with specificity the practice or methodology employed by INKA, since November 28, 2006, to compute or calculate premium costs for all health insurance plans and policies offered or provided by INKA to any Denny's employee paid below the upper-tier minimum hourly wage determined by Nev. Const. art. XV, § 16 and the regulations and annual minimum wage announcements of the Nevada Labor Commissioner. This interrogatory shall be understood to encompass and include medical, dental, and vision benefits plans.

RESPONSE 10:

Objection. Interrogatory No. 10 is vague and ambiguous. The reference to "premium costs for all health insurance" does not specify between costs to the employer and costs to the employees. Moreover, Interrogatory No. 10 is overly broad, unduly burdensome, and not likely to lead to the discovery of admissible evidence. Claims for alleged minimum wage violations before May 30, 2012 are barred by the statute of limitations and, therefore, information about any "practice or methodology" prior to May 30, 2012 is not likely to lead to the discovery of admissible evidence. Moreover, any "practice or methodology" employed prior to May 30, 2012 is beyond the scope of this lawsuit.

INTERROGATORY NO. 11:

Describe with specificity the practice or methodology employed by INKA, since November 28, 2006, to compute or calculate whether premium costs for all health insurance plans and policies offered or provided by INKA to any Denny's employee paid below the upper-tier minimum hourly wage determined by Nev. Const. art. XV, § 16 and the regulations and annual minimum wage announcements of the Nevada Labor Commissioner does not exceed a total cost to the employee for

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702 862 8800

RESPONSE 18:

Objection. This Interrogatory is overly broad, unduly burdensome, and not likely to lead to the discovery of admissible evidence. Plaintiffs' claims for alleged minimum wage violations before May 30, 2012 are barred by the statute of limitations. Therefore, information relating to the insurance offered to Plaintiffs and/or members of the putative class which permitted Defendant to pay the lower tier minimum wage prior to May 30, 2012 is outside the scope of this litigation and not likely to lead to the discovery of admissible evidence. Subject to and without waiving these objections, Defendant responds that there is no single person employed by INKA with the specific responsibility of ensuring that the referenced plans and policies complied with Nev. Const. XV, § 16 and all regulations implementing that constitutional provision, between November 28, 2006 and the present.

Dated: November 5, 2014

Respectfully submitted,

RICK D. ROSKELLEY, ESQ.
ROGER L. GRANDGENETT II, ESQ.
KATIE BLAKEY, ESQ.
LITTLER MENDELSON, P.C.

Attorneys for Defendants

LITTLER MENDELSON, P.C.
ATTORNEYS AT LAW
3960 Howard Hughes Parkway
Suite 300
Las Vegas NV 89169-5937
702 862 8800

VERIFICATION

I, TERRY TIGIAMARINO, declare:

I am the Payroll Administrator/Benefits Manager of Mancha Development Companies, which is the Defendant in the above-entitled action, and I have been authorized to make this verification on its behalf.

I have read the foregoing Defendant INKA, LLC's Response to First Set of Interrogatories by Plaintiffs, on Behalf of the Putative Class, on file herein and know the contents thereof. The same is true of my own knowledge, except as to those matters which are therein stated on information and belief, and, as to those matters, I believe them to be true.

I declare under penalty of perjury under the laws of the United States and the State of California that the foregoing is true and correct.

Executed at Corona, California on this 3 day of November, 2014.

Terry Tigiamarino

TERRY TIGIAMARINO

ITLER MENDELSON, P.C.
Attorneys At Law
3960 Howard Hughes Parkway
Suite 300
Las Vegas, NV 89169-5937
702 862 8800

PROOF OF SERVICE

I am a resident of the State of Nevada, over the age of eighteen years, and not a party to the within action. My business address is 3960 Howard Hughes Parkway, Suite 300, Las Vegas, Nevada 89169. On November 5, 2014, I served the within document:

DEFENDANT INKA, LLC'S RESPONSE TO FIRST SET OF INTERROGATORIES BY PLAINTIFFS, ON BEHALF OF THE PUTATIVE CLASS

☒ By CM/ECF Filing – Pursuant to Administrative Order 14-2 and Rule 9 of the N.E.F.C.R. the above-referenced document was electronically filed and served upon the parties listed below through the Court's Case Management and Electronic Case Filing (Wiznet) System:

Don Springmeyer, Esq.
Bradley Schrager, Esq.
Daniel Bravo, Esq.
Wolf, Rifkin, Shapiro, Schulman & Rabkin, LLP
3556 E. Russell Road, 2nd Floor
Las Vegas, NV 89120-2234

I declare under penalty of perjury that the foregoing is true and correct. Executed on November 5, 2014, at Las Vegas, Nevada.

Debra Perkins

Debra Perkins

Firmwide:129188793.1 081404.1002

LITTLER MENDELSON, P.C.
Attorneys At Law
3960 Howard Hughes Parkway
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702 862 8800

Exhibit 9

Exhibit 9

INTG
RICK D. ROSKELLEY, ESQ., Bar # 3192
ROGER L. GRANDGENETT II, ESQ., Bar # 6323
KATIE BLAKEY, ESQ., Bar # 12701
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Telephone: 702.862.8800
Fax No.: 702.862.8811

Attorneys for Defendants

DISTRICT COURT

CLARK COUNTY, NEVADA

PAULETTE DIAZ, an individual; and LAWANDA GAIL WILBANKS, an individual; SHANNON OLSZYNSKI, and individual; CHARITY FITZLAFF, an individual, on behalf of themselves and all similarly-situated individuals, Plaintiffs, vs. MDC RESTAURANTS, LLC, a Nevada limited liability company; LAGUNA RESTAURANTS, LLC, a Nevada limited liability company; INKA, LLC, a Nevada limited liability company and DOES 1 through 100, Inclusive, Defendants.	Case No. A-14-701633-C Dept. No. XVI **DEFENDANT LAGUNA RESTAURANTS, LLC'S RESPONSES TO THIRD SET OF INTERROGATORIES BY PLAINTIFFS, ON BEHALF OF THE PUTATIVE CLASS**

PROPOUNDING PARTY: PLAINTIFFS, ON BEHALF OF PUTATIVE CLASS

RESPONDING PARTY: DEFENDANT LAGUNA RESTAURANTS, LLC

SET NO.: THREE (3)

Defendant Laguna Restaurants, LLC ("Defendant" or "Laguna") hereby submits its Responses to Third Set of Interrogatories by Plaintiffs, on Behalf of the Putative Class as follows:

///

///

PRELIMINARY STATEMENT

The information contained in the responses set forth below is based only upon the information and documents currently available to Defendant. Defendant's investigation and discovery in preparation for trial has not been completed. Additional investigation may disclose further information and documents relevant to these responses, as could information and documents obtained by Defendant from Plaintiff or third parties through additional discovery procedures. Therefore, Defendant expressly reserves the right to alter, amend, supplement, modify or otherwise revise its responses if, for any reason, such alterations, amendments, supplements, modifications or revisions become appropriate or warranted or as may be required by Rule 33 of the Nevada Rules of Civil Procedure.

All of Defendant's responses are made subject to this preliminary statement.

INTERROGATORIES

INTERROGATORY NO. 38:

State the number of employees employed at all Restaurants between November 28, 2006, and Present (by year), that were paid less than the Upper-tier minimum wage as a regular hourly wage rate, excluding any tips, gratuities, or bonuses. For purposes of this request, the term "Upper-tier minimum wage" shall mean and refer to the highest applicable minimum wage rate set forth in article XV, section 16 of the Nevada Constitution, N.A.C. 608.100, and/or as published by the office of the Nevada Labor Commissioner since November 28, 2006.

RESPONSE TO INTERROGATORY NO. 38:

Objection. Interrogatory No. 38 is overly broad, unduly burdensome, and not likely to lead to the discovery of admissible evidence. Claims for alleged minimum wage violations before May 30, 2012 are barred by the statute of limitations and, therefore, information about employees prior to May 30, 2012 is not likely to lead to the discovery of admissible evidence. Moreover, any employee whose employment with Defendant terminated prior to May 30, 2012 cannot be a part of the alleged class. Accordingly, this request seeks information outside the scope of this litigation that would be burdensome to retrieve and not likely to lead to the discovery of admissible evidence. Subject to and without waiving these objections, Defendant responds that all of Defendant's employees were paid

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at least $7.55 per hour prior to July 2010 and from Mary 30, 2012 to present, Defendant employed approximately 19 employees that were paid less than $8.25 per hour.

INTERROGATORY NO. 39:

Identify all Restaurants owned and/or operated by Laguna, and the dates of operation, since November 28, 2006, whether currently in operation or not. "Identify" with regard to a restaurant shall mean to state the restaurant's name or identification number, address, telephone number, form of business entity, owner(s) and their respective ownership interest, and current manager if still in operation.

RESPONSE TO INTERROGATORY NO. 39:

Objection. Interrogatory No. 39 is overly broad, unduly burdensome, and not likely to lead to the discovery of admissible evidence. Claims for alleged minimum wage violations before May 30, 2012 are barred by the statute of limitations and, therefore, information about stores prior to May 30, 2012 is not likely to lead to the discovery of admissible evidence. Moreover, any store which closed prior to May 30, 2012 is beyond the scope of this lawsuit. Subject to and without waiving these objections, Defendant responds as follows:

LAGUNA RESTAURANTS, LLC		
dba Mega Café Restaurant #3		
Coffee Shop at Whiskey Pete's 100 W. Primm Blvd. Jean, NV 89019	(702) 386-7867	Apr-30-2009 **closed** 7/31/2012
dba Gallery Café #1		
Terribles Prim Valley Resort & Casino 31900 Las Vegas Blvd. South Primm, Nevada 89109	(702) 679-5577	Nov-11-2009 **closed** 6/17/2012

INTERROGATORY NO. 40:

Describe with specificity, and indicate effective dates of all health insurance plans and policies offered or provided by Laguna between November 28, 2006, and Present, to any Restaurants' employee that was paid less than the Upper-tier minimum wage as a regular hourly wage rate, excluding any tips, gratuities, or bonuses. For purposes of this request, the term "Upper-

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tier minimum wage" shall mean and refer to the highest applicable minimum wage rate set forth in article XV, section 16 of the Nevada Constitution, N.A.C. 608.100, and/or as published by the office of the Nevada Labor Commissioner since November 28, 2006. This interrogatory shall be understood to encompass and include medical, dental, and vision benefits plans.

RESPONSE TO INTERROGATORY NO. 40:

Objection. This request for production is overly broad, unduly burdensome, and not likely to lead to the discovery of admissible evidence. Plaintiffs' claims for alleged minimum wage violations before May 30, 2012 are barred by the statute of limitations. Therefore, information relating to the insurance offered to Plaintiffs and/or members of the putative class which permitted Defendant to pay the lower tier minimum wage prior to May 30, 2012 is outside the scope of this litigation and not likely to lead to the discovery of admissible evidence. Subject to and without waiving these objections, Defendant refers to Defendants' First Supplemental Disclosures bates nos. MDC00129 – MDC00130. The effective dates of all health insurance plans and policies offered or provided by Defendant during the relevant time period are specified in the documents identified therein.

Dated: January 20, 2015

Respectfully submitted,

RICK D. ROSKELLEY, ESQ.
ROGER L. GRANDGENETT II, ESQ.
KATHRYN BLAKEY, ESQ.
LITTLER MENDELSON, P.C.

Attorneys for Defendants

LITTLER MENDELSON, P.C.
Attorneys At Law
3960 Howard Hughes Parkway
Suite 300
Las Vegas, NV 89169-5937
702.862.8800

VERIFICATION

I, TERRY TIGIAMARINO, declare:

I am the Payroll Administrator/Benefits Manager of Mancha Development Companies, which is the Defendant in the above-entitled action, and I have been authorized to make this verification on its behalf.

I have read the foregoing Defendant Laguna Restaurants, LLC's Responses to Second Set of Interrogatories by Plaintiffs, on Behalf of the Putative Class, on file herein and know the contents thereof. The same is true of my own knowledge, except as to those matters which are therein stated on information and belief, and, as to those matters, I believe them to be true.

I declare under penalty of perjury under the laws of the United States and the State of California that the foregoing is true and correct.

Executed at Corona, California on this 14 day of January, 2015.

TERRY TIGIAMARINO

LITTLER MENDELSON, P.C.
Attorneys At Law
3960 Howard Hughes Parkway
Suite 300
Las Vegas, NV 89169-5937
702.862.8800

PROOF OF SERVICE

I am a resident of the State of Nevada, over the age of eighteen years, and not a party to the within action. My business address is 3960 Howard Hughes Parkway, Suite 300, Las Vegas, Nevada 89169. On January 20, 2015, I served the within document:

DEFENDANT LAGUNA RESTAURANTS, LLC'S RESPONSES TO THIRD SET OF INTERROGATORIES BY PLAINTIFFS, ON BEHALF OF THE PUTATIVE CLASS

☒ Via Electronic Service - pursuant to N.E.F.C.R Administrative Order: 14-2.

Don Springmeyer, Esq.
Bradley Schrager, Esq.
Daniel Bravo, Esq.
Royi Moas, Esq.
Wolf, Rifkin, Shapiro, Schulman & Rabkin, LLP
3556 East Russell Road, Second Floor
Las Vegas, Nevada 89120

I declare under penalty of perjury that the foregoing is true and correct. Executed on January 20, 2015, at Las Vegas, Nevada.

Debra Perkins

Firmwide:130966134.1 081404.1002

LITTLER MENDELSON, P.C.
Attorneys At Law
3960 Howard Hughes Parkway
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Las Vegas, NV 89169.5937
702.862.8800

Exhibit 10

Exhibit 10

INTG
RICK D. ROSKELLEY, ESQ., Bar # 3192
ROGER L. GRANDGENETT II, ESQ., Bar # 6323
KATHRYN B. BLAKEY, ESQ., Bar # 12701
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Telephone: 702.862.8800
Fax No.: 702.862.8811

Attorneys for Defendants

EIGHTH JUDICIAL DISTRICT COURT

CLARK COUNTY, NEVADA

PAULETTE DIAZ, an individual; and LAWANDA GAIL WILBANKS, an individual; SHANNON OLSZYNSKI, and individual; CHARITY FITZLAFF, an individual, on behalf of themselves and all similarly-situated individuals,

Plaintiffs,

vs.

MDC RESTAURANTS, LLC, a Nevada limited liability company; LAGUNA RESTAURANTS, LLC, a Nevada limited liability company; INKA, LLC, a Nevada limited liability company and DOES 1 through 100, Inclusive,

Defendants.

Case No. A701633

Dept. No. XV

DEFENDANT MDC RESTAURANTS, LLC'S SUPPLEMENTAL RESPONSE TO INTERROGATORY NO. 5

PROPOUNDING PARTY: PLAINTIFFS, ON BEHALF OF PUTATIVE CLASS

RESPONDING PARTY: DEFENDANT MDC RESTAURANTS, LLC

SET NO.: ONE

Defendant MDC Restaurants, LLC ("Defendant" or "MDC") hereby submits its Supplemental Response to Interrogatory No. 5 by Plaintiffs, on Behalf of the Putative Class as follows:

PRELIMINARY STATEMENT

The information contained in the responses set forth below is based only upon the information and documents currently available to Defendant. Defendant's investigation and discovery in preparation for trial has not been completed. Additional investigation may disclose further information and documents relevant to these responses, as could information and documents obtained by Defendant from Plaintiff or third parties through additional discovery procedures. Therefore, Defendant expressly reserves the right to alter, amend, supplement, modify or otherwise revise its responses if, for any reason, such alterations, amendments, supplements, modifications or revisions become appropriate or warranted or as may be required by Rule 33 of the Nevada Rules of Civil Procedure.

All of Defendant's responses are made subject to this preliminary statement.

INTERROGATORIES

INTERROGATORY NO. 5:

State the number of employees employed at all Denny's between July 1, 2010, and the present that were paid less than $8.25 per hour as a regular hourly wage rate, excluding any tips, gratuities, or bonuses.

RESPONSE 5:

Objection. Interrogatory No. 5 is overly broad, unduly burdensome, and not likely to lead to the discovery of admissible evidence. Claims for alleged minimum wage violations before May 30, 2012 are barred by the statute of limitations and, therefore, information about employees prior to May 30, 2012 is not likely to lead to the discovery of admissible evidence. Moreover, any employee whose employment with Denny's terminated prior to May 30, 2012 cannot be a part of the alleged class. Accordingly, this request seeks information outside the scope of this litigation that would be burdensome to retrieve and not likely to lead to the discovery of admissible evidence. Subject to and without waiving these objections, and in compliance with the Discovery Commissioner's Report and Recommendation entered on March 13, 2015, Defendant responds that from July 1, 2010 to time of production, it has employed approximately 2,100 employees that were paid less than $8.25 per hour.

ITTLER MENDELSON, P.C.
ATTORNEYS AT LAW
3960 Howard Hughes Parkway
Suite 300
Las Vegas, NV 89169-5937
702 862 8800

Dated: March 26, 2015

Respectfully submitted,

RICK D. ROSKELLEY, ESQ.
ROGER L. GRANDGENETT II, ESQ.
KATHRYN B. BLAKEY, ESQ.
LITTLER MENDELSON, P.C.

Attorneys for Defendants

LITTLER MENDELSON, P.C.
Attorneys At Law
3960 Howard Hughes Parkway
Suite 300
Las Vegas, NV 89169-5937
702 862 8800

VERIFICATION

I, TERRY TIGIAMARINO, declare:

I am the Payroll Administrator/Benefits Manager of Mancha Development Companies, which is the Defendant in the above-entitled action, and I have been authorized to make this verification on its behalf.

I have read the foregoing Defendant MDC Restaurants, LLC's Supplemental Response to Interrogatory No. 5 by Plaintiffs, on Behalf of the Putative Class, on file herein and know the contents thereof. The same is true of my own knowledge, except as to those matters which are therein stated on information and belief, and, as to those matters, I believe them to be true.

I declare under penalty of perjury under the laws of the United States and the State of California that the foregoing is true and correct.

Executed at Corona, California on this 26 day of March, 2015.

Terry L Tigiamarino

TERRY TIGIAMARINO

LITTLER MENDELSON, P.C.
ATTORNEYS AT LAW
3960 Howard Hughes Parkway
Suite 300
Las Vegas, NV 89169.5937
702.862.8800

PROOF OF SERVICE

I am a resident of the State of Nevada, over the age of eighteen years, and not a party to the within action. My business address is 3960 Howard Hughes Parkway, Suite 300, Las Vegas, Nevada 89169. On March 26, 2015, I served the within document:

DEFENDANT MDC RESTAURANTS, LLC'S SUPPLEMENTAL RESPONSE TO INTERROGATORY NO. 5

☒ By CM/ECF Filing – Pursuant to Administrative Order 14-2 and Rule 9 of the N.E.F.C.R. the above-referenced document was electronically filed and served upon the parties listed below through the Court's Case Management and Electronic Case Filing (Wiznet) System:

Don Springmeyer, Esq.
Bradley Schrager, Esq.
Daniel Bravo, Esq.
Royi Moas, Esq.
Wolf, Rifkin, Shapiro, Schulman & Rabkin, LLP
3556 E. Russell Road, 2nd Floor
Las Vegas, NV 89120-2234

I declare under penalty of perjury that the foregoing is true and correct. Executed on March 26, 2015, at Las Vegas, Nevada.

Debra Perkins

Firmwide:132385638.1 081404.1002

LITTLER MENDELSON, P.C.
ATTORNEYS AT LAW
3960 Howard Hughes Parkway
Suite 300
Las Vegas, NV 89169-5937
702 862 8800

Exhibit 11

Exhibit 11

ELECTRONICALLY SERVED
03/26/2015 05:18:42 PM

INTG
RICK D. ROSKELLEY, ESQ., Bar # 3192
ROGER L. GRANDGENETT II, ESQ., Bar # 6323
KATIE BLAKEY, ESQ., Bar # 12701
LITTLER MENDELSON, P.C.
3960 Howard Hughes Parkway
Suite 300
Las Vegas, NV 89169-5937
Telephone: 702.862.8800
Fax No.: 702.862.8811

Attorneys for Defendants

EIGHTH JUDICIAL DISTRICT COURT

CLARK COUNTY, NEVADA

PAULETTE DIAZ, an individual; and LAWANDA GAIL WILBANKS, an individual; SHANNON OLSZYNSKI, and individual; CHARITY FITZLAFF, an individual, on behalf of themselves and all similarly-situated individuals,

Plaintiffs,

vs.

MDC RESTAURANTS, LLC, a Nevada limited liability company; LAGUNA RESTAURANTS, LLC, a Nevada limited liability company; INKA, LLC, a Nevada limited liability company and DOES 1 through 100, Inclusive,

Defendants.

Case No. A701633

Dept. No. XV

DEFENDANT INKA, LLC'S SUPPLEMENTAL RESPONSE INTERROGATORY NO. 5

PROPOUNDING PARTY: PLAINTIFFS, ON BEHALF OF PUTATIVE CLASS

RESPONDING PARTY: DEFENDANT INKA, LLC

SET NO.: ONE

Defendant INKA Restaurants, LLC ("Defendant" or "INKA") hereby submits its Supplemental Response to Interrogatory No. 5 by Plaintiffs, on Behalf of the Putative Class as follows:

///

PRELIMINARY STATEMENT

The information contained in the responses set forth below is based only upon the information and documents currently available to Defendant. Defendant's investigation and discovery in preparation for trial has not been completed. Additional investigation may disclose further information and documents relevant to these responses, as could information and documents obtained by Defendant from Plaintiff or third parties through additional discovery procedures. Therefore, Defendant expressly reserves the right to alter, amend, supplement, modify or otherwise revise its responses if, for any reason, such alterations, amendments, supplements, modifications or revisions become appropriate or warranted or as may be required by Rule 33 of the Nevada Rules of Civil Procedure.

All of Defendant's responses are made subject to this preliminary statement.

INTERROGATORIES

INTERROGATORY NO. 5:

State the number of employees employed at all Denny's between July 1, 2010, and the present that were paid less than $8.25 per hour as a regular hourly wage rate, excluding any tips, gratuities, or bonuses.

RESPONSE 5:

Objection. Interrogatory No. 5 is overly broad, unduly burdensome, and not likely to lead to the discovery of admissible evidence. Claims for alleged minimum wage violations before May 30, 2012 are barred by the statute of limitations and, therefore, information about employees prior to May 30, 2012 is not likely to lead to the discovery of admissible evidence. Moreover, any employee whose employment with Denny's terminated prior to May 30, 2012 cannot be a part of the alleged class. Accordingly, this request seeks information outside the scope of this litigation that would be burdensome to retrieve and not likely to lead to the discovery of admissible evidence. Subject to and without waiving these objections, and in compliance with the Discovery Commissioner's Report and Recommendation entered on March 13, 2015, Defendant responds that from July 1, 2010 to time of production, it has employed approximately 426 employees that were paid less than $8.25 per hour.

JACKSON LEWIS P.C.
ATTORNEYS AT LAW
3960 Howard Hughes Parkway
Suite 300
Las Vegas, NV 89169-5937
702 862 8800

Dated: March 26, 2015

Respectfully submitted,

RICK D. ROSKELLEY, ESQ.
ROGER L. GRANDGENETT II, ESQ.
KATHRYN B. BLAKEY, ESQ.
LITTLER MENDELSON, P.C.

Attorneys for Defendants

LITTLER MENDELSON, P.C.
ATTORNEYS AT LAW
3960 Howard Hughes Parkway
Suite 300
Las Vegas NV 89169-5937
702 862 8800

VERIFICATION

I, TERRY TIGIAMARINO, declare:

I am the Payroll Administrator/Benefits Manager of Mancha Development Companies, which is the Defendant in the above-entitled action, and I have been authorized to make this verification on its behalf.

I have read the foregoing Defendant INKA, LLC's Supplemental Response to Interrogatory No. 5 by Plaintiffs, on Behalf of the Putative Class, on file herein and know the contents thereof. The same is true of my own knowledge, except as to those matters which are therein stated on information and belief, and, as to those matters, I believe them to be true.

I declare under penalty of perjury under the laws of the United States and the State of California that the foregoing is true and correct.

Executed at Corona, California on this 26 day of March, 2015.

Terry L DiGiamarino

TERRY TIGIAMARINO

LITTLER MENDELSON, P.C.
ATTORNEYS AT LAW
3960 Howard Hughes Parkway
Suite 300
Las Vegas, NV 89169-5937
702.862.8800

PROOF OF SERVICE

I am a resident of the State of Nevada, over the age of eighteen years, and not a party to the within action. My business address is 3960 Howard Hughes Parkway, Suite 300, Las Vegas, Nevada 89169. On March 26, 2015, I served the within document:

DEFENDANT INKA, LLC'S SUPPLEMENTAL RESPONSE INTERROGATORY NO. 5

☒ By CM/ECF Filing – Pursuant to Administrative Order 14-2 and Rule 9 of the N.E.F.C.R. the above-referenced document was electronically filed and served upon the parties listed below through the Court's Case Management and Electronic Case Filing (Wiznet) System:

Don Springmeyer, Esq.
Bradley Schrager, Esq.
Daniel Bravo, Esq.
Royi Moas, Esq.
Wolf, Rifkin, Shapiro, Schulman & Rabkin, LLP
3556 E. Russell Road, 2nd Floor
Las Vegas, NV 89120-2234

I declare under penalty of perjury that the foregoing is true and correct. Executed on March 26, 2015, at Las Vegas, Nevada.

Debra Perkins

Firmwide:132386422.1 081404.1002

ITTLER MENDELSON, P.C.
ATTORNEYS AT LAW
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Las Vegas, NV 89169-5937
702 862 8800

Exhibit 12

Exhibit 12

ELECTRONICALLY SERVED
03/26/2015 05:17:19 PM

RICK D. ROSKELLEY, ESQ., Bar # 3192
ROGER L. GRANDGENETT II, ESQ., Bar # 6323
KATHRYN BLAKEY, ESQ., Bar # 12701
LITTLER MENDELSON, P.C.
3960 Howard Hughes Parkway
Suite 300
Las Vegas, NV 89169-5937
Telephone: 702.862.8800
Fax No.: 702.862.8811

Attorneys for Defendants

IN THE DISTRICT COURT OF THE STATE OF NEVADA

IN AND FOR THE COUNTY OF CLARK

PAULETTE DIAZ, an individual; and LAWANDA GAIL WILBANKS, an individual; SHANNON OLSZYNSKI, and individual; CHARITY FITZLEFF, an individual, on behalf of themselves and all similarly-situated individuals,

Plaintiffs,

vs.

MDC RESTAURANTS, LLC, a Nevada limited liability company; LAGUNA RESTAURANTS, LLC, a Nevada limited liability company; INKA, LLC, a Nevada limited liability company and DOES 1 through 100, Inclusive,

Defendants.

Case No. A701633

Dept. No. XV

DEFENDANTS MDC RESTAURANTS, LLC'S, LAGUNA RESTAURANTS, LLC'S, AND INKA, LLC'S FIFTH SUPPLEMENTAL DISCLOSURE STATEMENT

Pursuant to the Nevada Rules of Civil Procedure ("NRCP") Rule 16.1, Defendants MDC RESTAURANTS, LLC, LAGUNA RESTAURANTS, LLC, and INKA, LLC, ("Defendants") by and through their attorneys of record, Littler Mendelson, hereby submit its Second Supplemental Disclosures of documents and witnesses.

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IN THE SUPREME COURT OF THE STATE OF NEVADA

MDC RESTAURANTS, LLC, a Nevada limited liability company; LAGUNA RESTAURANTS, LLC, a Nevada limited liability company; INKA, LLC, a Nevada limited liability company,
Petitioners,

vs.

THE EIGHTH JUDICIAL DISTRICT COURT OF THE STATE OF NEVADA in and for the County of Clark and THE HONORABLE TIMOTHY C. WILLIAMS, District Court Judge,
Respondents,

vs.

PAULETTE DIAZ, an individual; LAWANDA GAIL WILBANKS, an individual; SHANNON OLSZYNSKI, an individual; and CHARITY FITZLAFF, an individual, on behalf of themselves and all similarly-situated individuals,
Real Parties in Interest.

Case No.

District Court Case No. A-14-701633-C

District Court Dept. No. XVI

PETITIONERS' APPENDIX

RICK D. ROSKELLEY, ESQ., Nevada Bar # 3192
ROGER L. GRANDGENETT II, ESQ., Nevada Bar # 6323
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PROOF OF SERVICE

I am a resident of the State of Nevada, over the age of eighteen years, and not a party to the within action. My business address is 3960 Howard Hughes Parkway, Suite 300, Las Vegas, Nevada 89169. On July 30, 2015, I served the within document:

PETITIONERS APPENDIX

☒ Via **Electronic Service** - pursuant to N.E.F.C.R Administrative Order: 14-2.

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Attorneys for Real Party in Interest

Honorable Timothy C. Williams
Eighth Judicial District Court, Dept. 16
200 Lewis Avenue
Las Vegas, NV 89155
Respondents

I declare under penalty of perjury that the foregoing is true and correct. Executed on July 30, 2015, at Las Vegas, Nevada.

/s/ Erin J. Melwak
Erin J. Melwak

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