

Benefit Descriptions Continued

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 80% 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;

Benefit Descriptions Continued

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 cesarean 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 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)
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 copay Starbridge pays	\$15 100%	\$15 100%
Inpatient Care Starbridge pays maximum amount paid by plan	100% \$2,000 per coverage year	100% \$2,000 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 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*	discount program included* \$15/generic, \$30/pref. brand 100% \$300 per coverage year
Injury		
Accident Coverage 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 (care you could receive in a doctor's office), your coverage is reduced to: \$100 deductible per occurrence, the plan pays 60% of total bill with a \$500 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.

* The total amount Starbridge pays will count toward your Outpatient Care Maximum. ** The prescription discount program is not insurance.

* Provision varies by state. ** Work related injuries are not covered. The benefits above are provided by policy form SSCA-GMP-02.

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

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 towards 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 1-877-200-7088. Representatives are available Monday through Friday, 9 AM to 6 PM, Mountain Standard time.

LIMITATION FOR PRE-EXISTING CONDITION * - 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 * - 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 * - 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 or 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

- * Provisions, Limitations & Exclusions may vary where required by state law.

Underwritten by Connecticut General Life Insurance Company. This plan may not be available in all states. Plan design and rates may vary. "CIGNA" and "CIGNA HealthCare" refer to various operating subsidiaries of CIGNA Corporation. Products and services are provided by these subsidiaries and not by CIGNA Corporation. These subsidiaries include Connecticut General Life Insurance Company, TD-Drug, Inc. and its affiliates, CIGNA Behavioral Health, Inc., Intrepid, and JACO or service company subsidiaries of CIGNA Health Corporation and CIGNA Dental Health, Inc.

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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.

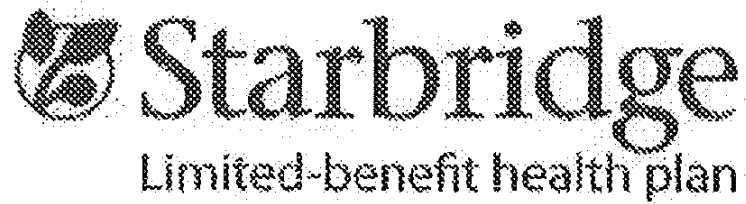
If you have any questions or concerns about this notice, contact Cigna at 1-800-420-6308.

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) 333-1597	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.



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

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Your Plan Information

Plan Name:	CIGNA Starbridge 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 1-800-800-0080. Office hours are from 9 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 1-800-800-0080. El horario de oficina es de las 9 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.
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Accidental Death Benefit

Plan Pays	\$10,000	Amount paid to beneficiary in the event of loss of life due to an accident.
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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/Occurrences	\$1,000 per Occurrence	

The benefits above are provided by policy form SBCIL-CMP-02. All policy benefits are paid per coverage year.

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

Benefit Descriptions

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 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;

Benefit Descriptions Continued

19. 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 expenses 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 80% 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 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 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 complications 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:

Benefit Descriptions Continued

- 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.cignaofvoluntary.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.

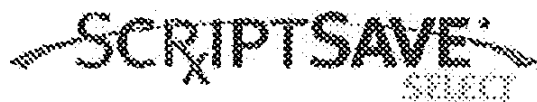
CIGNA HealthCare PPO Network*

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



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.

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: We cannot accept photocopies or faxes for any claim. You must mail the original documents.

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. For 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 increases or decreases 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; or
3. 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 work sites 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 participant's spouse or dependent) 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 plan's 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

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Important Information Continued

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.

Your 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.

Important Information Continued

Newborns' and Mothers' Health Protection Act (NHPA) - 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

Important Information Continued

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.

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

Important Information -- COBRA and Continuation of Coverage Continued

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 55270
Phoenix, Arizona 85078
or call 1-800-859-0086

Notice of Privacy Practices

Si desea recibir esta Aviso Sobre Prácticas 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.

Notice of Privacy Practices Continued

- **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
Charlotte, 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.

"CIGNA HealthCare" refers to various operating subsidiaries of CIGNA Corporation. Products and services are provided by those operating subsidiaries and not by CIGNA Corporation. Those operating subsidiaries include Connecticut General Life Insurance Company, Tel-Drug, Inc. and its affiliate, CIGNA Behavioral Health, Inc., Indacorp, and HMO of service company subsidiaries of CIGNA Health Corporation and CIGNA United Health, Inc.
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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.

1. The following information is required for the purpose of the above mentioned project:

22

22

MCC000118

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
1-800-859-0086

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 <input type="checkbox"/> No <input type="checkbox"/>
City & State	If Yes, Date	
Patient Name (if other than Employee)		Male <input type="checkbox"/> Female <input type="checkbox"/>
Patient Relationship to Employee	Patient Birth Date	Is Patient Married? Yes <input type="checkbox"/> No <input type="checkbox"/>
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.

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

INSURANCE DOCUMENT ENCLOSED

OE0207 144935_SampleOrder.pdf 000001 000001 012

<Mailing_Name>

<Address>

<CITY>, <STATE> <Zip Code>

BACK_0708A

883

MDC000120

Exhibit 17

Exhibit 17

TransChoice® Advance hospital indemnity insurance

Benefit		\$100	\$500	\$1,000
Daily In-Hospital Indemnity Benefit	Pays benefits per day of hospital confinement, up to the annual maximum.	\$100 31 Days per confinement	\$500 31 Days per confinement	\$1,000 31 Days per confinement
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.	\$50 6 Days	\$70 6 Days	\$70 6 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.	\$50 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
		Outpatient surgery	\$250	\$500
		Outpatient minor surgery	\$50	\$100
		Anesthesia percentage	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 90 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
		Name brand prescription	\$20	\$30
		Annual maximum	12 Days per Year	12 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. <i>Dependent percentage</i>	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, Omaha, Nebraska.
Policy Form Series CH01000 and CH01001. Terms and conditions may vary. Coverage may not be available in all jurisdictions.
Underwrite and exclusions apply. Refer to the policy, certificate and riders for complete details.

Issue State: NY

Class: 1500

Classification: No 14,001,000

EC: 5872

Policy type: Voluntary

Age-GR: 50

MDC000129

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 60 Days.	\$ 100	\$ 100	\$ 100
Ambulance Indemnity Benefit	Pays each day a covered person receives licensed ambulance transportation within 96 hours of a covered accident or onset of sickness. Air ambulance pays three times the amount.	No Coverage	\$ 200	\$ 300
Individual Health Insurance Options				
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
Individual Health Insurance Options				
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
TelMedicine 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 Benefit, Ltd.	Provides access to a discount vision plan, nurses' hotline, counseling services and discounts for hearing aids.	Included	Included	Included
PPD Network offered by WGBPA	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 cost paycheck	Employee	Employee + Spouse	Employee + Children	Family
Plan I	\$0.00	\$3.74	\$9.63	\$12.37
Plan II	\$1.64	\$5.43	\$9.34	\$15.51
Plan III	\$3.36	\$10.80	\$9.70	\$12.53

Non-Insurance Benefits

TelMedicine

Healthiestyou provides insureds with telmedicine 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 Benefit 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 ("Insurer")
Home Office: Cedar Rapids, IA
Administrative Office: Wab-TPA
P.O. Box 310, Grapevine, TX 76089-0310

Hospital Indemnity Enrollment Form

<input type="checkbox"/> First Application		<input type="checkbox"/> Add Dependents -- Policy # _____		<input type="checkbox"/> Change Coverage -- Policy # _____	
Group Name		Group Number		Location	
Applicant (Last, First, M.I.)		<input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security No.	Date of birth	Date of marriage
Spouse ¹ (Last, First, M.I.)		<input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security No.	Date of birth	
Email Address		Do you agree to receive correspondence about your coverage electronically? <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Monthly <input type="checkbox"/> Other	
I Am Applying For: <input type="checkbox"/> Individual <input type="checkbox"/> Individual & Spouse <input type="checkbox"/> Individual & Children <input type="checkbox"/> Individual & Family	
Hospital Indemnity Coverage	Premium per Mode
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.	<input type="checkbox"/> Yes <input type="checkbox"/> 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.	<input type="checkbox"/> Yes <input type="checkbox"/> 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.	<input type="checkbox"/> Yes <input type="checkbox"/> No

STATEMENTS AND AGREEMENTS:	
I have read or had read to me the completed enrollment form. I represent (<i>Residents of MN and VA:</i> 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, NM, & 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.

IL: 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.

MI: 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.

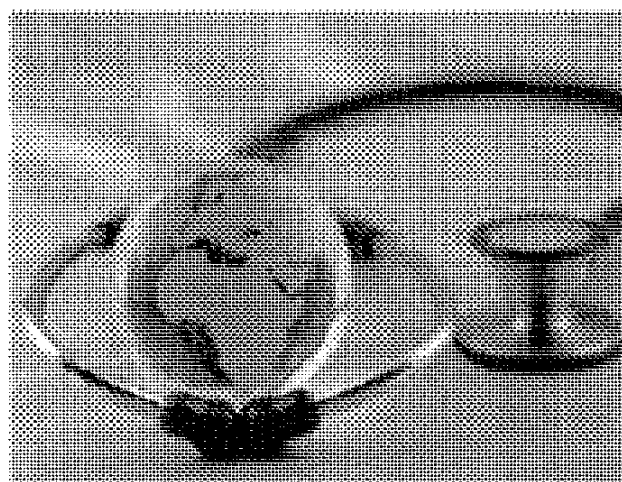
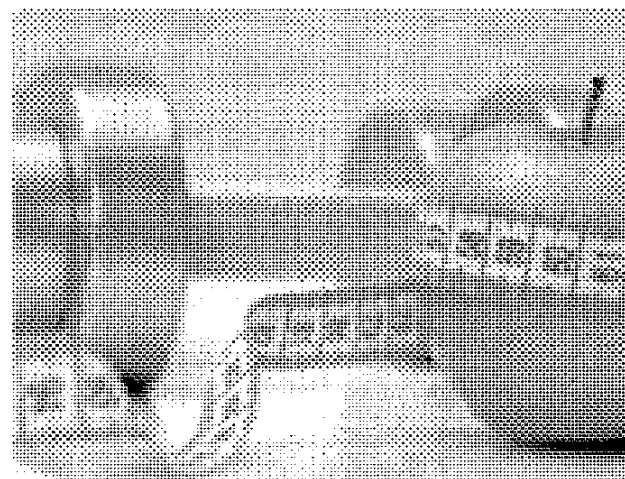
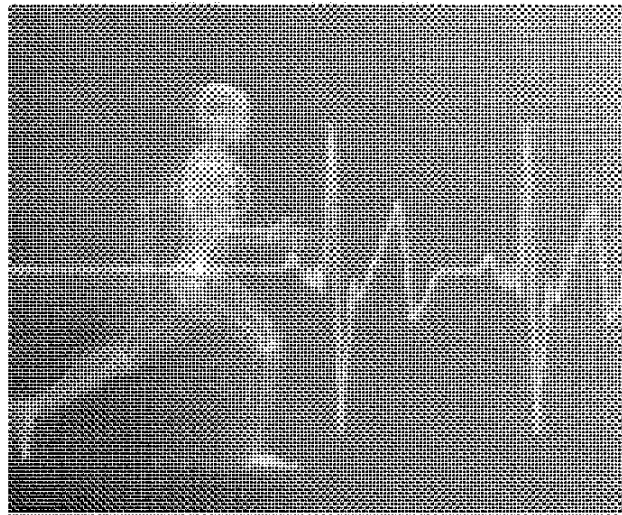
VT: I understand that any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, any information concerning any fact material 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.

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 biotech/specialty medication covered?

All biotech 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
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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 Hypertension/COR Pulmonale	2 Office exams per plan year *Spirometry *12 months of supplemental O2 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

MDC000776



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: <input type="checkbox"/> M <input type="checkbox"/> F	SS #:	No. Hours Work/per week:	
Home Phone #:		Work Phone #:	
Street Address:	City:	State:	Zip:
Please check one of the following: <input type="checkbox"/> New employee OR <input type="checkbox"/> Current employee newly eligible for benefits OR <input type="checkbox"/> 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:					
<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner	Last Name:	First:	SS#:	DOB:	<input type="checkbox"/> Male <input type="checkbox"/> Female
	Last Name:	First:	SS#:	DOB:	<input type="checkbox"/> Male <input type="checkbox"/> Female
<input type="checkbox"/> Child <input type="checkbox"/> Disabled ¹ <input type="checkbox"/> Court Ordered ²					
	Last Name:	First:	SS#:	DOB:	<input type="checkbox"/> Male <input type="checkbox"/> Female
<input type="checkbox"/> Child <input type="checkbox"/> Disabled ¹ <input type="checkbox"/> Court Ordered ²					
	Last Name:	First:	SS#:	DOB:	<input type="checkbox"/> Male <input type="checkbox"/> Female
<input type="checkbox"/> Child <input type="checkbox"/> Disabled ¹ <input type="checkbox"/> Court Ordered ²					
	Last Name:	First:	SS#:	DOB:	<input type="checkbox"/> Male <input type="checkbox"/> Female
<input type="checkbox"/> Child <input type="checkbox"/> Disabled ¹ <input type="checkbox"/> Court Ordered ²					
	Last Name:	First:	SS#:	DOB:	<input type="checkbox"/> Male <input type="checkbox"/> Female
<input type="checkbox"/> Child <input type="checkbox"/> Disabled ¹ <input type="checkbox"/> Court Ordered ²					

¹For disabled dependents; SUBMIT appropriate documentation as proof of disabled status with this enrollment form.

²If 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

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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

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EIGHTH JUDICIAL DISTRICT COURT
IN AND FOR CLARK COUNTY, STATE OF NEVADA

PAULETTE DIAZ, an individual;
LAWANDA GAIL WILBANKS, an
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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.

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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:

WOLF RIFKIN SHAPIRO SCHULMAN & RABKIN, LLP
BY: DANIEL BRAVO
BY: JORDAN J. BUTLER
Attorney at Law
3556 East Russell Road, 2nd Floor
Las Vegas, Nevada 89120
702.341.5200
Dbravo@wrslawyers.com

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INDEX

DEPONENT

EXAMINATION

TERRY DIGIAMARINO

BY MR. BRAVO

5

EXHIBITS

PLAINTIFF'S

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1 Irvine, California, Thursday, March 12, 2015

2 9:06 a.m. - 12:51 p.m.

3

4 TERRY DIGIAMARINO,

5 having been first placed under oath,

6 was examined and testified as follows:

7

8 EXAMINATION

9 BY MR. BRAVO:

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

12 A It's --

13 Q And spell it.

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

16 Q May I call you Terry?

17 A Yes, please.

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

24 Terry, where do you currently reside?

25 A My full address?

Page 5

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

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

8 Q Okay. Do you know what the current plan is for
9 2015 for insurance in Nevada?

10 A For hourly, it's called an MVP.

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

13 A Transamerica.

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

17 A Starbridge. Cigna. Starbridge.

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

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

22 Q Does the MVP plan provide dental?

23 A Separate. Totally separate.

24 Q Does the MVP plan provide vision?

25 A It's totally separate.

1 Q Do you know what the MVP plan provides Nevada
2 hourly employees?

3 A No.

4 Q Prior to the MVP plan, was the Transamerica or
5 TransChoice plan provided to all Nevada hourly
6 employees?

7 A Yes.

8 Q Prior to Transamerica/TransChoice plan, was the
9 Starbridge offered to all hourly employees?

10 A Yes.

11 Q Has the dental plan changed from Guardian? To
12 Guardian? Excuse me. Was there -- was there a dental
13 plan prior to Guardian?

14 A Yes.

15 Q What was that?

16 A Assurant.

17 Q Were Nevada hourly employees offered Assurant?

18 A Yes.

19 Q Was every hourly employee offered Assurant?

20 A Yes.

21 Q And was there a different vision plan prior to
22 VSP?

23 A Not since I've been there, no.

24 Q Okay. The -- do you know if the VSP plan was
25 always offered to hourly employees since you began?

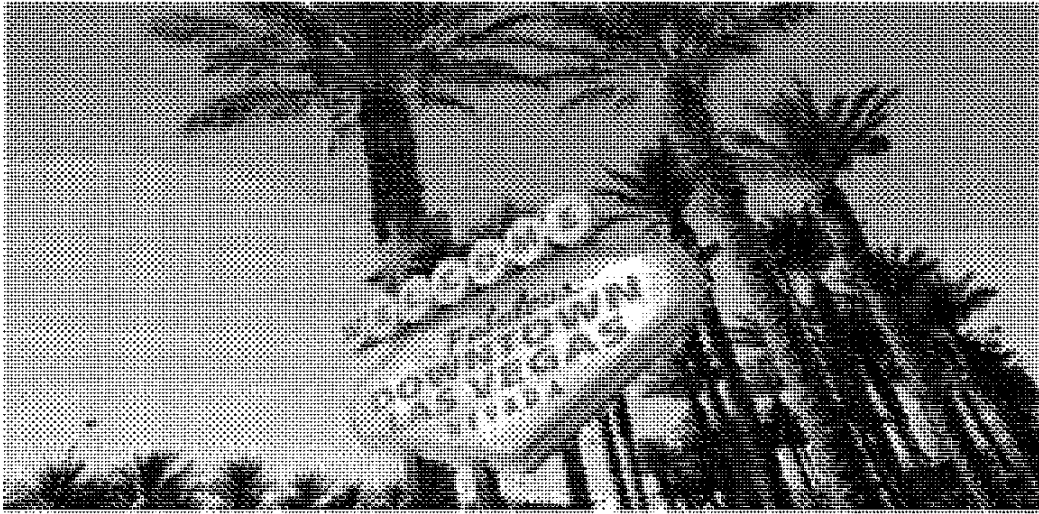
1 I, the undersigned, a Certified Shorthand
2 Reporter of the State of California, Registered
3 Professional Reporter, do hereby certify:
4 That the foregoing proceedings were taken
5 before me at the time and place herein set forth; that
6 any witnesses in the foregoing proceedings, prior to
7 testifying, were duly sworn; that a record of the
8 proceedings was made by me using machine shorthand which
9 was thereafter transcribed under my direction; that the
10 foregoing transcript is a true record of the testimony
11 given.
12 Further, that if the foregoing pertains to the
13 original transcript of a deposition in a Federal Case,
14 before completion of the proceedings, review of the
15 transcript [] was [] was not requested.
16 I further certify I am neither financially interested in
17 the action nor a relative or employee of any attorney or
18 party to this action.
19 IN WITNESS WHEREOF, I have this date subscribed
20 my name.
21
22 Dated: 03/26/2015
23
24 <%signature%>
CARA JACOBSEN
CSR No. 13053
25

Page 109

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:

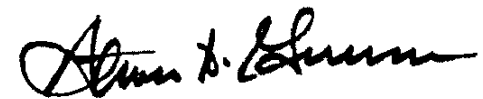
- Arbitration of Owner Disputes
- Bankruptcy Advice & Monitoring
- Drafting, Interpretation and Enforcement of Bylaws and CC&Rs
- Collection and Lien Foreclosure
- Construction Defect Litigation
- General Business Advice
- Insurance Related Litigation and Damage Claims
- Participation in Homeowner Meetings 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.

Exhibit B



CLERK OF THE COURT

RICK D. ROSKELLEY, ESQ., Bar # 3192
ROGER L. GRANDGENETT II, ESQ., Bar # 6323
MONTGOMERY Y. PAEK, ESQ., Bar #10176
KATHRYN B. 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 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. XVI

**DEFENDANTS' OPPOSITION TO
MOTION FOR PARTIAL SUMMARY
JUDGMENT ON LIABILITY AS TO
PLAINTIFF PAULETTE DIAZ'S FIRST
CLAIM FOR RELIEF**

Hearing Date: June 16, 2015

Hearing Time: 9:00 a.m.

Defendants, by and through their counsel of record, hereby oppose the Motion for Partial Summary Judgment on Liability as to Plaintiff Paulette Diaz's First Claim for Relief and submits its Countermotion for Partial Summary Judgment on Liability for an Order finding that employers who offer their employees qualified health insurance are permitted under the MWA to pay those employees below the upper tier minimum wage. This Opposition is based on the attached Memorandum of Points and Authorities, all papers and files on file herein and any oral argument permitted.

1 MEMORANDUM OF POINTS & AUTHORITIES

2 **I. INTRODUCTION**

3 Plaintiff Daiz's Motion seeking a partial summary judgment turns on the definition of a
4 single word: provide. In order to prevail on his Motion, Plaintiff Diaz must convince this Court that
5 unless she actually personally enrolled in the health plan admittedly made available to her by her
6 employer, Defendant did not "provide" health benefits as that term is used in Nev. Const. art XV §
7 16 (Nevada Constitution's Minimum Wage Amendment or "MWA").¹ **See, Diaz Motion, at 3:6-7.**
8 There is, however, one problem with this argument. It is flat out wrong.

9 Even a cursory review of his Points and Authorities reveals that Plaintiff has engaged in
10 extensive verbal gyrations and resorted to blatant omissions to arrive at the tortured definition she
11 proffers to support her unwonted position. Indeed, Plaintiff intentionally ignored numerous terms
12 and synonyms to the contrary in order to argue that "provide" as used in the MWA requires that she
13 actually enroll in health benefits. Citing but one example, the online Merriam-Webster Dictionary
14 cited by Plaintiff prominently contains among its first definitions of the term "provide" "to make
15 (something) available." Moreover, Plaintiff doubles down on his deliberately obfuscated definition
16 by failing to quote the sentence following language of the MWA on which he relies: a sentence
17 which unmistakably clarifies that the terms provide and offer were intended by the drafters of the
18 MWA to be synonymous. "Offering health benefits within the meaning of this section shall consist
19 of making health insurance available to the employee for the employee and the employee's
20 dependents...." Nev. Const. art XV § 16.

21 The putrescence of Plaintiff's argument is further highlighted by the fact that she completely
22 fails to discuss the regulations implementing the MWA. The regulations specifically state that
23 qualification to pay the lower tier minimum wage is predicated on making health insurance
24 "available to the employee and any dependents of the employee," not on actual enrollment by the
25 employee. NAC 608.102(2). Finally, by taking the position he has in this case, Plaintiff is in
26 essence asking this Court to vitiate duly enacted regulations on which Defendant WOLV, and
27

28 ¹ Although Plaintiff Diaz has filed this lawsuit against all three Defendants, Defendant MDC Restaurants is the only Defendant to have employed Diaz during the relevant statute of limitations.

1 practically every other employer in Nevada, has reasonably relied. The retroactive effect of such a
2 ruling would be a classic blunder and clear violation of WOLV's and other Nevada employers' due
3 process.

4 Accordingly, there is but one clear meaning of the word provide in the MWA. Indeed, the
5 unambiguous language of the MWA, the implementing regulations and even the various dictionaries
6 Plaintiff cites confirm that health benefits are provided within the meaning of the Nevada
7 Constitution when an employer offers or makes "health insurance available" to its employees.

8 **II. STANDARD OF REVIEW**

9 The Nevada Supreme Court has long held that entry of summary judgment is proper when
10 there are no issues of fact in dispute and that the moving party is entitled to an expedited judgment
11 as a matter of law. *Riley v. OPP IX, L.P.*, 112 Nev. 826, 830, 919 P.2d 1071, 1074 (1996). A
12 genuine issue of material fact is such that a reasonable jury could return a verdict for the non-moving
13 party. *Id.* (Citing *Valley Bank v. Marble*, 105 Nev. 366, 367, 775 P.2d 1278, 1279 (1989)).
14 Moreover, the Nevada Supreme Court has adopted the same summary judgment principles espoused
15 by the United States Supreme Court in *Celotex Corp v. Catrett*, 477 U.S. 317, 106 S. Ct. 2548
16 (1986). *Wood v. Safeway, Inc.*, 121 Nev. 724, 731, 121 P.3d 1026, 1031 (2005). In *Wood*, the
17 Nevada Supreme Court held that NRCP 56 mandates the entry of summary judgment against a party
18 who fails to make a showing sufficient to establish the existence of an element essential to that
19 party's case, and on which that party will bear the burden of proof at trial. *Wood* at 731. One of the
20 principal purposes of the summary judgment rule is to isolate and dispose of factually unsupported
21 claims. *Id.* at 324. Here, Plaintiff cannot prove any of the required elements to sustain her Motion
22 and thus her Motion should be denied in its entirety.

23 **III. ADDITIONAL UNDISPUTED FACTS**

24 Defendants concur that the facts 1-5 in Plaintiff's Section III Undisputed Facts are correct,
25 with the exception that Defendants contend that Plaintiff's employer did provide qualifying health
26 insurance benefits for all its hourly employees, including Plaintiff. In addition, Defendants proffer
27 the following undisputed facts which are material to a resolution of the instant Motion:

- 28 1. Plaintiff Diaz was offered insurance at her time of hire. **See Plaintiff Diaz Insurance**

3.

1 **Enrollment Form, produced as bates no. MDC000002, attached hereto as Exhibit 1.**

2 2. Plaintiff Diaz declined the health insurance offered to her. *See Plaintiff Diaz Insurance*
3 **Enrollment Form, produced as bates no. MDC000002, attached hereto as Exhibit 1.**

4 **IV. ARGUMENT**

5 The MWA sets forth a very clear directive for Nevada employers paying minimum wage: if
6 they provide health insurance to their employees, they may pay the lower-tier minimum wage. Nev.
7 Const. art XV § 16. Indeed, the parties agree that this is inherent in the plain language of the MWA.
8 *See Diaz Motion, at 7:5-6.* The disagreement therefore, rests solely on what is meant by the word
9 “provide.” According to Plaintiff, provide in this context means that an employer must not only
10 provide benefits by making them available to its employees but the employees must also actually
11 enroll in the employer-based insurance plans. In other words, Plaintiff claims that benefits are not
12 provided unless forced on employees.

13 Such an interpretation of the word provide is ludicrous for three key reasons: (1) the MWA
14 directs employers to offer insurance and it does not require employees to enroll in insurance; (2) the
15 regulations implementing the MWA specifically state that employers need only offer qualifying
16 health insurance benefits in order to pay the lower-tier minimum wage; and (3) the retroactive effect
17 of a ruling requiring employees to be enrolled in insurance prior to being paid the lower-tier
18 minimum wage would be a violation of due process.

19 The fact that Plaintiff chose not to enroll in the health insurance provided to her is irrelevant.
20 Accordingly, Defendants respectfully request that the Court deny Plaintiff’s Motion in its entirety
21 and enter an order to the effect that employers who offer their employees qualified health insurance
22 are compliant with the MWA.

23 **A. The Nevada Constitution Directs Employers to Offer Insurance to Employees In**
24 **Order to Pay the Lower-Tier Minimum Wage**

25 The MWA focuses on what actions employers must take in order to pay below the upper tier
26 minimum wage. *See Nev. Const. art XV § 16.* Specifically, it directs employers to offer health
27 insurance benefits to their employees. *Id.* At no point does it discuss or even mention any action
28 that must be taken by employees. *See id.* Thus, Plaintiff’s assertion that the MWA states that

1 employees must enroll in the health insurance plan provided to them by their employers in order to
2 be paid below the upper tier minimum wage is completely erroneous and contrary to the clear
3 directive of the MWA. **See Diaz Motion, at 4:3-5.**

4 Indeed, the MWA directs only that employers must offer insurance and Plaintiff's argument
5 that employees must enroll in insurance fails for three reasons: (1) the plain language of the MWA
6 permits payment of the lower-tier minimum wage where the employer offers health benefits to its
7 employees; (2) Plaintiff's unreasonably restricted definition of the word "provide" renders the
8 language of the MWA nugatory; and (3) Plaintiff's purported authority for his position is inapposite
9 to the instant matter.

10 1. The Plain Language of the MWA Permits Payment of the Lower-Tier Minimum
11 Wage Where the Employer Offers Health Benefits to its Employees

12 When the words of a statute have a definite and ordinary meaning, the court should not look
13 beyond "the plain language of the statute, unless it is clear that this meaning was not intended."
14 *Harris Associates v. Clark Cnty. Sch. Dist.*, 119 Nev. 638, 641-42, 81 P.3d 532, 534 (2003) (citing
15 *State v. Quinn*, 117 Nev. 709, 713, 30 P.3d 1117, 1120 (2001)); see also *Glover v. Concerned*
16 *Citizens for Fuji Park*, 118 Nev. 488 (2002) (stating that "[i]t is well established that when the
17 language of a statute is unambiguous, a court should give that language its ordinary meaning"),
18 *overruled in part by Garvin v. Dist. Ct.*, 118 Nev. 749 (2002). Here, the plain language of the MWA
19 is clear:

20 Each employer shall pay a wage to each employee of not less than the
21 hourly rates set forth in this section. The rate shall be five dollars and
22 fifteen cents (\$5.15) per hour worked, if the employer provides health
benefits as described herein, or six dollars and fifteen cents (\$6.15) per
hour if the employer does not provide such benefits.

23 Nev. Const. art. XV § 16. Thus, if an employer provides health insurance to its employees, it may
24 pay those employees the lower-tier minimum wage. The plain and ordinary meaning of the word
25 "provide" is "to make available." See i.e. <<http://www.merriam-webster.com/dictionary/provide>>.
26 Therefore, if an employer makes health insurance available to its employees, it may pay the lower
27 tier minimum wage.

28 In an attempt to contort the very straight-forward directive of the MWA, Plaintiff requests

1 that this Court adopt a nonsensical definition of the word “provide.” Specifically, Plaintiff asserts
2 that the word “provide” means that there must be some form of acceptance or assertion of control or
3 possession by the person to whom a service or item is being provided. **See Diaz Motion, at 4:3-5.**
4 Thus, according to Plaintiff, a service or item has not been provided unless the person for whom the
5 service or item is intended actually uses or takes that service or item. **Id.** This is completely contrary
6 to every definition of the word “provide,” including the definitions used by the sources Plaintiff
7 cites. Specifically, Plaintiff directs the Court to the online Merriam-Webster Dictionary’s Thesaurus
8 definition for the word provide. **Diaz Motion, at 7:26.** However, even that definition explains that
9 there is no need for actual acceptance or use:

10 **PROVIDE**

11 to put (something) into the possession of someone for use or
12 consumption <this luxury hotel provides all the comforts of home to
well-heeled vacationers>

13 <<http://www.merriam-webster.com/thesaurus/provide>>. As the example sets forth, providing
14 is the same as making available for use. If a “well-heeled vacationer” doesn’t use or keep the towels,
15 it doesn’t mean the “comforts of home” weren’t provided. Rather, if the towels were available for
16 use, they were provided – plain and simple. Whether the guest actually uses the towels is irrelevant
17 to the inquiry. For example, if person A invites person B over for dinner and then prepares and
18 offers person B dinner, person A has provided person B dinner regardless of whether person B eats
19 the food provided. What matters is that dinner was made available.

20 Next, Plaintiff completely omits the actual dictionary definition of the online Merriam-
21 Webster Dictionary. **Diaz Motion, at 7:26.** The online Merriam-Webster Dictionary defines
22 “provide” as follows:

23 **Provide:**

24 : to make (something) available : to supply (something that is wanted
or needed)

25 : to give something wanted or needed to (someone or something) : to
supply (someone or something) with something

26 . . .

27 : to supply or make available (something wanted or needed) <provided
new uniforms for the band>; *also* : afford <curtains provide privacy>

28 : to make something available to <provide the children with free
balloons>

1 <<http://www.merriam-webster.com/dictionary/provide>> (emphasis added). Thus, according to
2 Plaintiff's own source and which he outlandishly ignores in his Motion, the very first definition of
3 the word "provide" is "to make available." *Id.* Nowhere in this definition is there a requirement that
4 the person being provided an item or service must actually use or accept that item or service in order
5 for it to be considered "provided."

6 This is also true in the definition given by Black's Law Dictionary: "An act of furnishing or
7 supplying a person with a product." <<http://thelawdictionary.org/provide/>> (Black's Law Dictionary
8 Online). Thus, according to Black's, if a person furnishes or supplies a product, they have made it
9 available. There is no requirement that the supplied or furnished product is accepted or used or taken
10 into possession by the offeree.

11 Another source, and one which arguably offers the most "ordinary and everyday meaning" of
12 the word "provide," is Google. Indeed, there is no other definition of "provide" that is more
13 "accessible, ordinary, or everyday" in today's world than that given by a simple internet search.
14 Accordingly, a Google search of "provide definition" gives the following result:

15 **pro·vide**

16 *verb*

16 1. make available for use; supply.

17 2. make adequate preparation for (a possible event).

18
19 If a Nevada voter or minimum wage worker were curious about the definition of the word
20 provide, this is more than likely the definition they would locate first. Thus, it would be clear that
21 this definition, like all the others, in no way requires acceptance or use by the person to whom a
22 service or item is being provided.

23 To further display this point, yet another source that defines "provide" is Roget's II: The
24 New Thesaurus. *Roget's II: The New Thesaurus. 3rd ed. Boston: Houghton Mifflin, 1995.* Therein,
25 "provide" is defined as "[t]o make (something) readily available." *Id.*, at 647, 701. Thus every
26 single definition of the word "provide" is the same. It means to make available for use. There is no
27 ambiguity and there is no requirement of actual acceptance or use.

28 The definition of the word "provide" is "to make available for use." Accordingly, as

1 explained above, the plain language of the MWA is clear: if an employer makes insurance available
2 to its employees, it may pay those employees the lower-tier minimum wage. It is that simple.

3 2. Plaintiff's Unreasonably Restricted Definition of the Word "Provide" Renders the
4 Language of the MWA Nugatory

5 Whenever possible, statutes are construed "such that no part of the statute is rendered
6 nugatory or turned to mere surplusage" or to "produce absurd or unreasonable results." *Albios v.*
7 *Horizon Communities, Inc.*, 122 Nev. 409, 418, 132 P.3d 1022, 1028 (2006); *Harris*, 119 Nev. at
8 642, 81 P.3d at 534. Here, Plaintiff has requested that this Court adopt a definition of the word
9 "provide" that is so restrictive that whether an employer offers insurance to its employees would
10 have no bearing whatsoever on whether that employer is permitted to pay the lower-tier minimum
11 wage. This is in complete contrast to the actual language of the MWA. Indeed, directly after setting
12 forth that employers must provide insurance, the MWA goes on to explain exactly what providing
13 health insurance means. Specifically, it states:

14 Offering health benefits within the meaning of this section shall
15 consist of making health insurance available to the employee for the
16 employee and the employee's dependents at a total cost to the
employee for premiums of not more than 10 percent of the employee's
gross taxable income from the employer.

17 It is not setting forth a separate and distinct act by the employer. It is clarifying what sort of
18 insurance should be provided by the employer. Thus, the MWA uses the terms "provide" and
19 "offer" synonymously. To assert otherwise is nonsensical. If "offer" and "provide" mean entirely
20 separate things, as Plaintiff suggests, then the second sentence is essentially meaningless and would
21 be rendered nugatory. This of course is not the case. The drafters, aware that employers cannot
22 forcibly enroll their employees in insurance, indicated that the relevant act for compliance with the
23 MWA is the employer's offer of insurance – not an employee's acceptance. Thus, Plaintiff's
24 contention that "[t]he term '[o]ffering' is not concerned with whether an employer qualifies for
25 paying the lower tier wage addressed in the prior sentence," is blatantly inaccurate. **Diaz Motion, at**
26 **10:11-13.** The word "offering" is clearly used in conjunction with the type of insurance that must be
27 made available in order for employers to qualify to pay below the upper-tier minimum wage. Thus
28

1 the use of the word “offering” is relevant and it is directly addressing whether an employer qualifies
2 to pay the lower-tier minimum wage.

3 Moreover, looking to the subject matter of the MWA – minimum wage and insurance – it is
4 clear making insurance available to minimum wage employees was the goal. It was not to allow
5 minimum wage employees to select their own rate of pay. Such a result would be completely
6 contrary to the concepts of both minimum wage and insurance. Enrolling in insurance is a voluntary
7 process. Minimum wage employees are free to choose, just as anyone else would be, which
8 insurance they would like to select, if any. Employers cannot require their employees to enroll in
9 insurance. Thus, if the MWA intended to mandate that employees be enrolled in a company health
10 insurance in order to be paid the lower-tier wage, it would be inherently discriminatory towards
11 employees without other sources of insurance. For example, any employee who over the age of 26
12 and therefore cannot be covered by their parents insurance – at no cost to themselves – would
13 invariably earn less than their younger counterparts. Similarly, an un-married employee who could
14 not be on a spouse’s insurance would also earn less. The result would be absurd.

15 Accordingly, the MWA discusses “offering insurance” because that is its mandate to
16 employers paying the lower-tier minimum wage – they must offer employees health insurance.

17 3. Plaintiff’s Purported Authority For His Position is Inapposite to The Instant Matter

18 Most likely aware that his argument requires the Court to ignore the plain language of the
19 MWA and the obvious directives therein, Plaintiff makes tenuous arguments based on inapposite
20 authority that does not actually support his position. For example, in an effort to skew the clear
21 definition of the word “provide,” Plaintiff makes a tenuous argument regarding the word “furnish.”
22 **Diaz Motion, at 8:16-25.** Specifically, he notes that “furnish” is synonymous with “provide” and
23 then cites to a criminal case wherein a prisoner was charged with furnishing a controlled substance
24 to himself. **Id.** Plaintiff notes that the Nevada Supreme Court stated that furnishing “calls for
25 delivery by one person to another person.” **Id.** However, what Plaintiff leaves out is that the
26 sentence goes on to say “you can’t deliver to yourself.” *State v. Powe, No. 55909, 2010 WL*
27 *3462763, at *1 (Nev. July 19, 2010).* Thus, the Nevada Supreme Court was in no way indicating
28 that the words “provide” or “furnish” mean there must be some acceptance or use or ongoing

1 possession by the person for whom an item or service is intended. Rather, the point of the statement
2 was that a person cannot transfer something to themselves. *See id.*

3 Next, Plaintiff relies upon an Internal Revenue Service (“IRS”) interpretation from 1976 of
4 Treasury Regulation § 601.201(o)(3) which stands for the exact opposite of Plaintiff’s position.
5 **Diaz Motion, at 8 fn. 4.** Specifically, at issue was whether applicants must be given copies of all
6 comments on an application or allowed to inspect and copy materials on request. **Id.** The IRS
7 determined that the applicant must be given copies, “not merely given the opportunity to obtain
8 them” and, therefore, “rather than adopting a strained reading of the word ‘provide,’ the regulation
9 should be amended.” **Id.** Thus, the IRS was stating that as written the regulation was indicating an
10 “opportunity to obtain” may be implied by the use of the word “provide.”

11 Plaintiff further relies on a case which makes a distinction between the use of the terms “state
12 office” and “local governing body” in an effort to show that the MWA intended two entirely
13 different meanings by using the words “provide” and “offer.” **Diaz Motion; at 11:19-24.** At issue
14 in that case was the drafter’s intent in Nev. Const. art. XV § 3 by using different terms in addressing
15 how term limits apply in state and local elections. *Lorton v. Jones*, 130 Nev. Adv. Op. 8, 322 P.3d
16 1051, 1056 (2014), *reh’g denied* (Mar. 5, 2014). This is in no way analogous to the matter at hand.
17 “Provide” and “offer” are not materially different terms. As discussed above, provide means to
18 make available. By the very nature of the subject matter of the MWA, naturally an offer must occur.
19 The two terms go hand in hand.

20 Finally, Plaintiff refers to the “findings and purposes” of the MWA. **Diaz Motion, at 14:7-**
21 **26.** As evident from Plaintiff’s motion, the “findings and purposes” make no reference whatsoever
22 to the alleged requirement that an employee must enroll in insurance. **Id.**

23 **B. The Regulations Implementing the MWA Specifically State That Employers Need**
24 **Only Offer Qualifying Health Insurance In Order to Pay the Lower-Tier Minimum**
25 **Wage**

26 In what can only be described as a blatant attempt to mislead the Court, Plaintiff quite
27 egregiously failed to make any reference whatsoever to the regulations that support the MWA.² This

28 ² Instead, Plaintiff cites to a series of articles and press releases which were likely copied and pasted from one another
and are of no controlling precedent whatsoever. **Diaz Motion, at 16-17.** Indeed, many of the citations were published

1 is likely because the regulations make it abundantly clear that employers who “offer” insurance to
2 their employees qualify to pay the lower-tier minimum wage. Specifically, NAC 608.102 states:
3 “To qualify to pay an employee the minimum wage set forth in paragraph (a) of subsection 1 of
4 NAC 608.100 . . . [t]he employer must offer a health insurance plan.” NAC 608.102(1) (emphasis
5 added). The regulation goes on to state that, “[t]he health insurance plan must be made available to
6 the employee and any dependents of the employee.” NAC 608.102(2) (emphasis added). It says
7 absolutely nothing about requiring an employee to enroll in insurance. Rather, the directive is clear:
8 employers must offer insurance in order to pay the lower-tier minimum wage.

9 NAC 608.102 also makes clear that the Labor Commissioner understood that the definition
10 of the word “provide” is “to make available.” Moreover, the Labor Commissioner interpreted the
11 MWA as a whole to require employers to offer insurance to their employees – not to require
12 employees to enroll in insurance. The Court must give deference to this interpretation as long as it is
13 “based on a permissible construction of the statute.” *Chevron v. Natural Resources Defense*
14 *Council*, 467 U.S. 837, 842-843, 104 S.Ct. 2778, 81 L.Ed.2d 694 (1984). In other words, the agency
15 interpretation is upheld unless it is arbitrary or capricious. *Deukmejian v. United States Postal*
16 *Service*, 734 F.2d 460 (9th Cir.1984); *Lane v. U.S. Postal Serv.*, 964 F. Supp. 1435, 1437 (D. Nev.
17 1996). Here, as discussed above, interpreting the word “provide” to mean “to make available” is
18 consistent with every definition of the word. Therefore, there is no argument that the Labor
19 Commissioner’s interpretation of the MWA is or was arbitrary or capricious.

20 Next, NAC 608.102 is also due deference because it explains what sort of coverage must be
21 included in the offered health insurance plan. Therefore, if the Court were to ignore NAC 608.102 or
22 determine it is somehow inapplicable or void, there would be no guidance whatsoever on what sort
23 of coverage must be included in the offered insurance. The result would be truly absurd. NAC
24 608.102 has been in place since 2007 and its directives have been essential in the interpretation of
25 the MWA.

26 Another regulation that sets forth the requirements of the MWA is NAC 608.106 which
27
28 before there was any clarification by the Labor Commissioner via the regulations and lack any indication of actual
research into the MWA whatsoever. See *id.*

1 further elaborates that the MWA is designed to incentivize offering insurance. Specifically, it sets
2 forth that employees are free to decline the offered insurance:

3 If an employee declines coverage under a health insurance plan that
4 meets the requirements of NAC 608.102 and which is offered by the
5 employer the employer must maintain documentation that the
employee has declined coverage.

6 NAC 608.102 (emphasis added). It does not state that the employee will be paid the upper-tier wage
7 if they decline insurance. Instead, it contemplates an offer of insurance, which employees are free to
8 decline.

9 Finally, NAC 608.108 is yet another regulation that explains that it is the offer of insurance
10 that is relevant. NAC 608.108 clearly sets forth that the requirements for payment of the upper-tier
11 minimum wage are as follows:

12 If an employer does not offer a health insurance plan, or the health
13 insurance plan is not available or is not provided within 6 months of
14 employment, the employee must be paid at least the minimum wage
set forth in paragraph (b) of subsection 1 of NAC 608.100 . . .

15 NAC 608.108 (emphasis added). Accordingly, since at least 2007, the express mandate to employers
16 is that offering health insurance to their minimum wage employees qualifies them to pay below the
17 upper-tier minimum wage.

18 The regulations, like the MWA, are clear: employers must offer health insurance to pay
19 below the upper-tier minimum wage. Actual coverage which would occur in the event an employee
20 selects the insurance has no bearing on the rate of pay.

21 **C. The Retroactive Effect of A Ruling Requiring Employees to be Enrolled in**
22 **Insurance Prior to Being Paid the Lower-Tier Minimum Wage Would be a**
Violation of Due Process

23 Plaintiff's Motion urges the Court to ignore the above discussed regulations. As a result, if
24 the Court were to take this approach, it would have to address the nine-years in which employers in
25 Nevada have relied on those regulations. The Supreme Court has held that "a court is to apply the
26 law in effect at the time it renders its decision" in the absence of manifest injustice or evidence of
27 legislative intent to the contrary. *Bradley v. School Board*, 416 U.S. 696, 711, 94 S.Ct. 2006, 2016,
28 40 L.Ed.2d 476 (1974). Thus, in the event the Court agrees with Plaintiff's argument, the

1 constitutional concerns would be substantial. Specifically, when interpreting a statute, courts have
2 long applied the “cardinal principle” that a fair construction which permits the court to avoid
3 constitutional questions will be adopted. *United States v. Security Industrial Bank*, 459 U.S. 70, 78,
4 103 S.Ct. 407, 412, 74 L.Ed.2d 235 (1982) (quoting *Lorillard v. Pons*, 434 U.S. 575, 577, 98 S.Ct.
5 866, 868, 55 L.Ed.2d 40 (1978)); *Lowe v. S.E.C.*, 472 U.S. 181, —, 105 S.Ct. 2557, 2562, 85
6 L.Ed.2d — (1985). Where a statute may be construed to have either retrospective or prospective
7 effect, a court will choose to apply the statute prospectively if constitutional problems can thereby be
8 avoided. *In re Ashe*, 712 F.2d 864, 865–66 (3d Cir.1983), cert. denied, 465 U.S. 1024, 104 S.Ct.
9 1279, 79 L.Ed.2d 683 (1984); *Roth v. Pritikin*, 710 F.2d 934, 939–40 (2d Cir.), cert. denied, 464 U.S.
10 961, 104 S.Ct. 394, 78 L.Ed.2d 377 (1983). Resolution of the constitutional issue need not be
11 certain; there need only be a “substantial doubt,” *Security Industrial Bank*, 459 U.S. at 78, 103 S.Ct.
12 at 412, or an indication that the constitutional question is “non-frivolous.” *Ashe*, 712 F.2d at 865.
13 Accord *Roth*, 710 F.2d at 939 (“[e]ven the spectre of a constitutional issue” is sufficient to construe
14 the statute to provide for only prospective relief).

15 Here, retroactive application of Plaintiff’s “must be enrolled” argument could raise
16 constitutional questions concerning both the Ex Post Facto Clause, U.S. Const., art. I, § 9, cl. 3, and
17 the Due Process Clause of the Fifth Amendment. Therefore, the Court should select the construction
18 that renders constitutional analysis unnecessary. However, in the event the Court does not and
19 agrees with Plaintiff, Plaintiff’s Motion must still be denied because the voiding of the Labor
20 Commissioner’s regulations would have to be applied prospectively – not retroactively.

21 V. CONCLUSION

22 For the forgoing reasons, Defendants respectfully request that the Court deny Plaintiff Diaz’s
23 Motion in its entirety and enter an order finding that employers who offer their employees qualified
24 health insurance are permitted under the MWA to pay those employees below the upper tier
25 minimum wage.

26 ///

27 ///

28 ///

1 Dated: May 22, 2015

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Respectfully submitted,



RICK D. ROSKELLEY, ESQ.
ROGER L. GRANDGENETT, ESQ.
MONTGOMERY Y. PAEK, ESQ.
KATHRYN BLAKEY, ESQ.
LITTLER MENDELSON, P.C.

Attorneys for Defendants

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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 May 22, 2015, I served the within document:

DEFENDANTS' OPPOSITION TO MOTION FOR PARTIAL SUMMARY JUDGMENT ON LIABILITY AS TO PLAINTIFF PAULETTE DIAZ'S FIRST CLAIM FOR RELIEF

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

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 declare under penalty of perjury that the foregoing is true and correct. Executed on May 22, 2015, at Las Vegas, Nevada.


Debra Perkins

Firmwide:133575283.1 081404.1002

EXHIBIT 1



Enrollment Application
Effective Date: _____

PERSONAL INFORMATION

Last Name: Diaz First Name: Paulette M.I.: A Date of Birth: 07-07-64 Social Security Number: Redacted

Address: 7405 Burnham Ave City: #2007 Las Vegas State: NV Zip Code: 89123

Date of Hire: 1/23 Home Phone: 702-742-4208 Email Address: _____

☐ Male ☒ Female ☒ Single ☐ Married

Enrollment Reason: ☐ Open Enrollment ☐ Loss of Coverage ☐ New Hire ☐ Change

Are you, your spouse or any of your dependents covered by other group health benefits? ☐ Yes ☐ No

If yes, write the name of other plan here: _____ Contract #: _____

MEDICAL ELECTIONS - RATES ARE PER PAY

Select One: ☐ Enroll ☒ Decline

	Starbridge Level 1	Starbridge Level 2
Employee	<input type="checkbox"/> \$17.45	<input type="checkbox"/> \$43.47
EE + Spouse	<input type="checkbox"/> \$55.49	<input type="checkbox"/> \$119.34
EE + Child(ren)	<input type="checkbox"/> \$55.49	<input type="checkbox"/> \$119.34
EE + Family	<input type="checkbox"/> \$88.32	<input type="checkbox"/> \$164.78

Family Members (last name, first name, middle initial)	Gender	Birth Date	Social Security#	Add / Delete
Spouse/DP	M / F	/ /		A / D
1	M / F	/ /		A / D
2	M / F	/ /		A / D
3	M / F	/ /		A / D
4	M / F	/ /		A / D

Exhibit C

1 DISTRICT COURT
2 CLARK COUNTY, NEVADA
3

4 PAULETTE DIAZ, an)
individual; and LAWANDA)
5 GAIL WILBANKS, an)
individual; SHANNON)
6 OLSZYNSKI, an) Case No. A-14-701633-C
individual; CHARITY) Dept No. XV
7 FITZLAFF, an individual,)
on behalf of themselves)
8 and all)
similarly-situated)
9 individuals,)
Plaintiffs,)
10 vs.)
11 MDC RESTAURANT, LLC, a)
Nevada limited liability)
12 company; LAGUNA)
RESTAURANTS, LLC, a)
13 Nevada limited liability)
company; INKA, LLC, a)
14 Nevada limited liability)
company and DOES 1)
15 through 100, inclusive,)
Defendants.)
16
17
18

**CERTIFIED
COPY**

19 DEPOSITION OF PAULETTE CHARISSE DIAZ
20 Taken on Tuesday, May 19, 2015
21 At 9:32 a.m.
22 At 3960 Howard Hughes Parkway, Suite 300
23 Las Vegas, Nevada
24
25 REPORTED BY: JO A. SCOTT, RPR, CCR NO. 669

1 mentioned to me that I could have health
2 insurance.

3 Q. And I understand that, but -- and we'll
4 discuss that a little bit later.

5 A. But at that time, no.

6 Q. So when you first started at Coco's in
7 2010, you did not have anyone mention health
8 insurance to you; is that correct?

9 A. That's correct.

10 Q. And you did not inquire about health
11 insurance; is that correct?

12 A. I don't recall. I don't -- no, I don't
13 recall.

14 Q. No, or you don't recall?

15 A. I don't recall inquiring about health
16 insurance.

17 Q. Do you know why you might not have
18 inquired about health insurance?

19 A. Because I'm Native American, and I can go
20 to a Native American clinic for my -- a lot of my
21 medical. However, later in my employment there,
22 the type of medical attention that I needed was
23 for an appendectomy, and it cannot be performed at
24 my Native American clinic.

25 Q. So prior to your employment at Coco's,

1 you had your medical issues covered because you
2 were Native American; is that correct?

3 A. Yes.

4 Q. And you received some sort of government
5 assistance due to that, correct?

6 A. Incorrect.

7 Q. What do you receive for being Native
8 American, or how are your -- let me ask this
9 another way. How are your health insurance needs
10 covered as a Native American? How does that work?

11 A. I'm Native American, so I can be seen at
12 a Native American clinic with a copay. Also, some
13 of my medications are paid for with a copay, some
14 medications are not paid for. No surgeries are
15 paid for unless I return to my Native American
16 reservation in South Dakota. Dental is a copay.
17 Eyeglasses is a copay. But they do provide the
18 services with a copay.

19 Q. Is there a name for that program, that
20 you are aware of?

21 A. I'm unaware of the name of it. It's
22 just --

23 Q. Do you have a card, or --

24 A. Tribal -- no. We -- I have a tribal
25 membership number, and whenever I go to a

1 different Native American clinic, I have to take
2 my tribal membership proof that I'm a tribal
3 member, and then I can be seen at the tribal
4 clinics and hospitals. There is not a tribal
5 hospital in Las Vegas.

6 Q. I see. So you do have some kind of
7 registration under this tribal membership number,
8 correct?

9 A. Right. I'm a tribal -- I'm a tribal
10 member of the Oglala Sioux Tribe.

11 Q. How do you spell that?

12 A. O-g-l-a-l-a S-i-o-u-x, O-g-l-a-l-a
13 S-i-o-u-x, and it's from Pine Ridge, South Dakota.

14 Q. You said they don't have any treatment
15 centers in Las Vegas, Nevada; is that correct?

16 A. They have a clinic and a dental clinic
17 and an optical center, but they do not have
18 anything like day surgeries, anywhere to get a
19 cast put on your broken leg, anything like that.

20 Q. I see.

21 A. It's just like your basic care.

22 Q. I see. So they do have some basic care
23 offered in Las Vegas, Nevada, they just don't have
24 surgical, for example?

25 A. Exactly, yes.

1 half an hour.

2 Q. And are you aware of the minimum wage
3 amendment, or Article 15, Section 16 of the Nevada
4 Constitution?

5 A. No.

6 Q. Do you have any understanding of the
7 minimum wage amendment?

8 A. Yes.

9 Q. What's your understanding?

10 A. That you must be paid minimum wage.

11 Q. And what is that minimum wage amount?

12 A. Right now?

13 Q. Yes.

14 A. I'm -- I'm unaware of what the minimum
15 wage is here, because I don't live here. I live
16 in Oregon.

17 Q. The minimum wage while you were employed
18 at any of the defendants' restaurants?

19 A. I don't recall.

20 Q. You don't recall the minimum wage at any
21 time during your employment?

22 Well, you recalled the rate of pay you
23 received while you were employed at defendants,
24 correct?

25 A. Yes.

1 Q. And you recalled that you were paid
2 anywhere from 8.25 to \$10 to \$11 to 7.25; is that
3 correct?

4 A. That's correct.

5 Q. So what's your understanding of what the
6 minimum wage was, for example, in 2013 when you
7 were paid 7.25 an hour, or do you have any
8 understanding?

9 A. I don't have an understanding.

10 Q. So sitting here today, you have no
11 understanding of what the minimum wage rate should
12 have been during your employment for defendants,
13 correct?

14 A. Correct, because it kept fluctuating.

15 Q. Because your rate of pay kept changing?

16 A. Right.

17 Q. But you are not sure what the minimum
18 wage rate under the minimum wage amendment or
19 under Article 15, Section 16 of the Nevada
20 constitution should have been, correct?

21 A. Correct. It fluctuated like \$4, and it's
22 still only going up to like \$11, so that's a large
23 fluctuation.

24 Q. So we went over your off-the-clock work
25 and your being offered health insurance claims as

1 conclusion here. I'm just asking --

2 A. Right.

3 Q. -- for your understanding of what the
4 claims are. That's it.

5 A. Okay.

6 Q. So you have no idea where your
7 off-the-clock claim is in this Complaint, correct,
8 or if you even have one, correct?

9 A. Correct.

10 Q. At any time during your employment with
11 defendants, did you receive any documents or any
12 sort of information having to do with insurance,
13 health insurance?

14 A. No.

15 Q. No or you don't recall?

16 A. I don't recall. I would recall that
17 because I had two major medical problems, one
18 being an appendectomy, and one being a much needed
19 hysterectomy, so I would recall that.

20 (Whereupon, Defendants' Exhibit 4
21 was marked for identification.)

22 BY MR. PAEK:

23 Q. You've just been handed what's been
24 marked as Deposition Exhibit Number 4, which is an
25 enrollment application that had been previously

1 produced as MDC2 in this matter.

2 Is that your handwriting underneath where
3 it says personal information, Ms. Diaz?

4 A. Yes, it is.

5 Q. Are you familiar with this document?

6 A. I don't recall this document.

7 Q. You don't recall, but you do recognize
8 your own handwriting?

9 A. Yes, I do.

10 This address is an address that I lived
11 at when I lived with my daughter in 2012.

12 Q. So this was in 2012, you believe?

13 A. I believe.

14 Q. So when were you -- and the address you
15 are referring to is 7405 Burnham Avenue,
16 B-u-r-n-h-a-m, Avenue, Number 2007, Las Vegas,
17 Nevada 89123; is that correct?

18 A. That's correct.

19 Q. And when were you at that address, in
20 2012?

21 A. Uh-huh.

22 Q. So you were never at this address prior
23 to 2012, correct?

24 A. No.

25 Q. And do you see this area in the middle

1 that says, Medical Elections, Rates Are Per Pay,
2 and it says, Select One, either Enroll or Decline?

3 A. Yes, I do.

4 Q. And did you select Decline there?

5 A. I guess. I don't know. I don't recall
6 this form. I don't recall this.

7 Q. You don't recall doing this, but --

8 A. No, I don't recall this.

9 Q. You don't recall any sort of paperwork
10 like -- so do you dispute that this is your
11 handwriting on this form?

12 A. No, I don't dispute that that's my
13 handwriting.

14 Q. Do you have any reason to believe that
15 this is not your form that you filled out sometime
16 during your employment with defendants?

17 A. I don't -- I'm not saying that I didn't
18 fill that -- this top part out, but it doesn't
19 look like everything is filled out on it, either.
20 Like where it says Date of Hire, it just says dash
21 23.

22 Q. And I'm not asking you about that. I'm
23 asking you whether or not you filled this out.

24 A. I don't remember filling this out.

25 Q. So you don't remember; so you could have,

1 you could have not?

2 A. True. It looks like my handwriting,
3 though. That's my handwriting.

4 Q. So it does look like your handwriting,
5 and you don't have -- do you have any reason to
6 believe that this is not a document you filled out
7 during that time?

8 A. I don't recall.

9 Q. So you can't recall all the documents you
10 may have filled out during your employment with
11 defendants, correct?

12 A. I don't recall this document.

13 Q. Do you recall -- but we talked earlier
14 about documents you can recall, and you couldn't
15 recall any documents, correct, that you filled
16 out?

17 A. I don't know. I don't remember filling
18 out paper -- this paper out.

19 Q. But do you remember filling any papers
20 out?

21 A. Of course you have to fill out a W-2, you
22 have to fill out an application.

23 Q. That's in the normal course of any
24 business, correct?

25 A. Right, right.

1 Q. And do you recall if there is any other
2 position changes we've left out during your
3 employment at defendants?

4 A. No.

5 Q. We pretty much covered it?

6 A. Yes.

7 Q. What shifts did you work while you were
8 employed with defendants?

9 A. I worked every shift. I worked
10 everything from morning to the graveyard shift to
11 swings, every shift.

12 Q. Were you always full time while you
13 worked for defendants?

14 A. Sometimes I was full time, sometimes I
15 was part time, depending on location and depending
16 on periods of employment.

17 Q. Were you full time when you first started
18 as a hostess at Coco's?

19 A. Yes, I was.

20 Q. And that was in 2010 at West Sahara,
21 correct?

22 A. Yes.

23 Q. You were full time for that whole time
24 you were a hostess?

25 A. Yes.

1 Q. And then when you got moved up to a
2 waitress at that same Coco's, were you full time?

3 A. Yes.

4 Q. So you were full time for your entire
5 work at the 2400 West Sahara location, correct?

6 A. Yes.

7 Q. How about at Buffalo Bill's?

8 A. Yes, I was full time.

9 Q. 40 hours or more per week, correct?

10 A. Yes.

11 Q. How about when you were employed at
12 Denny's in Fiesta Henderson?

13 A. Full time.

14 Q. 40 hours or more per week, correct?

15 A. No. At first it was part time, then I
16 was also part time at Sahara and Buffalo at the
17 same time period of employment, and then I became
18 full time.

19 Q. I see.

20 A. Okay.

21 Q. Were those combined 40 hours a week?

22 A. Almost.

23 Q. Almost?

24 A. Uh-huh.

25 Q. Do you remember how many hours you get at

1 Fiesta Henderson versus how many hours you got
2 at --

3 A. I don't recall. I don't recall that.

4 Q. Was it roughly 20/20, or --

5 A. No. It was more at Fiesta and less at
6 Sahara.

7 Q. So do you think you had combined more
8 than 30 hours a week at those two locations?

9 A. Yes.

10 Q. You just don't know if it hit 40,
11 correct?

12 A. Right. Once it started hitting over 40,
13 they couldn't have me having overtime because they
14 started cutting back on overtime during that
15 period, and so I had to quit working at Sahara.

16 Q. I see. So there was a period where it
17 got high enough where you were going 40 hours?

18 A. It was a risk -- or it was going to be a
19 risk to go over.

20 Q. I see. So you were hitting pretty close
21 at a certain point, correct?

22 A. Correct.

23 Q. While you were employed at those two
24 locations, which is Fiesta Henderson --

25 A. Yes.

1 Q. -- and Sahara and Buffalo, correct?

2 A. Yes.

3 Q. And then when you were employed at
4 8001 West Sahara, were you full time or part time?

5 A. Part time.

6 Q. How many hours?

7 A. 30.

8 Q. 30 hours a week?

9 A. Yes.

10 Q. And was that the amount of hours you got
11 for your entire employment at 8001 West Sahara?

12 A. Yes.

13 Q. And then when you were employed at Nellis
14 and Stewart, were you full time or part time?

15 A. Part time.

16 Q. How many hours per week?

17 A. Probably 30, 35.

18 Q. For your entire employment there?

19 A. Yes.

20 Q. And that was the last place that you were
21 employed at for defendants, correct?

22 A. Yes.

23 Q. So at your first three of defendants'
24 locations, you averaged 40 hours or close to
25 40 hours per week? Let me state that a different

1 way.

2 At your first two locations that you
3 worked for defendant, which is the Coco's on West
4 Sahara in 2010 and the Buffalo Bill's location,
5 you had 40 hours a week, where you worked full
6 time, correct?

7 A. Yes.

8 Q. And every location after that, you worked
9 part time, correct?

10 A. Correct.

11 Q. But it was over 30 hours per week,
12 correct?

13 A. Correct.

14 Q. And did you always report time through
15 the cash register system at each of those
16 locations?

17 A. Yes.

18 Q. So at each of those locations,
19 clock-in/clock-out was handled by the cash
20 register, correct?

21 A. Yes. I did have some problems receiving
22 all of my pay on several occasions when I worked
23 for Coco's.

24 Q. What kind of problems did you have?

25 A. For some reason they would say, when I

1 A. Maybe less than five times.

2 Q. Throughout your entire employment with
3 defendants, correct?

4 I mean, it wasn't like a once a week
5 thing, correct?

6 A. It could be a once a week thing.

7 Q. I'm not asking what could be. I'm asking
8 what happened in your experience?

9 A. Okay. I would say maybe once a month.

10 Q. So once a month that could happen?

11 A. Yes.

12 Q. Other than that, you received tips every
13 day, correct?

14 A. Yes, yes.

15 Q. So there was never a two-week period
16 where you didn't receive any tips, correct?

17 A. No.

18 Q. And did you always report your tips?

19 A. Yes.

20 Q. You always reported to your employer?

21 A. Yes.

22 Q. Did you always report your tips to the
23 IRS?

24 A. To the IRS, yes.

25 Q. What's your understanding of how much of

1 your tips you had to report to the IRS?

2 A. How many you made.

3 Q. Which is, what, everything?

4 A. Yes.

5 Q. So did you report all your tips to the

6 IRS?

7 A. Yes.

8 Q. And you reported all your tips to

9 defendants?

10 A. Yes.

11 Q. Always?

12 A. You have to, yes. It's the law.

13 Q. Not a percentage?

14 A. No.

15 (Whereupon, Defendants' Exhibit 5

16 was marked for identification.)

17 BY MR. PAEK:

18 Q. You've just been handed Individual

19 Earning Report for yourself, Paulette Diaz, that

20 covers the range of period from, you will see at

21 the top of that left-hand corner, September 15th,

22 2013, and if you'll go down to the next page, it

23 says April 18th, 2010.

24 And we've already kind of discussed your

25 periods of employment and off and on again

1 that is blank?

2 A. I don't. I don't. I believe -- I
3 know -- I know very well that I had never brought
4 home \$252.66 in tips in one day in the restaurant,
5 so I believe that these are combined tips from a
6 few days, okay, because --

7 Q. So you are talking about --

8 A. Because I didn't make this amount of
9 tips, okay. This is not true that I made \$252 in
10 tips on the 15th of July.

11 Q. So if these are combined --

12 A. Yeah.

13 Q. -- so, for example, July 15th, 2012, you
14 are pointing to that last column that says
15 \$252.66, correct?

16 A. Yes.

17 Q. So you are saying there was never a
18 two-week period. So what was your average amount
19 of tips that you would receive in a two-week
20 period, then?

21 A. Maybe about that.

22 Q. Maybe about?

23 A. At the most.

24 Q. \$252?

25 A. Yeah, that's going to be the most I'm

1 going to make in two weeks.

2 Q. In a two-week period?

3 A. Yes. I believe this is like combined
4 tips from the previous days. See how it's blank
5 from the previous days?

6 Q. So do you think that \$252.66 represents
7 the 6/30/2012 period, as well?

8 A. Yes, I believe. I don't know. I don't
9 know what those -- this is not my paper. Like
10 I've never seen this before, this is not my
11 documentation, so I have no clue what these totals
12 are.

13 Q. Do you have documentation of how much
14 tips you reported during these periods?

15 A. I have some. I've given them to Daniel.

16 Q. Everything you have, you've given them to
17 Daniel?

18 A. Uh-huh.

19 Q. Which are tax records?

20 A. No. Those are my clock-out slips. And
21 on my clock-out slips, it will say how much my
22 tips were.

23 Q. Do you know if -- so you produced your
24 clock-out slips to your attorney; is that correct?

25 A. Yes. Just recently, though. Yesterday.

1 CERTIFICATE OF REPORTER

2

3 STATE OF NEVADA)
4) ss:
5 COUNTY OF CLARK)

6

7 I, Jo A. Scott, a certified court
8 reporter, State of Nevada, do hereby certify:
9 That I reported the deposition of PAULETTE
10 CHARISSE DIAZ, commencing on Tuesday,
11 May 19, 2015, at 9:32 a.m.

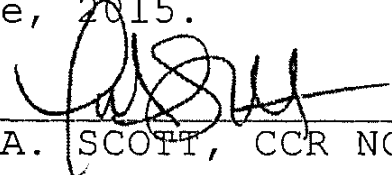
12 That prior to being deposed, the witness
13 was duly sworn by me to testify to the truth.
14 That I thereafter transcribed my said shorthand
15 notes into typewriting and that the typewritten
16 transcript is a complete, true, and accurate
17 transcription of my said shorthand notes. That
18 prior to the conclusion of the proceedings, the
19 reading and signing of the transcript was
20 requested by the witness or a party.

21 I further certify that I am not a
22 relative or employee of counsel of any of the
23 parties, nor a relative or employee of the parties
24 involved in said action, nor a person financially
25 interested in the action.

IN WITNESS WHEREOF, I have set my hand in
my office in the County of Clark, State of Nevada,
this 1st day of June, 2015.

17

18


JO A. SCOTT, CCR NO. 669

19

20

21

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23

24

25

Exhibit D

1 DISTRICT COURT
2 CLARK COUNTY, NEVADA
3

4 PAULETTE DIAZ, an)
individual; and LAWANDA)
5 GAIL WILBANKS, an)
individual; SHANNON)
6 OLSZYNSKI, an) Case No. A-14-701633-C
individual; CHARITY) Dept No. XV
7 FITZLAFF, an individual,)
on behalf of themselves)
8 and all)
similarly-situated)
9 individuals,)

10 Plaintiffs,)

11 vs.)

12 MDC RESTAURANT, LLC, a)
Nevada limited liability)
13 company; LAGUNA)
RESTAURANTS, LLC, a)
14 Nevada limited liability)
company; INKA, LLC, a)
15 Nevada limited liability)
company and DOES 1)
16 through 100, inclusive,)

17 Defendants.)
18

**CERTIFIED
COPY**

19 DEPOSITION OF LAWANDA GAIL WILBANKS

20 Taken on Tuesday, May 19, 2015

21 At 1:46 p.m.

22 At 3960 Howard Hughes Parkway, Suite 300

23 Las Vegas, Nevada

24

25 REPORTED BY: JO A. SCOTT, RPR, CCR NO. 669

1 Q. So earlier today you told me your wage
2 was actually 7.45 per hour?

3 A. Yes. It was either 7.25 or 7.45. I'm
4 sorry.

5 Q. So it's possible it was 7.25?

6 A. Yes, ma'am. It's possible it was 7.25 or
7 7.45.

8 Q. Are you just saying that it's 7.25
9 because you are looking at this now, or --

10 A. No, no, no, no. It's either -- it's
11 either one of the two.

12 Q. You just don't recall?

13 A. I just don't remember, yes. I'm sorry.

14 Q. No need to apologize.

15 Are these dates of employment correct,
16 June 2000 --

17 A. To the best of my knowledge. I know I
18 quit in January. I know that one. I'm not sure
19 when I started, but I know January is when I --
20 when I quit, when I left.

21 Q. And just as a reminder, let's make sure
22 that I get my whole question out.

23 A. I'm sorry.

24 Q. That's all right. And now the same
25 paragraph says you have one dependent. Earlier

1 insurance with anyone at Denny's?

2 A. No, ma'am.

3 Q. Were you interested in getting insurance
4 through your employer?

5 A. I don't -- no, ma'am.

6 Q. You don't know, or, no, you weren't
7 interested?

8 A. I don't think -- no, I wasn't interested.
9 Denny's is run weird. It's really run weird, so
10 it's not like a place that if they offered you
11 insurance, it's one of those places it would be
12 too expensive, you couldn't afford it, anyway.
13 Denny's is not run like -- I worked a lot of
14 restaurants, and Denny's is run really, really
15 different.

16 Q. So if in that paperwork you were handed
17 there was an offer of insurance, there was some
18 insurance information, you wouldn't have accepted
19 that insurance anyways?

20 A. I would have accepted it if I could
21 afford it.

22 Q. So you were interested in getting
23 insurance through Denny's?

24 A. If I could afford it, I would probably
25 say yes.

1 Q. Do you know what you could have afforded?

2 A. I don't know what I could afford, no.

3 Q. Did you have health insurance at the
4 time?

5 A. No.

6 Q. Have you ever had health insurance?

7 A. Yes.

8 Q. When did you have health insurance?

9 A. I've had culinary health insurance. I've
10 had to go through the State of Nevada sometimes
11 for health insurance. But my main concern was my
12 daughter, and she was covered through her dad's
13 insurance.

14 Q. Okay.

15 A. So that's probably why I didn't push the
16 issue of health insurance.

17 Q. So you had no interest in trying to get
18 insurance for your daughter because she already
19 had insurance, correct?

20 A. Yeah. Probably, yes.

21 Q. Yes. Okay. Do you know what open
22 enrollment is?

23 A. Yes, ma'am. It is the time you can open
24 enroll for your insurance.

25 Q. Did you ever see any flyers or hear

1 better shifts. That's how it was determined. It
2 wasn't by seniority, it wasn't by any of that.

3 Q. What, the general manager set the shifts?

4 A. Yes, ma'am.

5 Q. And so the general manager was a store
6 level employee?

7 A. Yes, ma'am.

8 Q. And so you said at the end of your
9 employment, you were working two eight-hour
10 shifts; is that correct?

11 A. Two four-hour shifts.

12 Q. Two four-hour shifts, so eight hours a
13 week total?

14 A. Yes, ma'am.

15 Q. And when you first started, how often
16 were you working?

17 A. 40 hours a week.

18 Q. And when did your number of hours
19 decrease?

20 A. When -- every time we got a new general
21 manager. Abby, she came after Denise, and she
22 took me off graveyard and put me swing. Swing
23 shift you don't have eight-hour shifts. You have
24 like four-hour shifts five-hour shifts.

25 And so then after she left, Sherry came

1 in. Sherry put me on day shift and swing shift.

2 And, again, rarely do you have an eight-hour shift
3 on days or swing.

4 And then after Sherry left, Kiyon came
5 along, and he put me on graveyard. And then he's
6 the one who jerked me from graveyard and gave me
7 the eight hours a week.

8 Q. When you were back on graveyard, how many
9 hours were you working?

10 A. I was working 40 hours.

11 Q. So approximately --

12 A. On the clock.

13 Q. So approximately how long were you doing
14 it the two four-hour shifts?

15 A. Probably two weeks, three weeks at the
16 most.

17 Q. And then is that when you left the
18 company?

19 A. Yes, ma'am.

20 Q. And why did you leave the company?

21 A. Well, I -- when I was on graveyard, I was
22 robbed at gunpoint, and that had been the third
23 time the store had been robbed since I had been
24 there. So I told my manager, I kept telling him
25 before that I wanted off grave, I wanted off

1 Q. Okay.

2 A. Do you understand what I'm saying?

3 Q. No.

4 A. Okay. Let's see. How do I explain it?

5 I don't know how to explain it any better. I

6 don't know.

7 Q. Well, here, let's just focus on a single

8 scenario, which is if you picked up a cash tip

9 from a table, did you report that?

10 A. No, I didn't report it.

11 Q. What did you do with it?

12 A. I put it in my pocket.

13 Q. And that was your practice during the

14 time that the computer was automatically

15 handling --

16 A. Right. It would automatically come out

17 of our checks.

18 Q. So you would just keep the cash and not

19 report it?

20 A. Right.

21 Q. Do you understand that you are a class

22 representative for this action, this lawsuit?

23 A. Yes.

24 Q. Do you know what your role is as a class

25 representative?

1 Q. So you would receive more money in your
2 paycheck, and would that be based on credit card
3 tips?

4 A. No, we wouldn't receive more money. We
5 wouldn't receive more money. We would -- they
6 told me that if you are making 8.25 an hour, they
7 are going to tax you like you are making
8 14-something an hour, and that's going to be your
9 tips.

10 Q. So it's like an assumption that you've
11 made a certain amount?

12 A. Yes, ma'am.

13 Q. But you never actually told them exactly
14 what you made?

15 A. No, ma'am.

16 Q. All right. Can I turn your attention to
17 Page 6, Request for Admission Number 13?

18 A. Okay.

19 Q. It says, Admit that when you went through
20 an orientation process at Denny's, you were given
21 an enrollment application wherein you could accept
22 or decline the health insurance provided to
23 defendants' hourly employees, and you've admitted
24 that; is that correct?

25 A. Yes.

1 Q. Yes, that is correct?

2 A. Yes.

3 Q. Okay.

4 A. But we didn't go through an orientation
5 process. There was no orientation process.

6 Q. So there's no orientation process, but
7 you were given an enrollment application?

8 A. Well, I wasn't sure, so I didn't want to
9 say no and be lying, so I just said, Okay, yes,
10 because I don't know for sure. I don't remember
11 if I was or not.

12 Q. So you don't remember?

13 A. Yes, ma'am.

14 Q. So this is an inaccurate response?

15 A. If I can say I don't remember, then, yes.

16 Q. You realize you answered these under --

17 A. Yes, ma'am.

18 Q. You verified that these were true?

19 A. Yes, ma'am.

20 Q. But now you are telling me that this is
21 not true?

22 A. I don't know if I was offered insurance.
23 I don't know, but -- so I just said yes because
24 I'm thinking maybe I was. I don't know. I know I
25 didn't go through orientation. There was no

1 orientation.

2 Q. So it's incorrect in that you didn't go
3 through an orientation, and then you don't know
4 whether or not you were offered insurance, but you
5 think it's possible that you were?

6 A. Yes, ma'am.

7 Q. Let's see here. Request for Admission
8 Number 14 says, Admit that you declined the health
9 insurance provided to defendants' hourly
10 employees. You deny that.

11 Did you ever accept any insurance?

12 A. No, ma'am.

13 Q. So why did you deny this?

14 A. Because I don't remember if I was offered
15 insurance or not.

16 Q. So it's, again, you don't recall?

17 A. Yes, ma'am.

18 Q. All right. And so now Number 17, at the
19 bottom of the page says, Admit that you were
20 offered the health insurance defendants provide to
21 their hourly employees each year that you worked
22 for Denny's during an open enrollment period.

23 You denied that earlier today. You
24 discussed you know what open enrollment is?

25 A. Yes, ma'am.

1 CERTIFICATE OF REPORTER

2

3 STATE OF NEVADA)
4) ss:
COUNTY OF CLARK)

5

6 I, Jo A. Scott, a certified court
reporter, State of Nevada, do hereby certify:
7 That I reported the deposition of LAWANDA GAIL
WILBANKS, commencing on Tuesday, May 19, 2015, at
8 1:46 p.m.

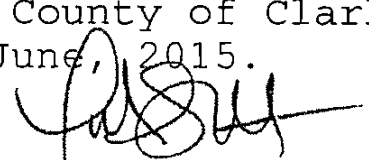
9 That prior to being deposed, the witness
was duly sworn by me to testify to the truth.
That I thereafter transcribed my said shorthand
10 notes into typewriting and that the typewritten
transcript is a complete, true, and accurate
11 transcription of my said shorthand notes. That
prior to the conclusion of the proceedings, the
12 reading and signing of the transcript was
requested by the witness or a party.

13 I further certify that I am not a
relative or employee of counsel of any of the
14 parties, nor a relative or employee of the parties
involved in said action, nor a person financially
15 interested in the action.

16 IN WITNESS WHEREOF, I have set my hand in
my office in the County of Clark, State of Nevada,
this 1st day of June, 2015.

17

18


JO A. SCOTT, CCR NO. 669

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Exhibit E

1 DISTRICT COURT
2 CLARK COUNTY, NEVADA
3
4 PAULETTE DIAZ, an)
individual; and LAWANDA)
5 GAIL WILBANKS, an)
individual; SHANNON)
6 OLSZYNSKI, an) Case No. A-14-701633-C
individual; CHARITY) Dept No. XV
7 FITZLAFF, an individual,)
on behalf of themselves)
8 and all)
similarly-situated)
9 individuals,)
)
10 Plaintiffs,)
)
11 vs.)
)
12 MDC RESTAURANT, LLC, a)
Nevada limited liability)
13 company; LAGUNA)
RESTAURANTS, LLC, a)
14 Nevada limited liability)
company; INKA, LLC, a)
15 Nevada limited liability)
company and DOES 1)
16 through 100, inclusive,)
)
17 Defendants.)
)

**CERTIFIED
COPY**

18
19 DEPOSITION OF SHANNON MARIE OLSZYNSKI
20 Taken on Wednesday, May 20, 2015
21 At 9:24 a.m.
22 At 3960 Howard Hughes Parkway, Suite 300
23 Las Vegas, Nevada
24
25 REPORTED BY: JO A. SCOTT, RPR, CCR NO. 669

1 Q. And how much were you hired at? What was
2 your rate?

3 A. I was hired at 5.13 an hour.

4 Q. What is your understanding of that rate
5 and the minimum wage in Colorado?

6 A. I have spoken with other people that work
7 in the same industry, which they are getting paid
8 the same, so I am -- to my understanding, it's
9 state -- it's the state minimum wage.

10 Q. And is that because you receive tips?

11 A. Yes.

12 Q. So were you concerned with that rate of
13 pay, given that you found out later when you were
14 hired in Nevada that you weren't being paid what
15 you thought was the minimum wage of 8.25 an hour?

16 A. Yes.

17 Q. Did you do anything about that concern?

18 A. No.

19 Q. And why is that?

20 A. As far as research with the Colorado
21 minimum wage, as I said, you know, other people
22 that work in the same industry are getting paid
23 the same amount, so based on that, I believe that
24 that is just the way the minimum wage is in
25 Colorado.

1 available?

2 A. I believe there was four.

3 Q. Do you recall what other plans were
4 available, other than the high deductible?

5 A. No.

6 Q. Do you recall approximately how many
7 pages that insurance packet was that you received
8 from Inka?

9 A. Approximately three.

10 Q. And in those three pages, it listed the
11 various plans and their various costs; is that
12 correct?

13 A. Yes.

14 Q. And it also detailed the coverage that
15 was available, as we went over earlier?

16 A. Yes.

17 Q. Such as hospital visits and maternity?

18 A. Yes.

19 (Whereupon, Defendants' Exhibit 4
20 was marked for identification.)

21 BY MR. PAEK:

22 Q. You've just been handed what we've marked
23 as Deposition Exhibit Number 4, which is the
24 Nevada Health Insurance Acceptance/Decline Form.

25 Are you familiar with this document,

1 Ms. Olszynski?

2 A. Yes. I'm sorry. Yes.

3 Q. And is that your signature at the bottom
4 of that page?

5 A. Yes.

6 Q. Where it says Signature?

7 A. Yes.

8 Q. And do you recall signing this on
9 June 13th of 2014?

10 A. Yes.

11 Q. And it says here at the top of this page
12 Nevada Health Insurance Acceptance/Decline Form.
13 I understand that I am being offered employee
14 health insurance coverage on my first day of
15 employment. I have been provided medical
16 insurance benefits summary information and rate
17 sheet.

18 Is that an accurate statement?

19 A. Yes.

20 Q. And below that, your initials are on the
21 blank decline.

22 Are those your initials?

23 A. Yes.

24 Q. That is dated June 13, 2014?

25 A. Yes.

1 Q. And below that it says, I have declined
2 health insurance coverage; is that correct?

3 A. Yes.

4 Q. So you do recall signing this, correct?

5 A. Yes.

6 Q. And is there anything inaccurate about
7 this form?

8 A. No.

9 Q. And you do recall declining health
10 insurance through this form, correct?

11 A. Yes.

12 Q. And that's your handwriting where it says
13 Print Name?

14 A. Yes.

15 Q. And did you receive this during that
16 first week of being hired or as part of your
17 orientation?

18 A. Yes.

19 Q. So do you understand that Inka offered
20 you health insurance immediately upon your hiring?

21 A. Yes.

22 Q. When you received this form, did you have
23 any discussion regarding this or what you were
24 doing with this form?

25 A. No.

1 cleaning.

2 Q. What employer was that with?

3 A. McCarran Airport.

4 Q. Any others?

5 A. Not that I can recall.

6 Q. While you were employed at Inka, LLC, did
7 your wage rate at any time change?

8 A. No.

9 Q. So while you were employed at Denny's in
10 Elko, Nevada, your wage rate was always 7.25 an
11 hour?

12 A. Yes.

13 Q. Plus tips?

14 A. Yes.

15 Q. Did your position ever change --

16 A. No.

17 Q. -- while you were employed at Denny's in
18 Elko, Nevada?

19 A. No.

20 Q. What shift did you work while you were
21 working in Elko, Nevada?

22 A. Primarily graveyard, but I also worked
23 other shifts, but it was more or less graveyard.

24 Q. Were those eight-hour shifts?

25 A. Yes. Well, okay. 11:00 to 5:00 a.m.,

1 A. No.

2 Q. You don't know, or you are not sure?

3 A. I do not -- I don't know if people were
4 actually complaining.

5 Q. Did she cite anyone regarding people
6 complaining, like was it a guest or employees?

7 A. She didn't specify who -- who was
8 complaining.

9 Q. And do you disagree with that assessment,
10 that you were not friendly and you were not
11 smiling?

12 A. I do disagree with that.

13 Q. And how many hours a week did you work on
14 average at the Denny's in Elko, Nevada?

15 A. 35 to 40 hours a week.

16 Q. Were you full time?

17 A. No.

18 Q. Sometimes you would have a full-time
19 week, though?

20 A. Yes.

21 Q. So you didn't really have an average
22 amount of hours you worked per week, it ranged
23 from 35 to 40?

24 A. Yes.

25 Q. And we said earlier you reported time by

1 about your 8.25 an hour, did you ever make any
2 other complaint about the wage rate you were
3 receiving?

4 A. No.

5 Q. So no other complaint that you didn't
6 receive the minimum wage, correct?

7 A. Correct.

8 Q. Do you know if there was ever a change in
9 the insurance that was offered to you?

10 A. I'm not sure.

11 Q. Do you know if the insurance you are
12 offered now at Cortez is different than the
13 insurance you were offered in Elko, Nevada?

14 A. I believe it is different.

15 Q. Do you know what the differences are?

16 A. I didn't review this -- that insurance,
17 because it wasn't presented to me. It wasn't
18 offered to me, so I didn't -- I haven't reviewed
19 that insurance.

20 Q. But are you aware that insurance is
21 available in Cortez, Colorado?

22 A. I don't believe it is.

23 Q. Oh, you don't believe they offer health
24 insurance in Cortez, Colorado?

25 A. Oh, I'm actually not sure.

1 Q. You've never inquired into it?

2 A. No.

3 Q. Because you didn't need it?

4 A. It's not -- it's not substantial enough
5 insurance for me.

6 Q. How do you know that?

7 A. I believe that Medicaid is a better -- a
8 better choice.

9 Q. So because you are already covered by
10 Medicaid, you don't have a need to get another
11 insurance --

12 A. Yes.

13 Q. -- is that correct?

14 A. Yes.

15 Q. So for your needs, you are satisfied with
16 having Medicaid, correct?

17 A. Yes.

18 Q. And when did you go on to Medicaid?

19 A. August of 2014.

20 Q. So that was during your employment at
21 Elko, Nevada, correct?

22 A. Yes.

23 Q. How did you become aware of the
24 availability of Medicaid?

25 A. I met the criteria of the rate of pay.

1 Q. Did you seek out that information or was
2 that information given to you somehow?

3 A. I seeked out that particular insurance.

4 Q. Was that online?

5 A. I went to the Health and Human Resources.

6 Q. For Clark County, Nevada?

7 A. For Elko County.

8 Q. Oh, I'm sorry. Yeah. For Elko, Nevada?

9 A. Yeah.

10 Q. Was there a particular reason why you
11 wanted Medicaid at that time, or did you just
12 decide it was time for insurance, or how did that
13 come about?

14 A. Both. I do need insurance. Also, it
15 is -- at this time, it's feasible for me.

16 Q. What do you mean by it's feasible for
17 you?

18 A. It's economically feasible as far as it's
19 affordable.

20 Q. And was that spurred on by your kind of
21 general knowledge of Obamacare or something like
22 that, or how did that come about?

23 A. Yes. I looked at my options as far as
24 Obamacare and Medicaid, and decided Medicaid was
25 the better choice.

1 Q. How often did you receive tips while you
2 were working at Denny's in Elko, Nevada?

3 A. Daily.

4 Q. Do you know on a weekly basis about how
5 much you averaged in tips when you were working at
6 Denny's in Elko, Nevada?

7 A. Average?

8 Q. Or a range.

9 A. 500 a week.

10 Q. How about now in Cortez?

11 A. Probably 250 to 300.

12 Q. That's significantly less, right?

13 A. Yes.

14 Q. And do you report all of your tips to
15 your employer?

16 A. Yes.

17 Q. 100 percent?

18 A. I believe it's 20 percent.

19 Q. So you report 20 percent of your tips to
20 your employer?

21 A. Yes, the allotted amount.

22 Q. What about to the IRS, how much do you
23 report to the IRS?

24 A. The allotted amount.

25 Q. Which is the 20 percent?

1 A. Yes.

2 Q. So did you report 20 percent of your tips
3 while you were employed at the Denny's in Elko,
4 Nevada?

5 A. Yes.

6 Q. And is that what you currently report as
7 employed in Cortez, Colorado, 20 percent?

8 A. Yes.

9 Q. Let me state that again. So do you
10 currently also report 20 percent of your tips in
11 Cortez, Colorado?

12 A. Yes.

13 Q. So if your tips go over that 20 percent,
14 you don't report that; is that correct?

15 A. There is a certain amount that you claim
16 every day. It gives -- it varies, you know, how
17 much you make. But you have to claim at least, I
18 believe it's 20 percent. And you don't have to
19 claim any more than that.

20 Q. So if you make less than 20 percent, you
21 report less; is that correct?

22 A. Yes. It's depending on how much you make
23 a day.

24 Q. But if you make more than 20 percent, you
25 don't report that; is that correct?

1 A. Yes.

2 Q. On average, do you know how often you
3 fall below 20 percent; is it frequent, or --

4 A. I would say working at Cortez, it would
5 be more frequent.

6 Q. How about when you were in Elko, Nevada?

7 A. It was less frequent.

8 Q. Rare?

9 A. Yes.

10 Q. Once a week, once a month?

11 A. Maybe once a week.

12 Q. Could you go whole weeks without dropping
13 below 20 percent when you were in Elko, Nevada?

14 A. No.

15 Q. So you would say at least once a week you
16 would probably drop below 20 percent in tips?

17 A. I'm not actually sure.

18 Q. That's fine if you are not sure.

19 A. Yeah.

20 Q. I don't want you to guess. I'm just
21 asking if you can recall.

22 A. I'm sorry.

23 Q. And what is your role as a class
24 representative in this lawsuit; do you know?

25 A. I'm not sure.

1 CERTIFICATE OF REPORTER

2

3 STATE OF NEVADA)
4) ss:
COUNTY OF CLARK)

5

6 I, Jo A. Scott, a certified court
reporter, State of Nevada, do hereby certify:
7 That I reported the deposition of SHANNON MARIE
OLSZYNSKI, commencing on Wednesday, May 20, 2015,
8 at 9:24 a.m.

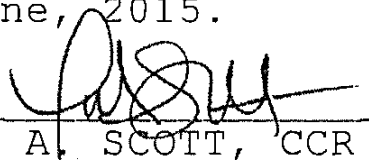
9 That prior to being deposed, the witness
was duly sworn by me to testify to the truth.
That I thereafter transcribed my said shorthand
10 notes into typewriting and that the typewritten
transcript is a complete, true, and accurate
11 transcription of my said shorthand notes. That
prior to the conclusion of the proceedings, the
12 reading and signing of the transcript was
requested by the witness or a party.

13 I further certify that I am not a
relative or employee of counsel of any of the
14 parties, nor a relative or employee of the parties
involved in said action, nor a person financially
15 interested in the action.

16 IN WITNESS WHEREOF, I have set my hand in
my office in the County of Clark, State of Nevada,
this 3rd day of June, 2015.

17

18


JO A. SCOTT, CCR NO. 669

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Exhibit F

Charity Ann Fitzlaff May 29, 2015
* * *Videoconference Deposition* * *

Page 1

1 DISTRICT COURT
2 CLARK COUNTY, NEVADA
3
4 PAULETTE DIAZ, an)
individual; and LAWANDA)
5 GAIL WILBANKS, an)
individual; SHANNON)
6 OLSZYNSKI, an) Case No. A-14-701633-C
individual; CHARITY) Dept No. XV
7 FITZLAFF, an individual,)
on behalf of themselves)
8 and all)
similarly-situated)
9 individuals,)
10 Plaintiffs,)
11 vs.)
12 MDC RESTAURANT, LLC, a)
Nevada limited liability)
13 company; LAGUNA)
RESTAURANTS, LLC, a)
14 Nevada limited liability)
company; INKA, LLC, a)
15 Nevada limited liability)
company and DOES 1)
16 through 100, inclusive,)
17 Defendants.)
18
19 VIDEOCONFERENCE DEPOSITION OF CHARITY ANN FITZLAFF
20 Taken on Friday, May 29, 2015
21 At 9:35 a.m.
22 At 1160 North Town Center Drive, Suite 300
23 Las Vegas, Nevada
24
25 REPORTED BY: JO A. SCOTT, RPR, CCR NO. 669

**CERTIFIED
COPY**

1 A. We went over what to do in case of a
2 customer accident, a co-worker accident, a fire, a
3 tornado, a flood.

4 Q. Did you go over -- you talked about you
5 got a handbook. Did you go over the stuff that
6 was in the handbook?

7 A. Just what to do in case of an accident.

8 Q. Can you repeat that again? I'm really
9 sorry.

10 A. The accident procedures and how to
11 handle --

12 Q. Handle what?

13 A. Accidents in the store.

14 Q. You said something after accidents. What
15 did you say?

16 A. And how to go about handling them.

17 Q. All right. Did they go over insurance
18 with you during that time?

19 A. We were told to deny the insurance, and
20 that anybody that wanted it, as soon as we opened
21 the restaurant, that they would handle that.

22 Q. So my question was: Did they discuss the
23 insurance options available to you?

24 A. No.

25 Q. What was told to you about insurance?

1 A. We had the paper, deny it for now, we'll
2 deal with it after we open the restaurant.

3 Q. And who told you that?

4 A. Laz.

5 Q. So if I go and look at everyone who
6 started with you, I'll find these forms of
7 everyone denying insurance on the exact same day?

8 MR. BUTLER: Object. Calls for
9 speculation.

10 BY MS. BLAKEY:

11 Q. You can answer the question.

12 MS. BLAKEY: I'm asking for her direct
13 knowledge of what she's just testified to. There
14 is no speculation.

15 MR. BUTLER: (Inaudible.)

16 MS. BLAKEY: I can't hear you.

17 THE WITNESS: I believe so.

18 BY MS. BLAKEY:

19 Q. All right. Thank you. Once you
20 started -- did you go on like a tour of the actual
21 facility where you would be working at, the actual
22 restaurant?

23 A. We helped set it up, yes.

24 Q. And was there a bulletin board there for
25 you guys to review?

1 (Whereupon, a recess was taken.)

2 MS. BLAKEY: Back on the record.

3 BY MS. BLAKEY:

4 Q. So we were looking at Exhibit 1, Page 44.

5 You were explaining to me what your understanding
6 was of the health insurance available to you.

7 A. We were told to deny it, and we would
8 delve deeper into it after we opened the
9 restaurant, and that's when they would take care
10 of anybody that wanted the insurance.

11 Q. And so you ultimately did enroll in the
12 insurance, correct?

13 A. Quite a few months later, yes.

14 Q. And so was that -- that was after the
15 restaurant opened, correct?

16 A. About eight or nine months after that,
17 yes.

18 Q. And so what did you -- how did that
19 process work?

20 A. I filled out -- I asked and asked to fill
21 out the application to get the insurance, because
22 I'm required to have it for my children. And I
23 never got the papers. Management kept switching
24 over, we changed managers so often. It -- I never
25 got the papers. When I finally did get the paper,

Charity Ann Fitzlaff May 29, 2015
* * *Videoconference Deposition* * *

Page 64

1 Q. And how big were your paychecks,
2 typically?

3 A. When I was just a server, not very big at
4 all, barely 75 to \$100.

5 Q. You received 75 to \$100 every two weeks?

6 A. If that, yes.

7 Q. How frequently did you work?

8 A. I started to work more and more as people
9 started leaving the restaurant, so it would vary.

10 Q. It varied, is that what you said?

11 A. Yes.

12 Q. Approximately how many hours a week did
13 you work?

14 A. 35-plus.

15 Q. You worked 35 hours a week?

16 A. Yes.

17 Q. And then your paycheck for two weeks was
18 \$75?

19 A. It would vary between 75 and over a
20 hundred, depending on how many hours, or if I had
21 done double shifts, or if I worked extra days.

22 Q. So you received \$7.25 an hour, and you
23 worked 35 hours a week?

24 A. 35-plus hours, so they would go -- my
25 paychecks fluctuated. There was no set schedule.

1 Q. And your paychecks would be 75 to \$100
2 for every two weeks?

3 A. Tips, plus that. It varied.

4 Q. Were your tips included in your paycheck?

5 A. I was taxed on my tips, yes.

6 Q. Did you receive them in your paycheck?

7 A. No.

8 Q. How did you receive tips?

9 A. At the end of your shift, you cash out.
10 Whatever tips are left on the credit cards, you
11 get from the register, from the hostess that would
12 cash you out.

13 Q. And so that's for credit card tips. Cash
14 tips, what was the process with those?

15 Can you speak louder, please?

16 A. People leave them on the table, and if
17 it's your table, then you take that tip.

18 Q. And you just put it -- you just keep it,
19 and that's it?

20 A. Yeah.

21 Q. Do you report it to Denny's or anything?

22 A. Yes.

23 Q. When do you do that?

24 A. End of your shift.

25 Q. And do you report all of your cash tips?

1 A. Yes.

2 Q. All right. And then is that added to
3 your credit card tips?

4 A. Yes.

5 Q. Do you have to give tips to bussers or
6 any other employees?

7 A. Actually, the person that trays up the
8 food, you tip out; the bussers, you tip out.

9 Q. Anyone else?

10 A. No. We didn't have bartenders.

11 Q. So what's the -- what was the process for
12 that?

13 A. Hand out your tips, and by how much they
14 helped you, you gave them tips.

15 Q. So was that at your discretion?

16 A. Yes.

17 Q. Can you say that again and louder?

18 A. Yes, it was at our discretion.

19 Q. Did you ever not tip out any -- an
20 employee?

21 A. When I didn't have that help, yes.

22 Q. And what about an employee who maybe
23 helped you, but didn't do a good job, did you not
24 tip them?

25 A. No, I would still tip them.

1 paycheck? Can you explain that to me?

2 A. I don't really know. I know that they
3 taxed us on whatever our credit card tips are and
4 whatever --

5 Q. And whatever what?

6 A. And whatever we claimed.

7 Q. So approximately how much would you
8 say -- because I'm -- is it correct to assume that
9 different days of the week, you would earn -- that
10 would kind of affect how much you would earn in
11 tips?

12 A. Yes.

13 Q. So on an average week, how much would you
14 earn in tips?

15 A. With it varying, I don't know. Anywhere
16 from 20 to over a hundred, I guess.

17 Q. In a week?

18 A. A week, 50 or 60 a day.

19 Q. Can you speak louder, please?

20 A. 50 or 60 a day for seven days; 300, \$400,
21 I believe.

22 Q. And you would take that money home on a
23 daily basis, it wouldn't be in your paycheck,
24 correct?

25 A. It would be claimed on my timecard with

Charity Ann Fitzlaff May 29, 2015
Videoconference Deposition

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1 CERTIFICATE OF REPORTER

2

3 STATE OF NEVADA)
4) ss:
5 COUNTY OF CLARK)

6

7 I, Jo A. Scott, a certified court
8 reporter, State of Nevada, do hereby certify:
9 That I reported the deposition of CHARITY ANN
10 FITZLAFF, commencing on Friday, May 29, 2015, at
11 9:35 a.m.

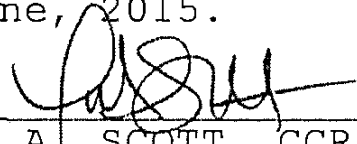
12 That prior to being deposed, the witness
13 was duly sworn by me to testify to the truth.
14 That I thereafter transcribed my said shorthand
15 notes into typewriting and that the typewritten
16 transcript is a complete, true, and accurate
17 transcription of my said shorthand notes. That
18 prior to the conclusion of the proceedings, the
19 reading and signing of the transcript was
20 requested by the witness or a party.

21 I further certify that I am not a
22 relative or employee of counsel of any of the
23 parties, nor a relative or employee of the parties
24 involved in said action, nor a person financially
25 interested in the action.

IN WITNESS WHEREOF, I have set my hand in
my office in the County of Clark, State of Nevada,
this 3rd day of June, 2015.

17

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JO A. SCOTT, CCR NO. 669

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Exhibit G

1 EIGHTH JUDICIAL DISTRICT COURT
2 IN AND FOR CLARK COUNTY, STATE OF NEVADA
3

4 PAULETTE DIAZ, an individual;
LAWANDA GAIL WILBANKS, an
5 individual; SHANNON OLSZYNSKI, an
individual; and CHARITY FITZLAFF,
6 an individual, on behalf of
themselves and all
7 similarly-situated individuals,
8 Plaintiffs,

ORIGINAL

9 vs. No. A-14-701633-C
10 MDC RESTAURANTS, LLC, a Nevada
limited liability company; LAGUNA
11 RESTAURANTS, LLC, a Nevada limited
liability company; INKA, LLC, a
12 Nevada limited liability company,
and DOES 1 through 100, Inclusive,
13
Defendants.

14
15
16 DEPOSITION OF TERRY DIGIAMARINO
17 Irvine, California
18 Thursday, March 12, 2015
19
20

21 Reported by:
22 CARA JACOBSEN
23 CSR NO. 13053
24 Job No. 2022661
25 Pages 1 - 109

Page 1

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877-955-3855

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

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

8 Q Okay. Do you know what the current plan is for
9 2015 for insurance in Nevada?

10 A For hourly, it's called an MVP.

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

13 A Transamerica.

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

17 A Starbridge. Cigna. Starbridge.

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

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

22 Q Does the MVP plan provide dental?

23 A Separate. Totally separate.

24 Q Does the MVP plan provide vision?

25 A It's totally separate.

1 Q Do you know what the MVP plan provides Nevada
2 hourly employees?

3 A No.

4 Q Prior to the MVP plan, was the Transamerica or
5 TransChoice plan provided to all Nevada hourly
6 employees?

7 A Yes.

8 Q Prior to Transamerica/TransChoice plan, was the
9 Starbridge offered to all hourly employees?

10 A Yes.

11 Q Has the dental plan changed from Guardian? To
12 Guardian? Excuse me. Was there -- was there a dental
13 plan prior to Guardian?

14 A Yes.

15 Q What was that?

16 A Assurant.

17 Q Were Nevada hourly employees offered Assurant?

18 A Yes.

19 Q Was every hourly employee offered Assurant?

20 A Yes.

21 Q And was there a different vision plan prior to
22 VSP?

23 A Not since I've been there, no.

24 Q Okay. The -- do you know if the VSP plan was
25 always offered to hourly employees since you began?

Page 44

Veritext Legal Solutions
877-955-3855

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

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

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

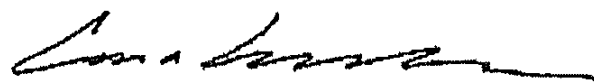
16 I further certify I am neither financially interested in
17 the action nor a relative or employee of any attorney or
18 party to this action.

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

21

22 Dated: 03/26/2015

23



24

CARA JACOBSEN

CSR No. 13053

25

Page 109

VOLUME 4

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
MONTGOMERY Y. PAEK, ESQ., Nevada Bar #10176
KATHRYN B. BLAKEY, ESQ., Nevada 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 Petitioners

INDEX OF APPENDIX

Name of Document	Appendix	Page Number
May 20, 2014 Class Action Complaint and June 5, 2014 Amended Class Action Complaint on June 5, 2014	Vol. 1	001-031
July 22, 2014 Answer to the Amended Class Action Complaint	Vol. 1	032-042
April 24, 2015 Plaintiff's Motion for Partial Summary Judgment on Liability as to Plaintiff Paulette Diaz's First Claim for Relief	Vol. 1	043-149
May 22, 2015 Defendants' Opposition to Motion for Partial Summary Judgment on Liability as to Plaintiff Paulette Diaz's First Claim for Relief	Vol. 1	150-167
June 5, 2015 Plaintiff's Reply to Defendants' Opposition to Motion for Partial Summary Judgment on Liability as to Plaintiff Paulette Diaz's First Claim for Relief	Vol. 1	168-207
June 25, 2015 minutes of hearing	Vol. 1	208
June 25, 2015 hearing transcript	Vol. 2	209-261
July 1, 2015, minute order regarding the hearing held on June 25, 2015	Vol. 2	262
July 17, 2015, the Notice of Order Regarding Motion for Partial Summary Judgment on Liability as to Plaintiff Paulette Diaz's First Claim for Relief	Vol. 2	263-269
July 9, 2015, hearing transcript on Plaintiff's Motion for Class Certification Pursuant to NRCP 23	Vol. 2	270-342
July 30, 2014, Notice of Petition for Writ of Mandamus or Prohibition	Vol. 2	343-345
June 8, 2015 Plaintiff's Motion for Class Certification Pursuant to NRCP 23	Vol. 3	346-501
June 25, 2015 Defendants' Opposition to this Motion for Class Certification	Vol. 4	502-769

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

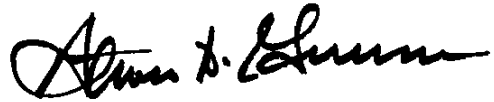
☒ Via **Electronic Service** - pursuant to N.E.F.C.R Administrative Order: 14-2.

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
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



CLERK OF THE COURT

OPPS
RICK D. ROSKELLEY, ESQ., Bar # 3192
ROGER L. GRANDGENETT II, ESQ., Bar # 6323
MONTGOMERY Y. PAEK, ESQ., Bar # 10176
KATHRYN B. 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. A701633

Dept. No. XVI

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

AND

**COUNTERMOTION TO
CONTINUE HEARING ON ORDER
SHORTENING TIME**

Hearing Date: July 9, 2015

Hearing Time: 9:00 a.m.

Defendants MDC RESTAURANTS, LLC; LAGUNA RESTAURANTS, LLC; and INKA, LLC (hereinafter "Defendants"), by and through their counsel of record, hereby oppose Plaintiffs PAULETTE DIAZ, LAWANDA GAIL WILBANKS, SHANNON OLSZYNSKI, and CHARITY FITZLAFF's (hereinafter "Plaintiffs") Motion for Class Certification Pursuant to Nevada Rule of Civil Procedure 23 and files their Countermotion to Continue Hearing on Order Shortening Time pending the resolution of the Motion to Disqualify Named Plaintiffs as Class Representatives and Dismiss Class Action Claims, which is being filed concurrently with this Opposition and

1 Countermotion. This Opposition and Countermotion is based on the Memorandum of Points and
2 Authorities below, all papers and files on file herein and any oral argument permitted.

3 **I. INTRODUCTION**

4 Since the filing of Plaintiffs' Amended Class Action Complaint for claims under the Nevada
5 Minimum Wage Amendment ("MWA") (also referred to as Article XV, Section 16 of the Nevada
6 Constitution), Plaintiffs have chosen to focus on their fabricated interpretation of how the MWA
7 functions rather than directly addressing the applicable law or facts. As a consequence, Plaintiffs'
8 Motion for Class Certification does not come close to meeting the rigorous analysis required by Rule
9 23. Nev. R. Civ. P. 23. Instead, Plaintiffs' Motion for Class Certification is premised on an entirely
10 flawed reading of what common questions are required by the MWA. Further, Plaintiffs have
11 completely glazed over the applicable facts by eschewing their own deposition testimony in favor of
12 declarations to minimize the many differences in answers between even the named Plaintiffs that go
13 straight to individualized claims and defenses. Thus, after voluminous written discovery responses
14 and the depositions of all of the named Plaintiffs and Defendants' representatives, Plaintiffs have
15 only highlighted the reasons why a Rule 23 class is unworkable for claims under the MWA.

16 Plaintiffs' Motion for Class Certification is completely premised on the ubiquitous error cited
17 in the United States Supreme Court case of *Wal-Mart v. Dukes*. In *Wal-Mart*, the Court noted that
18 commonality is "easy to misread" because "any competently crafted complaint literally raises
19 common 'questions.'" *Wal-Mart Stores, Inc. v. Dukes et al.*, 564 U.S. —, 131 S. Ct. 2541, 2550-
20 2551, 180 L. Ed. 2d 374 (2011). Instead of just "common questions", however, Plaintiffs have the
21 burden to show that a classwide proceeding has the capacity to "generate common answers apt to
22 drive the resolution of the litigation" and "resolve an issue that is central to the validity of each one
23 of the claims in one stroke." (Emphasis in original). *Wal-Mart Store, Inc.*, 131 S. Ct. 2541 at 2551.
24 With deposition testimony failing to yield answers that could resolve central issues in one stroke as
25 required by *Wal-Mart*, Plaintiffs' only refuge is to re-emphasize their question of "whether
26 Defendant was eligible to pay Plaintiffs and proposed class members below the upper-tier minimum
27 hourly rate." In this matter, Plaintiffs have now conducted extensive discovery into their posed
28 question and it has now become clear that Plaintiffs cannot meet the Rule 23 requirements of

ascertainability, commonality, typicality, predominance, superiority, numerosity and adequacy.

As explained below, Plaintiffs do not meet the threshold issue of ascertainability because Plaintiffs' class definition is imprecise and overbroad in that it simply includes any employee paid below the upper-tier minimum wage of \$8.25 an hour. As liability under the MWA is contingent on whether or not an employer offers health insurance, such a class definition concerning rate of pay does nothing to define the class or exclude employees who would not be class members. Further, Plaintiffs fail to show commonality under Rule 23 because their flawed contentions based on an incorrect definition of "provid[ing]" health insurance would not generate answers apt to resolve the litigation and Plaintiffs' own deposition testimony highlights that enrollment or declination in health insurance and determination of qualified health insurance is a highly individualized inquiry. Similarly, Plaintiffs have failed to show typicality because their claims are again based on an incorrect definition of "provid[ed]" health insurance under the MWA and even amongst the named Plaintiffs there are individualized differences in their claims and resultant defenses. Plaintiffs also fail to show predominance and superiority because of the individualized inquiries needed and the failure to show that these claims would best be resolved through class treatment. Further, Plaintiffs cannot meet the numerosity requirement because the Defendants had a policy to offer all employees health insurance and no employee has denied being offered health insurance. Finally, Plaintiffs' deposition testimony brought focus to a Rule 23 requirement that is often overlooked - adequacy. Throughout their depositions, the named Plaintiffs exemplified their inadequacy to act as class representatives by having no familiarity with the class claims, having an incorrect belief of claims or having knowledge of claims derived almost exclusively from counsel. Accordingly, Plaintiffs' Motion should be denied as they cannot meet the requirements for certification.

II. FACTS

The named Plaintiffs are four¹ individuals who allege that they have worked at a Denny's or Coco's restaurant in Clark County, Nevada. Plaintiffs filed their Class Action Complaint on May 30, 2014 and filed their Amended Class Action Complaint on June 5, 2014. In their Amended Class

¹The four named Plaintiffs in the Amended Class Action Complaint are (1) Paulette Diaz, (2) Lawanda Gail Wilbanks, (3) Shannon Olszynski and (4) Charity Fitzlaff.

1 Action Complaint, Plaintiffs, on behalf of a putative Rule 23 class, brought two claims for relief for
2 (1) Violation of Nev. Const. art. XV, § 16 Failure to Pay Lawful Minimum Wage and (2) Violation
3 of Nev. Const. art. XV, § 16 and N.A.C. § 608.102 Failure to Pay Lawful Minimum Wage, both of
4 which arise out of alleged violations of the Nevada minimum wage. As the second claim for relief is
5 nothing more than a duplicative claim for violation of the MWA that merely adds reference to a
6 Nevada Labor Commissioner's regulation on minimum wage, the only claim before this Court for
7 certification arises entirely out of Plaintiffs' claim for unpaid wages under the MWA.

8 In their Motion for Class Certification, Plaintiffs propose that their alleged "class" be
9 comprised of "All current and former employees of Defendants at all Nevada locations at any time
10 during the applicable period of limitation who were compensated at less than the upper-tier hourly
11 minimum wage set forth in Nev. Const. art XV, § 16." **Plaintiff's Motion for Class Certification**
12 **Pursuant to N.R.C.P. 23 (hereinafter "Plfs.' Mot.") attached hereto as Exhibit A at 3:2-4.**
13 Plaintiffs' proposed "class" of "employees . . . compensated at less than the upper-tier hourly
14 minimum wage" is not correctly based in the Plaintiffs' claims for relief under the MWA or any
15 question of law or fact pertinent to that claim for relief. Plaintiffs' class is for all employees paid
16 below the upper-tier minimum wage or below \$8.25 an hour. This class definition does not take into
17 account the language of the MWA that makes payment of \$8.25 an hour or higher expressly
18 contingent on whether or not an employee was offered health insurance. Instead, it creates a class on
19 one component, the rate of pay, without taking into account the express defense to the claim that an
20 \$8.25 an hour rate of pay was incorrect. This would be the equivalent of creating a "class" of all
21 employees who were paid bi-weekly or a "class" of all employees who wore a uniform. In other
22 words, there is a group of employees, but the group parameters are not linked to any issue to be
23 resolved for liability. Accordingly, the "class" of all employees "compensated at less than the upper-
24 tier hourly minimum wage" has no meaning within the context of the lawsuit.

25 Plaintiffs' class definition completely ignores the MWA's provision to pay the lower-tier
26 \$7.25 through an offer of health insurance. Whether or not the health insurance plans offered were
27 applicable for purposes of the MWA revolves around whether or not the cost of the premiums were
28 not more than 10% of an employee's gross taxable income and what a "qualified" health insurance

1 plan is under the Nevada Labor Commissioner's regulations. In their Motion for Class Certification,
2 however, Plaintiffs' class definition does not go to any of these issues and is again a common
3 question without an answer apt to drive the resolution of the litigation.

4 III. LEGAL ARGUMENT

5 A. Legal Standard For Class Certification.

6 Plaintiffs agree that the Nevada Supreme Court has cited the "analogous federal rule" of
7 Federal Rule of Civil Procedure 23 and its related case law when making determinations for
8 certification under Nevada Rule of Civil Procedure 23. *Beazer Homes Holding Corp. v. Eighth*
9 *Judicial Dist. Court of Nev.*, 128 Nev. Adv. Rep. 66, 291 P.3d 128, 136 n. 4 (2012) citing generally
10 *Wal-Mart Stores, Inc. v. Dukes*, 564 U.S. —, 131 S. Ct. 2541, 2558, 180 L. Ed. 2d 374 (2011);
11 *Shuette v. Beazer Homes Holdings Corp.*, 121 Nev. 837, 847-851 (2005) (citing Rule 23 case law
12 from the Second, Third, Fifth, Sixth, Seventh and Eleventh Circuits). Similarly, this Court may
13 evaluate certification under Nevada Rule of Civil Procedure 23 with analogous federal law.

14 As with certification under federal law, departure from the normal course of individual
15 litigation must be justified through an affirmative demonstration of compliance with the
16 prerequisites of Rule 23. The burden of making the affirmative demonstration is to be borne by
17 Plaintiffs and is subject to rigorous scrutiny by the Court. More specifically, the United States
18 Supreme Court has explained, "[t]he class action is 'an exception to the usual rule that litigation is
19 conducted by and on behalf of the individual named parties only.'" *Wal-Mart Stores, Inc. v. Dukes et*
20 *al.*, 564 U.S. —, 131 S. Ct. 2541, 2550, 180 L. Ed. 2d 374 (2011) (citing *Califano v. Yamasaki*, 442
21 U.S. 682, 700-701, 99 S. Ct. 2545, 61 L. Ed. 2d 176 (1979)). A departure from the usual rule of
22 litigation must be justified and cannot merely be assumed. *Id.* Indeed, the Rule "does not set forth a
23 mere pleading standard" and the Court may not simply rely upon Plaintiffs' representations in
24 determining whether a class action can be maintained. *Comcast Corp. v. Behrend*, 133 S. Ct. 1426,
25 1432, 185 L. Ed. 2d 515 (2013). Instead, the party seeking certification must affirmatively prove
26 each of the Rule's requirements and the Court must conduct a "rigorous analysis," in order to satisfy
27 itself that those requirements have each been met. *Wal-Mart Stores, Inc.*, 131 S. Ct. at 2551; *Gen.*
28 *Tel. Co. of Sw. v. Falcon*, 457 U.S. 147, 161 (1982). As set forth in the text of the rule, Rule 23(a)

1 requires that the party seeking certification demonstrate that:

2 “(1) the class is so numerous that joinder of all members is
3 impracticable,

4 “(2) there are questions of law or fact common to the class,

5 “(3) the claims or defenses of the representative parties are typical of
6 the claims or defenses of the class, and

7 “(4) the representative parties will fairly and adequately protect the
8 interests of the class”

9 Nev. R. Civ. P. 23(a). (Paragraph breaks added). Rule 23 also requires that the proposed class
10 satisfy at least one of the three requirements listed in Rule 23(b). Nev. R. Civ. P. 23(b). Here,
11 Plaintiffs rely on Rule 23(b)(3), which states that a class may be maintained where “questions of law
12 or fact common to the members of the class predominate over any questions affecting only
13 individual members” and a class action would be “superior to other available methods for the fair
14 and efficient adjudication of the controversy.” Nev. R. Civ. P. 23(b)(3); *Wal-Mart Stores, Inc.*, 131
15 S. Ct. at 2549 n.2.

16 As indicated above, although Defendant may bear certain burdens of proof at trial, Plaintiffs
17 must prove each requirement of Rule 23 certification by a preponderance of the evidence. See
18 *Messner v. NorthShore Univ. HealthSystem*, 669 F.3d 802, 811 (7th Cir. 2012); *Oshana v. Coca-*
19 *Cola Co.*, 472 F.3d 506, 513 (7th Cir. 2006); *Novak v. Boeing Co.*, No. SACV 09-01011-CJC, 2011
20 U.S. Dist. LEXIS 146676, *9 (C.D. Cal. Dec. 19, 2011). In further explanation of Plaintiffs’ burden
21 when attempting to establish Rule 23’s requirements the Supreme Court explained, “[a] party . . .
22 must be prepared to prove that there are in fact sufficiently numerous parties, common questions of
23 law or fact, etc.” *Wal-Mart Stores, Inc.*, 131 S. Ct. at 2551 (emphasis in original). A “court may not
24 simply assume the truth of the matters as asserted by the plaintiff. If there are material factual
25 disputes, the court must ‘receive evidence . . . and resolve the disputes before deciding whether to
26 certify the class.’” *Messner*, 669 F.3d at 811 (citations omitted).

27 In their Motion for Class Certification, Plaintiffs do not reach the Rule 23 requirements
28 because Plaintiffs have failed to define an ascertainable class by not basing their class definition on
anything beyond the upper tier \$8.25 an hour rate. In addition to failing to meet ascertainability,

1 Plaintiffs fail to meet the commonality, typicality, numerosity and adequacy requirements as
2 required by Rule 23(a). Further, the nature of claims under the MWA show that class litigation is
3 not superior to individual litigation and that Plaintiffs have not met the predominance requirement as
4 required by Rule 23(b)(3).

5 **B. Plaintiffs Have Failed To Meet The Ascertainability Requirement In Their Class**
6 **Definition.**

7 As a threshold matter, the Court need not review Rule 23's numerosity, commonality,
8 typicality, adequacy, superiority and predominance requirements because Plaintiffs have failed to
9 propose an ascertainable class. Ascertainability must be determined "[b]efore weighing the
10 enumerated [Rule 23] class certification factors." (Emphasis added). *Ratnayake v. Farmers Ins.*
11 *Exch.*, 2015 WL 875432, *4 (D. Nev. Feb. 27, 2015). Indeed, "[i]n determining whether to certify a
12 class, the court begins with the proposed definition of the class . . . [because] [a]bsent a cognizable
13 class, determining whether Plaintiffs or the putative class satisfy the other Rule 23(a) and (b)
14 requirements is unnecessary." *Robinson v. Gillespie*, 219 F.R.D. 179, 183-184 (D. Kan. 2003).
15 Accordingly, should this Court find no ascertainable class, there is no need to conduct a further
16 analysis of other class certification requirements.

17 Under ascertainability, the Court must determine whether it is "administratively feasible" to
18 ascertain whether an individual is a member of a proposed class. *Ratnayake* at *4. Further, if a
19 Court must make "detailed fact determinations to determine whether someone is a member of the
20 class" then "a class may not be ascertainable." *Id.* Thus, courts will look to the class definition to
21 determine whether a class is "ascertainable and clearly identifiable." *Konik v. Time Warner Cable*,
22 2010 U.S. Dist. LEXIS 136923, 32-33 (C.D. Cal. Nov. 24, 2010) citing *Mazur v. eBay Inc.*, 257
23 F.R.D. 563, 566 (N.D. Cal. 2009) (Patel, J.) (citing *Lamumba Corp. v. City of Oakland*, 2007 U.S.
24 Dist. LEXIS 81688, 2007 WL 3245282 (N.D. Cal. 2007).

25 Many courts have found that a proposed class is not ascertainable where it includes all users
26 or all employees, regardless of the injuries suffered, because such an overbroad class can encompass
27 a significant number of class members who lack standing to recover on the claims alleged. *See, e.g.*,
28 *Konik* at *33-35; *see also, McDonald v. Corr. Corp. of Am.*, 2010 U.S. Dist. LEXIS 122674, 7-8 (D.

1 Ariz. Nov. 4, 2010). In *Konik*, plaintiffs' proposed class definition stated "[a]ll California residential
2 and business persons who were customers of Adelphia Cable Television and who were switched
3 over to Time Warner after Time Warner's purchase of Adelphia Cable Television consummated in or
4 about August, 2006." Under this class definition, the court held that this class was not ascertainable
5 because "Plaintiff offers no way of determining what members of the class actually suffered service
6 interruptions" and that since "the class as currently defined would include these non-harmed
7 [people], this portion of the class definition is both imprecise and overbroad." *Konik* at *33. In
8 *McDonald*, plaintiff's proposed class for certification included "[a]ll individuals employed by
9 Corrections Corporation of America at any time since July 1, 2007, who have been or may be
10 subjected to termination, discipline, or reprimand, resulting from CCA's failure to comply with the
11 ADA." *McDonald* at 6-7. The court found that plaintiff's proposed class definition was "imprecise,
12 overbroad and unascertainable" and that the proposed class definition did not specify "whether class
13 members include all CCA employees, or only those employees similarly situated to McDonald in
14 terms of position . . . and facility." *McDonald* at 7-8.

15 Here, like in *Konik* and *McDonald*, Plaintiffs have proposed a class definition that is
16 imprecise and overbroad. As stated above, Plaintiffs propose the class definition of "[a]ll current
17 and former employees of Defendants at all Nevada locations at any time during the applicable period
18 of limitation who were compensated at less than the upper-tier hourly minimum wage set forth in
19 Nev. Const. art XV, § 16." *Plfs.' Mot., Exhibit A at 3:2-4*. Plaintiffs only use the compensation
20 rate of "less than the upper-tier hourly minimum wage" of \$8.25 an hour as a class definition. This
21 class definition is imprecise because liability under the MWA does not arise from just paying less
22 than \$8.25 an hour to an employee. More accurately, a violation under the MWA occurs only when
23 an employee is paid less than \$8.25 an hour is not "offered" health insurance benefits. Nev. Const.
24 Art. XV, § 16(A). Thus, liability is contingent on whether or not the employer "provides health
25 benefits as described herein" which the MWA "describe[s]" as "[o]ffering health benefits within the
26 meaning of this section shall consist of making health insurance available to the employee for the
27 employee and the employee's dependents at a total cost to the employee for premiums of not more
28 than 10 percent of the employee's gross taxable income from the employer." Nev. Const. Art. XV, §

1 16(A). The class definition is also overbroad because simply defining a class of employees who
2 made less than \$8.25 an hour would include non-class members such as those employees who were
3 properly exempt from the upper tier minimum wage because they were "offer[ed] health benefits"
4 when Defendant "ma[de] health insurance available to the employee." *Id.*

5 The Plaintiffs have failed to define their class precisely or narrowly. In fact, the definition is
6 not properly linked to any issue that would incur liability under the MWA. Accordingly, this Court
7 should deny Plaintiffs' Motion for Class Certification as a threshold issue.

8 **C. Plaintiffs Have Failed To Meet The Commonality Requirement.**

9 **1. Plaintiffs common contentions fail because they do not resolve any issue**
10 **central to liability under the MWA.**

11 Rule 23(a)'s prerequisite of commonality requires Plaintiffs to demonstrate that there are
12 "questions of law or fact common to the class." Nev. R. Civ. P. 23(a)(2). However, not just any
13 common question will do. As put by the Ninth Circuit, "it is insufficient to merely allege any
14 common question." *Ellis v. Costco Wholesale Corp.*, 657 F.3d 970, 981 (9th Cir. 2011). The
15 Supreme Court explained that the key inquiry is not whether the plaintiffs have raised common
16 questions, "even in droves," but rather, whether class treatment will "generate common answers apt
17 to drive the resolution of the litigation." *Wal-Mart Stores, Inc.*, 131 S. Ct. at 2551. (Emphasis in
18 original). Also, the common contentions must "resolve an issue that is central to the validity of each
19 one of the claims in one stroke." *Id.* Again, those seeking to meet this prerequisite "must
20 affirmatively demonstrate [their] compliance" and "prove that there are in fact . . . common
21 questions of law or fact . . ." *Id.* at 2551-2552. (Emphasis in original).

22 As the Supreme Court explained in *Wal-Mart Stores, Inc.*, "[a]ny competently crafted class
23 complaint literally raises common questions." *Id.* at 2551. This case is no exception as Plaintiffs
24 have proposed a class definition of all employees who were compensated "less than the upper-tier
25 hourly minimum wage set forth in Nev. Const. art XV, § 16". Plfs.' Mot., Exhibit A at 3:2-4. A
26 class of employees paid less than \$8.25 an hour does not provide any answers that would resolve the
27 litigation. Instead, it avoids the central issue of whether or not there would be liability under the
28 MWA for an employer who offered health insurance plans to its employees.

1 Additionally, Plaintiffs pose additional "common questions" in their Motion for Class
2 Certification that are based on a flawed reading of the MWA by stating:

3 The questions concerning Plaintiffs and the proposed Class are
4 straightforward. Did Defendants pay Class members below the upper-
5 tier hourly wage? If so, they had to meet the constitutional mandate
6 regarding provision of benefits. If they did not qualify to pay a lower
7 wage—either by offering a health insurance benefits plan that did not
8 meet coverage requirements, by offering a plan where employee
9 premium costs exceeded legal limits, or by not offering a qualifying
10 plan at all—then Defendants are liable to Plaintiffs and the Class for
11 back pay, damages, and other associated relief.

12 **Plfs.' Mot., Exhibit A at 1:11-17.** Plaintiffs' first common question is the same as the class
13 definition above as it asks "[d]id Defendants pay Class members below the upper-tier hourly wage?"
14 and does nothing to link the upper-tier rate to liability under the MWA. The second common
15 question posed sets out the qualification to pay the lower-tier rate in three instances that are not
16 based in the language of the MWA. The first qualification is "offering a health insurance benefits
17 plan that did not meet coverage requirements." This qualification is based in Plaintiffs' own
18 fabricated criteria as Plaintiffs can cite no MWA or NAC 608 language that would give rise to
19 "coverage requirements" that Plaintiffs claim were not met. The second qualification is not
20 supported in fact as Plaintiffs have not cited any evidence of an example offer in which "employee
21 premium costs exceeded legal limits." Finally, the third qualification of "not offering a qualifying
22 plan at all" is also not supported by evidence and a red herring. As will be explained below, there is
23 testimonial and written evidence that all four named Plaintiffs were offered health insurance by the
24 Defendants as two of the named Plaintiffs admit to being offered health insurance (with one Plaintiff
25 actually enrolling in the health insurance) and the other two named Plaintiffs used a sudden lack of
26 memory to avoid answering whether or not they were offered health insurance despite contrary
27 written evidence that they were offered health insurance.

28 The facts regarding Plaintiffs' underlying class claim requires clarification as Plaintiffs are
attempting to certify a class on misstated law. In their Motion for Class Certification, Plaintiffs
acknowledge that their claim is for an alleged violation of the MWA. **Plfs.' Mot., Exhibit A at 1:3-**
20. Instead of citing the actual language of the MWA, however, Plaintiffs base their certification
arguments on an incorrect interpretation of the language of the MWA. Specifically, Plaintiffs

1 misrepresent that Defendants had to "provide" qualifying health insurance instead of just "offer[ing]"
2 qualifying health insurance. Plfs.' Mot., Exhibit A at 10:14-17; *see also* 2:6-15. The language of
3 the MWA does contain the term "provide such benefits" but then immediately clarifies that provide
4 means "offering health benefits" by "making health insurance available to the employee."
5 (Emphasis added). Nev. Const. Art. XV, § 16(A). Thus, the relevant portion of Section A of the
6 MWA states:

7 Each employer shall pay a wage to each employee of not less than the
8 hourly rates set forth in this section. The rate shall be five dollars and
9 fifteen cents (\$5.15) per hour worked, if the employer provides health
10 benefits as described herein, or six dollars and fifteen cents (\$6.15) per
11 hour if the employer does not provide such benefits. Offering health
12 benefits within the meaning of this section shall consist of making
13 health insurance available to the employee for the employee and the
14 employee's dependents at a total cost to the employee for premiums of
15 not more than 10 percent of the employee's gross taxable income from
16 the employer.

13 (Emphasis added). Nev. Const. Art. XV, § 16(A). Contrary to the MWA's plain language, Plaintiffs
14 would request that this Court adopt a nonsensical definition of the work "provide" by asserting that
15 there must be some form of acceptance of assertion of control or possession by the person to whom a
16 service or item is provided. **Defendants' Opposition to Motion for Partial Summary Judgment**
17 **on Liability as to Plaintiff Paulette Diaz's First Claim for Relief (hereinafter "Dfts.' Opp. to**
18 **MPSJ") attached as Exhibit B at 5:28-6:5.** As more fully explained in Defendants' Opposition to
19 Plaintiffs' Motion for Partial Summary Judgment, however, the plain meaning of "provide" is "to
20 make available for use." *See Dfts.' Opp. to MPSJ, Exhibit B at 6:5-8:2.* Further, such an
21 interpretation that "provide" requires acceptance or possession would render the language of the
22 MWA nugatory and is not supported by other authority. *See Dfts.' Opp. to MPSJ, Exhibit B at*
23 *8:2-13:20.*

24 Additionally, the Nevada Labor Commissioner has promulgated numerous regulations that
25 further expand on what constitutes "offered qualified health insurance." *See also Dfts.' Opp. to*
26 *MPSJ, Exhibit B at 10:23-12:20.* In these Nevada Labor Commissioner regulations codified in
27 Chapter 608 of the Nevada Administrative Code that correspond to Chapter 608 of the minimum
28 wage laws in the Nevada Revised Statutes, the lower tier and upper tier minimum wage specifically

1 hinge on whether an employee is "offered" or "not offered" qualified health insurance. The
2 regulation provides that the "minimum wage for an employee . . . (a) If an employee is offered
3 qualified health insurance, is \$5.15 per hour; or (b) If an employee is not offered qualified health
4 insurance, is \$6.15 per hour." (Emphasis added). NAC 608.100(1) and (2). In the section
5 addressing an employer's "qualification to pay lower rate to employee offered health insurance",
6 again, the Nevada Labor Commissioner's regulations clearly require the "offer" of health insurance -
7 not "provision" of health insurance - by stating that the employer "must offer a health insurance plan
8 which: . . ." NAC 608.102.

9 Further, the Nevada Labor Commissioner's regulations make further distinctions between the
10 "offer" of health insurance and actual enrollment in a health insurance plan. NAC 608.108. Under
11 NAC 608.108, the regulations distinguish between the offer of health insurance from a separate and
12 disjunctive situation for when a plan "becomes effective." *Id.* Thus, NAC 608.108 adds further
13 guidance on the clear distinctions between offered health insurance and enrollment in health
14 insurance.

15 Additionally, in converse to enrollment, NAC 608.106 provides guidance as to declination of
16 an offered plan. Under NAC 608.106, an employer must maintain documentation of an employee
17 who "declines coverage under a health insurance plan." This regulation highlights the reality that
18 employers cannot force employees to enroll in health insurance plans. Thus, an employer can be in
19 compliance with the MWA by keeping a record of declined coverage. There would be no logical
20 reason for a regulation concerning the declination of coverage if an employer was required to enroll
21 employees rather than simply offer health insurance to employees.

22 As with the plain language of the MWA, the Labor Commissioner's regulations all contradict
23 Plaintiffs' arguments that the only requirement under the MWA is that employees must actually
24 enroll in health insurance benefits to employees to qualify for the lower-tier minimum wage rate,
25 rather than "offer" health insurance benefits. In fact, all of the regulatory language supports
26 Defendants having a complete defense by simply "offering" health insurance benefits that qualify
27 under the regulations. The issue of offering health insurance is also more thoroughly briefed before
28 this Court in Defendants' Opposition to Plaintiffs' Motion for Partial Summary Judgment. *See Dfts.'*

1 **Opp. to MPSJ, Exhibit B.**

2 The MWA's "offer" requirement also reflects the reality of how employees enroll or decline
3 in health insurance plans on a case-by-case and individual basis. As was borne out in the
4 depositions, although an employer can offer a health insurance plan, it cannot force an employee to
5 accept that health insurance plan as there are a variety of reasons why an employee may not require
6 health insurance - including an individual's pre-existing health insurance coverage from other
7 sources as with Plaintiff Diaz or the individual's refusal to have any deductions of any sort from their
8 pay. Thus, recognizing the realities of how these health plans are accepted or declined for a variety
9 of personal reasons, the Nevada Legislature and the Nevada Labor Commissioner expressly
10 structured the lower-tier minimum wage to be contingent on the more straightforward "offer" of
11 health insurance when drafting the laws and regulations concerning the Nevada minimum wage.

12 Plaintiffs' statements that the MWA requires a "provi[sion]" of insurance and nothing else is
13 unsupported by the explicit "offer" language contained in both the MWA and NAC 608. Thus,
14 Plaintiffs' certification issues are also irreparably misstated. The issues for certification, therefore,
15 must involve whether or not Defendants "offer[ed]" qualified health insurance as it goes to both
16 Plaintiffs' claims and Defendants' defenses under the MWA. In their Motion for Class Certification,
17 however, Plaintiffs have glossed over the "offer" requirement of the MWA by concocting their own
18 "provide" definition that is contradicted by the offer language in the MWA. *Plfs.' Mot., Exhibit A*
19 *at 10:14-21*. In doing so, Plaintiffs also proffer newly crafted declarations focusing on their own
20 definition of "provide" rather than citing the relevant deposition testimony that established that two
21 of the four named Plaintiffs, Olszynski and Fitzlaff, admitted to being "offered" health insurance
22 (with Fitzlaff actually enrolling in health insurance) while the other two named Plaintiffs, Diaz and
23 Wilbanks, were not able to "recall" being offered health insurance despite Diaz having executed a
24 written declination form and Wilbanks previously admitting to being offered health insurance in a
25 written Request for Admission response. *Plfs.' Mot. at 3:21-24; but see excerpts from Paulette*
26 *Diaz Deposition ("Diaz Depo.") attached hereto as Exhibit C at 113:23-116:3; Lawanda*
27 *Wilbanks Deposition ("Wilbanks Depo.") attached hereto as Exhibit D at 91:16-93:6; Shannon*
28 *Olszynski Deposition ("Olszynski Depo.") attached hereto as Exhibit E at 91:22-93:21; and*

1 Charity Fitzlaff Deposition ("Fitzlaff Depo.") attached hereto as Exhibit F at 47:4-13. Thus,
2 there is testimonial or written evidence that all four named Plaintiffs were, in fact, offered health
3 insurance by the Defendants.

4 2. Plaintiffs common contentions fail because the inquiry into liability under
5 the MWA is far too individualized.

6 Even if the MWA or Labor Commissioner's regulations under NAC 608 required that
7 employees be actually enrolled in health insurance for an employer to pay the lower tier wage-
8 which they do not - the resultant inquiry would be so individualized that there could be no class
9 treatment for such claims. For health insurance to be provided, the employer would first have to
10 offer a health plan that qualifies. To qualify, a health plan would have to not exceed 10% of each
11 Plaintiffs' gross taxable income. Nev. Const. Art. XV, § 16(A). "Gross taxable income . . . includes,
12 without limitation, tips, bonuses or other compensation." NAC 608.104(2). (Emphasis added).
13 Here, the four named Plaintiffs all had varying hours ranging from 8 to 40 hours a week: Diaz
14 worked 40 hours, 30 hours or 30-35 hours a week; Wilbanks worked 40 or 8 hours a week;
15 Olszynski worked 35-40 hours a week; and Fitzlaff worked 35 plus hours a week. Diaz Depo.,
16 Exhibit C at 144:12-148:13; Wilbanks Depo., Exhibit D at 69:8-70:16; Olszynski Depo.,
17 Exhibit E at 110:13-15; and Fitzlaff Depo., Exhibit F at 64:12-16. The four named Plaintiffs also
18 had varying rates of pay: Diaz made \$8.25 an hour, to \$10.00 an hour, to \$11.00 an hour and \$7.25
19 an hour; Wilbanks recalled making either \$7.25 or \$7.45 an hour; Olszynski made \$7.25 an hour and
20 then \$5.13 an hour in a Colorado location; and Fitzlaff made \$7.25 an hour. Diaz Depo., Exhibit C
21 at 84:20-85:4; Wilbanks Depo., Exhibit D at 63:1-13; Olszynski Depo., Exhibit E at 107:9-14
22 and 76:1-11; and Fitzlaff Depo., Exhibit F at 64:22-65:12. Importantly, the named Plaintiffs also
23 differed in how they reported the tips portion of their gross taxable income: Diaz and Fitzlaff
24 testified to reporting all tips they received; Olszynski never reported more than 20% of what she
25 received in tips; and Wilbanks did not report any of her tips. Diaz Depo., Exhibit C at 162:18-
26 163:13; Wilbanks Depo., Exhibit D at 79:7-20; Olszynski Depo., Exhibit E at 116:4-118:17; and
27 Fitzlaff Depo., Exhibit F at 65:14-66:4. Additionally, the Plaintiffs differed in the amount of tips
28 they averaged a week: Diaz averaged "at most" \$252 a week in tips; Olszynski averaged \$500 a

1 week in tips; and Fitzlaff averaged \$300 to \$400 a week in tips. Diaz Depo., Exhibit C at 165:17-
2 166:5; Olszynski Depo., Exhibit E at 116:4-118:17; and Fitzlaff Depo., Exhibit F at 68:13-21.
3 Thus, to determine whether each plan met the 10% test, each individual plaintiff would have to have
4 hours, rate of pay and tips examined on a yearly or weekly basis against the costs of the plans.
5 Further, there would have to be some other means of accurately gauging gross taxable income for
6 some Plaintiffs, such as Wilbanks and Olszynski, who did not accurately or lawfully report their tips.
7 Plaintiffs have presented no evidence that this issue could be resolved in one stroke or that the plans
8 failed to meet the 10% gross income requirement.

9 Further, even if this individualized inquiry was performed for each Plaintiff, then each
10 Plaintiffs' declination would have to be examined as some Plaintiffs declined insurance from a
11 personal choice that would give rise to an estoppel argument that it was impossible to "provide"
12 certain Plaintiffs with health insurance. For example, Diaz testified that she already had health
13 insurance coverage through her Native-American clinic as a member of the Oglala Sioux tribe. Diaz
14 Depo., Exhibit C at 62:17-64:10. Wilbanks, on the other hand, testified that her "main concern"
15 was for her daughter's health insurance coverage but that her daughter was already "covered through
16 her dad's insurance." Wilbanks Depo., Exhibit D at 65:3-66:20. Olszynski had enrolled in
17 Medicaid because she believed Medicaid was a "better choice." Olszynski Depo., Exhibit E at
18 112:11-114:19. Alternatively, Fitzlaff alleges that the manager told her to initially "deny the
19 insurance" and that health insurance would be handled after opening. Fitzlaff Depo., Exhibit F at
20 40:17-41:4 and 47:4-13. Despite this allegation of being told to decline health insurance, Fitzlaff
21 testified that she actually enrolled in the health insurance that was offered. Fitzlaff Depo., Exhibit F
22 at 47:4-13. Thus, an individualized inquiry is needed as to each Plaintiff's reasons for declining
23 insurance. This is especially true in cases where Plaintiffs allege that managers were affirmatively
24 dissuading employees from accepting insurance which may give rise to separate defenses that those
25 particular managers were not acting within the course and scope of their duties for Defendants by
26 expressly contradicting the Defendants' offer policies.

27 The most fundamental and searching questions, those apt to drive this litigation in terms of
28 Plaintiffs' claims and Defendants' defenses, simply do not lend themselves to class-wide resolution.

1 To make the matter even easier for the Court, Plaintiffs have offered no common answers or
2 evidence to affirmatively show that the commonality requirement might be met in this case. The
3 rigorous analysis required by the Court here must fall on nothing more than the gossamer strands of
4 conjecture which simply do not bear the weight of the inquiry. Accordingly, Plaintiffs' Motion
5 requesting Rule 23 certification fails.

6 **D. Plaintiffs Have Failed To Meet The Typicality Requirement.**

7 Rule 23's typicality requirement serves the important function of protecting absent class
8 members from the *res judicata* effect of a class action brought by representatives who may have
9 unique claims, defenses, or interests not shared by the members of the proposed class. Eloquently
10 put by the Sixth Circuit, "the premise of the typicality requirement is simply stated: as goes the claim
11 of the named plaintiff, so go the claims of the class." *Sprague v. General Motors Corp.*, 133 F.3d
12 388, 399 (6th Cir. 1998). Accordingly, even if the concepts underlying typicality is to be given a
13 permissive interpretation it is absolutely critical that the Court nevertheless engage in the rigorous
14 analysis called for by the Supreme Court to ensure that absentee class members are protected.

15 While typicality and commonality are each distinct requirements, the nature of the analysis
16 each requires tends to engender a certain amount of overlap. As explained by the United States
17 Supreme Court:

18 Both [typicality and commonality] serve as guideposts for determining
19 whether under the particular circumstances maintenance of a class
20 action is economical and whether the named plaintiff's claim and the
21 class claims are so interrelated that the interests of the class members
22 will be fairly and adequately protected in their absence. Those
23 requirements therefore also tend to merge with the adequacy-of-
representation requirement, although the latter requirement also raises
concerns about the competency of class counsel and conflicts of
interest.

24 *Wal-Mart Stores, Inc.*, 131 S. Ct. at 2551 n.5 (citing *General Telephone Co. of Southwest v. Falcon*,
25 457 U.S. 147, 157-158, n 13, 102 S. Ct. 2364, 72 L. Ed. 2d 740 (1982)).

26 In an attempt to meet their burden here, Plaintiffs assert the conclusion that "[h]ere, all
27 Plaintiffs were paid below the upper-tier minimum wage" and that Plaintiffs "allege that they were
28 not provided with qualifying health benefits." Plfs.' Mot., Exhibit A at 11:24-28. Thus, Plaintiffs'

1 typicality requirement suffers the same fatal flaw as in their ascertainability and commonality
2 requirements. Plaintiffs have premised the typicality of their claims on being paid below the upper-
3 tier minimum wage without being "provided" qualifying health benefits. As stated above, Plaintiffs'
4 argument regarding "provided" benefits is not supported by the language of the MWA or NAC 608.
5 Further, Plaintiffs' reference to "qualifying health benefits" does not provide any definitions but
6 Plaintiffs have failed to show that any individual named Plaintiffs did not have "qualified" health
7 insurance benefits as defined in NAC 608. Additionally, as shown above, the differences in
8 Plaintiffs' hours, pay, tips and reasons for declination give rise to an individualized inquiry as to
9 whether the 10% threshold of gross income was met, whether health insurance could actually be
10 provided and whether certain managers were properly following policies. Therefore, like with
11 ascertainability and commonality, Plaintiffs' typicality argument is not linked to any question of law
12 or fact that would give rise to liability under the MWA.

13 Plaintiffs simply have not shown that their claims are typical of the class they seek to
14 represent. The possibility that some class member may have his or her claim adjudicated without
15 proper representation absolutely undermines and contradicts a finding of typicality. While the
16 typicality requirement does not require Plaintiffs to demonstrate exact factual similarity amongst a
17 class, Plaintiffs are, nevertheless, required to prove that their claims and interests are sufficiently
18 typical of the proposed class members that representative litigation will be economical and that
19 absent class members will be adequately represented. *Wal-Mart Stores, Inc.*, 131 S. Ct. at 2551 n.5.
20 Plaintiffs have failed to meet this burden and so class certification would be improper.

21 **E. Plaintiffs Cannot Satisfy The Predominance And Superiority Requirements Of**
22 **Rule 23(b)(3).**

23 As indicated above, to certify a class action pursuant to Rule 23(b)(3) the court, through a
24 rigorous analysis, must find that Plaintiffs have affirmatively shown that (1) questions of law or fact
25 common to the members of the class predominate over any questions affecting only individual
26 members (a requirement often referred to as "predominance"); and (2) that a class action is superior
27 to other available methods for the fair and efficient adjudication of the controversy, (a requirement
28 commonly referred to as "superiority"). Nev. R. Civ. P. 23(b)(3); *See Comcast, Corp.*, 133 S. Ct. at

1 1432. As explained by one district court, the "predominance" and "superiority" "prongs of Rule 23
2 work together to ensure that certifying a class 'would achieve economies of time, effort, and expense,
3 and promote . . . uniformity of decision as to persons similarly situated, without sacrificing
4 procedural fairness or bringing about other undesirable results.'" *Ginsburg v. Comcast Cable Comm.
5 Mgmt. LLC*, 2013 U.S. Dist. LEXIS 55149, at *15, 20 Wage & Hour Cas. 2d (BNA) 1068 (W.D.
6 Wash. Apr. 17, 2013) (citing *Amchem Prods., Inc. v. Windsor*, 521 U.S. 591, 615, 117 S. Ct. 2231,
7 138 L. Ed. 2d 689 (1997)). As with other Rule 23 requirements, compliance with the standards of
8 Rule 23(b) must be affirmatively demonstrated by evidentiary proof. *Comcast, Corp.*, 133 S. Ct. at
9 1432.

10 **1. Plaintiffs cannot meet the demanding predominance requirement.**

11 Even if Plaintiffs had established commonality here, which they have not done,
12 "[c]ommonality alone is not sufficient" to satisfy Rule 23(b)(3) which requires a showing that
13 questions of law or fact common to class members predominate over any questions affecting only
14 individual members. *Brown v. Fed. Express Corp.*, 249 F.R.D. 580, 583 (C.D. Cal. 2008). The
15 predominance inquiry is "far more demanding" than the commonality requirement of Rule 23(a) and
16 imposes on the court the "duty to take a 'close look' at whether common questions predominate over
17 individual ones." *Comcast, Corp.*, 133 S. Ct. at 1432; *Amchem Prods. V. Windsor*, 521 U.S. 591,
18 623 (1997); *Zinser v. Accufix Research Inst., Inc.*, 253 F.3d 1180, 1186 (9th Cir. 2001). In taking its
19 "close look" at the demanding requirement of predominance, the Court "must first examine the
20 substantive issues raised by Plaintiff[] and second inquire into the proof relevant to each issue."
21 *Jimenez v. Domino's Pizza, Inc.*, 238 F.R.D. 241, 251-52 (C.D. Cal. 2006) (citing *Simer v. Rios*, 661
22 F.2d 655, 672 (7th Cir. 1981)) (denying certification, *inter alia*, because of the "individual, fact-
23 specific analysis" required as to each putative class member). "In determining whether common
24 issues predominate in accordance with Rule 23(b)(3) . . . differences among class members' claims
25 are crucial." *Ginsburg*, 2013 U.S. Dist. LEXIS 55149 at *15.

26 Plaintiffs cannot establish predominance in this matter because individual inquiries will
27 necessarily abound. As shown in the named Plaintiffs' depositions, the proof necessary to address
28 the issues involved in Plaintiffs' claims will require a case-by-case analysis of myriad individualized

1 factual issues. Plaintiffs attempt to meet their Rule 23(b)(3) burden by explaining that, the questions
2 of employee pay levels and "Defendant's eligibility to pay at reduced hourly minimum wage rates . .
3 . essentially describe the entirety of the suit." Plfs.' Mot., Exhibit A at 14:7-11. As before,
4 Plaintiffs proceed then to speculate that the inquiry required here will center on Plaintiffs' flawed
5 legal position of whether or not Defendants "provid[ed]" health insurance benefits plans. *Id.* at
6 14:11-14. Beyond this unsupported legal premise, the depositions thus far have shown that even
7 under a "provided" theory, the inquiry as to the claims and defenses for each named Plaintiffs are far
8 too individualized.

9 As explained above, the inquiry in this case will focus to a great extent on whether or not
10 particular health benefits were offered or made available to each particular employee at a total cost
11 to the employee for premiums of not more than 10 percent of the employee's gross taxable income
12 from the employer, pursuant to the Nevada Constitution, Article XV, Section 16(A). As explained
13 in Defendants' Opposition to Motion for Partial Summary Judgment, Plaintiffs have rested all of
14 their arguments on a flawed reading that the MWA requires an absolute providing of health
15 insurance that is beyond an offer. Further, even under this flawed reading, Plaintiffs have failed to
16 state or show questions of law or fact common to class members that predominate over any
17 questions affecting only individual members. Accordingly, Plaintiffs have failed to meet the
18 predominance requirement of Rule 23(b)(3).

19 **2. Plaintiffs cannot meet Rule 23(b)(3)'s superiority requirement.**

20 Under Rule 23(b)(3)'s superiority requirement, Plaintiffs must establish that deviation from
21 the normal course of litigation to a class action is the "superior" method of adjudicating and
22 resolving their claims. *See, e.g., Valentino v. Carter-Wallace, Inc.*, 97 F3d 1227, 1235 (9th Cir.
23 1996); *Jimenez*, 238 F.R.D. at 253. As part of this inquiry, the Court "must . . . consider trial
24 management concerns." *Weigle v. Fedex Ground Package Sys.*, 267 F.R.D. 614, 624 (S.D. Cal.
25 2010); *see also Maddock v. KB Homes, Inc.*, 248 F.R.D. 229, 240 (C.D. Cal. 2007) ("The
26 [superiority] requirement requires consideration of the difficulties likely to be encountered in the
27 management of this litigation as a class action, including, especially, whether and how the case may
28 be tried."). Again, this requirement is tied to the serious concerns regarding commonality and

1 predominance as, given the individual questions to be answered in this litigation, it is likely that
2 "trial administration would be overwhelming" if a class action were certified. *Id*; see also *Zinser v.*
3 *Accufix Research Inst., Inc.*, 253 F.3d 1180, 1192 (9th Cir. 2001) ("If each class member has to
4 litigate numerous and substantial separate issues to establish his or her right to recover individually,
5 a class action is not 'superior.'"); *Jimenez*, 238 F.R.D. at 253 (finding no superiority where "trial of
6 [the] case as a class action would be unmanageable because of the individualized inquiries
7 required").

8 Peripherally addressing what would certainly be the unmanageable individual inquiries class
9 litigation would present in this case, Plaintiffs speculate that the "advanced network computer . . .
10 systems" they believe Defendant has will allow "Class, wage, benefits and damages issues" to be
11 "resolved with relative ease." Plfs.' Mot., Exhibit A at 15:23-26. However, apart from being
12 absolutely unclear as to what issues Plaintiffs are referring, what, exactly, they believe these
13 "advanced" systems will be able to do, and to what the supposed "ease" would be relative to, the
14 conjecture is far from an affirmative demonstration that class adjudication could be efficiently
15 managed in this case.

16 Indeed, Plaintiffs have not affirmatively shown that a class action would be the superior
17 option in this matter, nor have they suggested any actual method for dealing with the individual
18 issues that will necessarily arise, choosing instead to merely ignore them. As explained above, if
19 interest in this case is minimal, the vastly superior option for continued litigation, and achieving each
20 of the efficiencies referenced by Plaintiffs, would be further use of the joinder mechanism. In fact,
21 Plaintiffs have already shown the efficacy of this option, adding two additional interested parties
22 after the initial complaint was filed. Joinder would avoid the difficulties of representative litigation
23 while still allowing all interested parties to have their claims heard in a single case and have their
24 costs shared.

25 Even if there were some benefit to representative litigation, which Plaintiffs have failed to
26 affirmatively demonstrate, that minimal benefit would nevertheless fail to justify certification of a
27 class action in this case. As explained by another district court, while there may always be some
28 benefit to allowing similar, yet nevertheless individual, claims to be heard in a single case, "because

1 of the individualized issues on which class members' claims would ultimately depend, a class action
2 would prove unmanageable" in these circumstances. *Ginsburg*, 2013 U.S. Dist. LEXIS 55149 at
3 *26. In a situation like this, especially where "Plaintiffs have proposed no method to efficiently
4 manage resolution of the individual questions," class action certification is not appropriate. *See id.*

5 **F. Plaintiffs Have Failed To Meet The Numerosity Requirement.**

6 Under Rule 23(a)(1), Plaintiffs must show that "the class is so numerous that joinder of all
7 members is impracticable." Nev. R. Civ. P. 23(a)(1). There is no bright line rule regarding a
8 particular number of class members that inherently suggests impracticability of joinder. *Twegbe v.*
9 *Pharmaca Integrative Pharm., Inc.*, 2013 U.S. Dist. LEXIS 100067 (N.D. Cal. July 17, 2013).
10 Courts canvassing precedent have concluded that the numerosity requirement is usually satisfied
11 where the class comprises 40 or more members, and generally not satisfied when the class comprises
12 21 or fewer members. *Twegbe* at *6 citing, 242 F.R.D. 544, 549 (N.D. Cal. 2007).

13 In this matter, numerosity may not be met if Defendants have a complete defense to the
14 claims under the MWA through its offering of health insurance. As stated, the parties dispute
15 whether or not liability under the MWA attaches when an employer offers its employee a health
16 insurance plan. Should Defendants prevail on this issue, Defendants would only remain liable for
17 any Plaintiffs who were not offered health insurance. At deposition, Defendants confirmed that all
18 of their employees were offered health insurance benefits during the applicable period. **Excerpts**
19 **from Terry DiGiamarino Deposition attached hereto as Exhibit G at 42:18-21, 44:4-9.** Of the
20 four named Plaintiffs, Olszynski and Fitzlaff admitted to being "offered" health insurance; Diaz
21 executed a written declination form; and Wilbanks admitted to being offered health insurance in a
22 written discovery response. *Diaz Depo., Exhibit C at 113:23-116:3; Wilbanks Depo., Exhibit D*
23 *at 91:16-93:6; Olszynski Depo., Exhibit E at 91:22-93:21; and Fitzlaff Depo., Exhibit F at 47:4-*
24 *13.* None of the named Plaintiffs disputed Defendants' known policy on offering health insurance
25 and only two named Plaintiffs, Diaz and Wilbanks, could not "recall" being offered health insurance
26 despite previous writings showing otherwise. *Id.* Thus, if an offer of health insurance allows an
27 employer to pay the lower tier minimum wage, then Plaintiffs have no evidence of class members
28 beyond two Plaintiffs who cannot "recall" what everyone else was offered.

1 Under Rule 23's numerosity requirement, courts have held that 40 or more members usually
2 satisfy this requirement. Clearly, two potential Plaintiffs do not meet this requirement. Therefore,
3 Plaintiffs have not met their burden to show that the proposed class meets the numerosity
4 requirement.

5 **G. Plaintiffs Have Failed To Meet The Adequacy Requirement.**

6 Under Rule 23(a)(4), the "representative parties" must "fairly and adequately protect the
7 interests of the class." Nev. R. Civ. P. 23(a)(4). When it is determined that a class representative
8 will be unable to fairly and adequately protect the interests of the class, courts will disqualify them
9 as representatives and not allow them to proceed in representing the class. *See i.e. In Re: Storage*
10 *Technology Corp. Secs. Litigation*, 113 F.R.D. 113 (D. Colo. 1986). Courts have determined that an
11 individual is an inadequate representative when: (1) the named representative displays a lack of
12 credibility regarding the allegations being made; or (2) a lack of knowledge or understanding
13 concerning what the suit is about. *See e.g., Robinson v. Gillispie*, 219 F.R.D. 179, 186 (D. Kan.
14 2003).

15 With respect to a class representative's credibility and honesty, a named plaintiff with
16 credibility and honesty problems that relate to issues directly relevant to the litigation or who have
17 confirmed examples of dishonesty, such as a criminal conviction for fraud, are inadequate
18 representatives. *Keegan v. Am. Honda Motor Co.*, 2012 WL 2250040 at *14 (C.D. Cal. June 12,
19 2012).

20 Next, in regards to knowledge about the lawsuit, the class representative must have a
21 sufficient level of knowledge regarding the litigation and claims asserted to provide the appropriate
22 "check on the otherwise unfettered discretion of counsel in prosecuting the suit." *Welling v. Alexy*,
23 155 F.R.D. 654, 659 (N.D. Cal. 1994). In considering the involvement and knowledge of a
24 prospective class representative, "the court must feel certain that the class representative will
25 discharge his fiduciary obligations by fairly and adequately protecting the interests of the class."
26 *Koenig* at 333-34. (Emphasis added).

27 In this matter, all of the named Plaintiffs should be disqualified as class representatives.
28 Specifically, every named Plaintiffs has either: (1) demonstrated severe credibility and/or honesty

1 issues that are directly related to the claims that they are pursuing on behalf of a putative class; (2)
2 demonstrated that they are totally unfamiliar with the claims they assert they are bringing on behalf
3 of a putative class as a purported class representative; and/or (3) taken a position adverse to the
4 punitive class. These arguments are summarized below and more fully briefed in Defendants'
5 Motion to Disqualify Named Plaintiffs filed concurrently herewith and incorporated herein.
6 **Defendants' Motion to Disqualify Named Plaintiffs as Class Representatives and Dismiss Class**
7 **Action Claims ("Mtn. to Disqualify") on file herein and incorporated by this reference.**

8 **1. Paulette Diaz is an inadequate class representative.**

9 Plaintiff Diaz is an inadequate class representative for three reasons: (1) she has lied under
10 oath about the facts relating to her allegations on at least two occasions, thus completely
11 undermining her credibility; (2) she does not understand the nature of her claims or her role as class
12 representative; and (3) she has actively taken a position adverse to the putative class.

13 At her deposition, Diaz provided misrepresented facts and provided contradictory evidence
14 as to whether or not she was offered health insurance by Defendants. *Mtn. to Disqualify* at 7:21-
15 9:13. Further, Diaz misrepresented her rate of pay in relation to the tiers of pay under the MWA.
16 *Id.* at 9:14-10:4. Thus, Diaz was not truthful or credible as to the facts involved in this litigation.

17 As to her requisite knowledge of her claims as a class representative, Diaz had an incorrect
18 understanding of what qualifying health insurance was, what her dependents were, what violations
19 under the MWA she was alleging, what the minimum wage rate was during her employment, what
20 her role was as class representative, what other named Plaintiffs were in the lawsuit, and an incorrect
21 assertion that this lawsuit involved off-the-clock claims. *Mtn. to Disqualify* at 10:5-12:9. Finally,
22 Diaz's individual legal assertions in her recently filed Motion for Partial Summary Judgment are in
23 contradiction to the claims filed by the putative class. *Id.* at 12:10-13:8. Accordingly, Diaz fails to
24 meet the adequacy requirement as a class representative under Rule 23(a)(4).

25 **2. Lawanda Gail Wilbanks is an inadequate class representative.**

26 Wilbanks is not an adequate representative because she has no knowledge about the lawsuit
27 whatsoever. Indeed, Wilbanks testified that she believes that she is in an entirely separate case.

28 At her deposition, Wilbanks testified that she believes that the lawsuit was led by her former

1 supervisor, Paul Watson, and that the basis of the action was alleged off-the-clock work. **Mtn. to**
2 **Disqualify at 13:9-14:12.** In actuality, Paul Watson is a former supervisor at one of Defendants'
3 restaurants who has filed an entirely separate Class Action Complaint in Department 6 of the Eighth
4 Judicial District entitled *Paul Watson v. Mancha Development Company, et al.* under case number
5 A-12-655630-C involving overtime and off-the-clock claims. *Id.* at 13:11-13 at fn. 1. As to claims
6 in this lawsuit, Wilbanks had no understanding of health insurance or its relevance to the Nevada
7 minimum wage. *Id.* at 14:13-20. Accordingly, Wilbanks fails to meet the adequacy requirement as
8 a class representative under Rule 23(a)(4).

9 **3. Shannon Olszynski is an inadequate class representative.**

10 Plaintiff Olszynski is an inadequate class representative for two reasons: (1) she actively
11 misrepresented her actual gross taxable income, which is directly relevant to this case, thus
12 completely undermining her credibility; and (2) she has no knowledge about the basic elements of
13 this case, specifically the minimum wage and Nevada's two-tiered minimum wage system.

14 At her deposition, Olszynski admitted that she failed to disclose a substantial portion of her
15 gross taxable income by unlawfully failing to report any tips in excess of 20% of sales. **Mtn. to**
16 **Disqualify at 14:26-16:8.** Thus, pursuant to the regulations which include tips for the purpose of
17 calculating gross taxable income for the MWA, Olszynski cannot possibly provide credible or
18 accurate evidence of her gross taxable income. *Id.*

19 Further, Olszynski had no understanding that there was a two-tiered minimum wage rate in
20 Nevada. **Mtn. to Disqualify at 16:10-17.** Instead, Olszynski asserted that there was only one
21 minimum wage rate of \$8.25 in Nevada and that \$7.25 was never the minimum wage rate in Nevada.
22 *Id.* at 16:18-17:5. As to health insurance under the MWA, Olszynski believed that the plan offered
23 to Defendants was a "legitimate plan" in direct contravention of the allegations of a deficient plan as
24 has been asserted in Plaintiffs' Complaint. *Id.* at 17:6-20. Accordingly, Olszynski fails to meet the
25 adequacy requirement as a class representative under Rule 23(a)(4).

26 **4. Charity Fitzlaff is an inadequate class representative.**

27 Plaintiff Fitzlaff is an inadequate class representative for two reasons: (1) she has lied under
28 oath about the facts relating to her allegations; and (2) she does not understand the nature of her

1 claims or her role as class representative.

2 In her Complaint, Fitzlaff alleged that she "was offered a purported health insurance plan"
3 and "Defendants, therefore, unlawfully paid [her] a sub-minimum wage for the entirety of her
4 employment." Mtn. to Disqualify at 18:3-5. At deposition and in her declaration, however,
5 Fitzlaff asserted that she was told that she had to decline insurance and that she had to "fight" the
6 company to receive health insurance. *Id.* at 18:5-17. Similarly, Fitzlaff was contradictory in her
7 testimony regarding whether or not her insurance application was submitted. *Id.* at 18:18-19:10.
8 Also, Fitzlaff changed her testimony mid-deposition regarding her rate of pay, revealing that she was
9 actually paid well above the upper-tier minimum wage rate when she became a supervisor and was
10 paid \$10.00 an hour. *Id.* at 19:11-20:10.

11 In addition to these credibility issues, Fitzlaff also had a lack of understanding of her claims
12 or a conflicting claim with the class. As stated, Fitzlaff's current co-Plaintiff Diaz has recently filed
13 a motion with the Court asserting that the MWA permits employers to pay the lower-tier minimum
14 wage only to employees enrolled in a company health insurance plan. Mtn. to Disqualify at 20:11-
15 16. This, of course, directly conflicts with Fitzlaff's allegations that the reason she was owed the
16 upper-tier minimum wage was because she was not offered a compliant health insurance plan. *Id.* at
17 20:17-19. Thus, if Fitzlaff intends to represent the class on this "must be enrolled" theory, then she
18 had an affirmative duty to plead in the Complaint that she had actually enrolled in the insurance. *Id.*
19 at 20:19-20. Instead, Fitzlaff either has a lack of familiarity with her claims or, alternatively, a
20 conflicting stance on the nature of her claims that contradicts the position of other class
21 representatives. Accordingly, Fitzlaff fails to meet the adequacy requirement as a class
22 representative under Rule 23(a)(4).

23 IV. CONCLUSION

24 For all the reasons set forth above, this Court should deny Plaintiffs' Motion for Class
25 Certification.

26 COUNTERMOTION TO CONTINUE HEARING ON ORDER SHORTENING TIME

27 I. FACTS AND ARGUMENT

28 Under EDCR 2.22(d), the Court may continue a hearing on a motion "upon a showing by

1 motion supported by affidavit or oral testimony that such continuance is in good faith, reasonably
2 necessary and is not sought merely for delay." Pursuant to EDCR 2.22(D), Defendants request a
3 continuance of the hearing on Plaintiffs' Motion for Class Certification Pursuant to N.R.C.P. 23 for
4 the following reasons. Pursuant to EDCR 2.26, Defendants bring this Countermotion on Order
5 Shortening Time because the hearing date that is requested to be continued is set to take place within
6 nine judicial days of the filing of this Countermotion and the Defendants wish to provide the parties
7 adequate notice of any continued hearing date. **Declaration of Montgomery Paek, Esq. ("Paek
8 Decl.") attached hereto.**

9 The hearing on Plaintiffs' Motion for Class Certification Pursuant to N.R.C.P. 23 has been set
10 for July 9, 2015 at 9:00 a.m. **Paek Decl.** Defendants' Motion to Disqualify Named Plaintiffs as
11 Class Representatives and Dismiss Class Action Claims was filed on June 25, 2015 and it is
12 anticipated that the hearing on this Motion will be set for some date after July 9, 2015. **Paek Decl.**
13 Thus, the current hearing setting on Plaintiff's Motion for Class Certification Pursuant to N.R.C.P.
14 23 does not allow enough time for this Court to consider and rule on Defendants' Motion to
15 Disqualify Named Plaintiffs as Class Representatives and Dismiss Class Action Claims. **Paek Decl.**

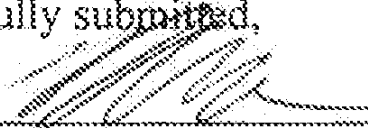
16 Defendants' Motion to Disqualify Named Plaintiffs as Class Representatives and Dismiss
17 Class Action Claims is a threshold issue to certification as the disqualification of the Named
18 Plaintiffs in this matter would render Plaintiffs' Motion for Class Certification Pursuant to N.R.C.P.
19 23 moot. **Paek Decl.** Should this Court grant Defendants' Motion to Disqualify Named Plaintiffs as
20 Class Representatives and Dismiss Class Action Claims, Plaintiffs will no longer have any class
21 representatives with which to move for certification. **Paek Decl.**

22 There would be no prejudice to the Plaintiffs to continue the hearing until a ruling on
23 Defendants' Motion to Disqualify Named Plaintiffs as Class Representatives and Dismiss Class
24 Action Claims as Plaintiffs moved for certification prior to the July 28, 2015 deadline and there are
25 no remaining deadlines that would be prejudiced by continuing the hearing on certification. **Paek
26 Decl.** Further, the disposition of the disqualification issue *before* certification will assist this Court
27 in its case management as the Court will not have to expend judicial resources on a certification
28 determination should the named Plaintiffs be disqualified to act as class representatives. **Paek Decl.**

1 Based on the above, Defendants respectfully requests that the hearing on Plaintiffs' Motion
2 for Class Certification Pursuant to N.R.C.P. 23 be moved from July 9, 2015 to a date convenient to
3 the Court that is after the Court issues a ruling on Defendants' Motion to Disqualify Named Plaintiffs
4 as Class Representatives.

5 Dated: June 25, 2015

6 Respectfully submitted,

7 
8 RICK D. ROSKELLEY, ESQ.
9 ROGER L. GRANDGENETT II, ESQ.
10 MONTGOMERY Y. PAEK, ESQ.
11 KATHRYN B. BLAKEY, ESQ.
12 LITTLER MENDELSON, P.C.
13 Attorneys for Defendants
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ORDER SHORTENING TIME
AND
NOTICE OF COUNTERMOTION

Defendants having filed a request to shorten time as to Plaintiff's Emergency Motion to Continue Hearing on Motion for Preliminary Injunction on Order Shortening Time, and good cause appearing therefore,

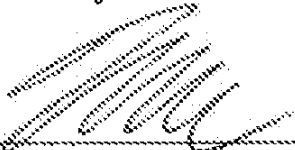
IT IS ORDERED that the time to hear the foregoing Countermotion to Continue Hearing on Plaintiffs' Motion for Class Certification Pursuant to N.R.C.P. 23 on Order Shortening Time is hereby shortened; and

IT IS FURTHER ORDERED that said Countermotion to Continue Hearing on Plaintiffs' Motion for Class Certification Pursuant to N.R.C.P. 23 on Order Shortening Time shall be heard, (if necessary), on the _____ day of _____, 2015 at _____:_____m. before the Honorable Timothy C. Williams.

IT IS SO ORDERED this _____ day of _____, 2015.

DISTRICT COURT JUDGE

Respectfully Submitted by:



RICK D. ROSKELLEY, ESQ.
ROGER L. GRANDGENETT II, ESQ.
MONTGOMERY Y. PAEK, ESQ.
KATHRYN B. BLAKEY, ESQ.
LITTLER MENDELSON, P.C.
Attorneys for Defendants

DECLARATION OF MONTGOMERY Y. PAEK, ESQ.

STATE OF NEVADA)
) ss:
COUNTY OF CLARK)

I, Montgomery Y. Paek, Esq., declare under penalty of perjury that the following is true and correct.

1. I am an attorney licensed to practice law within the State of Nevada with the law firm of Littler Mendelson, P.C. This firm represents Defendants MDC RESTAURANTS, LLC;

1 LAGUNA RESTAURANTS, LLC; and INKA, LLC ("Defendants") in the above-referenced matter.
2 I have personal knowledge of the matters stated herein and can testify of the same if called upon to
3 do so.

4 2. Defendants are filing a Countermotion to Continue Hearing on Plaintiffs' Motion for
5 Class Certification Pursuant to N.R.C.P. 23 on Order Shortening Time in this action. Pursuant to
6 EDCR 2.26, Defendants bring this Countermotion on Order Shortening Time because the hearing
7 date to be continued is set to take place within nine judicial days of the filing of this Countermotion
8 and the Defendants wish to provide the parties adequate notice of any continued hearing date.

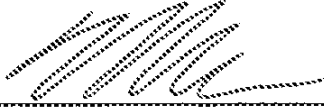
9 3. The hearing on Plaintiffs' Motion for Class Certification Pursuant to N.R.C.P. 23 has
10 been set for July 9, 2015 at 9:00 a.m. Paek Decl. Defendants' Motion to Disqualify Named
11 Plaintiffs as Class Representatives and Dismiss Class Action Claims was filed on June 25, 2015 and
12 it is anticipated that the hearing on this Motion will be set for some date after July 9, 2015. Thus, the
13 current hearing setting on Plaintiff's Motion for Class Certification Pursuant to N.R.C.P. 23 does not
14 allow enough time for this Court to consider and rule on Defendants' Motion to Disqualify Named
15 Plaintiffs as Class Representatives and Dismiss Class Action Claims.

16 4. Defendants' Motion to Disqualify Named Plaintiffs as Class Representatives and
17 Dismiss Class Action Claims is a threshold issue to certification as the disqualification of the Named
18 Plaintiffs in this matter would render Plaintiffs' Motion for Class Certification Pursuant to N.R.C.P.
19 23 moot. Should this Court grant Defendants' Motion to Disqualify Named Plaintiffs as Class
20 Representatives and Dismiss Class Action Claims, Plaintiffs will no longer have any class
21 representatives with which to move for certification.

22 5. There would be no prejudice to the Plaintiffs to continue the hearing until a ruling on
23 Defendants' Motion to Disqualify Named Plaintiffs as Class Representatives and Dismiss Class
24 Action Claims as Plaintiffs moved for certification prior to the July 28, 2015 deadline and there are
25 no remaining deadlines that would be prejudiced by continuing the hearing on certification. Further,
26 the disposition of the disqualification issue before certification will assist this Court in its case
27 management as the Court will not have to expend judicial resources on a certification determination
28 should the named Plaintiffs be disqualified to act as class representatives.

1 I declare under penalty of perjury under the laws of the United States of America that the
2 foregoing is true and correct and I am competent to testify to the facts contained in this Declaration
3 if called as a witness.

4 Executed this 25 day of June, 2015, in Las Vegas, Nevada.

5
6 
MONTGOMERY Y. PAEK, ESQ.

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8
9 **ORDER ON COUNTERMOTION TO CONTINUE HEARING ON ORDER SHORTENING**
10 **TIME**

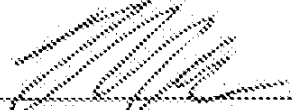
11 **IT IS HEREBY ORDERED, ADJUDGED AND DECREED** that Defendants'
12 Countermotion to Continue Hearing on Order Shortening Time is GRANTED.

13 **IT IS FURTHER ORDERED** that the Plaintiffs' Motion for Class Certification Pursuant to
14 N.R.C.P. 23 currently set for 9:00 a.m. on July 9, 2015 be continued to ____:____.m. on
15 _____, 2015.

16 DATED this 25 day of June, 2015.

17
18 _____
DISTRICT COURT JUDGE

19 Respectfully Submitted by:

20 
21 RICK D. ROSKELLEY, ESQ.
22 ROGER L. GRANDGENETT II, ESQ.
23 MONTGOMERY Y. PAEK, ESQ.
KATHRYN B. BLAKEY, ESQ.
LITTLER MENDELSON, P.C.
Attorneys for Defendants

1 PROOF OF SERVICE

2 I am a resident of the State of Nevada, over the age of eighteen years, and not a party to the
3 within action. My business address is 3960 Howard Hughes Parkway, Suite 300, Las Vegas, Nevada
4 89169. On June 25, 2015, I served the within document:

5 **DEFENDANTS' OPPOSITION TO PLAINTIFFS' MOTION FOR CLASS**
6 **CERTIFICATION PURSUANT TO N.R.C.P. 23**

7 **AND**

8 **COUNTERMOTION TO STAY HEARING ON ORDER SHORTENING TIME**

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

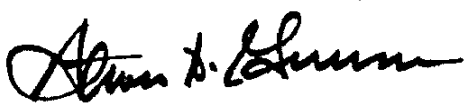
10
11 Don Springmeyer, Esq.
12 Bradley Schrager, Esq.
13 Daniel Bravo, Esq.
14 Royi Moas, Esq.
15 Jordan Butler, Esq.
16 Daniel Hill, Esq.
17 Wolf, Rifkin, Shapiro, Schulman & Rabkin, LLP
18 3556 East Russell Road, Second Floor
19 Las Vegas, Nevada 89120

20 I declare under penalty of perjury that the foregoing is true and correct. Executed on June
21 25, 2015, at Las Vegas, Nevada.



22
23
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28
Erin Melwak

Exhibit A



CLERK OF THE COURT

1 **MCC**
2 **DON SPRINGMEYER, ESQ.**
3 Nevada State Bar No. 1021
4 **BRADLEY SCHRAGER, ESQ.**
5 Nevada State Bar No. 10217
6 **DANIEL BRAVO, ESQ.**
7 Nevada State Bar No. 13078
8 **WOLF, RIFKIN, SHAPIRO,**
9 **SCHULMAN & RABKIN, LLP**
10 3556 E. Russell Road, 2nd Floor
11 Las Vegas, Nevada 89120-2234
12 Telephone: (702) 341-5200/Fax: (702) 341-5300
13 Email: dspringmeyer@wrslawyers.com
14 Email: bschrager@wrslawyers.com
15 Email: dbravo@wrslawyers.com
16 *Attorneys for Plaintiffs*

10 **EIGHTH JUDICIAL DISTRICT COURT**

11 **IN AND FOR CLARK COUNTY, STATE OF NEVADA**

12 **PAULETTE DIAZ; LAWANDA GAIL**
13 **WILBANKS; SHANNON OLSZYNSKI;**
14 **and CHARITY FITZLAFF, all on behalf of**
15 **themselves and all similarly-situated**
16 **individuals,**

15 **Plaintiffs,**

16 **vs.**

17 **MDC RESTAURANTS, LLC; LAGUNA**
18 **RESTAURANTS, LLC; INKA, LLC; and**
19 **DOES 1 through 100, Inclusive,**

20 **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 : 00 a m

21 COME NOW Plaintiffs, by and through her attorneys of record, and hereby move for an
22 order certifying this action as a class action pursuant to N.R.C.P. 23. The motion is based on the
23 Memorandum of Points and Authorities below, the papers and exhibits on file, the declarations of
24 Plaintiffs Paulette Diaz (**Exhibit 1**), Shannon Olszynski (**Exhibit 2**), Lawanda Wilbanks
25 (**Exhibit 3**), and Charity Fitzlaff (**Exhibit 4**), and attorneys Bradley Schrager, Esq. (**Exhibit 5**) and
26 Don Springmeyer, Esq. (**Exhibit 6**), and any oral argument this Court sees fit to allow at hearing on
27 this matter.
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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 / 1 5 at 9 : 0 0 a.m.~~xxx~~ 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
DON SPRINGMEYER, ESQ.
Nevada State Bar No. 1021
BRADLEY SCHRAGER, ESQ.
Nevada State Bar No. 10217
DANIEL BRAVO, ESQ.
Nevada State Bar No. 13078
3556 E. Russell Road, Second Floor
Las Vegas, Nevada 89120
Attorneys for Plaintiffs

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1 **MEMORANDUM OF POINTS AND AUTHORITIES**

2 **I. INTRODUCTION**

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

11 The questions concerning Plaintiffs and the proposed Class are straightforward. Did
12 Defendants pay Class members below the upper-tier hourly wage? If so, they had to meet the
13 constitutional mandate regarding provision of benefits. If they did not qualify to pay a lower
14 wage—either by offering a health insurance benefits plan that did not meet coverage requirements,
15 by offering a plan where employee premium costs exceeded legal limits, or by not offering a
16 qualifying plan at all—then Defendants are liable to Plaintiffs and the Class for back pay, damages,
17 and other associated relief. All employees paid below the upper-tier minimum hourly wage are
18 necessarily similarly situated because Defendants would have had to arrange for health insurance
19 benefits coverage common to all Plaintiffs and Class members in order to pay any of them less than
20 \$8.25 per hour. *See* N.A.C. 608.102(2)(a).

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

23 ¹ Since November 28, 2006, the Minimum Wage Amendment has been subject to an indexing
24 mechanism, and the state minimum wage rate has interacted with the federal minimum wage rate
25 over the last nine years. *See* Nev. Const. art. XV, § 16(A). On July 1, 2010, the upper-tier rate for
26 employees who are not provided qualifying health insurance benefits was raised to \$8.25 per hour,
27 and the lower-tier rate for employees who are provided qualifying health insurance benefits was
28 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.*

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

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

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

28

1 **II. THE PROPOSED CLASS**

2 Plaintiffs move for certification of the following proposed Class:

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

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

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

17 **III. FACTUAL BACKGROUND**

18 **A. Plaintiffs**

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

26 ///

27 ///

28 ///

///

1 **B. Defendants**

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

14 **II. PROCEDURAL BACKGROUND**

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

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

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

26 ⁴ Asked in Class Interrogatory No. 39 to list its Denny's or Coco's restaurant locations in
27 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
28 accurate copy of which is attached as **Exhibit 9**.

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

4 **III. ARGUMENT**

5 The language of Rule 23 of the Nevada Rules of Civil Procedure is similar to its federal
6 counterpart. *Compare* N.R.C.P. 23 *with* F.R.C.P. 23. Nevada courts therefore routinely look to
7 federal case law for guidance on class certification issues. See *Beazer Homes Holding Corp. v.*
8 *Dist. Ct.*, 128 Nev. Adv. Op. 66, 291 P.3d 128, 135 n. 4 (2012) (citing approvingly federal
9 precedent on Rule 23); *Shuette v. Beazer Homes Holdings Corp.*, 121 Nev. 837, 847, 124 P.3d 530,
10 537-38 (2005) (citing approvingly "analogous" Sixth Circuit analysis of F.R.C.P. 23).

11 "[T]he determination to use the class action is a discretionary function wherein the district
12 court must pragmatically determine whether it is better to proceed as a single action, or many
13 individual actions in order to redress a single fundamental wrong." *Deal v. 999 Lakeshore Ass'n*,
14 94 Nev. 301, 306, 579 P.2d 775, 778-79 (1978). Class actions serve three essential purposes: (1) to
15 facilitate judicial economy by the avoidance of multiple suits on the same subject matter; (2) to
16 provide a feasible means for asserting the rights of those who would have no realistic day in court
17 if a class action were not available; and (3) to deter inconsistent results, assuring a uniform,
18 singular determination of rights and liabilities. *American Pipe and Constr. Co. v. Utah*, 414 U.S.
19 538, 550, 94 S. Ct. 756, 764-65 (1974); *In re Syncor Erisa Litig.*, 227 F.R.D. 338, 343 (C.D. Cal.
20 2005).

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

1 Here, certification is appropriate under Rule 23(b)(3) because “questions of law or fact
2 common to class members predominate over any questions affecting only individual members, and
3 that a class action is superior to other available methods for fairly and efficiently adjudicating the
4 controversy.” *See* N.R.C.P. 23(b)(3). In determining whether class certification is appropriate, the
5 Court need not—and, where possible, should not—reach resolution of the substantive merits of the
6 claims. The trial court “should generally accept the allegations of the complaint as true; an
7 extensive evidentiary showing is not required.” *Meyer v. Eighth Judicial Dist. Court*, 110 Nev.
8 1357, 1363-64, 885 P.2d 622, 626 (1994). Rule 23(b)(3) requires only “a showing that questions
9 common to the class predominate, not that those questions will be answered, on the merits, in favor
10 of the class.” *Abdullah v. U.S. Sec. Associates, Inc.*, 731 F.3d 952, 964 (9th Cir. 2013) (internal
11 quotations and citations omitted). Applying these principles, class certification is appropriate in this
12 action.

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

14 Under N.R.C.P. 23(a), plaintiffs seeking to certify a case as a class action must establish
15 four prerequisites. *See Shuette*, 121 Nev. at 846; *Staton v. Boeing Co.*, 327 F.3d 938, 953 (9th Cir.
16 2003); *Amchem Products, Inc. v. Windsor*, 521 U.S. 591, 117 S. Ct. 2231 (1997). First, the
17 *numerosity* prerequisite requires that the members of a proposed class be so numerous that separate
18 joinder of each member is impracticable. N.R.C.P. 23(a)(1). Second, the *commonality* prerequisite
19 requires questions of law or fact common to each member of the class. N.R.C.P. 23(a)(2). Third,
20 *typicality* demands a showing that the representative parties’ claims or defenses are typical of the
21 class’s claims or defenses. N.R.C.P. 23(a)(3). Finally, under the *adequacy* prerequisite, the parties
22 must be able to fairly and adequately protect and represent each class member’s interests.
23 N.R.C.P. 23(a)(4).

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

26 **1. The Proposed Class Satisfies the Numerosity Requirement of Rule**
27 **23(a)(1)**

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

1 impracticable. The United States Supreme Court has cautioned that “[t]he numerosity requirement
2 requires examination of the specific facts of each case and imposes no absolute limitations.”
3 *General Tel. Co. of the Northwest, Inc. v. Equal Employment Opportunity Comm’n*, 446 U.S. 318,
4 330, 100 S. Ct. 1698 (1980). Although courts agree that numerosity mandates no minimum number
5 of individual members, a putative class of forty or more generally will be found to satisfy this
6 requirement. *See Shuette*, 121 Nev. at 847 (holding that numerosity is generally satisfied when
7 there are at least 40 or more class members); *Mazza v. AM. Honda Motor Co.*, 254 F.R.D. 610, 617
8 (C.D. Cal. 2008) (“As a general rule, classes of forty or more are considered sufficiently
9 numerous.”). Plaintiffs need not state exact figures of total potential Class members; instead, they
10 can satisfy the numerosity requirement by providing reasonable estimates. *See Sobel v. Hertz*
11 *Corp.*, 291 F.R.D. 525, 541 (D. Nev. 2013). Plaintiffs need only demonstrate that the Class “is so
12 large that proceedings as a class action is the only manageable method of resolving the
13 controversy.” *Cummings v. Charter Hosp. of Las Vegas, Inc.*, 111 Nev. 639, 643-44, 896 P.2d
14 1137, 1140 (1995).

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

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

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

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

15 **2. The Proposed Class Satisfies the Commonality Requirement of Rule**
16 **23(a)(2)**

17 Under the commonality requirement, class action certification is proper when there are
18 questions of law or fact common to the class. *See Shuette*, 121 Nev. at 848. "Commonality requires
19 the plaintiff to demonstrate that the class members have suffered the same injury, and the plaintiff's
20 common contention must be of such a nature that it is capable of class-wide resolution—which
21 means that determination of its truth or falsity will resolve an issue that is central to the validity of
22 each one of the claims in one stroke." *Hester v. Vision Airlines, Inc.*, 2014 WL 1366550 (D. Nev.
23 Apr. 7, 2014) (approving class settlement agreement; citing *Wal-Mart Stores, Inc. v. Dukes*, 131 S.
24 Ct. 2541, 2551 (2011)). Commonality assesses "the capacity of a class-wide proceeding to generate
25 common answers apt to drive the resolution of the litigation." *Wal-Mart Stores, Inc.*, 131 S. Ct. at
26 2551.

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

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

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

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

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

25 **2010 – 2012:** Starbridge Limited-Benefit Sickness and Accident Plan, an accurate copy of
26 which is attached as **Exhibit 15** (produced by Defendants as MDC000087-000096).

27 **2013:** Starbridge Limited-Benefit Sickness and Accident Plan, an accurate copy of which
28 is attached as **Exhibit 16** (MDC000097-000120).

1 **2014:** Transamerica TransChoice Advance Hospital Indemnity Insurance Plan, an accurate
2 copy of which is attached as **Exhibit 17** (MDC000129-000132).

3 **2015:** Key Benefit Minimum Value Plan (MVP Plan), an accurate copy of which is
4 attached as **Exhibit 18** (MDC000770-000777).

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

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

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

9 . . .

10 Q. Prior to the MVP Plan, was the Transamerica or TransChoice Plan provided
to all Nevada hourly employees?

11 A. Yes.

12 Q. Prior to TransAmerica/TransChoice plan, was the Starbridge offered to all
hourly employees?

13 A. Yes.

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

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

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

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

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

13 Typicality "is satisfied when each class member's claim arises from the same course of
14 events, and each class member makes similar legal arguments to prove the defendant's liability."
15 *Rodriguez v. Hayes*, 591 F.3d 1105, 1124 (9th Cir. 2009) (internal quotations and citation omitted).
16 "Under the [Rule 23]'s permissive standards, representative claims are 'typical' if they are
17 reasonably co-extensive with those of absent class members; they need not be substantially
18 identical." *Hanlon*, 150 F.3d at 1020; *see also Kristensen v. Credit Payment Services*, 12 F. Supp.
19 3d 1292, 1305 (D. Nev. 2014). The typicality prerequisite concentrates on the defendants' actions,
20 not on the plaintiffs' conduct. *See Rosario*, 963 F.2d at 1018. If the class representatives and
21 members of the class "share a common issue of law or fact" and "are sufficiently parallel to insure
22 a vigorous and full presentation of all claims for relief" then the typicality requirement is satisfied.
23 *California Rural Legal Assistance v. Legal Services Corp.*, 917 F.2d 1171, 1175 (9th Cir. 1990).

24 Here, all Plaintiffs were paid below the upper-tier minimum wage. *See* Amend. Compl.
25 ¶¶ 14-17, 24, 27, 30, 33; *see also* Diaz Decl. ¶ 6 (Ex. 1); Olszynski Decl. ¶ 6 (Ex. 2); Wilbanks
26 Decl. ¶ 7 (Ex. 3); Fitzlaff Decl. ¶ 6 (Ex. 4); Defs.' Ans. ¶¶ 14, 15, 16, 17, 24, 27, 30, 33. Plaintiffs
27 allege that they were not provided with qualifying health benefits, per the Minimum Wage
28 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

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

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

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

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

25 **1. Common Questions of Law and Fact Predominate**

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

1 *Amchem*, 521 U.S. at 623. In contrast to Rule 23(a)(2)'s commonality analysis, Rule 23(b)(3) tests
2 the interplay between the common and individual issues and determines their relative importance
3 within the action. "When common questions present a significant aspect of the case and they can be
4 resolved for all members of the class in a single adjudication, there is clear justification for
5 handling the dispute on a representative rather than on an individual basis." *Hanlon*, 150 F.3d at
6 1022.

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

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

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

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

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

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

27 **C. Undersigned Counsel Are Appropriate Class Counsel**

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

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

8 **IV. CONCLUSION**

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

13
14 DATED this 8th day of June, 2015.

15 **WOLF, RIFKIN, SHAPIRO,**
16 **SCHULMAN & RABKIN, LLP**

17 By: /s/ Bradley Schrager

18 DON SPRINGMEYER, ESQ.
19 Nevada State Bar No. 1021
20 BRADLEY SCHRAGER, ESQ.
21 Nevada State Bar No. 10217
22 DANIEL BRAVO, ESQ.
23 Nevada State Bar No. 13078
24 3556 E. Russell Road, Second Floor
25 Las Vegas, Nevada 89120
26 *Attorneys for Plaintiffs*
27
28

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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

1 DON SPRINGMEYER, ESQ.
Nevada State Bar No. 1021
2 BRADLEY SCHRAGER, ESQ.
Nevada State Bar No. 10217
3 DANIEL BRAVO, ESQ.
Nevada State Bar No. 13078
4 WOLF, RIFKIN, SHAPIRO,
SCHULMAN & RABKIN, LLP
5 3556 E. Russell Road, 2nd Floor
Las Vegas, Nevada 89120-2234
6 Telephone: (702) 341-5200/Fax: (702) 341-5300
Email: dspringmeyer@wrslawyers.com
7 Email: bschrager@wrslawyers.com
Email: dbravo@wrslawyers.com
8 *Attorneys for Plaintiffs*

9
10 **EIGHTH JUDICIAL DISTRICT COURT**

11 **IN AND FOR CLARK COUNTY, STATE OF NEVADA**

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

15 Plaintiffs,

16 vs.

17 MDC RESTAURANTS, LLC, a Nevada
18 limited liability company; LAGUNA
RESTAURANTS, LLC, a Nevada limited
19 liability company; INKA, LLC, a Nevada
limited liability company, and DOES 1
20 through 100, inclusive,

21 Defendants.

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

DECLARATION OF PAULETTE DIAZ

22
23 **DECLARATION OF PAULETTE DIAZ**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22
23 DATED this 19 day of May, 2015.

24
25 By: 

26 PAULETTE DIAZ

Exhibit 2

Exhibit 2

1 DON SPRINGMEYER, ESQ.
Nevada State Bar No. 1021
2 BRADLEY SCHRAGER, ESQ.
Nevada State Bar No. 10217
3 DANIEL BRAVO, ESQ.
Nevada State Bar No. 13078
4 **WOLF, RIFKIN, SHAPIRO,**
SCHULMAN & RABKIN, LLP
5 3556 E. Russell Road, 2nd Floor
Las Vegas, Nevada 89120-2234
6 Telephone: (702) 341-5200/Fax: (702) 341-5300
Email: dspringmeyer@wrslawyers.com
7 Email: bschrager@wrslawyers.com
Email: dbravo@wrslawyers.com
8 *Attorneys for Plaintiffs*

9
10 **EIGHTH JUDICIAL DISTRICT COURT**

11 **IN AND FOR CLARK COUNTY, STATE OF NEVADA**

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

15 Plaintiffs,

16 vs.

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

21 Defendants.

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

**DECLARATION OF SHANNON
OLSZYNSKI**

22
23 **DECLARATION OF SHANNON OLSZYNSKI**

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

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

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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

1 DON SPRINGMEYER, ESQ.
Nevada State Bar No. 1021
2 BRADLEY SCHRAGER, ESQ.
Nevada State Bar No. 10217
3 DANIEL BRAVO, ESQ.
Nevada State Bar No. 13078
4 **WOLF, RIFKIN, SHAPIRO,**
SCHULMAN & RABKIN, LLP
5 3556 E. Russell Road, 2nd Floor
Las Vegas, Nevada 89120-2234
6 Telephone: (702) 341-5200/Fax: (702) 341-5300
Email: dspringmeyer@wrslawyers.com
7 Email: bschrager@wrslawyers.com
Email: dbravo@wrslawyers.com
8 *Attorneys for Plaintiffs*

9
10 **EIGHTH JUDICIAL DISTRICT COURT**

11 **IN AND FOR CLARK COUNTY, STATE OF NEVADA**

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

15 Plaintiffs,

16 vs.

17 MDC RESTAURANTS, LLC, a Nevada
limited liability company; LAGUNA
18 RESTAURANTS, LLC, a Nevada limited
liability company; INKA, LLC, a Nevada
19 limited liability company, and DOES 1
through 100, inclusive,
20

21 Defendants.

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

DECLARATION OF LAWANDA GAIL WILBANKS

22
23 **DECLARATION OF LAWANDA GAIL WILBANKS**

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

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

1 2. I am currently a resident of the State of Nevada.
2 3. I have one dependent child, a seventeen year old daughter.
3 4. Upon information and belief, I worked as an hourly, non-exempt employee at a
4 Denny's restaurant owned and operated by Defendant MDC Restaurants, LLC. The Denny's
5 restaurant was located at 5318 Boulder Highway, Las Vegas, Nevada 89122.

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

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

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

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

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

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

15

16 DATED this 18th day of May, 2015.

17

BY: Lawanda Gail Wilbanks

18

LAWANDA GAIL WILBANKS

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Exhibit 4

Exhibit 4

1 DON SPRINGMEYER, ESQ.
Nevada State Bar No. 1021
2 BRADLEY SCHRAGER, ESQ.
Nevada State Bar No. 10217
3 DANIEL BRAVO, ESQ.
Nevada State Bar No. 13078
4 **WOLF, RIFKIN, SHAPIRO,**
SCHULMAN & RABKIN, LLP
5 3556 E. Russell Road, 2nd Floor
Las Vegas, Nevada 89120-2234
6 Telephone: (702) 341-5200/Fax: (702) 341-5300
Email: dspringmeyer@wrslawyers.com
7 Email: bschrager@wrslawyers.com
Email: dbravo@wrslawyers.com
8 *Attorneys for Plaintiffs*

9
10 **EIGHTH JUDICIAL DISTRICT COURT**

11 **IN AND FOR CLARK COUNTY, STATE OF NEVADA**

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

15
16 Plaintiffs,

17 vs.

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

21 Defendants.

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

**DECLARATION OF CHARITY
FITZLAFF**

22
23 **DECLARATION OF CHARITY FITZLAFF**

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

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

Exhibit 5

Exhibit 5

1 DON SPRINGMEYER, ESQ.
Nevada State Bar No. 1021
2 BRADLEY SCHRAGER, ESQ.
Nevada State Bar No. 10217
3 DANIEL BRAVO, ESQ.
Nevada State Bar No. 13078
4 **WOLF, RIFKIN, SHAPIRO,**
SCHULMAN & RABKIN, LLP
5 3556 E. Russell Road, 2nd Floor
Las Vegas, Nevada 89120-2234
6 Telephone: (702) 341-5200/Fax: (702) 341-5300
Email: dspringmeyer@wrslawyers.com
7 Email: bschrager@wrslawyers.com
Email: dbravo@wrslawyers.com
8 *Attorneys for Plaintiffs*

9
10 **EIGHTH JUDICIAL DISTRICT COURT**
11 **IN AND FOR CLARK COUNTY, STATE OF NEVADA**

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

15 Plaintiffs,

16 vs.

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

19 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**

20
21 **DECLARATION OF BRADLEY SCHRAGER, ESQ.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 MDC000087-000096.

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

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

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

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

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

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

16

17 DATED this 8th day of June, 2015.

18

/s/ Bradley Schrager

19

BRADLEY SCHRAGER, ESQ.

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Exhibit 6

Exhibit 6

1 DON SPRINGMEYER, ESQ.
Nevada State Bar No. 1021
2 BRADLEY SCHRAGER, ESQ.
Nevada State Bar No. 10217
3 DANIEL BRAVO, ESQ.
Nevada State Bar No. 13078
4 **WOLF, RIFKIN, SHAPIRO,**
SCHULMAN & RABKIN, LLP
5 3556 E. Russell Road, 2nd Floor
Las Vegas, Nevada 89120-2234
6 Telephone: (702) 341-5200/Fax: (702) 341-5300
Email: dspringmeyer@wrslawyers.com
7 Email: bschrager@wrslawyers.com
Email: dbravo@wrslawyers.com
8 *Attorneys for Plaintiffs*

9
10 **EIGHTH JUDICIAL DISTRICT COURT**
11 **IN AND FOR CLARK COUNTY, STATE OF NEVADA**

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

15 Plaintiffs,

16 vs.

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

19 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**

20
21 **DECLARATION OF DON SPRINGMEYER, ESQ.**

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

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

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

11 3. Wolf, Rifkin is eminently qualified to act as class counsel in this action. Wolf,
12 Rifkin was founded 1977 and is comprised of a team of over 40 attorneys who handle cases in all
13 areas of law, with offices in Los Angeles, Las Vegas, and Reno. The Firm's clientele includes
14 individuals and community associations as well as businesses ranging from fledgling firms to
15 Fortune 500 companies. I am the litigation partner in charge of class action and complex high
16 damages litigation for Wolf, Rifkin. I am headquartered in the Firm's Las Vegas office. I have 33
17 years of experience in high stakes litigation including class actions of all types, mass torts ranging
18 from medical device and pharmaceutical products to components of home building construction,
19 residential and commercial construction defects, real estate and condominium litigation, water
20 rights/environmental, and insurance bad faith. Within the last three years I have been designated as
21 lead counsel for class actions pending in six separate states, aside from Nevada. Within the last
22 year here in Nevada, I and the Firm have been designated as co-lead class counsel by Hon. Jennifer
23 Dorsey in the conditionally certified FLSA collective and class action entitled *Cardoza v. Bloomin'*
24 *Brands, Inc.*, 2:13-cv-01820-JAD-NJK—a case involving a putative class of approximately
25 135,000 hourly employees at Outback Steakhouse restaurants.

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

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

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

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

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

17
18 DATED this 8th day of June, 2015.

19 /s/ Don Springmeyer
20 DON SPRINGMEYER, ESQ.
21
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Exhibit 7

Exhibit 7

dba Denny's Restaurant Franchise				
7242	5045 W. Tropicana Ave. Las Vegas, NV 89103	(702) 967-5280 (702) 967-5283	December, 1999 Fax	
7243	9320 S. Eastern Ave. Las Vegas, NV 89123	(702) 990-4560 (702) 990-4565	December, 1999 Fax	
7518	4280 W. Craig Rd., Ste. 103 N. Las Vegas, NV 89031	(702) 947-0457 (702) 947-0461	November, 2000 Fax	
7632	310 N. Nellis Blvd. Las Vegas, NV 89110	(702) 452-5885 (702) 452-1918	June, 2002 Fax	
7633	7071 W. Craig Rd., Ste. 101 Las Vegas, NV 89129	(702) 395-9116 (702) 395-8376	March, 2002 Fax	
7671	3230 Losee Rd. N. Las Vegas, NV 89030	(702) 649-7671 (702) 649-1767	September, 2002 Fax	
7674	8000 W. Sahara Ave., Ste. 109 Las Vegas, NV 89117	(702) 948-8382 (702) 948-8387	August, 2001 Fax	
7764	1201 W. Warm Springs Rd. Henderson, NV 89014	(702) 454-7818 (702) 454-5247	August, 2003 Fax	
7765	6300 W. Charleston Blvd. #110 Las Vegas, NV 89102	(702) 309-0622 (702) 309-1218	Sept, 2006 Fax	
7825	7341 W. Lake Mead Blvd. Las Vegas, NV 89128	(702) 240-6015 (702) 240-9078	December, 2005 Fax	
7828	5585 Simmons St. Ste #5 North Las Vegas, NV 89031	(702) 631-0024 (702) 631-0047	May, 2006 Fax	
7914	2380 E. Tropicana Ave. Las Vegas, NV 89119	(702) 739-7001 (702) 739-9925	October, 2007 Fax	
7998	9310 W. Tropicana Ave. Las Vegas, NV 89123	(702) 868-3558 (702) 227-7343	July, 2008 Fax	
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	October, 2008 Fax	
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	13-Feb-09 Fax	
8188	Wildfire Lanes Casino 4451 E. Sunset Rd. Henderson, NV 89014	(702) 495-3810 (702) 495-3811	8-Feb-09 Fax	
8189	Wild Wild West 3330 W Tropicana Ave Las Vegas, NV 89103	(702) 495-3814 (702) 495-3815	24-Apr-09 Fax	
8563	5318 Boulder Hwy. Las Vegas NV 89122	(702) 333-2185 (702) 333-2187	29-Sep-10 Fax	
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	19-Jan-10 Fax	

MDC000158

Exhibit 8

Exhibit 8

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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1 **INTERROGATORY NO. 2:**

2 State the number of employees employed at all Denny's between July 1, 2007, and June 30,
3 2008, that were paid less than \$6.33 per hour as a regular hourly wage rate, excluding any tips,
4 gratuities, or bonuses.

5 **RESPONSE 2:**

6 Defendant incorporates its Response to Interrogatory No. 1.

7 **INTERROGATORY NO. 3:**

8 State the number of employees employed at all Denny's between July 1, 2008, and June 30,
9 2009, for which employees were paid less than \$6.85 per hour as a regular hourly wage rate,
10 excluding any tips, gratuities, or bonuses.

11 **RESPONSE 3:**

12 Defendant incorporates its Response to Interrogatory No. 1.

13 **INTERROGATORY NO. 4:**

14 State the number of employees employed at all Denny's between July 1, 2009, and June 30,
15 2010, that were paid less than \$7.55 per hour as a regular hourly wage rate, excluding any tips,
16 gratuities or bonuses.

17 **RESPONSE 4:**

18 Defendant incorporates its Response to Interrogatory No. 1.

19 **INTERROGATORY NO. 5:**

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

23 **RESPONSE 5:**

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

27 ///

28

<u>Dates</u>	<u>Total Number of INKA Denny's employees</u>
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

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

3 Terry Digiamarino
4 Payroll Manager/Benefits Representative
5 c/o Littler Mendelson
6 3960 Howard Hughes Parkway, Suite 300
7 Las Vegas, NV 89169

8 **INTERROGATORY NO. 8:**

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

12 **RESPONSE 8:**

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

16 **INTERROGATORY NO. 9:**

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

22 **RESPONSE 9:**

23 Objection. Interrogatory No. 9 is overly broad, unduly burdensome, and not likely to lead to
24 the discovery of admissible evidence. Claims for alleged minimum wage violations before May 30,
25 2012 are barred by the statute of limitations and, therefore, information about stores prior to May 30,
26 2012 is not likely to lead to the discovery of admissible evidence. Moreover, any store which closed
27 prior to May 30, 2012 is beyond the scope of this lawsuit. Subject to and without waiving these
28 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:

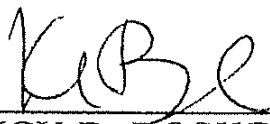
Describe with specificity the practice or methodology employed by INKA, since November 28, 2006, to compute or calculate whether premium costs for all health insurance plans and policies offered or provided by INKA to any Denny's employee paid below the upper-tier minimum hourly wage determined by Nev. 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

1 **RESPONSE 18:**

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

12
13 Dated: November 5, 2014

14
15 Respectfully submitted,

16 
17 _____
18 RICK D. ROSKELLEY, ESQ.
19 ROGER L. GRANDGENETT II, ESQ.
20 KATIE BLAKEY, ESQ.
21 LITTLER MENDELSON, P.C.

22 Attorneys for Defendants
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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

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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 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

Firmwide:129188793.1 081404.1002

Exhibit 9

Exhibit 9

1 INTG
RICK D. ROSKELLEY, ESQ., Bar # 3192
2 ROGER L. GRANDGENETT II, ESQ., Bar # 6323
KATIE BLAKEY, ESQ., Bar # 12701
3 LITTLER MENDELSON, P.C.
3960 Howard Hughes Parkway
4 Suite 300
Las Vegas, NV 89169-5937
5 Telephone: 702.862.8800
Fax No.: 702.862.8811
6
Attorneys for Defendants
7

8 **DISTRICT COURT**
9 **CLARK COUNTY, NEVADA**
10

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

14 Plaintiffs,

15 vs.

16 MDC RESTAURANTS, LLC, a Nevada
17 limited liability company; LAGUNA
RESTAURANTS, LLC, a Nevada limited
18 liability company; INKA, LLC, a Nevada
limited liability company and DOES 1
19 through 100, inclusive,

20 Defendants.
21

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**

22 **PROFOUNDING PARTY: PLAINTIFFS, ON BEHALF OF PUTATIVE CLASS**

23 **RESPONDING PARTY: DEFENDANT LAGUNA RESTAURANTS, LLC**

24 **SET NO.: THREE (3)**

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

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

3 **INTERROGATORY NO. 39:**

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

9 **RESPONSE TO INTERROGATORY NO. 39:**

10 Objection. Interrogatory No. 39 is overly broad, unduly burdensome, and not likely to lead to
11 the discovery of admissible evidence. Claims for alleged minimum wage violations before May 30,
12 2012 are barred by the statute of limitations and, therefore, information about stores prior to May 30,
13 2012 is not likely to lead to the discovery of admissible evidence. Moreover, any store which closed
14 prior to May 30, 2012 is beyond the scope of this lawsuit. Subject to and without waiving these
15 objections, Defendant responds as follows:

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

23 **INTERROGATORY NO. 40:**

24 Describe with specificity, and indicate effective dates of all health insurance plans and
25 policies offered or provided by Laguna between November 28, 2006, and Present, to any
26 Restaurants' employee that was paid less than the Upper-tier minimum wage as a regular hourly
27 wage rate, excluding any tips, gratuities, or bonuses. For purposes of this request, the term "Upper-
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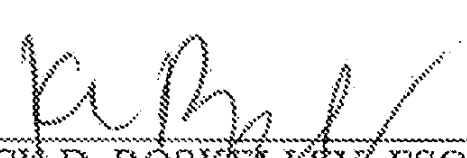
1 tier minimum wage" shall mean and refer to the highest applicable minimum wage rate set forth in
2 article XV, section 16 of the Nevada Constitution, N.A.C. 608.100, and/or as published by the office
3 of the Nevada Labor Commissioner since November 28, 2006. This interrogatory shall be
4 understood to encompass and include medical, dental, and vision benefits plans.

5 RESPONSE TO INTERROGATORY NO. 40:

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

16 Dated: January 20, 2015

17 Respectfully submitted,

18
19 
20 RICK D. ROSKELLEY, ESQ.
21 ROGER L. GRANDGENETT II, ESQ.
22 KATHRYN BLAKEY, ESQ.
23 LITTLER MENDELSON, P.C.

24 Attorneys for Defendants
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1 VERIFICATION

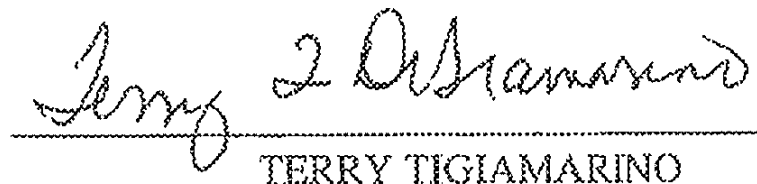
2 I, TERRY TIGIAMARINO, declare:

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

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

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

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

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15 TERRY TIGIAMARINO
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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 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

Exhibit 10

Exhibit 10

INTG
RICK D. ROSKELLEY, ESQ., Bar # 3192
ROGER L. GRANDGENETT II, ESQ., Bar # 6323
KATHRYN B. 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 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:

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

INTERROGATORY NO. 5:

RESPONSE 5:

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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

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VERIFICATION

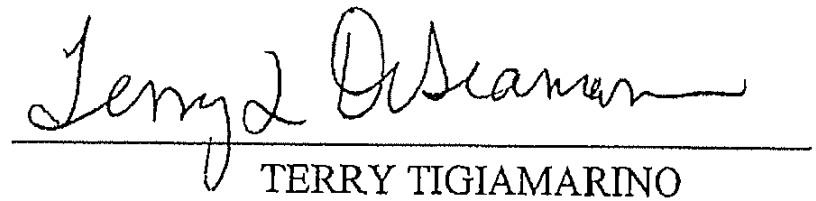
I, TERRY TIGIAMARINO, declare:

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 TIGIAMARINO

1 **PROOF OF SERVICE**

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

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

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

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

15 I declare under penalty of perjury that the foregoing is true and correct. Executed on March
16 26, 2015, at Las Vegas, Nevada.

17 

18 Debra Perkins

19 Firmwide:132385638.1 081404.1002

Exhibit 11

Exhibit 11

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:

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

INTERROGATORY NO. 5:

RESPONSE 5:

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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

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VERIFICATION

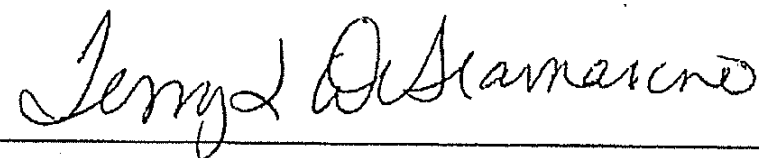
I, TERRY TIGIAMARINO, declare:

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 TIGIAMARINO

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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 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

Exhibit 12

Exhibit 12

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

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

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

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

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

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

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

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

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March 26, 2015

Respectfully submitted,



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

Attorneys for Defendants

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PROOF OF SERVICE

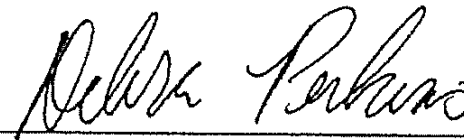
I am a resident of the State of Nevada, over the age of eighteen years, and not a party to the within action. My business address is 3960 Howard Hughes Parkway, Suite 300, Las Vegas, Nevada 89169-5937. On March 26, 2015, I served the within document:

**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

	A	B	C	D	E	F	G	H	I	J	K	L	M	N
	Company	Store #	SS#	Empl ID	Name	Hrly Rate	Last Name	First Name	Org Hire Date	Term Date	Rehire Date	EE Type	Status	DOB
1	MD4				Redacted	7.25								
2	MD4					8.00								
3	MD4					8.00								
4	MD4					8.00								
5	MD4					8.00								
6	MD4					8.00								
7	MD4					7.25								
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27	MD4					7.25								
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33	MD4					8.00								
34	MD4					8.00								

MDC000843

	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

1 INTG

RICK D. ROSKELLEY, ESQ., Bar # 3192

2 ROGER L. GRANDGENETT II, ESQ., Bar # 6323

KATIE BLAKEY, ESQ., Bar # 12701

3 LITTLER MENDELSON, P.C.

3960 Howard Hughes Parkway

4 Suite 300

Las Vegas, NV 89169-5937

5 Telephone: 702.862.8800

Fax No.: 702.862.8811

6 Attorneys for Defendants

8 DISTRICT COURT

9 CLARK COUNTY, NEVADA

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

14 Plaintiffs,

15 vs.

16 MDC RESTAURANTS, LLC, a Nevada
17 limited liability company; LAGUNA
RESTAURANTS, LLC, a Nevada limited
18 liability company; INKA, LLC, a Nevada
limited liability company and DOES 1 through
19 100, Inclusive,

20 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**

22 **PROPOUNDING PARTY: PLAINTIFFS, ON BEHALF OF PUTATIVE CLASS**

23 **RESPONDING PARTY: DEFENDANT INKA, LLC**

24 **SET NO.: TWO (2)**

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

27 ///

28 ///

1 PRELIMINARY STATEMENT

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

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

12 INTERROGATORIES

13 INTERROGATORY NO. 19:

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

16 RESPONSE TO INTERROGATORY NO 19:

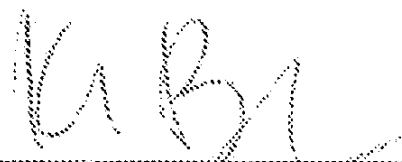
17 Objection. This interrogatory is overly broad, unduly burdensome, vague and ambiguous and
18 not likely to lead to the discovery of admissible evidence. Under the Nevada Rules of Civil
19 Procedure, the scope of discovery is limited to matters that are relevant to a party's claim or defense.
20 Nev.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

1 RESPONSE TO INTERROGATORY NO 37:

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

3
4 Dated: December 29, 2014

5 Respectfully submitted,

6 

7 _____
8 RICK D. ROSKELLEY, ESQ.
9 ROGER L. GRANDGENETT II, ESQ.
10 KATIE BLAKEY, ESQ.
11 LITTLER MENDELSON, P.C.

12 Attorneys for Defendants

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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

1 **PROOF OF SERVICE**

2 I am a resident of the State of Nevada, over the age of eighteen years, and not a party to the
3 within action. My business address is 3960 Howard Hughes Parkway, Suite 300, Las Vegas, Nevada
4 89169. On December 29, 2014, I served the within document:

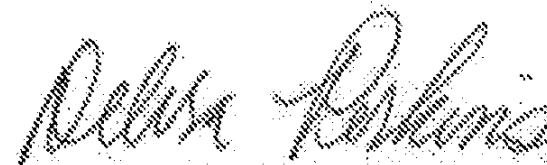
5 **DEFENDANT INKA, LLC'S RESPONSES TO SECOND SET OF INTERROGATORIES BY**
6 **PLAINTIFFS, ON BEHALF OF THE PUTATIVE CLASS**

7 ☒ by placing a true copy of the document listed above for collection and mailing following the
8 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:

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

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

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

20 

21 Debra Perkins

22 Firmwide: 130429494.1 081404.1002

Exhibit 14

Exhibit 14

1 **INTG**

2 RICK D. ROSKELLEY, ESQ., Bar # 3192
3 ROGER L. GRANDGENETT II, ESQ., Bar # 6323
4 KATIE BLAKEY, ESQ., Bar # 12701
5 LITTLER MENDELSON, P.C.
6 3960 Howard Hughes Parkway
7 Suite 300
8 Las Vegas, NV 89169-5937
9 Telephone: 702.862.8800
10 Fax No.: 702.862.8811

11 Attorneys for Defendants

12 **DISTRICT COURT**
13 **CLARK COUNTY, NEVADA**

14 PAULETTE DIAZ, an individual; and
15 LAWANDA GAIL WILBANKS, an
16 individual; SHANNON OLSZYNSKI, and
17 individual; CHARITY FITZLAFF, an
18 individual, on behalf of themselves and all
19 similarly-situated individuals,

20 Plaintiffs,

21 vs.

22 MDC RESTAURANTS, LLC, a Nevada
23 limited liability company; LAGUNA
24 RESTAURANTS, LLC, a Nevada limited
25 liability company; INKA, LLC, a Nevada
26 limited liability company and DOES 1
27 through 100, Inclusive,

28 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**

29 **PROPOUNDING PARTY: PLAINTIFFS, ON BEHALF OF PUTATIVE CLASS**

30 **RESPONDING PARTY: DEFENDANT MDC RESTAURANTS, LLC**

31 **SET NO.: TWO (2)**

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

34 ///

1 PRELIMINARY STATEMENT

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

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

12 INTERROGATORIES

13 INTERROGATORY NO. 19:

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

17 RESPONSE TO INTERROGATORY NO. 19:

18 Objection. This interrogatory is overly broad, unduly burdensome, vague and ambiguous and
19 not likely to lead to the discovery of admissible evidence. Under the Nevada Rules of Civil
20 Procedure, the scope of discovery is limited to matters that are relevant to a party's claim or defense.
21 Nev. R. Civ. P. 26(b)(1). This lawsuit is limited to and only relates to health insurance plans offered
22 to Defendant's hourly employees from May 30, 2012 to present. Therefore, any and all information
23 about health insurance plans offered to non-hourly employees and health insurance plans offered
24 before May 30, 2012 has no relevance to this matter and is outside the scope of this litigation.
25 Subject to and without waiving these objections, Defendant responds that during the relevant statute
26 of limitations, Mancha Development Company used an insurance broker who presented plans to the
27 Director of Human Resources. The HR Director and CFO in turn jointly make decision on a plan. As
28

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

3 **INTERROGATORY NO. 20:**

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

7 **RESPONSE TO INTERROGATORY NO. 20:**

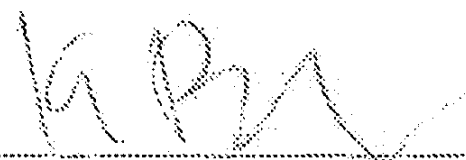
8 Objection. This interrogatory is overly broad, unduly burdensome, vague and ambiguous and
9 not likely to lead to the discovery of admissible evidence. Under the Nevada Rules of Civil
10 Procedure, the scope of discovery is limited to matters that are relevant to a party's claim or defense.
11 Nev.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

16 Defendant further objects that the reference to a "regular hourly rate" is vague and
17 ambiguous. Each employee's rate of pay can vary throughout their period of employment. Moreover,
18 this request is unduly burdensome as the rate of pay varies by individual. To the extent this
19 interrogatory seeks information about individual employees' rates of pay, it is premature.
20 Specifically, Courts have held that certain discovery is premature when the Court has yet to rule on
21 class action certification. *See, e.g., Doninger v. Pac. Northwest Bell, Inc.*, 564 F.2d 1304, 1307,
22 1313 (9th Cir. 1977) (noting discovery of personnel information could become appropriate only after
23 class certification); *Eisen v. Carlisle & Jacquelin*, 417 U.S. 156, 177-78, 94 S. Ct. 2140 (1974)
24 (indicating inquiry into the merits at the pre-certification stage is inappropriate because a defendant
25 may be substantially prejudiced and it contravenes the rules governing class actions); *McPhail v.*
26 *First Command Financial Planning, Inc.* 251 F.R.D. 514, 517 (S.D. Cal. Apr. 3, 2008) (finding prior
27 to class certification, discovery should be conducted on a class wide level only in the "rarest of
28 cases").

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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

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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 21st day of December, 2014.


TERRY TIGIAMARINO

1 PROOF OF SERVICE

2 I am a resident of the State of Nevada, over the age of eighteen years, and not a party to the
3 within action. My business address is 3960 Howard Hughes Parkway, Suite 300, Las Vegas, Nevada
4 89169. On December 29, 2014, I served the within document:

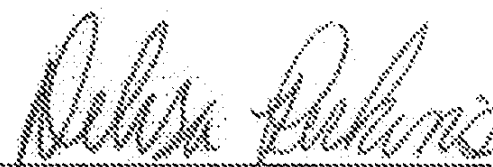
5 **DEFENDANT MDC RESTAURANTS, LLC'S RESPONSES TO SECOND SET OF**
6 **INTERROGATORIES BY PLAINTIFFS, ON BEHALF OF THE PUTATIVE CLASS**

7 ☒ by placing a true copy of the document listed above for collection and mailing following the
8 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:

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

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

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

20 
21 _____
22 Debra Perkins

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24 Firmwide: 130463463.1 081404.1002
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Exhibit 15

Exhibit 15



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

"CIGNA" and "CIGNA HealthCare" refer to various operating subsidiaries of CIGNA Corporation. These subsidiaries include Connecticut General Life Insurance Company and service company subsidiaries of CIGNA Health Corporation.

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:	Manchs 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 SM	866-909-3461	
Healthy Rewards SM	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 Sickmess and Accident Plan. If you have difficulty understanding any part of this Summary Plan Description, contact Connecticut General Life Insurance Company at 1-800-250-0025. Office hours are from 9 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 Starbridge Select. Si tiene dificultades para comprender cualquier parte de esta Descripción resumida del plan, comuníquese con Connecticut General Life Insurance Company al 1-800-250-0025. El horario de atención es de 9 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 SHCH-GHP-02. All yearly benefits are paid per coverage year.

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

Benefit Descriptions

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;

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 Jul 31 2015 10:50 a.m.
Tracie K. Lindeman
Clerk of Supreme Court
District Court Dept. No. XVI

PETITIONERS' APPENDIX

RICK D. ROSKELLEY, ESQ., Nevada Bar # 3192
ROGER L. GRANDGENETT II, ESQ., Nevada Bar # 6323
MONTGOMERY Y. PAEK, ESQ., Nevada Bar #10176
KATHRYN B. BLAKEY, ESQ., Nevada 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 Petitioners

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May 22, 2015 Defendants' Opposition to Motion for Partial Summary Judgment on Liability as to Plaintiff Paulette Diaz's First Claim for Relief	Vol. 1	150-167
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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
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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.

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
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