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

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

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

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

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

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

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

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

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

For each adopted child, you must:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Important Information – COBRA and Continuation of Coverage

CONTINUATION COVERAGE RIGHTS UNDER COBRA

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

What Is COBRA Continuation Coverage?

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

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

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

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

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

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

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

When Is COBRA Coverage Available?

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

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

You Must Give Notice of Some Qualifying Events

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

How Is COBRA Coverage Provided?

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

Disability extension of 18-month period of continuation coverage

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

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

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

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

How can you elect COBRA continuation coverage?

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

How much does COBRA continuation coverage cost?

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

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

First payment for continuation coverage

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

Periodic payments for continuation coverage

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

Grace periods for periodic payments

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

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

All payments for continuation coverage should be sent to: Connecticut General Life Insurance Company - P.O. Box 202302 Dallas, TX 75320-2302

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),

- 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 1-800-859-0686

Notice of Privacy Practices

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

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

This Notice is effective on July 1, 2004.

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

How We Protect Your Privacy

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

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

How We Use and Disclose Your Confidential Information

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

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

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

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

Uses and Disclosures With Your Written Authorization
We will not use or disclose your confidential information for any purpose other than the purposes described in this Notice without your written authorization. For example, we will not supply confidential information to another company for its marketing purposes or to a potential employer with whom you are seeking employment without your signed authorization. You may revoke an authorization that you previously have given by sending a written request to our Privacy Office, but not with respect to any actions we already have taken.
CIGNA HealthCare complies with state laws that place further restrictions on the disclosure of your personal health information without your authorization. For example, many states have laws that do not permit us to disclose a diagnosis of AIDS or mental illness. These laws have some limited exceptions.
Your Individual Rights

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

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

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

  You may contact our Privacy Office at:

  Privacy Office - CIGNA Healthcare
  PO Box 188014
  Chattanooga, TN 37422
  Telephone Number: 860.762.9940
  Fax Number: 860.226.9613

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/mdsc/privacy.html*. You also may obtain any new notice by calling Member Services at the toll-free number on your ID card.

STATE DISCLOSURES

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

Connecticut

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

Hawaii

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

Massachusetts

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

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

Montana

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

New Hampshire

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

North Dakota

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

Puerto Rico

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

Vermont

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

Washington

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

Claim Identification Form

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

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

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

CIGNA HealthCare
P.O. Box 188004
Chattanooga, TN 37422
1-800-859-0086

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 ☐ No ☐
City & State		If Yes, Date
Patient Name (if other than Employee)		Male ☐ Female ☐
Patient Relationship to Employee	Patient Birth Date	Is Patient Married? Yes ☐ No ☐

Nature of Sickness, Injury, Diagnosis or Medical Visit

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

Signed (Employee, All Claims) X _____ Date _____

Patient or Parent (if minor) X _____ Date _____

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

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

Employee Signature _____

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

CIF_APD_1110A

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

INSURANCE DOCUMENT ENCLOSED

000000 144939 SampleData.pdf 000001 000001 012
<Mailing Name>
<Address>
<CITY>, <STATE> <Zip Code>

Exhibit 10

Exhibit 10

TransChoice® Advance hospital indemnity insurance

[illegible]			[illegible]	[illegible]	[illegible]
Daily In-Hospital Indemnity Benefit	Pays benefits per day of hospital confinement, up to the annual maximum.		$ 100 31 Days per confinement	$ 200 31 Days per confinement	$ 300 31 Days per confinement
[illegible]					
Outpatient Physician Office Visit Indemnity Benefit	Pays each day a covered person receives outpatient treatment in a physician's office or at an urgent care facility as the result of a covered accident or sickness, up to the annual maximum days listed.		$ 50 6 Days	$ 70 8 Days	$ 70 8 Days
Outpatient Diagnostic Laboratory Test Indemnity Benefit	Pays each day a covered person undergoes an outpatient lab test performed for the purpose of diagnosis for a covered accident or sickness, up to the annual maximum days listed. Does not include tests covered under any other rider.		$ 10 2 Days	$ 15 4 Days	$ 15 4 Days
Outpatient Select Diagnostic Test Indemnity Benefit	Pays each day a covered person undergoes an outpatient X-ray, ultrasound, EEG or sleep study performed for the purpose of diagnosis for a covered accident or sickness, up to the annual maximum days listed.		$ 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	$ 1,000
		Outpatient surgery	$ 250	$ 500	$ 500
		Outpatient minor surgery	$ 50	$ 100	$ 100
		Anesthesia percentage	20%	20%	20%
Off-the-Job Accidental Injury Indemnity Benefit	Pays each day a covered person requires x-rays or receives treatment by a physician within 93 hours of a covered accident.		No Coverage	No Coverage	$200
Prescription Drug Indemnity Benefit	Pays each day a covered person fills a prescription as the result of a covered accident or sickness.	Generic prescription	$ 10	$ 15	$25
		Name brand prescription	$ 20	$ 30	$50
		Annual maximum	12 Days per Year	12 Days per Year	36 Days per Year
Critical Illness Indemnity Benefit	Pays once when diagnosed with invasive cancer, heart attack, stroke, end-stage renal failure or major organ failure. A subsequent benefit is payable if diagnosed more than 90 days later with a different critical illness. *Dependent percentage*		No Coverage	No Coverage	$5,000 50%
Wellness Indemnity Benefit	Pays each day a covered person undergoes a physical exam or stress test or specific health screening tests as defined in the policy, up to the annual maximum days listed. Includes four days for children 0-12 mos. and two days for children 12-24 mos for well baby exams.		$100 1 Day	$100 1 Day	$100 1 Day
Inpatient Mental and Nervous Disorder Indemnity Benefit	Pays each day a covered person is confined on an inpatient basis to a hospital or mental health facility as the result of a mental or nervous disorder. Annual maximum of 31 Days, lifetime maximum 60 Days.		$ 100	$ 100	$ 100

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

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

Issue State: NY Lives: 1500 Calculations: Ver. [illegible] SIC: [illegible] Pay type: Voluntary Male/Fem: [illegible]

Inpatient Drug and Alcohol Addiction Indemnity Benefit	Pays each day a covered person is confined as an inpatient basis to a hospital or residential treatment facility as the result of drug or alcohol addiction. Annual maximum of 31 Days, lifetime maximum 93 Days.	$ 100	$ 100	$ 100
Ambulance Indemnity Benefit	Pays each day a covered person receives licensed ambulance transportation within 96 hours of a covered accident or onset of sickness. Air ambulance pays three times the amount.	No Coverage	$ 200	$ 300
[illegible]				
Group Term Life Policy with Accidental Death and Dismemberment Rider	Employee	$ 10,000	$ 10,000	$ 10,000
	Spouse	$ 5,000	$ 5,000	$ 5,000
	Children *Accidental Death and Dismemberment does not extend to covered children*	$ 2,500	$ 2,500	$ 2,500
[illegible]				
Prescription Drug Discount Card *offered by ProCare*	By presenting the prescription drug discount card to one of the participating providers, an insured can receive a savings of at least 14% on retail pharmacy prices for brand-name drugs and up to 60% for generic drugs.	Included	Included	Included
Telemedicine Option	Around the clock telephone, video or e-mail access to a board-certified physician.	No Coverage	Health-saiyou	Health-saiyou
Employee Discount Card *offered by New Benefits, Ltd.*	Provides access to a discount vision plan, nurses' hotline, counseling services and discounts for hearing aids.	Included	Included	Included
PPO Network *offered by WebTPA*	Employee and covered dependents will receive contracted savings from the normal fees charged by network physicians, hospitals and outpatient X-ray and laboratory providers.	No Coverage	Included	Included

Employee Per Pay Period	Employee	Employee + Spouse	Employee + Children	Family
Plan I	19.69	40.74	29.57	62.34
Plan II	31.04	65.43	75.20	116.53
Plan III	51.90	110.80	93.70	142.45

Non-Insurance Benefits

Telemedicine

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

Prescription Drug Discount Card (provided by ProCare)

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

Employee Discount Card (provided by New Benefits Ltd.)

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

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

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

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

GROUP BENEFITS DISCLOSURE POLICY

Transamerica Employee Benefits (TEB) is a marketing division of Transamerica Life Insurance Company and Transamerica Financial Life Insurance Company. TEB markets and administers voluntary insurance benefits through a network of licensed insurance agents. These agents are typically appointed to sell our products, and products of other providers, and receive various forms of compensation from us for the services provided. We believe our compensation arrangements with our agents have been conducted with honesty, fairness and integrity. In addition, we realize that having trusted relationships between our agents and our customers is essential to all involved. To ensure this trust continues and to address any concerns within the industry, we recently outlined our policy on agent compensation disclosure.

TEB's policy supports transparency and full disclosure of agent compensation to our customers and prospective customers. In addition, we have put controls in place to facilitate this disclosure and obligate our agents to disclose compensation information to customers: 1) when asked by a customer; 2) when receiving both a fee from the customer and compensation from TEB; and 3) when otherwise required by law. Agents must comply with all applicable laws in the sale of TEB products, including any pertaining to the disclosure of compensation information.

TEB's Group Benefits Compensation Disclosure Notice (below) describes the various means by which agents may be compensated for the sale of our products. It is the responsibility of your agent to share with you, specific information surrounding his or her compensation arrangements with TEB. Accordingly, please direct any compensation disclosure questions directly to your agent.

COMPENSATION DISCLOSURE NOTICE TO ALL POLICYHOLDERS:

Agents selling and servicing our products are paid a commission, which varies by the type of insurance policy sold and the state where the policy was sold, and is based on a percentage of the premium received in the first year, and at policy renewal. Agents may receive advances or loans against anticipated commissions for cases sold or to be sold. These advances may or may not require the payment of interest, depending upon the agent's total business and historical experience with TEB.

Agents may receive other compensation in the form of cash or non-cash awards or prizes, based upon a variety of factors that may include the level of premium written or earned, persistency and growth of premium, or other performance measures. Agents who manage, supervise or recruit other agents or wholesale our products and services to other agents, may receive commission overrides on business that results from their efforts.

Some of our agents may receive additional payments for administrative services provided to our benefit plans. Fees for these services may be calculated on a per policy or per certificate basis or upon the premium volume associated with a specific case. TEB may additionally reimburse these agent/ administrators for certain expenses, such as the cost of mailings.

Agents may occasionally obtain exclusive rights to market TEB products or services to agents, employers, employees or association members. Certain groups or associations may also agree to endorse TEB's products to their members. TEB may pay a fee for these exclusive marketing rights or endorsements. See your proposed plan documents or policy certificate package for more information on any such arrangements.

For up to date information regarding our compensation practices, please consult our website at:
www.transamericaemployeebenefits.com

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TRANSAMERICA
EMPLOYEE BENEFITS

Transamerica Life Insurance Company
Monumental Life Insurance Company
Home Office: Cedar Rapids, Iowa

Administrative Office:
P.O. Box 310
Grapevine, Texas 76099-0310
Customer Service: (866) 975-4641

(Hereinafter referred to as "us" and "we")

NOTICE OF PRIVACY POLICY
Information Only - No Response Necessary

Protecting your privacy is very important to us. We want you to understand what information we collect and how we use it. We collect and use nonpublic personal information in order to provide our customers with a broad range of financial products and services. We treat your information with the utmost respect and in accordance with our Privacy Policy.

What Information We Collect and From Whom We Collect It

We may collect nonpublic personal information about you from the following sources:

* Information we receive from you on applications or other forms;
* Information about your transactions with us, our affiliates, or others; and
* Information we receive from non-affiliated third parties, including consumer reporting agencies and insurance support organizations.

Nonpublic personal information is nonpublic information about you that we obtain in connection with providing a financial product or service to you. In some states, personal information may also include your name, address and medical record information but not privileged information. This information may be collected in person, by mail, fax, or by other electronic means as permitted by law or as expressly authorized by you.

What Information We Disclose and To Whom We Disclose It

Depending upon the product or service offered, we may disclose nonpublic personal information we collect to:

* Persons or companies that perform services on our behalf.
* Other financial institutions with which we have joint marketing agreements as permitted by law. In Vermont this includes only your name, contact information, policy coverage and information about your transactions with us or our affiliates.
* A medical professional for the purpose of disclosing a medical problem of which you may not be aware.
* Other insurance support organizations for use in connection with an insurance transaction or to prevent fraud.
* An insurance regulatory authority.
* A law enforcement or other governmental authority to prevent or prosecute fraud or other unlawful activities.
* Organizations conducting actuarial research studies.
* If applicable, a group policyholder for reporting claims experience or conducting an audit.

We do not disclose any nonpublic personal information about you to either our affiliates or non-affiliates, except as permitted by law. Our affiliates are companies with which we share common ownership. They offer life and health insurance and pension and savings products.

Nonpublic personal information about you that we obtain from a report prepared by an insurance support organization may be retained by that organization and disclosed to other persons.

Your Right to Verify Accuracy of Information We Collect

Keeping your information accurate and up to date is very important to us. In some states, you may have the right to write to us in order to request that you have reasonable access to your nonpublic personal information (this includes a record of any subsequent disclosures of medical record information). You may not access information relating to or in anticipation of a claim or a criminal or civil proceeding. If you believe the information we collected about you is inaccurate, you may request that we amend, correct or delete it. We will notify you of our decision, give you our reasons and the opportunity to file a concise statement of dispute with us if you do not agree. Your statement will be made a part of our file and sent to persons or organizations that received your information in the past and in the future as required by law.

Our Security Procedures

We restrict access to nonpublic personal information and only allow disclosures to persons and companies as permitted or required by law to assist in providing products or services to you. We maintain physical, electronic, and procedural safeguards to protect your nonpublic personal information. Should your relationship with us end, we will maintain and only disclose your nonpublic personal information in accordance with this Privacy Policy.

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Determining Full-Time Employee Status Under the Affordable Care Act from *Health Care Reform for Employers: Now What?*, Lorman Education August 2013

The Impact of Health Care Reform's Mandates, Communiqué, The Magazine of the Clark County Bar Association March 2013

How Health Care Reform Affects You, Las Vegas Sun May 21, 2010

What Businesses Can Expect From Health Care Reform, Northern Nevada Business Weekly May 3, 2010

Current Status of Federal Health Care Reform, Communiqué, The Magazine of the Clark County Bar Association April 2010

Federal Regulation of Health Care: A Minefield for Doctors and Lawyers, Communiqué, The Magazine of the Clark County Bar Association October 2007

Application of Gramm-Leach-Bliley to Attorneys, Communiqué, The Magazine of the Clark County Bar Association February 2002

Presentations

Medicaid Update 2015, National Business Institute, Reno, Nevada March 2015

Health Reform Update, McLean Financial Annual 401(k) Breakfast, Reno, Nevada November 2014

Your Business & The Affordable Care Act, BOMA Nevada, Las Vegas, Nevada September 2013

Health Care Reform for Employers: Now What?, Lorman Education, Las Vegas, Nevada August 2013

Do You Really Understand Health Care Reform, Entrepreneurs Organization, Reno, Nevada August 2013

The Affordable Care Act and its Impact on Medical Care, University of Nevada School of Medicine Interdisciplinary Grand Rounds, Las Vegas, Nevada July 2013

Affordable Care Act: Hot Issues Update, Reno, Nevada May 2013

Breaking Down Healthcare Reform into Meaningful Business Strategies, Reno-Sparks Chamber of Commerce, Reno, Nevada March 2013

The Impact of the Affordable Care Act, Las Vegas Chamber of Commerce, Las Vegas, Nevada February 2013

Corporate Practice of Medicine: Finding Your Way Through the Maze, Holland & Hart Webinar, Las Vegas, Nevada February 2013

Health Care Reform for Employers, Carson City Chamber of Commerce, Carson City, Nevada January 2013

Health Care Reform and What it Means for Your Business, Northern Nevada Employer Forum, Reno, Nevada December 2012

Payment of Health Care Claims in Nevada, Nevada State Medical Association Provider-Payor Conference, Reno, Nevada October 2012

Ballot Initiatives in Nevada Courts, State Bar of Nevada Annual Meeting, San Diego, California June 2012

Health Information Exchanges in Nevada, IND Nevada Risk Management Seminar, Las Vegas, Nevada, November 2011

Legislative Update for In House Counsel: Employment and Business Law Update, Association of Corporate Counsel, Las Vegas, Nevada October 2011

What Every Attorney Needs to Know About Health Care Reform, State Bar of Nevada Annual Meeting, Kauai Hawaii June 2011

Memberships and Community Service

Memberships:

American Bar Association, American Bar Association Health Law Section and Physician Issues Focus Group, American Health Lawyers Association, National Association of College and University Attorneys, State Bar of Nevada, State Bar of Nevada Health and Insurance Law Section, State Bar of Nevada Appellate Law Section, Clark County Bar Association, Washoe County Bar Association

Professional Service:

State Bar of Nevada Insurance and Health Law Section

Chair	2013-2015
Vice-Chair	2012-2013
Secretary	2011-2012

Community Service:

Board of Trustees – Volunteers in Medicine of Southern Nevada

Board of Trustees – Win-Win Entertainment, Inc.
Treasurer – Georgetown Club of Las Vegas
Student Interviewer - Georgetown University Alumni Admissions Program
Youth Minister – Our Lady of the Snows Catholic Church, Reno, Nevada
Synod Delegate – Roman Catholic Diocese of Reno (2015)

Awards: Top 40 Professionals Under 40 Years Old – *In Business*, March 2011

Exhibit 3

Exhibit 3

ELECTRONICALLY SERVED
11/05/2014 11:31:19 AM

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

Attorneys for Defendants

EIGHTH JUDICIAL DISTRICT COURT

CLARK COUNTY, NEVADA

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

Plaintiffs,

vs.

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

Defendants.

Case No. A701633

Dept. No. XV

DEFENDANT MDC RESTAURANTS, 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 MDC RESTAURANTS, LLC

SET NO.: ONE

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

///

INTERROGATORY NO. 8:

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

RESPONSE 8:

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

INTERROGATORY NO. 9:

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

RESPONSE 9:

Objection. Interrogatory No. 9 is overly broad, unduly burdensome, and not likely to lead to the discovery of admissible evidence. Claims for alleged minimum wage violations before May 30, 2012 are barred by the statute of limitations and, therefore, information about stores prior to May 30, 2012 is not likely to lead to the discovery of admissible evidence. Moreover, any store which closed prior to May 30, 2012 is beyond the scope of this lawsuit. Subject to and without waiving these objections, Defendant refers to bates no. MDC000158 attached hereto.

INTERROGATORY NO. 10:

Describe with specificity the practice or methodology employed by MDC, since November 28, 2006, to compute or calculate premium costs for all health insurance plans and policies offered or provided by MDC 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.

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 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 L Tigiamarino

TERRY TIGIAMARINO

ETLER MENDELSON, P
Attorneys at Law
3960 Howard Hughes Parkway
Suite 200
Las Vegas, NV 89169-5937
702 862 2600

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 MDC RESTAURANTS, 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:129180421.1 081404.1002

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

Exhibit 4

Exhibit 4

ELECTRONICALLY SERVED
01/20/2015 10:30:03 AM

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

Attorneys for Defendants

DISTRICT COURT

CLARK COUNTY, NEVADA

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

Plaintiffs,

vs.

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

Defendants.

Case No. A-14-701633-C

Dept. No. XVI

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

PROPOUNDING PARTY: PLAINTIFFS, ON BEHALF OF PUTATIVE CLASS

RESPONDING PARTY: DEFENDANT LAGUNA RESTAURANTS, LLC

SET NO.: THREE (3)

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

///

///

PRELIMINARY STATEMENT

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

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

INTERROGATORIES

INTERROGATORY NO. 38:

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

RESPONSE TO INTERROGATORY NO. 38:

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

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

INTERROGATORY NO. 39:

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

RESPONSE TO INTERROGATORY NO. 39:

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

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

INTERROGATORY NO. 40:

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

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

RESPONSE TO INTERROGATORY NO. 40:

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

Dated: January 20, 2015

Respectfully submitted,

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

Attorneys for Defendants

VERIFICATION

I, TERRY TIGIAMARINO, declare:

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

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

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

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

Terry J DiGiamarino

TERRY TIGIAMARINO

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 5

Exhibit 5

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

INTG
RICK D. ROSKELLEY, ESQ., Bar # 3192
ROGER L. GRANDGENETT II, ESQ., Bar # 6323
KATIE BLAKEY, ESQ., Bar # 12701
LITTLER MENDELSON, P.C.
3960 Howard Hughes Parkway
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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:

///

///

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

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

INTERROGATORY NO. 8:

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

RESPONSE 8:

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

INTERROGATORY NO. 9:

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

RESPONSE 9:

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

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

INTERROGATORY NO. 10:

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

RESPONSE 10:

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

INTERROGATORY NO. 11:

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

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 L DiGiamarino

TERRY TIGIAMARINO

TYLER MENDELSON, P.C.
ATTORNEYS AT LAW
3960 Howard Hughes Parkway
Suite 300
Las Vegas, NV 89169-5937
702 EC7 8805

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 6

Exhibit 6

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

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

Plaintiffs,

vs. No. A701633

MDC RESTAURANTS, LLC, a Nevada limited liability company; LAGUNA RESTAURANTS, LLC, a Nevada limited liability company, INCA, LLC, a Nevada limited liability company and Does 1 through 100 inclusive,

Defendants.

DEPOSITION OF BLANCA VALLEJO

Irvine, California

Tuesday, March 10, 2015

Volume I

Reported by:
ANGELA METZ
CSR No. 12454
JOB No. 2028860

PAGES 1 - 140

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

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

Plaintiffs,

vs. No. A701633

MDC RESTAURANTS, LLC, a Nevada limited liability company; LAGUNA RESTAURANTS, LLC, a Nevada limited liability company, INCA, LLC, a Nevada limited liability company and Does 1 through 100 inclusive,

Defendants.

Deposition of BLANCA VALLEJO, taken on behalf of Plaintiffs, at 2050 Main Street, Suite 900, Irvine, California, beginning at 9:22 a.m. and ending at 1:44 p.m. on Tuesday, March 10, 2015, before ANGELA METZ, Certified Shorthand Reporter No. 12454.

APPEARANCES:

For Plaintiffs:

WOLF, RIFKIN, SHAPIRO & SCHULMAN
BY: JORDAN BUTLER
BY: DANIEL BRAVO
ATTORNEYS AT LAW
3556 East Russell Road, 2nd Floor
Las Vegas, Nevada 89120
(702) 341-5200

For Defendants:

LITTLER MENDELSON
BY: ROGER L. GRANDGENETT, II
ATTORNEY AT LAW
2050 Main Street, Suite 900
Irvine, California 92614
(949) 705-3015
rgrandgenett@littler.com

Q. And on the Etna PPO?

A. I don't recall.

Q. Can you tell me a little bit of the corporate structure of MDC?

A. Sure.

Q. It was a franchisee for Denny's Corp, correct?

A. Correct for Denny's Corp, Coco's as well. They had some Coco's under there, but, yeah. So it's Mancha Development Company and within Mancha you have four different entities. So it was Laguna. It was MDC --

Q. MDC Restaurants?

A. MDC Restaurants. I think Inca. Those were it.

Q. So those three?

A. Yes.

Q. Under MDC?

A. Yes.

Q. MDC is the parent corporation?

A. No, Mancha Development Company.

Q. Mancha Development Company is the corporate parent of Laguna, MDC Restaurants and Inca LLC?

A. Yes.

Q. Those are subsidiaries of Mancha Development Company?

A. Correct.

Q. And you were an employee of Mancha Development

Q. Kept them there?

A. Yes, uh-huh.

Q. Now you said you looked at Nevada and made the decision that you were going to pay the crew members at $7.25 once you looked at the issue. What was your basis for that?

A. Well, the basis was there was a discussion around that and again I didn't make the decision but there was a discussion around that and I know the CFO was involved and that would be Anthony Carrick.

Q. Thank you.

A. The president of the company and his name was Fred Nielson and the owner Vince Eupierre.

Q. Those three were the decision makers with regards to this issue?

A. Yes.

Q. And when you said you referred to a discussion, are you referring to discussions between those three or were you also part of the discussion?

A. I was part of the discussion.

Q. What do you recall about at that discussion?

A. So again the company was suffering financially and we were looking at ways to save the company money.

Q. So the decision to pay the crew members at $7.25 an hour was solely an economic decision?

A. Yes.

Q. As far as being able to pay crew members at that wage below -- you understood it was below the upper tier rate, correct?

A. Correct.

Q. What was your understanding of why Mancha Development Company could do that?

A. Because we offered health insurance.

Q. Any other reason?

A. No.

Q. Because you offered health insurance to the crew members?

A. Correct.

Q. Was there a discussion about, okay, we need to offer health insurance to the crew members and it needs to be of a certain quality or has to cover certain things or just the fact that we need to offer some type of plan to the employees?

A. I don't recall a discussion around that.

Q. Okay. So you don't recall a discussion regarding okay, since we're going to pay below the upper tier, we're going to pay $7.25 an hour, we need to make sure that our plans that we're offering have certain benefits?

A. Well, the plan did have already the certain benefits. It was my understanding, anyway that our plan,

correct?

A. Correct.

Q. 17.50, right?

A. Yes.

Q. So despite a 20 percent increase from 2010 to 2012 to the employee, Mancha continued to pay the same, correct?

A. Correct.

Q. And it looks like in 2013 you weren't around, I know, but it looks like the cost, overall cost of the plan stayed the same, right? So no increases to the employee?

A. Correct.

Q. Is that what it reflects?

A. Yes.

Q. Okay. And again affordability to Mancha was the primary criteria for renewing the Starbridge Plan, correct?

A. Correct.

Q. Outside of the letter that you received from Cigna did you do any independent research with respect to compliance with the Nevada minimum wage loss?

A. Not that I recall.

Q. Did anybody provide you with any sort of direction about compliance outside of the letter?

A. No, not that I recall.

Q. Is it fair to say that you relied on Cigna's representation or interpretation as far as your understanding of the compliance?

A. Yes.

Q. Did you do anything else besides make an inquiry and get the answer from Cigna with respect to compliance?

A. I don't recall.

Q. Is there anyone at Mancha that's in charge of making sure that Mancha's policies and benefits comply with the Nevada constitution?

A. Yes.

Q. Who?

A. That would be me, that would be the CFO, everyone. The owner of the company, the president.

Q. But there's no particular process other than asking Cigna if the plan complied, right?

A. Correct.

Q. Any follow up with Cigna as far as a basis or support for that opinion in the letter?

A. I don't recall.

Q. Back to enrollment really quick. My understanding is at the date of hire, when the employee is considered a new hire and they're hired on, they're not offered any insurance benefits at that juncture, correct?

A. Correct.

stores?

A. Correct.

Q. And you touched on a conversation about the fact that the rates were moving from $7.55 to 8.25?

A. Correct.

Q. Who was part of that discussion?

A. The president of the company, Anthony Carrick, and the owner.

Q. And yourself?

A. Correct.

Q. Anybody else?

A. No, not that I recall.

Q. And there was a discussion as to, Okay, this rate is increasing. The minimum is now going to be 8.25, what are we going to do?

A. Correct.

Q. Tell me more about that.

A. Well, there was a discussion and I can't recall exactly when that discussion took place. Of course it had to be before the affective date, which would have been maybe sometime around July of that same year and that's all I recall to be quite honest. I don't recall anything else.

Q. Nothing else about that discussion?

A. No.

Q. Do you recall -- well, you briefly mentioned there was consideration as to whether to move everybody up to 8.25?

A. Correct.

Q. What do you recall about that?

A. I recall Anthony Carrick kind of doing the analysis of how much that would cost. I recall that.

Q. Analysis of the cost?

A. Of the cost.

Q. Having to pay the knew upper tier minimum wage and the cost to the company?

A. Correct.

Q. So that's it? Do you recall what the cost would have been?

A. No, I don't.

Q. Was it deemed too heavy of a burden to move everybody up?

A. Yes.

Q. So instead what happened?

A. Well, instead -- I'm trying to remember what we did and I can't remember. I remember having those discussions and I remember that the company could not afford to make that -- to make that bump and I can't recall what happened.

Q. Do you recall roughly how many employees at the

time that would have affected?

A. The 6 to 700 employees in Nevada.

Q. The majority of all of which are the crew members we've been discussing?

A. Correct, I remember that, uh-huh.

Q. No one else needed to be bumped up, right?

A. No, it was just the crew members.

Q. Do recall whether there was any sort of internal debate about maybe we should do this to comply? Let's move everybody up to 8.25?

A. Oh, yes. There was discussion around that.

Q. And Mancha -- go ahead.

A. No, I was just going to say I know that Mancha was suffering financially and it wasn't affordable to bump it up.

Q. Who ultimately made that determination?

A. The owner of the company, the CFO.

Q. Those two individuals?

A. Correct.

Q. They were aware, Mancha was aware that they couldn't have paid everyone the 8.25 and not offered insurance and be in compliance, correct?

A. Correct.

Q. Was there any sort of discussion about the fact that, here we are paying -- at the time, is it your

understanding that the crew members were making $7.55 an hour?

A. Correct.

Q. In compliance with the upper tier?

A. Correct.

Q. And there was a conscience decision then to stop paying the upper minimum wage?

A. Correct.

Q. And that was entirely a financial decision then on behalf of the corporation, correct?

A. Correct.

Q. Was this the same time it was also determined to start new hires at $7.25?

A. It was probably around the same time.

Q. In conjunction with that decision?

A. Correct.

Q. So not only are we not going to increase to 8.25 to meet the upper tier minimum wage but we're going to start a dollar below that at $7.25?

A. Correct.

Q. Any further discussion about, Okay, in order to do that we need to do X, Y, and Z?

A. Well, I believe that is when we started looking at Cigna ensuring that it was in compliance in order for us to do this.

Q. So if we're going to start everybody at $7.25, which was even lower than what you were starting them beforehand, let's reach out to Cigna and see if we can do this and that's when you received the letter, right?

A. I believe so.

Q. Let me give you one more, knock on wood, last exhibit.

(Exhibit 8 was marked for identification.)

BY MR. BUTLER:

Q. Was there ever a conversation about if we're going to offer a subminimum wage at $7.25, then we need to offer these crew members an insurance plan on the date of hire?

A. Yes, I'm sure that discussion happened but we were already, from my recollection, offering the Starbridge Plan.

Q. But not on the date of hire though, right?

A. I don't recall.

Q. I think you already testified as to that. If you look at what's been marked as Exhibit 8 this is Bates MDC 000664. I believe it was produced as part of Defendants third supplemental disclosure. Do you see that?

A. Yes.

Q. This appears to be an e-mail dated September

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

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

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

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

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

Dated: 4/3/2015

ANGELA METZ
CSR No. 12454

Exhibit 7

Exhibit 7

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

Attorneys for Defendants

DISTRICT COURT

CLARK COUNTY, NEVADA

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

Plaintiffs,

vs.

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

Defendants.

Case No. A-14-701633-C

Dept. No. XVI

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

PROPOUNDING PARTY: PLAINTIFFS, ON BEHALF OF PUTATIVE CLASS

RESPONDING PARTY: DEFENDANT INKA, LLC

SET NO.: TWO (2)

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

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///

PRELIMINARY STATEMENT

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

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

INTERROGATORIES

INTERROGATORY NO. 19:

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

RESPONSE TO INTERROGATORY NO 19:

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

VERIFICATION

I, TERRY TIGIAMARINO, declare:

I am the Payroll Administrator/Benefits Manager of Mancho 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

PROOF OF SERVICE

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

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

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

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

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

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

Debra Perkins

Firmwide:130429894.1 08130.1002

Exhibit 8

Exhibit 8

Starbridge
Limited-benefit health plan

CIGNA

SUMMARY PLAN DESCRIPTION

LIMITED-BENEFIT SICKNESS and ACCIDENT PLAN

Underwritten by Connecticut General Life Insurance Company

for the Employees of

Mancha Development Company

ID Cards and Getting Started Information were mailed separately.

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

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

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

www.starbridge.com

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:	Mandix Development Company 2275 Simpson Ave, #201 Corona, CA 92879 (951) 271-4100
Type of Administration:	Insurer Administration
Program Administrator:	Connecticut General Life Insurance Company 2222 West Dunlap Avenue, Suite 350 Phoenix, AZ 85021-2866
Agent for Service of Legal Process:	Employer named above
Claims Administrator:	Connecticut General Life Insurance Company P.O. Box 55270 Phoenix, AZ 85078-5270 800-859-0086
Sources and Methods of Contributions to the Plan:	Employer contribution (if applicable) from general assets and Employee contribution through payroll deductions
Funding:	This Plan is underwritten by Connecticut General Life Insurance Company
Date of the Plan's Fiscal Year:	January 1 - December 31

Commonly Used Telephone Numbers:

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

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

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

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

PRIVACY POLICY

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

Important Notice Regarding Your Benefits

Who is eligible?
All Employees with 90 days of employment

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

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

This Summary Plan Description contains a summary in English of your plan rights and benefits under The CIGNA Starbridge Choices Sickness and Accident Plan. If you have difficulty understanding any part of this Summary Plan Description, contact Connecticut General Life Insurance Company at 1-800-858-0068. Office hours are from 8 AM to 6 PM Mountain Standard Time, Monday through Friday.

Este 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 1-800-858-0068. El horario de atención es de 8 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 SECR-CHB-97. All yearly benefits are paid per Coverage year.

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

Doctor Office Visits

Each insured person is responsible for the Doctor Office Visit Copay listed in the Benefit Chart. The plan will pay 100% of the remaining service charge made by the Doctor up to the usual and customary amount. In addition, Related Charges in connection with the office visit are paid at 60% once the individual insured coverage year deductible is met. Related Charges include, but are not limited to the following: injections, laboratory, pathology, radiology, diagnostic testing and venipuncture. Any Doctor Office Visit benefit amount, whether paid to the insured or Doctor, will count towards the Outpatient Care Maximum Benefit per Coverage Year.

Outpatient Care

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

List of Covered Expenses for Outpatient Care

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

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

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

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

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

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

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

Benefit Limitations for Outpatient Care

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

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

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

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

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

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

If services are not considered to be:

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

Non-Emergency Care in Emergency Room

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

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

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

Outpatient Wellness Benefit

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

Benefits are payable for:

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

This benefit is payable:

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

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

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

Inpatient Care (Illness)

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

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

Hospital means an establishment that:

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

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

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

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

In-Hospital Surgery & Maternity Benefit

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

List of Covered Expenses - Inpatient Care

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

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

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

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

Benefit Limitations Inpatient Care
Coverage is not provided for services, supplies or equipment for which a charge is not customarily made in the absence of insurance.
In addition to the Benefit Limitations listed under the Outpatient Care, no coverage is provided for loss caused by or resulting from:
1. Any period of Custodial Care confinement in a Hospital or Skilled Nursing Facility;
2. Charges for home health care services, unless provided in lieu of a Hospital confinement;

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

Accident Medical Benefit

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

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

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Medical Benefits Chart (applies to each covered individual)

	Level 1 (Plan 370)	Level 2 (Plan 371)
Illness		
Outpatient Care deductible Starbridge pays maximum amount paid by plan	$100 per coverage year 80% $1,000 per coverage year	$100 per coverage year 80% $1,250 per coverage year
Doctor Office Visits [1] [2] copay Starbridge pays	$15 100%	$15 100%
Inpatient Care Starbridge pays maximum amount paid by plan	100% $2,000 per coverage year	100% $3,000 per coverage year
Additional In-Hospital Surgery Starbridge pays maximum amount paid by plan	covered in Inpatient Care	100% $1,500 per occurrence
Additional Maternity Benefit Starbridge pays maximum amount paid by plan	covered in Inpatient Care	100% $1,500 per occurrence
Wellness		
Wellness Benefit [3] copay Starbridge pays number of occurrences maximum amount paid by plan	not covered	$20 100% 1 per coverage year $100 per coverage year
Pharmacy [4]		
Prescription Benefit copay Starbridge pays maximum amount paid by plan	discount program included[5]	discount program included[5] $15/generic; $30/pref. brand 100% $300 per coverage year
Injury		
Accident Coverage [1] [6] deductible Starbridge pays number of occurrences maximum per occurrence [2] maximum amount paid by plan	$50 per occurrence 80% 2 per coverage year $1,000 $2,000 per coverage year	$50 per occurrence 80% 2 per coverage year $2,500 $5,000 per coverage year
Accidental Death Benefit Starbridge pays	$10,000	$15,000

PLEASE NOTE: If visiting the ER for a true emergency, your benefits may come out of Outpatient, Inpatient, and/or Accident Coverage. If you receive *non-emergency treatment in the Emergency Room*[1] (care you could receive in a doctor's office), your coverage is reduced to: $100 deductible per occurrence, the plan pays 60% of total bill with a $300 maximum per year. You will be responsible for the remaining balance.

More valuable services that are included in your plan:

Online Tools

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

CIGNA 24-Hour EAP

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

Healthy Rewards®

Healthy Rewards® offers you discounts on health products and services such as: weight loss programs, vitamins, and dental products. You'll receive discounts of up to 50% on brand names like Weight Watchers, Jenny Craig® and much more.

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

[1] The total amount Starbridge pays will count toward your Outpatient Care Maximum. [2] The prescription discount program is not insurance.
[3] Provision varies by state. [4] Work related injuries are not covered. [5] The benefits above are provided by policy form GBD-GMP-00.

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 toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, placement for adoption, or Qualified Medical Child Support Order you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

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

Loss of eligibility for coverage as a result of legal separation, divorce, cessation of dependent status (such as exceeding 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 1-877-309-7038. Representatives are available Monday through Friday, 6 AM to 6 PM, Mountain Standard time.

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

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

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

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

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

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

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

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

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

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

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

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

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

FOOTNOTES

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

Exhibit 9

Exhibit 9

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) 656-2299	MN	*	OK	(800) 522-0071	WV	(888) 879-9842
HI	*	MS	(877) 314-3843	OR	(855) 999-3210	WI	*
ID	*	MO	(800) 726-7390	PA	(877) 881-6388	WY	*

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

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

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

Starbridge
Limited-benefit health plan

Cigna.

SUMMARY PLAN DESCRIPTION

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

Underwritten by Connecticut General Life Insurance Company

for the Employees of

Mancha Development Company-NV Hourly

ID Cards and Getting Started Information were mailed separately.

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

Notice of Grandfathered Plan Status

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

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

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

Your Plan Information

Plan Name:	CIGNA Starbridge Choices
Plan Type:	LIMITED-BENEFIT SICKNESS and ACCIDENT PLAN ("Plan")
Plan ID Number:	BIN: 33-0974550 PN: 351
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 Stabilidge Choice® Sickness and Accident Plan. If you have difficulty understanding any part of this Summary Plan Description, contact Connecticut General Life Insurance Company at 1-800-806-0265. Office hours are from 5 AM to 6 PM Mountain Standard Time, Monday through Friday.

Esta Descripción resumida del plan contiene un resumen en inglés de los derechos y los beneficios que le otorga el plan según el Plan para Enfermedades y Accidentes de CIGNA Stabilidge Choice®. Si tiene problemas para entender alguna parte de la Descripción resumida del plan, póngase en contacto con Connecticut General Life Insurance Company al 1-800-806-0265. El horario de oficina es de las 5 a.m. a las 6 p.m. hora estándar de montaña, de lunes a viernes.

Benefit Table

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

This benefits chart is provided by policy form SBCR-GHP-02. All yearly benefits are paid per coverage year.

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

Doctor Office Visits

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

Outpatient Care

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

List of Covered Expenses for Outpatient Care

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

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

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

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

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

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

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

Benefit Limitations for Outpatient Care

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

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

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

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

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

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

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

If services are not considered to be:

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

Non-Emergency Care in Emergency Room

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

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

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

Inpatient Care (Illness)

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

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

Hospital means an establishment that:

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

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

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

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

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

List of Covered Expenses - Inpatient Care

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

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

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

Benefit Limitations Inpatient Care

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

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

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

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

Accident Medical Benefit

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

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

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

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

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

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

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

Accidental Death Benefit

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

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

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

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

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

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

Conversion Privilege
The right to convert the medical insurance to conversion coverage is available to any Covered Person whose insurance under the Policy ceases for any reason except:

a. Termination of the Policy;
b. Termination of the class of Covered Persons; or
c. Non-Payment of premium.

The conversion coverage will be issued subject to the following:

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

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

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

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

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

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

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

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

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

CIGNA HealthCare PPO Network*

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

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

Prescription Savings Program

SCRIPTSAVE® SELECT

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

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

The ScriptSave® Select program also offers:

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

Find a Participating Pharmacy

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

Plan Your Prescription Purchases

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

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

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

Claims Procedures

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

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

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

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

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

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

Subrogation
This plan does not subrogate.

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

Important Information

Effect of Section 125 Tax Regulation on this Plan

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

A. Coverage Elections

Per Section 125 regulations, you are generally allowed to enroll for or change coverage only before each annual benefit period. However, exceptions are allowed if your employer agrees and you enroll for or change coverage within 31 days of the following (or 90 days for Section D below):

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

B. Change in Status

A change in status is defined as:

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

C. Court Order

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

D. Medicare or Medicaid Eligibility/Entitlement

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

E. Change in Cost of Coverage

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

F. Changes in Coverage of Spouse or Dependent Under Another Employer's Plan

You may make a coverage election change if the plan of your spouse or dependent:

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

Statement of ERISA Rights

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Dependent Coverage
Your Dependent is:

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

Provisions may vary where required by state law.

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

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

Coverage will terminate on the earlier of:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Their second expert opined that, because he considers it to be a form of "health insurance," Defendants could have offered merely a dental plan—and a dental plan alone, with no other medical benefits whatsoever—and been able to pay down to $7.25 under the Amendment.

Defendants are more or less forced to take this kind of extreme position, due to the terribly poor quality of the health benefits plans they did provide to their minimum wage employees. These were limited-benefits plans and hospital indemnity plans (which are not considered benefits for health care at all under law), featuring ridiculously low benefits limits and hideous exclusions—for example, the 2015 Plan excludes all inpatient services entirely, and will not even cover stitches for a simple laceration. Collectively, the Plans are barely worth the paper they are printed on. In no event do they comply with any state or federal standard for "health insurance." In fact, most of the Plans say so expressly on their faces.[5] These Plans are only useful, if at all, as supplemental benefits to real health insurance. The plans fail to meet nearly every state law requirement for employer-provided health insurance; administrative regulations governing health insurance; or pertinent federal requirements for health insurance.

In sum, Plaintiffs argue that when the drafters of the Amendment, in 2006, used the term "health insurance," they had to know and mean health insurance within the meaning of state and federal law, and Defendants' Plans do not comply with state or federal laws regulating employer-provided health insurance. Defendants claim that because the Amendment says only "health insurance," anything they can characterize as insurance at all, with no regard to prevailing law or minimum requirements for health insurance, can qualify them to pay down to $7.25 per hour. But insurance generally, and health insurance specifically, is among the most highly regulated fields in our society. In Nevada, any group or individual health insurance provided by employers to employees has

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[5] For example, Defendants' 2014 Plan carries the following bolded disclaimer:

> **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.**

See **Exhibit 10** at MDC000129 (emphasis in original).

fundamental requirements under N.R.S. Chapters 608, 689A, and 689B. The drafters of the Amendment must be presumed to have known that and to have intended that.

Defendants cannot provide these benefits plans to Plaintiffs and the proposed Class and then withhold from them up to a dollar for every hour worked. In no respect do these Plans qualify Defendants to assume that privilege under the Nevada Constitution.

II. PROCEDURAL HISTORY

Plaintiffs first filed this motion, at the insistence of Defendants, on August 25, 2016. The Court will recall that Defendants demanded that this issue be heard and decided prior to the certification of a second Rule 23 class in this action. The Court had already ruled in favor of Plaintiff Paulette Diaz that Defendants had to actually provide—i.e., furnish—health benefits, rather than merely offer them, in order to qualify to pay her less than $8.25 an hour. See Order Regarding Motion for Partial Summary Judgment on Liability as to Plaintiff Paulette Diaz's First Claim for Relief, at 2 (July 17, 2015). The Court subsequently also certified a class of all those of Defendants' employees who had been paid less than $8.25 and had not enrolled in Defendants' offered benefits plans. See Order Granting Class Certification, Designating Class Representatives, and Designating Class Counsel, at 4 (October 16, 2015).

On October 16, 2015, the Court denied Plaintiffs' original Motion for Partial Summary Judgment Regarding Defendants' Health Benefits Plans, without prejudice to renewal and re-filing, "not based upon the underlying merits of the motion, but because ... there should have been a Nevada Rule of Civil Procedure 16.1 initial expert disclosure as it relates to Dean Matthew Milone." Id. at 4, ¶ 11. On October 12, 2015, Plaintiffs served their Fourth Supplemental Disclosure, which included Dean Milone's full expert report and all other materials required by the rules in disclosing an expert. See **Exhibit 2**. In its order denying Plaintiffs' motion without prejudice, the Court granted Defendants 45 days from October 16, 2015 to "designate their own expert on the issue of Liability Regarding Defendants' Health Benefits Plans." See Order Granting Class Certification at 4, ¶ 12. After numerous extensions of time to fulfill their obligations, Defendants disclosed experts and their reports on March 14, 2016, and the experts for both sides were deposed during March, 2016.

This first discovery phase of this action (class certification discovery) closed on June 20, 2015,

nearly a year ago. The second phase (merits and damages discovery) has yet to commence.

The parties long ago agreed to submit briefing on the present issue, although it concerns the liability of Defendants and Plaintiffs maintain it is more properly considered as a Phase II motion. Defendants, however, demanded this issue be heard as a predicate to certification proceedings on the second proposed class in this action.

III. LEGAL STANDARD FOR PARTIAL SUMMARY JUDGMENT

Summary judgment under N.R.C.P. 56(a) is "appropriate and shall be rendered forthwith when the pleadings and other evidence on file demonstrate that no genuine issue as to any material fact [remains] and that the moving party is entitled to a judgment as a matter of law." Wood v. Safeway, 121 Nev. 724, 729, 121 P.3d 1026, 1029 (2005) (internal quotations omitted). "While the pleadings and other proof must be construed in a light most favorable to the nonmoving party, that party bears the burden to do more than simply show that there is some metaphysical doubt as to the operative facts in order to avoid summary judgment being entered in the moving party's favor." Id. at 732, 121 P.3d at 1031. The nonmoving party "must, by affidavit or otherwise, set forth specific facts demonstrating the existence of a genuine issue for trial or have summary judgment entered against him." Id.; see also Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 250, 106 S. Ct. 2505, 2511 (1986); United States v. Arango, 670 F.3d 988, 992 (9th Cir. 2012). Because partial summary judgment allows a court "to isolate and dispose of factually unsupported claims or defenses," the court construes the evidence before it "in the light most favorable to the opposing party." Celotex Corp. v. Catrett, 477 U.S. 317, 323-24, 106 S. Ct. 2548, 2553 (1986). N.R.C.P. 56(a) specifically permits the Court to entertain issues on partial summary judgment on part of a claim or defense, and partial summary judgment can be useful for courts in focusing the issues to be litigated, thus conserving judicial resources.

In a putative class action, courts have discretion to entertain motions regarding all or some liability issues, and in exercising this discretion, courts often consider the merits of the claims and any doubts as to those merits, the efficiency ruling upon such a motion may offer, and the potential for prejudice to the parties or the putative class. "Under the proper circumstances—where it is more practicable to do so and where the parties will not suffer significant prejudice—the district court has discretion to rule on a motion for summary judgment before it decides the certification issue." Wright

v. Schock, 742 F.2d 541, 543-44 (9th Cir. 1984).

IV. UNDISPUTED FACTS

Defendants MDC Restaurants ("MDC") LLC, Laguna Restaurants, LLC ("Laguna"), and Inka, LLC ("Inka") (collectively, "Defendants") are Nevada limited-liability companies. They own and operate, or have owned and operated, numerous Denny's and CoCo's Restaurant locations in Nevada. See **Exhibit 3**, Defendant MDC's Response to Plaintiffs' Interrogatory No. 9; **Exhibit 4**, Defendant Laguna's Response to Plaintiffs' Interrogatory No. 39; **Exhibit 5**, Defendant Inka's Response to Plaintiffs' Interrogatory No. 9.

Mancha Development Company, a California corporation, is the parent company of Defendants. See **Exhibit 6**, Transcr. Depo. Blanca Vallejo, Fmr. HR Mgr., at 31:3-24 (Mar. 10, 2015). It selects and contracts for health benefit plans for the employees of Defendants. See **Exhibit 7**, Defendant Inka's Response to Plaintiffs' Interrogatory No. 19.

Plaintiff Paulette Diaz was employed by MDC between April 2010 and September 2013, and MDC admits to having paid her at a rate of $7.25. See Ans. ¶ 14. Plaintiff Lawanda Gail Wilbanks was employed by MDC between June 2011 and January 2013, and MDC admits to having paid her at a rate of $7.25. See Ans. ¶ 15. Plaintiff Shannon Olszynski was employed by Inka between May 2014 and November 2014, and Inka admits to having paid her at a rate of $7.25. See Ans. ¶ 16. Plaintiff Charity Fitzlaff was employed by Inka between July 2012 and October 2013, and Inka admits to having paid her at a rate of $7.25. See Ans. ¶ 17.

Between July 1, 2010 and December 31, 2013, Defendants maintained, and claim to have offered Plaintiffs Diaz, Wilbanks, and Fitzlaff, a limited-benefits health plan known as the CIGNA Starbridge Plan (the "Starbridge Plan"), accurate copies of which are here attached as **Exhibit 8**, the 2010-2012 Plan versions (the "2010-2012 Plan"), which Defendants produced as MDC000087-000096, and **Exhibit 9**, the 2013 Plan version (the "2013 Plan"), which Defendants produced as MDC000097-000120.

Between January 1, 2014 and December 31, 2014, Defendants maintained, and claim to have offered Plaintiff Olszynski, a fixed-indemnity benefits health plan known as the Transamerica TransChoice Advance Plan (the "TransChoice Plan"), an accurate copy of which is here attached as

Exhibit 10 (the "2014 Plan"), which Defendants produced as MDC000129-000130 and MDC000686-000757.

For 2015, Defendants maintained, and claimed to offer to all employees earning less than $8.25 per hour, a benefits plan known as the Minimum Value Plan, or MVP (the "MVP Plan"), administered by Key Benefits Administrators, an accurate copy of which is here attached as **Exhibit 11** (the "2015 Plan"), which Defendants produced as MDC000770-000777.

Defendants claim to have offered the Plans to each Plaintiff at time of hire. See **Exhibit 12**, Transcr. Depo. Yvette Galimore, Fmr. HR Dir., at 181:1-4 (Mar. 11, 2015) ("The employee always received the enrollment form on the first day inside the new-hire packet. The insurance was always offered on the first day to the Nevada associates[.]").

V. DEFENDANTS' WAGE AND BENEFITS HISTORY

Just prior to July 1, 2010, the Nevada upper-tier minimum wage was $7.55 per hour. See Nevada Minimum Wage Announcement, Office of the Nevada Labor Commissioner, 2009. Defendants claim that prior to that date, it paid employees at least the upper-tier hourly minimum wage of $7.55 per hour. On July 1, 2010, the upper-tier wage in Nevada, pursuant to the Minimum Wage Amendment, increased to $8.25 an hour, and the lower-tier wage for employers providing qualifying health insurance was set at $7.25 an hour. See Nevada Minimum Wage Announcement, Office of the Nevada Labor Commissioner, 2010.

When the wage increased in 2010, Defendants made a corporate decision not to increase wages of most, if not all, of their minimum wage employees from $7.55 to $8.25. See **Exhibit 6**, Transcr. Depo. Blanca Vallejo, Fmr. HR Mgr., at 128:3-132:17. In fact, it explored the option of lowering the hourly wages of employees already making $7.55 down to $7.25, on the argument that "those pennies add up and $7.25 is **the right thing to do** to be consistent in Nevada." See Email from Colleen Fulton, Defs.' Training Mgr., to Terry DiGiamarino, Payroll Mgr. (Sept. 25, 2014) (emphasis added), which Defendants produced as MDC000664, an accurate copy of which is attached as **Exhibit 13**.[6] It was

[6] Colleen Fulton is Defendants' Training Manager. See **Exhibit 14**, Defs.' Initial Disclosures. Terry DiGiamarino is the current Payroll Manager for Mancha Development Company, Defendants' parent

(footnote continued on next page)

determined instead that newly-hired minimum wage employees should all receive $7.25 an hour. See **Exhibit 6**, Transcr. Depo. Blanca Vallejo, Fmr. HR Mgr., at 128:3-132:17. This decision was, not surprisingly, grounded in economic benefit to the Defendants:

> Q: What do you recall about that discussion?
> A: So again, the company was suffering financially and we were looking at ways to save the company money.
> Q: So the decision to pay the crew members at $7.25 an hour was solely an economic decision?
> A: Yes.

See **Exhibit 6**, Transcr. Depo. Blanca Vallejo, Fmr. HR Mgr., at 57:21-58:1.

In order to pay what Defendants themselves refer to as the "sub minimum wage" i.e., below $8.25 and all the way down to $7.25, Defendants communicated among their personnel that they "must offer insurance to every employee on their hire date." See Email from Colleen Fulton, Defs.' Training Mgr., to Joe Soraci (Sept. 6, 2014), which Defendants produced as MDC000653, an accurate copy of which is attached as **Exhibit 15**. It was at that point that Defendants began offering the limited-benefits Starbridge Plan, and subsequently the TransChoice Plan in 2014 and then the MVP Plan in 2015, in an effort to qualify to pay employees the subminimum wage and reap the resultant economic benefit.

The Starbridge Plan, offered between 2010 and 2013, became defunct at the end of 2013. See "Urgent Benefit Information" Letter, an accurate copy of which is here attached as **Exhibit 16**, which Defendants produced as MDC000318-000319. The Starbridge limited-benefit plans, as well as limited benefit plans like it offered by other insurers, were no longer viable healthcare products; they were no longer grandfathered under federal law, and they became flatly illegal because of their meager coverage and terrible benefit levels. Such plans were never really "insurance" anyway, and policymakers long recognized them as dangerous and misleading to sell to consumers.

Defendants were entirely aware of the insufficiency—or at least undesirability—of the benefits plans they were offering to Nevada subminimum wage employees. In September of 2014, during the pendency of the TransChoice Plan, Ms. Colleen Fulton, Mancha Development Company's Training

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corporation. Id.

Manager, in an email to another employee directing him to ensure that employees are paid at the $7.25 level rather than at $7.55 an hour and noting Nevada's insurance requirement, states that "Most employees decline it, they can do better in the state of Nevada insurance marketplace." See **Exhibit 15**, Email from Colleen Fulton, Defs.' Training Mgr., to Joe Soraci (Sept. 6, 2014).

It does not appear that Defendants did much to satisfy themselves that their Plans did, in fact, qualify them legally to pay less than the upper-tier minimum wage under the Amendment when they were considering which plans to adopt. In 2010, the extent of their investigation into plan qualification appears to be having asked the insurer—whose interest was, of course, in selling the plan to Defendants' employees—whether it thought the Starbridge Plan did qualify under the Minimum Wage Amendment. Unsurprisingly, CIGNA (the insurer) responded with a terse, single-sentence letter: "Per your request, please accept this letter as a confirmation that our Starbridge plan is considered a Qualified Health plan for the NV Minimum Wage Law." See Correspondence from Darren Weidlein, CIGNA Voluntary, New Business Manager, to Blanca Vallejo, Director of HR, Mancha Development Company (June 25, 2010), which Defendants produced as MDC000382, an accurate copy of which is attached as **Exhibit 17**. There was no discussion of why or how this might be true, and no citation to any legal or administrative provision, or any other authority supporting the claim. Defendants, for their part, were generally uncurious about the issue. Regarding this correspondence with CIGNA, Defendants' former Human Resources Manager Ms. Vallejo testified as follows:

> Q: Outside of the letter that you received from CIGNA did you do any independent research with respect to compliance with Nevada minimum wage laws?
> A: Not that I recall.
> Q: Did anybody provide you with any sort of direction about compliance outside of that letter?
> A: No, not that I recall.
> Q: Is it fair to say that you relied on Cigna's representation or interpretation as far as your understanding of the compliance?
> A: Yes.
> Q: Did you do anything else besides make an inquiry and get an answer from CIGNA with respect to compliance?
> A: I don't recall.

See **Exhibit 6**, Transcr. Depo. Blanca Vallejo, Fmr. HR Mgr., at 107:19-108:7.

In selecting the 2014 TransChoice Plan, after the Starbridge Plan was discontinued as a viable health care product by CIGNA, Defendants do not appear to have made even any effort at all to

consider coverage or benefit levels for compliance purposes, as Yvette Galimore, Defendants' former Human Resources Director, testified:

> Q: Did you have an understanding as to whether [the 2014 TransChoice Plan] qualified or did not qualify for purposes of the Nevada minimum wage law?
>
> Mr. Grandgenett: Object. Calls for a legal conclusion.
>
> A: What I remember, is we discussed on whether or not it met the Affordable Care Act requirements, not the minimum wage law.
>
> Q: Okay. So any discussions that you would have had regarding compliance for the TransChoice plan centered around the ACA?
>
> A: Yes.
>
> Q: Exclusively?
>
> A: Yes.
>
> * * *
>
> Q: Did you ever ask for anything in writing, that this TransChoice plan comply with the Nevada minimum wage law?
>
> A: No.
>
> * * *
>
> Q: Was whether TransChoice constituted a major medical insurance plan a factor in making the decision to select TransChoice?
>
> Mr. Grandgenett: Same Objection. Calls for a legal conclusion.
>
> A: No.
>
> Q: Was whether TransChoice was a comprehensive medical plan a factor in selecting the TransChoice plan?
>
> Mr. Grandgenett: Objection. Same Objection. What is comprehensive medical, what does it mean?
>
> A: No.

See **Exhibit 12**, Transcr. Depo. Yvette Galimore, Fmr. HR Dir., at 58:2-16, 68:11-14, 75:18-76:5.

This approach was consistent with the attitude towards compliance Defendants' personnel evinced generally:

> Q: And your statement there, that Mancha offers medical insurance on the first day of hire, and, therefore, they could pay a subminimum wage, was that your understanding of how the law in Nevada worked?
>
> A: Yes.
>
> Q: Okay. That Mancha could offer any type of insurance and qualify to pay below that particular minimum wage?
>
> A: Yes.
>
> Q: Even with the limited plan?
>
> A: Yes.
>
> Q: What did you mean by medical insurance, just any type of plan?
>
> A: Yes.

See **Exhibit 12**, Transcr. Depo. Yvette Galimore, Fmr. HR Dir., at 159:23-25, 160:1-11.

In summary, Defendants did little or nothing to ensure their Plans complied with Nevada law in

order to pay a subminimum wage. The driving force—their priority—was being able to pay employees all the way down to $7.25, irrespective of the type of plan or quality of benefits offered.

VI. LEGAL ARGUMENT

Under Nevada law, any health insurance plans provided by Defendants to Plaintiffs and other of its employees, for any purpose, have to comply with the substantive requirements of N.R.S. Chapters 689A and 689B regarding individual or group health insurance. See N.R.S. 608.1555 ("Any employer who provides benefits for health care to his or her employees shall provide the same benefits and pay providers of health care in the same manner as a policy of insurance pursuant to chapters 689A and 689B of NRS.").[7] Certainly, employer-provided health insurance plans which Defendants use to claim the prerogative of paying employees less than the full minimum hourly wage under the Nevada Constitution are no different, and no exception exists that places such insurance plans outside of the requirements of state law. Defendants, therefore, must demonstrate that the health benefits plans they provided to Plaintiffs and the Class—and for which Defendants claimed the right to pay less than $8.25 per hour to their employees—are and were health insurance that meets the substantive requirements of pertinent Nevada law.

Furthermore, there are additional specific coverage requirements in the Labor Code and in the Insurance Code regarding the provision of health insurance benefits. Both codes mandate that employer-provided group health insurance contain particular ranges of coverage and sets of benefits. None of Defendants' Plans contain the required coverage or benefits. The drafters of the Minimum Wage Amendment, as well as the people in enacting it, are presumed to know the law at the time of enactment. See Sengler v. IGT, 116 Nev. 565, 573, 2 P.3d 258, 262-263 (2012) (quoting Smith v. State, 38 Nev. 477, 481, 151 P. 512, 513 (1915)) ("Everyone is presumed to know the law, and this presumption is not even rebuttable."). N.R.S. 608.1555, for example, has been the law of Nevada since 1985, long preceding the 2006 Amendment. It cannot be presumed, therefore, that the Amendment

[7] N.R.S. 608.1555 exists in order to protect against sham benefits policies and to require that any employer-offered health care benefits hew to the same standards as are required by any individual or group health benefits plan sold in Nevada. In the Labor Code, it functions as an employee-protection mechanism.

intended some new category of unregulated health insurance when all health insurance in Nevada, including those policies provided by employers to employees, is so heavily regulated.

A. Limited-Benefits And Fixed-Benefits Plans

All of Defendants' Plans between 2010 and 2015 were and are some form of limited-benefit plans. The 2010-2013 Plans are plain vanilla limited-benefit plans. See **Exhibits 8, 9**. The 2014 Plan, however, represents a subset—a significantly more worthless and vacant subset—of limited-benefit plans known as fixed-indemnity plans, or hospital indemnity plan. See **Exhibit 10**; see also **Exhibit 18**, an accurate copy of Nevada Division of Insurance, Bulletin No. 13-011, at 2 (Dec. 31, 2013) ("Supplemental or limited health plans include those plans commonly referred to as hospital indemnity or other fixed indemnity policies[.]"). Defendants' 2015 Plan—the Plan they instituted after having been sued for failing to provide qualifying health insurance to their subminimum wage employees—is the absolute worst of the lot, and represents a tremendous plunge in benefits and coverage for Defendants' minimum wage employees, even from the already-poor programs in place before it. See **Exhibit 11**. In other words, Defendants' offered Plans steadily got worse over the last five years.

1. Limited-Benefits Plans

Also known as "mini-meds," limited-benefits plans are products that cap payouts to beneficiaries who need health services at very low annual limits, usually between $1,000 and $5,000. These plans also contain internal caps under which, for example, inpatient or outpatient services or prescription drugs are subject to even lower payouts or reimbursements.[8]

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[8] These kinds of "insurance" products have long been a source of concern by policymakers. As far back as 2007, then-Connecticut Attorney General, now-United States Senator, Richard Blumenthal investigated Aetna's limited benefits plans, stating, "We found that a particular policy set forth by Aetna had benefits so small as to be virtually worthless. We were also concerned that people were led to believe they had significantly more coverage than they actually had. While we are currently investigating this particular plan to determine whether it violates existing law, we want to leave no doubt that sham policies are not permitted in Connecticut." See Ctr. for American Progress, Limited *Benefits: Insurers Peddle "Limited Health Care" to America's Working Poor*, https://www.americanprogress.org/issues/healthcare/news/2007/05/07/3076/limited-benefits-insurers-peddle-limited-health-care-to-americas-working-poor/ (May 7, 2007) (accessed August 23, 2015).

In 2009, still well before the enactment of the ACA, ranking member of the Senate Committee on Finance U.S. Senator Charles Grassley was sounding the oversight alarm, worried that these plans "had been marketed in a misleading way" and pressing Congress to "make limited benefit indemnity plans

(footnote continued on next page)

Compare these types of plans to traditional comprehensive or major medical insurance policies, which have neither annual nor lifetime caps on coverage, and instead feature annual out-of-pocket maximums pursuant to which insured persons can be secure in the knowledge that health care expenses beyond deductibles and co-pays will be paid by the insurer. This is important in an industry where a single day in a Nevada hospital, in 2013, according to the Kaiser Family Foundation, cost an average of **$1,913**. See Kaiser Family Found., Hospital Adjusted Expenses per Inpatient Day, Nevada, http://kff.org/other/state-indicator/expenses-per-inpatient-day/ (accessed August 23, 2015). Knee replacement surgery averages about **$32,000** in Nevada, and knee ACL repair almost **$12,000**; the birth of a child through caesarean procedure will cost a patient more than **$13,000**; even basic carpal tunnel surgery will run more than **$4,000** in Nevada. See Guroo, All Conditions, Care Bundles, and Tests, http://www.guroo.com/#!a-to-z-list (accessed August 23, 2015). These figures do not even begin to approach the costs of serious or chronic illnesses, such as cancer or diabetes, which by their terms limited-benefits plans are not designed, intended, or equipped to cover.

2. Fixed-Indemnity, or Hospital Indemnity Plans

Fixed-indemnity benefits plans are health care products that pay a fixed amount per visit or service, given directly to the beneficiary. These plans pay a small, specific amount each time an enrollee sees a doctor or goes to a hospital, regardless of the seriousness of the care needed or the health condition at issue.

The Center on Health Insurance Reforms, housed in Georgetown University's Health Policy Institute, notes that "federal law (and most states) do not consider fixed indemnity insurance to be traditional medical insurance." See Ctr. on Health Ins. Reform, Update on Fixed Indemnity Insurance: No Longer an ACA Loophole?, http://chirblog.org/update-on-fixed-indemnity-insurance-no-longer-an-aca-loophole/ (Mar. 19, 2014) (accessed August 23, 2015). Instead, such products "have been considered **income replacement policies**, to help compensate people for time out of work." Id

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obsolete by making meaningful insurance coverage available and affordable." See U.S. Senate Comm. on Finance, Press Release, http://www.finance.senate.gov/newsroom/ranking/release/?id=2f7af1bb-78f8-41d2-8813-7d6ae06b5705 (Apr. 22, 2009) (accessed August 23, 2015).

(emphasis supplied). Furthermore, "both state federal and state regulators have expressed concerns that insurance companies could attempt to market these policies **in such a way that they appear to consumers to be health insurance**." Id. (emphasis supplied). This concern arose out of the prospect of consumers "being duped into buying a fixed indemnity policy as their sole source of health coverage." Id.

In 2015, in fact, the Nevada Division of Insurance issued Bulletin No. 15-001, wherein the Insurance Commissioner directs that fixed-indemnity policies may no longer be sold to individuals in Nevada unless the purchaser is made to attest that he or she already has "major medical health insurance that meets the requirements of minimum essential coverage as defined by the Affordable Care Act." See **Exhibit 19**, an accurate copy of Nevada Division of Insurance, Bulletin No. 15-001 (Apr. 2, 2015). In other words, the plan that Defendants offered to their subminimum wage employees in 2014 to purportedly qualify them to under pay the full constitutional wage today cannot be sold to an individual in Nevada if that person does not swear, under penalty of perjury, to having acquired actual health insurance. This is, of course, to avoid the duping of consumers into thinking fixed-indemnity policies were suitable as one's primary source of health insurance. Furthermore, the Commissioner notes in the Bulletin that federal law mandates that fixed-indemnity policies must carry the 14-point font warning notice that "THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE," and directs that these types of policies carry that text in Nevada. Id. A version of warning is, in fact, stamped upon Defendants' 2014 Plan. See **Exhibit 10** at MDC000129.

In general, all limited-benefits plans are designed to be supplemental to real, comprehensive, major medical insurance. Neither limited-benefit plans nor fixed-indemnity plans function as reliable or useful health benefits policies on their own.

3. Other Plans, Designed to Mislead Employees and Regulators

This Court has already, at multiple hearings, warned that it is fully cognizant of attempts by insurers and businesses to pass off junk policies as "health insurance." Defendants' 2015 Plan is just such a "plan," a fake or imitation benefits policy, as will be described in-depth further below.

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B. Analysis of the Coverage and Benefits of Defendants' Plans

The particular benefits included in the successive Plans presented by Defendants paint a clear picture of the quality of those policies, and their salient aspects and omissions are described below.

1. 2010-2013: Defendants' Limited-Benefits Plans

Between 2010 and 2013, Defendants offered their Nevada minimum wage hourly employees CIGNA Starbridge Limited Benefits Plans. See **Exhibits 8, 9**. The 2013 Plan underwent minor downward modifications in coverage and benefits levels from the 2010-2012 levels. As Dean Milone states:

The Plan carries an express warning:

> Starbridge is a sickness & accident plan that covers everyday medical expenses. It is not a major medical plan and is not designed to cover major health problems like heart disease or cancer.

See **Exhibit 20**, a true and accurate copy of the Summary of the Starbridge Plan, which Defendants produced as MDC000785-000792, at MDC000786.

Once the annual maximums are met for a particular service, the Plan makes no further payment, and the employee is responsible for 100% of the cost of that service for the rest of the year. The limits themselves are tiny; and, when compared with the actual cost of even a basic health expense, they cannot function as useful "insurance." The 2010-2013 Plans had no out-of-pocket maximums for policyholders. That, of course, is the definition of a limited-benefit plan, and why they are dangerous health benefits products, if marketed or purchased as comprehensive coverage.

The 2010-12 Plan contains an annual maximum of $1,250/year for outpatient care paid by the Plan, and an annual maximum of $3,000/year for inpatient care. See **Exhibit 8** at MDC000090. This Plan pays a maximum of $1,500 toward each surgery, and will only pay $1,500 toward costs incurred in a pregnancy. Id. The 2010-12 Plan only contains benefits for inpatient surgery. Id. There is no annual limit for maternity benefits, but the 2010-12 Plan will only pay $1,500 toward costs incurred in each pregnancy. See **Exhibit 8.**

The 2010-12 Plan provides no coverage for chiropractic care, treatment of mental or nervous disorders, treatment of substance abuse, home health services (except when in lieu of hospital confinement), and skilled nursing facility charges. See **Exhibit 8** at MDC000091-000092. The 2013

version of the Starbridge limited-benefits Plan is similar in structure to the 2010-2012 version, with one general exception: It got worse. The annual inpatient maximum for the 2013 Plan is now reduced to only $2,000, from the $3,000 maximum in the 2010-2012 Plan. See **Exhibit 8**.

All of these Plans purport to include prescription drug discount programs, but these are virtually useless, as the Plans specifically state such programs "are not insured benefits." See **Exhibit 20** at MDC000791. In other words, the Plans provide no specific insurance coverage for prescription drugs. See also **Exhibit 9** at MDC000097: "Prescription Coverage: Discount Only program, limits do not apply."

In offering these "benefits" to their employees, Defendants included in their summary materials a letter, representing an attempt to dress up the meager benefits the Plans provided, stating:

> Did you know that 89% of all people use less than $2,000 in health benefits per year? That's why we feel that although Starbridge benefits are more limited than a traditional major medical plan, Starbridge can still save you money on your everyday health needs.
>
> * * *
>
> Starbridge helps you plan for unexpected health expenses.

See **Exhibit 20** at MDC000788.

Of note here is not only the admission that Starbridge is not a "traditional major medical plan," but further that it can somehow help a beneficiary plan for "unexpected health expenses." That is, of course, unless those expenses involve real money above the incredibly low annual limits on benefits the Plans maintain, and unless the unexpected health need is a major problem—like cancer, or heart disease, or any other condition the costs of which "traditional" health insurance is normally expected to help defray.

Each of the 2010-2013 Plans contained exclusions for pre-existing conditions, lasting up to a full year. See **Exhibit 20** at MDC000792. For a year-long policy, this would effectively mean that a pre-existing condition would go uncovered entirely by the Plan. For employees in a high-turnover industry such as fast food, this means, in practical terms, that pre-existing conditions are excluded from coverage by the Plans.

There are a great number of requirements under law for health insurance in Nevada that the Plans do not include or reference. For example, N.R.S. 608.156 requires an employer to provide

treatment for abuse of alcohol and drugs with an outpatient maximum of $1,500/year and an inpatient benefit of $9,000/year. See N.R.S. 608.156. The 2010-12 Plan and the 2013 Plan exclude treatment for abuse of drugs and alcohol. Even if such services were covered the annual outpatient maximum benefit is $1,250 (less than $1,500) and the maximum inpatient benefit is $3,000 under the 2010-12 Plan and $2,000 under the 2013 Plan (less than $9,000).

Furthermore, the 2010-12 Plan and the 2013 do not contain any provision for benefits from expenses arising from home health care, as required by N.R.S. 689B.030(4). The Plans only provide home health services in lieu of hospital confinement. There is no provision for benefits for the expenses of hospice care, as required by N.R.S. 689B.030(5). The 2010-12 Plan and the 2013 Plan do not include hospice within the definition of hospital and do not otherwise provide for hospice. The 2010-12 Plan and the 2013 Plan cannot comply with further coverage requirements of Chapter 689B, including a $36,000 annual maximum for Autism Spectrum Disorders (see N.R.S. 689B.0335) and $2,500/year in coverage for food products related to metabolic diseases (see N.R.S. 689B.0353). These requirements exceed what is even available under the limited benefits provided by the 2010-12 Plan and the 2013 Plan—there is no way for these plans to comply with state law on these matters. The 2010-2013 Plans are noncompliant as a basic matter of state law.

2. 2014: Defendants' Fixed-Indemnity Plans

In 2014, Defendants switched to offering their subminimum wage workers the TransChoice Hospital Indemnity Plan, for reasons discussed supra at section v.

Right off the bat, the 2014 Plan alerts prospective enrollees that it is not suitable for use as traditional, comprehensive health insurance, stating on its face that it is "NOT MAJOR MEDICAL INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL INSURANCE." See **Exhibit 10** at MDC000129, MDC000692. The same notice is contained again at MDC000700. Both also state that the 2014 Plan does not qualify as minimum essential coverage under the Patient Protection and Affordable Care Act ("ACA"). See **Exhibit 10**.

Unlike the 2010-2013 limited-benefits plan, which at least tried to look like coverage for actual health events and expenses, the 2014 Plan provides only payments in connection with events, not actual health care costs. It provides, for example, fixed payments of $100/day for up to 31 days a year,

with no connection to the actual cost of that health care service. See **Exhibit 10** at MDC000702-000703. This $100/day payment obviously would not be sufficient to cover the average daily cost of a hospital stay in Nevada; it would not even approach the real cost of such an event. Nursing homes, extended care facilities, skilled nursing facilities, institutions for the treatment of mental disorders, rest homes, rehabilitation centers, or centers for the treatment of alcohol or drugs are not included in the definition of "hospital" under the 2014 Plan. See **Exhibit 10** at MDC000709. Thus, the 2014 Plan would not apply to such services.

Defendants' 2014 Plan also offers limited fixed payments for certain outpatient services including a maximum payment of $200/year for advanced diagnostic tests (such as an MRI or CT Scan), $50/year for other diagnostic tests (such as an x-ray or ultrasound), $20/year for laboratory tests, and $300/year for doctor office visits. It offers limited payments for certain surgical services including a maximum payment of $500/year for an inpatient surgery (plus $100 for anesthesia), $250/year for outpatient surgery (plus $50 for anesthesia), and $50/year for "minor" outpatient surgery (plus $10 for anesthesia). Id.

The function of any of these "payments" is not that of insurance in any event—at best, they may be considered supplemental income-replacement, and not very good income-replacement at that: The employee remains responsible for payment of all health care costs over and above the fixed payment. Any costs for a 1 day hospital stay in excess of $100 would be paid by the employee, as would any costs for an outpatient surgery in excess of $250 for the surgery and $50 for the anesthesia. Id.

The 2014 Plan also expressly excludes some of the most necessary and common healthcare expenses, providing no benefits for care in the emergency room of a hospital, ambulance services, rehabilitative care and treatments, immunization shots, or routine examinations such as mammograms or pap smears. See **Exhibit 10** at MDC000710, MDC000714.

Defendants' 2014 Plan does not even provide lawful COBRA continuation coverage. Under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), employers with more than 20 employees and who offer a group health plan are required to offer COBRA continuing coverage. See 29 U.S.C. § 1161 et seq. Clearly, Defendants employ more than 20 persons. Do they claim 1) The

Plans are not "group health plans" after all? or 2) That the Minimum Wage Amendment supersedes, in a sharply downward fashion, the requirements of federal law regarding continuing coverage? The most likely reason that the 2014 Plan does not offer COBRA coverage, of course, is that as fixed-indemnity policies, they were never meant—in any context—to function as stand-alone health insurance policies, and therefore the only time anyone would run afoul of 29 U.S.C. § 1161 et seq. is when an employer tries to portray them as health insurance policies in full.

Again, N.R.S. 608.156 requires an employer to provide treatment for abuse of alcohol and drugs with an outpatient maximum of $1,500/year and an inpatient benefit of $9,000/year. See N.R.S. 608.156. The 2014 Plan contains no outpatient benefit for treatment for abuse of alcohol and drugs and a maximum inpatient benefit of $3,100. N.R.S. 689B.030(4) requires a provision for benefits for expenses arising from home health care, but the 2014 Plan does not provide any benefit for home health services. See N.R.S. 689B.030; see also **Exhibit 10** at MDC 000702-000703. N.R.S. 689B.030(5) mandates a provision for benefits for the expenses of hospice care, but the 2014 Plan does not include hospice within the definition of hospital and excludes all rest care from its coverage provisions. See N.R.S. 689B.030; see also **Exhibit 10** at MDC000709, MDC000714. N.R.S. 689B.0313 requires a provision providing coverage for the human papillomavirus vaccine, but the 2014 Plan does not provide benefits for vaccinations. See N.R.S. 689B.0313; see also **Exhibit 10** at MDC000714. N.R.S. 689B.0335 mandates $36,000 in annual maximum for Autism Spectrum Disorders, while N.R.S. 689B.0353 prescribes $2,500/year in coverage for food products related to metabolic diseases. See N.R.S. 689B.0335. N.R.S. 689B.0357 requires a provision covering costs related to self-management of diabetes, but the 2014 Plan does not provide an indemnity benefit for this condition. See N.R.S. 689B.0357; see also **Exhibit 10** at MDC 000702-000703.

These are not optional requirements under law. Defendants do not get to pick and choose which aspects of Nevada health insurance law they deem necessary or unnecessary, or what conditions or services mandated by the Legislature for coverage their employees will not receive. The Plans, demonstrably and concretely, fall short of many, many statutory requirements for employee health insurance.

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3. 2015: The Bogus Plan

In 2015—after having been sued for maintaining substandard benefits plans to their subminimum wage employees—Defendants made a curious choice to switch from the 2014 TransChoice Plan to what it calls the MVP Plan. See **Exhibit 11**.

At first glance Defendants' 2015 Plan appears to be a parody of insurance, someone's idea of a joke. This Plan is the absolute worst of the bunch, not only because it excludes just about everything a consumer would expect health insurance to provide, as a matter of the basic expectations of society, it also attempts to conceal its insufficiency through its marketing, by appropriating a term form the Affordable Care Act to mislead consumers. "MVP" stands for "minimum value plan," and Key Benefits actually calls this policy its "ACA Minimum Value Plan." See **Exhibit 11** at MDC000772. In truth, however, the 2015 Plan is so far from constituting insurance, on any level, that it really does boggle the mind.

The 2015 excludes surgery. All surgery. To the point where it will not cover stitches, or the setting of broken bones. See **Exhibit 11** at MDC000773. It also fails to cover just about the entire range of any other useful healthcare services: It provides NO coverage whatsoever for inpatient hospital stays, surgery, ambulatory surgery center charges, mental health, substance abuse treatment, rehabilitative services, ambulance services, chiropractic care, infusion, chemotherapy, injections, skilled nursing facility charges, or any facility charges of any kind. See **Exhibit 11** at MDC000772-000775. These are not just health care services health care services that one would expect to be covered by "health insurance," many of them are required by law to be contained in any lawful health insurance policy provided by employers to employees—for obvious reasons.

Further, the 2015 Plan contains a perverse "benefit" regarding emergency room services. It will pay for emergency room visits, after a $400 co-pay by the insured, but even that benefit is rescinded if the person going to the emergency room actually needs to be admitted to the hospital. Additionally, the ambulance to the emergency room would not be covered. See **Exhibit 11** at MDC000774. These coverage limitations are not consistent with health insurance offered through the exchange under the ACA or health insurance, generally.

Given the foregoing, it is unsurprising that childbirth "delivery and inpatient charges" are not

covered." See **Exhibit 11** at MDC000773. Neither are "all medical supplies, durable medical equipment [or] prosthetics." Id. "Ambulance services are not covered." Id. Neither are injections. Id. Do not even think about "infusion, chemotherapy, or radiation," or "mental health and substance abuse services"—"not covered." Id. Prescription drug "coverage" is "limited to a 34-day supply." See **Exhibit 11** at MDC000776. Not 34 necessary fills, or 34 separate prescription needs: 34 days' worth of supply of any needed drug. Id. The 2015 Plan's schedule regarding Chronic Disease Management is itself an amazing document. See **Exhibit 11** at MDC000776. There one finds that an epileptic will be covered for "1 office exam per plan year," although a sufferer of congestive heart failure or multiple sclerosis will be generously covered for two. Id. Defendants' 2015 Plan does not meet any of the requirements under state law for health insurance, and it cannot be used to justify underpayment of the upper-tier minimum wage by Defendants.

* * *

Each of Defendants' successive annual Plans is a woeful product, the use of which to justify paying the subminimum wage in Nevada is unlawful. And each iteration of the Plan between 2010 and 2015 got worse, until finally reaching a nadir in 2015, when Defendants' duty of providing or offering actual benefits really just descended into mockery with the MVP Plan.

In sum, none of Defendants' Plans provide the "same benefits" as required by N.R.S. Chapter 689A and 689B and cannot properly be considered "group health insurance," or "benefits for health care," or even simply "health insurance" under Nevada law at all. Because the Plans do not meet basic legal mandates for employer-provided health insurance under state law, they certainly cannot meet the requirements of the Minimum Wage Amendment—or its associated administrative regulations, should they apply—as qualifying health insurance permitting payment of the subminimum wage to Plaintiffs.

C. Federal Law Regarding Health Insurance, And Consequences For Defendants' Employees

It is both undisputed and indisputable that Defendants' Plans do not meet the minimum requirements for under the Affordable Care Act, and the Plans in question carry disclaimers on their faces saying exactly that. See **Exhibit 9** at MDC000097; **Exhibit 10** at MDC000129.

Although their experts contradict one another diametrically on this point, it is likely Defendants

undoubtedly will argue that the Affordable Care Act has nothing to do with this action, or the applicable standards involved in it. But consider this: Since January 1, 2014, individuals have had to purchase real, actual, qualifying health insurance or face a tax penalty from the I.R.S. The health insurance those individuals must buy is required to meet certain standards—minimum essential coverage and essential health benefits. Any insurance product bought on the state or federal exchanges is certain to contain those elements.

Here is how Defendants' Plans and the Affordable Care Act intersect: None of Defendants' employees who enrolls in either the 2014 or 2015 Plans are freed from the necessity of either purchasing real health insurance or paying the penalty for not having done so. The Plans are not qualified under federal law, by their own express terms, and do not allow Plaintiffs or the Class to avoid those penalties. In other words, Defendants claim the privilege of withholding up to a dollar for every hour worked simply for having offered the Plans, but if any Plaintiff were actually to accept those benefits and enroll in any of Defendants' Plans, she would still either have to buy real insurance or pay a fine, only now with significantly less money in her pocket to go and do so, because Defendants have withheld more than 12% of their lawful wages.

Defendants, for their part, are certainly aware of the insufficiency of their plan under federal law. The Starbridge Plans, for 2010-2013 were obviously known to be subpar per federal law, but were chosen anyway:

Q: Okay. What was the plan for hourly employees in Nevada in 2013, if you recall?
A: The plan name?
Q: Uh-huh.
A: For 2013, I believe it was Starbridge.
Q: Did you have an opportunity to become familiar with that plan?
A: Yes.
Q: How so?
A: Reviewing the information, the documents, the benefits summary sheet.
Q: Okay. When did you do that, upon being hired?
A: After I was hired and on board.
Q: Do you understand that plan to constitute a major medical insurance plan?
A: No.
Q: It was not a major medical insurance plan, correct?
A: No.
Q: My statement's correct?
A: It is not a major, it's a limited plan.
Q: What does that mean?
A: It means that it's not a major, full plan.

* * *

Q: Do you know if it met the minimum standards by the ACA?
A: No.
Q: It did not meet the standards, correct?
A: No.

See **Exhibit 12**, Transcr. Depo. Yvette Galimore, Fmr. HR Dir., at 30:18-31:15, 31:23-32:2.

Similarly, the 2014 TransChoice fixed-indemnity Plan—after imposition of the individual mandate under the Affordable Care Act—was also known to Defendants to be legally insufficient:

Q: And with respect to compliance, the discussion centered around the ACA --
A: Yes.
Q: -- does this plan comply with the ACA?
A: TransChoice?
Q: No, the discussions were whether or not the plan complied with the ACA.
A: Yes.
Q: And did the TransChoice plan comply with the ACA?
A: At that time, no.
Q: At any time did it?
A: At the time that I was there for approximately one year, no.

See **Exhibit 12**, Transcr. Depo. Yvette Galimore, Fmr. HR Dir., at 59:4-17.

Defendants' former Human Resources Director was unclear on why, if the Plan was non-compliant, it would have been offered by Defendants at all:

Q: If the TransChoice plan did not comply with the ACA, why was it selected?
A: When we looked at the plan, moving from Starbridge in a similar offering, TransChoice was one of the selections. I do not remember the other plans that were offered for us to look at, but there were a couple of other ones that we did look at it.

* * *

Q: Ultimately, why did Mancha decide to go with the TransChoice plan?
Mr. Grandgenett: I'm going to object based on speculation.
A: From what I remember, in looking at TransChoice and moving toward the future for 2015, TransChoice was a product where we would be able to utilize ACA compliance for 2015.
Q: How so?
A: The specifics, I do not remember.
Q: So the plan was selected because in 2015 it could potentially become compliant with ACA?
A: What I remember, as part of that criteria, is that it would be compliant in 2015.
Q: Who told you that?
A: It would be -- that was through Benebiz. It would be -- it was a product that had other offerings that would bring us into compliance for 2015.
Q: What about for 2014?
A: No, not for 2014.

Q: Okay. And Mancha was aware that TransChoice did not meet the requirements for ACA for 2014?
A: Yes.

See **Exhibit 12**, Transcr. Depo. Yvette Galimore, Fmr. HR Dir., at 60:3-9, 63:6-64:4. In the end, Defendants did not continue with TransChoice in 2015 anyway, but instead selected the MVP Plan to replace it; the false concern for compliance in 2015 was never borne out, in other words.

Defendants did, internally and with employees, discuss the clear likelihood that employees offered these non-ACA-compliant Plans would have to look elsewhere for health insurance coverage:

A: We provided to employees information on different options that they could choose outside of Mancha on going to the exchange or the marketplace, as it's called, to seek out insurance.
Q: Why would they need to do that?
A: Because the TransChoice plan was a limited plan and they may have qualified for the marketplace or exchange.
Q: For real insurance?
Mr. Grandgenett: Object based on the characterization of the question.
A: For the insurance that was offered through the marketplace.
Q: But if they already had the TransChoice plan, why would they need to do that?
A: Because our plan was a limited plan.

See **Exhibit 12**, Transcr. Depo. Yvette Galimore, Fmr. HR Dir., at 172:9-25.

In an email communication to "All Restaurants" dated January 2, 2015, after rolling out the new 2015 MVP Plan, Training Manager Colleen Fulton, in a "Recap of Insurance Call," directed managerial personnel to "Encourage employees to look at state approved/sponsored health care programs that they will qualify for." See **Exhibit 21**, Email from Colleen Fulton, Defs.' Training Mgr., to All Restaurants (Jan. 2, 2015), which Defendants produced as MDC000407. In other words, in recognition of the substandard quality of Defendants' offered Plans, Defendants were to encourage these employees to seek out and enroll in state and federal programs (presumably including subsidies, for which minimum-wage workers would no doubt qualify) in order to receive true health insurance.[9]

[9] As part of the MVP Plan roll-out process, a representative of Defendants' insurance broker, the Leavitt Group, had presciently warned that "Payroll is justifiably concerned that these voluntary benefits are of limited value or interest to employees earning low wages," and that "Everyone, including Leavitt, is concerned that employees who purchase voluntary benefits may have buyer's remorse and wish to cancel benefits quickly after electing benefits resulting in added work and stress for payroll." See Email from Jackie Kohorst to Conallee Moss, Mancha Director of HR (Dec. 9, 2014), which Defendants produced as MDC000434-000436, an accurate copy of which is attached as **Exhibit 22** at MDC000435.

D. Qualifying Health Insurance Benefits Plans Under N.A.C. 608.102

Defendants also will likely point to N.A.C. 608.102, and mount some attempt to argue that the Plans here meet its terms. But just like every other standard discussed herein—even if the Court were to accept that administrative regulations, and not the Nevada Constitution or state statutes, control what must be provided to Plaintiffs here--Defendants' Plans fail this hurdle as well.

N.A.C. 608.102, in pertinent part, states that,

> To qualify to pay an employee the minimum wage set forth in paragraph (a) of subsection 1 of NAC 608.100, an employer must meet each of the following requirements:
>
> 1. The employer must offer a health insurance plan which:
>
> (a) Covers those categories of health care expenses that are generally deductible by an employee on his individual federal income tax return pursuant to 26 U.S.C. § 213 and any federal regulations relating thereto, if such expenses had been borne directly by the employee[.]

N.A.C. 608.102.

This is a very difficult and rigorous standard to meet, in fact. 26 U.S.C. § 213 establishes the tax deduction for expenses paid for medical care generally, which is defined at § 213(d) as "amounts paid" for "the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body." Id. It is difficult to imagine a more expansive definition of "medical care."

There are dozens of categories of health care expenses that are deductible. The Internal Revenue Service goes to the trouble of providing a near-comprehensive list of those categories of health care services that are deductible on an individual's federal tax return. The 2014 list, for example, is found in I.R.S. Publication No. 502 for Tax Year 2014, an accurate copy of which is attached here as **Exhibit 23**. Expenses paid for any of the expenses listed by the I.R.S. are tax deductible, above a certain minimum threshold, on an individual's federal tax return.[10]

Even a cursory review of the I.R.S. list demonstrates that Defendants' Plans do not provide

[10] The threshold does nothing to affect the categories of health care expenses that are deductible once the threshold is reached; neither does the threshold affect what categories must be covered pursuant to the Minimum Wage Amendment in Nevada.

coverage for the range of categories of health care expenses that individuals could deduct on their federal tax returns if they paid for the services themselves, out of pocket. The Labor Commissioner, in promulgating N.A.C. 608.102, did not state that "some," or a "few," or a "small proportion" of those health care expenses that would be deductible need only be covered; the regulation states "those categories of health care expenses[.]" N.A.C. 608.102(1) (emphasis supplied). Defendants' 2010-12 Plan and the 2013 Plan do not cover chiropractic care, hearing aids, infertility treatments, treatment of mental or nervous disorders, treatment of substance abuse, home health services (except when in lieu of hospital confinement), and skilled nursing facility charges—all of which are services are generally deductible by an employee on his individual federal income tax return pursuant to 26 U.S.C. § 213. The 2014 Plan does not cover emergency room care at a hospital, ambulance services, rehabilitative care and treatments, immunization shots, or routine examinations such as mammograms or pap smears, again all of which are generally deductible by an employee on his individual federal income tax return pursuant to 26 U.S.C. § 213. See **Exhibit 10** at MDC000710, MDC000714.

In any event, it is impossible—almost by definition—for limited-benefits or fixed-indemnity health benefits plan to meet the requirements of N.A.C. 608.102(1), because of the limitations on coverage and the paucity of benefits included in such policies. Defendants cannot rely on N.A.C. 608.102 to bless their benefits plans. They will argue, of course, that as long as the plans they offer cover some, any, kinds of health care that could be deducted on a federal tax return that the plans therefore qualify to pay less than $8.25. There is no record, of course, of Defendants ever challenging N.A.C. 608.102(1) or requesting declaratory relief confirming such a narrow view. Surely they cannot be rescued from a decade of noncompliance with both the Amendment and the regulation by putting forth such a crabbed interpretation now.

E. Health Insurance, Social Expectations, And The Minimum Wage Amendment

Lastly, the issue arises regarding the public understanding and expectation, leading up to and in the period after its enactment, of the kinds of health insurance benefits that Nevadans considered that the beneficiaries of the Amendment—low-wage workers—would receive as part of the bargain inherent in the statewide measure. See Hotel Employees & Rest. Employees Int'l Union, AFL-CIO v. State ex rel. Nevada Gaming Control Bd., 103 Nev. 588, 591, 747 P.2d 878, 880 (1987); Pohlabel v.

State, 128 Nev. Adv. Op. 1, 268 P.3d 1264, 1269 (2012). It cannot seriously be suggested that the intent of the Minimum Wage Amendment was to allow supplemental, non-regular—in the end, unlawful—health benefits to be passed off by employers as full health insurance, and to allow the lowering of wages on that basis. Plaintiffs believe that Nevadans who voted, twice, to raise compensation for fellow Nevadans took both work and health care more seriously than that.

Plaintiffs and the Class had no input into what plans, coverage levels, or specific benefits Defendants selected in their attempt to pay a subminimum wage to employees. Defendants selected policies that cost them next to nothing but that provided almost no benefit to the employees themselves or, what may be worse, gave employees false confidence that they were insured in the traditional sense. It seems unlikely, however, that such a remedial act of the people would be so debased by failure to provide the one thing it allowed to be traded in exchange for a portion of the wages of the lowest-paid workers in Nevada, appropriate health insurance.

* * *

Nothing can help Defendants overcome the basic truth that their Plans do not meet the standard—any legitimate standard—for health insurance. They do not meet state law requirements for health insurance under N.R.S. Chapters 608, 689A, or 689B. They do not meet federal requirements for health insurance under the Affordable Care Act. They do not meet administrative regulations governing the Minimum Wage Amendment under N.A.C. 608.102. They do not even meet the most basic expectations regarding coverage that any person, much less an employee trading a full dollar of her income for every hour worked, would have. In short, the Plans do not qualify Defendants to pay Plaintiffs less than $8.25 per hour, and the present motion should be granted.

VII. EXPERT OPINIONS

A. Plaintiffs' Expert, Dean Matthew Milone

The report of Plaintiffs' expert Dean Milone supports their legal argument, and the Court is urged to consider Milone's application of Defendants' Plans to the pertinent Nevada law, as well as to federal law, including the ACA. See **Exhibit 2**. He notes the shortfalls of Defendants' Plans throughout. One thing to note is that Milone was never asked, and did not opine, on whether Defendants were able to pay Plaintiffs and the Class the lower-tier wage pursuant to the Minimum

Wage Amendment. This is a step, however, that Defendants' experts did make, in effect attempting to answer the ultimate question in this lawsuit through their reports. In that respect, Plaintiffs object to those of Defendants' experts' opinions that cross that line, as they do throughout.

B. Defendants' Experts, Michael Arrigo And Timothy Mulliner

Defendants identified and disclosed reports from two separate experts in this matter, Michael Arrigo of California[11] and Timothy Mulliner of Nevada. It is not entirely clear why they did that, because the two experts collaborated on their reports and approaches from the very start. See **Exhibit 24,** Emails between Arrigo and Mulliner, which Defendants produced as Mulliner005051-5052. Even so, the two experts had a hard time staying out of each other's way, and even flatly contradicted one another on points fundamental to their analyses. Mr. Arrigo, for example, pins his opinions to an interpretation of the Affordable Care Act, arguing that the ACA preempts, exempts, or otherwise entirely relieves employers of any duty regarding specific kinds of health insurance—or, indeed, whether they need to provide health insurance at all—under the Nevada Minimum Wage Amendment. It is the ACA that forms the linchpin of Mr. Arrigo's analysis of Defendants' Plans.[12] Mr.

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[11] Mr. Arrigo also appears to be an expert, if in any field at all, in medical billing and coding practices, and consequently much of his report is irrelevant filler meant to convey technical expertise. In fact, Mr. Arrigo claims at several places in his report to have reviewed medical records in this case in forming his opinions. See **Exhibit 25**, Arrigo Report, at MDC001305-001307. There are no medical records in this case, a fact Mr. Arrigo was forced to admit at deposition. **Exhibit 26**, Transcr. Depo. Michael Arrigo, Defense Expert, at 40:7-45:16.

[12] Indeed, Mr. Arrigo testified that he had not reviewed Nevada law at all, including the Minimum Wage Amendment itself:

> Q: Did you review Article 15, section 16 of the Nevada Constitution, which I'll refer to as the minimum wage amendment?
> A: No.
> Q: You did not?
> A: No.
>
> * * *
>
> Q: Did you review NRS Chapter 689A regarding individual health insurance?
> A: I relied on Mr. Mulliner's report, since he's an attorney practicing in Nevada, and I believe he stated that 689A and B don't apply.
> Q: Okay. So the answer is no?
> A: I did read them briefly, but I also believe they don't apply.... And rather than focusing on 689A and B, I focused on the national standards that are used to define health insurance coverage, since the Nevada minimum wage law doesn't say what health insurance coverage is.

(footnote continued on next page)

Mulliner, however, could not be clearer in stating exactly the opposite:

> Q: In fact – I just want to be clear. Your position appears to be that the ACA is irrelevant to the issues presented.
> A: It is certainly irrelevant to the Minimum Wage Amendment and whether a particular insurance would entitle an employer to pay a lower minimum wage . . .
>
> * * *
>
> Q: Okay. So it's irrelevant to the issues in the case, as far as you're concerned?
> A: Absolutely.

See **Exhibit 27**, Transcr. Depo. Timothy Mulliner, Defense Expert, at 73:23-75:3; see also **Exhibit 28**, Mulliner Expert Report, at MDC001375, MDC001381.

Perhaps this sort of contradiction was to be expected, as both experts were asked by Defendants to opine on the same questions:

1. Whether or not Defendants' plans are "qualifying health insurance" as contemplated by the Minimum Wage Amendment; and

2. Whether the benefits the Defendants are providing are health insurance as health insurance is defined and used within the industry.

See **Exhibit 29**, Email correspondence between Defense Counsel and both Mr. Mulliner and Mr. Arrigo, March 9, 2016, produced by Defendants as Mulliner0005204.

This second point is, in fact, the common thread running through both defense experts' approaches: Both experts maintain, at bottom, that because the Minimum Wage Amendment uses the term "health insurance," Nevada employers like Defendants need only provide anything that the industry might plausibly identify as health insurance—with no regard, in the end, for what state or federal law may have to say about coverage requirements or quality of content and substance. Both

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> * * *
>
> Q: Are they preempted? Are they invalid?
> A: Yes.
> Q: So 689A and 689B in large part, given the things we're talking about, are now invalid?
> A: Yes.
> Q: And that's one of the reasons they don't apply?
> A: Yes.

See **Exhibit 26**, Transcr. Depo. Michael Arrigo, Defense Expert, at 20:16- 21, 24:5- 19; 39:19- 40:1.

experts reduce their analyses to very simple definitions of what they believe "health insurance" is, in the most general sense:

For Mr. Arrigo: Health insurance includes "marketing to make health insurance available, publishing a medical coverage determination policy ('benefits') for medical care, enrollment of those who wish to have these benefits, collecting premiums from insured members, and redistributing funds collected to those members with medical claims ..." See **Exhibit 25**, Arrigo Expert Report, MDC001261.

For Mr. Mulliner: Health insurance is "an employer's plan to offer its employees health benefits, usually as part of a larger benefits package made available by the employer to the employee, and someone to administer the plan through the payment of claims submitted by [employees] under the plan. See **Exhibit 28**, Mulliner Expert Report, MDC001378.

That represents the heart of these expert's opinions. As long as Defendants' Plans met these definitions—which both experts confirmed at deposition they believe impose absolutely no coverage or quality requirements whatsoever—then the experts consider that Defendants have met the mandates of the Minimum Wage Amendment and may pay all the way down to $8.25 per hour. This is what leads Mr. Mulliner to the conclusion that Defendants could have offered merely a dental or a vision plan, by themselves with no additional medical benefits at all, and paid employees $7.25. Dental and vision plans are part of an employer's efforts to make benefits available to employees, and they normally feature an administrator handling enrolled employees' dental claims. Ergo, they are health insurance as Mulliner defines it, and even standing alone could have qualified defendants for the lower tier rate. See **Exhibit 27**, Transcr. Depo. Mulliner, at 41:4 -43:5. This is the logical result of Mulliner and Arrigo's limited, and in the end unhelpful, inquiries. They do not wrestle with whether Defendants' 2010-2015 Plans meet the requirements of Nevada law; they argue instead that the Plans have no need to meet those requirements. The "industry" considers these benefits to be "health insurance," according to these experts, and therefore so does the Minimum Wage Amendment, they maintain.

This is not even a position the "industry" takes on these matters, or these Plans. For example, in responding to a subpoena in this action seeking information on Defendants' health insurance 2014 Plan, Transamerica Life Insurance Company ("Transamerica") stated numerous times in its objections

that "Transamerica does not offer 'health insurance plans, policies, or products;' rather, Transamerica underwrites supplemental health insurance products, including specifically group limited benefit hospital indemnity insurance." (emphasis added) See **Exhibit 30**, a true and accurate copy of Transamerica Life Insurance Company's Response to Subpoena Duces Tecum, at 1-4. Asked about this at his deposition, Mr. Arrigo could not respond:

> Q: It says, "Transamerica does not offer health insurance plans or products."
> A: I have no other opinion on that letter and don't know what the attorneys were thinking who wrote it.
>
> * * *
>
> Q: You pointed to the Transamerica 2014 Plan as a health insurance plan, policy, or product. And they're saying—and this is not just a lawyer—this is his or her client, this is Transamerica Life saying this in a legal paper, that's not health insurance. it's not a hypothetical.
> A: Are you saying an attorney didn't write that?
> Q: It's got nothing to do with it.
> A: I don't know. I have no other opinion on that. It certainly wasn't one of the documents that was given to me to consider in writing my report.
> Q: That's true.
> A: I have no other opinion.
> Q: I'm just pointing out that the actual insurer says it's not health insurance and you say it is. We'll leave it at that. Okay?
> A: Okay.

See **Exhibit 26**, Transcr. Depo. Michael Arrigo, Defense Expert, at 165:24-166:3, 166:13-167:5.

The Court can readily see the determination it needs to make to resolve this motion. With which approach does it concur, that "health insurance" has the meaning assigned to it by law in Nevada, or does it merely appear in the Minimum Wage Amendment as an industry term, and anything that resembles a premiums-and-claims procedure meets its requirements? Everything else is more or less white noise, and none of any of the expert opinions in this case have much import until the Court resolves that question for itself and the parties.

There are, of course, other aspects to the defense experts' opinions. Arrigo, for example, engages in a long exercise attempting to prove that Defendants pay Plaintiffs and the Class so little that it is likely that each one of them qualifies for Medicaid—which in his opinion should mean that Defendants no longer have any obligation to provide health insurance at all, but should still get to pay these workers $7.25 per hour. See **Exhibit 25** at MDC001261.

Mulliner, for his part, tries very hard to characterize Defendants' 2010-2013 Plans as

"individual" rather than "group" insurance plans, despite the definition of "group health insurance" in Nevada law,[13] the identification of Defendants as "Group Policy Holders" on the policies themselves,[14] and the assignment of a "Group Policy Number" to the plans by the insurer.[15] Mulliner does this, presumably, because he thinks individual insurance is subject to different criteria than group insurance under Nevada law, even as he argues that defendants' plans ought not be judged under Nevada law at all. It really does not matter, however; Defendants' Plans fail just as clearly when analyzed under N.R.S. Chapter 689A ("Individual Health Insurance") as they do under Chapter 689B ("Group and Blanket Health Insurance"). Each of the coverage requirements for group plans discussed above under N.R.S. 689B exist for individual plans under 689A, as even a cursory comparison will confirm. The fact is that Defendants plans are group plans; they were arranged for a group (Defendants' minimum wage employees), offered to that group, given group plan treatment by both the insurer and Defendants, and at no time did any of Defendants' employees have the option of negotiating, individually, either the substantive terms of these Plans or with which carrier Defendants contracted to make them available. All of those, coupled with the clear definition of group health insurance found in N.R.S. 689B.020, means Defendants' are group plans and subject to the coverage requirements of N.R.S. Chapter 689B.

In summary, Defendants' experts do very little to assist the Court in understanding the facts and evidence in this case, except to the extent they make crystal clear Defendants' position on the basic dispute in this motion, implausible though it is.

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[13] N.R.S. 689B.020 "Group health insurance" defined; eligible groups and benefits.

1. "Group health insurance" is hereby declared to be that form of health insurance covering groups of two or more persons, formed for a purpose other than obtaining insurance.

[14] See **Exhibit 10** at MDC000692, MDC000702; see also **Exhibit 30** at Diaz_Transamerica000001.

[15] Id.

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VIII. CONCLUSION

Based upon the foregoing, Plaintiffs ask this court to grant the present Motion and render a partial summary judgment order to the effect that Defendants' health benefits plans between 2010 and 2015 do not meet the requirements of Nevada law regulating employer-provided health insurance, and did not qualify them to pay Plaintiffs Diaz, Wilbanks, Olszynski, and Fitzlaff at a rate below $8.25 per hour at any time. The present motion, there, should be granted.

DATED this 18th day of April, 2016.

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
JORDAN BUTLER, ESQ.
Nevada State Bar No. 10531
3556 E. Russell Road, Second Floor
Las Vegas, Nevada 89120
Attorneys for Plaintiffs

CERTIFICATE OF SERVICE

I hereby certify that on this 19th day of April, 2016, a true and correct copy of **PLAINTIFFS' RENEWED MOTION FOR PARTIAL SUMMARY JUDGMENT ON LIABILITY REGARDING DEFENDANTS' HEALTH BENEFITS PLANS** 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

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EXHIBIT 1

EXHIBIT 1

DECL
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Attorneys for Plaintiffs

EIGHTH JUDICIAL DISTRICT COURT

IN AND FOR CLARK COUNTY, STATE OF NEVADA

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

Plaintiffs,

vs.

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

Defendants.

Case No: A-14-701633-C

Dept. No.: XVI

DECLARATION OF BRADLEY SCHRAGER, ESQ. IN SUPPORT OF PLAINTIFFS' RENEWED MOTION FOR PARTIAL SUMMARY JUDGMENT ON LIABILITY REGARDING DEFENDANTS' HEALTH BENEFITS PLANS

DECLARATION OF BRADLEY SCHRAGER, ESQ.

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

1. I am an attorney with the law firm Wolf, Rifkin, Shapiro, Schulman & Rabkin, LLP, duly admitted to practice law in the state of Nevada, and counsel for Plaintiffs in the above-captioned action. I make this declaration of personal, firsthand knowledge and, if called and sworn as a witness, I could and would testify competently thereto. I have personal knowledge of the facts

stated herein and submit this Declaration in support of Plaintiffs' Renewed Motion for Partial Summary Judgment on Liability Regarding Defendants' Health Benefits Plans.

2. Attached, as **Exhibit 2**, is a true and accurate copy of the expert report of Matthew T. Milone, Senior Associate Dean for Legal Affairs at the University of Nevada School of Medicine and longtime practitioner of Nevada and federal health insurance law, and whose curriculum vitae is included with his report.

3. Attached, as **Exhibit 3**, is a true and accurate copy of Defendant MDC Restaurants LLC's Response to Plaintiffs' Interrogatory No. 9.

4. Attached, as **Exhibit 4**, is a true and accurate copy of Defendant Laguna's Restaurants, LLC's Response to Plaintiffs' Interrogatory No. 39.

5. Attached, as **Exhibit 5**, is a true and accurate copy of Defendant Inka, LLC's Response to Plaintiffs' Interrogatory No. 9.

6. Attached, as **Exhibit 6**, is a true and accurate copy of the pertinent portions of Blanca Vallejo's deposition transcript.

7. Attached, as **Exhibit 7**, is a true and accurate copy of Defendant Inka, LLC's Response to Plaintiffs' Interrogatory No. 19.

8. Attached, as **Exhibit 8**, is a true and accurate copy of Defendants' 2010-2012 CIGNA Starbridge Plan, which Defendants produced as MDC000087-000096.

9. Attached, as **Exhibit 9**, is a true and accurate copy of Defendants' 2013 CIGNA Starbridge Plan, which Defendants produced as MDC000097-000120.

10. Attached, as **Exhibit 10**, is a true and accurate copy of Defendants' 2014 Transamerica TransChoice Advance Plan, which Defendants produced as MDC000129-000130 and MDC000686-000757.

11. Attached, as **Exhibit 11**, is a true and accurate copy of Defendants' 2015 Minimum Value Plan, administered by Key Benefits Administrators, which Defendants produced as MDC000770-000777.

12. Attached, as **Exhibit 12**, is a true and accurate copy of the pertinent portions of Yvette Galimore's deposition transcript.

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13. Attached, as **Exhibit 13**, is a true and accurate copy of an email from Colleen Fulton, Defs.' Training Mgr., to Terry DiGiamarino, Payroll Mgr., dated September 25, 2014, which Defendants produced as MDC000664.

14. Attached, as **Exhibit 14**, is a true and accurate copy of Defendants' Initial Disclosures.

15. Attached, as **Exhibit 15**, is a true and accurate copy of an email from Colleen Fulton, Defs.' Training Mgr., to Joe Soraci, dated September 6, 2014, which Defendants produced as MDC000653.

16. Attached, as **Exhibit 16**, is a true and accurate copy of a letter from MDC Restaurants, LLC to all employees, entitled "Urgent Benefit Information", dated December 13, 2013, which Defendants produced as MDC000318-000319.

17. Attached, as **Exhibit 17**, is a true and accurate copy of correspondence from Darren Weidlein, CIGNA Voluntary, New Business Manager, to Blanca Vallejo, Director of HR, Mancha Development Company, dated June 25, 2010, which Defendants produced as MDC000382.

18. Attached, as **Exhibit 18**, is a true and accurate copy of Nevada Division of Insurance, Bulletin No. 13-011 (Dec. 31, 2013).

19. Attached, as **Exhibit 19**, is a true and accurate copy of Nevada Division of Insurance, Bulletin No. 15-001 (Apr. 2, 2015).

20. Attached, as **Exhibit 20**, is a true and accurate copy of the summary of Defendants' CIGNA Starbridge Plan, which Defendants produced as MDC000785-000792.

21. Attached, as **Exhibit 21**, is a true and accurate copy of an email from Colleen Fulton, Defs.' Training Mgr., to All Restaurants, dated January 1, 2015, which Defendants produced as MDC000407.

22. Attached, as **Exhibit 22**, is a true and accurate copy of an email from Jackie Kohorst to Conallee Moss, Mancha Director of HR, dated December 9, 2014, which Defendants produced as MDC000434-000436.

23. Attached, as **Exhibit 23**, is a true and accurate copy of I.R.S. Publication No. 502 for Tax Year 2014.

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24. Attached, as **Exhibit 24**, is a true and accurate copy of emails between Michael Arrigo and Timothy Mulliner, which Defendants produced as MULLINER005051-5052.

25. Attached, as **Exhibit 25**, is a true and accurate copy of Michael Arrigio's Expert Report, which Defendants produced in their Ninth Supplemental Disclosures as MDC001251-001373.

26. Attached, as **Exhibit 26**, is a true and accurate copy of the pertinent portions of Michael Arrigio's deposition transcript.

27. Attached, as **Exhibit 27**, is a true and accurate copy of the pertinent portions of Timothy Mulliner's deposition transcript.

28. Attached, as **Exhibit 28**, is a true and accurate copy of the pertinent portions of Timothy Mulliner's Expert Report, which Defendants produced in their Tenth Supplemental Disclosures as MDC001374-001381.

29. Attached, as **Exhibit 29**, is a true and accurate copy of an email between Defense Counsel and both Mr. Mulliner and Mr. Arrigo, dated March 9, 2016, which Defendants produced as MULLINER0005204.

30. Attached, as **Exhibit 30**, is a true and accurate copy of Transamerica Life Insurance Company's Response to Subpoena Duces Tecum.

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 15th day of April 2016.

/s/ Bradley Schrager
BRADLEY SCHRAGER, ESQ.

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EXHIBIT 2

EXHIBIT 2

EIGHTH JUDICIAL DISTRICT COURT

IN AND FOR CLARK COUNTY, STATE OF NEVADA

PAULETTE DIAZ; LAWANDA GAIL WILBANKS; SHANNON OLSZYNSKI; and CHARITY FITZLAFF, all on behalf of themselves and all similarly-situated individuals, Plaintiffs, vs. MDC RESTAURANTS, LLC; LAGUNA RESTAURANTS, LLC; INKA, LLC; and DOES 1 through 100, Inclusive, Defendants.	Case No.: A701633 Dept. No.: XVI **EXPERT REPORT OF MATTHEW T. MILONE**

I. Overview and Qualifications

I have been retained by Plaintiff to provide this expert report in the case of Diaz, et al v. MDC Restaurants LLC, having Eighth Judicial District Court Case No. A701633 (the "Case"). Plaintiff has requested that I provide expert opinions regarding: (1) the standards that exist to determine what is "health insurance" as that term is used in Article 15, Section 16 of the Nevada Constitution; and (2) analysis of "plan documents" produced in this Case in light of these standards.

I am the current Senior Associate Dean for Legal Affairs of the University of Nevada School of Medicine and have been practicing law in Nevada since December 2000, primarily in the areas of health and insurance law. I am the immediate past chairperson of the Insurance of Health Law Section of State Bar of Nevada, of which I was a founding member. I am also a member of the American Bar Association's Health Law Section, and the American Association of Health Lawyers. I have spoken and written articles regarding insurance and health law with a focus on the requirements of employers to provide health insurance to employees under the

Patient Protection and Affordable Care Act ("ACA"). A full copy of my curriculum vitae identifying my qualifications and experience is attached to this report as exhibit 1.

My opinions in the Case are included in this Report.

II. Nevada's Constitutional Amendment Regarding Minimum Wage

Article XV, Section 16 of the Nevada Constitution provides that an employer earns the privilege of paying employees a minimum wage of $1.00 less than the standard minimum wage if the "employer provides health benefits." Article XV, Section 16 also states that offering health benefits "shall consist of making health insurance available to the employee and the employee's dependents[.]" (Emphasis Added). This report addresses the requirement in Article XV, Section 16 of the Nevada Constitution that "health insurance" be provided to the employee in order for the employer to obtain the benefit of paying a reduced minimum wage and examines the standards that exist to determine whether the various plans in the Case are properly considered "health insurance."

III. Documents Reviewed

In drafting this report, I reviewed documents with Bates labels MDC 000157 ("2010-13 Rate Sheet"), MDC 000087-000096 ("2010-12 Plan"), MDC 000097-000120 ("2013 Plan"), MDC 000121-000128 ("2013 Benefit Summary"), MDC 000686-000750 ("2014 Plan"), MDC 000129-000130 ("2014 Benefit Summary"), MDC 000751-000757 ("2014 Proposal"), MDC 000770-000777 ("2015 Plan"). I reviewed the statutes, regulations and cases identified in this report. I also reviewed: (a) the CMS Actuarial Value Calculator for 2014 & 2015 available at https://www.cms.gov/cciio/resources/regulations-and-guidance/index.html; (b) the NAIC Consumer Alert dated January 2010 available at http://www.naic.org/documents/consumer_alert_high_deductible_plans.htm; (c) the NAIC Uniform Life, Accident, & Health, Annuity and Credit Product Coding Matrix, Effective January 1, 2015, available at http://www.naic.org/documents/industry_pcm_lahac.pdf. I also visited and reviewed the web pages referenced in this report. Such review of web pages, however, was

limited to the information expressly referenced in this report and not a complete review of the page or pages linked to it.

IV. Standards for Determining what is "Health Insurance"

Health insurance, like all insurance in the United States, is a regulated industry. Traditionally, regulation of insurance fell to the states. *See* 15 U.S.C. §§ 1011-1015 (also known as the McCarran Ferguson Act, which exempts state insurance laws from federal regulation). More recently, health insurance has also been subject to federal regulation, in particular reforms to the health insurance marketplace. The primary federal laws that have altered the health insurance marketplace are the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and associated regulations (which reduced the reach pre-existing condition limitations in health insurance policies for persons that did not have a "significant break" between two separate policies of health insurance) and the Patient Protection and Affordable Care Act of 2010 ("ACA") and its associated regulations (which enacted several reforms to the health insurance marketplace to expand available coverage which are discussed in additional detail below).

Because health insurance is a highly regulated industry, determining what is "industry standard" must encompass an assessment of the applicable statutes and regulations. Therefore, analysis of whether a particular plan is "health insurance" requires examination of:

- State insurance laws and regulations;
- Other applicable state laws and regulations;
- Applicable federal laws and regulations;
- The language of the plan itself; and
- Other standards, such as guidance from the National Association of Insurance Commissioners.

A. State Insurance Laws and Regulations for Determining What is Health Insurance

The Nevada Insurance Code is set forth in Title 57 of the Nevada Revised Statutes. This includes chapters from NRS 679A through NRS 697. Several of these chapters potentially apply to health insurance issued in Nevada including: NRS 679A (General Provisions); NRS 680A

(Authorization of Insurers); NRS 686A (Trade Practices); NRS 687B (Contracts of Insurance); NRS 695C (Health Maintenance Organizations); and NRS 695G (Managed Care). When trying to determine what is "health insurance" the most important chapters are NRS 689A, governing individual health insurance, NRS 689B, governing group health insurance, and NRS 689C, governing health insurance for small employers (employers having between 2 and 50 employees).[1]

Most relevant to this case is NRS 689B which identifies the standards for group health insurance issued in Nevada. NRS 689B identifies what is required for an insurance plan that proposes to cover two or more persons in Nevada. Thus, in order to be considered group health insurance under Nevada law, the policy or plan issued must comply with the provisions of NRS 689B.[2] Chapter 689B sets forth various types of requirements of group health insurance policies which include:

- Required coverage provisions – these provisions mandate that certain coverages be included in a policy group health insurance. For example, each Group Health Insurance Policy must include coverage for the cost of receiving the vaccine for the human papillomavirus. NRS 689B.0313.
- Provisions governing reimbursement and payment for certain types of services and providers, such as services of a psychologist or podiatrist.
- Standards for payment of claims.
- Portability of policies (as required by HIPAA).
- Resolution of disputes with the insurer.

Group health insurance has developed in the United States as one of the principal ways that Americans obtain coverage for health related costs. Because group health insurance is so common there are substantial state based laws and regulations to ensure that persons are

[1] The Insurance Savings Clause of ERISA saves all state laws that regulate insurance. *See* 29 U.S.C. § 1144(b)(2)(A). The savings clause protects the Nevada Insurance Code generally and NRS Chapters 689A and 689B specifically, from preemption by ERISA. Thus, the requirements of Nevada law for individual and group health insurance survive preemption. Moreover, because laws regulating insurance are saved from preemption, Nevada may establish what constitutes "health insurance" under Nevada law.

[2] Similarly, NRS 689A identifies what is required of an Individual Insurance Policy issued in Nevada.

receiving at least the minimum coverage as determined by the Nevada Legislature. These minimum requirements are included in NRS 689B.

It is important to note that the Nevada Insurance Code permits sale of products that would not be individual or group "health insurance." These include "Medical Discount Plans" (NRS Chapter 695H) and "Prepaid Limited Benefit Plans" (695F). While such plans may legally be sold, they are not individual or group health insurance because they do not comply with the provisions of NRS 689A and/or NRS 689B.

In this case, review of the required coverage provisions are critical to determine whether the plans offered through Defendant are "health insurance."

B. Other Applicable State Laws and Regulations

NRS Chapter 608 governs wages and compensation paid by employers to employees in Nevada. That chapter includes NRS 608.1555 through NRS 608.1585 which provider certain standards and rules regarding health insurance purchased by an employer for the benefits of its employees. Of relevance to the Case is NRS 608.1555 requires that "benefits for health care" provided by an employer to its employees must be consistent with the benefits required by NRS Chapters 689A and 689B. This statute states:

> **NRS 608.1555 Benefits for health care: Provision in same manner as policy of insurance.** Any employer who provides benefits for health care to his or her employees shall provide the same benefits and pay providers of health care in the same manner as a policy of insurance pursuant to chapters 689A and 689B of NRS.

This statute confirms that employer provided health care benefits in Nevada should comply with the provisions of the Insurance Code (NRS 689A & NRS 689B) that set for the requirements for individual and group health insurance, respectively. In addition requiring the same benefits as required by NRS Chapters 689A and 689B, NRS Chapter 608 mandates that, "if an employer provides health benefits," the employer must provide certain coverage which is set forth in NRS 608.156 through NRS 608.1576.

In addition to the statutory provisions of NRS Chapter 608, NAC 608.102, an interpretive

regulation issued by the Labor Commissioner, the employer must offer a "health insurance plan" in order to earn the privilege identified in Article XV, section 16 of the Nevada Constitution. The "health insurance plan" offered by the employer must cover "those categories of health care expenses that are generally deductible by an employee on his individual federal income tax return pursuant to 26 U.S.C. § 213 and any federal regulations relating thereto, if such expenses had been borne directly by the employee" or be offered pursuant to a Taft-Hartley Trust. *See* NAC 608.102. While an administrative regulation does not carry the same legal force as statute or the Nevada Constitution, it does indicate that the Labor Commissioner interpreted Article XV, Section 16 of the Nevada Constitution to require that the employer provide a "health insurance plan" in order to qualify the privilege allowed by the Constitution.

C. Applicable Federal Laws and Regulations

1. ACA Prohibits Health Insurance which limit Essential Health Benefits

Section 1001 of the ACA (Section 2711 of the Public Health Service Act) forbids a "group health plan and a health insurance issuer" from offering "group or individual health insurance coverage" that has either lifetime limits on coverage or, for plan years beginning after January 1, 2014, annual limits on coverage. *See also* 29 CFR 2590.715-2711(a).[3] The prohibition on

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[3] This regulation provides:

> § 2590.715-2711 No lifetime or annual limits.
>
> (a) *Prohibition*—
>
> (1) *Lifetime limits.* Except as provided in paragraph (b) of this section, a group health plan, or a health insurance issuer offering group health insurance coverage, may not establish any lifetime limit on the dollar amount of benefits for any individual.
>
> (2) *Annual limits*—
>
> (i) *General rule.* Except as provided in paragraphs (a)(2)(ii), (b), and (d) of this section, a group health plan, or a health insurance issuer offering group health insurance coverage, may not establish any annual limit on the dollar amount of benefits for any individual.
>
> (ii) *Exception for health flexible spending arrangements.* A health flexible spending arrangement (as defined in section 106(c)(2) of the Internal Revenue Code) is not subject to the requirement in paragraph (a)(2)(i) of this section.

annual limits applies to all essential health benefits as defined by the ACA. 29 CFR 2590.715-2711(b) & (c). The ACA also enacted several other insurance market reforms that would apply to health insurance covering essential health benefits, these include: no pre-existing condition exclusions, limits on annual cost sharing, limits on annual deductibles, limits on rescission of coverage, and not waiting periods longer than ninety days. Any group health plan issued that does not comply with the market reforms included in the ACA (e.g. issued with lifetime limits after 9/23/10 or annual limits after 1/1/14) is subject to an excise tax of $100 per employee per day. *See* 26 U.S.C § 4980D.

Health insurance made available by an employer to their employees, therefore, must either comply with the market reforms of ACA or subject the employer to the excise tax. Alternatively, an employer may make certain plans available which are considered excepted benefits. These excepted benefits, however, would be supplements to and outside the definition of health insurance. In other words an employer can either: (a) offer health insurance that complies with ACA; (b) pay the excise tax on non-compliant health insurance; or (c) offer excepted benefits, which are not health insurance for essential benefits, usually as a supplement to a health insurance plan.

2. Health Insurance Plans under ACA

The ACA has tiered plans based on the concept of actuarial value. Actuarial value is a calculation through which it is determined the percentage of health care costs that are covered by a health plan. Bronze plans have an actuarial value of 60%-69% (the plan pays 60%-69% of health care costs), silver plans have an actuarial value of 70%-79%, gold plans have an actuarial value of 80%-89%, and platinum plans have an actuarial value of 90% or higher. *See* https://www.healthcare.gov/choose-a-plan/plans-categories/.

In order to avoid the penalties under the ACA Individual Mandate, each person must either have an exception, be covered by Medicare or Medicaid, employer provided coverage that can be offered in the group health insurance market (**in Nevada this means compliance**

with NRS Chapter 689B) or at least a bronze level plan purchased on the exchange.[4] *See* http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families/ACA-Individual-Shared-Responsibility-Provision-Minimum-Essential-Coverage

Therefore, if, after January 1, 2014, a plan offered by to Defendant to its employees does not either comply with NRS Chapter 689B or provide at least "bronze" level coverage, **the employee may still be subject to penalties under the Individual Mandate, even if they purchase the plan from the employer**. *See* http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families/Individual-Shared-Responsibility-Provision. Plans that would not protect an employee from penalties under the individual mandate should not be considered "health insurance coverage" provided by the employer.

D. Plan Language

Health Plans often contain language in the plan itself or in materials explaining the plan that set forth the nature of the plan. Such language may describe the plan as "comprehensive health insurance" or "major medical insurance." Other similar terms could be "health maintenance organization" or a "preferred provider organization" plan. These would be examples of terms within the industry that would generally indicate a "health insurance" plan. After the passage of ACA a "gold" "silver" or "bronze" level plan would also indicate that the plan is "health insurance." By contract a plan that states that it is a "supplement," has "limited benefits," provides "hospital indemnity," or even states that it is "not comprehensive health insurance" would generally indicate that the plan is not health insurance. Plans with such descriptors are usually meant as supplements to health insurance and/or do not have any real value for the beneficiary.

E. Other Industry Standards

1. Transfer of Risk

One of the key concepts of insurance is the transfer of risk. For insurance to truly exist the

[4] The ACA also allows for "Catastrophic" plans in certain instances. Catastrophic plans are plans with an actuarial value of less than 60% that are for persons under 30 years of age who have received a hardship exemption.

risk of one party (the insured or beneficiary) must be transferred to another party (the insurer or plan). Absent the transfer of risk, a product cannot be considered "insurance." Therefore, in reviewing each plan, whether risk is actually transferred should be one of the factors reviewed in determining if a plan should be considered "health insurance."

2. NAIC Guidance on Limited Benefit Plans

In addition to this general standard, the National Association of Insurance Commissioners ("NAIC") is an organization that represents the insurance commissioners of the US states and territories. It often publishes model regulations and standards. Additionally, the NAIC will publish consumer alerts regarding issues that it sees in the marketplace. Relevant to this Case is a "Consumer Alert" issued in January 2010 regarding "Limited Benefit Plans, High Deductible Plans and Health Savings Plans." That alert identifies that limited benefit plans are "intended to supplement comprehensive health insurance plans, not be an alternate to them." The alert also warns that consumers with limited benefit plans "may reach your cap quickly, leaving you responsible for the balance of the bill."

V. Analysis of Plan Documents and Opinions

A. The 2010-12 Plan and the 2013 Plan

The 2010-12 Plan and the 2013 Plan are limited benefit plans also called limited medical plans. This means that the total amount of benefits paid by the plan are limited and there are limits on the specific services that an employee enrolled in the plan. Such plans do not offer the same protection as traditional health insurance as they do not protected the enrolled employee against the costs of managing serious or chronic illness and often do not provide coverage for more than 1-2 days in the hospital.

The 2010-12 Plan contains an annual maximum of $1,250/year for outpatient care paid by the Plan. *See* MDC 000090. This benefit is also subject to a $100.00 deductible (an amount the employee must spend on health care services before the Plan makes any payment) and 80%/20% coinsurance (after the deductible is met the Plan pays 80% of the costs and the

employee pays 20% of the costs). *Id.* The 2010-12 Plan contains an annual maximum of $3,000/year for inpatient care paid by the Plan. *Id.* Surgery is not subject to an annual limit, but the 2010-12 Plan will pay a maximum of $1,500 toward each surgery. *Id.* The 2010-12 Plan only contains benefits for inpatient surgery. *Id.* There is no annual limit for maternity benefits, but the 2010-12 Plan will only pay $1,500 toward costs incurred in each pregnancy. *Id.*

The $3,000 limit for inpatient care includes the both the charges from the hospital itself (facility charges) as well as charges from any physician that treats the employee while he/she is in the hospital (professional charges) and any charges for tests, such as x-rays, while in the hospital (technical charges). *See* MDC 000092. When a person is inpatient in a hospital they will typically generate bills for three types of charges. The first is the hospital or facility charge which is billed by the hospital for the room, equipment, nurse care and other services and supplies provided by the hospital. The second is by any physicians that treat the patient while they are in the hospital, which is called a professional or physician charge. This is billed by the physician or physician group. The third is a technical charge for certain tests such as x-rays or CT Scans. These are billed either by the hospital or the owner/operator of the test. Under a traditional medical insurance plan, there is separate coverage for the hospital charges and the professional charges. By comparison the 2010-12 Plan, there is a single $3,000 limit for all of the services the employee may receive in the hospital in an entire year.

Once the annual maximums are met for a particular service the 2010-12 Plan makes no further payment and the employee is responsible for 100% of the cost of that service for the rest of the year.

The 2010-12 Plan provides no coverage for chiropractic care, treatment of mental or nervous disorders, treatment of substance abuse, home health services (except when in lieu of hospital confinement), and skilled nursing facility charges. MDC 000091-000093.

The 2013 Plan contains similar "benefits" and limitations to the 2010-12 Plan as identified in paragraphs 10-13 above. The one major difference for the 2013 Plan is the reduction of the annual maximum for inpatient care from $3,000 annually (the 2010-12 Plan) to $2,000 annually

(the 2013 Plan). *See* MDC 000102. The 2013 Plan provides in the plan documents that the inpatient benefit provided under the 2013 Plan would pay for approximately 1.07 days in the hospital each year. MDC 000097. The 2013 Plan also contains disclosures that there is no out of pocket limit or maximum for the employee. MDC 000121. Further, in the state specific disclosures for Connecticut, the 2013 Plan provides that it "DOES NOT PROVIDE COMPREHENSIVE MEDICAL COVERAGE" and "IS NOT DESIGNED TO COVER THE COST OF SERIOUS OR CHRONIC ILLNESS." MDC 000117

It is my opinion based on what is set forth above and my experience with health insurance, that the 2010-12 Plan and the 2013 Plan do not provide the benefits mandated by NRS Chapter 608. For example, NRS 608.156 requires an employer to provide treatment for abuse of alcohol and drugs with an outpatient maximum of $1,500/year and an inpatient benefit of $9,000/year. The 2010-12 Plan and the 2013 Plan exclude treatment for abuse of drugs and alcohol. Even if such services were covered the annual outpatient maximum benefit is $1,250 (less than $1,500) and the maximum inpatient benefit is $3,000 under the 2010-12 Plan and $2,000 under the 2013 Plan (less than $9,000).

It is my opinion based on what is set forth above and my experience with health insurance, that the 2010-12 Plan and the 2013 Plan do not provide the "same benefits" as required by NRS Chapter 689B ("Group and Blanket Health Insurance"). The 2010-12 Plan and the 2013 Plan do not contain the required provisions identified in NRS 689B.030 through NRS 689B.0379. For example, and without limitation, the 2010-12 Plan and the 2013 do not contain:

- A provision for benefits from expenses arising from home health care. NRS 689B.030(4). The 2010-12 Plan and the 2013 only provide home health services in lieu of hospital confinement.
- A provision for benefits for the expenses of hospice care. NRS 689B.030(5). The 2010-12 Plan and the 2013 do not include hospice within the definition of hospital and do not otherwise provide for hospice

The 2010-12 Plan and the 2013 Plan cannot meet the coverage requirements of Chapter

689B including, but not limited to, providing a $36,000 annual maximum for Autism Spectrum Disorders (NRS 689B.0335) and $2,500/year in coverage for food products related to metabolic diseases (NRS 689B.0353). These mandated coverage amounts exceed what is available under the limited benefits provided by the 2010-12 Plan and the 2013 Plan.

It is my opinion based on what is set forth above and my experience with health insurance, that the 2010-12 Plan and the 2013 Plan do not cover all of the "categories of health care expenses that are generally deductible by an employee on his individual federal income tax return pursuant to 26 U.S.C. § 213 and any federal regulations relating thereto." *See* NAC 608.102. For example, and without limitation, the 2010-12 Plan and the 2013 Plan do not cover chiropractic care, treatment of mental or nervous disorders, treatment of substance abuse, home health services (except when in lieu of hospital confinement), and skilled nursing facility charges. These services are generally deductible by an employee on his individual federal income tax return pursuant to 26 U.S.C. § 213 and any federal regulations relating thereto.

It is my opinion based on what is set forth above and my experience with health insurance, that the 2010-12 Plan and the 2013 Plan, by their own terms admit that they are not "health insurance." In particular, the 2013 Plan includes the disclaimers that it "DOES NOT PROVIDE COMPREHENSIVE MEDICAL COVERAGE" and "IS NOT DESIGNED TO COVER THE COST OF SERIOUS OR CHRONIC ILLNESS." MDC 000117

It is my opinion based on what is set forth above and my experience with health insurance, that the 2010-12 Plan and the 2013 Plan are the type of limited benefit Plans that the NAIC warned in its January 2010 Consumer Alert are "intended to supplement comprehensive health insurance plans, not be an alternate to them."

B. The 2014 Plan

The 2014 Plan is a "Hospital Indemnity" plan. *See* MDC 000129. A hospital indemnity plan pays the employee a predetermined amount of money in the event that the employee accesses certain health care services. It is different than a traditional health insurance plan in that it does not pay a percentage of health care costs incurred by the employee and does not

pay medical providers for services provided to the employee. Some persons may use a hospital indemnity plan as a supplement to a health insurance plan to cover the costs of deductibles, co-insurance, and copayments.

A hospital indemnity plan is not a substitute for health insurance. Indeed, the 2014 Benefit Summary states that the 2014 Plan is "NOT MAJOR MEDICAL INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL INSURANCE." *See* MDC 000129. The 2014 Proposal contains the same notification that the 2014 is not major medical insurance and is not a substitute for major medical insurance. *See* MDC 000752. Likewise, the 2014 Plan states in the plan documents that it "IS NOT MAJOR MEDICAL INSURANCE AND IS NOT A SUBSITUTE FOR MAJOR MEDICAL INSURANCE." MDC 000692. The same notice is contained again at MDC 000700. Both MDC 000692 and 000700 also state that the 2014 Plan does not qualify as minimum essential coverage under the Patient Protection and Affordable Care Act ("ACA").

The 2014 Plan provides fixed indemnity payments of $100/day for up to 31 days a year. *See* MDC 000702-000703. This $100/day payment would not be sufficient to cover the average daily cost of a hospital stay in Nevada. Nursing homes, extended care facilities, skilled nursing facilities, institutions for the treatment of mental disorders, rest homes, rehabilitation centers, or centers for the treatment of alcohol or drugs are not included in the definition of "hospital" under the 2014 Plan. *See* MDC 000709. Thus, the hospital indemnity benefit under the 2014 Plan would not apply to such services.[5]

The 2014 Plan also offers limited fixed indemnity payments for certain outpatient services including a maximum payment of $200/year for advanced diagnostic tests (such as an MRI or CT Scan), $50/year for other diagnostic tests (such as an x-ray or ultrasound), $20/year for laboratory tests, and $300/year for doctor office visits. The 2014 Plan offers limited fixed indemnity payments for certain surgical services including a maximum payment of $500/year

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[5] The 2014 Plan does include a benefit of $100/day for up to 31 days in a year and 60 days in a lifetime for an inpatient stay at a facility that treats mental and nervous disorders and an inpatient stay for the treatment for addiction to alcohol and drugs. *See* MDC 000702.

for an inpatient surgery (plus $100 for anesthesia), $250/year for outpatient surgery (plus $50 for anesthesia), and $50/year for "minor" outpatient surgery (plus $10 for anesthesia).

The employee is responsible for payment of all health care costs in excess of the indemnity payment. Thus any costs for a 1 day hospital stay in excess of $100 would be paid by the employee, regardless of the additional amount. Similarly any costs for an outpatient surgery in excess of $250 for the surgery and $50 for the anesthesia would be paid by the employee regardless of the additional amount.

The 2014 Plan provides no benefits whatsoever for care in the emergency room of a hospital, ambulance services, rehabilitative care and treatments, immunization shots, or routine examinations such as mammograms or pap smears. *See* MDC 000710 and MDC 000714.

The 2014 Plan includes a "portability option" identified on MDC 000712. This portability option, however, is inconsistent with benefits under the Consolidated Omnibus Budget Reconciliation Act of 1985 (known as "COBRA"). COBRA allows for an employee to obtain coverage within sixty (60) days of a qualifying event at a costs of 102% of the full premium cost of the plan. *See* http://www.dol.gov/ebsa/faqs/faq-consumer-cobra.html. The 2014 Plan only allows for a 31 day election period and the premium would include unstated "administrative cost." *See* MDC 000712. Thus, the 2014 Plan does not include COBRA benefits which are generally included in all health insurance for entities having 20 or more employees. *See* http://www.dol.gov/ebsa/faqs/faq-consumer-cobra.html.

It is my opinion based on what is set forth above and my experience with health insurance, that the 2014 Plan does not provide the benefits mandated by NRS Chapter 608. For example, NRS 608.156 requires an employer to provide treatment for abuse of alcohol and drugs with an outpatient maximum of $1,500/year and an inpatient benefit of $9,000/year. The 2014 Plan contains no outpatient benefit for treatment for abuse of alcohol and drugs and a maximum inpatient benefit of $3,100.

It is my opinion based on what is set forth above and my experience with health

insurance, that the 2014 Plan does not provide the "same benefits" as required by NRS Chapter 689B ("Group and Blanket Health Insurance"). The 2014 Plan does not contain the required provisions identified in NRS 689B.030 through NRS 689B.0379. For example, and without limitation, the 2015 Plan does not contain:

- A provision for benefits from expenses arising from home health care. NRS 689B.030(4). The 2014 Plan does not provide any benefit for home health services. MDC 000702-000703.
- A provision for benefits for the expenses of hospice care. NRS 689B.030(5). The 2014 Plan does not include hospice within the definition of hospital and excludes all rest care. MDC 000709 and MDC 000714.
- A provision providing coverage for the human papillomavirus vaccine. NRS 689B.0313. The 2014 Plan does not provide benefits for vaccinations. MDC 000714.
- A provision covering costs related to self-management of diabetes. *See* NRS 689B.0357. The 2014 Plan does not provide an indemnity benefit for self-management of diabetes. MDC 000702-000703.

The 2014 Plan cannot meet the coverage requirements of Chapter 689B including, but not limited to, providing a $36,000 annual maximum for Autism Spectrum Disorders (NRS 689B.0335) and $2,500/year in coverage for food products related to metabolic diseases (NRS 689B.0353). These mandated coverage amounts exceed what is available as indemnity benefits under the 2014 Plan.

It is my opinion based on what is set forth above and my experience with health insurance, that based on the coverage provided by the 2014 Plan, the 2014 Plan does not cover all of the "categories of health care expenses that are generally deductible by an employee on his individual federal income tax return pursuant to 26 U.S.C. § 213 and any federal regulations relating thereto." *See* NAC 608.102. For example, and without limitation, the 2014 Plan does not cover emergency room of a hospital, ambulance services, rehabilitative care and

treatments, immunization shots, or routine examinations such as mammograms or pap smears. MDC 000710 and 000714. These services are generally deductible by an employee on his individual federal income tax return pursuant to 26 U.S.C. § 213 and any federal regulations relating thereto.

As a hospital indemnity plan, the 2014 Plan would be an excepted benefit and outside of what is considered health insurance for essential benefits under the ACA. Further, if the 2014 had not been excluded from the definition of Group Health Insurance, Defendant would be subject to an excise tax penalty of $100/employee/day because the 2014 Plan does not comply with ACA's health insurance market reforms prohibiting limited benefits.

It is my opinion that because it is either a non-compliant plan under ACA or an excepted benefit plan, the 2014 Plan, even if purchased by the employee, would not prevent the employee from being subject to penalties under the ACA individual mandate. *See* http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families/Individual-Shared-Responsibility-Provision.

It is my opinion based on what is set forth above and my experience with health insurance, that the 2014 Plan, by its own terms admits that it is not "health insurance." In particular, the 2014 Plan includes the disclaimer that it is "NOT MAJOR MEDICAL INSURANCE AND IS NOT A SUBSITUTE FOR MAJOR MEDICAL INSURANCE." *See* MDC 000129

It is my opinion based on what is set forth above and my experience with health insurance, that the 2014 Plan is the type of limited benefit Plans that the NAIC warned in its January 2010 Consumer Alert are "intended to supplement comprehensive health insurance plans, not be an alternate to them."

C. The 2015 Plan

The 2015 Plan is referred to as an "ACA Minimum Value Plan." *See* MDC 000772. This term is inaccurate, as the 2015 Plan is not similar to plans permitted under the ACA. The 2015 Plan provides NO coverage whatsoever for inpatient hospital stays, surgery, ambulatory surgery center charges, mental health, substance abuse treatment, rehabilitative services, ambulance

services, chiropractic care, infusion, chemotherapy, injections, skilled nursing facility charges, or any facility charges of any kind. *See* MDC 000772-000775. These are all health care services that are typically covered by "health insurance."

The 2015 Plan provides benefits for physician office visits (as long as no surgery is performed) and diagnostic tests performed on an outpatient basis. The 2015 Plan also has an emergency room benefit, however, that benefit does not apply if the employee is required to spend more than 23 hours in the hospital or is admitted to the hospital from the ER for treatment/evaluation. *See* MDC 000772-000775. Further, any ambulance to the emergency room would not be covered. *See* MDC 000774. These coverage limitations are not consistent with health insurance offered through the exchange under the ACA or health insurance generally.

The ACA has tiered plans based on the concept of actuarial value. Actuarial value is a calculation through which it is determined the percentage of health care costs that are covered by a health plan. Bronze plans have an actuarial value of 60%-69% (the plan pays 60%-69% of health care costs), silver plans have an actuarial value of 70%-79%, gold plans have an actuarial value of 80%-89%, and platinum plans have an actuarial value of 90% or higher. *See* https://www.healthcare.gov/choose-a-plan/plans-categories/. The ACA also allows for "Catastrophic" plans in certain instances. Catastrophic plans are plans with an actuarial value of less than 60% that are for persons under 30 years of age who have received a hardship exemption. *See* https://www.healthcare.gov/choose-a-plan/catastrophic-plans/.

The Centers for Medicare and Medicaid Services ("CMS") provides an Actuarial Value Calculator that can be used to calculate the actuarial value of certain plans. The CMS Actuarial Value Calculator for 2015 is available at https://www.cms.gov/cciio/resources/regulations-and-guidance/index.html. The CMS Actuarial Value Calculator does not consider premium cost in determining actuarial value.

The CMS Actuarial Value Calculator for 2015 **will not even allow a calculation for the 2015 Plan** because: (a) The CMS Actuarial Value Calculator requires an out of pocket maximum

of $6850 or less for hospitalizations, the 2015 Plan has no out of pocket maximum for hospitalizations because it is not covered; (b) the CMS Actuarial Value Calculator has fields for surgery, surgical centers, rehabilitation services and skilled nursing which cannot be completed because the 2015 Plan does not provide coverage for any of these services; and (c) the CMS Actuarial Value Calculator requires an out of pocket maximum for out of network services of $6850 or less, the 2015 Plan has no out of pocket limit.

Therefore, because the 2015 Plan does not comply with NRS Chapter 689B and does not provide at least "bronze" level coverage it is my opinion that the 2015 Plan, even if purchased by the employee, would not prevent the employee from being subject to penalties under the ACA individual mandate. *See* http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families/Individual-Shared-Responsibility-Provision.

Further, it is my opinion based on what is set forth above and my experience with health insurance, that the 2015 Plan does not provide the benefits mandated by NRS Chapter 608. For example, NRS 608.156 requires an employer to provide treatment for abuse of alcohol and drugs with an outpatient maximum of $1,500/year and an inpatient benefit of $9,000/year. The 2015 Plan excludes treatment of alcohol and substance abuse.

It is my opinion based on what is set forth above and my experience with health insurance, that the 2015 Plan does not provide the "same benefits" as required by NRS Chapter 689B ("Group and Blanket Health Insurance"). The 2015 Plan does not contain the required provisions identified in NRS 689B.030 through NRS 689B.0379. For example, and without limitation, the 2015 Plan does not contain:

- A provision for benefits from expenses arising from home health care. NRS 689B.030(4). The 2015 Plan does not provide for home health services. MDC 000772-000775.
- A provision for benefits for the expenses of hospice care. NRS 689B.030(5). The 2015 Plan excludes all facility charges. MDC 000774.
- A provision providing for drugs for the treatment of cancer. NRS 689B.0365.

The 2015 Plan excludes infusion, chemotherapy and radiation (MDC 000774) as well as specialty drugs (MDC 000772).

It is my opinion based on what is set forth above and my experience with health insurance, that based on the coverage provided by the 2015 Plan, the 2015 Plan does not cover all of the "categories of health care expenses that are generally deductible by an employee on his individual federal income tax return pursuant to 26 U.S.C. § 213 and any federal regulations relating thereto." *See* NAC 608.102.

For example, and without limitation, the 2015 Plan does not cover for inpatient hospital stays, surgery, ambulatory surgery center charges, mental health, substance abuse treatment, rehabilitative services, ambulance services, chiropractic care, infusion, chemotherapy, injections, skilled nursing facility charges, or any facility charges of any kind. *See* MDC 000772-000775. These services are generally deductible by an employee on his individual federal income tax return pursuant to 26 U.S.C. § 213 and any federal regulations relating thereto.

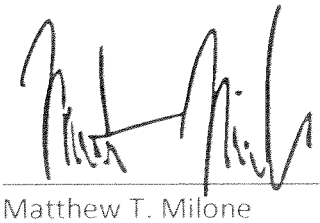
VI. Expert Disclosures

A copy of my curriculum vitae is attached to this report as exhibit 1.

My rates in this matter are $350.00 for testimony and $275.00 for all other work.

I have provided Declarations in this Case as well as the cases of *Leoni v. Terrible Herbst, Inc.*, EJDC Case No. A-14-704428-C, *Hanks v. Briad Restaurant Group, LLC*, USDC Case No. 2:14-cv-00786 and *Tyus v. Wendy's of Las Vegas, Inc.*, USDC Case No. 2:14-cv-00729 in 2015. I have not provided any other expert testimony or reports in the past five (5) years.

Dated this 12th day of October 2015



Matthew T. Milone

Exhibit 1

Exhibit 1

MATTHEW T. MILONE
Matthew.T.Milone@gmail.com

Admissions:

Nevada Supreme Court 2000
Nevada Federal Courts 2001
U.S. Court of Appeals, Ninth Circuit 2002
U.S. Court of Appeals, Fourth Circuit 2011

Employment Experience:

University of Nevada School of Medicine, Senior Associate Dean of Legal Affairs
Reno, Nevada 2013-Present

Holland & Hart LLP, Partner, Insurance & Health Law Practice
Las Vegas, Nevada 2012-2013

Jones Vargas Law Firm, Associate/Shareholder
Las Vegas, Nevada 2004-2012

The Law Firm of Wadhams & Akridge, Associate
Las Vegas, Nevada 2000-2004

Education

Tulane Law School, J.D. *cum laude* with Certificate in Sports Law
New Orleans, Louisiana May 2000

Georgetown University, A.B. in Theology and Government
Washington, D.C. May 1997

Publications

The State Bar of Nevada's Insurance and Health Law Section: On the Forefront of the Law, Nevada Lawyer August 2014

Ownership of Medical Practices After the Affordable Care Act from *Inside the Minds: Health Care Law Enforcement and Compliance*, Aspatore Books 2013

Preparing for the Affordable Care Act, Nevada Business November 1, 2013

Overview of Health Care Reform from *Health Care Reform for Employers: Now What?*, Lorman Education August 2013

No._____
(Clark County District Court No. A-14-701633-C)

In the Supreme Court of the State of Nevada

MDC RESTAURANTS, LLC; LAGUNA RESTAURANTS, LLC; AND INKA, LLC,

Defendants and Petitioners,

VS.

EIGHTH JUDICIAL DISTRICT COURT OF THE STATE OF NEVADA IN AND FOR THE COUNTY OF CLARK; THE HONORABLE TIMOTHY C. WILLIAMS, DISTRICT JUDGE

Respondents,

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

Plaintiffs and Real Parties in Interest.

APPENDIX TO PETITION FOR WRIT OF MANDAMUS OR OTHER EXTRAORDINARY RELIEF
VOLUME 1 OF 6

REQUEST FOR TEMPORARY STAY

Petition From an Order Deeming Petitioners' Health Benefits Plans Invalid Under Article XV, Section 16(A) of the Nevada Constitution

MORRIS POLICH & PURDY LLP
Nicholas M. Wieczorek, No. 6170
Deanna L. Forbush, No. 6646
Jeremy J. Thompson, No. 12503
3800 Howard Hughes Parkway, Suite 500
Las Vegas, Nevada 89169
Telephone: (702) 862-8300

Attorneys for Defendants and Petitioners
MDC RESTAURANTS, LLC; LAGUNA RESTAURANTS, LLC; INKA, LLC.

Chronological Index

Alphabetical Index

CIVIL COVER SHEET

A-14-701633-C

Clark County, Nevada

XV

Case No. _____
(Assigned by Clerk's Office)

I. Party Information

Plaintiff(s) (name/address/phone): PAULETTE DIAZ, an individual; and LAWANDA GAIL WILBANKS, an individual, on behalf of themselves and all similarly-situated individuals Attorney (name/address/phone):Don Springmeyer, Esq., Wolf, Rifkin, Shapiro, Schulman & Rabkin, LLP, 3556 E. Russell Rd, 2nd Floor, Las Vegas, NV, 89120, (702) 341-5200	Defendant(s) (name/address/phone): 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 Attorney (name/address/phone):

II. Nature of Controversy (Please check applicable bold category and applicable subcategory, if appropriate)

☐ **Arbitration Requested**

Civil Cases

Real Property

- ☐ **Landlord/Tenant**
  - ☐ Unlawful Detainer
- ☐ **Title to Property**
  - ☐ Foreclosure
  - ☐ Liens
  - ☐ Quiet Title
  - ☐ Specific Performance
- ☐ **Condemnation/Eminent Domain**
- ☐ **Other Real Property**
  - ☐ Partition
  - ☐ Planning/Zoning

Torts

Negligence

- ☐ **Negligence – Auto**
- ☐ **Negligence – Medical/Dental**
- ☐ **Negligence – Premises Liability** (Slip/Fall)
- ☐ **Negligence – Other**

- ☐ **Product Liability**
  - ☐ Product Liability/Motor Vehicle
  - ☐ Other Torts/Product Liability
- ☐ **Intentional Misconduct**
  - ☐ Torts/Defamation (Libel/Slander)
  - ☐ Interfere with Contract Rights
- ☐ **Employment Torts** (Wrongful termination)
- ☐ **Other Torts**
  - ☐ Anti-trust
  - ☐ Fraud/Misrepresentation
  - ☐ Insurance
  - ☐ Legal Tort
  - ☐ Unfair Competition

Probate

Estimated Estate Value: _____

- ☐ **Summary Administration**
- ☐ **General Administration**
- ☐ **Special Administration**
- ☐ **Set Aside Estates**
- ☐ **Trust/Conservatorships**
  - ☐ Individual Trustee
  - ☐ Corporate Trustee
- ☐ **Other Probate**

Other Civil Filing Types

- ☐ **Construction Defect**
  - ☐ Chapter 40
  - ☐ General
- ☐ **Breach of Contract**
  - ☐ Building & Construction
  - ☐ Insurance Carrier
  - ☐ Commercial Instrument
  - ☐ Other Contracts/Acct/Judgment
  - ☐ Collection of Actions
  - ☐ Employment Contract
  - ☐ Guarantee
  - ☐ Sale Contract
  - ☐ Uniform Commercial Code
- ☐ **Civil Petition for Judicial Review**
  - ☐ Foreclosure Mediation
  - ☐ Other Administrative Law
  - ☐ Department of Motor Vehicles
  - ☐ Worker's Compensation Appeal

- ☐ **Appeal from Lower Court** (also check applicable civil case box)
  - ☐ Transfer from Justice Court
  - ☐ Justice Court Civil Appeal
- ☐ **Civil Writ**
  - ☐ Other Special Proceeding
- ☒ **Other Civil Filing**
  - ☐ Compromise of Minor's Claim
  - ☐ Conversion of Property
  - ☐ Damage to Property
  - ☐ Employment Security
  - ☐ Enforcement of Judgment
  - ☐ Foreign Judgment – Civil
  - ☐ Other Personal Property
  - ☐ Recovery of Property
  - ☐ Stockholder Suit
  - ☒ Other Civil Matters

III. Business Court Requested (Please check applicable category; for Clark or Washoe Counties only.)

- ☐ NRS Chapters 78-88
- ☐ Commodities (NRS 90)
- ☐ Securities (NRS 90)
- ☐ Investments (NRS 104 Art. 8)
- ☐ Deceptive Trade Practices (NRS 598)
- ☐ Trademarks (NRS 600A)
- ☐ Enhanced Case Mgmt/Business
- ☐ Other Business Court Matters

May 30, 2014
Date

/s/ Don Springmeyer
Signature of initiating party or representative

See other side for family-related case filings.

0001

COMJD
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Attorneys for Plaintiffs

EIGHTH JUDICIAL DISTRICT COURT

IN AND FOR CLARK COUNTY, STATE OF NEVADA

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

Plaintiffs,

vs.

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

Defendants.

Case No: A-14-701633-C

Dept. No.: XV

CLASS ACTION COMPLAINT

The above-referenced Plaintiffs (herein "Plaintiffs") through undersigned counsel, on behalf of themselves and all persons similarly situated, complain and allege as follows:

INTRODUCTION

1. This lawsuit is an individual and class action brought by Plaintiffs, on behalf of themselves and all similarly-situated employees of MDC RESTAURANTS, LLC; LAGUNA RESTAURANTS, LLC; and INKA, LLC ("MDC," "Laguna," "Inka," and, collectively,

"Defendants"), owners and operators of Denny's and CoCo's restaurants (the "Restaurants") in Nevada.

2. This lawsuit is a result of the Defendants' failure to pay Plaintiffs and other similarly-situated employees who are members of the Class the lawful minimum wage, because the Defendants have improperly claimed eligibility to compensate employees at a reduced minimum wage rate under Nev. Const. art. XV, § 16.

3. At the 2006 General Election, Nevada voters approved, for the second time, a constitutional amendment regarding the minimum wage to be paid to all Nevada employees.[1] The amendment became effective in November, 2006, and was codified as new Article XV, § 16 of the Nevada Constitution.

4. The 2006 amendment guaranteed to each Nevada employee, with very few exceptions, a particular hourly wage: "Each employer shall pay a wage to each employee of not less than the hourly rates set forth in this section. The rate shall be five dollars and 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."

5. The amendment contained an index/increase mechanism, such that since 2010 the Nevada minimum wage level is $7.25 per hour if the employer provides qualifying health benefits, or $8.25 per hour if the employer does not provide such qualifying health benefits. Employers, like Defendants, who claim eligibility to pay the reduced wage rate, therefore, can pay employees up to 12.2% less than workers paid at the $8.25 level.

6. The public policy underlying the minimum wage amendment was to benefit Nevada's minimum wage employees, and to incentivize employers to provide low-cost, comprehensive health insurance benefits to the state's lowest-paid workers.

7. The opportunity to compensate employees at a level beneath the standard minimum wage rate is a privilege offered to employers by the voters of Nevada. Employers must qualify for that privilege by providing, offering, and maintaining health insurance plans for their employees

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[1] See Exhibit 1 here attached, a true and correct copy of the text of Nev. Const. art. XV, § 16.

that meet very specific regulatory standards.

8. In order to qualify to pay employees at a reduced minimum wage rate, the health insurance benefits plan provided, offered, and/or maintained must be truly comprehensive in its coverage, and cover "those categories of health care expenses that are generally deductible by an employee on his/her individual federal income tax return pursuant to 26 U.S.C. § 213 and any federal regulations relating thereto, if such expenses had been borne directly by the employee." N.A.C. 608.102(1)(a).

9. Furthermore, the cost of health insurance benefit premiums for the employee, and all his or her dependents, may not exceed "10 percent of the employee's gross taxable income from the employer." Nev. Const. art. XV, § 16.

10. Failure to meet the specific requirements that establish a qualified health insurance benefits plan means that the employer forfeits the right to pay employees at anything less than the full minimum wage rate under Nev. Const. art. XV, § 16, currently $8.25 per hour.

11. Defendants here pay Plaintiffs and members of the Class at an hourly rate below $8.25 per hour.

12. Defendants do not provide, offer, and/or maintain qualifying health insurance plan benefits for the benefit of Plaintiffs and members of the Class. In the case of named Plaintiffs, Defendants have failed to offer any health benefit plans at all, and therefore can claim no basis for paying Plaintiffs less than $8.25 per hour at any time.

13. Defendants are not, and have not been, eligible to pay Plaintiffs and members of the Class at the reduced minimum wage rate. They have forfeited the privilege extended to it under Article XV, § 16. Instead, they now owe back pay and damages to all employees they have unlawfully underpaid since passage of the minimum wage amendment in 2006.

PARTIES

A. Plaintiffs

14. Plaintiff Paulette Diaz is a resident of Oregon, and worked as a server at numerous Denny's and CoCo's restaurants owned and operated by Defendants in Clark County, Nevada between April 2010 and September 2013. Her wage was $7.25 per hour. She has two dependents.

15. Plaintiff Lawanda Gail Wilbanks is a resident of Nevada, and worked as a server at a Denny's restaurant owned and operated by Defendants in Clark County, Nevada between June 2011 and January 2013. Her wage was $7.25 per hour. She has one dependent.

B. Defendants

16. Plaintiffs are informed and believe and thereon allege that at all times material hereto Defendant MDC RESTAURANTS, LLC, was and is a Nevada limited liability company, and it and any subsidiaries or affiliated companies were and are engaged in the ownership and operation of franchise and non-franchise restaurants located in Clark County and throughout Nevada. Upon information and belief, this Defendant owns and operates approximately thirteen Denny's restaurants in Clark County and elsewhere in Nevada, employed Plaintiffs and/or employed and employs Class members, and is conducting business in good standing in the State of Nevada. Its sole listed officer is manager Vince Eupierre.

17. Plaintiffs are informed and believe and thereon allege that at all times material hereto Defendant LAGUNA RESTAURANTS, LLC, was and is a Nevada limited liability company, and it and any subsidiaries or affiliated companies were and are engaged in the ownership and operation of franchise and non-franchise restaurants located in Clark County and throughout Nevada. Upon information and belief, this Defendant owns and operates approximately four Denny's and CoCo's restaurants in Clark County and elsewhere in Nevada, employed Plaintiffs and/or employed and employs Class members, and is conducting business in good standing in the State of Nevada. Its sole listed officer is manager Vince Eupierre.

18. Plaintiffs are informed and believe and thereon allege that at all times material hereto Defendant INKA, LLC, was and is a Nevada limited liability company, and it and any subsidiaries or affiliated companies were and are engaged in the ownership and operation of franchise and non-franchise restaurants located in Clark County and throughout Nevada. Upon information and belief, this Defendant owns and operates approximately three Denny's restaurants in Clark County and elsewhere in Nevada, employed Plaintiffs and/or employed and employs Class members, and is conducting business in good standing in the State of Nevada. Its two listed officers are managers Vince Eupierre and Joseph Soraci.

19. Plaintiffs sue fictitious Defendants DOES 1 through 100, inclusive, as Plaintiffs do not know their true names and/or capacities, and upon ascertainment, will amend the Complaint with their true names and capacities. Plaintiffs are informed and believe and on that basis allege that each of said fictitiously named Defendants is responsible in some manner for the occurrences herein alleged, and that Plaintiffs' damages were proximately caused by their conduct mentioned herein, each of the Defendants, including DOES 1 through 100, was an agent, joint-venturer, representative, alter ego, and/or employee of the other defendants, and was acting both individually and in the course and scope of said relationship at the time of the events herein alleged, and all aided and abetted the wrongful acts of the others.

JURISDICTION AND VENUE

20. This Court has subject matter jurisdiction over this action pursuant to Nev. Const, art. XV, § 16(B).

21. Venue is proper because acts giving rise to the claims of the Plaintiffs herein occurred within this judicial district, and all Defendants regularly conduct business in and have engaged and continue to engage in the wrongful conduct alleged herein—and, thus, are subject to personal jurisdiction—in this judicial district.

GENERAL ALLEGATIONS

A. Plaintiffs' Allegations

22. Plaintiff Diaz worked as a server at Denny's and CoCo's restaurants owned and operated by Defendants in Clark County, Nevada, where she earned $7.25 per hour, below the constitutional minimum wage under Nev. Const. art XV, § 16 of $8.25 per hour.

23. Ms. Diaz was never offered a company health insurance plan at all, much less a plan that would qualify Defendants for the constitutional privilege of paying less than the full hourly minimum hourly wage rate per Nev. Const. art. XV, § 16.

24. Defendants, therefore, were unlawfully paying Ms. Diaz a sub-minimum wage for the entirety of her employment.

25. Plaintiff Wilbanks worked as a server at a Denny's restaurant owned and operated by Defendants in Clark County, Nevada, where she earned $7.25 per hour, below the

constitutional minimum wage under Nev. Const. art XV, § 16 of $8.25 per hour.

26. Ms. Wilbanks was never offered a company health insurance plan at all, much less a plan that would qualify Defendants for the constitutional privilege of paying less than the full hourly minimum hourly wage rate per Nev. Const. art. XV, § 16.

27. Defendants, therefore, were unlawfully paying Ms. Wilbanks a sub-minimum wage for the entirety of her employment

B. Defendants' Control of the Restaurants

28. Defendants maintain control, oversight, and direction over the operation of the Restaurants, including their employment and/or labor practices.

29. Defendants (i) create uniform wage and benefit policies and practices for use at the Restaurants, (ii) impose uniform wage and benefit policies and practices at the Restaurants, and (iii) maintain centralized human resource functions which implement wage and benefit policies and practices at the Restaurants.

30. Defendants have common ownership and management and, upon information and belief, formulate and execute uniform human resource and benefit policies affecting Plaintiffs and members of the Class.

C. Defendants' Unlawful Minimum Wage Practices

31. Defendants paid Plaintiffs and members of the Class for many years at a reduced minimum wage rate pursuant to Nev. Const. art. XV, § 16.

32. Defendants do not provide, offer, and/or maintain health insurance plan benefits that meet necessary requirements in order to qualify to pay Plaintiffs and members of the Class at the reduced minimum wage level.

33. Defendants, therefore, have been unlawfully paying all Class members a sub-minimum wage during employment at the Restaurants.

34. Defendants are aware of, and perpetuate, this ongoing violation of Nevada's constitutional provision regarding minimum wage, and associated regulatory provisions implementing same.

35. As a result, pursuant to Nev. Const. art. XV, § 16, Plaintiffs and the members of the

Class are owed back pay and damages for every hour worked during the applicable period.

CLASS ACTION ALLEGATIONS

36. Plaintiffs re-allege and incorporate herein by this reference all the paragraphs above in this Complaint as though fully set forth herein.

37. Plaintiffs bring this action pursuant to N.R.C.P. 23 on behalf of themselves and all others similarly situated, as representative members of the following proposed Class:

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

38. Numerosity: The members of the proposed Class are so numerous that individual joinder of all members is impracticable under the circumstances of this case, and the disposition of their claims as a Class will benefit the parties and the Court. The precise number of members should be readily available from a review of Defendants' personnel, payroll, and benefits records, and upon information and belief numbers in the thousands.

39. Commonality/Predominance: Common questions of law or fact are shared by the members of the proposed Class. This action is suitable for class treatment because these common questions of fact and law predominate over any questions affecting individual members. These common legal and factual questions, include, but are not limited to, the following:

i. Whether Defendants paid Class members the required minimum wage pursuant to the Nevada Constitution;

ii. Whether, when paying minimum wage employees the reduced minimum wage level pursuant to Nev. Const. art. XV, § 16, Defendants provided qualifying health insurance benefit plans, with appropriate coverage and at appropriate premium cost, to the members of the Class;

iii. The applicable statute of limitations, if any, for Plaintiffs' and Class members' claims;

iv. Whether Defendants are liable for pre-judgment interest; and

v. Whether Defendants are liable for attorneys' fees and costs.

40. Typicality: Plaintiffs' claims 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. Plaintiffs and all other proposed Class members sustained similar losses, injuries, and damages as a direct and proximate result of Defendants' same unlawful policies and/or practices. Plaintiffs' claims arise from Defendants' same unlawful policies, practices, and/or course of conduct as all other proposed Class members' claims in that Plaintiffs were denied lawful wages for hours worked, and Plaintiffs' legal theories are based on the same legal theories as all other proposed Class members. Defendants' compensation and benefit policies and practices affected all Class members similarly, and Defendants benefited from the same type of unfair and/or wrongful acts done to each Class member.

41. Adequacy: Plaintiffs are adequate representatives of the proposed Class because Plaintiffs are members of the proposed Class they seek to represent and their interests do not conflict with the interests of the other members of the proposed Class that Plaintiffs seek to represent. Plaintiffs have retained counsel that is competent and experienced in complex class action litigation, and Plaintiffs intend to prosecute this action vigorously. The interests of members of the proposed Class will be fairly and adequately protected by Plaintiffs and their counsel. Neither Plaintiffs nor their counsel have interests that are contrary to, or conflicting with, the interests of the proposed Class.

42. Superiority: A class action is superior to other available methods for the fair and efficient adjudication of the controversy, because, inter alia, as minimum wage employees it is economically infeasible for proposed Class members to prosecute individual actions of their own given the relatively small amount of damages at stake for each individual. Important public interests will be served by addressing the matter as a class action. The cost to the court system and the public for the adjudication of individual litigation and claims would be substantial and substantially more than if the claims are treated as a class action. Prosecution of separate actions by individual Class members would create a risk of inconsistent and/or varying adjudications with respect to the individual members of the Class, establishing incompatible standards of conduct for Defendants and resulting in the impairment of Class members' rights and the disposition of their

interests through actions to which they were not parties. The issues in this action can be decided by means of common, class-wide proof. In addition, if appropriate, the Court can and is empowered to, fashion methods to efficiently manage this action as a class action.

43. The case will be manageable as a class action. Plaintiffs and their counsel know of no unusual difficulties in the case, and Defendants have advanced networked computer, payroll, and benefit systems that will allow the class, wage, benefits, and damages issues in the case to be resolved with relative ease.

44. Because the elements of Rule 23(b)(3), or in the alternative Rule 23(c)(4), are satisfied in the case, class certification is appropriate.

FIRST CLAIM FOR RELIEF

Violation of Nev. Const. art. XV, § 16

Failure to Pay Lawful Minimum Wage

(On Behalf of Plaintiffs and the Class against Defendants)

45. All preceding paragraphs in this Complaint are re-alleged and incorporated by reference as though fully set forth herein.

46. As described and alleged herein, Defendants pay, and have paid, Plaintiffs and members of the Class at a reduced minimum wage level pursuant to Nev. Const. art XV, § 16 without providing qualifying health insurance benefits as required by that provision.

47. Defendants are not, and/or were not, eligible to pay Plaintiffs and members of the Class at a reduced minimum wage during any period where qualifying benefits were not provided by Defendants.

48. Pursuant to Nev. Const. art XV, § 16, Defendants are liable to Plaintiffs and members of the Class for their unpaid wages for any period during which Defendants were ineligible to compensate Plaintiffs and members of the Class at a reduced minimum wage; an award of damages; costs of the action; reasonable attorneys' fees; and any other relief deemed appropriate by this Court.

///

///

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs, on behalf of themselves and all other similarly-situated members of the Class, request that this Court enter an Order:

A. Certifying this matter as a class action pursuant to N.R.C.P. 23, designating Plaintiffs as Class representatives, and appointing the undersigned as Class counsel;

B. Declaring the practices here complained of as unlawful under appropriate law;

C. Granting judgment to Plaintiffs and the members of the Class on their claims of unpaid wages as secured by law, as well as damages, interest, attorneys' fees and costs as applicable and appropriate;

D. Granting punitive and exemplary damages against the Defendants pursuant to law; and

E. Ordering such other relief as the Court may deem necessary and just.

JURY TRIAL DEMAND

Pursuant to Rule 38(b) of the Nevada Rules of Civil Procedure, Plaintiffs demand a trial by jury on all issues so triable.

DATED this 30th day of May, 2014.

WOLF, RIFKIN, SHAPIRO,
SCHULMAN & RABKIN, LLP

By: /s/ Don Springmeyer, Esq.
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

EXHIBIT "1"

EXHIBIT "1"

Nev. Const. Art 15, Sec. 16. **Payment of minimum compensation to employees.**

A. Each employer shall pay a wage to each employee of not less than the hourly rates set forth in this section. The rate shall be five dollars and 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. Offering health benefits within the meaning of this section shall consist of making health insurance available to the employee for the 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. These rates of wages shall be adjusted by the amount of increases in the federal minimum wage over $5.15 per hour, or, if greater, by the cumulative increase in the cost of living. The cost of living increase shall be measured by the percentage increase as of December 31 in any year over the level as of December 31, 2004 of the Consumer Price Index (All Urban Consumers, U.S. City Average) as published by the Bureau of Labor Statistics, U.S. Department of Labor or the successor index or federal agency. No CPI adjustment for any one-year period may be greater than 3%. The Governor or the State agency designated by the Governor shall publish a bulletin by April 1 of each year announcing the adjusted rates, which shall take effect the following July 1. Such bulletin will be made available to all employers and to any other person who has filed with the Governor or the designated agency a request to receive such notice but lack of notice shall not excuse noncompliance with this section. An employer shall provide written notification of the rate adjustments to each of its employees and make the necessary payroll adjustments by July 1 following the publication of the bulletin. Tips or gratuities received by employees shall not be credited as being any part of or offset against the wage rates required by this section.

B. The provisions of this section may not be waived by agreement between an individual employee and an employer. All of the provisions of this section, or any part hereof, may be waived in a bona fide collective bargaining agreement, but only if the waiver is explicitly set forth in such agreement in clear and unambiguous terms. Unilateral implementation of terms and conditions of employment by either party to a collective bargaining relationship shall not constitute, or be permitted, as a waiver of all or any part of the provisions of this section. An employer shall not discharge, reduce the compensation of or otherwise discriminate against any employee for using any civil remedies to enforce this section or otherwise asserting his or her rights under this section. An employee claiming violation of this section may bring an action against his or her employer in the courts of this State to enforce the provisions of this section and shall be entitled to all remedies available under the law or in equity appropriate to remedy any violation of this section, including but not limited to back pay, damages, reinstatement or injunctive relief. An employee who prevails in any action to enforce this section shall be awarded his or her reasonable attorney's fees and costs.

C. As used in this section, "employee" means any person who is employed by an employer as defined herein but does not include an employee who is under eighteen (18) years of age, employed by a nonprofit organization for after school or summer employment or as a trainee for a period not longer than ninety (90) days. "Employer" means any individual, proprietorship, partnership, joint venture, corporation, limited liability company, trust, association, or other entity that may employ individuals or enter into contracts of employment.

D. If any provision of this section is declared illegal, invalid or inoperative, in whole or in part, by the final decision of any court of competent jurisdiction, the

IAFD
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EIGHTH JUDICIAL DISTRICT COURT

IN AND FOR CLARK COUNTY, STATE OF NEVADA

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

Plaintiffs,

vs.

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

Defendants.

Case No: A-14-701633-C

Dept. No.: XV

INITIAL APPEARANCE FEE DISCLOSURE (NRS CHAPTER 19)

Pursuant to NRS Chapter 19, as amended by Senate Bill 106, filing fees are submitted for parties appearing in the above entitled action as indicated below:

1. Plaintiff, PAULETTE DIAZ: $270.00

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2.	Plaintiff, LAWANDA GAIL WILBANKS	$ 30.00
	TOTAL REMITTED:	$300.00

DATED this 30th day of May, 2014.

WOLF, RIFKIN, SHAPIRO,
SCHULMAN & RABKIN, LLP

By: /s/ Don Springmeyer, Esq.
DON SPRINGMEYER, ESQ.
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EIGHTH JUDICIAL DISTRICT COURT

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

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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.

Case No: A701633

Dept. No.: XV

AMENDED CLASS ACTION COMPLAINT

The above-referenced Plaintiffs (herein "Plaintiffs") through undersigned counsel, on behalf of themselves and all persons similarly situated, complain and allege as follows:

INTRODUCTION

1. This lawsuit is an individual and class action brought by Plaintiffs, on behalf of themselves and all similarly-situated employees of MDC RESTAURANTS, LLC; LAGUNA

RESTAURANTS, LLC; and INKA, LLC ("MDC," "Laguna," "Inka," and, collectively, "Defendants"), owners and operators of Denny's and CoCo's restaurants (the "Restaurants") in Nevada.

2. This lawsuit is a result of the Defendants' failure to pay Plaintiffs and other similarly-situated employees who are members of the Class the lawful minimum wage, because the Defendants have improperly claimed eligibility to compensate employees at a reduced minimum wage rate under Nev. Const. art. XV, § 16.

3. At the 2006 General Election, Nevada voters approved, for the second time, a constitutional amendment regarding the minimum wage to be paid to all Nevada employees.[1] The amendment became effective in November, 2006, and was codified as new Article XV, § 16 of the Nevada Constitution.

4. The 2006 amendment guaranteed to each Nevada employee, with very few exceptions, a particular hourly wage: "Each employer shall pay a wage to each employee of not less than the hourly rates set forth in this section. The rate shall be five dollars and 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."

5. The amendment contained an index/increase mechanism, such that since 2010 the Nevada minimum wage level is $7.25 per hour if the employer provides qualifying health benefits, or $8.25 per hour if the employer does not provide such qualifying health benefits. Employers, like Defendants, who claim eligibility to pay the reduced wage rate, therefore, can pay employees up to 12.2% less than workers paid at the $8.25 level.

6. The public policy underlying the minimum wage amendment was to benefit Nevada's minimum wage employees, and to incentivize employers to provide low-cost, comprehensive health insurance benefits to the state's lowest-paid workers.

7. The opportunity to compensate employees at a level beneath the standard minimum wage rate is a privilege offered to employers by the voters of Nevada. Employers must qualify for

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[1] See Exhibit 1 here attached, a true and correct copy of the text of Nev. Const. art. XV, § 16.

that privilege by providing, offering, and maintaining health insurance plans for their employees that meet very specific regulatory standards.

8. In order to qualify to pay employees at a reduced minimum wage rate, the health insurance benefits plan provided, offered, and/or maintained must be truly comprehensive in its coverage, and cover "those categories of health care expenses that are generally deductible by an employee on his/her individual federal income tax return pursuant to 26 U.S.C. § 213 and any federal regulations relating thereto, if such expenses had been borne directly by the employee." N.A.C. 608.102(1)(a).

9. Furthermore, the cost of health insurance benefit premiums for the employee, and all his or her dependents, may not exceed "10 percent of the employee's gross taxable income from the employer." Nev. Const. art. XV, § 16.

10. Failure to meet the specific requirements that establish a qualified health insurance benefits plan means that the employer forfeits the right to pay employees at anything less than the full minimum wage rate under Nev. Const. art. XV, § 16, currently $8.25 per hour.

11. Defendants here pay Plaintiffs and members of the Class at an hourly rate below $8.25 per hour.

12. Defendants do not provide, offer, and/or maintain qualifying health insurance plan benefits for the benefit of Plaintiffs and members of the Class. In the case of named Plaintiffs, Defendants have failed to offer any health benefit plans at all, and therefore can claim no basis for paying Plaintiffs less than $8.25 per hour at any time.

13. Defendants are not, and have not been, eligible to pay Plaintiffs and members of the Class at the reduced minimum wage rate. They have forfeited the privilege extended to it under Article XV, § 16. Instead, they now owe back pay and damages to all employees they have unlawfully underpaid since passage of the minimum wage amendment in 2006.

PARTIES

A. Plaintiffs

14. Plaintiff Paulette Diaz is a resident of Oregon, and worked as a server at numerous Denny's and CoCo's restaurants owned and operated by Defendants in Clark County, Nevada

between April 2010 and September 2013. Her wage was $7.25 per hour. She has two dependents.

15. Plaintiff Lawanda Gail Wilbanks is a resident of Nevada, and worked as a server at a Denny's restaurant owned and operated by Defendants in Clark County, Nevada between June 2011 and January 2013. Her wage was $7.25 per hour. She has one dependent.

16. Plaintiff Shannon Olszynski is a resident of Nevada, and works as a server at a Denny's restaurant owned and operated by Defendants in Elko County, Nevada beginning in May of 2014 to the present. Her wage is $7.25 per hour.

17. Plaintiff Charity Fitzlaff is a resident of Nevada, and worked as a server at a Denny's restaurant owned and operated by Defendants in Elko County, Nevada between June 2012 and October 2013. Her wage was $7.25 per hour. She has three dependents.

B. Defendants

18. Plaintiffs are informed and believe and thereon allege that at all times material hereto Defendant MDC RESTAURANTS, LLC, was and is a Nevada limited liability company, and it and any subsidiaries or affiliated companies were and are engaged in the ownership and operation of franchise and non-franchise restaurants located in Clark County and throughout Nevada. Upon information and belief, this Defendant owns and operates approximately thirteen Denny's restaurants in Clark County and elsewhere in Nevada, employed Plaintiffs and/or employed and employs Class members, and is conducting business in good standing in the State of Nevada. Its sole listed officer is manager Vince Eupierre.

19. Plaintiffs are informed and believe and thereon allege that at all times material hereto Defendant LAGUNA RESTAURANTS, LLC, was and is a Nevada limited liability company, and it and any subsidiaries or affiliated companies were and are engaged in the ownership and operation of franchise and non-franchise restaurants located in Clark County and throughout Nevada. Upon information and belief, this Defendant owns and operates approximately four Denny's and CoCo's restaurants in Clark County and elsewhere in Nevada, employed Plaintiffs and/or employed and employs Class members, and is conducting business in good standing in the State of Nevada. Its sole listed officer is manager Vince Eupierre.

20. Plaintiffs are informed and believe and thereon allege that at all times material

hereto Defendant INKA, LLC, was and is a Nevada limited liability company, and it and any subsidiaries or affiliated companies were and are engaged in the ownership and operation of franchise and non-franchise restaurants located in Clark County and throughout Nevada. Upon information and belief, this Defendant owns and operates approximately three Denny's restaurants in Clark County and elsewhere in Nevada, employed Plaintiffs and/or employed and employs Class members, and is conducting business in good standing in the State of Nevada. Its two listed officers are managers Vince Eupierre and Joseph Soraci.

21. Plaintiffs sue fictitious Defendants DOES 1 through 100, inclusive, as Plaintiffs do not know their true names and/or capacities, and upon ascertainment, will amend the Complaint with their true names and capacities. Plaintiffs are informed and believe and on that basis allege that each of said fictitiously named Defendants is responsible in some manner for the occurrences herein alleged, and that Plaintiffs' damages were proximately caused by their conduct mentioned herein, each of the Defendants, including DOES 1 through 100, was an agent, joint-venturer, representative, alter ego, and/or employee of the other defendants, and was acting both individually and in the course and scope of said relationship at the time of the events herein alleged, and all aided and abetted the wrongful acts of the others.

JURISDICTION AND VENUE

22. This Court has subject matter jurisdiction over this action pursuant to Nev. Const, art. XV, § 16(B).

23. Venue is proper because acts giving rise to the claims of the Plaintiffs herein occurred within this judicial district, and all Defendants regularly conduct business in and have engaged and continue to engage in the wrongful conduct alleged herein—and, thus, are subject to personal jurisdiction—in this judicial district.

GENERAL ALLEGATIONS

A. Plaintiffs' Allegations

24. Plaintiff Diaz worked as a server at Denny's and CoCo's restaurants owned and operated by Defendants in Clark County, Nevada, where she earned $7.25 per hour, below the constitutional minimum wage under Nev. Const. art XV, § 16 of $8.25 per hour.

25. Ms. Diaz was never offered a company health insurance plan at all, much less a plan that would qualify Defendants for the constitutional privilege of paying less than the full hourly minimum hourly wage rate per Nev. Const. art. XV, § 16.

26. Defendants, therefore, were unlawfully paying Ms. Diaz a sub-minimum wage for the entirety of her employment.

27. Plaintiff Wilbanks worked as a server at a Denny's restaurant owned and operated by Defendants in Clark County, Nevada, where she earned $7.25 per hour, below the constitutional minimum wage under Nev. Const. art XV, § 16 of $8.25 per hour.

28. Ms. Wilbanks was never offered a company health insurance plan at all, much less a plan that would qualify Defendants for the constitutional privilege of paying less than the full hourly minimum hourly wage rate per Nev. Const. art. XV, § 16.

29. Defendants, therefore, were unlawfully paying Ms. Wilbanks a sub-minimum wage for the entirety of her employment.

30. Plaintiff Olszynski works as a server at a Denny's restaurant owned and operated by Defendants in Elko County, Nevada, where she earns $7.25 per hour, below the constitutional minimum wage under Nev. Const. art XV, § 16 of $8.25 per hour.

31. Ms. Olszynski was offered a purported company health insurance plan (the "Plan"). The Plan offered to Ms. Olszynski (which, upon information and belief, is the plan offered by Defendants to employees in their Nevada locations) is not, and was not, in compliance with Nev. Const. art XV, § 16 or N.A.C. 608.102, as it did not cover those categories of health care expenses that are generally deductible by an employee on his/her individual federal income tax return pursuant to 26 U.S.C. § 213 and any federal regulations relating thereto, if such expenses had been borne directly by the employee.

32. Defendants, therefore, have been unlawfully paying Ms. Olszynski a sub-minimum wage for the entirety of her employment.

33. Plaintiff Fitzlaff worked as a server at a Denny's restaurant owned and operated by Defendants in Elko County, Nevada, where she earned $7.25 per hour, below the constitutional minimum wage under Nev. Const. art XV, § 16 of $8.25 per hour.

34. Ms. Fitzlaff was offered a purported company health insurance plan, he Plan. The Plan offered to Ms. Fitzlaff is not, and was not, in compliance with Nev. Const. art XV, § 16 or N.A.C. 608.102, as it did not cover those categories of health care expenses that are generally deductible by an employee on his/her individual federal income tax return pursuant to 26 U.S.C. § 213 and any federal regulations relating thereto, if such expenses had been borne directly by the employee.

35. Defendants, therefore, unlawfully paid Ms. Fitzlaff a sub-minimum wage for the entirety of her employment.

B. Defendants' Control of the Restaurants

36. Defendants maintain control, oversight, and direction over the operation of the Restaurants, including their employment and/or labor practices.

37. Defendants (i) create uniform wage and benefit policies and practices for use at the Restaurants, (ii) impose uniform wage and benefit policies and practices at the Restaurants, and (iii) maintain centralized human resource functions which implement wage and benefit policies and practices at the Restaurants.

38. Defendants have common ownership and management and, upon information and belief, formulate and execute uniform human resource and benefit policies affecting Plaintiffs and members of the Class.

C. Defendants' Unlawful Minimum Wage Practices

39. Defendants paid Plaintiffs and members of the Class for many years at a reduced minimum wage rate pursuant to Nev. Const. art. XV, § 16.

40. Defendants do not provide, offer, and/or maintain health insurance plan benefits that meet necessary requirements in order to qualify to pay Plaintiffs and members of the Class at the reduced minimum wage level.

41. Defendants, therefore, have been unlawfully paying all Class members a sub-minimum wage during employment at the Restaurants.

42. Defendants are aware of, and perpetuate, this ongoing violation of Nevada's constitutional provision regarding minimum wage, and associated regulatory provisions

implementing same.

43. As a result, pursuant to Nev. Const. art. XV, § 16, Plaintiffs and the members of the Class are owed back pay and damages for every hour worked during the applicable period.

CLASS ACTION ALLEGATIONS

44. Plaintiffs re-allege and incorporate herein by this reference all the paragraphs above in this Complaint as though fully set forth herein.

45. Plaintiffs bring this action pursuant to N.R.C.P. 23 on behalf of themselves and all others similarly situated, as representative members of the following proposed Class:

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

46. Numerosity: The members of the proposed Class are so numerous that individual joinder of all members is impracticable under the circumstances of this case, and the disposition of their claims as a Class will benefit the parties and the Court. The precise number of members should be readily available from a review of Defendants' personnel, payroll, and benefits records, and upon information and belief numbers in the thousands.

47. Commonality/Predominance: Common questions of law or fact are shared by the members of the proposed Class. This action is suitable for class treatment because these common questions of fact and law predominate over any questions affecting individual members. These common legal and factual questions, include, but are not limited to, the following:

i. Whether Defendants paid Class members the required minimum wage pursuant to the Nevada Constitution;

ii. Whether, when paying minimum wage employees the reduced minimum wage level pursuant to Nev. Const. art. XV, § 16, Defendants provided qualifying health insurance benefit plans, with appropriate coverage and at appropriate premium cost, to the members of the Class;

iii. The applicable statute of limitations, if any, for Plaintiffs' and Class members' claims;

iv. Whether Defendants are liable for pre-judgment interest; and

v. Whether Defendants are liable for attorneys' fees and costs.

48. Typicality: Plaintiffs' claims 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. Plaintiffs and all other proposed Class members sustained similar losses, injuries, and damages as a direct and proximate result of Defendants' same unlawful policies and/or practices. Plaintiffs' claims arise from Defendants' same unlawful policies, practices, and/or course of conduct as all other proposed Class members' claims in that Plaintiffs were denied lawful wages for hours worked, and Plaintiffs' legal theories are based on the same legal theories as all other proposed Class members. Defendants' compensation and benefit policies and practices affected all Class members similarly, and Defendants benefited from the same type of unfair and/or wrongful acts done to each Class member.

49. Adequacy: Plaintiffs are adequate representatives of the proposed Class because Plaintiffs are members of the proposed Class they seek to represent and their interests do not conflict with the interests of the other members of the proposed Class that Plaintiffs seek to represent. Plaintiffs have retained counsel that is competent and experienced in complex class action litigation, and Plaintiffs intend to prosecute this action vigorously. The interests of members of the proposed Class will be fairly and adequately protected by Plaintiffs and their counsel. Neither Plaintiffs nor their counsel have interests that are contrary to, or conflicting with, the interests of the proposed Class.

50. Superiority: A class action is superior to other available methods for the fair and efficient adjudication of the controversy, because, inter alia, as minimum wage employees it is economically infeasible for proposed Class members to prosecute individual actions of their own given the relatively small amount of damages at stake for each individual. Important public interests will be served by addressing the matter as a class action. The cost to the court system and the public for the adjudication of individual litigation and claims would be substantial and substantially more than if the claims are treated as a class action. Prosecution of separate actions by individual Class members would create a risk of inconsistent and/or varying adjudications with

respect to the individual members of the Class, establishing incompatible standards of conduct for Defendants and resulting in the impairment of Class members' rights and the disposition of their interests through actions to which they were not parties. The issues in this action can be decided by means of common, class-wide proof. In addition, if appropriate, the Court can and is empowered to, fashion methods to efficiently manage this action as a class action.

51. The case will be manageable as a class action. Plaintiffs and their counsel know of no unusual difficulties in the case, and Defendants have advanced networked computer, payroll, and benefit systems that will allow the class, wage, benefits, and damages issues in the case to be resolved with relative ease.

52. Because the elements of Rule 23(b)(3), or in the alternative Rule 23(c)(4), are satisfied in the case, class certification is appropriate.

FIRST CLAIM FOR RELIEF

Violation of Nev. Const. art. XV, § 16

Failure to Pay Lawful Minimum Wage

(On Behalf of Plaintiffs and the Class against Defendants)

53. All preceding paragraphs in this Complaint are re-alleged and incorporated by reference as though fully set forth herein.

54. As described and alleged herein, Defendants pay, and have paid, Plaintiffs and members of the Class at a reduced minimum wage level pursuant to Nev. Const. art XV, § 16 without providing qualifying health insurance benefits as required by that provision.

55. Defendants are not, and/or were not, eligible to pay Plaintiffs and members of the Class at a reduced minimum wage during any period where qualifying benefits were not provided by Defendants.

56. Pursuant to Nev. Const. art XV, § 16, Defendants are liable to Plaintiffs and members of the Class for their unpaid wages for any period during which Defendants were ineligible to compensate Plaintiffs and members of the Class at a reduced minimum wage; an award of damages; costs of the action; reasonable attorneys' fees; and any other relief deemed appropriate by this Court.

SECOND CLAIM FOR RELIEF

Violation of Nev. Const. art. XV, § 16 and N.A.C. 608.102

Failure to Pay Lawful Minimum Wage

(On Behalf of Plaintiffs and the Class against Defendants)

57. All preceding paragraphs in this Complaint are re-alleged and incorporated by reference as though fully set forth herein.

58. As described and alleged herein, the Restaurants pay, and have paid, Plaintiff and members of the Class at a reduced minimum wage level pursuant to Nev. Const. art XV, § 16 without providing qualifying health insurance benefits as required by that provision.

59. Health insurance benefits provided and/or offered to Plaintiff and members of the Class and their dependents did not meet coverage requirements under Nev. Const. art XV, § 16 and N.A.C. 608.102, and therefore the Restaurants are not, and/or were not, eligible to pay Plaintiff and members of the Class at the reduced minimum wage tier during any period where such qualifying benefits were not provided, offered, and/or maintained by the Restaurants. Pursuant to Nev. Const. art XV, § 16, the Restaurants are liable to Plaintiff and members of the Class for their unpaid wages for any period during which the Restaurants were ineligible to compensate Plaintiff and members of the Class at the reduced minimum wage tier; an award of damages; costs of the action; reasonable attorneys' fees; and any other relief deemed appropriate by this Court.

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs, on behalf of themselves and all other similarly-situated members of the Class, request that this Court enter an Order:

A. Certifying this matter as a class action pursuant to N.R.C.P. 23, designating Plaintiffs as Class representatives, and appointing the undersigned as Class counsel;

B. Declaring the practices here complained of as unlawful under appropriate law;

C. Granting judgment to Plaintiffs and the members of the Class on their claims of unpaid wages as secured by law, as well as damages, interest, attorneys' fees and costs as applicable and appropriate;

D. Granting punitive and exemplary damages against the Defendants pursuant to law; and

E. Ordering such other relief as the Court may deem necessary and just.

JURY TRIAL DEMAND

Pursuant to Rule 38(b) of the Nevada Rules of Civil Procedure, Plaintiffs demand a trial by jury on all issues so triable.

DATED this 5th day of June, 2014.

WOLF, RIFKIN, SHAPIRO, SCHULMAN & RABKIN, LLP

By: /s/ Don Springmeyer, Esq.
DON SPRINGMEYER, ESQ.
Nevada State Bar No. 1021
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Nevada State Bar No. 10217
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Nevada State Bar No. 13078
3556 E. Russell Road, Second Floor
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Attorneys for Plaintiffs

EXHIBIT "1"

EXHIBIT "1"

Nev. Const. Art 15, Sec. 16. **Payment of minimum compensation to employees.**

A. Each employer shall pay a wage to each employee of not less than the hourly rates set forth in this section. The rate shall be five dollars and 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. Offering health benefits within the meaning of this section shall consist of making health insurance available to the employee for the 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. These rates of wages shall be adjusted by the amount of increases in the federal minimum wage over $5.15 per hour, or, if greater, by the cumulative increase in the cost of living. The cost of living increase shall be measured by the percentage increase as of December 31 in any year over the level as of December 31, 2004 of the Consumer Price Index (All Urban Consumers, U.S. City Average) as published by the Bureau of Labor Statistics, U.S. Department of Labor or the successor index or federal agency. No CPI adjustment for any one-year period may be greater than 3%. The Governor or the State agency designated by the Governor shall publish a bulletin by April 1 of each year announcing the adjusted rates, which shall take effect the following July 1. Such bulletin will be made available to all employers and to any other person who has filed with the Governor or the designated agency a request to receive such notice but lack of notice shall not excuse noncompliance with this section. An employer shall provide written notification of the rate adjustments to each of its employees and make the necessary payroll adjustments by July 1 following the publication of the bulletin. Tips or gratuities received by employees shall not be credited as being any part of or offset against the wage rates required by this section.

B. The provisions of this section may not be waived by agreement between an individual employee and an employer. All of the provisions of this section, or any part hereof, may be waived in a bona fide collective bargaining agreement, but only if the waiver is explicitly set forth in such agreement in clear and unambiguous terms. Unilateral implementation of terms and conditions of employment by either party to a collective bargaining relationship shall not constitute, or be permitted, as a waiver of all or any part of the provisions of this section. An employer shall not discharge, reduce the compensation of or otherwise discriminate against any employee for using any civil remedies to enforce this section or otherwise asserting his or her rights under this section. An employee claiming violation of this section may bring an action against his or her employer in the courts of this State to enforce the provisions of this section and shall be entitled to all remedies available under the law or in equity appropriate to remedy any violation of this section, including but not limited to back pay, damages, reinstatement or injunctive relief. An employee who prevails in any action to enforce this section shall be awarded his or her reasonable attorney's fees and costs.

C. As used in this section, "employee" means any person who is employed by an employer as defined herein but does not include an employee who is under eighteen (18) years of age, employed by a nonprofit organization for after school or summer employment or as a trainee for a period not longer than ninety (90) days. "Employer" means any individual, proprietorship, partnership, joint venture, corporation, limited liability company, trust, association, or other entity that may employ individuals or enter into contracts of employment.

D. If any provision of this section is declared illegal, invalid or inoperative, in whole or in part, by the final decision of any court of competent jurisdiction, the

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CLERK OF THE COURT

SUMM
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BRADLEY SCHRAGER, ESQ.
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Attorneys for Plaintiffs

EIGHTH JUDICIAL DISTRICT COURT

IN AND FOR CLARK COUNTY, STATE OF NEVADA

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

Plaintiffs,

vs.

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

Defendants.

Case No: A701633

Dept. No.: XV

SUMMONS

NOTICE! YOU HAVE BEEN SUED. THE COURT MAY DECIDE AGAINST YOU WITHOUT YOUR BEING HEARD UNLESS YOU RESPOND WITHIN 20 DAYS. READ THE INFORMATION BELOW.

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TO THE DEFENDANT: A civil Amended Class Action Complaint has been filed by the Plaintiffs against you for the relief set forth in the Amended Class Action Complaint.

LAGUNA RESTAURANTS, LLC
Morris Polich & Purdy, LLP, Resident Agent
500 S. Rancho Drive, Suite 17
Las Vegas, NV 89106

1. If you intend to defend this lawsuit, within 20 days after this Summons is served on you exclusive of the day of service, you must do the following:

a. File with the Clerk of this Court, whose address is shown below, a formal written response to the Complaint in accordance with the rules of the Court.

b. Serve a copy of your response upon the attorney whose name and address is shown below.

2. Unless you respond, your default will be entered upon application of the Plaintiff and this Court may enter a judgment against you for the relief demanded in the Complaint, which could result in the taking of money or property or other relief requested in the Complaint.

3. If you intend to see the advice of an attorney in this matter, you should do so promptly so that your response may be filed on time.

4. The State of Nevada, its political subdivisions, agencies, officers, employees, board members, commission members and legislators each have 45 days after service of this Summons within which to file an Answer or other responsive pleading to the Complaint.

Issued at direction of:
WOLF, RIFKIN, SHAPIRO,
SCHULMAN & RABKIN, LLP

By: _____
BRADLEY S. SCHRAGER, ESQ.
Nevada Bar No. 10217
Attorneys for Plaintiff
3556 E. Russell Avenue, 2nd Floor
Las Vegas, Nevada 89119
(702) 341-5200

Steven D. Grierson,
CLERK OF THE COURT

By: _____
Deputy Clerk
Regional Justice Center
200 Lewis Ave
Las Vegas, Nevada 89155

AFFIDAVIT OF SERVICE

STATE OF NEVADA)
)
COUNTY OF CLARK)

CATHY V. HOLMES, being duly sworn deposes and says: that at all times herein affiant was and is a citizen of the United States, over 18 years of age, licensed to serve civil process in the state of Nevada under license #389, and not a party to or interested in the proceeding in which this affidavit is made. The affiant received on Wednesday June 11 2014; 1 copy(ies) of the:

SUMMONS; AMENDED CLASS ACTION COMPLAINT

I served the same on Thursday June 12 2014 at 01:59PM by:

Serving Defendant LAGUNA RESTAURANT, LLC, A NEVADA LIMITED LIABILITY COMPANY BY SERVING MORRIS POLICH & PURDY, LLP, REGISTERED AGENT

Substituted Service. by leaving the copies with or in the presence of: NICHOLAS WIECZOREK, ATTORNEY ON BEHALF OF MORRIS POLICH & PURDY, LLP, REGISTERED AGENT, PURSUANT TO NRS 14.020 SUBSECTION 6(B), AS A PERSON OF SUITABLE AGE AND DISCRETION AT THE ADDRESS BELOW, WHICH ADDRESS IS THE MOST RECENT ACTUAL PHYSICAL LOCATION IN THIS STATE AT WHICH THE REGISTERED AGENT IS AVAILABLE FOR SERVICE OF PROCESS, AS SHOWN ON THE CURRENT CERTIFICATE OF DESIGNATION FILED WITH THE SECRETARY OF STATE Authorized Agent. at the Defendant's Business located at 500 S. RANCHO DR., STE 17, Las Vegas, NV 89106.

SUBSCRIBED AND SWORN to before me on this
Thursday June 12 2014 By the Affiant.

Notary Public

1389

IRINA NISTRATOVAN
NOTARY PUBLIC
STATE OF NEVADA
Appt. No. 04-91784-1
My Appt. Expires Oct. 10, 2017

Affiant: CATHY V. HOLMES #R012488
LEGAL WINGS, INC. - NV LIC #389
1118 FREMONT STREET
Las Vegas, NV 89101
(702) 384-0305, FAX (702) 384-8638

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CLERK OF THE COURT

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

EIGHTH JUDICIAL DISTRICT COURT

IN AND FOR CLARK COUNTY, STATE OF NEVADA

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

Plaintiffs,

vs.

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

Defendants.

Case No: A701633

Dept. No.: XV

SUMMONS

NOTICE! YOU HAVE BEEN SUED. THE COURT MAY DECIDE AGAINST YOU WITHOUT YOUR BEING HEARD UNLESS YOU RESPOND WITHIN 20 DAYS. READ THE INFORMATION BELOW.

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TO THE DEFENDANT: A civil Amended Class Action Complaint has been filed by the Plaintiffs against you for the relief set forth in the Amended Class Action Complaint.

MDC RESTAURANTS, LLC
Morris Polich & Purdy, LLP, Resident Agent
500 S. Rancho Drive, Suite 17
Las Vegas, NV 89106

1. If you intend to defend this lawsuit, within 20 days after this Summons is served on you exclusive of the day of service, you must do the following:

a. File with the Clerk of this Court, whose address is shown below, a formal written response to the Complaint in accordance with the rules of the Court.

b. Serve a copy of your response upon the attorney whose name and address is shown below.

2. Unless you respond, your default will be entered upon application of the Plaintiff and this Court may enter a judgment against you for the relief demanded in the Complaint, which could result in the taking of money or property or other relief requested in the Complaint.

3. If you intend to see the advice of an attorney in this matter, you should do so promptly so that your response may be filed on time.

4. The State of Nevada, its political subdivisions, agencies, officers, employees, board members, commission members and legislators each have 45 days after service of this Summons within which to file an Answer or other responsive pleading to the Complaint.

Issued at direction of:
WOLF, RIFKIN, SHAPIRO
SCHULMAN & RABKIN, LLP

By: _____
BRADLEY S. SCHRAGER, ESQ
Nevada Bar No. 10217
Attorneys for Plaintiff
3556 E. Russell Avenue, 2nd Floor
Las Vegas, Nevada 89119
(702) 341-5200

Steven D. Grierson,
CLERK OF THE COURT

By: _____
Deputy Clerk
Regional Justice Center
200 Lewis Ave
Las Vegas, Nevada 89155

AFFIDAVIT OF SERVICE

STATE OF NEVADA)
)
COUNTY OF CLARK)

CATHY V. HOLMES, being duly sworn deposes and says: that at all times herein affiant was and is a citizen of the United States, over 18 years of age, licensed to serve civil process in the state of Nevada under license #389, and not a party to or interested in the proceeding in which this affidavit is made. The affiant received on Wednesday June 11 2014; 1 copy(ies) of the:

SUMMONS; AMENDED CLASS ACTION COMPLAINT

I served the same on Thursday June 12 2014 at 01:59PM by:

Serving Defendant MDC RESTAURANTS, LLC, A NEVADA LIMITED LIABILITY COMPANY BY SERVING MORRIS POLICH & PURDY, LLP, REGISTERED AGENT

Substituted Service, by leaving the copies with or in the presence of: NICHOLAS WIECZOREK, ATTORNEY ON BEHALF OF MORRIS POLICH & PURDY, LLP, REGISTERED AGENT, PURSUANT TO NRS 14.020 SUBSECTION 6(B), AS A PERSON OF SUITABLE AGE AND DISCRETION AT THE ADDRESS BELOW, WHICH ADDRESS IS THE MOST RECENT ACTUAL PHYSICAL LOCATION IN THIS STATE AT WHICH THE REGISTERED AGENT IS AVAILABLE FOR SERVICE OF PROCESS, AS SHOWN ON THE CURRENT CERTIFICATE OF DESIGNATION FILED WITH THE SECRETARY OF STATE Authorized Agent. at the Defendant's Business located at 500 S. RANCHO DR., STE 17, Las Vegas, NV 89106.

SUBSCRIBED AND SWORN to before me on this
Thursday June 12 2014 By the Affiant.

Notary Public

1389

NONA MICHELSON
STATE OF NEVADA

Affiant: CATHY V. HOLMES #R012468
LEGAL WINGS, INC. - NV LIC #389
1118 FREMONT STREET
Las Vegas, NV 89101
(702) 384-0305, FAX (702) 384-8638

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CLERK OF THE COURT

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

EIGHTH JUDICIAL DISTRICT COURT

IN AND FOR CLARK COUNTY, STATE OF NEVADA

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

Plaintiffs,

vs.

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

Defendants.

Case No: A701633

Dept. No.: XV

SUMMONS

NOTICE! YOU HAVE BEEN SUED. THE COURT MAY DECIDE AGAINST YOU WITHOUT YOUR BEING HEARD UNLESS YOU RESPOND WITHIN 20 DAYS. READ THE INFORMATION BELOW.

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TO THE DEFENDANT: A civil Amended Class Action Complaint has been filed by the Plaintiffs against you for the relief set forth in the Amended Class Action Complaint.

INKA, LLC
Joseph R. Soraci, Registered Agent
10 Placa Santa Maria Ct.
Henderson, NV 89011

1. If you intend to defend this lawsuit, within 20 days after this Summons is served on you exclusive of the day of service, you must do the following:

a. File with the Clerk of this Court, whose address is shown below, a formal written response to the Complaint in accordance with the rules of the Court.

b. Serve a copy of your response upon the attorney whose name and address is shown below.

2. Unless you respond, your default will be entered upon application of the Plaintiff and this Court may enter a judgment against you for the relief demanded in the Complaint, which could result in the taking of money or property or other relief requested in the Complaint.

3. If you intend to see the advice of an attorney in this matter, you should do so promptly so that your response may be filed on time.

4. The State of Nevada, its political subdivisions, agencies, officers, employees, board members, commission members and legislators each have 45 days after service of this Summons within which to file an Answer or other responsive pleading to the Complaint.

Issued at direction of:
WOLF, RIFKIN, SHAPIRO,
SCHULMAN & RABKIN, LLP

By: _____
BRADLEY S. SCHRAGER, ESQ.
Nevada Bar No. 10217
Attorneys for Plaintiff
3556 E. Russell Avenue, 2nd Floor
Las Vegas, Nevada 89119
(702) 341-5200

Steven D. Grierson,
CLERK OF THE COURT

By: _____
Deputy Clerk
Regional Justice Center
200 Lewis Ave
Las Vegas, Nevada 89155

0039

AFFIDAVIT OF SERVICE

STATE OF NEVADA)
)
COUNTY OF CLARK)

THEODORE M TUBE, being duly sworn deposes and says: that at all times herein affiant was and is a citizen of the United States, over 18 years of age, licensed to serve civil process in the state of Nevada under license #389, and not a party to or interested in the proceeding in which this affidavit is made. The affiant received on Wednesday June 11 2014; 1 copy(ies) of the:

SUMMONS; AMENDED CLASS ACTION COMPLAINT

I served the same on Friday June 13 2014 at 07:33PM by:

Serving Defendant INKA, LLC, A NEVADA LIMITED LIABILITY COMPANY BY SERVING JOSEPH R. SORACI, REGISTERED AGENT

Substituted Service, by leaving the copies with or in the presence of: KAREN SORACI, WIFE ON BEHALF OF JOSEPH R. SORACI, REGISTERED AGENT, PURSUANT TO NRS 14.020 SUBSECTION 6(B), AS A PERSON OF SUITABLE AGE AND DISCRETION AT THE ADDRESS BELOW, WHICH ADDRESS IS THE MOST RECENT ACTUAL PHYSICAL LOCATION IN THIS STATE AT WHICH THE REGISTERED AGENT IS AVAILABLE FOR SERVICE OF PROCESS, AS SHOWN ON THE CURRENT CERTIFICATE OF DESIGNATION FILED WITH THE SECRETARY OF STATE person of suitable age and discretion residing therein. at the Defendant's Home located at 10 PLACA SANTA MARIA CT, HENDERSON, NV 89011.

SUBSCRIBED AND SWORN to before me on this
Monday June 16 2014 By the Affiant.

Notary Public

1389

MARIANNE L. TELISMAN
Notary Public State of Nevada
No. 14-13146-1
My appt. exp. Apr. 9, 2018

Affiant: THEODORE M TUBE #R-032462
LEGAL WINGS, INC. - NV LIC #389
1116 FREMONT STREET
Las Vegas, NV 89101
(702) 384-0305, FAX (702) 384-8638

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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

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

ANSWER TO AMENDED CLASS ACTION COMPLAINT

Defendants MDC RESTAURANTS, LLC, LAGUNA RESTAURANTS, LLC, AND INKA, LLC (collectively "Defendants"), by and through their counsel of record Littler Mendelson, P.C., hereby answer Plaintiffs' Amended Class Action Complaint as follows:

INTRODUCTION

1. Answering paragraph 1 of the Amended Complaint, Defendants respond that the allegations of this paragraph do not allege any act or omission by Defendants and do not require a response. To the extent that a response is required, Defendants lack knowledge or information

sufficient to form a belief about the truth of said allegation, which statement has the effect of a denial.

2. Defendants deny the allegations set forth in Paragraph 2 of the Amended Complaint.

3. Answering paragraph 3 of the Amended Complaint, Defendants respond that the allegations of this paragraph do not allege any act or omission by Defendants and do not require a response. To the extent that a response is required, Defendants lack knowledge or information sufficient to form a belief about the truth of said allegation, which statement has the effect of a denial.

4. Answering paragraph 4 of the Amended Complaint, Defendants respond that the allegations of this paragraph do not allege any act or omission by Defendants and do not require a response. To the extent that a response is required, Defendants lack knowledge or information sufficient to form a belief about the truth of said allegation, which statement has the effect of a denial.

5. Answering paragraph 5 of the Amended Complaint, Defendants respond that the allegations of this paragraph do not allege any act or omission by Defendants and do not require a response. To the extent that a response is required, Defendants lack knowledge or information sufficient to form a belief about the truth of said allegation, which statement has the effect of a denial.

6. Answering paragraph 6 of the Amended Complaint, Defendants respond that the allegations of this paragraph do not allege any act or omission by Defendants and do not require a response. To the extent that a response is required, Defendants deny the allegations set forth in paragraph 6 of the Amended Complaint.

7. Answering paragraph 7 of the Amended Complaint, Defendants respond that the allegations of this paragraph do not allege any act or omission by Defendants and do not require a response. To the extent that a response is required, Defendants deny the allegations set forth in paragraph 7 of the Amended Complaint.

8. Answering paragraph 8 of the Amended Complaint, Defendants respond that the allegations of this paragraph do not allege any act or omission by Defendants and do not require a

response. To the extent that a response is required, Defendants deny the allegations set forth in paragraph 8 of the Amended Complaint.

9. Answering paragraph 9 of the Amended Complaint, Defendants respond that the allegations of this paragraph do not allege any act or omission by Defendants and do not require a response. To the extent that a response is required, Defendants lack knowledge or information sufficient to form a belief about the truth of said allegation, which statement has the effect of a denial.

10. Answering paragraph 10 of the Amended Complaint, Defendants respond that the allegations of this paragraph do not allege any act or omission by Defendants and do not require a response. To the extent that a response is required, Defendants deny the allegations set forth in paragraph 10 of the Amended Complaint.

11. Answering paragraph 11 of the Amended Complaint, Defendants admit that some employees are paid an hourly rate less than $8.25 per hour. Defendants lack knowledge or information sufficient to form a belief about the truth of the remaining allegations of paragraph 11 of the Amended Complaint, which has the effect of a denial.

12. Defendants deny the allegations set forth in paragraph 12 of the Amended Complaint.

13. Defendants deny the allegations set forth in paragraph 13 of the Amended Complaint.

PARTIES

A. Plaintiffs

14. Answering paragraph 14 of the Amended Complaint, Defendants admit that Plaintiff Paulette Diaz worked at numerous Denny's restaurants owned and operated by Defendant MDC Restaurants in Clark County, Nevada, between April 2010 and September 2013 and that she was paid $7.25 per hour. Defendants deny that Plaintiff Diaz worked for Defendants INKA or Laguna Restaurants. Defendants lack knowledge or information sufficient to form a belief about the truth of the remaining allegations of paragraph 14 of the Amended Complaint, which has the effect of a denial.

15. Answering paragraph 15 of the Amended Complaint, Defendants admit that Plaintiff Lawanda Gail Wilbanks worked at a Denny's restaurant owned and operated by Defendant MDC

Restaurants in Clark County, Nevada, between June 2011 and January 2013 and that she was paid $7.25 per hour. Defendants deny that Plaintiff Wilbanks worked for Defendants INKA or Laguna Restaurants. Defendants lack knowledge or information sufficient to form a belief about the truth of the remaining allegations of paragraph 15 of the Amended Complaint, which has the effect of a denial.

16. Answering paragraph 16 of the Amended Complaint, Defendants admit that Plaintiff Shannon Olszynski has worked at a Denny's restaurant owned and operated by Defendant INKA in Elko County, Nevada, since May 2014 and that she is paid $7.25 per hour. Defendants deny that Plaintiff Olszynski worked for Defendants MDC Restaurants or Laguna Restaurants. Defendants lack knowledge or information sufficient to form a belief about the truth of the remaining allegations of paragraph 16 of the Amended Complaint, which has the effect of a denial.

17. Answering paragraph 17 of the Amended Complaint, Defendants admit that Plaintiff Charity Fitzlaff worked at a Denny's restaurant owned and operated by Defendant INKA in Elko County, Nevada, and that she was paid $7.25 per hour. Defendants deny that Plaintiff Fitzlaff worked for Defendants MDC Restaurants or Laguna Restaurants. Defendants deny that Plaintiff Fitzlaff worked between June 2012 and October 2013. Defendants lack knowledge or information sufficient to form a belief about the truth of the remaining allegations of paragraph 17 of the Amended Complaint, which has the effect of a denial.

B. Defendants

18. Answering paragraph 18 of the Amended Complaint, Defendants deny that MDC Restaurants, LLC, is engaged in the ownership and operation of non-franchise restaurants, that it owns and operates approximately thirteen Denny's restaurants, that it owns and operates restaurants throughout Nevada, and that it employed Plaintiffs. Defendants admit the remaining allegations in paragraph 18 of the Amended Complaint.

19. Answering paragraph 19 of the Amended Complaint, Defendants admit that Laguna Restaurants, LLC, was a Nevada limited liability company that was engaged in the ownership and operation of franchise restaurants in Clark County. Defendants deny the remaining allegations in paragraph 19 of the Amended Complaint.

20. Answering paragraph 20 of the Amended Complaint, Defendants deny that INKA, LLC, is engaged in the ownership and operation of non-franchise restaurants, that it owns and operates approximately three Denny's restaurants, and that it employs Plaintiffs. Defendants admit the remaining allegations in paragraph 20 of the Amended Complaint.

21. Answering paragraph 21 of the Amended Complaint, Defendants respond that the allegations of this paragraph do not allege any act or omission by Defendants and do not require a response. To the extent that a response is required, Defendants deny the allegations set forth in paragraph 21 of the Amended Complaint.

JURISDICTION AND VENUE

22. Answering paragraph 22 of the Amended Complaint, Defendants respond that the allegations of this paragraph do not allege any act or omission by Defendants and do not require a response. To the extent that a response is required, Defendants deny the allegations set forth in paragraph 22 of the Amended Complaint.

23. Answering paragraph 23 of the Amended Complaint, Defendants respond that the allegations of this paragraph do not allege any act or omission by Defendants and do not require a response. To the extent that a response is required, Defendants deny the allegations set forth in paragraph 23 of the Amended Complaint.

GENERAL ALLEGATIONS

24. Answering paragraph 24 of the Amended Complaint, Defendants admit that Plaintiff Díaz worked at Denny's restaurants owned and operated by Defendant MDC Restaurants in Clark County, Nevada, and that she was paid $7.25 per hour. Defendants deny the remaining allegations of paragraph 24 of the Amended Complaint.

25. Defendants deny the allegations set forth in paragraph 25 of the Amended Complaint.

26. Defendants deny the allegations set forth in paragraph 26 of the Amended Complaint.

27. Answering paragraph 27 of the Amended Complaint, Defendants admit that Plaintiff Wilbanks worked at a Denny's owned and operated by Defendant MDC Restaurants in Clark County, Nevada, and that she was paid $7.25 per hour. Defendants deny the remaining allegations of paragraph 27 of the Amended Complaint.

28. Defendants deny the allegations set forth in paragraph 28 of the Amended Complaint.

29. Defendants deny the allegations set forth in paragraph 29 of the Amended Complaint.

30. Answering paragraph 30 of the Amended Complaint, Defendants admit that Plaintiff Olszynski works at a Denny's owned and operated by Defendant INKA in Elko County, Nevada, and that she is paid $7.25 per hour. Defendants deny the remaining allegations of paragraph 30 of the Amended Complaint.

31. Answering paragraph 31 of the Amended Complaint, Defendants admit that Plaintiff Olszynski was offered the company health insurance plan. Defendants deny the remaining allegations of paragraph 31 of the Amended Complaint.

32. Defendants deny the allegations set forth in paragraph 32 of the Amended Complaint.

33. Answering paragraph 33 of the Amended Complaint, Defendants admit that Plaintiff Fitzlaff worked at a Denny's owned and operated by Defendant INKA in Elko County, Nevada, and that she was paid $7.25 per hour. Defendants deny the remaining allegations of paragraph 33 of the Amended Complaint.

34. Answering paragraph 34 of the Amended Complaint, Defendants admit that Plaintiff Fitzlaff was offered the company health insurance plan. Defendants deny the remaining allegations of paragraph 34 of the Amended Complaint.

35. Defendants deny the allegations set forth in paragraph 35 of the Amended Complaint.

36. Defendants deny the allegations set forth in paragraph 36 of the Amended Complaint.

37. Defendants deny the allegations set forth in paragraph 37 of the Amended Complaint.

38. Defendants deny the allegations set forth in paragraph 38 of the Amended Complaint.

39. Defendants deny the allegations set forth in paragraph 39 of the Amended Complaint.

40. Defendants deny the allegations set forth in paragraph 40 of the Amended Complaint.

41. Defendants deny the allegations set forth in paragraph 41 of the Amended Complaint.

42. Defendants deny the allegations set forth in paragraph 42 of the Amended Complaint.

43. Defendants deny the allegations set forth in paragraph 43 of the Amended Complaint.

CLASS ACTION ALLEGATIONS

44. Defendants repeat and re-allege by reference each and every response, denial and

admission contained in Paragraphs 1 through 43, and incorporate the same as though fully set forth herein.

45. Answering paragraph 45 of the Amended Complaint, Defendants respond that the allegations of this paragraph do not allege any act or omission by Defendants and do not require a response. To the extent that a response is required, Defendants deny the allegations set forth in paragraph 45 of the Amended Complaint.

46. Defendants deny the allegations set forth in paragraph 46 of the Amended Complaint.

47. Defendants deny the allegations set forth in paragraph 47 and all subparts thereto of the Amended Complaint.

48. Defendants deny the allegations set forth in paragraph 48 of the Amended Complaint.

49. Defendants deny the allegations set forth in paragraph 49 of the Amended Complaint.

50. Defendants deny the allegations set forth in paragraph 50 of the Amended Complaint.

51. Defendants deny the allegations set forth in paragraph 51 of the Amended Complaint.

52. Defendants deny the allegations set forth in paragraph 52 of the Amended Complaint.

FIRST CLAIM FOR RELIEF

(Violation of Nev. Const. art. XV, § 17 Failure to Pay Lawful Minimum Wage)

53. Defendants repeat and re-allege by reference each and every response, denial and admission contained in Paragraphs 1 through 52, and incorporate the same as though fully set forth herein.

54. Defendants deny the allegations set forth in paragraph 54 of the Amended Complaint.

55. Defendants deny the allegations set forth in paragraph 55 of the Amended Complaint.

56. Defendants deny the allegations set forth in paragraph 56 of the Amended Complaint.

SECOND CLAIM FOR RELIEF

(Violation of Nev. Const. art XV, § 16 and N.A.C. 608.102 Failure to Pay Lawful Minimum Wage)

57. Defendants repeat and re-allege by reference each and every response, denial and admission contained in Paragraphs 1 through 56, and incorporate the same as tough fully set forth herein.

58. Defendants deny the allegations set forth in paragraph 58 of the Amended Complaint.

59. Defendants deny the allegations set forth in paragraph 59 of the Amended Complaint.

PLAINTIFFS' PRAYER FOR RELIEF

Defendants are not required to respond to Plaintiffs' prayer for relief. However, to the extent Plaintiffs' prayer asserts allegations, Defendants deny the allegations in Plaintiff's prayer.

AFFIRMATIVE DEFENSES

1. For and as a first, separate defense to the Amended Complaint, Defendants allege that the Amended Complaint fails to state a claim upon which relief may be granted.

2. For and as a second, separate defense to the Amended Complaint, Defendants allege that some or all of the claims asserted in the Amended Complaint are barred by the equitable doctrines of laches, waiver, estoppel, release and/or unclean hands.

3. For and as a third, separate defense to the Amended Complaint, Defendants allege that some or all of the claims asserted in the Amended Complaint, and each purported claim contained therein, is barred by the applicable statute of limitations.

4. For and as a fourth, separate defense to the Amended Complaint, Defendants allege that the Amended Complaint is barred to the extent Plaintiffs or any member of the alleged class which Plaintiffs purports to represent, the existence of which is expressly denied, have executed a compromise and release of any claims asserted in this lawsuit.

5. For and as a fifth, separate defense to the Amended Complaint, Defendants allege that Plaintiffs' Amended Complaint and each cause of action asserted therein, are subject to the doctrine of accord and satisfaction and therefore, any remedy or recovery to which Plaintiffs might have been entitled must be denied or reduced accordingly.

6. For and as a sixth, separate defense to the Amended Complaint, Defendants allege that Plaintiffs have already been fully compensated for all hours worked.

7. For and as a seventh, separate defense to the Amended Complaint, Defendants allege that with respect to some or all of the claims brought by Plaintiffs that any act(s) and/or omissions which may be found to be in violation of state law, occurred in good faith in conformity with and in

reliance on a written administrative regulation, order, ruling, approval and/or interpretation Nevada Labor Commission, with respect to the class of employers to which Defendants belong.

8. For and as a eighth, separate defense to the Amended Complaint, Defendants allege that Plaintiffs have failed to timely make demand in writing for wages due and payable.

9. For and as a ninth, separate defense to the Amended Complaint, Defendants allege that the Amended Complaint is barred to the extent that Plaintiffs lacks standing to raise some or all of the claims of the alleged class of persons whom Plaintiffs purport to represent, the existence of which is expressly denied.

10. For and as a tenth, separate defense to the Amended Complaint, Defendants allege that the class of persons that Plaintiffs purport to represent, the existence of which is expressly denied, is not so numerous that joinder is impracticable.

11. For and as an eleventh, separate defense to the Amended Complaint, Defendants allege that the Amended Complaint is barred to the extent that the claims alleged by Plaintiffs are neither common to nor typical of those, if any, of the alleged class of persons whom they purport to represent, the existence of which is expressly denied.

12. For and as a twelfth, separate defense to the Amended Complaint, Defendants allege that the Amended Complaint is barred to the extent that Plaintiffs are inadequate representatives of the alleged class of persons whom they purport to represent, the existence of which is expressly denied.

13. For and as a thirteenth, separate defense to the Amended Complaint, Defendants allege that the types of claims alleged by Plaintiffs on behalf of themselves and the class of persons whom Plaintiffs purport to represent, the existence of which is expressly denied, are matters in which individual questions predominate and not appropriate for class treatment.

14. For and as a fourteenth, separate defense to the Amended Complaint, Defendants allege that because liability may not be determined by a single jury on a class wide basis, allowing this action to proceed as a collective action would violate Defendants' rights under the Seventh Amendment.

15. For and as a fifteenth, separate defense to the Amended Complaint, Defendants allege that Plaintiffs have failed to exhaust their administrative, statutory, and/or contractual remedies.

16. For and as a sixteenth, separate defense to the Amended Complaint, Defendants allege that Defendants acted in a good faith belief that they were in compliance with all applicable statutes, law, and regulations concerning payment of wages and any other compensation owed to Plaintiffs.

17. For and as a seventeenth, separate defense to the Amended Complaint, Defendants allege that at no time did Defendants pay Plaintiffs in a manner known or believed to violate any applicable minimum wage laws, nor did Defendants compensate Plaintiffs in willful disregard of any applicable minimum wage laws.

Because the Amended Complaint is couched in conclusory and vague terms, Defendants cannot fully anticipate all affirmative defenses that may be applicable to this case. Accordingly, Defendants hereby reserve the right to assert additional affirmative defenses.

WHEREFORE, Defendants pray as follows:

1. For judgment decreeing that the Plaintiffs are entitled to recover nothing by way of their Complaint and that the Complaint be dismissed with prejudice;

2. For an award of attorneys' fees and costs of suit incurred herein; and

3. For such other and further relief as the Court deems proper.

Dated: July 2, 2014

Respectfully submitted,

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

Attorneys for Defendants

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 22, 2014, I served the within document:

ANSWER TO AMENDED CLASS ACTION COMPLAINT

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

Don Springmeyer
Wolf Rifkin Shapiro Schulman Rabkin, LLP
3556 East Russell Road, Second Floor
Las Vegas, Nevada 89120

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

I declare under penalty of perjury that the foregoing is true and correct. Executed on July 22, 2014, at Las Vegas, Nevada.

Debra Perkins

Electronically Filed
10/16/2015 02:58:55 PM

ORDR

CLERK OF THE COURT

DISTRICT COURT
CLARK COUNTY, NEVADA

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

Plaintiffs,

vs.

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

Defendants.

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

ORDER GRANTING CLASS CERTIFICATION, DESIGNATING CLASS REPRESENTATIVES, AND DESIGNATING CLASS COUNSEL

Hearing Date: September 25, 2015
Hearing Time: 9:30 a.m.

On June 8, 2015, Plaintiffs filed their Motion for Class Certification. On June 25, 2015, Defendants filed their Opposition to Plaintiffs' Motion for Class Certification. On June 30, 2015, Plaintiffs filed their Reply in Support of their Motion for Class Certification. On July 9, 2015, the Court held a hearing on Plaintiffs' Motion for Class Certification, and ordered supplemental briefing regarding Plaintiffs' Motion for Class Certification.

On July 16, 2015, Plaintiffs filed their Supplemental Brief in Support of their Motion for Class Certification. On July 31, 2015, Defendants filed their Opposition to

TIMOTHY C. WILLIAMS
DISTRICT JUDGE

DEPARTMENT SIXTEEN
LAS VEGAS NV 89155

Plaintiffs' Supplemental Brief. On August 7, 2015, Plaintiffs filed their Reply in Support of their Supplemental Brief.

On September 25, 2015, the Court held a hearing on Plaintiffs' continued Motion for Class Certification and supplemental briefing; Defendants' continued Motion to Stay Proceedings on Application for Order Shortening Time; Plaintiffs' Motion for Partial Summary Judgment on Liability Regarding Defendants' Health Benefits Plans; and Defendants' Countermotion to Strike Undisclosed Purported Expert and for Sanctions, with Bradley S. Schrager, Esq., Jordan J. Butler, Esq., and Daniel Bravo, Esq. appearing for Plaintiffs, and Montgomery Y. Paek, Esq. and Kathryn B. Blakey, Esq. appearing for Defendants.

After review and consideration of the record, the points and authorities on file herein, and oral arguments of counsel at hearing, the Court finds the following facts and states the following conclusions of law.[1]

FINDINGS OF FACT AND CONCLUSIONS OF LAW

1. Plaintiffs Diaz, Wilbanks, and Olszynski have proposed the following Class, pursuant to Rule 23 of the Nevada Rules of Civil Procedure:

> **All current and former Nevada employees of Defendants paid less than $8.25 per hour at any time since July 1, 2010, who did not enroll in Defendants' health insurance plan.**
>
> **(hereinafter the "Not Enrolled" Class).**

2. The Court finds that the requirements of Rule 23(a) and (b) of the Nevada Rules of Civil Procedure, as described herein, are met, and that certification of the "Not Enrolled" Class pursuant to rule is appropriate.

3. The Court finds that the proposed "Not Enrolled" Class consists of approximately 2,022 putative members, and that it therefore satisfies the numerosity

[1] If any finding herein is in truth a conclusion of law, or if any conclusion stated is in truth a finding of fact, it shall be deemed so.

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DEPARTMENT SIXTEEN
LAS VEGAS NV 89155

requirement of Rule 23(a)(1).

4. The Court finds that the commonality requirement of Rule 23(a)(2) is satisfied, as there are common questions of law or fact applicable to all members of the "Not Enrolled" Class, including, but not limited to: Whether a "Not Enrolled" Class member is or was an employee of the Defendant; Whether a "Not Enrolled" Class member is or was employed by Defendants at any time since July 1, 2010; Whether a "Not Enrolled" Class member was enrolled in Defendants' health insurance plan; and, Whether a "Not Enrolled" Class member was paid less than $8.25 an hour at any time during the stated period.

5. The Court finds that the typicality requirement of Rule 23(a)(3) is satisfied, as the claims of Plaintiffs Diaz, Wilbanks, and Olszynski are typical of the claims of the "Not Enrolled" Class, including, but not limited to the fact that Plaintiffs allege they were paid less than $8.25 an hour, and were not enrolled in Defendants' health insurance plan.

6. The Court finds that the adequacy requirement of Rule 23(a)(4) is satisfied, as Plaintiffs Diaz, Wilbanks, and Olszynski are factually within the definition of the "Not Enrolled" Class, and there are no other issues that indicate that the proposed Class representatives would be inadequate under the facts of this matter.

7. The Court finds that the law firm of Wolf, Rifkin, Shapiro, Schulman & Rabkin, LLP satisfies the adequacy requirement to serve as counsel for the "Not Enrolled" Class.

8. The Court finds that the predominance requirement of Rule 23(b)(3) is satisfied, as the common questions of law or fact identified herein predominate over any questions affecting individual members.

9. The Court finds that the superiority requirement of Rule 23(b)(3) is satisfied, as a class action would be far superior than having over 2,000 individual claims filed in and burdening the district court.

10. The Court finds that as to Defendants' Motion to Stay Proceedings on Application for Order Shortening Time, the Court denies the Motion as to the "Not Enrolled" Class.

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11. The Court finds that as to Plaintiffs' Motion for Partial Summary Judgment on Liability Regarding Defendants' Health Benefits Plans, the Court denies the motion without prejudice, not based upon the underlying merits of the motion, but because for the Court to even consider the motion, there should have been a Nevada Rule of Civil Procedure 16.1 initial expert disclosure as it relates to Dean Matthew T. Milone.

12. The Court finds that as to Defendants' Countermotion to Strike Undisclosed Purported Expert and for Sanctions, the Court denies the motion based upon the timing of the new issue of Liability Regarding Defendants' Health Benefits Plan, which was raised on August 13, 2015, where the Court itself recognized that expert input would be helpful to reach its decision. Defendants shall be given 45 days to designate their own expert on the issue of Liability Regarding Defendants' Health Benefits Plan.

IT IS THEREFORE ORDERED that Plaintiffs' Motion for Class Certification is **GRANTED**, and the Court certifies the "Not Enrolled" Class consisting of

> **All current and former Nevada employees of Defendants paid less than $8.25 per hour at any time since July 1, 2010, who did not enroll in Defendants' health insurance plan.**

IT IS FURTHER ORDERED that Plaintiffs Paulette Diaz, Lawanda Gail Wilbanks, and Shannon Olszynski are designated representatives of the certified "Not Enrolled" Class;

IT IS FURTHER ORDERED that the law firm of Wolf, Rifkin, Shapiro, Schulman & Rabkin, LLP is approved as Class Counsel for the "Not Enrolled" Class certified by this Order.

IT IS FURTHER ORDERED that Defendants' Motion to Stay Proceedings on Application for Order Shortening Time is **DENIED** as to the "Not Enrolled" Class.

IT IS FURTHER ORDERED that Plaintiffs' Motion for Partial Summary Judgment on Liability Regarding Defendants' Health Benefits Plans is **DENIED without prejudice**.

IT IS FURTHER ORDERED that Defendants' Countermotion to Strike Undisclosed Purported Expert and for Sanctions is **DENIED**.

. . .

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IT IS FURTHER ORDERED that Defendants shall be given 45 days to designate their own expert on the issue of Liability Regarding Defendants' Health Benefits Plan.

IT IS SO ORDERED this 13th day of October, 2015.

TIMOTHY C. WILLIAMS
DISTRICT COURT JUDGE

CERTIFICATE OF SERVICE

I hereby certify that on the date filed, this document was electronically served to all registered parties for case number A701633 as follows:

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EIGHTH JUDICIAL DISTRICT COURT

IN AND FOR CLARK COUNTY, STATE OF NEVADA

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

Plaintiffs,

vs.

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

Defendants.

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

PLAINTIFFS' RENEWED MOTION FOR PARTIAL SUMMARY JUDGMENT ON LIABILITY REGARDING DEFENDANTS' HEALTH BENEFITS PLANS

Hearing Date: May 31, 2016
Hearing Time: 9:00 a.m.

Plaintiffs here renew filing of their Motion for Partial Summary Judgment on Liability Regarding Defendants' Health Benefits Plans. The Motion is based on the Memorandum of Points and Authorities below, all papers and exhibits on file herein, the declarations of Bradley S. Schrager, Esq. (See **Exhibit 1**) and the expert report of Matthew T. Milone (See **Exhibit 2**), Senior Associate Dean for Legal Affairs at the University of Nevada School of Medicine and longtime practitioner of Nevada and federal health insurance law, and whose curriculum vitae is included with his report and declaration, and any oral argument at hearing in this matter.

/ / /

NOTICE OF MOTION

TO: ALL PARTIES AND THEIR COUNSEL OF RECORD:

Please take notice that the undersigned will bring **PLAINTIFFS' RENEWED MOTION FOR PARTIAL SUMMARY JUDGMENT ON LIABILITY REGARDING DEFENDANTS' HEALTH BENEFITS PLANS** on for hearing before this Court at the Eighth Judicial District Court, 200 Lewis Avenue, Las Vegas, Nevada 89155, on **May 31, 2016** at **9:00 a.m.** in Dept. XVI or as soon thereafter as counsel can be heard.

DATED this 18th day of April, 2016.

WOLF, RIFKIN, SHAPIRO, SCHULMAN & RABKIN, LLP

By: /s/ Bradley Schrager

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I. INTRODUCTION

Article XV, section 16(A) of the Nevada Constitution (the "Minimum Wage Amendment" or the "Amendment") states:

> Each employer shall pay a wage to each employee of not less than the hourly rates set forth in this section. The rate shall be five dollars and 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. Offering health benefits within the meaning of this section shall consist of making **health insurance** available to the employee for the 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.

Nev. Const. art. XV, § 16(A) (emphasis added). Defendants here have claimed the right to pay Plaintiffs at the lower-tier minimum wage rate under the Amendment, on the basis of having provided health benefits plans (collectively, the "Plans") that they purport qualify them to have done so.[1]

This motion asks and answers two questions: First, what is meant by "health insurance" as used in the Amendment—what are its elements and requirements under law?[2] Second, do Defendants' health plans offered to Plaintiffs annually between 2010 and 2015 meet those requirements, so that Defendants may pay employees to whom the plans were provided less than $8.25 per hour worked?[3]

---

[1] The Court will recall that of the 2,500 employees Defendants identified as having been paid less than $8.25 since 2010, approximately 500 of those accepted or enrolled in Defendants' plans at one time or another during their employment. The Court has already certified a Rule 23 class in this action consisting of "All current and former Nevada employees of Defendants paid less than $8.25 per hour at any time since July 1, 2010, who did not enroll in Defendants' health insurance plan."

[2] The Nevada Labor Commissioner has stated that the elements of "health benefits" under the Minimum Wage Amendment, in order to pay the lower-tier rate, means that the benefits "must be

> (1) actual health insurance;
> (2) must be made available to the employee;
> (3) must provide coverage for the employee and dependents; and
> (4) must satisfy the 10 percent cost cap" for premiums paid by the employee.

See Opening Brief of the State of Nevada, Office of the Labor Commissioner, Nev. Sup. Ct. Case No. 68770, at 10 (November 30, 2015); see also Reply Brief of the State of Nevada, Office of the Labor Commissioner, Nev. Sup. Ct. Case No. 68770, at 4 (January 14, 2016).

[3] In discovery, Plaintiffs have requested Defendants' 2016 health benefits plan, if one exists. Defendants have so far failed to produce any such plan.

The basic disagreement between the parties regarding Defendants' health benefits plans is that Plaintiffs maintain that the term "health insurance," as used in the Amendment, necessarily means health insurance lawful for the purposes it is offered. Health insurance is highly regulated in this state, as it is in every state. Accordingly, Defendants' Plans must comply with the basic legal requirements of health insurance in Nevada. In this state, health insurance offered by employers to their employees is regulated by N.R.S. Chapters 608 (Labor Code), 689A (Individual Health Insurance), and 689B (Group and Blanket Health Insurance) and, therefore, Defendants' Plans must comply with those provisions of law in order to be lawful "health insurance" under the Amendment, or in any other context. The Minimum Wage Amendment did not create, for the first time, some new and unregulated category of bare-bones employer-offered health insurance. Rather, it intends that the "health insurance" provided to minimum wage employees for the purposes of reducing their wages under the Amendment be meaningful health insurance, just as the Legislature had required of any employer providing health insurance to employees to meet coverage and procedural minimums so that the health insurance in question functions as health insurance. Health insurance under the Amendment cannot be junk benefits like Defendants' Plans. The Plans at issue here do not meet Nevada's legal requirements for health insurance and therefore Defendants cannot pay Plaintiffs below the upper-tier minimum hourly rate.[4]

Defendants, on the other hand, believe that "health insurance" under the Minimum Wage Amendment means any benefit at all for which premiums are paid and claims of some type that are paid out to beneficiaries—with no coverage minimums and no substantive requirements whatsoever. In other words, Defendants argue that the Amendment takes "health insurance" out of its customary regulatory world entirely, and that there is no floor or lower limit to the type or quality of benefits that such plans may contain in order for employers to withhold a dollar per hour from their employees. Defendants' first expert goes so far as to say that because minimum wage employees like Plaintiffs are so poorly paid that they may qualify for state and federal assistance through Medicaid, employers like Defendants do not have to provide any health benefits at all in order to pay down to $7.25 per hour.

[4] Neither do Defendants' plans meet state regulatory or federal statutory requirements, as described below. In fact, there are no legitimate legal standards that these plans do meet.