To help us develop a more useful index, please let us know if you have ideas for index entries. See "Comments and Suggestions" in the "Introduction" for the ways you can reach us.

T

V

W

X

EXHIBIT 24

EXHIBIT 24

Timothy Mulliner

From: Timothy Mulliner
Sent: Thursday, February 25, 2016 12:47 PM
To: Michael Arrigo
Subject: Re: Contact Info

Aside from a 3:45 appointment today, I think I have cleared my schedule through Monday. I am currently researching some background of NRS Chapter 608.

I will try reaching you shortly.

Sent from my iPhone

On Feb 25, 2016, at 11:24 AM, Michael Arrigo <marrigo@noworldborders.com> wrote:

> Good morning Tim. I placed a call to you at 11am to touch base. Here is an update since it sounds like we may not speak before our 2:30pm today with Morris Polich attorneys.
> I have placed calls to Michael Tenchek and State of NV / Leeta Brown / Mary Huck to see if they can speak with us at either 1:30pm PT or after 3:30pm PT today.
>
> ---
>
> **From:** Timothy Mulliner <tmulliner@mullinerlaw.com>
> **Date:** Thursday, February 25, 2016 at 9:47 AM
> **To:** Michael Arrigo <marrigo@noworldborders.com>
> **Subject:** Re: Contact Info
>
> Michael,
>
> My apologies for not having the time this morning I anticipated. I am currently at my 9:30 and will keep you updated as to when I free up.
>
> Our timeframe is less than desirable to say the least. I am hoping they can secure a more realistic deadline by the time we speak again this afternoon.
>
> Tim
>
> Sent from my iPhone
>
> On Feb 25, 2016, at 5:06 AM, Michael Arrigo <marrigo@noworldborders.com> wrote:
>
> > Tim, thank you for your email. I look forward to working with you as well.
> >
> > I think it would be good if we can speak before your 9:30am if possible. 8am to 9:30am are open for me.
> >
> > I would like to see if we can get in 1-2 calls with the former commissioner and the State or at least agree on when we can mutually schedule time.

I am also thinking that to maximize our collaboration and meet the deadline I may need to come to you so we can work together on Sunday. I'm willing to drive out to Las Vegas Saturday.

Regards,

Michael Arrigo
949-633-5664 mobile
949-335-5580 x101 office
marrigo@noworldborders.com

No World Borders
Experts in healthcare data, regulations and economics
No World Borders, Inc.
620 Newport Center Drive
Suite 100
Newport Beach CA 92660
949-335-5580 main
http://www.noworldborders.com

From: Timothy Mulliner <tmulliner@mullinerlaw.com>
Date: Wednesday, February 24, 2016 at 9:47 PM
To: Michael Arrigo <marrigo@noworldborders.com>
Subject: Contact Info

Michael,

My apologies for the delay. My full contact info is below.

After checking my calendar, I have appointments at 9:30 am and 3:45 pm tomorrow. Are you able to connect in between, around 11:00 am to discuss status and strategy? I can be free before my 9:30 as well. Thanks and I look forward to working with you.

Tim

Timothy R. Mulliner, Esq.
Mulliner Law Group, Chtd.
8379 West Sunset Road, Suite 140
Las Vegas, NV 89113

Office: 702-240-8545
Cell: 702-468-9302
Fax: 702-920-8606

EXHIBIT 25

EXHIBIT 25

March 14, 2016

Ms. Deanna Forbush and Mr. Nicholas Wieczorek
Partners
Morris Polich & Purdy LLP
500 South Rancho Drive
Suite 17
Las Vegas, NV 89106-4847

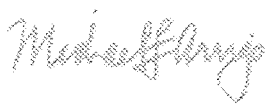
Re: Paulette Diaz, Lawanda Gail Wilbanks, Shannon Olsynski; and Charity Fitzlaff on behalf on themselves and all similarly-situation individuals, Plaintiffs, vs. MDC Restaurants, LLC; Laguna Restaurants, LLC; Inka, LLC; and DOES 1 through 100, inclusive, Defendants. (Hereinafter Diaz v. MDC)

Dear Ms. Forbush and Mr. Wieczorek:

Your firm requested that I review and respond to certain aspects of an expert report submitted by Mr. Matthew Milone on behalf of Diaz et al. Specifically, I was requested to respond to Mr. Milone's opinion of whether health insurance coverage offered by MDC to employees earning $7.25 per hour in Nevada between 2010 and 2015 complies with NRS § 608.102 "Nevada Minimum Wage Law."

Please see my findings herein and in the included PowerPoint slides which are intended to be an integral part of this rebuttal report.

Respectfully,



Michael F. Arrigo

MICHAEL F ARRIGO 620 NEWPORT CENTER DRIVE SUITE 1100 NEWPORT BEACH CA 92660
Offices in Boston, New York, Washington DC, Nashville, Atlanta, Jacksonville
Seattle, Salt Lake City, Denver, Chicago, Dallas, San Francisco, Palo Alto, Los Angeles, San Diego

I, Michael F. Arrigo, declare:

I am familiar with health insurance in this case by virtue of my training, education, specialized knowledge, and experience. I am the Managing Partner of No World Borders. This declaration is based upon my personal knowledge except where otherwise indicated, and if called as a witness, I could and would competently testify to the facts stated herein.

OVERVIEW

I was provided with an expert report by Matthew Milone ("The Milone Report,") over 300 pages of records, reports, data, deposition excerpts, pleadings, and correspondence regarding insurance coverage under NRS § 608.102. I was requested respond to certain aspects of an expert report submitted by Mr. Matthew Milone on behalf of Diaz et al. Specifically, I was requested to respond to Mr. Milone's opinion of whether health insurance coverage offered by MDC to employees earning $7.25 per hour in Nevada between 2010 and 2015 complies with The Nevada Administrative Code § 608.102 and § 608.104.

This report details the methods used, according to the documents available to me, my training, education, knowledge, and experience, and the documented methodology I used in **Exhibit B**

I accounted for and considered possible alternative explanations and outcomes of these results in TEST RESULTS - **Exhibit C** My opinion on these matters grows naturally and directly out of research in the field of work I practice, and in my experience this Methodology reaches reliable results similar to the opinions I am providing in this Declaration with reasonable certainty, when an expert with similar qualifications and experience applies them.

My opinions are based on my work experience, knowledge, and education as well as published research that I have conducted independent of the litigation consulting in this matter. I provided the same degree of care in formulating my opinions as I do in my regular professional work independent of litigation consulting as an expert. I am providing an independent opinion and I derive no benefit in any outcome of this matter based on the opinions provided in this Declaration.

SUMMARY OF OPINIONS

Standards for Determining What is "Health Insurance"

The Milone report implies that in all cases MDC falls short of requirements to provide "health insurance coverage," and is therefore unhelpful in explaining what a reasonable employer in Nevada should do. The claim in the Milone report that MDC falls short is significantly overstated, because the report assumes only one criteria. The report does not consider multiple time frames, gender specific programs, disease specific and diagnosis specific programs, children's programs, Medicaid, Nevada Medicaid Expansion that preempt prior employer industry standards and best practices for health insurance coverage, and that an MDC worker earning $7.25 per hour who qualifies for Medicaid or children's health insurance (CHIP, also known in Nevada as "Check Up") may mitigate the employee's cost of medical care without any insurance from MDC.

A centerpiece of the Patient Protection and Affordable Care Act—often referred to as "Obamacare"—is the expansion of Medicaid eligibility to people with annual incomes below 138 percent of the federal poverty level. Medicaid, the national health insurance program for low-income people, is administered by States and is as in Nevada a no cost, no premium program to adults that covers 100% of their medical costs (children's' programs may cost $8 to $27 per month for all children). The Milone report does not address this and how Medicaid, according to the Internal Revenue Service, industry best practices noted by national CPA firms and thought leadership groups, is an essential factor in determining whether employers have a duty to provide insurance to a cohort of their employees, or whether employers would be subject to penalties (*See IRS Publication* – What Counts as Minimum Essential Coverage [i], Washington Council Ernst & Young Presentation February 2013, [ii] and Kaiser Family Foundation "... firms will not face a penalty for workers who qualify for Medicaid ..."[iii]).

Programs for Women

The Milone Report makes no mention of special programs under Medicaid for women. Women are more likely to hold low-wage or part-time jobs, so Medicaid may be their only possible source of coverage.[iv] [v] Since women comprise the majority (59 percent) of Nevada's adult Medicaid beneficiaries [vi], in my opinion this segment of the MDC worker population earing $7.25 per hour must be considered specifically, matching the relevant programs before and after January 1, 2014.

As of February 2010, Medicaid played a critical role in providing health coverage for women (*See* National Women's Law Center, Women and Medicaid in Nevada, February 2010). Nationally, nearly 17 million nonelderly women— including 6 percent of those living in Nevada—are covered through Medicaid.[vii] [viii] In my opinion, Medicaid programs for women would cover some if not all of this cohort of the MDC employees earning $7.25 per hour.

Ambiguity of Standards

The Milone report does not take into consideration the lack of specificity in the Minimum Wage Law which was acknowledged by the Nevada Insurance Commissioner at the time immediately after the law was enacted. *"What is health insurance? That a very good question. The [minimum wage] amendment doesn't say what it is, just that the employer has to offer it in order to take advantage of the lower rate. As pointed out earlier, there are all sorts of different kinds of health benefits that are available. Think of group health, HMO's, PPO's, self-funded plans, cost reimbursement plans, and the list goes on. You have to be careful with this question, because it is really easy to get bogged down in the complexity Insurance.*[ix]"

Insurance for Expenses that Would Have Been Borne by Employee Not Addressed

The Milone report does not specifically address what the employer must offer as health insurance coverage based on the IRS tax code reference and is therefore unhelpful in explaining what a reasonable Nevada employer should do. The Nevada Labor Commissioner's guidance states, "To determine if your health insurance is a qualified plan, you may refer to NAC 608.102 and NAC 608.104x." NAC § 608.102 states, 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; ...or...'0378

In my opinion, since some or all MDC workers earning $7.25 per hour would more likely than not qualify for Medicaid, after January 1, 2014, they may not bear any expenses for medical care, even without MDC health insurance coverage.

Unhelpful Regarding Education or Guidance to Employers on ERISA

The Milone report does not specifically address what the employer must offer as health insurance coverage based on the ERISA guidelines (Employee Retirement Income Security Act, better known as ERISA, passed in 1974 to regulate private pension funds, including Taft-Hartley Trusts) and I can see no specific guidance that would be helpful to employers. My understanding is that this requirement was originally designed for self-insured employers, not for the Minimum Wage Law. Continuing from the immediate prior section above, the alternate form §608.102 provides for is, " (b) Provides health benefits pursuant to a Taft-Hartley trust which: (1) Is formed pursuant to 29 U.S.C. § 186(c)(5); and (2) Qualifies as an employee welfare benefit plan: (I) Under the guidelines of the Internal Revenue Service; or (II) Pursuant to the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 et seq."

Unfortunately, ERISA does not provide any specific guidance for an employer either, since it is very broad, stating that any plan fund or program paying for a broad category of medical services and non-medical services fall under ERISA. This is unhelpful to employers who must make finite decisions regarding coverage. Section 3(1) of Title I of ERISA defines the term "employee welfare benefit plan" to include:

> "[A]ny plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 302(c) of the Labor Management Relations Act, 1947 [29 USCS section 186(c)] (other than pensions on retirement or death, and insurance to provide such pensions)[xi]."

The Milone report implies that states currently are exempt from federal regulations regarding insurance (*See* page 3 of 19 of Milone Report, Section IV Bates number DIAZ000105). However, with the implementation of the Affordable Care Act (ACA), the federal government also regulates insurance.

The Milone report mentions HIPAA and The Patient Protection and Affordable Care Act ("ACA") but does not examine the definitions of 'health insurance coverage' provided in each. HIPAA, having been mandated well before 2010 provides one definition, and the ACA along with Medicaid expansion became effective January 1, 2014 also provides a definition, along with new coverage requirements and exemptions and Safe Harbors for employers (*See* page 3 of 19 of Milone Report, Section IV Bates number DIAZ000105).

Minimum Essential Coverage Standard Applied without Considering All Possible Outcomes

The Milone Report implies that the application of Affordable Care Act standards, presumably Minimum Essential Coverage ("MEC") is the only appropriate way to measure the MDC plans offered on and after January 1, 2014. This biases the analysis, since the Affordable Care Act also provides that employees who qualify for Medicaid are not part of the total shared contribution penalties that may be levied by the IRS on an employer (See What counts as Minimum Essential Coverage? "... Medicaid Coverage, CHIP...." U.S. Internal Revenue Service (IRS) https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision, Washington Council Ernst & Young Presentation February 2013, http://www.nahu.org/meetings/capitol/2013/attendees/jumpdrive/employer_aca_reference_deck_02_14_2013.pdf and Kaiser Family Foundation "... firms will not face a penalty for workers who qualify for Medicaid ..."http://kff.org/health-reform/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid-an-update/)

Insurer Certification of Compliance with Minimum Wage Act

The Milone report implies that MDC did not provide a minimum level of health insurance coverage but fails to acknowledge that MDC requested and received certification from Cigna that it's Starbridge Plan met Nevada Minimum Wage Act standards.

Affordability and Best Efforts to Provide Insurance

The Milone report omits entirely the issue of affordability of premiums which and whether MDC made reasonable efforts in light of all of these provisions to provide health insurance coverage. In my opinion, it actual compensation of the employee is unknowable for a future period and therefore an employer must make reasonable efforts to provide insurance. In my opinion, MDC made reasonable efforts (*See* Affordability and Reasonable Efforts to Provide Insurance, page 19).

Flaws in Methodology and Testing

The Milone Report uses methods that prevent or weaken inferences that apply findings to a broader set of circumstances by not considering all possible factors, many of which I have listed above. The report also states that Mr. Milone uses an Actuarial Value Calculator when the correct tool is a Minimum Value Calculator for a plan with standard features and for plans with non-standard features to secure actuarial certification (See Minimum Value and Affordability, IRS web site, updated March 3, 2016[xiii]).

Flaws in Methodology and Testing of Milone

Milone's lack of documented methodology makes erroneous assumptions that lead to systematic underreporting of benefits available to MDC workers earning $7.25 per hour. Milone biases his estimates of the rate of health insurance coverage available by only analyzing coverage based on limited sets of data and possible outcomes, without taking into consideration all coverage information, multiple time frames, gender specific programs, disease specific and diagnosis specific programs, children's programs, Medicaid, Nevada Medicaid Expansion that preempt prior requirements. Milone's report fails to consider that other factors may mitigate the employee's cost of medical care without any insurance from MDC, MDC's reasonable efforts to provide health insurance coverage in light of those factors, or that because some or all MDC workers in this cohort may not need other insurance since they may more likely than not qualify for no-cost Medicaid. The Milone report also implies that limits on insurance coverage mean that it is not insurance coverage in a 'traditional' sense, which his not accurate in my opinion (*See* Analysis of Plan Documents and Opinions – 2010 to 2012 Plan and 2013 Plan Limits page 18)

In my opinion, MDC offered benefits to minimum wage workers at the $7.25 rate is "health insurance coverage" from 2010 to 2013, and from 2014 to 2015 onward MDC made reasonable efforts to offer health insurance coverage, given that in my opinion it is exempt from having to provide insurance to some if not all workers earning $7.25 per hour because they qualify for Medicaid.

Plan Name	Applied Industry Best Practices, Guidelines and Statutes Applicable by Year for MDC hourly workers earning $7.25		
	2010, 2011, 2012 2013	2014	2015
Cigna Starbridge	MDC Meets Standard as "Health Insurance Coverage"		
Transamerica Trans Choice		MDC Provides reasonable insurance; "Minimum Essential Coverage" Does not Apply, Coverage Met Through Medicaid	
MVP			MDC Provides reasonable insurance, "Minimum Essential Coverage" Does not Apply, Coverage Met Through Medicaid

Figure 3 - Summary of Benefits Offered by Year vs. Annual Best Practices, Guidelines and Statutes

In my opinion, the functions of a health insurer providing *health insurance coverage* include 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 ("reimbursement") by determining what claims in compliance with the medical policy determined medically necessary will be paid, pended or denied.

> Mr. Milone writes in his 2015 report, "The primary federal laws that have altered the health insurance marketplace are the Health Insurance Portability and Accountability and Accountability Act of 1996 ("HIPAA") … and the Patient Protection and Affordable Care Act of 2010 ("ACA") …"

HIPAA From 1996 Consistent with MDC Benefits As "Health Insurance Coverage" 0383

HIPAA provides a clear definition of health insurance coverage.

HIPAA SEC. 2791. DEFINITIONS (b) DEFINITIONS RELATING TO HEALTH INSURANCE.— provides,

> "(1) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer.[xiii]"

Title XXVII of the Public Health Service Act (PHS Act), as added by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) references CFR 144.103. In a 1999 memorandum from the U.S. Department of Health and Human Services Healthcare Financing Administration (HCFA, now renamed CMS) cites Definitions in CFR 144.103 (*See* Program Memorandum Insurance Commissioners Insurance Issuers Transmittal No. 99-02, Date June 1999)[xiv].

CMS Definition Consistent with MDC "Health Insurance Coverage"

The U.S. Health and Human Services (HHS) Centers for Medicare and Medicaid (CMS) define Health Insurance as,

> *"A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium."* [xv] *Where Premium is defined as The amount that must be paid for your health insurance*[xvi] *or plan. You and/or your employer usually pay it monthly, quarterly or yearly*

In my opinion, MDC employees paid $7.25 per hour more likely than not qualify for Nevada State Government supplied healthcare ("Medicaid," also known in Nevada as "Access Nevada") to mitigate their cost of healthcare (*See* Medicaid & Nevada Check Up – Nevada Health Link can help you determine if you or your family members qualify for government supplied healthcare [xvii]). Exceptions to these income calculations may include tips, alimony, per diem and travel reimbursement, however I not know which MDC employees have these types of income, nor whether the State of Nevada has made determinations as to weather these apply (*See* Nevada Department of Welfare Services BACKGROUND & EXPLANATION of policy

changes/clarifications/updates For November 1, 2015[xviii]).

MDC Benefits Are "Health Insurance Coverage" Under Medicaid Expansion and ACA

A centerpiece of the Patient Protection and Affordable Care Act—often referred to as "Obamacare"—is the expansion of Medicaid eligibility to people with annual incomes below 138 percent of the federal poverty level.

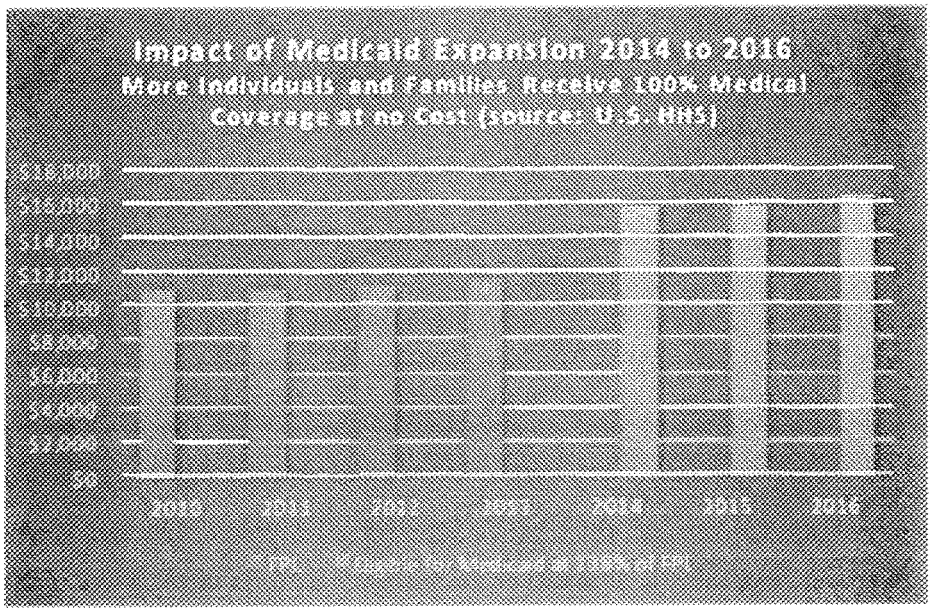


Figure 2 - Federal Poverty Level (FPL) income 2010 to 2013 compared to level of incomes included in eligibility for Medicaid (higher earners may still receive 100% health coverage at zero or minimal out of pocket cost)

The definition of *Health Insurance coverage* in the ACA matches the language in HIPAA, and expands on acceptable forms of insurance[xix]. The ACA provides a consistent definition of 'health insurance coverage' from matching the language from 1996 when HIPAA was mandated to current references in the ACA and elaborating on the types of insurance including group, individual, and short-term, limited duration:

> *"Health insurance coverage* means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer. [expanded language follows] Health insurance coverage includes group health insurance coverage, individual health insurance coverage, and short-term, limited-duration insurance.[xx]"

Register relating to health care quality in the Exchanges,[6] enrollee experience measures and domains,[7] and the QRS, which provided valuable feedback on quality reporting and quality rating requirements.[8] We considered all of the public input as we developed the policies in this final rule.

C. Structure of Final Rule

The regulations outlined in this final rule will be codified in 45 CFR parts 144, 146, 147, 148, 153, 154, 155, 156, and 158. Part 144 outlines requirements relating to health insurance coverage, limit on cost-sharing for years after 2014; minimum certification standards; standards for recognition of certain types of coverage as minimum essential coverage; quality standards for QHPs; and other QHP issuer responsibilities. Part 158 outlines standards related to the MLR program, including standards related to treatment of ICD–10 conversion costs, standards related to adjustments for issuers affected by the HHS transitional policy and issuers that incurred costs due to the technical issues during the implementation of the Exchanges, and standards related to discussed nearly all of the proposed policies in the preamble to the HHS Notice of Benefit and Payment Parameters for 2015 final rule published on March 11, 2014 (79 FR 13744).[9] HHS believes that interested stakeholders had adequate opportunity to provide comment on the policies established in this final rule.

A. Part 144—Requirements Relating to Health Insurance Coverage

Definitions of Product and Plan (§ 144.103)

Figure 3 - Federal Register / Vol. 79, No. 101 Rules and Regulations citation of 144.103 - Definitions
https://www.gpo.gov/fdsys/pkg/FR-2014-05-27/pdf/2014-11657.pdf

MDC Employees at $7.25 Below 138% of FPL, Qualify for Medicaid to Mitigate Medical Costs

In my opinion, for MDC employees at $7.25 per hour, an employee of MDC would have income of $15,130.75 working a full-time equivalent of 2,087 hours which is below 138% of the federal poverty level, (In 2015, 138% of poverty level is $16,240 for an individual or $33,460 for a family of four, an MDC employee would qualify for Medicaid and provides a wealth of services and waivers offered under §1915(c) of the Social Security Act even before the effective date of the ACA, and that additional coverage under State Medicaid expansion mandated by the ACA is now available.

Benefits under Nevada Medicaid waivers include care management services to individuals with certain qualifying conditions including:

- asthma;
- chronic obstructive pulmonary disease/
- chronic bronchitis/
- emphysema; pregnancy and complications of pregnancy;
- diabetes mellitus;
- end stage renal disease/
- chronic kidney disease;
- heart disease/coronary artery disease;
- HIV/AIDS;
- mental health;
- neoplasm/tumor/cancer;
- obesity; substance use disorder;
- cerebrovascular disease/
- aneurysm/
- epilepsy; and musculoskeletal system problems
- case management,
- home maker, respite care attendant care,
- specialized medical equipment and supplies
- assisted living,
- home delivered meals,
- home and community based waivers for persons with Acquired or Traumatic Brain Injury,
- dependents of workers who are Aged/Elderly,
- Children's Health Insurance through Nevada Check Up, and or those with Autism, other Intellectual and/or Developmental Disabilities,
- Fragile and/or Technology-Dependent,
- Mental Illness, or who are Physically or Otherwise Disabled.

In addition Nevada received over $50 million from the federal government to fund inpatient services via Disproportionate Share Hospital (DSH) adjustment payments which provide additional help to those hospitals that serve a significantly disproportionate number of low-income patients[21]. Other Home and Community Based Services (HCBS) are provided in Nevada[22].

MDC Employees Earning $7.25 per Hour Have Easy Access to Medicaid Information and Applications

In my opinion, MDC employees paid $7.25 per hour under Medicaid would not be subject to limited-enrollment period, meaning they can enroll at any time, and once covered through Medicaid (*See* Medicaid & Nevada Check Up – Nevada Health Link can help you determine if you or your family members qualify for government supplied healthcare [23]). Additionally, in a few clicks of a mouse button, an employee can go to Healthcare.gov on a computer and determine if they qualify for Medicaid, and initiate an application.

MDC Employees Earning $7.25 per Hour for CHIP and Pregnancy Benefits, Waivers

In my opinion, an MDC employee paid $7.25 per hour, working a full-time equivalent of 2,087 hours would more likely than not have individual or household income below 138% of poverty (about $16,105 for a single person in 2014 and $16,394 in 2016), an MDC employee who is a pregnant woman, would qualify with income up to 160% of FPL, and children are eligible for CHIP with household income up to 200% of FPL. MDC employees paid $7.25 per hour who qualify for Nevada Medicaid would pay nothing for coverage (no premiums) and would be provided with medical and dental benefits (*See* Nevada Department of Welfare and Supportive Services [24 25])

In my opinion, MDC employees paid $7.25 per hour would also meet insurance requirements of the Affordable Care Act (*See* Medicaid & Nevada Check Up – Nevada Health Link can help you determine if you or your family members qualify for government supplied healthcare [26]).

In my opinion, the children of MDC employees paid $7.25 per living in households with an annual income of up to 200% of the federal poverty level more likely than not would qualify for coverage through Nevada Check Up. This is $47,700 for a family of four (based on 2014 FPLs) and $48,600 in 2016 (*See* Medicaid & Nevada Check Up – Nevada Health Link can help you determine if you or your family members qualify for government supplied healthcare [27]). The only cost to the Nevada Check Up enrollee is a quarterly premium. Enrollees are not required to pay co-payments, deductibles, or other charges for covered services. Premiums are determined by family size and income. Quarterly premiums range between $25 and $80 dollars and are charged per family, not per child (*See* Nevada Check Up, Authorized under Title XXI of the Social Security Act, Nevada Check Up (NCU) is the State of Nevada's Children's Health Insurance Program (CHIP) [28].

In my opinion, both before the Affordable Care Act ("ACA") and after the ACA, Medicaid, Medicaid Waivers under Section 1915 of the Social Security Act, and Medicaid Expansion under the ACA provide a wealth of services which supplement MDC benefits, mitigate Plaintiff's cost of care, and would be available more likely than not to most if not all MDC employees paid at $7.25 per hour based on the 138% of Federal Poverty Level (FPL) eligibility standard. Other programs may be available to insureds with higher incomes.

Analysis of Plan Documents and Opinions – 2010 to 2012 Plan and 2013 Plan Limits

The Milone Report implies that since the health insurance coverage provided by MDC in this time frame limits the total amount of benefits paid by the plans, it means that they are not 'traditional health insurance.' That claim is significantly overstated because the report implies that any limit paid on the amount paid out for any medical care means that a policy is not health insurance. In my opinion, **all** health insurance has limits, and no insurance pays an unlimited amount, even under new plans mandated by the Affordable Care Act. In fact, health insurance coverage plans pay different amounts of the total costs of an average person's care by taking into account the plans monthly premium, deductible, copayments, coinsurance, and out-of-pocket maximum. The actual percentage paid in total or per service may depend on the services used during the year [29]. Other plans limit insured's choices or charge more if you use providers outside their network [30].

Milone Report Uses Methodologies that are Speculative, Unreliable and Not Applicable to Determining "Health Insurance Coverage"

Mr. Milone's report ("the Plaintiff's Expert Report) uses methodology(ies) that are speculative and unreliable, applies non-applicable standards, undocumented methods, tests, and test results and applies incorrect standards to draw conclusions.

Plaintiff's Expert Report uses methodology(ies) that are speculative and unreliable, since Mr. Milone applies incorrect or undocumented methods, tests, and test results to draw conclusions and opinions. The Milone Report does not demonstrate through standardized, documented methods and test results. Specifically, the Plaintiff's Expert Report incorrectly applies an 'Actuarial Calculator' (the correct terminology in the ACA Minimum Essential Coverage or MEC determination as mentioned earlier in my report is a Minimum Value Calculator) which was designed to determine network liability for the health plan, and does not consider all possible outcomes including FPL calculations for the benefits to the prospective MDC wage earners at $7.25 as insureds.

Affordability and Reasonable Efforts to Provide Insurance

Since in my opinion more likely than not most if not all MDC employees earning $7.25 per hour are eligible for Medicaid, it is also likely that these employees can secure health insurance coverage for no cost for adults and their children can receive full care for under $27.00 per month for all children in the family. If, however an MDC employee does not qualify for Medicaid, the Milone report does not acknowledge difficulties for employers in setting insurance premiums less than ten percent of total earnings when the employee's total future income is unknowable. An employee's eligibility for a premium tax credit [31] is unknowable at the time he or she obtains coverage because her eligibility generally depends on her annual household income for a future year[32]. For example, credits for coverage purchased in October 2014 for the 2015 taxable year depend on household income for that future year. This correspondingly makes it impossible for an employer to know if it will face a penalty,[33] because it can't predict whether an employee will properly get a credit, and it can't predict whether employer-provided coverage is affordable to a given employee. Under the ACA, if an employee receives a tax credit because they have secured their own insurance, the employer is to have shared responsibility for contributing to the cost of insurance, unless the employee qualifies for Medicaid.

Of course, the employer will know the employee's projected wages for the future year, a tax the credit depends on actual household income, not projected wages. Household income could be greater or lower than projected wages, on account of non-wage income items or any allowable items of deduction. And it would be very uncommon for an employer to receive information on all these items. I do not know of any employer who, for example, routinely asks its employees to reveal the amount of deductible alimony they pay to their ex-spouses. Consequently, were it not for exceptions employers would have difficulty providing the right health insurance coverage at the right cost, therefore avoiding shared responsibility obligations ("penalties"). There are provisions that allow large employers to avoid their shared responsibility if they reasonable efforts to offer insurance [34].

QUALIFICATIONS

I earned my Bachelor of Science in Business Administration from the University of Southern California, Marshall School of Business, in 1981. I am currently attending Stanford Medical School studying Biomedical Informatics with an emphasis on mHealth and statistical analytics for population health management.

I previously worked for various Silicon Valley companies, including Oracle, Hewlett Packard, Symantec, Borland and Intel, with roles ranging from analyst to Product Manager, Vice President of Marketing and Sales, Corporate Development and Management Consultant. I was also previously the Senior Vice President of eCommerce for Fidelity and CoreLogic.

I am currently the Managing Partner of No World Borders. In this role, I consult with and advise healthcare organizations and investors regarding healthcare-related regulations, including medical record and billing documentation, the International Classification of Diseases version 10 from the World Health Organization (WHO) (ICD-10) which is the new coding standard as of October 1, 2015 in support of Section 1886(d) of the Social Security Act and Title 42: Public Health Part 412—Prospective Payment Systems for Inpatient Hospital Services, Current Procedural Terminology (CPT) coding, compliance programs, business damages, Medicare and Medicaid insurance fraud, Workers Compensation medical bills and fraud under California Labor code §4600, Usual, Customary and Reasonable (UCR) medical charges (Criteria for determining reasonable charges 45 CFR §405.502), the Health Insurance Portability and Accountability Act (HIPAA Privacy Rule 45 CFR Part 160 and Subparts A and E of §164, and HIPAA Security Rule 45 CFR §160 and Subparts A and C of §164), the Meaningful Use provisions of the American Recovery and Reinvestment Act of 2009 (ARRA) specifically the Health Information Technology for Economic and Clinical Health including security risk analysis (HITECH Act 45 CFR §164.308(a)(1)), Meaningful Use Provisions for Electronic Health Record certification criteria (including § 170.304-§ 170.314), Standards for the Electronic Health Record Technology Incentive Program (physician and hospital HITECH Act Stimulus funds) 42 CFR Part 495 Subpart B—Requirements Specific to the Medicare Program and Subpart D—Requirements Specific to the Medicaid Program, the Confidentiality of Medical Information Act ("CMIA") California Civil Code section 56, *et seq.* In addition to these

regulations, I also consult with and advise healthcare organizations regarding health care claims reimbursement, coverage determination provisions of the Patient Protection and Affordable Care Act of 2010 including Prohibition of Preexisting Condition Exclusions (45 CFR § 147.108), Medicare Expansion and Health Insurance Exchanges, the Office of the Inspector General (OIG) self-disclosure, and HIPAA data breach response and remediation. A copy of my curriculum vitae is attached hereto as **Exhibit A**.

In my role as Managing Partner of No World Borders and based on my education and experience, I have knowledge regarding the industry standards and regulations, guidelines and best practices in private insurance, Medicare, Medicaid, Workers Compensation, private insurance, and other payors under fee for service, capitated, and risk based payment methods under Medicare Part C and the Affordable Care Act. By virtue of my training, education, knowledge and experience, I can fairly evaluate the issues in this case.

My relevant experience in these topics including Medicaid and The Affordable Care Act prior to this case include:

- ***Confidential v. Confidential in matter before Federal Trade Commission; as well as preparation for litigation filings in California, New York, Florida, Texas State Attorneys General*** - Estimates of financial impact on U.S. health population under fee for service Medicine and the future Affordable Care Act, based on new regulations. Litigants are two of the largest healthcare firms in America with market capitalizations of over $10 billion. Medical coding and economics healthcare expert for landmark litigation; December 2011 to June 2012; worked directly with Jonathan Schiller at Boies Schiller and Flexner LLP re provider ICD-9, CPT and ICD-10 medical coding and billing as provided for in 45 CFR 162.1002 that adopted the ICD-10-CM and ICD-10 PCS code sets as HIPAA standards. Expert testimony regarding functions of encoder software, computer assisted coding, data sources from Meaningful Use of Electronic Health Records under the ARRA HITECH Act, access to data as precursor to computer assisted coding, anti-trust and macroeconomics of care in health plans based on data interoperability; payor-provider contracting practices and economics; preparation for expert report and Daubert hearing; case settled and is sealed. Development of peer-

reviewed expert report, facilitating review with MD, PhD in Computer Science, PhD in economics. Due to the terms of the settlement agreement, the case is sealed and I am not permitted to disclose the names of the litigants.

- **Natalie Torres v Pocatello Children and Adolescent Clinic, et al.,** *Case CV-2013-1553. District Court of Sixth Judicial District of the State of Idaho, Bannock County. Expert opinion re: future medical expenses. Review deposition testimony of opposing counsel's healthcare economist, medical experts and consider Affordable Care Act and the policies of insurance available under the ACA through the Idaho Exchange, as well as Medicaid under a §1915(c) of the Social Security Act, Home and Community-Based Services Waiver Medicare-Medicaid Coordinated Plan (MMCP), as described in Idaho Law (IDAPA 16.03.17). Determine applicability of Prohibition of Preexisting Condition Exclusions (45 CFR § 147.108), Medicare Expansion and Health Insurance Exchanges.*
- Rhodes v Renown – *CV14-02054 in the Second Judicial District Court of the State of Nevada in and for the County of Washoe. Patient financial services, Medical coding, usual customary and reasonable (UCR) cost of care and documentation of necessity for outpatient obstetrics surgical procedure and CPT codes. Applicable State Statutes include: Uninsured patient discount (NRS 439B.260); Federal statutes and best practices: Fair and Accurate Credit Transactions Act ("FACTA") **Fair Credit Reporting Act** (FCRA). FACTA §312(a), (FACTA§312(c), FCRA §623(e)(1)), FCRA §623(a)(8)); Ability of patients as consumers to dispute information with companies that report to credit bureaus; **Affordable Care Act** (not for profit hospitals required to offer community benefit in exchange for its tax-exempt status[1] (see Rev. Rul. 69-545, 1969-2 C.B. 117.))*[35]
- TennCare II – **Tennessee State Medicaid and TN Insurance Exchange eligibility** - *Expert*

---

[1] "Examples illustrate whether a nonprofit hospital claiming exemption under section 501(c)(3) of the Code is operated to serve a public rather than a private interest; Revenue Ruling 56-185 modified." – IRS.gov/pub/irs-tege/rr69-545.pdf (see Rev. Rul. 69-545, 1969-2 C.B. 117.)

advisor and consultant regarding TennCare application and eligibility determination process and the implementation of the Affordable Care Act and Medicaid expansion and resulting mandated changes to eligibility. TennCare II is a continuation of the state's demonstration, funded through titles XIX and XXI of the Social Security Act. Focus: state exchange including income and federal poverty level ("FPL") percentage cancelations, behavioral health components, Federal (HHS) Exchanges "Federally-Facilitated Marketplace (FFM)," and State Based Exchange ("SBEs"), State MMIS – Medicaid Management Information Systems, which provide some of the eligibility technology platform for the Exchanges. Focus components include: Behavioral health, Assisted Care Living Facilities (ACLF), prior authorizations for medications via Magellan partnership.

- ***United States of America ex. rel. (Confidential) vs. Confidential defendants.*** Review of coding, billing, and applicable industry best practiced and statutes regarding percutaneous tests (scratch, puncture, prick) with allergenic extracts, including test interpretation and report, number(s) of tests, and professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; single or multiple antigens. Provide opinion on appropriate billable dosages and whether they vary from physician prescribed clinical dosages. Provide opinion on future value of these serves as damages under the Affordable Care Act.

-

- ***Essence Health Plan*** – *on behalf of* ***Kleiner Perkins Caufield & Byers, St. Louis MO.*** *compliance risk in coding, clinical documentation, for compliance with the Affordable Care Act, HITECH Act, ICD-10, Medicare Part A, Medicare Part B, Medicare Part C (Medicare Advantage), Medicare Part D. Accountable Care (Medicare Shared Savings Plan 'MSSP'), Economic value, IT and processes for patient and provider referrals and network management in value based care. Evaluate risk of coding and clinical documentation using RADV audits, analytics, §31 U.S.C. § 3729 (a) False Claims Act; Usual, Customary and Reasonable medical and prescription charges under ICD-10, Section 1886(d) of the Social Security Act and (42 CFR §412, Prospective Payment Systems for Inpatient Hospital Services*

- *Expert advisor to largest self-insured employer globally re: CORE Operating Rules, Patient Protection and value of care under the Affordable Care Act, ICD-10 medical coding; HIPAA*

5010 EDI (45 CFR §162) Administrative Requirements for healthcare claims processing, employer costs; evaluation of Third Party Administration provided by Blue Cross Blue Shield; (45 CFR § 162.1002) and Usual, Customary and Reasonable medical and prescription charges under ICD-10third party liability claims and worker's compensation insurance. On site advisory at global headquarters with health & wellness leadership.

FACTS AND DATA CONSIDERED

Based on the documents provided to me, the facts I considered in rendering my opinions include but are not limited to the following subsequent paragraphs of this section and the documents provided by counsel and reviewed by me in **Exhibit E** at the end of this report.

Between July 1, 2010 and December 31, 2013, MDC offered health insurance coverage via the CIGNA Starbridge Plan (the "Starbridge Plan"), (the "2010-2012 Plan"), MDC000087-000096, and Exhibit 9, the 2013 Plan version (the "2013 Plan"), MDC000097-000120.

Between January 1, 2014 and December 31, 2014, MDC offered health insurance coverage via the Transamerica Trans Choice Advance Plan (the "Trans Choice Plan"), (the "2014 Plan"), MDC000129-000130 and MDC000686-000757.

For 2015, MDC offered health insurance coverage via the Minimum Value Plan, or MVP (the "MVP Plan"), administered by Key Benefits Administrators, (the "2015 Plan"), which Defendants produced as MDC000770-000777.

DISCUSSION

"The Minimum Wage amendment set out three requirements for the health benefits:

1. Health insurance must be made " ... available to the employee ... "
2. The insurance must be " ... for the employee and the employee's dependents ... "
3. The " ... total cost to the employee for premiums ... " cannot be " ... more than 10 percent of the employee's gross taxable income from the employer."

In order to qualify to use the lower rate, the employer must meet all three requirements. If any one of the requirements is not met, the employer must pay the higher rate. This is the major area

of confusion over the amendment (*See* Tanchek, Michael State Labor Commissioner "Discussion of the Impacts of the New Minimum Wage Law Senate Commerce and Labor Committee February 8, 2007 page 8 of 17).[36]"

However, in my opinion new regulations, industry best practices and guidelines preempt the Nevada Minimum Wage Law and clarify alternatives. As of January 2016, 31 states were expanding their Medicaid programs. Medicaid eligibility for adults in states expanding their programs has rapidly expanded the number of total insureds. Since Medicaid expansion also exempts employers from their burden to provide insurance to those who qualify, I can see no reason to force MDC to provide insurance to those earning $7.25 per hour who qualify.

Because the ACA envisioned low-income people receiving coverage through Medicaid, it does not provide financial assistance to people below poverty for other coverage options. As a result, in states that do not expand Medicaid, many adults fall into a "coverage gap" of having incomes above Medicaid eligibility limits but below the lower limit for Marketplace premium tax credits[37].

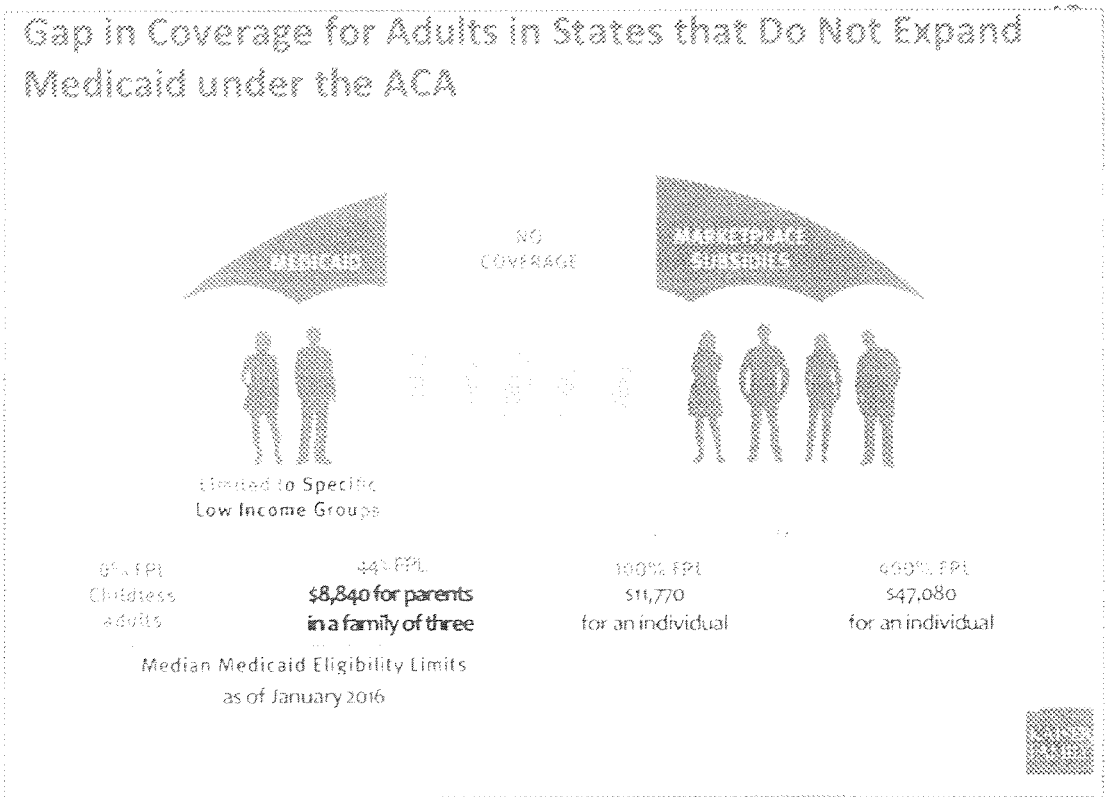


Figure 1 - Before Medicaid Expansion - Gap in Coverage. Source: Kaiser Family Foundation

Nevada's Governor Brian Sandoval announced in December 2012 that the state would expand Medicaid starting in 2014[38]. Nevada expanded Medicaid in 2014 under the guidelines laid out in the ACA. As a result, there are 266,000 newly-eligible Nevada residents. From the fall of 2013 through June 2015, total net enrollment in Nevada's Medicaid program increased by 69 percent. This is a much higher percentage increase than most states, and is second only to Kentucky, where Medicaid enrollment has increased by 84 percent[39]. Nevada's uninsured rate also fell by 24 percent from 2013 to the first half of 2015, going from 20 percent to 15.2 percent. The expanded access to Medicaid played a significant role in decreasing the uninsured population. According to the Reno Gazette Journal, "Many more Nevadans than expected enrolled in Medicaid after Gov. Brian Sandoval opted to expand eligibility, meaning the state will be paying more than projected once the federal government scales back its support. State officials said as of July 20, 2015 that 181,051 people are now receiving benefits as a direct result of the Republican governor's decision, which extends Medicaid eligibility to all non-disabled adults with incomes at or below 138 percent of the federal poverty level — currently $16,243 for an individual." The Federal Poverty Level is based on annual household income, which means that if an individual loses or gain income during the year their cost assistance eligibility can change.

The expansion of Medicaid and the publicity surrounding the expansion has helped to bump up Nevada's total Medicaid enrollment by more than two-thirds in just a year and a half.
In addition to the newly-eligible population, enrollment has been growing among people who were already eligible for Medicaid but had not enrolled prior to the start of the 2014 open enrollment (open enrollment only applies to private plans; Medicaid enrollment is year-round, but the publicity surrounding it has encouraged many Medicaid-eligible residents to seek coverage).

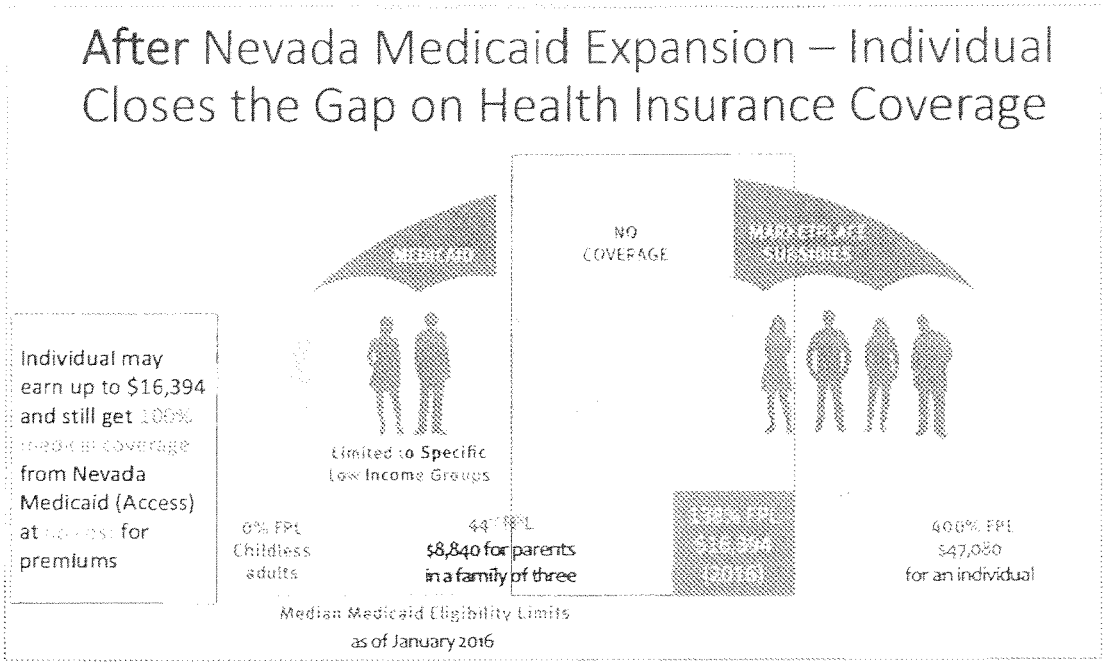


Figure 5 – Medicaid Expansion Closes Coverage Gap, More Likely than Not All MDC workers at $7.25 per hour would qualify for coverage in one or more programs

CONCLUSIONS

The Milone Report concludes that MDC did not provide insurance and did not consider several factors in determining what benefits it would offer its employees who earn $7.25 per hour. I disagree. When all possible scenarios are considered, including multiple time frames, multiple plans and important demographic factors such as the fact that the majority of lower wage earners are women it is clear that MDC workers had other options available to them.

OPINION: MDC Provided Reasonable Health Insurance Coverage Based Industry Best Practices, Guidelines and Statutes

In 2010 to 2013, MDC meets "Health Insurance Coverage" standard.

In 2014, MDC is not obligated to insure employees earning below FPL guidelines who would qualify for Medicaid, but did offer insurance through a group plan as an option for workers earning $7.25 / hour.

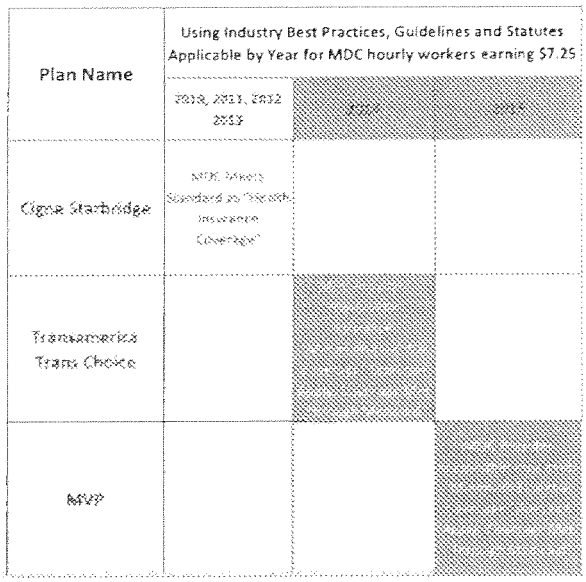


Figure 6 - Illustration of Time Frames, and Plans

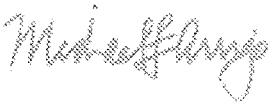
MDC made reasonable efforts to provide health insurance coverage and to modify and improve coverage for various regulatory periods, and all three plans qualify as "health insurance coverage" using reasonable standards documented in detail in this report.

More likely than not, most if not all MDC workers earning $7.25 per hour would qualify for Medicaid, both before Medicaid Expansion and After Medicaid Expansion which provides 100% coverage of their health care needs in nearly all demographic scenarios (single, pregnant woman with two or more dependents in household, etc.). Before Medicaid expansion, MDC workers could have mitigated their cost of healthcare by securing Medicaid in some if not all scenarios. After Medicaid Expansion, it would be reasonable to assume that a health care consumer would seek Medicaid coverage if they were earning $7.25 per hour.

Milone's omissions of all factors and outcomes are likely to be an error.

I specifically reserve the right to add to, amend or subtract from the report as new evidence comes into discovery or as new opinions are formulated.

Signed,



Michael F. Arrigo

(949) 335-5580 x101 / 949-633-5664 mobile / marrigo@noworldborders.com
Offices in New York, Boston, Washington DC, Seattle, Denver, San Francisco, Palo Alto, Los Angeles, San Diego, Salt Lake, Chicago, Dallas, Nashville, Atlanta, Jacksonville

Education

- **Stanford Medical School, Palo Alto CA** - Candidate, Masters in Biomedical Informatics (*see end note* [i]) *(Expected 2017)* Focus: Computational Methods for Biomedical Image Analysis and Interpretation, ontologies (data structures for coding and clinical documentation) mHealth, statistical analytics for population health including disease management (incidence of diagnosis codes and procedure codes, data driven interventions etc.) benefits of shared data with requisite privacy, security.

- **University of Southern California, Marshall School of Business, Los Angeles** – Bachelor of Science, Business Administration, 1981; studied in Entrepreneur Program which focuses on the management, marketing and finance of startups, first of its kind U.S.

Clinical Documentation, ICD-9, ICD-10, CPT, CDT Medical Coding Training:

1. Behavioral health, November 2013[1]
2. Cardiology, November 2013
3. Family practice and internal medicine, November 2013
4. Obstetrics, November 2013
5. Oncology, November 2013
6. Urology, November 2013
7. Orthopedics, November 2013
8. General Surgery, and Dental, November 2013
9. Plastic Surgery, November 2013
10. HCC, risk adjustment, November 2013[2]
11. DRG calculations, ICD-10, IPPS, OPPS payment systems November 2013[3]
12.
13. Diagnostic Imaging & Nuclear Medicine (PET-Scans) September 2014[4]
14. Medical Auditing, including focus on anesthesiology, pathology, evaluation management, radiology, chemotherapy, psychotherapy, physical therapy, modifiers, medical necessity. November 2015[5]
15. Dietetics and Nephrology, insulin DME billing for diabetes, December 2015, AHIMA
16. Outpatient physical, occupational, and speech therapy, January 2016[6]

[1] Training delivered by MD, board certified orthopedic surgeon and AHIMA certified trainer who advised CMS in all 50 states, AHIMA certified inpatient coder and chart auditor, AAPC certified outpatient coder and chart auditor

[2] Used in Medicare Part C (Medicare Advantage "MAO") Accountable Care (ACO) organizations

[3] Training delivered by MD, board certified orthopedic surgeon who advised CMS in all 50 states

[4] Training delivered by Radiology Certified Coder (RCC), Certified Interventional Radiology Cardiovascular Coder (CIRCC), Certified Professional Coder (CPC) credentialed instructor

[5] American Academy of Professional Coders (AAPC)

[6] Training delivered by National Association of Rehabilitation Providers (NARP) trainer

Additional Coursework and Training:

- **University of Calif., Irvine** – Computer Science, Statistics, Economics 1976 – 1978
- **Wharton School, University of Pennsylvania** – Leadership Strategies - 1982
- **Villanova University** – Lean Six Sigma and Process improvement 2007

Legal Experience

(See separate document for list of cases, testimony, basis for opinions)

Please see separate exhibit – testimony before the U.S. Federal Trade Commission, other Federal, State and County Superior Court jurisdictions, written testimony in expert reports, depositions, and court appearances.

Engaged by plaintiff, relator, defendant with experience across payors (including Medicare, Medicaid, social security, workers' compensation, private insurance / health plans), hospital systems, patients and healthcare IT engagements pharmaceuticals, medical devices, orthotics, diagnostic imaging, orthopedics, cardiology, pediatrics. User of eDiscovery tools such as *Relativity* for document discovery work.

Expert opinions in superior court, state court, and federal court (continued)

- ARRA HITECH Act (meaningful use of electronic health records and PHI Safeguards)
- Health care claims reimbursement including all medical codes and insurance HIPAA X12 EDI transactions
- Patient Protection and Affordable Care Act ("ACA") pre-existing conditions, ACOs, risk corridors, population health and disease management, Medicaid expansion and community health
- Medicare, Medicaid Insurance fraud and payment practices;
- HIPAA privacy and security practices as well as state privacy laws
- Provider & payor disputes; compliance with FACTA and FCRA collections practices
- Value based care (accountable care) economics including:
- Patient and provider referrals
- Eligibility, risk adjusted factors
- Diagnostic imaging professional component and technical component customary reimbursement
- JCAHO best practice standards, National Patient Safety Goals
- Medical record & billing documentation;
- ICD & CPT coding for a variety of medical specialties including orthopedics, obstetrics and cardiology;
- Business damages; Plaintiffs duty to mitigate damages including healthcare costs
- Personal injury;
- OIG self disclosure;
- Healthcare antitrust testimony before the FTC re: ICD-10

Scholarly Writings & Lectures

Arrigo, M. F. (2016) Strategic Financial Management for Healthcare Providers: Value Based Care Trends. Healthcare Financial Management (HFMA).

Arrigo, M. F. (2015) Mobile Health, HIPAA Privacy and Security
Blackberry Sharpens Security with Good Technology Acquisition. Gov. Health IT
http://www.govhealthit.com/blog/commentary/blackberry-sharpens-security-good-technology-acquisition

Arrigo, M. F. (2015) Five Interest-Piquing Trends at HIMSS15. Gov. Health IT
http://www.govhealthit.com/news/5-interest-piquing-trends-himss15

Arrigo, M. F. (2014) Cloud and Mobile Convergence: The Regulatory View. Gov. Health IT
http://www.govhealthit.com/blog/cloud-and-mobile-convergence-regulatory-view

Arrigo, M.F. (2014) HIPAA Plain and Simple / HIPAA for Behavioral Health – Credible Behavioral Health E.H.R. Software Users Conference, Baltimore Maryland (18 March 2014)

Arrigo, M.F. (2014) DSM 5 and ICD-10 – Credible Behavioral Health E.H.R. Software Users Conference, Baltimore Maryland (18 March 2014)

Arrigo, M.F. (2014) Managed Care and Accountable Care for Behavioral Health – Credible Behavioral Health E.H.R. Software Users Conference, Baltimore Maryland (18 March 2014)

Arrigo, M. F. (2011) ICD-10 financial impact vs. mortgage crisis? Gov. Health IT
http://www.govhealthit.com/news/could-icd-10-have-big-financial-impact-mortgage-crisis

Arrigo, M. F. (2012) How a Flaw in the ACO Model Leaves Patients Out. Gov. Health IT
http://www.govhealthit.com/news/how-flaw-aco-model-leaves-patients-out

Arrigo, M. F. (2012) 10 ICD-10 Regulation Myths Demystified. Gov. Health IT
http://www.govhealthit.com/news/10-icd-10-regulations-demystified

Arrigo, M. F. (2012) Real-time location, mobile health gain traction. Gov. Health IT
http://www.govhealthit.com/news/real-time-location-and-mobile-health-solutions-gain-traction-show-roi

Arrigo, M. F. (2013) 3 Top Priorities for CommonWell. Gov. Health IT
http://www.govhealthit.com/news/3-top-priorities-commonwell

Arrigo, M. F. (2013) Commentary: ICD-10 Arrives Early, New Claims Form. Gov. Health IT
http://www.govhealthit.com/news/commentary-icd-10-arrives-early-claims-CMS-coding-HIPAA-icd-9

Arrigo, M. F. (2014) Increased Spending - Big Data, Cloud, mHealth Social. Gov. Health IT

http://www.govhealthit.com/blog/increased-spending-and-savings-tap-big-data-cloud-mhealth-and-social

Arrigo, M. F. (2014) Ebola: How cloud, mHealth, and ICD-10 could help. mHealth News http://www.mhealthnews.com/blog/ebola-how-cloud-mhealth-and-icd-10-could-help

Arrigo, M. F. (2014) How Cloud and mHealth Ease Claims Processing. Gov. Health IT http://www.govhealthit.com/news/how-cloud-and-mhealth-promise-ease-claims-processing

Arrigo, M. F. (2014) How to Get Behavioral Health Codes Right. Gov. Health IT http://www.govhealthit.com/blog/how-get-your-behavioral-health-codes-right

Lectures, Adjunct Faculty, Conference Speaking Engagements

- Arrigo, M. (Speaker) (2015, November 2015) **Medical Device Reimbursement, FDA, FCC and CMS regulatory disruption and opportunities under the Affordable Care Act, ICD-10 and HITECH Act.** BioMed Device and Wireless Device Conference, San Jose California

- Arrigo, M. (Speaker) (2015, September 2015). **Meaningful Use of Electronic Health Records, HIPAA Privacy and Security and potential damages for breaches under the HITECH Act as a foundation for the International Classification of Diseases from the World Health Organization (ICD-10)** – Discussion of risks and opportunities in these two regulations; discrete data, quality measures, medical codes: clinical Documentation, clinical decision support, physician and patient engagement, HIPAA Privacy and Security and revenue cycle. Wolters Kluwer Corporate event presented to audience of over 1,800 participants.

- Arrigo, M. and Nichols J. MD - (Speakers) (2013, November). Claims Data, Clinical Data – Working together to Improve Clinical Documentation for **International Classification of Diseases from the World Health Organization (ICD-10). Workgroup for Electronic Data Interchange (WEDI)** National Conference.

- Arrigo, M. (Speaker) (2012, April 14). **The Perfect Storm in Healthcare - How Disruptive Regulations and Technologies Create Risks and Opportunities** for Medical Coding and Revenue Cycle Management. Affordable Care Act, ICD-10, CORE Operating Rules, and HITECH Act. American Academy of Professional Coders (AAPC)

National Conference. Lecture conducted from Las Vegas, NV. http://news.aapc.com/icd-10-monitor-wish-i-were-in-las-vegas/

- Arrigo, M. (Speaker) (2012, June 14). **ICD-10: Impact on Payment Reform. Wisconsin Medical Society**. Lecture conducted from Madison, Wisconsin. http://bit.ly/16acjDy

- Arrigo, M. (Speaker) (2013, April 23). The Perfect Storm in Healthcare - How Disruptive Regulations and Technologies Create Risks and Opportunities for Medical Coding and Revenue Cycle Management. Affordable Care Act, ICD-10, CORE Operating Rules, and HITECH Act. **Scripps Healthcare Summit 2013. Lecture** conducted from La Jolla, San Diego California.

- Arrigo, M. (Speaker) (2012, May). How **ICD-10 and Payment Reform Will Change** the Radiology Revenue Cycle. Radiology Business Management Association (RBMA), Orlando Florida.

- Arrigo, M. (Speaker) (1994 - 1995). **Impact of the Internet on medical and financial** businesses. Loyola University, Los Angeles CA

- Arrigo, M. (Speaker) (1994 - 1995). **Impact of the Internet on medical and financial businesses, University of California, Irvine CA**

Non- Litigation Consulting Experience in Healthcare, Software, Financial Services

2007 to Present - No World Borders – I lead a healthcare data, regulatory, and economic consulting firm as Managing Partner. Our business provides advisory services on disruptive health care regulations for hospitals, insurance companies, self-insured employers, and health IT companies and investors.

Summary of Accomplishments and Experience

I work with hospital systems, physician groups, and health IT companies, health plans, investors, and law firms. I was selected as an expert for a landmark Federal Trade Commission case regarding healthcare data, regulations and economics. I currently serve as managing partner of No World Borders. I am:

- A writer and speaker quoted in Wall Street Journal, and a regular speaker with published works as an expert in the field.
- Prepared by leading litigation firm in Rule 702 including applying scientific or specialized knowledge (702(a)); facts (702(b)); application of principles and methods (702(c)); application of criteria, principles, methodology, test methods (amended in *Daubert*, 2000 - (702(d)) before FTC Commissioner Brill.
- An advisor to value based care companies including Medicare Advantage, Medicare Shared Savings Accountable Care Organizations.
- Led investor diligence on $4 billion in health care merger and acquisition transactions.
- Trained in clinician, coder, medical billing, claims, E.H.R, hospital and practice management software, regulatory, usual, customary and reasonable (UCR) medical and prescription charges.
- Opinions on over $1 billion in medical reimbursements for inpatient facilities (inpatient prospective payment system or IPPS and DRGs, ICD-9) and ambulatory (non-facility using CPT codes)

I competed for, won and led these among other account engagements where large global firms were also bidding on the business:

Regulatory Consulting for Health Care Provider and Healthcare I.T. Firms

- Duke Life Point Academic Medical Ctr Pittsburgh - *ACO, ICD-10, Revenue Cycle Strategy; HCC risk adjustment for Medicare Advantage. Evaluate over $1 billion in health care claims for risk adjustment, audit quality using RADV methods, clinical documentation coding quality. Evaluate Meaningful Use compliance risk with respect to storage and security of discrete data from medical records, data conversion strategies, analytics strategies.*

- **Advisory to E.H.R., Accountable Care Organizations, practice management IT companies** - *manage a team that has advised over 100 companies on Meaningful Use, Medicare Advantage, ACA, ICD-10 regulations. Ambulatory, acute care – MU1, MU2, DSM-5, CPT, ICD-9, ICD-10, clinical documentation, HIPAA, Clinical Quality Measures, CA Civil Code §56;*
- **Nemours Children's Hospital, Orlando Florida** *Meaningful Use of Electronic Health Records, HIPAA transactions for claims processing, HIPAA secure clinical and physical plant data interoperability strategy of clinical and health care claims data using enterprise web services solutions. Sharing of data in emergencies between clinical staff and security to protect pediatric patients.*
- **Credible, Inc. a leading behavioral health electronic health record software vendor** Advise regarding compliance with HIPAA Privacy and Security in general and specific privacy and security rules for the Behavioral Health specialty, International Classification of Diseases version 10 versus DSM 5, Accountable Care Organizations and Managed Care for Behavioral Health.

Regulatory Consulting for Health Plan and Self-Insured Employer Regulations

- Excellus Blue Cross Blue Shield – Rochester New York. Lead consulting engagement to remediate health plan enrollment process and Trizetto Facets Claims system. Rescue project from off-budget, off plan and restore to on time on budget.

- **Blue Cross Blue Shield / Triple – S** (Salud Puerto Rico) – Lead implementation of TriZetto QNXT claims system including all process models, software implementation and project management office.

- Preferred Care – **Florida** - Medicare Advantage HEDIS 5-Star Ratings, provider network clinical data, Utilization Management, Coordination of Benefits, Case Management and claims processing, chart review quality audits and analytics, risk adjustment using HCC and ICD-9 coding, RADV audit methods, RAPS file analytics.

- **United Healthcare, Florida** - Medicare Advantage HEDIS 5-Star Ratings, provider network clinical data, Utilization Management, Coordination of Benefits, Case Management and claims processing using HCC and ICD-9 coding, RADV audit methods, RAPS file analytics.

- **Public Employees Health Plan – Salt Lake City Utah** – Advise and assess re: new medical coding and medical policy management remediation to comply with ICD-10 which impacts medical policy plan design, actuarial processes, covered amounts, utilization management, eligibility, referrals, covered amount calculations and other factors.

- **Regence BlueCross BlueShield, Seattle, Salt Lake, Portland** - HITECH Act, HIPAA 5010, ICD-10 processes, DRGs, Ambulatory claims, Ancillary Services, and IT architecture to enable these capabilities which impacts medical policy plan design, actuarial processes, covered amounts, utilization management, eligibility, referrals, covered amount calculations and other factors.

- Walmart – **largest self-insured non-military employer globally** – advise regarding HIPAA insurance claims transactions, CORE operating rules, ICD-10, Affordable Care act business and regulatory issues and underlying systems and process issues for the largest self-insured employer in the world.

- **TennCare – Tennessee Medicaid and TN Insurance Exchange eligibility**

- ***Citra Health Solutions, Jacksonville FL*** – *Advisor to CEO. Advise leadership regarding value based care, HIPAA privacy and security, meaningful use, strategic partnerships and acquisitions for Medicare Advantage and Accountable Care market. Focus on Value Based Pricing, Medicare Advantage Risk Adjustment using HCCs;*

population health, patient and physician engagement and quality reporting.

Investor Diligence - $4 billion in Health IT M&A transactions

- London PE Firm - pre-IPO cloud security business for healthcare.
- **Kleiner Perkins Caufield & Byers**, Silicon Valley – work with founding partners of VC that funded Google, Netscape, Amazon, Amgen, Intel, Sun Microsystems on largest cloud healthcare investment *in Medicare Advantage and Accountable Care population health management and analytics*
- In-Network and Out of Network medical charges, 340B Drug discount provider
- NY PE Firm – diligence on $500 million acquisition of Medicare Administrative Contractor (MAC) electronic data connectivity and services company. Evaluate financial projections and growth potential, capabilities regarding claims status, new EDI standards, medical policy plan design, actuarial processes, covered amounts, utilization management, eligibility, referrals, covered amount calculations and other factors.

Medical Device, Pharmaceutical Regulatory Compliance

- Abbott Labs - Regulatory Affairs, FDA Compliance – led global complaint handling roll out (US, UK, EU, Asia) of pharmacovigilance solution supporting FDA Adverse event reporting rules, National Drug Codes (NDCs), formularies, and health insurance coverage determinations for pharmaceuticals.

2010 to present **Instructor, HIPAA Privacy and Security, HITECH Act Electronic Health Records, value based care, Affordable Care Act**

Best practices in HIPAA and HITECH Act Information Privacy and Security[7] and Meaningful Use, Best practices Health IT, process improvement, eligibility and coverage determinations under the Affordable Care Act for value based care[8] Recent courses included instruction at these venues:

- JP Morgan Healthcare Conference 2015
- Wolters Kluwer 2015
- Duke Life Health System 2013
- HIMSS 2014
- AAPC Annual Conference 2012

[7] Trained by published author in HIPAA privacy and security and advisor to CMS, HHS on Meaningful use of Electronic Health Records, currently lead training sessions for HIPAA covered entities

[8] Lead training for pharmacists, hospitals, physicians, health IT value based care firms

Prior Experience

October 2002 to February 2007 – First American / CoreLogic - SVP eCommerce – *Banking solutions $8 billion firm. Led one of the largest most complex Sarbanes Oxley IT audits in the U.S. according to attorneys and accounting firm.*

September 2002 to October 2003 - SVP eCommerce – *Banking solutions $12 billion firm*

February 2000 to June 2002 – Citrix Systems – President & CEO (Erogo, a SaaS Cloud billing company) Built *cloud SaaS billing company from $500k to $10 million in revenue and investment by Citrix*

June 1997 to December 1999 - Heidrick & Struggles, Silicon Valley – President & CEO, **LeadersOnline** – *Set strategy acquired assets led launch of Internet recruiting business as portion of IPO prospectus (S-1) and IPO road show with Goldman Sachs adding $100 million to market cap of Heidrick at IPO*

September 1981 – May 1997 – Smith Tool, **Oracle, HP, Symantec, Intel, ParcPlace Systems, Borland, Ashton-Tate** – Silicon Valley, Southern California, Boston – roles from analyst to Product Manager, VP Marketing and Sales, Corporate Development. Built a company from $2 million to $50 million buyout, owner of $350 million P&L and brand re-launch, turn around.

ATTACHMENT 1
Healthcare Transactions and Processes
to Support Claims, Care Coordination and Financial Value of Care

Health Care Processes – Health Plans

- Value Based Care Reporting for **Medicare Part C** and **Medicare Shared Savings Plan Accountable Care Organizations** including: HEDIS, MSSP 33 measures, HCC coding, risk adjustment, risk corridors, RADV and RAC audits, compliance platforms
- Payor - provider contracting – Mr. Arrigo leads a team that has over **30 years of** health care provider and health insurance contract negotiation experience for hospitals, clinics and diagnostic services providers. Mr. Arrigo and his team have advised 18 hospitals and clinics, four medical device and pharmaceutical firms, two healthcare IT firms, and two four insurance firms as well as CMS in all 50 states on new regulatory impacts. He and his team have advised on over 2,000 contracts.
- Explanation of benefits – Mr. Arrigo's team advises health plans on the revisions in EOBs that must be made to comply with new laws and regulations such as ICD-10.
- Actuarial & Underwriting – Mr. Arrigo and his team advise health plans on shifts in coverage determinations and medical policy based on the Affordable Care Act, ICD-10, CORE Operating rules and other regulations.
- **Coverage determination** planning and policy, IT systems supporting new regulations.
- Claims processing metrics – pass through rates, manual vs. electronic claims adjudication and **Utilization Management (UM) rates**.

Health Care Processes and IT – Hospitals, Clinics Physicians and Other Providers

- Payor - provider contracting – Mr. Arrigo leads a team that has over **30 years of** health care provider and health insurance contract negotiation experience for hospitals, clinics and diagnostic services providers. Mr. Arrigo and his team have advised 18 hospitals and clinics, four medical device and pharmaceutical firms, two healthcare IT firms, and two four insurance firms as well as CMS in all 50 states on new regulatory impacts. Over time he and his team have advised on over 2,000 contracts.
- Readmissions metrics
- Clinical documentation, coding, claims reimbursement
- Admission and discharge processes and metrics
- Revenue cycle management and metrics (DNFB – discharged not final billed, etc.)
- Four of the Top 10 Electronic Health Record Companies – Cerner, Athenahealth, NextGen; assessed five mid-tier E.H.R. companies with respect to Meaningful Use, HIPAA and Information Safeguards compliance.

ATTACHMENT 2

Private Payor, ACO, IDN, Medicare (Part A, Part B, Part C, Part D), Health IT Experience

Additional Experience with Health Systems Providers

ICD-10, HIPAA 5010, HIPAA Privacy and Security, Clinical Quality Measures Consulting Expert Work

Feather River Hospital -
http://www.frhosp.org

Frank R. Howard Memorial Hospital -
http://www.howardhospital.com

Glendale Adventist Medical Center -
http://www.glendaleadventist.com

Loma Linda University and Loma Linda Medical Center -
http://www.llu.edu/llumc/

San Joaquin Community Hospital -
http://www.sjch.us

Selma Community Hospital -
http://www.adventisthealthcv.com

Sonora Community Hospital -
http://www.sonoramedicalcenter.org

St. Helena Hospital -
http://www.sthelenahospital.org

Ukiah Valley Medical Center -
http://www.uvmc.org

White Memorial Medical Center -
http://www.whitememorial.com

Additional Experience with Health Plans

ICD-10, HIPAA 5010, HIPAA Privacy and Security, Clinical Quality Measures Consulting Expert Work

- Blue Cross Blue Shield of Oregon
- Blue Cross Blue Shield of Utah
- Public Employees Health Plan of Utah
- Blue Cross Blue Shield of Idaho
- Blue Cross Blue Shield of Washington State
- CareFirst Blue Cross – Mid-Atlantic Region
- BCBS of Tennessee – Chattanooga, TN

Over ten **Value Based Care Organizations** (**Accountable Care Organizations or ACOs** and **Medicare Advantage / Part C** Plans including Essence Health Plan St. Louis, United Healthcare and Preferred Care Partners.

ATTACHMENT 3

Investor Transactions and Diligence – Healthcare Market supporting body of knowledge for expert work

Investor	Target Company	Enterprise Value ($millions)
Confidential $4 billion PE fund, New York	Ability Networks (leading Medicare claims technology infrastructure)	$550
Confidential $4 billion PE fund, New York	HealthPort, an electronic release of HIPAA information service provider	$120
$300 million specialty PE fund, New York	Orange Health (now Citra Health) (Value based care for ACOs, MA plans)	$25
$300 million specialty PE fund, New York	MZI, a health care claims processing software vendor	$25
Kleiner Perkins Caufield & Byers, Menlo Park CA	Lumeris, an Essence Global Holdings Co. (Value based care for ACOs, MA plans)	$600
Large Private Equity firm, London	Covisint, a spin out of Compuware (cloud user access mgmt)	$450
U.S. Private Equity firm, San Francisco	Evaluation of Diabetic population insulin initiation and titration mobile technology for glycemic control compared with standard clinical practices.	TBD
U.S. Private Equity firm, San Francisco	Greenway Health Electronic Health Record software vendor	$644
Public Debt Investor	Greenway Health debt offering	confidential
Confidential	Confidential healthcare analytics business	$280
Confidential	Confidential hospital revenue cycle management (RCM) business	$190
Confidential	Confidential Electronic Data Interchange claims business for health insurance	$150
Confidential	Genetic Testing and Precision Medicine	$300
Confidential	Health system with multi-sight hospital, physician group, clinic and diagnostic imaging businesses	$1,000
Confidential	Health IT solutions : Dispensary automation and inventory tracking for oral and Intravenous Anti-Emetic Drugs for Chemotherapy Chemotherapeutic Regimen	confidential
Confidential	Pharmacy Benefit Management (PBM)	$600
	Total Enterprise Value ($millions)	$4,934

ATTACHMENT D (page 1 of 2)

Affordable Care Act, Medicaid, Social Security, Insurance Exchange, Benefits Determination and Orthotics Reimbursement

Experience with regulations, technology and requirements for systems supporting 15 State HHS Medicaid insurance Exchange eligibility systems including these business requirements, which in turn provide state-by-state eligibility for Affordable Care Act insurance mandates:

Types of Exchanges and Enrollee Characteristics:

- Federal (HHS) Exchanges "Federally-Facilitated Marketplace" ("FFM") which are being used in states such (FL, GA, NC, SC, VA, AL, MS, MO, AR, LA, OH, PA, IL, OK, MT, UT, ND, SD, NE) and provider contracting
- State Based Exchange ("SBEs") and state-by-state variances (CA, WA, ID, CO, KY, MN, NY, VT, RI, CT, MA, DE, MD, DC)
- State MMIS – Medicaid Management Information Systems, which provide some of the eligibility technology platform for the Exchanges

Eligibility Process, Technology for State Health and Public Welfare

- Request for insurance, pre-existing conditions under Affordable Care Act
- 42 CFR MAGI – Modified Adjusted Gross Income (U.S. Citizenship, criminal and State Residency, household size and FPL % [see FPL])
- FPL percentage – percent of Federal Poverty Level
- TANF – Temporary Assistance to Needy Families (formerly AFDC) created by The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104-193) and TEFRA
- SNAP – Supplemental Nutrition Assistance Program (formerly food stamps)
- Medicaid – free and low-cost health care to low income families
- CHIP – Children's Health Insurance Program (Medicaid for kids)
- Women, Infants & Children (WIC) – nutritional supplement for pregnant women, infants and children (until school age)
- Section **1619(b) of the Social Security Act** re: Social Security beneficiaries and Medicaid coverage eligibility.

Off-The-Shelf (OTS) Orthotic HCPCS Codes

Section 1847(a)(2) of the Social Security Act (the Act) defines OTS orthotics as those orthotics described in section 1861(s)(9) of the Act for which payment would otherwise be made under section 1834(h) of the Act, which require minimal self-adjustment for appropriate use and do not require expertise in trimming, bending, molding, assembling, or customizing to fit to the individual. Orthotics that are currently paid under section 1834(h) of the Act and are described in section 1861(s)(9) of the Act are leg, arm, back and neck braces. The Medicare Benefit Policy Manual (Publication 100-02), Chapter 15, Section 130 provides the longstanding Medicare definition of "braces." Braces are defined in this section as "rigid or semi-rigid devices which are used for the purpose of supporting a weak or deformed body member or restricting or eliminating motion in a diseased or injured part of the body."

Orthotics market diligence on Orthotics Providers Hangar Clinic, NovaCare Rehabilitation, Boas Surgical, Union, Eschen, AlliedOP, Lawall

Mancha Development Company

Starbridge
Limited-benefit health plan

Health coverage is within your reach.

Hurry! Your opportunity to enroll ends soon.
Ofrecemos seguro médico. Favor de marcar el 1-877-209-7098.

CIGNA®

Who is eligible?
All Employees with 90 days of employment.

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

SB531.1_3449

092608

Is a Starbridge health plan right for you?

CIGNA's Starbridge limited-benefit health plans are designed to provide affordable health insurance to hard-working people like you. Starbridge plans provide coverage for everyday medical expenses and can help you pay for unexpected costs related to illnesses and accidents. It is not a major medical plan. Ask yourself the following questions to see if a Starbridge plan is right for you. If you answer "yes" to one or more of these questions, your employer and CIGNA HealthCare are here to help.

☐ yes ☐ no	Do you skip check-ups or visits to the doctor for an illness because you're uninsured?
☐ yes ☐ no	Have you had to take unpaid time off work in the past year due to an illness or health problem?
☐ yes ☐ no	Is it hard for you to find quality health care providers because you don't have an insurance card?
☐ yes ☐ no	Do you buy over-the-counter medicines instead of going to the doctor or filling a prescription?
☐ yes ☐ no	Have you ever relied on help from family, friends or the government to pay for basic medical care?

There are many ways to save with Starbridge.

Network Discounts

Our network includes the doctors that have lowered their prices for our members. Using a network provider can save you money because you'll get more services without using up all your benefits (see medical benefits chart). Many providers offer our members discounts of about 30-50% off of their usual charges. Even if you reach the benefit maximums, you'll continue to receive discounted prices from many of our network providers.

Outpatient Benefits

Starbridge outpatient benefits cover services outside of the hospital—things like doctor's office visits, outpatient surgery, laboratory work, X-rays and urgent care.

For example, with our plans you pay only a copay for each doctor visit. A copay is the up-front cost you pay at the time of service. The plan covers the remainder of the cost, up to a benefit maximum (see medical benefits chart). For all other outpatient services, the plan pays coinsurance, which is a percentage of the covered expenses, and you pay the rest.

Inpatient (Hospital) Benefits

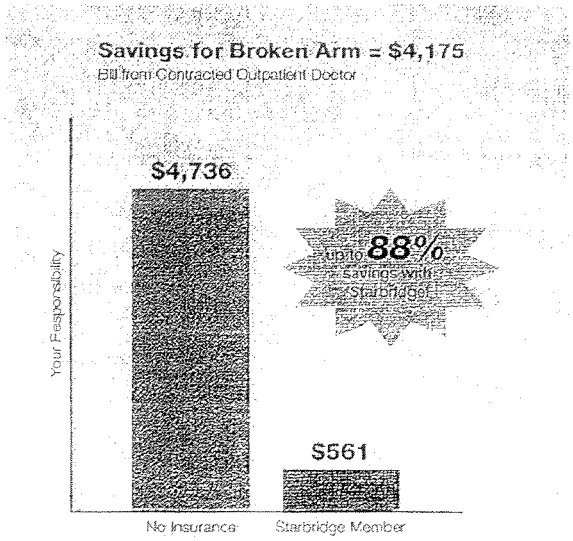
Inpatient benefits cover a portion of the cost of hospital visits if an overnight visit is required. Some plans also offer additional coverage for surgeries and maternity.

Prescription Drug Programs

Starbridge offers a variety of prescription drug programs to meet your budget. All of our plans feature a prescription discount program that offers an average of 15% off of brand name drugs and 40% off of generics. Some of our plans also offer prescription benefits that are similar to the coverage for doctor visits—you simply pay a low copay at the pharmacy until you reach the benefit maximum.

Wellness Benefits

Starbridge wellness benefits are designed to help you stay healthy and prevent serious illnesses. Some of our plans cover wellness services (after you pay a $20 copay) which can include childhood immunizations, annual wellness exams and many types of screenings. Provision varies by state.



Starbridge member pays $561 after network discounts and covered benefits.

Amounts reflected serve as an example only and may not accurately reflect your plan. 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.

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

STEP 1: Choose the plan that's right for you.

Please refer to the medical chart at the back of this brochure for more detailed information.

Because these are limited-benefit plans, it's best to choose the highest level of coverage that you can afford. If you're having trouble matching your budget with your health plan needs, you may find the following guidelines useful, or you can contact a Starbridge Benefit Specialist for help at 1-877-209-7098.

Level 1 Plan

Semi-Monthly Rates	
Myself only	$21.32
Myself and 1 dependent	$52.24
Family	$78.89

Stay healthy and active.
Plan for the unexpected.

If you're healthy and active and have a limited budget, this plan is your most affordable option.

"Even after I reach my benefit maximum, I still pay less at the doctor because CIGNA negotiates great discounts for me."

Level 2 Plan

Semi-Monthly Rates	
Myself only	$40.93
Myself and 1 dependent	$100.27
Family	$151.43

Discover the security that comes with health coverage. Feel better about life.

If you're fairly healthy but looking for more than basic coverage, Starbridge Level 2 Plan is a reasonable option. Prescription and Wellness benefits are included in this plan.

"Starbridge helps me with everyday medical expenses like prescriptions and doctor visits—plus it helps me budget for them."

A special message from your employer at Mancha Development Company.

Dear Mancha Development Company Employee:

Mancha Development Company is pleased to offer you this Starbridge limited-benefit health plan. As a hard-working employee, you deserve help with your health care needs and we believe that this plan will have a positive impact on your life at home and at work.

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. Plus, you'll save even more when using a network doctor, because CIGNA negotiates great discounts for you.

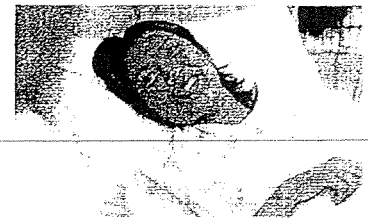
Still not sure whether you should sign up? Think about this:

- If you stay healthy, you won't have to take time off work and lose income
- You can better provide for your family
- Starbridge helps you plan for unexpected health expenses
- Starbridge has many added features such as online tools to help you save money and make better health care decisions
- You'll have a health plan ID card accepted by quality health care providers
- You can establish an ongoing relationship with a doctor who cares about you and your family's health

If you're ready to improve your health on a daily basis, we encourage you to enroll today! If you have any questions about the plan or how to sign up, please contact a Starbridge benefit specialist at the number below.

Thank you,
Mancha Development Company

Choose Starbridge for value and peace-of-mind.



I was injured playing a sport and it turned out to be a broken arm. I went straight to the emergency room and showed them my Starbridge ID card. The doctor was great and I felt better knowing that I had insurance coverage. Thanks to Starbridge, I didn't have to stress about big bills or lots of time off work. I saved a lot of money and was back on the job in no time! I only had to pay about $500, much better than the $4,500 total bill I would have been responsible for without insurance.

I was paying $100 for a doctor's visit when I was uninsured. Now that I have Starbridge, I pay just a copay. For my plan, it's $20. Starbridge pays the rest, up to a benefit maximum. Even after I reach my benefit maximum, I can still pay less at the doctor because Starbridge negotiates great discounts for me.

I had to take my kids to the doctor four times last year...and I saved $320 thanks to Starbridge! Plus I paid less for prescriptions and other services throughout the year. I feel good just knowing that I can provide for my family and make sure that they stay healthy.

Turn this page for Step 2 to enroll!

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

STEP 2: Enroll Now.

Starbridge
limited-benefit health plan

Enrollment Form: Simply complete this enrollment form and turn it in to your manager.

Store/Unit Number:_____

ENROLLMENT FORM Underwritten by Connecticut General Life Insurance Company, P.O. Box 55270 • Phoenix, AZ • 85078

First Name_____Middle Initial_____Last Name_____

Street Address_____City_____

State_____Zip Code_____Date of Birth† ___/___/_____Gender† M / F

Social Security #___ ___ ___ - ___ ___ - ___ ___ ___ ___Hire Date ___/___/____

1. **Select the Plan You Want:**
   Select only one medical plan. ❑ Level 1 Plan ❑ Level 2 Plan

2. **Select Who You Want to Cover:** Check only one, even if multiple plans are selected.
   ❑ I want to cover myself only ❑ I want to cover myself and 1 dependent
   ❑ I want to cover my family

3. **Dependent Information:** If additional space is needed, please attach separate sheet.

Spouse's Full Name		Social Security #	Date of Birth
Child's Full Name	Son/Daughter	Social Security #	Date of Birth
Child's Full Name	Son/Daughter	Social Security #	Date of Birth

4. **Beneficiary Information:** Person who will receive benefits in the event of your death.

Full Name			Relationship to You
Street Address	City	State	Zip Code

†This information is being collected for administrative purposes only, and not for medical underwriting.

For Oregon residents only. Have you had prior coverage (less than a 63 day gap)? Please forward us the Certificate of Creditable Coverage from your prior carrier. **For Florida residents only.** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. **For all other states' residents.** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime, may be violating state law, and may be subject to fines and confinement in prison.

5. Sign to Enroll: X_____ ___/___/____

SBCII593.1 [Date]

Now that you've enrolled, please complete this section.
This information is being collected so it can help us to better serve you with our products. The data will be used for internal purposes only and we will not share your personal information. To review our Privacy Statement, please visit www.cignavoluntary.com.

E-mail Address_____Phone #___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___

Reason for enrollment: ❑ New Hire ❑ Status Change ❑ Open Enrollment ❑ Life Event*

*If Life Event, specify Event_____Date___/___/____

I prefer to receive updates relating to my benefits by: ❑ Phone ❑ Mail ❑ Email ❑ Do not contact

Authorization: I hereby elect to participate in the Starbridge Insurance Plan for benefits made available under Internal Revenue Code Section 79, 105, 106, 125 and these Sections as amended. I understand that the Plan will automatically convert to pre-tax status any eligible payroll deductions which are provided through the Plan. I understand that by participating in this Plan my Social Security benefits may be reduced since these premiums will be deducted before my salary is taxed. This election will remain in effect for the Plan Year. My election CANNOT be changed during the Plan Year in accordance with Internal Revenue Service Guidelines unless a qualifying event occurs which includes: marriage, divorce, legal separation, death of spouse, birth or legal adoption of child, death of child, spousal change of employment affecting insurance coverage, eligibility to Medicare or Medicaid or change in residence affecting insurance coverage. Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a crime and may be subject to fines and confinement in prison.
Declination Notice: No, I do not wish to enroll in the coverage offered above.WAIVER OF COVERAGE: Failure to elect coverage (for yourself and/or any of your dependents) during the Open Enrollment Period may result in no coverage until the next Open Enrollment Period. It may not be necessary to wait for the next Open Enrollment Period if you qualify as a Special Enrollee. Please fill out too, sign, and date.

Sign here if you do not want to enroll: X_____ ___/___/____ Date

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

SBCII593.1 020107

MDC000790

0332

Medical Benefits Chart (applies to each covered individual)

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

PLEASE NOTE: If visiting the ER for a true emergency, your benefits may come out of Outpatient, Inpatient, and/or Accident Coverage. If you receive *non-emergency treatment in the Emergency Room*[1] (care you could receive in a doctor's office), your coverage is reduced to: $100 deductible per occurrence, the plan pays 50% of total bill with a $500 maximum per year. You will be responsible for the remaining balance.

More valuable services that are included in your plan:

Online Tools

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

CIGNA 24-Hour EAP

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

Healthy Rewards®

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

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

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

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

SPECIAL ENROLLMENT

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

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

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

To request special enrollment or obtain more information, contact a Customer Service representative at 1-877-209-7098. Representatives are available Monday through Friday, 5 AM to 6 PM, Mountain Standard time.

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

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

The Pre-Existing Condition Limitation above does not apply to newborn or adopted children, or to any pregnancy. Pregnancy, and genetic information with no related treatment, will not be considered Pre-Existing Conditons. 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. Treatment of mental or nervous disorders, alcoholism, or any form of substance abuse;
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 unmarried children under 19 years old, and
3. Your unmarried children who are 19 years old through 25 years old if the child is attending an accredited school full time and is dependent on you for support.

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

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

TERMINATION

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

1. The date the Policy terminates;
2. The date this Certificate terminates;
3. The date coverage is terminated by Us for all certificate holders in Your state;
4. The date We receive Your written request to have Your insurance terminated.
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] This provision or limitation varies by state.

EXHIBIT 21

EXHIBIT 21

Message

From: Colleen Fulton [Cfulton@manchastores.com]
Sent: 1/2/2015 8:11:24 AM
To: _All Restaurants [restaurants@manchadev.com]
CC: Conallee Moss [cmoss@manchadev.com]
Subject: Recap of Insurance Call

Managers print a list of employees, check off as you go

Post the insurance enrollment sheet where your employees will see it

Train your managers to assist employees in accepting or declining

Assign daily to your managers employees to check off for each shift

Make sure you tell them it does not cover hospitalization, cost is about 10% of gross up to a max of $189 per month for employee only, additional amount for dependants

Encourage employees to look at state approved/sponsored health care programs that they will qualify for

Email questions to Conallee or myself

If you have an employee that you believe should qualify for insurance but computer is saying they do not, email their name, social, unit to Conallee she will check into this

If your employee is interested in the Leavitt group insurance person to contact them email their name and contact number to Conallee and she will forward to Leavitt

In Nevada we will continue to use the accept or decline form for new hires until we are notified of change

Have everyone complete by payday, the 10th

Colleen Fulton

Director of Training

702-420-6998

Good to Great - Never Compromise

--

EXHIBIT 22

EXHIBIT 22

Message

From: Conallee Moss [cmoss@manchadev.com]
Sent: 12/9/2014 9:56:45 AM
To: Colleen Fulton [cfulton@manchastores.com]
CC: Anwaar Hassan [ahassan@manchastores.com]; Paul Schmidt [pschmidt@manchastores.com]
Subject: FW: Mancha Enrollment Strategies and Dates

Colleen:

Can you give me a call to discuss this strategy when you have a moment? I thought we could come up with a few key store locations in each area? Any other thoughts? We should try to get this firmed up today so the messages can get out - thanks for everyone's help!

Conallee Moss, SPHR-CA

Director, Human Resources

Mancha Companies

cmoss@manchadev.com

(951) 642-7249: Mobile

(951) 271-4813: Office

(951) 356-8182: Fax

MDC Restaurants, LLC | Mancha Development Co., LLC | TICI, LLC | InKa, LLC | JoVi, LLC | VFE, LLC

"Passionately committed to running great restaurants each and every day!"

From: Jackie Kohorst [mailto:jackie-kohorst@leavitt.com]
Sent: Tuesday, December 09, 2014 8:27 AM
To: cmoss@manchadev.com
Cc: Kevin Garrett; brian@dgbenefits.com; Michelle Payne; Jennifer Ray; Del Downey
Subject: Mancha Enrollment Strategies and Dates

Good Morning Conallee:

Once again, it was very nice working through our enrollment strategies and plans together yesterday.

As we agreed, I have recapped our conversation and plans below.

First things first. Here are the dates we would like to work with for enrollment meetings in each of the three geographic areas where your restaurants are located:

- December 19
- December 20 - we know this is a Saturday, but we are happy to hold meetings on this day if desirable.
- December 22
- December 29

We will discuss which locations we want to schedule on which days during our 9:30 call this morning. But we are available on each of these dates in all three states/cities.

As we discussed yesterday, chief among our considerations for open enrollment are Mancha's goals and needs related to operations and communications. Here are the factors that guided our planning.

1. Mancha does not wish to make meetings mandatory nor be obligated to pay wages to employees who attend enrollment sessions or meetings.
2. Every Nevada employee regardless of benefit eligibility under ACA must elect benefits or waive coverage in order to qualify Mancha for the lower minimum wage available to companies in Nevada who offer coverage. We must have 100% compliance on this.
3. Payroll is justifiably concerned that these voluntary benefits are of limited value or interest to employees earning low hourly wages.
4. 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.

Given these objectives and concerns, here is how we agreed to organize and roll-out the enrollment plan.

1. We will have 3 or 4 large group meetings where any employee interested in benefits can attend to learn more about the benefits and enroll in them. This morning you will let me know which locations you have selected for each of these meetings based on the suitability and size of the restaurant and central geography in Las Vegas, Southern California and Colorado. We want to locate the general group meetings in locations that will be most easily accessible to the largest number of employees.
2. Along with the group informational meetings, we will also roll-out our self-enrollment platform where any employee may log on and opt in or waive benefits for any of the medical, dental or voluntary benefits available at Mancha for 2015. It is our goal to set up a laptop in each restaurant in conjunction with the manager so that every employee who wants to self-enroll will have ready and easy access to the online enrollment site. It is our goal to get as many self-enrollments conducted at each restaurant as possible, rather than asking employees to do this at their homes.
3. We will also make our call center available for clean up at the end of the month if it is required.
4. Following open enrollment, we will provide electronic enrollment data to all of the carriers as well as valid waivers where required. We also provide a deduction report to you and payroll so that new deductions for benefits can be added to your first payroll in January.
5. Also on an on-going basis, we will organize a central monthly communications and enrollment process through our self-enrollment website to handle all elections and waivers of coverage on a monthly basis. This will ensure managers and district managers do not have to get involved in distributing or collecting and information or applications related to benefits.

Overall, all of our communications will follow the same general guidelines.

1. Evaluate each employee's suitability for enrollment in Medicaid or Medical and provide them with the information they need to enroll if it looks as though they may qualify.
2. Assist employees who have coverage available through spouses or

parents to know how and when to enroll.
3. Limit the sale of any voluntary products to only those employees who have been actively at work for 6 months or greater to reduce the risk of multiple terminations and changes to payroll deductions.
4. Keep the sale of voluntary benefits to an average of no more than one hour of wages per pay period in order to limit impact on take home pay. It will be our objective to ensure that any employee who elects voluntary benefits can afford them and truly understands their value to their family.

Please let me know if you have any questions or would like to add to this summary of our discussion yesterday.

Thanks for everything, Conallee and I will speak with you at 9:30.

Jackie

Jackie Kohorst

Director of Enrollment Services

The Leavitt Group

7881 West Charleston Blvd., Suite 140

Las Vegas, NV 89117

jackie-kohorst@leavitt.com

702-947-4084 (direct)

702-767-5463 (mobile)

EXHIBIT 23

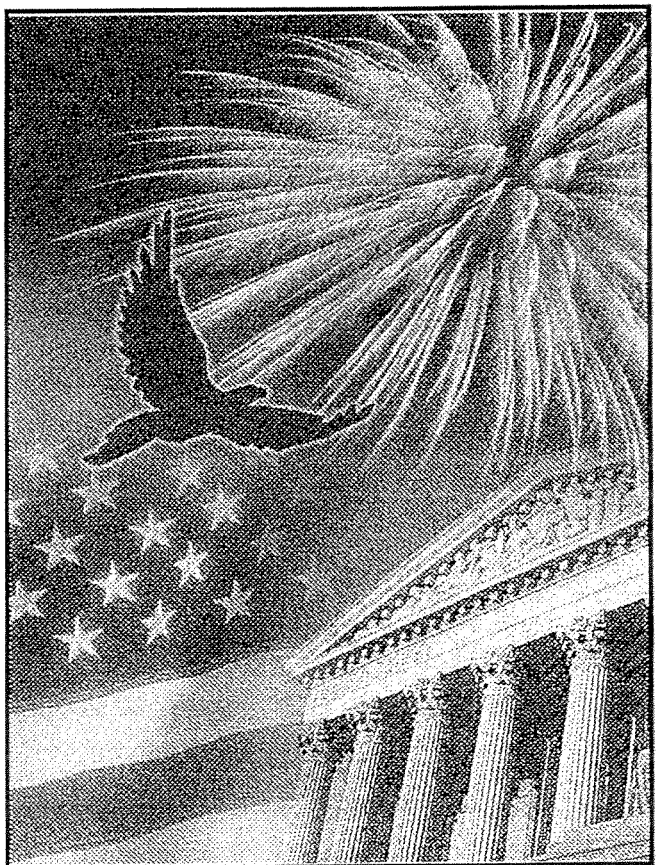
EXHIBIT 23

Department of the Treasury
Internal Revenue Service

Publication 502
Cat. No. 15002Q

Medical and Dental Expenses

For use in preparing
2014 Returns



Get forms and other information faster and easier at:
- IRS.gov (English)
- IRS.gov/Spanish (Español)
- IRS.gov/Chinese
- IRS.gov/Korean (한국어)
- IRS.gov/Russian (Русский)
- IRS.gov/Vietnamese (TiếngViệt)

Dec 31, 2014

Contents

What's New

Premium tax credit. You may be eligible to claim the premium tax credit if you, your spouse, or a dependent enrolled in health insurance through the Health Insurance Marketplace. See the instructions for line 69 in the Form 1040 instructions and Form 8962 for more information.

Advance payment of the premium tax credit. Advance payments of the premium tax credit may have been made to the health insurer to help pay for the insurance coverage of you, your spouse, or your dependent. If advance payments of the premium tax credit were made, you must file a 2014 tax return and Form 8962. If you enrolled someone who is not claimed as a dependent on your tax return or for more information, see the Instructions for Form 8962.

Standard mileage rate. The standard mileage rate allowed for operating expenses for a car when you use it for medical reasons is 23.5 cents per mile. See *Transportation* under *What Medical Expenses Are Includible*.

Reminders

Future developments. For the latest information about developments related to Publication 502, such as

legislation enacted after it was published, go to www.irs.gov/pub502.

Photographs of missing children. The Internal Revenue Service is a proud partner with the National Center for Missing and Exploited Children. Photographs of missing children selected by the Center may appear in this publication on pages that would otherwise be blank. You can help bring these children home by looking at the photographs and calling 1-800-THE-LOST (1-800-843-5678) if you recognize a child.

Introduction

This publication explains the itemized deduction for medical and dental expenses that you claim on Schedule A (Form 1040). It discusses what expenses, and whose expenses, you can and cannot include in figuring the deduction. It explains how to treat reimbursements and how to figure the deduction. It also tells you how to report the deduction on your tax return and what to do if you sell medical property or receive damages for a personal injury.

Medical expenses include dental expenses, and in this publication the term "medical expenses" is often used to refer to medical and dental expenses.

You can deduct on Schedule A (Form 1040) only the part of your medical and dental expenses that is more than 10% of your adjusted gross income (AGI). But if either you or your spouse was born before January 2, 1950, you can deduct the amount of your medical and dental expenses that is more than 7.5% of your AGI. If your medical and dental expenses are not more than 10% of your AGI (7.5% if either you or your spouse was born before January 2, 1950), you cannot claim a deduction.

This publication also explains how to treat impairment-related work expenses and health insurance premiums if you are self-employed.

Pub. 502 covers many common medical expenses but not every possible medical expense. If you cannot find the expense you are looking for, refer to the definition of medical expenses under *What Are Medical Expenses*.

See *How To Get Tax Help* near the end of this publication for information about getting publications and forms.

Comments and suggestions. We welcome your comments about this publication and your suggestions for future editions.

You can send us comments from www.irs.gov/formspubs. Click on "More Information" and then on "Give us feedback."

Or you can write to:

Internal Revenue Service
Tax Forms and Publications
1111 Constitution Ave. NW, IR-6526
Washington, DC 20224

We respond to many letters by telephone. Therefore, it would be helpful if you would include your daytime phone number, including the area code, in your correspondence.

Although we cannot respond individually to each comment received, we do appreciate your feedback and will consider your comments as we revise our tax products.

Ordering forms and publications. Visit www.irs.gov/formspubs to download forms and publications. Otherwise, you can go to www.irs.gov/orderforms to order forms or call 1-800-829-3676 to order current and prior-year forms and instructions. Your order should arrive within 10 business days.

Tax questions. If you have a tax question, check the information available on IRS.gov or call 1-800-829-1040. We cannot answer tax questions sent to the above address.

Useful Items

You may want to see:

Publication

- ❑ **969** Health Savings Accounts and Other Tax-Favored Health Plans

Forms (and Instructions)

- ❑ **1040** U.S. Individual Income Tax Return
- ❑ **Schedule A (Form 1040)** Itemized Deductions
- ❑ **8962** Premium Tax Credit (PTC)

What Are Medical Expenses?

Medical expenses are the costs of diagnosis, cure, mitigation, treatment, or prevention of disease, and the costs for treatments affecting any part or function of the body. These expenses include payments for legal medical services rendered by physicians, surgeons, dentists, and other medical practitioners. They include the costs of equipment, supplies, and diagnostic devices needed for these purposes.

Medical care expenses must be primarily to alleviate or prevent a physical or mental defect or illness. They do not include expenses that are merely beneficial to general health, such as vitamins or a vacation.

Medical expenses include the premiums you pay for insurance that covers the expenses of medical care, and the amounts you pay for transportation to get medical care. Medical expenses also include amounts paid for qualified long-term care services and limited amounts paid for any qualified long-term care insurance contract.

What Expenses Can You Include This Year?

You can include only the medical and dental expenses you paid this year, regardless of when the services were provided. (But see *Decedent* under *Whose Medical Expenses Can You Include*, for an exception.) If you pay

medical expenses by check, the day you mail or deliver the check generally is the date of payment. If you use a "pay-by-phone" or "online" account to pay your medical expenses, the date reported on the statement of the financial institution showing when payment was made is the date of payment. If you use a credit card, include medical expenses you charge to your credit card in the year the charge is made, not when you actually pay the amount charged.

If you did not claim a medical or dental expense that would have been deductible in an earlier year, you can file Form 1040X, Amended U.S. Individual Income Tax Return, for the year in which you overlooked the expense. Do not claim the expense on this year's return. Generally, an amended return must be filed within 3 years from the date the original return was filed or within 2 years from the time the tax was paid, whichever is later.

You cannot include medical expenses that were paid by insurance companies or other sources. This is true whether the payments were made directly to you, to the patient, or to the provider of the medical services.

Separate returns. If you and your spouse live in a noncommunity property state and file separate returns, each of you can include only the medical expenses each actually paid. Any medical expenses paid out of a joint checking account in which you and your spouse have the same interest are considered to have been paid equally by each of you, unless you can show otherwise.

Community property states. If you and your spouse live in a community property state and file separate returns or are registered domestic partners in Nevada, Washington, or California, any medical expenses paid out of community funds are divided equally. Generally, each of you should include half the expenses. If medical expenses are paid out of the separate funds of one individual, only the individual who paid the medical expenses can include them. If you live in a community property state and are not filing a joint return, see Publication 555, Community Property.

How Much of the Expenses Can You Deduct?

Generally, you can deduct on Schedule A (Form 1040) only the amount of your medical and dental expenses that is more than 10% of your AGI. But if either you or your spouse was born before January 2, 1950, you can deduct the amount of your medical and dental expenses that is more than 7.5% of your AGI.

Death before age 65. A taxpayer is considered to be age 65 on the day before the taxpayer's 65th birthday. If the taxpayer was not age 65 or older at the time of death, the 7.5% threshold does not apply for that taxpayer or the spouse of that taxpayer who is under age 65. For example, a taxpayer who was born on February 14, 1949 dies on February 13, 2014. The taxpayer is considered age 65 at the time of death and the 7.5% threshold applies. However, if the taxpayer died on February 12, 2014, the taxpayer is not considered age 65 and the 7.5% threshold does not apply.

Example. You are unmarried and were born after January 2, 1950, and your AGI is $40,000, 10% of which is $4,000. You paid medical expenses of $2,500. You cannot deduct any of your medical expenses because they are not more than 10% of your AGI.

Whose Medical Expenses Can You Include?

You can generally include medical expenses you pay for yourself, as well as those you pay for someone who was your spouse or your dependent either when the services were provided or when you paid for them. There are different rules for decedents and for individuals who are the subject of multiple support agreements. See *Support claimed under a multiple support agreement*, later, under *Qualifying Relative*.

Spouse

You can include medical expenses you paid for your spouse. To include these expenses, you must have been married either at the time your spouse received the medical services or at the time you paid the medical expenses.

Example 1. Mary received medical treatment before she married Bill. Bill paid for the treatment after they married. Bill can include these expenses in figuring his medical expense deduction even if Bill and Mary file separate returns.

If Mary had paid the expenses, Bill could not include Mary's expenses in his separate return. Mary would include the amounts she paid during the year in her separate return. If they filed a joint return, the medical expenses both paid during the year would be used to figure their medical expense deduction.

Example 2. This year, John paid medical expenses for his wife Louise, who died last year. John married Belle this year and they file a joint return. Because John was married to Louise when she received the medical services, he can include those expenses in figuring his medical expense deduction for this year.

Dependent

You can include medical expenses you paid for your dependent. For you to include these expenses, the person must have been your dependent either at the time the medical services were provided or at the time you paid the expenses. A person generally qualifies as your dependent for purposes of the medical expense deduction if both of the following requirements are met.

1. The person was a qualifying child (defined later) or a qualifying relative (defined later), and
2. The person was a U.S. citizen or national or a resident of the United States, Canada, or Mexico. If your qualifying child was adopted, see *Exception for adopted child*, later.

You can include medical expenses you paid for an individual that would have been your dependent except that:

1. He or she received gross income of $3,950 or more in 2014,
2. He or she filed a joint return for 2014, or
3. You, or your spouse if filing jointly, could be claimed as a dependent on someone else's 2014 return.

Exception for adopted child. If you are a U.S. citizen or national and your adopted child lived with you as a member of your household for 2014, that child does not have to be a U.S. citizen or national, or a resident of the United States, Canada, or Mexico.

Qualifying Child

A qualifying child is a child who:

1. Is your son, daughter, stepchild, foster child, brother, sister, stepbrother, stepsister, half brother, half sister, or a descendant of any of them (for example, your grandchild, niece, or nephew),
2. Was:
   a. Under age 19 at the end of 2014 and younger than you (or your spouse, if filing jointly),
   b. Under age 24 at the end of 2014, a full-time student, and younger than you (or your spouse, if filing jointly), or
   c. Any age and permanently and totally disabled,
3. Lived with you for more than half of 2014,
4. Did not provide over half of his or her own support for 2014, and
5. Did not file a joint return, other than to claim a refund.

Adopted child. A legally adopted child is treated as your own child. This child includes a child lawfully placed with you for legal adoption.

You can include medical expenses that you paid for a child before adoption if the child qualified as your dependent when the medical services were provided or when the expenses were paid.

If you pay back an adoption agency or other persons for medical expenses they paid under an agreement with you, you are treated as having paid those expenses provided you clearly substantiate that the payment is directly attributable to the medical care of the child.

But if you pay the agency or other person for medical care that was provided and paid for before adoption negotiations began, you cannot include them as medical expenses.

TIP *You may be able to take a credit for other expenses related to an adoption. See the Instructions for Form 8839, Qualified Adoption Expenses, for more information.*

Child of divorced or separated parents. For purposes of the medical and dental expenses deduction, a child of divorced or separated parents can be treated as a dependent of both parents. Each parent can include the medical expenses he or she pays for the child, even if the other parent claims the child's dependency exemption, if:

1. The child is in the custody of one or both parents for more than half the year,
2. The child receives over half of his or her support during the year from his or her parents, and
3. The child's parents:
   a. Are divorced or legally separated under a decree of divorce or separate maintenance,
   b. Are separated under a written separation agreement, or
   c. Live apart at all times during the last 6 months of the year.

This does not apply if the child's exemption is being claimed under a multiple support agreement (discussed later).

Qualifying Relative

A qualifying relative is a person:

1. Who is your:
   a. Son, daughter, stepchild, or foster child, or a descendant of any of them (for example, your grandchild),
   b. Brother, sister, half brother, half sister, or a son or daughter of any of them,
   c. Father, mother, or an ancestor or sibling of either of them (for example, your grandmother, grandfather, aunt, or uncle),
   d. Stepbrother, stepsister, stepfather, stepmother, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law, or
   e. Any other person (other than your spouse) who lived with you all year as a member of your household if your relationship did not violate local law,
2. Who was not a qualifying child (see *Qualifying Child*, earlier) of any taxpayer for 2014, and
3. For whom you provided over half of the support in 2014. But see *Child of divorced or separated parents*, earlier, *Support claimed under a multiple support agreement*, next, and *Kidnapped child* under *Qualifying Relative* in Publication 501.

Support claimed under a multiple support agreement. If you are considered to have provided more than

half of a qualifying relative's support under a multiple support agreement, you can include medical expenses you pay for that person. A multiple support agreement is used when two or more people provide more than half of a person's support, but no one alone provides more than half.

Any medical expenses paid by others who joined you in the agreement cannot be included as medical expenses by anyone. However, you can include the entire unreimbursed amount you paid for medical expenses.

Example. You and your three brothers each provide one-fourth of your mother's total support. Under a multiple support agreement, you treat your mother as your dependent. You paid all of her medical expenses. Your brothers repaid you for three-fourths of these expenses. In figuring your medical expense deduction, you can include only one-fourth of your mother's medical expenses. Your brothers cannot include any part of the expenses. However, if you and your brothers share the nonmedical support items and you separately pay all of your mother's medical expenses, you can include the unreimbursed amount you paid for her medical expenses in your medical expenses.

Decedent

Medical expenses paid before death by the decedent are included in figuring any deduction for medical and dental expenses on the decedent's final income tax return. This includes expenses for the decedent's spouse and dependents as well as for the decedent.

The survivor or personal representative of a decedent can choose to treat certain expenses paid by the decedent's estate for the decedent's medical care as paid by the decedent at the time the medical services were provided. The expenses must be paid within the 1-year period beginning with the day after the date of death. If you are the survivor or personal representative making this choice, you must attach a statement to the decedent's Form 1040 (or the decedent's amended return, Form 1040X) saying that the expenses have not been and will not be claimed on the estate tax return.

Qualified medical expenses paid before death by the decedent are not deductible if paid with a tax-free distribution from any Archer MSA, Medicare Advantage MSA, or health savings account.

What if the decedent's return had been filed and the medical expenses were not included? Form 1040X can be filed for the year or years the expenses are treated as paid, unless the period for filing an amended return for that year has passed. Generally, an amended return must be filed within 3 years of the date the original return was filed, or within 2 years from the time the tax was paid, whichever date is later.

Example. John properly filed his 2013 income tax return. He died in 2014 with unpaid medical expenses of $1,500 from 2013 and $1,800 in 2014. If the expenses are paid within the 1-year period, his survivor or personal representative can file an amended return for 2013 claiming a deduction based on the $1,500 medical expenses. The $1,800 of medical expenses from 2014 can be included on the decedent's final return for 2014.

What if you pay medical expenses of a deceased spouse or dependent? If you paid medical expenses for your deceased spouse or dependent, include them as medical expenses on your Schedule A (Form 1040) in the year paid, whether they are paid before or after the decedent's death. The expenses can be included if the person was your spouse or dependent either at the time the medical services were provided or at the time you paid the expenses.

What Medical Expenses Are Includible?

Following is a list of items that you can include in figuring your medical expense deduction. The items are listed in alphabetical order.

This list does not include all possible medical expenses. To determine if an expense not listed can be included in figuring your medical expense deduction, see *What Are Medical Expenses*, earlier.

Abortion

You can include in medical expenses the amount you pay for a legal abortion.

Acupuncture

You can include in medical expenses the amount you pay for acupuncture.

Alcoholism

You can include in medical expenses amounts you pay for an inpatient's treatment at a therapeutic center for alcohol addiction. This includes meals and lodging provided by the center during treatment.

You can also include in medical expenses amounts you pay for transportation to and from Alcoholics Anonymous meetings in your community if the attendance is pursuant to medical advice that membership in Alcoholics Anonymous is necessary for the treatment of a disease involving the excessive use of alcoholic liquors.

Ambulance

You can include in medical expenses amounts you pay for ambulance service.

Annual Physical Examination

See *Physical Examination*, later.

Artificial Limb

You can include in medical expenses the amount you pay for an artificial limb.

Artificial Teeth

You can include in medical expenses the amount you pay for artificial teeth.

Bandages

You can include in medical expenses the cost of medical supplies such as bandages.

Birth Control Pills

You can include in medical expenses the amount you pay for birth control pills prescribed by a doctor.

Body Scan

You can include in medical expenses the cost of an electronic body scan.

Braille Books and Magazines

You can include in medical expenses the part of the cost of Braille books and magazines for use by a visually impaired person that is more than the cost of regular printed editions.

Breast Pumps and Supplies

You can include in medical expenses the cost of breast pumps and supplies that assist lactation.

Breast Reconstruction Surgery

You can include in medical expenses the amounts you pay for breast reconstruction surgery, as well as breast prosthesis, following a mastectomy for cancer. See *Cosmetic Surgery*, later.

Capital Expenses

You can include in medical expenses amounts you pay for special equipment installed in a home, or for improvements, if their main purpose is medical care for you, your spouse, or your dependent. The cost of permanent improvements that increase the value of your property may be partly included as a medical expense. The cost of the improvement is reduced by the increase in the value of your property. The difference is a medical expense. If the value of your property is not increased by the improvement, the entire cost is included as a medical expense.

Certain improvements made to accommodate a home to your disabled condition, or that of your spouse or your dependents who live with you, do not usually increase the value of the home and the cost can be included in full as medical expenses. These improvements include, but are not limited to, the following items.

- Constructing entrance or exit ramps for your home.
- Widening doorways at entrances or exits to your home.
- Widening or otherwise modifying hallways and interior doorways.
- Installing railings, support bars, or other modifications to bathrooms.
- Lowering or modifying kitchen cabinets and equipment.
- Moving or modifying electrical outlets and fixtures.
- Installing porch lifts and other forms of lifts (but elevators generally add value to the house).
- Modifying fire alarms, smoke detectors, and other warning systems.
- Modifying stairways.
- Adding handrails or grab bars anywhere (whether or not in bathrooms).
- Modifying hardware on doors.
- Modifying areas in front of entrance and exit doorways.
- Grading the ground to provide access to the residence.

Only reasonable costs to accommodate a home to a disabled condition are considered medical care. Additional costs for personal motives, such as for architectural or aesthetic reasons, are not medical expenses.

Capital expense worksheet. Use Worksheet A to figure the amount of your capital expense to include in your medical expenses.

Worksheet A. **Capital Expense Worksheet**

Keep for Your Records

Instructions: Use this worksheet to figure the amount, if any, of your medical expenses due to a home improvement.

1. Enter the amount you paid for the home improvement ..... 1. _____
2. Enter the value of your home immediately after the improvement ..... 2. _____
3. Enter the value of your home immediately before the improvement ..... 3. _____
4. Subtract line 3 from line 2. This is the increase in the value of your home due to the improvement ..... 4. _____
   - If line 4 is more than or equal to line 1, you have no medical expenses due to the home improvement; stop here.
   - If line 4 is less than line 1, go to line 5.
5. Subtract line 4 from line 1. These are your medical expenses due to the home improvement ..... 5. _____

Operation and upkeep. Amounts you pay for operation and upkeep of a capital asset qualify as medical expenses, as long as the main reason for them is medical care. This rule applies even if none or only part of the original cost of the capital asset qualified as a medical care expense.

Improvements to property rented by a person with a disability. Amounts paid to buy and install special plumbing fixtures for a person with a disability, mainly for medical reasons, in a rented house are medical expenses.

Example. John has arthritis and a heart condition. He cannot climb stairs or get into a bathtub. On his doctor's advice, he installs a bathroom with a shower stall on the first floor of his two-story rented house. The landlord did not pay any of the cost of buying and installing the special plumbing and did not lower the rent. John can include in medical expenses the entire amount he paid.

Car

You can include in medical expenses the cost of special hand controls and other special equipment installed in a car for the use of a person with a disability.

Special design. You can include in medical expenses the difference between the cost of a regular car and a car specially designed to hold a wheelchair.

Cost of operation. The includible costs of using a car for medical reasons are explained under *Transportation*, later.

Chiropractor

You can include in medical expenses fees you pay to a chiropractor for medical care.

Christian Science Practitioner

You can include in medical expenses fees you pay to Christian Science practitioners for medical care.

Contact Lenses

You can include in medical expenses amounts you pay for contact lenses needed for medical reasons. You can also include the cost of equipment and materials required for using contact lenses, such as saline solution and enzyme cleaner. See *Eyeglasses* and *Eye Surgery*, later.

Crutches

You can include in medical expenses the amount you pay to buy or rent crutches.

Dental Treatment

You can include in medical expenses the amounts you pay for the prevention and alleviation of dental disease. Preventive treatment includes the services of a dental hygienist or dentist for such procedures as teeth cleaning, the application of sealants, and fluoride treatments to prevent tooth decay. Treatment to alleviate dental disease include services of a dentist for procedures such as X-rays, fillings, braces, extractions, dentures, and other dental ailments. But see *Teeth Whitening* under *What Expenses Are Not Includible*, later.

Diagnostic Devices

You can include in medical expenses the cost of devices used in diagnosing and treating illness and disease.

Example. You have diabetes and use a blood sugar test kit to monitor your blood sugar level. You can include the cost of the blood sugar test kit in your medical expenses.

Disabled Dependent Care Expenses

Some disabled dependent care expenses may qualify as either:

- Medical expenses, or
- Work-related expenses for purposes of taking a credit for dependent care. (See Publication 503, Child and Dependent Care Expenses.)

You can choose to apply them either way as long as you do not use the same expenses to claim both a credit and a medical expense deduction.

Drug Addiction

You can include in medical expenses amounts you pay for an inpatient's treatment at a therapeutic center for drug addiction. This includes meals and lodging at the center during treatment.

Drugs

See *Medicines*, later.

Eye Exam

You can include in medical expenses the amount you pay for eye examinations.

Eyeglasses

You can include in medical expenses amounts you pay for eyeglasses and contact lenses needed for medical reasons. See *Contact Lenses*, earlier, for more information.

Eye Surgery

You can include in medical expenses the amount you pay for eye surgery to treat defective vision, such as laser eye surgery or radial keratotomy.

Fertility Enhancement

You can include in medical expenses the cost of the following procedures to overcome an inability to have children.

- Procedures such as *in vitro* fertilization (including temporary storage of eggs or sperm).
- Surgery, including an operation to reverse prior surgery that prevented the person operated on from having children.

Founder's Fee

See *Lifetime Care—Advance Payments*, later.

Guide Dog or Other Service Animal

You can include in medical expenses the costs of buying, training, and maintaining a guide dog or other service animal to assist a visually impaired or hearing disabled person, or a person with other physical disabilities. In general, this includes any costs, such as food, grooming, and veterinary care, incurred in maintaining the health and vitality of the service animal so that it may perform its duties.

Health Institute

You can include in medical expenses fees you pay for treatment at a health institute only if the treatment is prescribed by a physician and the physician issues a statement that the treatment is necessary to alleviate a physical or mental defect or illness of the individual receiving the treatment.

Health Maintenance Organization (HMO)

You can include in medical expenses amounts you pay to entitle you, your spouse, or a dependent to receive medical care from an HMO. These amounts are treated as medical insurance premiums. See *Insurance Premiums*, later.

Hearing Aids

You can include in medical expenses the cost of a hearing aid and batteries, repairs, and maintenance needed to operate it.

Home Care

See *Nursing Services*, later.

Home Improvements

See *Capital Expenses*, earlier.

Hospital Services

You can include in medical expenses amounts you pay for the cost of inpatient care at a hospital or similar institution if a principal reason for being there is to receive medical care. This includes amounts paid for meals and lodging. Also see *Lodging*, later.

Insurance Premiums

You can include in medical expenses insurance premiums you pay for policies that cover medical care. You cannot include in medical expenses insurance premiums that were paid and for which you are claiming a credit or deduction. Medical care policies can provide payment for treatment that includes:

- Hospitalization, surgical services, X-rays,
- Prescription drugs and insulin,
- Dental care,
- Replacement of lost or damaged contact lenses, and
- Long-term care (subject to additional limitations). See *Qualified Long-Term Care Insurance Contracts* under *Long-Term Care*, later.

If you have a policy that provides payments for other than medical care, you can include the premiums for the medical care part of the policy if the charge for the medical part is reasonable. The cost of the medical part must be separately stated in the insurance contract or given to you in a separate statement.

Employer-Sponsored Health Insurance Plan

Do not include in your medical and dental expenses any insurance premiums paid by an employer-sponsored health insurance plan unless the premiums are included on your Form W-2, Wage and Tax Statement. Also, do not include any other medical and dental expenses paid by the plan unless the amount paid is included on your Form W-2.

Example. You are a federal employee participating in the premium conversion plan of the Federal Employee Health Benefits (FEHB) program. Your share of the FEHB premium is paid by making a pre-tax reduction in your salary. Because you are an employee whose insurance premiums are paid with money that is never included in your gross income, you cannot deduct the premiums paid with that money.

Long-term care services. Contributions made by your employer to provide coverage for qualified long-term care services under a flexible spending or similar arrangement must be included in your income. This amount will be reported as wages on your Form W-2.

Retired public safety officers. If you are a retired public safety officer, do not include as medical expenses any health or long-term care insurance premiums that you elected to have paid with tax-free distributions from a retirement plan. This applies only to distributions that would otherwise be included in income.

Health reimbursement arrangement (HRA). If you have medical expenses that are reimbursed by a health reimbursement arrangement, you cannot include those expenses in your medical expenses. This is because an HRA is funded solely by the employer.

Medicare A

If you are covered under social security (or if you are a government employee who paid Medicare tax), you are enrolled in Medicare A. The payroll tax paid for Medicare A is not a medical expense.

If you are not covered under social security (or were not a government employee who paid Medicare tax), you can voluntarily enroll in Medicare A. In this situation you can include the premiums you paid for Medicare A as a medical expense.

Medicare B

Medicare B is a supplemental medical insurance. Premiums you pay for Medicare B are a medical expense. Check the information you received from the Social Security Administration to find out your premium.

Medicare D

Medicare D is a voluntary prescription drug insurance program for persons with Medicare A or B. You can include as a medical expense premiums you pay for Medicare D.

Prepaid Insurance Premiums

Premiums you pay before you are age 65 for insurance for medical care for yourself, your spouse, or your dependents after you reach age 65 are medical care expenses in the year paid if they are:

1. Payable in equal yearly installments or more often, and
2. Payable for at least 10 years, or until you reach age 65 (but not for less than 5 years).

Unused Sick Leave Used To Pay Premiums

You must include in gross income cash payments you receive at the time of retirement for unused sick leave. You also must include in gross income the value of unused sick leave that, at your option, your employer applies to the cost of your continuing participation in your employer's health plan after you retire. You can include this cost of continuing participation in the health plan as a medical expense.

If you participate in a health plan where your employer automatically applies the value of unused sick leave to the cost of your continuing participation in the health plan (and you do not have the option to receive cash), do not include the value of the unused sick leave in gross income. You cannot include this cost of continuing participation in that health plan as a medical expense.

Insurance Premiums You Cannot Include

You cannot include premiums you pay for:

- Life insurance policies,
- Policies providing payment for loss of earnings,
- Policies for loss of life, limb, sight, etc.,
- Policies that pay you a guaranteed amount each week for a stated number of weeks if you are hospitalized for sickness or injury,
- The part of your car insurance that provides medical insurance coverage for all persons injured in or by your car because the part of the premium providing insurance for you, your spouse, and your dependents is not stated separately from the part of the premium providing insurance for medical care for others, or
- Health or long-term care insurance if you elected to pay these premiums with tax-free distributions from a retirement plan made directly to the insurance

provider and these distributions would otherwise have been included in income.

Taxes imposed by any governmental unit, such as Medicare taxes, are not insurance premiums.

Coverage for nondependents. Generally, you cannot deduct any additional premium you pay as the result of including on your policy someone who is not your spouse or dependent, even if that person is your child under age 27. However, you can deduct the additional premium if that person is:

- Your child whom you do not claim as a dependent because of the rules for children of divorced or separated parents,
- Any person you could have claimed as a dependent on your return except that person received $3,950 or more of gross income or filed a joint return, or
- Any person you could have claimed as a dependent except that you, or your spouse if filing jointly, can be claimed as a dependent on someone else's 2014 return.

Also, if you had family coverage when you added this individual to your policy and your premiums did not increase, you can enter on Schedule A (Form 1040) the full amount of your medical and dental insurance premiums.

Intellectually and Developmentally Disabled, Special Home for

You can include in medical expenses the cost of keeping a person who is intellectually and developmentally disabled in a special home, not the home of a relative, on the recommendation of a psychiatrist to help the person adjust from life in a mental hospital to community living.

Laboratory Fees

You can include in medical expenses the amounts you pay for laboratory fees that are part of medical care.

Lactation Expenses

See *Breast Pumps and Supplies*, earlier.

Lead-Based Paint Removal

You can include in medical expenses the cost of removing lead-based paints from surfaces in your home to prevent a child who has or had lead poisoning from eating the paint. These surfaces must be in poor repair (peeling or cracking) or within the child's reach. The cost of repainting the scraped area is not a medical expense.

If, instead of removing the paint, you cover the area with wallboard or paneling, treat these items as capital expenses. See *Capital Expenses*, earlier. Do not include the cost of painting the wallboard as a medical expense.

Learning Disability

See *Special Education*, later.

Legal Fees

You can include in medical expenses legal fees you paid that are necessary to authorize treatment for mental illness. However, you cannot include in medical expenses fees for the management of a guardianship estate, fees for conducting the affairs of the person being treated, or other fees that are not necessary for medical care.

Lifetime Care—Advance Payments

You can include in medical expenses a part of a life-care fee or "founder's fee" you pay either monthly or as a lump sum under an agreement with a retirement home. The part of the payment you include is the amount properly allocable to medical care. The agreement must require that you pay a specific fee as a condition for the home's promise to provide lifetime care that includes medical care. You can use a statement from the retirement home to prove the amount properly allocable to medical care. The statement must be based either on the home's prior experience or on information from a comparable home.

Dependents with disabilities. You can include in medical expenses advance payments to a private institution for lifetime care, treatment, and training of your physically or mentally impaired child upon your death or when you become unable to provide care. The payments must be a condition for the institution's future acceptance of your child and must not be refundable.

Payments for future medical care. Generally, you cannot include in medical expenses current payments for medical care (including medical insurance) to be provided substantially beyond the end of the year. This rule does not apply in situations where the future care is purchased in connection with obtaining lifetime care of the type described earlier.

Lodging

You can include in medical expenses the cost of meals and lodging at a hospital or similar institution if a principal reason for being there is to receive medical care. See *Nursing Home*, later.

You may be able to include in medical expenses the cost of lodging not provided in a hospital or similar institution. You can include the cost of such lodging while away from home if all of the following requirements are met.

1. The lodging is primarily for and essential to medical care.
2. The medical care is provided by a doctor in a licensed hospital or in a medical care facility related to, or the equivalent of, a licensed hospital.

3. The lodging is not lavish or extravagant under the circumstances.
4. There is no significant element of personal pleasure, recreation, or vacation in the travel away from home.

The amount you include in medical expenses for lodging cannot be more than $50 for each night for each person. You can include lodging for a person traveling with the person receiving the medical care. For example, if a parent is traveling with a sick child, up to $100 per night can be included as a medical expense for lodging. Meals are not included.

Do not include the cost of lodging while away from home for medical treatment if that treatment is not received from a doctor in a licensed hospital or in a medical care facility related to, or the equivalent of, a licensed hospital or if that lodging is not primarily for or essential to the medical care received.

Long-Term Care

You can include in medical expenses amounts paid for qualified long-term care services and premiums paid for qualified long-term care insurance contracts.

Qualified Long-Term Care Services

Qualified long-term care services are necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, rehabilitative services, and maintenance and personal care services (defined later) that are:

1. Required by a chronically ill individual, and
2. Provided pursuant to a plan of care prescribed by a licensed health care practitioner.

Chronically ill individual. An individual is chronically ill if, within the previous 12 months, a licensed health care practitioner has certified that the individual meets either of the following descriptions.

1. He or she is unable to perform at least two activities of daily living without substantial assistance from another individual for at least 90 days, due to a loss of functional capacity. Activities of daily living are eating, toileting, transferring, bathing, dressing, and continence.
2. He or she requires substantial supervision to be protected from threats to health and safety due to severe cognitive impairment.

Maintenance and personal care services. Maintenance or personal care services is care which has as its primary purpose the providing of a chronically ill individual with needed assistance with his or her disabilities (including protection from threats to health and safety due to severe cognitive impairment).

Qualified Long-Term Care Insurance Contracts

A qualified long-term care insurance contract is an insurance contract that provides only coverage of qualified long-term care services. The contract must:

1. Be guaranteed renewable,
2. Not provide for a cash surrender value or other money that can be paid, assigned, pledged, or borrowed,
3. Provide that refunds, other than refunds on the death of the insured or complete surrender or cancellation of the contract, and dividends under the contract must be used only to reduce future premiums or increase future benefits, and
4. Generally not pay or reimburse expenses incurred for services or items that would be reimbursed under Medicare, except where Medicare is a secondary payer, or the contract makes *per diem* or other periodic payments without regard to expenses.

The amount of qualified long-term care premiums you can include is limited. You can include the following as medical expenses on Schedule A (Form 1040).

1. Qualified long-term care premiums up to the following amounts.
   a. Age 40 or under – $370.
   b. Age 41 to 50 – $700.
   c. Age 51 to 60 – $1,400.
   d. Age 61 to 70 – $3,720.
   e. Age 71 or over – $4,660.
2. Unreimbursed expenses for qualified long-term care services.

Note. The limit on premiums is for each person.

Also, if you are an eligible retired public safety officer, you cannot include premiums for long-term care insurance if you elected to pay these premiums with tax-free distributions from a qualified retirement plan made directly to the insurance provider and these distributions would otherwise have been included in your income.

Meals

You can include in medical expenses the cost of meals at a hospital or similar institution if a principal reason for being there is to get medical care.

You cannot include in medical expenses the cost of meals that are not part of inpatient care. Also see *Weight-Loss Program* and *Nutritional Supplements*, later.

Medical Conferences

You can include in medical expenses amounts paid for admission and transportation to a medical conference if

the medical conference concerns the chronic illness of yourself, your spouse, or your dependent. The costs of the medical conference must be primarily for and necessary to the medical care of you, your spouse, or your dependent. The majority of the time spent at the conference must be spent attending sessions on medical information.

The cost of meals and lodging while attending the conference is not deductible as a medical expense.

Medical Information Plan

You can include in medical expenses amounts paid to a plan that keeps medical information in a computer data bank and retrieves and furnishes the information upon request to an attending physician.

Medicines

You can include in medical expenses amounts you pay for prescribed medicines and drugs. A prescribed drug is one that requires a prescription by a doctor for its use by an individual. You can also include amounts you pay for insulin. Except for insulin, you cannot include in medical expenses amounts you pay for a drug that is not prescribed.

Imported medicines and drugs. If you imported medicines or drugs from other countries, see *Medicines and Drugs From Other Countries*, under *What Expenses Are Not Includible*, later.

Nursing Home

You can include in medical expenses the cost of medical care in a nursing home, home for the aged, or similar institution, for yourself, your spouse, or your dependents. This includes the cost of meals and lodging in the home if a principal reason for being there is to get medical care.

Do not include the cost of meals and lodging if the reason for being in the home is personal. You can, however, include in medical expenses the part of the cost that is for medical or nursing care.

Nursing Services

You can include in medical expenses wages and other amounts you pay for nursing services. The services need not be performed by a nurse as long as the services are of a kind generally performed by a nurse. This includes services connected with caring for the patient's condition, such as giving medication or changing dressings, as well as bathing and grooming the patient. These services can be provided in your home or another care facility.

Generally, only the amount spent for nursing services is a medical expense. If the attendant also provides personal and household services, amounts paid to the attendant must be divided between the time spent performing household and personal services and the time spent for nursing services. For example, because of your medical condition you pay a visiting nurse $300 per week for medical and household services. She spends 10% of her time doing household services such as washing dishes and laundry. You can include only $270 per week as medical expenses. The $30 (10% × $300) allocated to household services cannot be included. However, certain maintenance or personal care services provided for qualified long-term care can be included in medical expenses. See *Maintenance and personal care services* under *Long-Term Care*, earlier. Additionally, certain expenses for household services or for the care of a qualifying individual incurred to allow you to work may qualify for the child and dependent care credit. See Publication 503.

You can also include in medical expenses part of the amount you pay for that attendant's meals. Divide the food expense among the household members to find the cost of the attendant's food. Then divide that cost in the same manner as in the preceding paragraph. If you had to pay additional amounts for household upkeep because of the attendant, you can include the extra amounts with your medical expenses. This includes extra rent or utilities you pay because you moved to a larger apartment to provide space for the attendant.

Employment taxes. You can include as a medical expense social security tax, FUTA, Medicare tax, and state employment taxes you pay for an attendant who provides medical care. If the attendant also provides personal and household services, you can include as a medical expense only the amount of employment taxes paid for medical services as explained earlier. For information on employment tax responsibilities of household employers, see Publication 926, Household Employer's Tax Guide.

Operations

You can include in medical expenses amounts you pay for legal operations that are not for unnecessary cosmetic surgery. See *Cosmetic Surgery* under *What Expenses Are Not Includible*, later.

Optometrist

See *Eyeglasses*, earlier.

Organ Donors

See *Transplants*, later.

Osteopath

You can include in medical expenses amounts you pay to an osteopath for medical care.

Oxygen

You can include in medical expenses amounts you pay for oxygen and oxygen equipment to relieve breathing problems caused by a medical condition.

Physical Examination

You can include in medical expenses the amount you pay for an annual physical examination and diagnostic tests by a physician. You do not have to be ill at the time of the examination.

Pregnancy Test Kit

You can include in medical expenses the amount you pay to purchase a pregnancy test kit to determine if you are pregnant.

Prosthesis

See *Artificial Limb* and *Breast Reconstruction Surgery*, earlier.

Psychiatric Care

You can include in medical expenses amounts you pay for psychiatric care. This includes the cost of supporting a mentally ill dependent at a specially equipped medical center where the dependent receives medical care. See *Psychoanalysis*, next, and *Transportation*, later.

Psychoanalysis

You can include in medical expenses payments for psychoanalysis. However, you cannot include payments for psychoanalysis that is part of required training to be a psychoanalyst.

Psychologist

You can include in medical expenses amounts you pay to a psychologist for medical care.

Special Education

You can include in medical expenses fees you pay on a doctor's recommendation for a child's tutoring by a teacher who is specially trained and qualified to work with children who have learning disabilities caused by mental or physical impairments, including nervous system disorders.

You can include in medical expenses the cost (tuition, meals, and lodging) of attending a school that furnishes special education to help a child to overcome learning disabilities. A doctor must recommend that the child attend the school. Overcoming the learning disabilities must be a principal reason for attending the school, and any ordinary education received must be incidental to the special education provided. Special education includes:

- Teaching Braille to a visually impaired person,
- Teaching lip reading to a hearing disabled person, or
- Giving remedial language training to correct a condition caused by a birth defect.

You cannot include in medical expenses the cost of sending a child with behavioral problems to a school where the course of study and the disciplinary methods have a beneficial effect on the child's attitude if the availability of medical care in the school is not a principal reason for sending the student there.

Sterilization

You can include in medical expenses the cost of a legal sterilization (a legally performed operation to make a person unable to have children). Also see *Vasectomy*, later.

Stop-Smoking Programs

You can include in medical expenses amounts you pay for a program to stop smoking. However, you cannot include in medical expenses amounts you pay for drugs that do not require a prescription, such as nicotine gum or patches, that are designed to help stop smoking.

Surgery

See *Operations*, earlier.

Telephone

You can include in medical expenses the cost of special telephone equipment that lets a person who is deaf, hard of hearing or has a speech disability communicate over a regular telephone. This includes teletypewriter (TTY) and telecommunications device for the deaf (TDD) equipment. You can also include the cost of repairing the equipment.

Television

You can include in medical expenses the cost of equipment that displays the audio part of television programs as subtitles for persons with a hearing disability. This may be the cost of an adapter that attaches to a regular set. It also may be the part of the cost of a specially equipped television that exceeds the cost of the same model regular television set.

Therapy

You can include in medical expenses amounts you pay for therapy received as medical treatment.

Transplants

You can include in medical expenses amounts paid for medical care you receive because you are a donor or a possible donor of a kidney or other organ. This includes transportation.

You can include any expenses you pay for the medical care of a donor in connection with the donating of an organ. This includes transportation.

Transportation

You can include in medical expenses amounts paid for transportation primarily for, and essential to, medical care.

You can include:

- Bus, taxi, train, or plane fares or ambulance service,
- Transportation expenses of a parent who must go with a child who needs medical care,
- Transportation expenses of a nurse or other person who can give injections, medications, or other treatment required by a patient who is traveling to get medical care and is unable to travel alone, and
- Transportation expenses for regular visits to see a mentally ill dependent, if these visits are recommended as a part of treatment.

Car expenses. You can include out-of-pocket expenses, such as the cost of gas and oil, when you use a car for medical reasons. You cannot include depreciation, insurance, general repair, or maintenance expenses.

If you do not want to use your actual expenses for 2014, you can use the standard medical mileage rate of 23.5 cents a mile.

You can also include parking fees and tolls. You can add these fees and tolls to your medical expenses whether you use actual expenses or the standard mileage rate.

Example. In 2014, Bill Jones drove 2,800 miles for medical reasons. He spent $500 for gas, $30 for oil, and $100 for tolls and parking. He wants to figure the amount he can include in medical expenses both ways to see which gives him the greater deduction.

He figures the actual expenses first. He adds the $500 for gas, the $30 for oil, and the $100 for tolls and parking for a total of $630.

He then figures the standard mileage amount. He multiplies 2,800 miles by 23.5 cents a mile for a total of $658. He then adds the $100 tolls and parking for a total of $758.

Bill includes the $758 of car expenses with his other medical expenses for the year because the $758 is more than the $630 he figured using actual expenses.

Transportation expenses you cannot include. You cannot include in medical expenses the cost of transportation in the following situations.

- Going to and from work, even if your condition requires an unusual means of transportation.
- Travel for purely personal reasons to another city for an operation or other medical care.
- Travel that is merely for the general improvement of one's health.
- The costs of operating a specially equipped car for other than medical reasons.

Trips

You can include in medical expenses amounts you pay for transportation to another city if the trip is primarily for, and essential to, receiving medical services. You may be able to include up to $50 for each night for each person. You can include lodging for a person traveling with the person receiving the medical care. For example, if a parent is traveling with a sick child, up to $100 per night can be included as a medical expense for lodging. Meals are not included. See *Lodging*, earlier.

You cannot include in medical expenses a trip or vacation taken merely for a change in environment, improvement of morale, or general improvement of health, even if the trip is made on the advice of a doctor. However, see *Medical Conferences*, earlier.

Tuition

Under special circumstances, you can include charges for tuition in medical expenses. See *Special Education*, earlier.

You can include charges for a health plan included in a lump-sum tuition fee if the charges are separately stated or can easily be obtained from the school.

Vasectomy

You can include in medical expenses the amount you pay for a vasectomy.

Vision Correction Surgery

See *Eye Surgery*, earlier.

Weight-Loss Program

You can include in medical expenses amounts you pay to lose weight if it is a treatment for a specific disease diagnosed by a physician (such as obesity, hypertension, or heart disease). This includes fees you pay for membership in a weight reduction group as well as fees for attendance at periodic meetings. You cannot include membership dues in a gym, health club, or spa as medical expenses, but you can include separate fees charged there for weight loss activities.

You cannot include the cost of diet food or beverages in medical expenses because the diet food and beverages substitute for what is normally consumed to satisfy nutritional needs. You can include the cost of special food in medical expenses only if:

1. The food does not satisfy normal nutritional needs,
2. The food alleviates or treats an illness, and
3. The need for the food is substantiated by a physician.

The amount you can include in medical expenses is limited to the amount by which the cost of the special food exceeds the cost of a normal diet. See also *Weight-Loss Program* under *What Expenses Are Not Includible*, later.

Wheelchair

You can include in medical expenses amounts you pay for a wheelchair used mainly for the relief of sickness or disability, and not just to provide transportation to and from work. The cost of operating and maintaining the wheelchair is also a medical expense.

Wig

You can include in medical expenses the cost of a wig purchased upon the advice of a physician for the mental health of a patient who has lost all of his or her hair from disease.

X-ray

You can include in medical expenses amounts you pay for X-rays for medical reasons.

What Expenses Are Not Includible?

Following is a list of some items that you cannot include in figuring your medical expense deduction. The items are listed in alphabetical order.

Baby Sitting, Childcare, and Nursing Services for a Normal, Healthy Baby

You cannot include in medical expenses amounts you pay for the care of children, even if the expenses enable you, your spouse, or your dependent to get medical or dental treatment. Also, any expense allowed as a childcare credit cannot be treated as an expense paid for medical care.

Controlled Substances

You cannot include in medical expenses amounts you pay for controlled substances (such as marijuana, laetrile, etc.) that are not legal under federal law, even if such substances are legalized by state law.

Cosmetic Surgery

Generally, you cannot include in medical expenses the amount you pay for unnecessary cosmetic surgery. This includes any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease. You generally cannot include in medical expenses the amount you pay for procedures such as face lifts, hair transplants, hair removal (electrolysis), and liposuction.

You can include in medical expenses the amount you pay for cosmetic surgery if it is necessary to improve a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease.

Example. An individual undergoes surgery that removes a breast as part of treatment for cancer. She pays a surgeon to reconstruct the breast. The surgery to reconstruct the breast corrects a deformity directly related to the disease. The cost of the surgery is includible in her medical expenses.

Dancing Lessons

You cannot include in medical expenses the cost of dancing lessons, swimming lessons, etc., even if they are recommended by a doctor, if they are only for the improvement of general health.

Diaper Service

You cannot include in medical expenses the amount you pay for diapers or diaper services, unless they are needed to relieve the effects of a particular disease.

Electrolysis or Hair Removal

See *Cosmetic Surgery*, earlier.

Flexible Spending Account

You cannot include in medical expenses amounts for which you are fully reimbursed by your flexible spending account if you contribute a part of your income on a pre-tax basis to pay for the qualified benefit.

Funeral Expenses

You cannot include in medical expenses amounts you pay for funerals.

Future Medical Care

Generally, you cannot include in medical expenses current payments for medical care (including medical insurance) to be provided substantially beyond the end of the year. This rule does not apply in situations where the future care is purchased in connection with obtaining lifetime care or long-term care of the type described at *Lifetime Care—Advance Payments* or *Long-Term Care*, earlier, under *What Medical Expenses Are Includible*.

Hair Transplant

See *Cosmetic Surgery*, earlier.

Health Club Dues

You cannot include in medical expenses health club dues or amounts paid to improve one's general health or to relieve physical or mental discomfort not related to a particular medical condition.

You cannot include in medical expenses the cost of membership in any club organized for business, pleasure, recreation, or other social purpose.

Health Savings Accounts

You cannot include in medical expenses any payment or distribution for medical expenses out of a health savings account. Contributions to health savings accounts are deducted separately. See Publication 969.

Household Help

You cannot include in medical expenses the cost of household help, even if such help is recommended by a doctor. This is a personal expense that is not deductible. However, you may be able to include certain expenses paid to a person providing nursing-type services. For more information, see *Nursing Services*, earlier, under *What Medical Expenses Are Includible*. Also, certain maintenance or personal care services provided for qualified long-term care can be included in medical expenses. For more information, see *Long-Term Care*, earlier, under *What Medical Expenses Are Includible*.

Illegal Operations and Treatments

You cannot include in medical expenses amounts you pay for illegal operations, treatments, or controlled substances whether rendered or prescribed by licensed or unlicensed practitioners.

Insurance Premiums

See *Insurance Premiums* under *What Medical Expenses Are Includible*, earlier.

Maternity Clothes

You cannot include in medical expenses amounts you pay for maternity clothes.

Medical Savings Account (MSA)

You cannot include in medical expenses amounts you contribute to an Archer MSA. You cannot include expenses you pay for with a tax-free distribution from your Archer MSA. You also cannot use other funds equal to the amount of the distribution and include the expenses. For more information on Archer MSAs, see Publication 969.

Medicines and Drugs From Other Countries

In general, you cannot include in your medical expenses the cost of a prescribed drug brought in (or ordered shipped) from another country. You can only include the cost of a drug that was imported legally. For example, you can include the cost of a prescribed drug the Food and Drug Administration announces can be legally imported by individuals.

You can include the cost of a prescribed drug you purchase and consume in another country if the drug is legal in both the other country and the United States.

Nonprescription Drugs and Medicines

Except for insulin, you cannot include in medical expenses amounts you pay for a drug that is not prescribed.

Example. Your doctor recommends that you take aspirin. Because aspirin is a drug that does not require a physician's prescription, you cannot include its cost in your medical expenses.

Nutritional Supplements

You cannot include in medical expenses the cost of nutritional supplements, vitamins, herbal supplements, "natural medicines," etc. unless they are recommended by a medical practitioner as treatment for a specific medical condition diagnosed by a physician. Otherwise, these items are taken to maintain your ordinary good health, and are not for medical care.

Personal Use Items

You cannot include in medical expenses the cost of an item ordinarily used for personal, living, or family purposes unless it is used primarily to prevent or alleviate a physical or mental defect or illness. For example, the cost of a toothbrush and toothpaste is a nondeductible personal expense.

In order to accommodate an individual with a physical defect, you may have to purchase an item ordinarily used as a personal, living, or family item in a special form. You can include the excess of the cost of the item in a special form over the cost of the item in normal form as a medical expense. (See *Braille Books and Magazines* under *What Medical Expenses Are Includible*, earlier.)

Swimming Lessons

See *Dancing Lessons*, earlier.

Teeth Whitening

You cannot include in medical expenses amounts paid to whiten teeth. See *Cosmetic Surgery*, earlier.

Veterinary Fees

You generally cannot include veterinary fees in your medical expenses, but see *Guide Dog or Other Service Animal* under *What Medical Expenses Are Includible*, earlier.

Weight-Loss Program

You cannot include in medical expenses the cost of a weight-loss program if the purpose of the weight loss is the improvement of appearance, general health, or sense of well-being. You cannot include amounts you pay to lose weight unless the weight loss is a treatment for a specific disease diagnosed by a physician (such as obesity, hypertension, or heart disease). If the weight-loss treatment is not for a specific disease diagnosed by a physician, you cannot include either the fees you pay for membership in a weight reduction group or fees for attendance at periodic meetings. Also, you cannot include membership dues in a gym, health club, or spa.

You cannot include the cost of diet food or beverages in medical expenses because the diet food and beverages substitute for what is normally consumed to satisfy nutritional needs.

See *Weight-Loss Program* under *What Medical Expenses Are Includible*, earlier.

How Do You Treat Reimbursements?

You can include in medical expenses only those amounts paid during the tax year for which you received no insurance or other reimbursement.

Insurance Reimbursement

You must reduce your total medical expenses for the year by all reimbursements for medical expenses that you receive from insurance or other sources during the year. This includes payments from Medicare.

Even if a policy provides reimbursement only for certain specific medical expenses, you must use amounts you receive from that policy to reduce your total medical expenses, including those it does not reimburse.

Example. You have insurance policies that cover your hospital and doctors' bills but not your nursing bills. The insurance you receive for the hospital and doctors' bills is more than their charges. In figuring your medical deduction, you must reduce the total amount you spent for medical care by the total amount of insurance you received, even if the policies do not cover some of your medical expenses.

Health reimbursement arrangement (HRA). A health reimbursement arrangement is an employer-funded plan that reimburses employees for medical care expenses and allows unused amounts to be carried forward. An HRA is funded solely by the employer and the reimbursements for medical expenses, up to a maximum dollar amount for a coverage period, are not included in your income.

Other reimbursements. Generally, you do not reduce medical expenses by payments you receive for:

- Permanent loss or loss of use of a member or function of the body (loss of limb, sight, hearing, etc.) or disfigurement to the extent the payment is based on the nature of the injury without regard to the amount of time lost from work, or
- Loss of earnings.

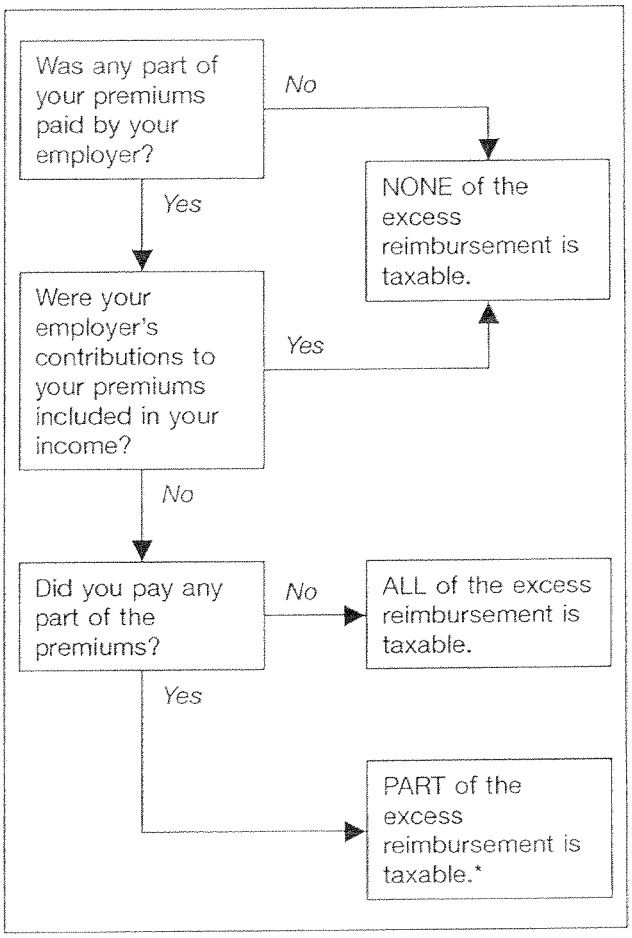
You must, however, reduce your medical expenses by any part of these payments that is designated for medical costs. See *How Do You Figure and Report the Deduction on Your Tax Return*, later.

For how to treat damages received for personal injury or sickness, see *Damages for Personal Injuries*, later.

What If Your Insurance Reimbursement Is More Than Your Medical Expenses?

If you are reimbursed more than your medical expenses, you may have to include the excess in income. You may want to use Figure 1 to help you decide if any of your reimbursement is taxable.

Figure 1. Is Your Excess Medical Reimbursement Taxable?



*See *Premiums paid by you and your employer.*

Premiums paid by you. If you pay either the entire premium for your medical insurance or all the costs of a plan similar to medical insurance and your insurance payments or other reimbursements are more than your total medical expenses for the year, you have excess reimbursement. Generally, you do not include the excess reimbursement in your gross income. However, gross income does include total payments in excess of $330 a day ($120,450 for 2014) for qualified long-term care services.

Premiums paid by you and your employer. If both you and your employer contribute to your medical insurance plan and your employer's contributions are not included in your gross income, you must include in your gross income the part of your excess reimbursement that is from your employer's contribution.

If you are not covered by more than one policy, you can figure the amount of the excess reimbursement you must include in gross income using Worksheet B. If you are covered under more than one policy, see *More than one policy*, later.

Worksheet B. Excess Reimbursement Includible in Income When You Have Only One Policy

Keep for Your Records

Instructions: Use this worksheet to figure the amount of excess reimbursement you must include in income when both you and your employer contributed to your medical insurance and your employer's contributions are not included in your gross income.

1.	Enter the amount contributed to your medical insurance for the year by your employer	1. _____
2.	Enter the total annual cost of the policy	2. _____
3.	Divide line 1 by line 2	3. _____
4.	Enter the amount of excess reimbursement	4. _____
5.	Multiply line 3 by line 4. This is the amount of the excess reimbursement you must include as other income on Form 1040	5. _____

Premiums paid by your employer. If your employer or your former employer pays the total cost of your medical insurance plan and your employer's contributions are not included in your income, you must report all of your excess reimbursement as other income.

More than one policy. If you are covered under more than one policy, the cost of at least one of which is paid by both you and your employer, you must first divide the medical expenses among the policies to figure the excess reimbursement from each policy. Then divide the policy costs to figure the part of any excess reimbursement that is from your employer's contribution. Any excess reimbursement that is due to your employer's contributions is includible in your income.

You can figure the part of the excess reimbursement that is from your employer's contribution by using Worksheet C. Use Worksheet C only if both you and your employer paid part of the cost of at least one policy. If you had more than one policy, but you did not share in the cost of at least one policy, do not use Worksheet C.

Worksheet C. Excess Reimbursement Includible in Income When You Have More Than One Policy

Keep for Your Records

Instructions: Use this worksheet to figure the amount of excess reimbursement you must include as income on your tax return when (a) you are reimbursed under two or more health insurance policies, (b) at least one of which is paid for by both you and your employer, and (c) your employer's contributions are not included in your gross income. If you and your employer did not share in the cost of at least one policy, do not use this worksheet.

1.	Enter the reimbursement from your employer's policy	1. _____
2.	Enter the reimbursement from your own policy	2. _____
3.	Add lines 1 and 2	3. _____
4.	Divide line 1 by line 3	4. _____
5.	Enter the total medical expenses you paid during the year. If this amount is at least as much as the amount on line 3, stop here because there is no excess reimbursement	5. _____
6.	Multiply line 4 by line 5	6. _____
7.	Subtract line 6 from line 1	7. _____
8.	Enter employer's contribution to the annual cost of the employer's policy	8. _____
9.	Enter total annual cost of the employer's policy	9. _____
10.	Divide line 8 by line 9. This is the percentage of your total excess reimbursement you must report as other income	10. _____
11.	Multiply line 7 by line 10. This is the amount of your total excess reimbursement you must report as other income on Form 1040	11. _____

What If You Receive Insurance Reimbursement in a Later Year?

If you are reimbursed in a later year for medical expenses you deducted in an earlier year, you generally must report the reimbursement as income up to the amount you previously deducted as medical expenses.

However, do not report as income the amount of reimbursement you received up to the amount of your medical deductions that did not reduce your tax for the earlier year.

For more information about the recovery of an amount that you claimed as an itemized deduction in an earlier year, see *Recoveries* in Publication 525, Taxable and Nontaxable Income.

What If You Are Reimbursed for Medical Expenses You Did Not Deduct?

If you did not deduct a medical expense in the year you paid it because your medical expenses were not more than 10% of your AGI (7.5% of your AGI if either you or your spouse was born before January 2, 1950), or because you did not itemize deductions, do not include the reimbursement, up to the amount of the expense, in income. However, if the reimbursement is more than the expense, see *What If Your Insurance Reimbursement Is More Than Your Medical Expenses*, earlier.

Example. Last year, you were unmarried, you were born after January 2, 1950, and you had $500 of medical expenses. You cannot deduct the $500 because it is less than 10% of your AGI. If, in a later year, you are reimbursed for any of the $500 of medical expenses, you do not include that amount in your gross income.

How Do You Figure and Report the Deduction on Your Tax Return?

Once you have determined which medical expenses you can include, figure and report the deduction on your tax return.

What Tax Form Do You Use?

You report your medical expense deduction on Schedule A, Form 1040. You cannot claim medical expenses on Form 1040A, U.S. Individual Income Tax Return, or Form 1040EZ, Income Tax Return for Single and Joint Filers With No Dependents. See the instructions for Schedule A (Form 1040) for more detailed information on figuring your medical and dental expense deduction.

Recordkeeping. You should keep records of your medical and dental expenses to support your deduction. Do not send these records with your paper return.

Sale of Medical Equipment or Property

If you deduct the cost of medical equipment or property in one year and sell it in a later year, you may have a taxable gain. The taxable gain is the amount of the selling price that is more than the adjusted basis of the equipment or property.

The adjusted basis is the portion of the cost of the equipment or property that you could not deduct because of the 10% limit (or 7.5% if either you or your spouse was born before January 2, 1950), used to compute the medical deduction. Use Worksheet D, later, to figure the adjusted basis of the equipment or property.

Worksheet D. Adjusted Basis of Medical Equipment or Property Sold

Keep for Your Records

Instructions: Use this worksheet if you deducted the cost of medical equipment or property in one year and sold the equipment or property in a later year. This worksheet will give you the adjusted basis of the equipment or property you sold.

1.	Enter the cost of the equipment or property	1.
2.	Enter your total includible medical expenses for the year you included the cost in your medical expenses	2.
3.	Divide line 1 by line 2	3.
4.	Enter 10% (or 7.5% if either you or your spouse was born before January 2, 1950), of your AGI for the year the cost was included in your medical expenses	4.
5.	Multiply line 3 by line 4. If your allowable itemized deductions for the year you purchased the equipment or property were not more than your AGI for that year, stop here. This is the adjusted basis of the equipment or property. If your allowable itemized deductions for the year you purchased the equipment or property were more than your AGI for that year, complete lines 6 through 11	5.
6.	Subtract line 5 from line 1	6.
7.	Enter your total allowable itemized deductions for the year the cost was included in your medical expenses	7.
8.	Divide line 6 by line 7	8.
9.	Enter your AGI for the year the cost was included in your medical expenses	9.
10.	Subtract line 9 from line 7	10.
11.	Multiply line 8 by line 10	11.
12.	Add line 5 to line 11. If your allowable itemized deductions for the year you purchased the equipment or property were more than your AGI for that year, this is the adjusted basis of the equipment or property	12.

Next, use Worksheet E to figure the total gain or loss on the sale of the medical equipment or property.

Worksheet E. Gain or Loss On the Sale of Medical Equipment or Property

Keep for Your Records

Instructions: Use the following worksheet to figure total gain or loss on the sale of medical equipment or property that you deducted in an earlier year.

1.	Enter the amount that the medical equipment or property sold for	1.
2.	Enter your selling expenses	2.
3.	Subtract line 2 from line 1	3.
4.	Enter the adjusted basis of the equipment or property from Worksheet D, line 5, or line 12, if applicable	4.
5.	Subtract line 4 from line 3. This is the total gain or loss from the sale of the medical equipment or property	5.

If you have a loss, it is not deductible. If you have a gain, it is includible in your income. The part of the gain that is a recovery of an amount you previously deducted is taxable as ordinary income. Enter it on Form 1040. Any part of the gain that is more than the recovery of an amount you previously deducted is taxable as a capital gain. Enter it on Form 8949, Sales and Other Dispositions of Capital Assets, and Schedule D (Form 1040), Capital Gains and Losses.

For more information about the recovery of an amount that you claimed as an itemized deduction in an earlier year, see *Recoveries* in Publication 525.

Damages for Personal Injuries

If you receive an amount in settlement of a personal injury suit, part of that award may be for medical expenses that you deducted in an earlier year. If it is, you must include that part in your income in the year you receive it to the extent it reduced your taxable income in the earlier year. See *What If You Receive Insurance Reimbursement in a Later Year*, discussed earlier under *How Do You Treat Reimbursements*.

Example. You sued this year for injuries you suffered in an accident last year. You sought $10,000 for your injuries and did not itemize your damages. Last year, you paid $500 for medical expenses for your injuries. You deducted those expenses on last year's tax return. This year you settled your lawsuit for $2,000. Your settlement did not itemize or allocate the damages. The $2,000 is first presumed to be for the medical expenses that you deducted. The $500 is includible in your income this year because you deducted the entire $500 as a medical expense deduction last year.

Future medical expenses. If you receive an amount in settlement of a damage suit for personal injuries, part of that award may be for future medical expenses. If it is, you must reduce any future medical expenses for these injuries until the amount you received has been completely used.

Example. You were injured in an accident. You sued and sought a judgment of $50,000 for your injuries. You settled the suit for $45,000. The settlement provided that $10,000 of the $45,000 was for future medical expenses for your injuries. You cannot include the first $10,000 that you pay for medical expenses for those injuries.

Workers' compensation. If you received workers' compensation and you deducted medical expenses related to that injury, you must include the workers' compensation in income up to the amount you deducted. If you received workers' compensation, but did not deduct medical expenses related to that injury, do not include the workers' compensation in your income.

Impairment-Related Work Expenses

If you are a person with disabilities, you can take a business deduction for expenses that are necessary for you to be able to work. If you take a business deduction for these impairment-related work expenses, they are not subject to the 10% limit (or 7.5% if either you or your spouse was born before January 2, 1950), that applies to medical expenses.

You have a disability if you have:

- A physical or mental disability (for example, blindness or deafness) that functionally limits your being employed, or
- A physical or mental impairment (for example, a sight or hearing impairment) that substantially limits one or more of your major life activities, such as performing manual tasks, walking, speaking, breathing, learning, or working.

Impairment-related expenses defined. Impairment-related expenses are those ordinary and necessary business expenses that are:

- Necessary for you to do your work satisfactorily,
- For goods and services not required or used, other than incidentally, in your personal activities, and
- Not specifically covered under other income tax laws.

Where to report. If you are self-employed, deduct the business expenses on the appropriate form (Schedule C, C-EZ, E, or F) used to report your business income and expenses.

If you are an employee, complete Form 2106, Employee Business Expenses, or Form 2106-EZ, Unreimbursed Employee Business Expenses. Enter on Schedule A (Form 1040), that part of the amount on Form 2106, or Form 2106-EZ, that is related to your impairment. Enter the amount that is unrelated to your impairment on Schedule A (Form 1040). Your impairment-related work expenses are not subject to the 2%-of-adjusted-gross-income limit that applies to other employee business expenses.

Example. You are blind. You must use a reader to do your work. You use the reader both during your regular working hours at your place of work and outside your regular working hours away from your place of work. The reader's services are only for your work. You can deduct your expenses for the reader as business expenses.

Health Insurance Costs for Self-Employed Persons

If you were self-employed and had a net profit for the year, you may be able to deduct, as an adjustment to income, amounts paid for medical and qualified long-term care insurance on behalf of yourself, your spouse, your dependents, and your children who were under age 27 at the end of 2014. For this purpose, you were self-employed if you were a general partner (or a limited partner receiving guaranteed payments) or you received wages from an S corporation in which you were more than a 2% shareholder. The insurance plan must be established under your trade or business and the deduction cannot be more than your earned income from that trade or business.

You cannot deduct payments for medical insurance for any month in which you were eligible to participate in a health plan subsidized by your employer, your spouse's employer or an employer of your dependent or your child under age 27 at the end of 2014. You cannot deduct payments for a qualified long-term care insurance contract for any month in which you were eligible to participate in a long-term care insurance plan subsidized by your employer or your spouse's employer.

If you qualify to take the deduction, use the Self-Employed Health Insurance Deduction Worksheet in the Form 1040 instructions to figure the amount you can deduct. But if any of the following applies, do not use that worksheet.

- You had more than one source of income subject to self-employment tax.

- You file Form 2555, Foreign Earned Income, or Form 2555-EZ, Foreign Earned Income Exclusion.
- You are using amounts paid for qualified long-term care insurance to figure the deduction.

If you cannot use the worksheet in the Form 1040 instructions, use the worksheet in Publication 535, Business Expenses, to figure your deduction.

Use Publication 974 instead of the worksheet in the Form 1040 instructions if the insurance plan established, or considered to be established, under your business was obtained through the Health Insurance Marketplace and you are claiming the premium tax credit.

When figuring the amount you can deduct for insurance premiums, do not include amounts paid for health insurance coverage with retirement plan distributions that were tax-free because you are a retired public safety officer.

Where to report. You take this deduction on Form 1040. If you itemize your deductions and do not claim 100% of your self-employed health insurance costs on Form 1040, include any remaining premiums with all other medical expenses on Schedule A (Form 1040), subject to the 10% limit (or 7.5% if either you or your spouse was born before January 2, 1950).

Child under age 27. If the insurance policy covers your nondependent child who was under age 27 at the end of 2014, you can claim the premiums for that coverage on Form 1040. If you cannot claim 100% of your self-employed health insurance costs on Form 1040, any excess amounts attributable to that child are not eligible to be claimed on Schedule A (Form 1040).

Generally, family health insurance premiums do not increase if coverage for an additional child is added. If this is the situation, no allocation would be necessary. If the premiums did increase (such as where coverage was expanded from single to family to add the nondependent child), you can allocate the amount on Form 1040 to the nondependent child and any excess amounts not attributable to that child would be eligible to be claimed on Schedule A.

Example 1. Kate is self-employed in 2014 and has self-only coverage for health insurance. Her premium for that coverage was $5,000 for the year. She changes to family coverage only to add her 26-year-old nondependent child to the plan. Her health insurance premium increases to $10,000 for the year. After completing the Self-Employed Health Insurance Deduction Worksheet in the instructions for Form 1040, she can only deduct $4,000 on Form 1040. The $4,000 is allocable to the nondependent child. On Schedule A, she can only claim the $5,000 allocable to her coverage. She cannot claim the $1,000 excess premiums allocable to the nondependent child.

Example 2. The facts are the same as in Example 1, except that Kate had family coverage when she added her 26-year-old nondependent child to the policy. There was no increase in the $10,000 premium. In this case, she could claim $4,000 on Form 1040 and $6,000 on Schedule A.

More information. For more information, see Publication 535.

How To Get Tax Help

Do you need help with a tax issue or preparing your tax return, or do you need a free publication or form?

Preparing and filing your tax return. Find free options to prepare and file your return on IRS.gov or in your local community if you qualify.

- Go to IRS.gov and click on the Filing tab to see your options.
- Enter "Free File" in the search box to use brand name software to prepare and *e-file* your federal tax return for free.
- Enter "VITA" in the search box, download the free IRS2Go app, or call 1-800-906-9887 to find the nearest Volunteer Income Tax Assistance or Tax Counseling for the Elderly (TCE) location for free tax preparation.
- Enter "TCE" in the search box, download the free IRS2Go app, or call 1-888-227-7669 to find the nearest Tax Counseling for the Elderly location for free tax preparation.

The Volunteer Income Tax Assistance (VITA) program offers free tax help to people who generally make $53,000 or less, persons with disabilities, the elderly, and limited-English-speaking taxpayers who need help preparing their own tax returns. The Tax Counseling for the Elderly (TCE) program offers free tax help for all taxpayers, particularly those who are 60 years of age and older. TCE volunteers specialize in answering questions about pensions and retirement-related issues unique to seniors.

Getting answers to your tax law questions. IRS.gov and IRS2Go are ready when you are—24 hours a day, 7 days a week.

- Enter "ITA" in the search box on IRS.gov for the Interactive Tax Assistant, a tool that will ask you questions on a number of tax law topics and provide answers. You can print the entire interview and the final response.
- Enter "Tax Map" or "Tax Trails" in the search box for detailed information by tax topic.
- Enter "Pub 17" in the search box to get Pub. 17, Your Federal Income Tax for Individuals, which features details on tax-saving opportunities, 2014 tax changes, and thousands of interactive links to help you find answers to your questions.
- Call TeleTax at 1-800-829-4477 for recorded information on a variety of tax topics.

- Access tax law information in your electronic filing software.
- Go to IRS.gov and click on the Help & Resources tab for more information.

Tax forms and publications. You can download or print all of the forms and publications you may need on www.irs.gov/formspubs. Otherwise, you can:

- Go to www.irs.gov/orderforms to place an order and have forms mailed to you, or
- Call 1-800-829-3676 to order current-year forms, instructions, publications, and prior-year forms and instructions (limited to 5 years).

You should receive your order within 10 business days.

Where to file your tax return.

- There are many ways to file your return electronically. It's safe, quick and easy. See *Preparing and filing your tax return*, earlier, for more information.
- See your tax return instructions to determine where to mail your completed paper tax return.

Getting a transcript or copy of a return.

- Go to IRS.gov and click on "Get Transcript of Your Tax Records" under "Tools."
- Download the free IRS2Go app to your smart phone and use it to order transcripts of your tax returns or tax account.
- Call the transcript toll-free line at 1-800-908-9946.
- Mail Form 4506-T or Form 4506T-EZ (both available on IRS.gov).

Using online tools to help prepare your return. Go to IRS.gov and click on the Tools bar to use these and other self-service options.

- The *Earned Income Tax Credit Assistant* determines if you are eligible for the EIC.
- The *First Time Homebuyer Credit Account Look-up* tool provides information on your repayments and account balance.
- The *Alternative Minimum Tax (AMT) Assistant* determines whether you may be subject to AMT.
- The *Online EIN Application* helps you get an Employer Identification Number.
- The *IRS Withholding Calculator* estimates the amount you should have withheld from your paycheck for federal income tax purposes.
- The *Electronic Filing PIN Request* helps to verify your identity when you do not have your prior year AGI or prior year self-selected PIN available.

Understanding identity theft issues.

- Go to www.irs.gov/uac/Identity-Protection for information and videos.
- If your SSN has been lost or stolen or you suspect you are a victim of tax-related identity theft, visit www.irs.gov/identitytheft to learn what steps you should take.

Checking on the status of a refund.

- Go to www.irs.gov/refunds.
- Download the free IRS2Go app to your smart phone and use it to check your refund status.
- Call the automated refund hotline at 1-800-829-1954.

Making a tax payment. You can make electronic payments online, by phone, or from a mobile device. Paying electronically is safe and secure. The IRS uses the latest encryption technology and does not store banking information. It's easy and secure and much quicker than mailing in a check or money order. Go to IRS.gov and click on the Payments tab or the "Pay Your Tax Bill" icon to make a payment using the following options.

- *Direct Pay* (only if you are an individual who has a checking or savings account).
- Debit or credit card.
- Electronic Federal Tax Payment System.
- Check or money order.

What if I can't pay now? Click on the Payments tab or the "Pay Your Tax Bill" icon on IRS.gov to find more information about these additional options.

- An *online payment agreement* determines if you are eligible to apply for an installment agreement if you cannot pay your taxes in full today. With the needed information, you can complete the application in about 30 minutes, and get immediate approval.
- An offer in compromise allows you to settle your tax debt for less than the full amount you owe. Use the *Offer in Compromise Pre-Qualifier* to confirm your eligibility.

Checking the status of an amended return. Go to IRS.gov and click on the Tools tab and then *Where's My Amended Return?*

Understanding an IRS notice or letter. Enter "Understanding your notice" in the search box on IRS.gov to find additional information about your IRS notice or letter.

Visiting the IRS. Locate the nearest Taxpayer Assistance Center using the Office Locator tool on IRS.gov. Enter "office locator" in the search box. Or choose the "Contact Us" option on the IRS2Go app and search Local Offices. Before you visit, use the Locator tool to check hours and services available.

Watching IRS videos. The IRS Video portal www.irsvideos.gov contains video and audio presentations on topics of interest to individuals, small businesses, and tax professionals. You'll find video clips of tax topics,

archived versions of live panel discussions and Webinars, and audio archives of tax practitioner phone forums.

Getting tax information in other languages. For taxpayers whose native language is not English, we have the following resources available.

1. Taxpayers can find information on IRS.gov in the following languages.
   a. *Spanish*.
   b. *Chinese*.
   c. *Vietnamese*.
   d. *Korean*.
   e. *Russian*.
2. The IRS Taxpayer Assistance Centers provide over-the-phone interpreter service in over 170 languages, and the service is available free to taxpayers.

The Taxpayer Advocate Service Is Here To Help You

What is the Taxpayer Advocate Service?

The Taxpayer Advocate Service (TAS) is an ***independent*** organization within the Internal Revenue Service that helps taxpayers and protects taxpayer rights. Our job is to ensure that every taxpayer is treated fairly and that you know and understand your rights under the *Taxpayer Bill of Rights*.

What Can the Taxpayer Advocate Service Do For You?

We can help you resolve problems that you can't resolve with the IRS. And our service is free. If you qualify for our assistance, you will be assigned to one advocate who will work with you throughout the process and will do everything possible to resolve your issue. TAS can help you if:

- Your problem is causing financial difficulty for you, your family, or your business,
- You face (or your business is facing) an immediate threat of adverse action, or
- You've tried repeatedly to contact the IRS but no one has responded, or the IRS hasn't responded by the date promised.

How Can You Reach Us?

We have offices *in every state, the District of Columbia, and Puerto Rico*. Your local advocate's number is in your local directory and at *www.taxpayeradvocate.irs.gov*. You can also call us at 1-877-777-4778.

How Can You Learn About Your Taxpayer Rights?

The Taxpayer Bill of Rights describes ten basic rights that all taxpayers have when dealing with the IRS. Our Tax Toolkit at *www.taxpayeradvocate.irs.gov* can help you understand *what these rights mean to you* and how they apply. These are ***your*** rights. Know them. Use them.

How Else Does the Taxpayer Advocate Service Help Taxpayers?

TAS works to resolve large-scale problems that affect many taxpayers. If you know of one of these broad issues, please report it to us at *www.irs.gov/sams*.

Low Income Taxpayer Clinics

Low Income Taxpayer Clinics (LITCs) serve individuals whose income is below a certain level and need to resolve tax problems such as audits, appeals, and tax collection disputes. Some clinics can provide information about taxpayer rights and responsibilities in different languages for individuals who speak English as a second language. To find a clinic near you, visit *www.irs.gov/litc* or see IRS Publication 4134, *Low Income Taxpayer Clinic List*.

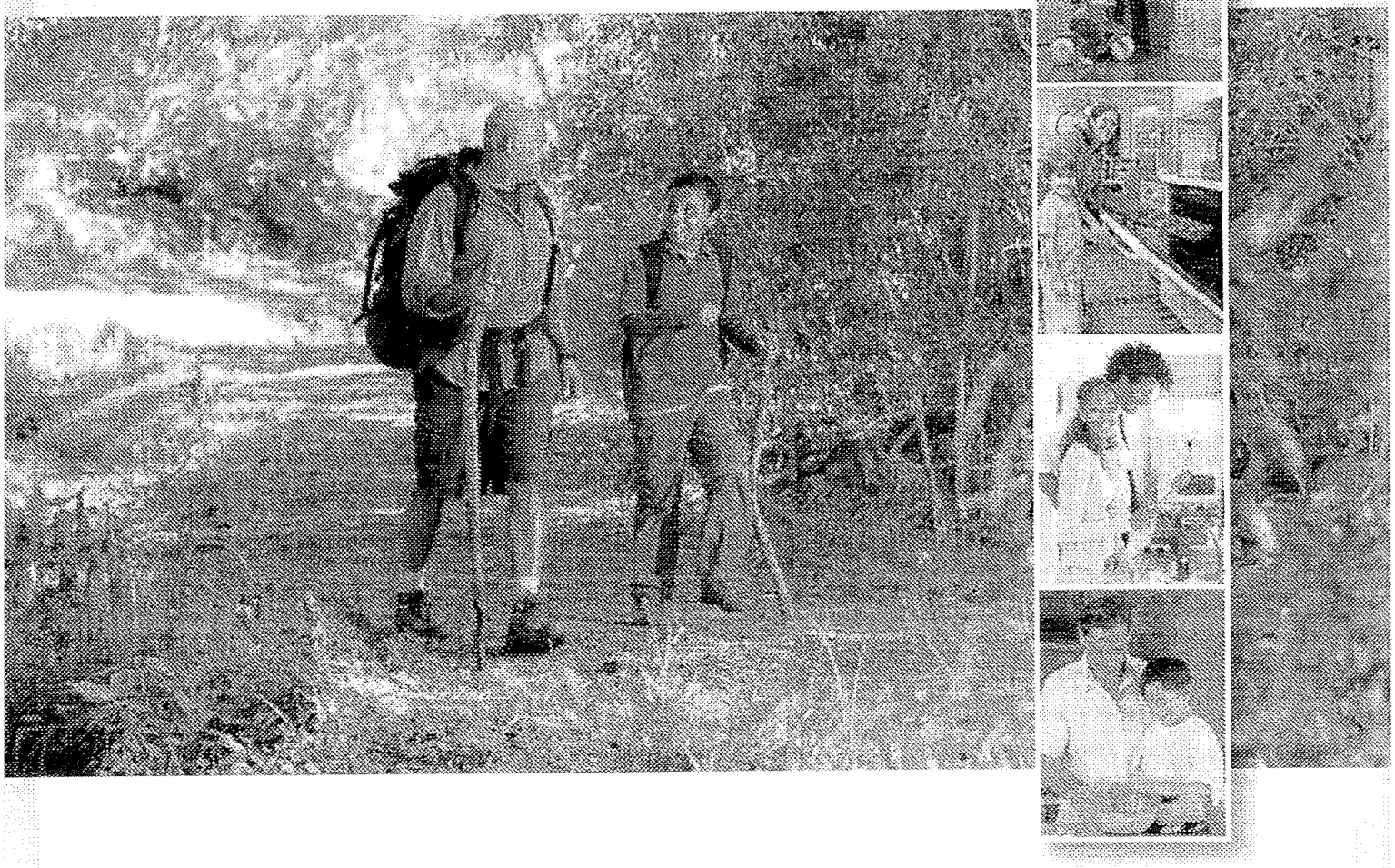
TransChoice® Advance Proposal

hospital indemnity insurance

Underwritten by ***Transamerica Life Insurance Company,*** *Cedar Rapids, Iowa.*

for the employees of

Mancha Development



presented by

Sherri Guedea

proposal date

November 15, 2013

TRANSAMERICA®
Employee Benefits

www.transamericabenefits.com

Quoted rates are valid for 90 days, then they are subject to change without notice. This proposal describes coverage highlights only. This is not an offer. Limitations and exclusions apply. No contract will result until an application is submitted and approved by the insurance company and a policy or certificate is issued.

TransChoice® Advance hospital indemnity insurance

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

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

[illegible] TransChoice® Advance [illegible] underwritten by Transamerica Life Insurance Company [illegible] Coverage may not be available in all jurisdictions. [illegible] Refer to the policy, certificate and riders for complete details.

Inpatient Drug and Alcohol Addiction Indemnity Benefit	Pays each day a covered person is confined on an inpatient basis to a hospital or residential treatment facility as the result of drug or alcohol addiction. Annual maximum of **31 Days**, lifetime maximum **60 Days.**	$ 100	$ 100	$ 100
Ambulance Indemnity Benefit	Pays each day a covered person receives licensed ambulance transportation within 96 hours of a covered accident or onset of sickness. Air ambulance pays three times the amount.	No Coverage	$ 200	$ 350
Additional Optional Coverages				
Group Term Life Policy with Accidental Death and Dismemberment Rider	Employee	$ 10,000	$ 10,000	$ 10,000
	Spouse	$ 5,000	$ 5,000	$ 5,000
	Child(ren) *(Accidental Death and Dismemberment Rider not available to dependent children)*	$ 2,500	$ 2,500	$ 2,500
Non-Insurance Discount Programs				
Prescription Drug Discount Card *offered by ProCare*	By presenting the prescription drug discount card to one of the participating providers, an insured can receive a savings of at least 14% on retail pharmacy prices for brand-name drugs and up to 60% for generic drugs.	Included	Included	Included
TeleMedicine Option	Around the clock telephone, video or e-mail access to a board-certified physician.	No Coverage	Healthiestyou	Healthiestyou
Employee Discount Card *offered by New Benefits, Ltd.*	Provides access to a discount vision plan, nurses' hotline, counseling services and discounts for hearing aids.	Included	Included	Included
PPO Network *offered by 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

Monthly Premiums	Employee	Employee + Spouse	Employee + Children	Family
Plan I	$ 55.67	$ 114.97	$ 96.73	$ 142.13
Plan II	$ 100.78	$ 204.36	$ 168.11	$ 248.51
Plan III	$ 120.22	$ 247.09	$ 204.89	$ 302.35

Non-Insurance Benefits

Telemedicine

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

Prescription Drug Discount Card (provided by ProCare)

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

Employee Discount Card (provided by New Benefits Ltd.)

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

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

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

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

- answers about medication usage and interaction,
- information on non-medical support groups,
- translation services for non-English speaking callers, and
- full-time medical director on staff.

Counseling services allow you to speak with a counselor 24 hours a day, 7 days a week regarding personal problems.

Hearing aid benefit provides savings of up to 15% on retail costs on more than 70 hearing aid models and a free hearing test when utilizing one of the 1,350 participating Beltone® locations nationwide. Or, they can also realize savings up to 37-58% on the suggested retail price on more than 90 hearing aid models in more than 700 locations nationwide.

Contact New Benefits, Ltd., by mail at 1420 Proton Road, Dallas, Texas, 75344; or by phone at (800) 800-7616.

Vision Benefit is not available to VT residents.

PPO Network Benefit (offered by WebTPA)

Employee and covered dependents will receive contracted savings from the normal fees charged by MultiPlan's network physicians, hospitals and outpatient X-ray and laboratory providers. A member's PPO savings continue even after the TransChoice Advance benefits have been exhausted.

A fulfillment package, sent to each insured employee by WebTPA, will contain access information for the employee and prescription drug discount cards. Network access information for the Preferred Provider Network (PPO) will be included in the package if available.

Limitations and Exclusions for TransChoice Advance

Confinement for the same or related condition within 30 days of discharge will be treated as a continuation of the prior confinement. Successive confinements separated by more than 30 days will be treated as a new and separate confinement.

No benefits under this contract will be payable as the result of the following:

- Suicide or attempted suicide, whether while sane or insane.
- Intentionally self-inflicted injury.
- Rest care or rehabilitative care and treatment.
- Immunization shifts and routine examinations such as: physical examinations, mammograms, Pap smears, immunizations, flexible sigmoidoscopy, prostate-specific antigen tests and blood screenings (unless Wellness Indemnity Benefit Rider is included).
- Any pregnancy of a dependent child including confinement rendered to her child after birth.
- Routine newborn care (unless Wellness Indemnity Benefit Rider is included).
- A covered person's abortion, except for medically necessary abortions performed to save the mother's life
- Treatment of mental or emotional disorder (unless Inpatient Mental and Nervous Disorder Indemnity Benefit Rider is included).
- Treatment of alcoholism or drug addiction (unless Inpatient Drug and Alcohol Addiction Indemnity Benefit Rider is included).
- Participation in a felony, riot, or insurrection.
- Any accident caused by the participation in any activity or event, including the operation of a vehicle, while under the influence of a controlled substance (unless administered by a physician or taken according to the physician's instructions) or while intoxicated (intoxicated means that condition as defined by the law of the jurisdiction in which the accident occurred).
- Dental care or treatment, except for such care or treatment due to accidental injury to sound natural teeth within 12 months of the accident and except for dental care or treatment necessary due to congenital disease or anomaly.
- Sex change, reversal of tubal ligation or reversal of vasectomy.
- Artificial insemination, in vitro fertilization, and test tube fertilization, including any related testing, medications or physician's services, unless required by law.
- Committing, attempting to commit, or taking part in a felony or assault, or engaging in an illegal occupation.
- Traveling in or descending from any vehicle or device for aerial navigation, except as a fare-paying passenger in an aircraft operated by a commercial airline (other than a charter airline) on a regularly scheduled passenger trip.
- Any loss incurred while on active duty status in the armed forces. (If you notify us of such active duty, we will re-

fund any premiums paid for any period for which no coverage is provided as a result of this exception.)

- An accident or sickness arising out of or in the course of any occupation for compensation, wage or profit or for which benefits may be payable under an Occupational Disease Law or similar law, whether or not application for such benefits has been made.
- Involvement in any war or act of war, whether declared or undeclared.

Termination of Insurance

The insurance terminates on the earliest of:

- The insured's death.
- The premium due date when we fail to receive a premium, subject to the grace period.
- The date of written notice to cancel coverage.
- The date the policy terminates, subject to the portability option.
- The date the insured ceases to be eligible for coverage.

Dependent coverage ends on the earliest of:

- The date the insured's coverage terminates for any of the reasons above.
- The date the dependent no longer meets the definition of a dependent.
- The premium due date when we fail to receive a premium, subject to the grace period.
- The date of written notice to cancel coverage.
- The date the policy is modified so as to exclude dependent coverage.

The insurance company has the right to terminate the coverage of any insured who submits a fraudulent claim. Termination will not impact any claim which begins before the date of termination.

Critical Illness Indemnity Benefit Rider

Invasive Cancer does not include: Carcinoma in Situ; pre-malignant conditions or conditions with malignant potential; prostatic cancers which are histologically described as TNM Classification T1 (including T1(a) or T1(b), or of other equivalent or lesser classification; any malignancy associated with the diagnosis of HIV; or Skin Cancer.

Skin Cancer does not include malignant melanoma or mycosis fungoides.

Stroke does not include cerebral symptoms due to: Transient Ischemic Attack (TIA); reversible neurological deficit; migraine; cerebral injury resulting from trauma or hypoxia; or vascular disease affecting the eye, optic nerve or vestibular functions.

The Subsequent Critical Illness Benefit is not payable for Skin Cancer or Carcinoma In Situ.

Off-the-Job Accidental Injury Indemnity Benefit Rider

Does not cover injuries which are caused by an accident that occurs while in the course of any legal or illegal occupation, activity, or employment for pay, benefit or profit.

Surgical and Anesthesia Indemnity Benefit Rider

As an exception to the dental care or treatment exclusion above, we will pay the following dental or oral surgery procedures under this rider:

- excision of impacted third molars.
- closed or open reduction of fractures or dislocation of the jaw.

Additional Benefits

The following may be sold in conjunction with TransChoice Advance.

Group Term Life Insurance Policy with Accidental Death and Dismemberment (AD&D) Rider

Coverage is available for children 6 months and older. All children in a family will be covered for the same amount. The AD&D Rider is included in employee and spouse coverage. This rider is not available for dependent children. The AD&D coverage amount will match the amount of group term life insurance. This rider pays the following specified percentages of the coverage amount when a covered accident results in any of the following losses, subject to any limitations/

exclusions:

Covered Loss	% of Death Benefit Payable
Loss of life or loss of two or more members (hand, foot, sight of an eye)	100%
Quadriplegia (total and permanent paralysis of both upper and lower limbs)	100%
Loss of speech AND hearing in both ears	100%
Paraplegia (loss or paralysis of both lower limbs)	75%
Loss of one member, or loss of speech, or loss of hearing in both ears	50%
Hemiplegia (total and permanent paralysis of the upper and lower limbs of one side of the body)	50%
Loss of hearing in one ear, or loss of thumb and index finger of same hand	25%

Only one such amount will be paid as a result of a single covered accident.

This is a brief summary of Group Term Life insurance underwritten by Transamerica Life Insurance Company, Cedar Rapids, Iowa.

Policy form series GP1000200 and GC1000400; Rider form series GR1011100. 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.

Limitations and Exclusions for Group Term Life Policy with AD&D Rider

We will not pay a death benefit if a covered person dies by suicide, while sane within two years of the date his or her insurance starts. If an insured employee or insured spouse dies by suicide, we will refund the premiums paid for the insurance. If an insured child dies by suicide, we will refund the premiums paid for the dependent child insurance only if there are no surviving insured children. If any death benefit is increased, this suicide exclusion starts anew, but will only apply to the amount of the increase.

The AD&D rider terminates on the employee's 70th birthday.

Age Reduction Schedule: Death benefits automatically reduce to the following percentages, or flat amount, on the Group Master Policy Anniversary Date that follows the applicable birthday, as follows:

Birthday	Death Benefit Payable
65th	65% of pre-age 65 death benefit
70th	50% of pre-age 65 death benefit
75th	25% of pre-age 65 death benefit
80th	The lesser of $5,000 or 25% of pre-age 65 death benefit

We will not pay any benefits under the AD&D Rider if the loss, directly or indirectly results from any of the following, even if the means or cause of the loss is accidental:

- suicide or intentionally self-inflicted injury, while sane or insane.
- commission of or attempt to commit an assault or felony.
- sickness or mental illness, disease of any kind, or medical or surgical treatment for any sickness, illness, or disease.
- injuries received while under the influence of alcohol, a controlled substance or other drugs as defined by the laws of the state where the accident occurs, except as prescribed by a doctor.
- any poison or gas voluntarily taken, administered, absorbed, or inhaled, except in the course of employment.
- any poison or gas voluntarily taken, administered, absorbed, or inhaled (except in the course of employment or as a result of accidental means.)
- flight in any kind of aircraft, except as a fare paying passenger on a regularly scheduled commercial aircraft.
- any bacterial or viral infection.
- war or act of war, declared or undeclared, while serving in the military service or any auxiliary unit attached thereto.

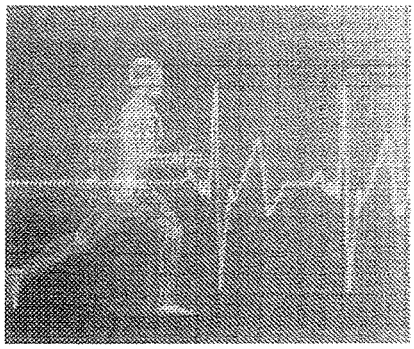
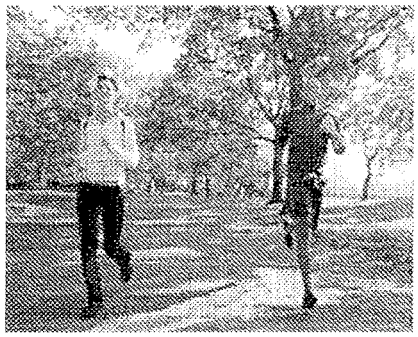
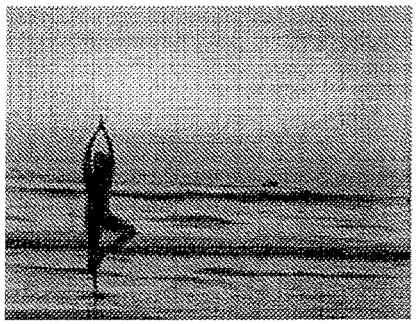
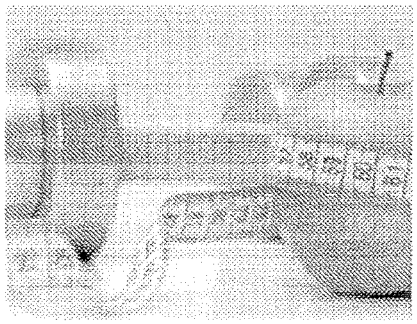
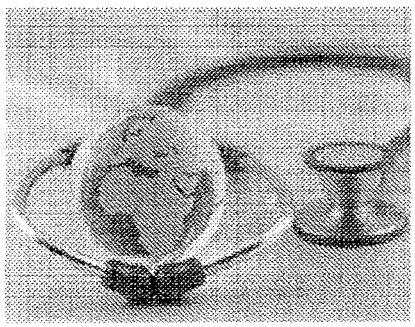
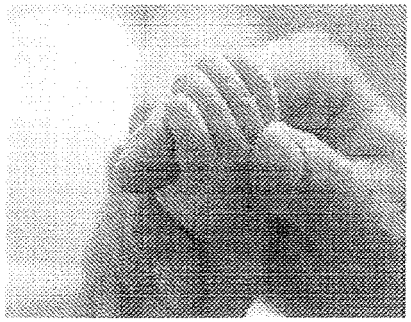
If more than one covered loss is sustained as a result of the same accidental bodily injury, payment shall be made for only the one loss for which the largest amount is payable.

Up to date information regarding our compensation practices can be found in the Disclosures section of our website at www.tebcs.com.

Exhibit 11

Exhibit 11

Mancha Companies

2015 Employee Benefit Guide

January 1, 2015 – December 31, 2015

CONTACT INFORMATION

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

CUSTOMER SERVICE: KEY BENEFITS ADMINISTRATION

Member Services: (877) 851-0906

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

PROVIDER NETWORK: MULTIPLAN

Member Services: (888) 342-7427

On-Line Services: www.multiplan.com

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

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

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

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

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

— MVP Plan —

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

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

Plan Exclusions:

1) **Hospital inpatient services are not covered by the plan.** This means any inpatient service billed by the hospital.
2) Outpatient Surgery Physician/Surgical and Ambulatory Surgical Center services are not covered.
3) Specialty drugs are not covered.
4) Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services are not covered with the exception of services covered under the MEC benefits.
5) Rehabilitative Speech, Rehabilitative Occupational and Rehabilitative Physical Therapy services are not covered.
6) Skilled Nursing Facility services are not covered.

FREQUENTLY ASKED QUESTIONS:

What is covered in an emergency room visit?

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

Are services rendered in an urgent care facility covered?

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

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

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

Are mental health and substance abuse services covered?

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

Are contraceptives covered?

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

Is surgery covered?

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

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

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

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

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

FREQUENTLY ASKED QUESTIONS:

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

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

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

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

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

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

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

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

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

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

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

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

Deductible

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

Coinsurance

	100%	40%	Not applicable

Out-of-Pocket Maximums

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

Hospital Services

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

Physician Services

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

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

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

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

Chronic Disease Management (CDM) Benefits

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

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

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

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

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

KEY BENEFIT ADMINISTRATORS

KEYSOLUTION

Minimum Value Plan (MVP) Enrollment Form

1. Enrollee Information

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

2. Dependent Information

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

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

[2]If a court decree requires you to cover your dependent under this plan, SUBMIT that portion of the court decree with this enrollment form.

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

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

Employee (print name): ____________________ Employee Signature: ____________________ Date:________

Revised 7-15-14

Exhibit 12

Exhibit 12

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

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

Plaintiffs,

vs.

MDC RESTAURANTS, LLC, a Nevada limited liability company; et al.,

Defendants.

No. A-14-701633-C

DEPOSITION OF YVETTE GALIMORE
Irvine, California
Wednesday, March 11, 2015
Volume I

Reported by:
SHARON LINDSAY-MILNIKEL
CSR No. 5335
Job No. 2022658

PAGES 1 - 205

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

PAULETTE DIAZ, an individual; LAWANDA GAIL WILBANKS, an individual; SHANNON OLSZYNSKI, an individual; and CHARITY FITZLAFF, an individual, on behalf of themselves and all similarly-situated individuals, Plaintiffs, vs. 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.	No. A-14-701633-C

Deposition of YVETTE GALIMORE, Volume I, taken on behalf of Plaintiffs, at 2050 Main Street, Suite 900, Irvine, California, beginning at 9:26 a.m. and ending at 3:04 p.m. on Wednesday, March 11, 2015, before SHARON LINDSAY-MILNIKEL, Certified Shorthand Reporter No. 5335.

APPEARANCES:

For Plaintiffs:

WOLF, RIFKIN, SHAPIRO, SCHULMAN & RABKIN
BY: JORDAN J. BUTLER
BY: DANIEL BRAVO
Attorneys at Law
3556 East Russell Road, Second Floor
Las Vegas, Nevada 89120
(702) 341-5300
jb@wrslawyers.com
dbravo@wrslawyers.com

For Defendants:

LITTLER MENDELSON
BY: ROGER L. GRANDGENETT, II
Attorney at Law
3960 Howard Hughes Parkway, Suite 300
Las Vegas, Nevada 89169
(702) 862-8800
rgrandgenett@littler.com

management team in reviewing the annual enrollment process in reference to the selection of products for the plan.

Q Okay. What type of communications were distributed to the employees?

A Announcements such as a memo regarding the enrollment process, enrollment time frame, enrollment forms.

Q Okay. If you were there for a little over a year towards the end of 2013, am I correct in assuming that you participated in the process of renewing the plan for 2014?

A Yes.

Q Okay. Any other -- then before you left in October 2014, were you a part of any renewal process for 2015?

A No.

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 Not a comprehensive insurance plan?

MR. GRANDGENETT: I'm going to object based on calls for legal conclusion, ambiguous as to the term "comprehensive."

THE WITNESS: No, it's not a comprehensive plan.

BY MR. BUTLER:

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.

Q As far as the annual limits are concerned, out-of-pocket limits, correct?

A I do not remember the out-of-limit or out-of-pocket amounts.

Q So when you state that the plan did not meet minimum standards by the ACA, what does that mean to you?

MR. GRANDGENETT: I'm going to object. It's not specifying a particular year of compliance with the ACA.

THE WITNESS: The information that was presented to us by our brokers were that in 2- -- I believe it was 2015, employers would have to offer a plan that was different from what we were offering at that time in reference to the, quote unquote, limited plan.

BY MR. BUTLER:

Q The message from the broker was that Mancha would need to provide a more comprehensive plan to the hourly employees by 2015?

A I was never told that by the broker.

Q What were you told?

A I was told that in 2015 that we could offer

TransChoice was a limited plan.

Q Did you have an understanding as to whether that limited plan qualified or did not qualify for purposes of the Nevada minimum wage law?

MR. GRANDGENETT: Object. Calls for a legal conclusion.

THE WITNESS: What I remember, is we discussed on whether or not it met the Affordable Care Act requirements, not the minimum wage law.

BY MR. BUTLER:

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 Okay. So whether or not the plan had qualified under Nevada was not considered?

A Your question to me was whether or not it was required in reference to the minimum wage. The discussion, our forefront discussion, was the basic offerings of what was going to be available to the associates in reference to the benefit summaries and also what the associate -- just economically, looking at what had been in place already with Starbridge and

how we were going to move forward with the plan. That was the basis of the discussion.

Q Right.

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.

Q Okay. How about the issue of annual dollar limits under the plan, was that a factor in the renewal process?

A Not that I remember.

Q Okay. Do you know what the annual dollar limits were under the Starbridge plan?

A No.

Q Do you know what the minimum annual amount is

required under the ACA?

A No.

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 You were trying to look at plans that were similar to Starbridge in terms of cost and the benefits offered?

A Yes.

Q And those are limited plans, correct?

A Yes.

Q Is that all you looked at, were limited plans in making the decision to replace the Starbridge plan?

A For the other plans that were offered, I do not remember if they were other plans, other than limited plans, I do not remember.

Q But based on your criteria, that the plan be similar to Starbridge, would you -- would it be fair to say that the other plans looked at were likely limited plans?

A I didn't base my criteria that it had to be

Q -- if they were limited plans?

A I do not remember.

Q Were they the same types of offerings that you were looking for?

A With Leavitt, I do not remember.

Q Ultimately, why did Mancha decide to go with the TransChoice plan?

MR. GRANDGENETT: I'm going to object based on speculation.

THE WITNESS: 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.

BY MR. BUTLER:

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.

Q And Mancha did not consider whether TransChoice qualified as a -- as a health plan for Nevada minimum wage law purposes?

A TransChoice was offered in Nevada, so we would have to be -- that would have been a consideration.

Q Okay. What do you recall about that issue, then?

A What I remember, one, it was not an issue, but what I do remember is that we did talk with our brokers to ensure that we could offer that plan in Nevada, TransChoice.

Q You're making this distinction that it's not an issue. What do you mean by that, it wasn't a problem, it didn't matter? What do you mean when you say that?

A I don't know because you're saying "issue," and I'm telling you that it's not an issue.

Q Well, you're taking what I'm saying and telling me it means something else?

What do you mean --

MR. GRANDGENETT: I object to that --

TransChoice -- that was a Benebiz product, or at least they were the ones that were making the proposal to you, correct?

A They made the proposal to us, yes.

Q Yeah, okay. So any discussions or representations regarding compliance with Nevada minimum wage law would have come from Benebiz, right?

A Yes.

Q And were all of these discussions verbal?

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 Did you ever receive anything in writing from Benebiz or anybody else?

A In retrospect to TransChoice, I don't remember. I don't remember.

Q And you said you relied on their knowledge because they were more familiar with both the products and Nevada minimum wage law, correct?

A They were bringing me up to speed when I came on board because they had already been in place and had been dealing with the plans previously.

Q Okay. And they had been dealing with the

Q In making the decision to select TransChoice, did you consider whether the plan was a major medical insurance plan?

MR. GRANDGENETT: Object based on the vague and ambiguous --

BY MR. BUTLER:

Q Was that a factor?

MR. GRANDGENETT: -- vague and ambiguous term --

BY MR. BUTLER:

Q Was that factor?

MR. GRANDGENETT: -- "major medical," whatever that means.

THE WITNESS: I'm sorry. The two of you -- could you just repeat the question. Sorry.

BY MR. BUTLER:

Q Sure.

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.

THE WITNESS: No.

BY MR. BUTLER:

Q Was whether TransChoice was a comprehensive

medical plan a factor in selecting a TransChoice plan?

MR. GRANDGENETT: Objection. Same objection.

What is comprehensive medical, what does it mean?

THE WITNESS: No.

BY MR. BUTLER:

Q Okay. And you've already testified that Mancha was aware that the plan was not ACA compliant, at least going into 2014, at the time that the plan was selected, right?

A Yes.

Q Okay. Do you consider the TransChoice plan major medical insurance?

MR. GRANDGENETT: Same objection.

THE WITNESS: No.

BY MR. BUTLER:

Q Do you consider it as a substitute for major medical insurance?

MR. GRANDGENETT: Same objection.

THE WITNESS: As a substitute? Well, it's a limited plan.

BY MR. BUTLER:

Q And, again, what does that term mean to you when you say that?

MR. GRANDGENETT: Vague and ambiguous.

A I'm only making an assumption, that she said in her previous E-mails some people were paid at 7.25, 7.55 and, et cetera, so that would be the other wage amounts.

Q Okay. And what about the "sub minimum wage" portion here, "we pay a sub minimum wage because we offer medical insurance," was she asking how is it that Mancha can get away with subminimum wage?

A No, I think she was asking why there were different wage rates and we weren't consistent.

Q Why do you think?

A Because that was in the information that she found. She said some people were paid at 7.55, some people were paid at 8.25, some people were paid at 7.25.

Q Okay. Well, what does that have to do as far as the reason for paying a subminimum wage, the fact they're differing wage amounts?

A I was explaining to her that in Nevada we offer -- we offer the insurance and so, therefore, we were paying at 7.25.

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 health plan?

A Yes.

Q What did you mean by medical insurance, just any type of plan?

A Yes.

Q Is it your understanding that the 10 percent rule that we talked about applies regardless of whether the employee has dependents or a spouse or a family on the plan?

A My understanding, it's based on their -- simply based upon their gross wages, that they would be paying 10 percent, no more than 10 percent, I'm sorry.

Q The enrollment form that we looked at earlier for the TransChoice plan, I didn't mark it as an exhibit, the MDC -131, if you look at that.

Is there a space there for the employee to identify whether or not they're enrolling for themselves or any dependents?

A Yes.

A Yes.

Q -- would have gone through Terry for all plans?

A Yes.

Q -315, "Exchange Notice Letters."

"New Hires. Exchange notice letters must be given to new hires."

What is this about?

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.

THE WITNESS: For the insurance that was offered through the marketplace.

BY MR. BUTLER:

Q But if they already had the TransChoice plan, why would they need to do that?

A Because our plan was a limited plan.

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 --

Q During your tenure.

A -- the change was an accept-or-decline form that was added to the packet.

Q Why would they need both, though? It just seems superfluous. If they have an enrollment form, presumably, if they're going to enroll and select the insurance, they're going to fill that out and send that back, right?

A Yes.

Q And if they don't, they don't?

A What I remember is we wanted to make sure we had information on whether they accepted or they simply declined, to make sure that we had that information.

Q So prior to that if the enrollment form was not returned, Mancha would assume that the employee did not accept coverage; is that correct?

A Yes.

Q And that's the only way they would know prior to the change, right, if the enrollment form came back or not, that's the only way they would know?

A No. Again, I don't remember specifically. I

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

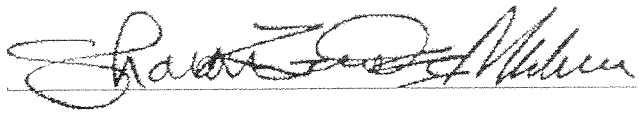
That the foregoing proceedings were taken before me at the time and place herein set forth; that any witnesses in the foregoing proceedings, prior to testifying, were administered an oath; that a record of the proceedings was made by me using machine shorthand which was thereafter transcribed under my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

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

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

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

Dated: 03/23/2015



SHARON LINDSAY-MILNIKEL

CSR No. 5335

Exhibit 13

Exhibit 13

Message

From: Colleen Fulton [cfulton@manchastores.com]
Sent: 9/25/2014 9:11:00 AM
To: Terry Digiamarino [tdigiamarino@manchadev.com]
CC: Yvette Galimore [ygalimore@manchadev.com]; Paul Schmidt [pschmidt@manchastores.com]
Subject: Re: Minimum Wage in Vegas

I think if a server is above 7.25 we should say something because those pennies add up and 7.25 is the right thing to do to be consistent in Nevada.

Sent from my iPhone

On Sep 25, 2014, at 8:58 AM, Terry Digiamarino <tdigiamarino@manchadev.com> wrote:

I totally agree was this way when I returned so I didn't bring it up it should be the same for all our job codes. I will check on whom is at 8.00 not sure how that happened if I see anyone hire above 7.55 I bring it to the ADO's attention.

Thank You

Terry DiGiamarino

Payroll Manager

tdigiamarino@manchadev.com <tdigiamarino@manchadev.com>

951-271-4808

E-Fax: 951-356-8180

Fax: 951-271-4101

"Passionately committed to running GREAT restaurants, each and every day!"

From: Colleen Fulton [mailto:Cfulton@manchastores.com]
Sent: Wednesday, September 24, 2014 11:48 PM
To: Terry Digiamarino; Yvette Galimore
Cc: Paul Schmidt
Subject: RE: Minimum Wage in Vegas

It should be uniform, it should be $7.25 for new hire, as I have been working with schedules this week I noticed this, we have so many new people (managers) they don't understand why we have different rates.

5 years ago the law in Nevada was if a server worked over 30 hours a week we paid them $7.25 but under we paid $7.55. That law changed about 3 years ago and the direction we were given by Blanca was leave everyone at their current rate, whether it was 7.25 or 7.55 but all new hires come in at 7.25.

I asked a few managers why they are hiring in at a different rate they said they thought it was their choice.

I saw one server at unit 7671 at $8.00 per hour.

I think we could save a bit of money if we issued a memo stating tipped employees are $7.25 per hour. I don't think it is my place to do that

Exhibit 14

Exhibit 14

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 FITZLEFF, an individual, on behalf of themselves and all similarly-situated individuals,

Plaintiffs,

vs.

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

Defendants.

Case No. A701633

Dept. No. XV

DEFENDANTS MDC RESTAURANTS, LLC'S, LAGUNA RESTAURANTS, LLC'S, AND INKA, LLC'S INITIAL APPERANCE FEE DISCLOSURE

Pursuant to the Nevada Rules of Civil Procedure ("NRCP") Rule 16.1, Defendants MDC RESTAURANTS, LLC, LAGUNA RESTAURANTS, LLC, and INKA, LLC, ("Defendants") by and through their attorneys of record, Littler Mendelson, hereby submit its initial disclosures of documents and witnesses.

A. **Individuals likely to have discoverable information relevant to disputed facts.**

The following are persons Defendants believe may have knowledge relevant to this matter. Defendants reserve the right to amend this list as necessary if they discover additional information

about the persons listed below or other persons who may have knowledge relevant to this matter since discovery is in its early stages.

1. Paulette Diaz
c/o 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

Plaintiff Paulette Diaz has knowledge regarding the allegations and claims contained in her Complaint.

2. Lawanda Gail Wilbanks
c/o 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

Plaintiff Lawanda Gail Wilbanks has knowledge regarding the allegations and claims contained in her Complaint.

3. Shannon Olszynski
c/o 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

Plaintiff Shannon Olszynski has knowledge regarding the allegations and claims contained in her Complaint.

4. Charity Fitzleff
c/o 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

Plaintiff Charity Fitzlaff has knowledge regarding the allegations and claims contained in her Complaint.

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

Terry Digiamarino would have knowledge concerning the allegations of the Complaint and Defendants' defenses thereto.

6. Colleen Fulton
Training Manager
c/o Littler Mendelson
3960 Howard Hughes Parkway, Suite 300
Las Vegas, NV 89169

Colleen Fulton would have knowledge concerning the allegations of the Complaint and Defendant's defenses thereto.

7. Yvette Galimore
HR Director
c/o Littler Mendelson
3960 Howard Hughes Parkway, Suite 300
Las Vegas, NV 89169

Yvette Galimore would have knowledge concerning the allegations of the Complaint and Defendant's defenses thereto.

8. All witnesses identified by Plaintiff.

9. All witnesses needed for rebuttal.

10. All Custodians of Record necessary to authenticate documents.

Defendants reserve the right to supplement this list.

B. Relevant documents, data compilations and tangible things in the possession, custody or control of Defendants.

The following documents that are currently known and available that may be used in support of allegations, denials, and/or affirmative defenses contained in Defendants' Answer to Plaintiffs' Complaint are attached hereto. Further, Defendants reserve the right to supplement this list as necessary if additional information and documents related to this matter are discovered.

1. Plaintiffs Diaz, Fitzleff, and Olszynski's personnel files (bates nos. MDC000001 - MDC000047);

2. Plaintiffs' time cards showing compensation and hours worked from May 2012 to

present (bates nos. MDC000048 - MDC000080);

3. Plaintiffs Diaz, Fitzleff, and Wilbanks' W-2 Reports from 2012 to present (bates nos. MDC000081 - MDC000086);

C. Computation of damages.

Not Applicable.

D. Insurance agreement which may be used for indemnification or reimbursement purposes.

Not applicable.

The undersigned certifies that to the best of her knowledge, information, and belief formed after reasonable inquiry, the disclosure is complete and correct as of the date below.

Dated: September 9, 2014

Respectfully submitted,

RICK D. ROSKELLEY, ESQ.
ROGER L. GRANDGENETT II, 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 89169-5937. On September 9, 2014, I served the within document(s):

DEFENDANT'S INITIAL DISCLOSURES

☒ 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 September 9, 2014, at Las Vegas, Nevada.

Debra Perkins

Debra Perkins

EXHIBIT 15

EXHIBIT 15

Message

From: Colleen Fulton [Cfulton@manchastores.com]
Sent: 9/6/2014 2:11:40 PM
To: Joe Soraci [jsoraci@manchadev.com]
CC: Denny's 8659 [8659@manchastores.com]
Subject: Hourly Pay Rates

Joe I did forget to mention to you when I was reviewing the employee schedule at unit 8659 I noticed the servers pay rates were not what I am used to seeing. All servers are in at $7.55 per hour. I asked BJ why that is and she said that is what they were when she came to the unit and thought that is what it is supposed to be. I let her know that is not correct. Wage for tipped employees is $7.25 per hour. 4 years ago minimum wage was different, if servers worked a certain number of hours they were to be paid $7.55 and above that number of hours it was $7.25. That law is no longer valid, MDC HR, Blanca told us to leave rates as they are but hire in at $7.25 per hour. We have been hiring in at $7.55 at 8659. I don't know if we can lower the people we already have in at 7.55, I doubt it, if you are interested in doing this I would consult Yvette Galimore. There was another job code that seemed off to me, I believe it was server assistant, could be host though, it was a bit high. To me this is $353 a month, $4236 a year we are over paying.

BJ and I talked about correct starting salaries for each job code. Servers $7.25, tipped server assistants $7.25, non tipped server assistants $8.00, hosts – depending on experience, $7.25 to $8.00. Cooks depending in experience $9 to $12 per hour, there will be talented cooks we need to pay more to, this is what causes our cooks line to be clean, meeting speed of service goals, pass every inspection with few criticals for the year. Any cook hired in more than $12 needs to discuss with ADO. We must offer insurance to every employee on their hire date to be able to pay this sub minimum wage. (8.25 is minimum wage in Nevada) they do not have to accept this insurance but we have to offer it. This insurance would not take effect if hey choose to accept it until they have been with us 60 days. Most employees decline it, they can do better in the state of Nevada insurance marketplace.

I just need to make you aware Joe when I see things that need correcting.

Thanks,

Colleen

EXHIBIT 16

EXHIBIT 16

MDC RESTAURANTS, LLC

URGENT BENEFIT INFORMATION

December 13, 2013

Attn: ALL Employees

RE: Limited Medical Benefit Plan - Changes

Effective January 1, 2014, the current Starbridge plan will no longer be available. All employees who are currently covered on this plan will be **automatically transferred** over to the corresponding plan with Transamerica. This transition will be made during the week of December 16, 2013 and those of you currently on the Starbridge plan should receive Transamerica ID Cards in the mail, no later than the first week of January 2014.

If you are currently covered.....

For those of you who are currently covered but wish to make changes to that coverage, please contact your Benefit Counselor, Jujuan Laverick, @ 888-516-2094 Ext 102 All changes need to be made prior to December 30, 2013. You can also email Jujuan – JujuanL@Benebizworksite.com Assistance will also be available in Spanish.

If you are not covered but would like to get coverage.....

For employees who wish to enroll in the Transamerica Limited Medical coverage but are not currently on the Starbridge plan, **you can enroll now**. Please call Jujuan Laverick and let him know you are a NEW enrollee and wish to obtain coverage under the Transamerica Limited Medical Benefit Plan. You have until December 30, 2013 to enroll.

QUESTIONS ?

– Please Call – Jujuan Laverick 888-516-2094 Ext 102

MDC RESTAURANTS, LLC
BENEFICIOS E INFORMACION URGENTE

13 de diciembre 2013

A la atención de : Todos los empleados

RE : Limitada del Plan de Prestaciones Médicas - Cambios

Efectivo el 1 de enero de 2014, el actual plan Starbridge ya no estará disponible. Todos los empleados que están cubiertos actualmente en este plan se asignarán automáticamente a la planta correspondiente con Transamerica . Esta transición se realizará durante la semana del 16 de diciembre de 2013 y los de usted actualmente en el plan Starbridge debe recibir tarjetas de identificación de Transamerica en el correo, no más tarde de la primera semana de enero de 2014.

Si usted está cubierto actualmente .....

Para aquellos de ustedes que actualmente están cubiertos , pero que desean realizar cambios en dicha cobertura , por favor póngase en contacto con su asesor de beneficios , Jujuan Laverick , @ 888-516-2094 Ext 102 Todos los cambios deben hacerse antes del 30 de diciembre de 2013. También puede enviar por correo electrónico Jujuan - JujuanL@Benebizworksite.com asistencia también estará disponible en español .

Si usted no está cubierto , pero le gustaría obtener cobertura .....

Para los empleados que deseen inscribirse en la cobertura de Transamerica médicos limitados , pero no se encuentran actualmente en el plan Starbridge , puede inscribirse ahora . Por favor llame Jujuan Laverick y hágale saber que usted es un nuevo inscrito y desea obtener cobertura bajo el Plan de Prestaciones Médicas de Transamerica Limited . Tienes hasta el 30 de diciembre 2013 para inscribirse.

PREGUNTAS?
Contactar - Jujuan Laverick 888-516-2094 Ext 102

EXHIBIT 17

EXHIBIT 17

Darren Weidlein
New Business Manager

Darren Weidlein
2222 W. Dunlap Avenue
Suite 350
Phoenix, AZ 85021-2866
Telephone 602.749.7533
Cell: 602.350-6132

June 25, 2010

Blanca Vallejo
Direct of Human Resources
Mancha Development Company

Re: NV Minimum Wage Law

Good afternoon Blanca,

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.

Best wishes,

Darren Weidlein,
New Business Manager
CIGNA Voluntary

EXHIBIT 18

EXHIBIT 18

BRIAN SANDOVAL
Governor

STATE OF NEVADA

BRUCE H. BRESLOW
Director

SCOTT J. KIPPER
Commissioner

DEPARTMENT OF BUSINESS AND INDUSTRY
DIVISION OF INSURANCE
1818 East College Pkwy., Suite 103
Carson City, Nevada 89706
(775) 687-0700 • Fax (775) 687-0787
Website: doi.nv.gov
E-mail: insinfo@doi.nv.gov

Bulletin No. 13-011

December 31, 2013

DISCLOSURES BY SUPPLEMENTAL OR LIMITED HEALTH INSURANCE PLANS

The Patient Protection and Affordable Care Act[1] ("ACA") requires applicable individuals to have health insurance that contains minimum essential coverage.[2] For the group and individual markets, certain health insurance plans offered in Nevada may not meet the minimum essential coverage requirement. These plans are considered supplemental or limited health coverage, which could be confused with plans that provide minimum essential coverage. This Bulletin addresses filing and disclosure requirements for supplemental or limited health plans in order to minimize consumer confusion about whether these supplemental or limited health plans meet requirements of the ACA.[3]

Issuers of supplemental or limited health plans that do not meet the minimum essential coverage requirements must notify consumers as soon as practicable, but no later than March 15, 2014, via a clear, conspicuous, and understandable disclosure that the insurance coverage (1) does not constitute comprehensive health insurance coverage (often referred to as "major medical coverage"), and (2) that such coverage does not satisfy the individual mandate of the ACA because the coverage does not meet the requirements of minimum essential coverage. Issuers must also provide this disclosure at the time of solicitation and again at policy issuance or renewal. Issuers must file forms containing this disclosure with the Division of Insurance no later than February 1, 2014, and forms must be approved by February 28, 2014, for use beginning on March 1, 2014.

---

[1] The Patient Protection and Affordable Care Act, Pub. L. No. 111-148 (Mar. 23, 2010) (codified as amended in scattered sections of 20, 21, 25, 26, 28, 29, 30, 36 & 42 U.S.C.).

[2] 26 U.S.C. § 5000A. "Minimum essential coverage" means a government-sponsored plan, an employer-sponsored plan, plans in the individual market, grandfathered plans, and other coverage set out in the ACA. 26 U.S.C. § 5000A(f). The term does not include excepted benefits. 26 U.S.C. § 5000A(f)(3); 42 U.S.C. §§ 300gg-21, -91.

[3] This Bulletin is issued to ensure that supplemental or limited health insurance plans properly disclose a significant exception, reduction, or limitation that applies to the policy. See Nev. Rev. Stat. §§ 689A.390, 689B.027, 689C.270, 695B.172 & 695C.193.

Supplemental or limited health plans include those plans commonly referred to as hospital indemnity or other fixed indemnity policies (e.g., hospital/surgical/medical expense policies and sickness policies), specified or "dread" disease policies, and other forms of excepted benefits coverage as specified by the ACA.

For questions or clarification with regard to this Bulletin, please contact the Life & Health Section at (888-872-3234) or insinfo@doi.nv.gov.

SCOTT J. KIPPER
Commissioner of Insurance

EXHIBIT 19

EXHIBIT 19

BRIAN SANDOVAL
Governor

STATE OF NEVADA

BRUCE H. BRESLOW
Director

SCOTT J. KIPPER
Commissioner

DEPARTMENT OF BUSINESS AND INDUSTRY
DIVISION OF INSURANCE
1818 East College Pkwy., Suite 103
Carson City, Nevada 89706
(775) 687-0700 • Fax (775) 687-0787
Website: doi.nv.gov
E-mail: insinfo@doi.nv.gov

Bulletin No. 15-001
Replaces Bulletins 13-011 and 13-012

April 2, 2015

REQUIREMENTS FOR HOSPITAL INDEMNITY OR OTHER FIXED INDEMNITY INSURANCE PLANS

On January 24, 2013, the U.S. Department of Labor, the U.S. Department of Health and Human Services, and the U.S. Department of the Treasury (collectively "federal departments") issued guidance regarding hospital indemnity or other fixed indemnity insurance plans.[1] These health insurance plans are considered "excepted benefits" and, therefore, not subject to requirements of the Patient Protection and Affordable Care Act ("ACA" or "Affordable Care Act"). 42 U.S.C. § 300gg–91 (2013). On May 27, 2014, the federal departments issued a final rule entitled "Patient Protection and Affordable Care Act: Exchange and Insurance Market Standards for 2015 and Beyond." 79 Fed. Reg. 30240 [hereinafter "market rules"]. These market rules and subsequent guidance establish conditions for the sale of hospital indemnity or other fixed indemnity plans in the individual market.[2] This Bulletin explains the impact of the federal departments' market rules and guidance in Nevada.

The market rules and this Bulletin apply to hospital indemnity or other fixed indemnity insurance policies sold in the individual market, but do not apply to any other type or category of insurance that is listed separately as excepted benefits in the Public Health Service Act,[3] regardless of whether benefits under such coverage are paid as a fixed dollar amount.

---

[1] U.S. Dep't of Health & Human Serv., Ctr. For Consumer Info. & Ins. Oversight, Ctr. For Medicare & Medicaid Serv., Affordable Care Act Implementation FAQs – Set 11 (Jan. 24, 2013), http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs_11.html (last visited Dec. 20, 2013).

[2] On December 31, 2013, the Commissioner of Insurance issued Bulletin 13-012 to provide guidance to affected carriers and set forth a Schedule of Compliance.

[3] *See* 42 U.S.C. § 300gg-91(c) (2013) (listing, e.g., disability income, specified disease insurance, and accident insurance as excepted benefits).

In the market rules and related guidance, the federal departments have established the following conditions for a hospital indemnity or other fixed indemnity insurance policy sold in the individual market:

1. The benefits are provided only to the individuals who attest, in their hospital indemnity or other fixed indemnity insurance application, that they have other health coverage that is considered minimum essential coverage within the meaning of 26 U.S.C. § 5000A(f);
2. There is no coordination between the provision of benefits and an exclusion of benefits under any other health coverage;
3. The benefits are paid in a fixed dollar amount per period hospitalization or illness and/or per service regardless of the amount of expenses incurred and without regard to the amount of benefits provided with respect to the event or service under any other health coverage; and
4. A notice is displayed prominently in the application materials in at least 14-point font that has the following language:

   THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

Policies Issued on or After May 1, 2015

For individual hospital indemnity or other fixed indemnity policies issued with an effective date beginning on or after May 1, 2015, the insurer must include in the initial insurance application a notice and written attestation that the purchaser has minimum essential coverage as defined by the market rules and subsequent guidance. This is a one-time notice and attestation requirement. The insurer shall not be required to confirm continuous minimum essential coverage by the purchaser.

It is recommended that the following attestation clause be placed above the signature line:

> I hereby attest that I have major medical health insurance or Medicare that meets the requirements of minimum essential coverage as defined by the Affordable Care Act.

Additionally, federal guidance requires that the following notice be displayed prominently in the application materials in at least 14-point font:

> THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

Policies Issued Before May 1, 2015

- **Policies Requiring a Renewal Application:** For individual hospital indemnity or other fixed indemnity policies issued with an effective date before May 1, 2015, the same one-time notice and attestation requirement applies to the first renewal application with an effective date on or after October 1, 2016. Alternatively, the carrier has the option to provide the notice and collect the attestation at any earlier date.

- **Policies Not Requiring a Renewal Application:** For individual hospital indemnity or other fixed indemnity policies issued with an effective date before May 1, 2015, that do not require an application as a condition of renewal, but are guaranteed renewable or non-cancellable (with the only condition for renewal being timely payment of premium), the one-time notice and attestation is not required. However, these policies are subject to the one-time notice and attestation requirement applicable to policies effective on or after May 1, 2015, if an insured is required for any reason to fill out a new application form. As denoted in the market rules, the notice and attestation are only required on an application form. However, no later than October 1, 2016, the carrier shall send notice to each insured who was not given notice at the point of sale, in clear, conspicuous, and ordinary language, that the hospital or other fixed indemnity insurance does not meet the minimum essential coverage requirements of the ACA.

It is recommended that carriers use language substantially similar to the following notice:

> THIS INSURANCE POLICY DOES NOT MEET THE AFFORDABLE CARE ACT'S REQUIREMENT THAT YOU MAINTAIN MINIMUM ESSENTIAL COVERAGE, ALSO KNOWN AS MAJOR MEDICAL INSURANCE. FAILURE TO MAINTAIN MINIMUM ESSENTIAL COVERAGE MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES. THIS INSURANCE POLICY WILL REMAIN IN FORCE AS LONG AS YOU CONTINUE TO PAY YOUR PREMIUMS.

For questions or clarification with regard to this Bulletin, please contact the Life & Health Section at (888-872-3234) or insinfo@dol.ny.

SCOTT J. KIPPER
Commissioner of Insurance

EXHIBIT 20

EXHIBIT 20

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 2 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

Document No.	Document	Date	Page No.
12. Cont.	Notice of Lodgment of Exhibits to Defendants' Opposition to Plaintiffs' Motion for Partial Summary Judgment on Liability Regarding Defendants' Health Benefits Plans	05/13/16	1047
7.	Order Granting Class Certification, Designating Class Representatives, and Designating Class Counsel	10/16/15	0051
8.	Plaintiff's Renewed Motion for Partial Summary Judgment on Liability Regarding Defendants' Health Benefits Plans	04/19/16	0056
8. Cont.	Plaintiff's Renewed Motion for Partial Summary Judgment on Liability Regarding Defendants' Health Benefits Plans	04/19/16	0207
8. Cont.	Plaintiff's Renewed Motion for Partial Summary Judgment on Liability Regarding Defendants' Health Benefits Plans	04/19/16	0417
13.	Plaintiffs' Reply in Support of Their Renewed Motion for Partial Summary Judgment on Liability Regarding Defendants' Health Benefits Plans	05/20/16	1161
14.	Reporter's Transcript of Motion Before The Honorable Judge Timothy C. Williams, District Court Judge	05/31/16	1174
10.	Second Amended Order Setting Civil Jury Trial, Pre-Trial/Calendar Call	04/27/16	0543
9.	Stipulation and Order Amending Briefing Deadlines and Re-Noticing Hearing Re: Plaintiffs' Renewed Motion For Partial Summary Judgment on Liability Regarding Defendants' Health Benefits Plans	04/19/16	0541
5.	Summons	06/20/15	0038

TRANSAMERICA
EMPLOYEE BENEFITS

Transamerica Life Insurance Company
Monumental Life Insurance Company

Notice of Privacy Practices

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

The terms of this Notice of Privacy Practices apply to Transamerica Employee Benefits (referred to as "we," "us," or "our") as an affiliated covered entity with respect to the medical expense coverage provided by the companies listed above (referred to as "Company" individually or as "Companies" collectively). We will share protected health information of insureds as necessary to carry out payment and health care operations as permitted by law.

The Companies are required by law to maintain the privacy of the protected health information of their insureds who have medical expense coverage and to provide them with notice of our legal duties and privacy practices with respect to their protected health information. We are required to abide by the terms of this Notice so long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make the new Notice effective for all protected health information maintained by us. Copies of revised notices will be mailed to all insureds who have medical expense coverage and copies may be obtained by mailing a request to the address provided at the end of this Notice.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

Your Authorization. Except as outlined below, we will not use or disclose your protected health information for any other purpose unless you have signed a form authorizing the use or disclosure. You have the right to revoke that authorization in writing, except to the extent we have taken any action in reliance on the authorization.

Uses and Disclosures for Payment. We will make uses and disclosures of your protected health information as necessary for payment purposes. For instance, we may use information regarding your medical procedures and treatment to process and pay claims or forward such information to another health plan or another carrier which may also have an obligation to process and pay claims on your behalf.

Uses and Disclosures for Health Care Operations. We will use and disclose your protected health information as necessary, and as permitted by law, for our health care operations which could include enrollment, underwriting, reinsurance, compliance, auditing, rating, and other functions related to the medical expense coverage you have with one of the Companies.

Family and Friends Involved In Your Care. With your approval, we may from time to time disclose your protected health information to designated family, friends, and others who are involved in your care or in payment for your care in order to facilitate that person's involvement in caring for you or paying for your care. If you are unavailable, incapacitated, or facing an emergency medical situation, and we determine that a limited disclosure may be in your best interest, we may share limited protected health information with such individuals without your approval.

Business Associates. Certain aspects and components of our services are performed through contracts with outside persons or organizations, such as auditing, actuarial services, legal services, etc. At times it may be necessary for us to provide certain of your protected health information to one or more of these outside persons or organizations who assist us with our health plan operations. They may also, in the course of performing services for us, obtain protected health information. In all cases, we require these business associates to appropriately safeguard the privacy of your information.

Payment of Claims and Other Services. We may communicate with you regarding your claims, premiums or other things connected with your heath plan. You have the right to request, and we will accommodate reasonable requests by you, to receive communications regarding your protected health information from us by alternative means or at alternative locations. For instance, if you wish messages to not be left on voice mail or sent to a particular address, we will accommodate reasonable requests. You may request such confidential communication in writing and may send your request to the address provided at the end of this Notice.

Other Uses and Disclosures. We are permitted or required by law to make certain other uses and disclosures of your protected health information without your authorization. We may:

* share protected health information with our operations that administer life insurance or disability insurance coverage you may have with one of the Companies in order to allow them to administer that other coverage.
* release your protected health information for any purpose required by law;
* release your protected health information for public health activities, such as required reporting of disease, injury, and birth and death, and for required public health investigations;
* release your protected health information as required by law if we suspect child abuse or neglect or believe you to be a victim of abuse, neglect, or domestic violence;

* release your protected health information to the Food and Drug Administration if necessary to report adverse events, product defects, or to participate in product recalls;
* release your protected health information to your plan sponsor; provided, however, your plan sponsor must certify that the information provided will be maintained in a confidential manner and not used for employment related decisions or for other employee benefit determinations or in any other manner not permitted by law;
* release your protected health information if required by law to a government oversight agency conducting audits, investigations, or civil or criminal proceedings;
* release your protected health information if required to do so by a court or administrative ordered subpoena or discovery request; in most cases you will have notice of such release;
* release your protected health information to law enforcement officials as required by law to report wounds and injuries and crimes;
* release your protected health information to coroners and/or funeral directors consistent with the law;
* release your protected health information for certain research purposes when such research is approved by an institutional review board with established rules to ensure privacy;
* release your protected health information if you are a member of the military as required by armed forces services or if necessary for national security or intelligence activities; and
* release your protected health information to workers' compensation agencies if necessary for your workers' compensation benefit determination.

RIGHTS THAT YOU HAVE

Any written requests to exercise these rights should be directed to the address provided at the end of this notice.

Access to Your Protected Health Information. You have the right to copy and/or inspect much of the personal health information that we retain on your behalf. We are not always required to grant such requests but each request will be carefully reviewed and approved if warranted. All requests for access must be made in writing and signed by you or your representative. We may charge a reasonable fee according to our schedule of fees for copying, locating and retrieving copies of certain of your protected health information that we have. We will also charge for postage if you request a mailed copy and will charge for the time to prepare a summary of the requested information if you request such summary.

Amendments to Your Protected Health Information. You have the right to request in writing that protected health information that we maintain about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. All amendment requests, in order to be considered by us, must be in writing, signed by you or your representative, and must state the reasons for the requested amendment or correction. If we make an amendment or correction you request, we may also notify others who have copies of the uncorrected record, if we believe that such notification is necessary.

Accounting for Disclosures of Your Protected Health Information. You have the right to receive an accounting of certain disclosures made by us of your protected health information. Requests must be made in writing and signed by you or your representative. The first accounting in any 12-month period is free. You will be charged a fee according to our fee schedule for each subsequent accounting you request within the same 12-month period.

Restrictions on Use and Disclosure of Your Protected Health Information. You have the right to request restrictions on certain of our uses and disclosures of your protected health information for treatment, payment, or health care operations. Your request must describe in detail the restriction you are requesting. We are not required to agree to your request but will attempt to accommodate reasonable requests when appropriate and we retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination. You also have the right to terminate, in writing or orally, any agreed-to restriction.

Complaints. If you believe your privacy rights have been violated, you may file a complaint. The complaint must be in writing. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services in Washington D.C. in writing within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

FOR FURTHER INFORMATION

If you have questions or need further assistance regarding this Notice, you may contact our Customer Service Department at 1-888-763-7474. As an insured you have the right to obtain a paper copy of this Notice of Privacy Practices, even if you have requested such copy by e-mail or other electronic means.

EFFECTIVE DATE

This Notice of Privacy Practices is effective April 14, 2003.

Transamerica Employee Benefits
Compliance Department
P.O. Box 8063
Little Rock, Arkansas 72203-8063

TRANSAMERICA LIFE INSURANCE COMPANY

Home Office: Cedar Rapids, Iowa 52499
A Stock Company

Policyholder: MDC Restaurants, LLC

Policy Number: MDCMDC01A

Address: 313 Pilot Road
Las Vegas, NV 89119

Policy Effective Date: January 1, 2014

Policy Anniversary Date: January 1

Premium Rate Guarantee Date: January 1, 2015

Governing Jurisdiction: NV

Transamerica Life Insurance Company ("the Company," "we," "us," and "our") agrees to pay the benefits described in this Group Master Policy ("Policy"), subject to all terms, conditions, and limitations, in consideration of:

1. The Policyholder Application, a copy of which is attached to and made a part of this Policy; and
2. The payment of the first premium.

By our acceptance of the first premium paid by the Policyholder and by the Policyholder's receipt of this Policy, the Policyholder agrees:

1. To be bound by the terms of this Policy; and
2. To pay all premiums to us according to the terms of this Policy.

This Policy is a legal contract between the Policyholder and us.

This Policy is subject to the laws of the governing jurisdiction in which it is issued. It is signed for the Company at our Home Office to take effect on the Policy Effective Date.

Craig D. Vermie
General Counsel and Secretary

Brenda Cline
President

Group Master Policy for Hospital Indemnity Insurance

LIMITED BENEFIT INSURANCE – READ THIS POLICY CAREFULLY

THIS POLICY 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. IF AN EMPLOYEE OR MEMBER PURCHASES THIS COVERAGE ONLY, IT WILL NOT SATISFY THE FEDERAL REQUIREMENT TO HAVE HEALTH COVERAGE, WHICH IS IN EFFECT BEGINNING JANUARY 1, 2014.

Administrative Office:
P.O. Box 310, Grapevine, Texas 76099-0310
Customer Service: 1-866-975-4641

TABLE OF CONTENTS

DEFINITIONS

The defined terms below, when used in this Policy, will have the following meanings.

Active Service – Performing in the usual manner all of the regular duties of the individual's occupation on a scheduled work day at the normal place of business or other location as directed by the employer.

An individual is considered to be in Active Service on a day which is not a scheduled work day only if the individual would meet the requirements above if it were a scheduled work day and was in Active Service on the last preceding regular work day.

Active Service does not apply if employment is not an eligibility requirement.

Amendment, Endorsement, or Rider – Any form issued by us which adds, modifies, changes, or deletes any Policy or Certificate provision or benefit.

Policyholder Application – The form completed and signed by the Policyholder to apply for this insurance coverage.

ELIGIBILITY

Employee or Member Eligibility – To be eligible for coverage under the Policy, an employee or member must:
1. Meet the eligibility requirements listed on the Policyholder Application;
2. Be in Active Service; and
3. Provide satisfactory Evidence of Insurability to us, if required.

Dependent Eligibility – To be eligible under the Policy, a Dependent must:
1. Meet the definition of an eligible Dependent;
2. Be able to perform a majority of the normal activities of a person of like age in good health;
3. Not be eligible as an employee or member under the Policy; and
4. Provide satisfactory Evidence of Insurability to us, if required.

If an employee/member and his or her Spouse/Other Adult Dependent are both eligible as an employee/member, the Children may be insured as Dependents of either employee/member, but not both.

PREMIUMS

Premium Calculation and Due Dates – The premium due will be the sum of the premiums applicable for all Insureds. The Policyholder must pay the premiums to us at our Administrative Office. The premiums are due and payable to us in advance by the Policyholder on each premium due date. The first premium due date is the Policy Effective Date.

Grace Period – A Grace Period of 31 days will be allowed for each premium payment after the first premium. Coverage will stay in force during this time. This Policy will terminate at the end of the Grace Period if the premium has not been paid. The Policyholder must still pay all unpaid premiums. This includes the premium due for the Grace Period.

The Grace Period will not apply if coverage is canceled on a premium due date and the premium has been paid through that date. If cancellation is during the Grace Period, the Policyholder will be liable for any unpaid premium including the pro rata premium for that part of the Grace Period during which coverage was in force.

Premium Rate Guarantee – The premium rates are guaranteed until the date shown on the Policy's cover page and are subject to the Change in Premium Rates provision.

Change in Premium Rates – We have the right to change the premium rates on any premium due date after the end of the Premium Rate Guarantee. If the rates are changed, we will give the Policyholder at least a 60-day advance written notice.

If a change in benefits contained in the Policy increases our liability, premium rates may be changed on the date our liability is increased, without regard to any Premium Rate Guarantee. If such premium increase takes place on a date other than a premium due date, a pro rata premium for the increase will be due on the next premium due date. The pro rata premium will be for the period from the date of the increase to the next premium due date. If such premium is not paid when due, the coverage will automatically be terminated as of the date the pro rata premium was due. Any partial payment of premium will be refunded.

POLICY CHANGES AND TERMINATION

Who May Change This Policy – The terms of this Policy may be changed at any time by written agreement between the Policyholder and us. The insurance provided by this Policy can be changed or canceled without the consent of or prior notice to any Insured. Any changes to the terms of this Policy can only be made by the addition of an endorsement or amendment signed by an officer of Transamerica Life Insurance Company. No agent has the right to change or waive any terms of this Policy. All changes are subject to the laws of the governing jurisdiction.

When Policy Changes Are Effective – Unless the Policyholder and the Company agree otherwise in writing, the Effective Date of any change in benefits will be the first day of the calendar month that coincides with or next follows the date we send notice to the Policyholder of the change in benefits and any corresponding change in premiums.

Termination – This Policy will end on the earliest of the following events:

1. If the Policyholder submits a 60-day advance written request to us to terminate this Policy, this Policy will terminate on the date specified in that request.
2. If we give a 60-day advance written notice to the Policyholder that we intend to terminate this Policy, this Policy will terminate on the date specified in that notice.
3. If any premium payable by the Policyholder is not paid within its Grace Period, this Policy will terminate on the day after the end of the Grace Period.
4. If the Policyholder fails to comply with any terms of this Policy or the Policyholder Application; fails to fulfill any obligations or duties under or pertaining to this insurance, or fails to comply with or cooperate with us in satisfying the requirements of any applicable law or regulation pertaining to this insurance; this Policy will terminate on the 32nd day after we have given the Policyholder written notice of our intent to terminate.

Termination of an Insured's coverage that was effective prior to the date the Policyholder's coverage terminated will be governed by the Termination of Insurance provision of the Certificate. The Policyholder is required to notify us of any such termination.

Minimum Participation Requirement – The Policyholder must maintain the participation levels described in the Policyholder Application. If participation falls below the minimum participation limit, we have the right to cancel this Policy.

POLICYHOLDER PROVISIONS

Duties – The Policyholder's primary duties include the following:

1. As required, give us any and all information we determine to be necessary for the enrollment and determination of eligibility of the Policyholder's employees or members, including Dependents, if applicable.
2. Receive and forward to us the Applications of the Policyholder's employees or members.
3. Maintain records pertaining to the insurance of the Policyholder's employees or members as we may reasonably require while this Policy is in force and for two years after this Policy terminates, and allow us the opportunity to examine these records at any reasonable time during normal business hours.
4. Pay premiums to us.
5. In the event that any of this insurance is to be stopped, the Policyholder is required to notify the insured employees or members, including any right to continue coverage, by either giving them a written notice or mailing a notice to their last known address as shown in the Policyholder's records.
6. Cooperate with us in delivering Certificates, disclosures and notices regarding this coverage to Insureds under the Policy.

Certificates - A Certificate will be issued for delivery to each Insured. The Certificate will describe the benefits, terms, limitations and other essential features of the Policy. If more than one Certificate is issued to an Insured under this Policy, only the last one issued will be in effect.

Inspection of Policy – The Policyholder must make this Policy available for inspection by the Policyholder's employees or members at all reasonable times during normal business hours.

Policyholder is an Agent of the Insured – For all purposes related to the insurance issued under this Policy, the Policyholder acts as an agent of the Insured. The Policyholder does not, therefore, act as our agent for any purposes related to insurance issued under this Policy.

GENERAL PROVISIONS

Adjustments in the Event of Clerical Error – Clerical error will not void insurance otherwise valid and in force, nor will it continue or make insurance valid that otherwise would cease or would never have been issued.

Conformity With State Laws – A provision of the Policy or Certificate that conflicts with a law of the governing jurisdiction is hereby changed to meet the minimum standards of that law.

Entire Contract – The entire contract consists of: this Policy; Policyholder Application; the Certificate Provisions; and any attached Amendments, Endorsements, and Riders.

Legal Action – No legal action may be brought to recover under the Policy and any Certificate:

1. Within 60 days after written Proof of Loss has been furnished as required; or
2. More than three years from the time written Proof of Loss is required to be furnished.

New Insureds – The group originally insured may be modified from time to time to add eligible new persons in accordance with the terms of the Policy.

Time Limit On Certain Defenses – We will not use any statement, except fraudulent statements, to void or reduce benefits under this Policy after it has been in force for two years from the Effective Date. Any such statements would have to be in a signed form. All statements made are considered representations and not warranties. No such statement will be used in any contest, unless a copy of such statement has been furnished to the Policyholder. The validity of this Policy cannot be contested after two years from its date of issue, except for nonpayment of premiums.

Any increase in benefit amount is subject to a new two-year contestable period for the increased amount only.

Time Effective – For any dates in this Policy, the effective time will be 12:01 a.m. at the Policyholder's main place of business.

CERTIFICATE PROVISIONS MADE A PART OF THIS POLICY

The remainder of this Policy consists of the provisions that appear in the Certificate, including any Amendments, Endorsements, or Riders that describe the insurance made available to the employees or members under this Policy.

THIS PAGE INTENTIONALLY LEFT BLANK

The Department of Business and Industry, Division of Insurance

has established a toll-free service to receive inquiries and complaints from consumers of health care in Nevada concerning health care plans.

Toll Free: (888) 872-3234

Monday - Friday
8:00 a.m. until 5:00 p.m. (Pacific Standard Time)

Carson City Residents Call - (775) 687-0700
Las Vegas Residents Call - (702) 486-4009

THIS PAGE INTENTIONALLY LEFT BLANK

TRANSAMERICA LIFE INSURANCE COMPANY

Home Office: Cedar Rapids, Iowa 52499
A Stock Company

About Your Insurance – This Certificate explains benefits provided under the Group Master Policy ("Policy") issued to the Policyholder named on the Schedule of Benefits. Read it closely to become familiar with your coverage.

Terms important to understanding this Certificate are defined in the Definitions section or in separate Certificate provisions and are capitalized.

Important Notice – Benefits are payable only as described in this Certificate for a covered loss that occurs while the Covered Person is insured under the Policy.

The Policy may be amended or canceled as stated in its provisions. Such an action may be taken without the consent of or notice to any Covered Person. Premiums are subject to change.

The benefits for Dependents described in this Certificate, if available under the Policy, are applicable only if you are insured, apply for Dependent coverage, receive our approval of such Dependents, and pay the premium required for each Dependent.

This Certificate is signed for us at our Home Office to take effect on the same date coverage becomes effective.

Craig D. Vermie
General Counsel and Secretary

Brenda Cline
President

Group Certificate for Hospital Indemnity Insurance

LIMITED BENEFIT – READ YOUR CERTIFICATE CAREFULLY

THIS CERTIFICATE 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. IF YOU PURCHASE THIS CERTIFICATE ONLY, YOU WILL NOT SATISFY THE FEDERAL REQUIREMENT THAT YOU HAVE HEALTH COVERAGE, WHICH IS IN EFFECT BEGINNING JANUARY 1, 2014.

Administrative Office:
P.O. Box 310, Grapevine, Texas 76099-0310
Customer Service: 1-866-975-4641

TABLE OF CONTENTS

SCHEDULE OF BENEFITS

POLICYHOLDER:	MDC Restaurants LLC
GROUP POLICY NUMBER:	MDCMDC01A
POLICY EFFECTIVE DATE:	January 1, 2014
GOVERNING JURISDICTION:	Nevada
MONTHLY PREMIUM:	

BENEFIT COVERAGE	BENEFIT PER COVERED PERSON
DAILY IN-HOSPITAL INDEMNITY BENEFIT	
DAILY IN-HOSPITAL INDEMNITY BENEFIT AMOUNT	$100
MAXIMUM NUMBER OF DAYS PER CONFINEMENT:	31

OPTIONAL RIDERS – The following Optional Riders are part of your coverage.

CRHA0400 - HOSPITAL CONFINEMENT INDEMNITY BENEFIT RIDER	
BENEFIT AMOUNT PER DAY	$500
MAXIMUM NUMBER OF DAYS PER CONFINEMENT	2
MAXIMUM NUMBER OF DAYS PER CALENDAR YEAR	2
CRDA0400 - INPATIENT DRUG AND ALCOHOL ADDICTION INDEMNITY BENEFIT RIDER	
BENEFIT AMOUNT PER DAY	$100
MAXIMUM NUMBER OF DAYS PER CALENDAR YEAR	31
LIFETIME MAXIMUM NUMBER OF DAYS	60
CRMN0400 - INPATIENT MENTAL AND NERVOUS DISORDER INDEMNITY BENEFIT RIDER	
BENEFIT AMOUNT PER DAY	$100
MAXIMUM NUMBER OF DAYS PER CALENDAR YEAR	31
LIFETIME MAXIMUM NUMBER OF DAYS	60
CRASD400 - OUTPATIENT ADVANCED STUDIES DIAGNOSTIC TEST INDEMNITY BENEFIT RIDER	
BENEFIT AMOUNT PER DAY	$200
MAXIMUM NUMBER OF DAYS PER CALENDAR YEAR	1
CRLAB400 - OUTPATIENT DIAGNOSTIC LABORATORY TEST INDEMNITY BENEFIT RIDER	
BENEFIT AMOUNT PER DAY	$10
MAXIMUM NUMBER OF DAYS PER CALENDAR YEAR	2
CROPV400 - OUTPATIENT PHYSICIAN OFFICE VISIT INDEMNITY BENEFIT RIDER	
BENEFIT AMOUNT PER DAY	$50
MAXIMUM NUMBER OF DAYS PER CALENDAR YEAR	6
CRSDT400 - OUTPATIENT SELECT DIAGNOSTIC TEST INDEMNITY BENEFIT RIDER	
BENEFIT AMOUNT PER DAY	$50
MAXIMUM NUMBER OF DAYS PER CALENDAR YEAR	1

SCHEDULE OF BENEFITS
(Continued)

BENEFIT COVERAGE	BENEFIT PER COVERED PERSON
CRRX0400 –PRESCRIPTION DRUG INDEMNITY BENEFIT RIDER	
GENERIC PRESCRIPTION BENEFIT AMOUNT PER DAY	$10
BRAND NAME PRESCRIPTION BENEFIT AMOUNT PER DAY	$20
MAXIMUM NUMBER OF DAYS PER CALENDAR YEAR	12
CRSRGP00 – SURGICAL AND ANESTHESIA INDEMNITY BENEFIT RIDER	
INPATIENT SURGICAL BENEFIT PER DAY	$500
MAXIMUM NUMBER OF DAYS PER CALENDAR YEAR	1
OUTPATIENT SURGICAL BENEFIT PER DAY	$250
MAXIMUM NUMBER OF DAYS PER CALENDAR YEAR	1
OUTPATIENT MINOR SURGICAL BENEFIT PER DAY	$50
MAXIMUM NUMBER OF DAYS PER CALENDAR YEAR	1
ANESTHESIA INDEMNITY BENEFIT PER DAY	20% OF SURGERY INDEMNITY
CRHWEL00 – WELLNESS INDEMNITY BENEFIT RIDER	
BENEFIT AMOUNT PER DAY	$100
MAXIMUM NUMBER OF DAYS PER CALENDAR YEAR PER COVERED PERSON OVER AGE 2	1
MAXIMUM NUMBER OF WELL BABY DAYS PER CALENDAR YEAR	
PER COVERED PERSON AGE NEWBORN TO 12 MONTHS	4
PER COVERED PERSON AGE 13 MONTHS TO 2ND BIRTHDAY	2

SCHEDULE OF BENEFITS

POLICYHOLDER:	MDC Restaurants LLC
GROUP POLICY NUMBER:	MDCMDC01A
POLICY EFFECTIVE DATE:	January 1, 2014
GOVERNING JURISDICTION:	Nevada
MONTHLY PREMIUM:	

BENEFIT COVERAGE	BENEFIT PER COVERED PERSON
DAILY IN-HOSPITAL INDEMNITY BENEFIT	
DAILY IN-HOSPITAL INDEMNITY BENEFIT AMOUNT	$300
MAXIMUM NUMBER OF DAYS PER CONFINEMENT:	31

OPTIONAL RIDERS – The following Optional Riders are part of your coverage.

CRAMB400 – AMBULANCE INDEMNITY BENEFIT RIDER	
BENEFIT AMOUNT PER DAY FOR GROUND/WATER AMBULANCE	$200
BENEFIT AMOUNT PER DAY FOR AIR AMBULANCE	$600
MAXIMUM NUMBER OF DAYS PER CALENDAR YEAR	3
CRHA0400 - HOSPITAL CONFINEMENT INDEMNITY BENEFIT RIDER	
BENEFIT AMOUNT PER DAY	$1,000
MAXIMUM NUMBER OF DAYS PER CONFINEMENT	2
MAXIMUM NUMBER OF DAYS PER CALENDAR YEAR	2
CRDA0400 - INPATIENT DRUG AND ALCOHOL ADDICTION INDEMNITY BENEFIT RIDER	
BENEFIT AMOUNT PER DAY	$100
MAXIMUM NUMBER OF DAYS PER CALENDAR YEAR	31
LIFETIME MAXIMUM NUMBER OF DAYS	60
CRMN0400 - INPATIENT MENTAL AND NERVOUS DISORDER INDEMNITY BENEFIT RIDER	
BENEFIT AMOUNT PER DAY	$100
MAXIMUM NUMBER OF DAYS PER CALENDAR YEAR	31
LIFETIME MAXIMUM NUMBER OF DAYS	60
CRASD400 - OUTPATIENT ADVANCED STUDIES DIAGNOSTIC TEST INDEMNITY BENEFIT RIDER	
BENEFIT AMOUNT PER DAY	$300
MAXIMUM NUMBER OF DAYS PER CALENDAR YEAR	2
CRLAB400 - OUTPATIENT DIAGNOSTIC LABORATORY TEST INDEMNITY BENEFIT RIDER	
BENEFIT AMOUNT PER DAY	$15
MAXIMUM NUMBER OF DAYS PER CALENDAR YEAR	4
CROPV400 - OUTPATIENT PHYSICIAN OFFICE VISIT INDEMNITY BENEFIT RIDER	
BENEFIT AMOUNT PER DAY	$70
MAXIMUM NUMBER OF DAYS PER CALENDAR YEAR	6
CRSDT400 - OUTPATIENT SELECT DIAGNOSTIC TEST INDEMNITY BENEFIT RIDER	
BENEFIT AMOUNT PER DAY	$75
MAXIMUM NUMBER OF DAYS PER CALENDAR YEAR	2

SCHEDULE OF BENEFITS
(Continued)

BENEFIT COVERAGE	BENEFIT PER COVERED PERSON
CRRX0400 –PRESCRIPTION DRUG INDEMNITY BENEFIT RIDER	
GENERIC PRESCRIPTION BENEFIT AMOUNT PER DAY	$15
BRAND NAME PRESCRIPTION BENEFIT AMOUNT PER DAY	$30
MAXIMUM NUMBER OF DAYS PER CALENDAR YEAR	24
CRSRGP00 – SURGICAL AND ANESTHESIA INDEMNITY BENEFIT RIDER	
INPATIENT SURGICAL BENEFIT PER DAY	$1,000
MAXIMUM NUMBER OF DAYS PER CALENDAR YEAR	1
OUTPATIENT SURGICAL BENEFIT PER DAY	$500
MAXIMUM NUMBER OF DAYS PER CALENDAR YEAR	1
OUTPATIENT MINOR SURGICAL BENEFIT PER DAY	$100
MAXIMUM NUMBER OF DAYS PER CALENDAR YEAR	1
ANESTHESIA INDEMNITY BENEFIT PER DAY	20% OF SURGERY INDEMNITY
CRHWEL00 – WELLNESS INDEMNITY BENEFIT RIDER	
BENEFIT AMOUNT PER DAY	$100
MAXIMUM NUMBER OF DAYS PER CALENDAR YEAR PER COVERED PERSON OVER AGE 2	1
MAXIMUM NUMBER OF WELL BABY DAYS PER CALENDAR YEAR	
PER COVERED PERSON AGE NEWBORN TO 12 MONTHS	4
PER COVERED PERSON AGE 13 MONTHS TO 2ND BIRTHDAY	2

SCHEDULE OF BENEFITS

POLICYHOLDER:	MDC Restaurants LLC
GROUP POLICY NUMBER:	MDCMDC01A
POLICY EFFECTIVE DATE:	January 1, 2014
GOVERNING JURISDICTION:	Nevada
MONTHLY PREMIUM:	

BENEFIT COVERAGE	BENEFIT PER COVERED PERSON
DAILY IN-HOSPITAL INDEMNITY BENEFIT	
DAILY IN-HOSPITAL INDEMNITY BENEFIT AMOUNT	$300
MAXIMUM NUMBER OF DAYS PER CONFINEMENT:	31

OPTIONAL RIDERS – The following Optional Riders are part of your coverage.

CRAMB400 – AMBULANCE INDEMNITY BENEFIT RIDER	
BENEFIT AMOUNT PER DAY FOR GROUND/WATER AMBULANCE	$350
BENEFIT AMOUNT PER DAY FOR AIR AMBULANCE	$1,050
MAXIMUM NUMBER OF DAYS PER CALENDAR YEAR	3
CRCI0400 – CRITICAL ILLNESS INDEMNITY BENEFIT RIDER	
CRITICAL ILLNESS BENEFIT-	
INSURED	$5,000
DEPENDENT	50% OF INSURED BENEFIT
SKIN CANCER BENEFIT	5% OF CRITICAL ILLNESS BENEFIT
CARCINOMA IN SITU BENEFIT	5% OF CRITICAL ILLNESS BENEFIT
SUBSEQUENT CRITICAL ILLNESS BENEFIT	100% OF CRITICAL ILLNESS BENEFIT
CRHA0400 - HOSPITAL CONFINEMENT INDEMNITY BENEFIT RIDER	
BENEFIT AMOUNT PER DAY	$1,000
MAXIMUM NUMBER OF DAYS PER CONFINEMENT	2
MAXIMUM NUMBER OF DAYS PER CALENDAR YEAR	2
CRDA0400 - INPATIENT DRUG AND ALCOHOL ADDICTION INDEMNITY BENEFIT RIDER	
BENEFIT AMOUNT PER DAY	$100
MAXIMUM NUMBER OF DAYS PER CALENDAR YEAR	31
LIFETIME MAXIMUM NUMBER OF DAYS	60
CRMN0400 - INPATIENT MENTAL AND NERVOUS DISORDER INDEMNITY BENEFIT RIDER	
BENEFIT AMOUNT PER DAY	$100
MAXIMUM NUMBER OF DAYS PER CALENDAR YEAR	31
LIFETIME MAXIMUM NUMBER OF DAYS	60
CRACIN00 - OFF-THE-JOB ACCIDENTAL INJURY INDEMNITY BENEFIT RIDER	
BENEFIT AMOUNT PER DAY	$700
MAXIMUM NUMBER OF DAYS PER ACCIDENT	1
MAXIMUM NUMBER OF ACCIDENTS PER CALENDAR YEAR	5
CRASD400 - OUTPATIENT ADVANCED STUDIES DIAGNOSTIC TEST INDEMNITY BENEFIT RIDER	
BENEFIT AMOUNT PER DAY	$300
MAXIMUM NUMBER OF DAYS PER CALENDAR YEAR	2

SCHEDULE OF BENEFITS
(Continued)

BENEFIT COVERAGE	BENEFIT PER COVERED PERSON
CRLAB400 - OUTPATIENT DIAGNOSTIC LABORATORY TEST INDEMNITY BENEFIT RIDER	
BENEFIT AMOUNT PER DAY	$15
MAXIMUM NUMBER OF DAYS PER CALENDAR YEAR	4
CROPV400 - OUTPATIENT PHYSICIAN OFFICE VISIT INDEMNITY BENEFIT RIDER	
BENEFIT AMOUNT PER DAY	$70
MAXIMUM NUMBER OF DAYS PER CALENDAR YEAR	6
CRSDT400 - OUTPATIENT SELECT DIAGNOSTIC TEST INDEMNITY BENEFIT RIDER	
BENEFIT AMOUNT PER DAY	$75
MAXIMUM NUMBER OF DAYS PER CALENDAR YEAR	2
CRRX0400 –PRESCRIPTION DRUG INDEMNITY BENEFIT RIDER	
GENERIC PRESCRIPTION BENEFIT AMOUNT PER DAY	$25
BRAND NAME PRESCRIPTION BENEFIT AMOUNT PER DAY	$50
MAXIMUM NUMBER OF DAYS PER CALENDAR YEAR	36
CRSRGP00 – SURGICAL AND ANESTHESIA INDEMNITY BENEFIT RIDER	
INPATIENT SURGICAL BENEFIT PER DAY	$1,000
MAXIMUM NUMBER OF DAYS PER CALENDAR YEAR	1
OUTPATIENT SURGICAL BENEFIT PER DAY	$500
MAXIMUM NUMBER OF DAYS PER CALENDAR YEAR	1
OUTPATIENT MINOR SURGICAL BENEFIT PER DAY	$100
MAXIMUM NUMBER OF DAYS PER CALENDAR YEAR	1
ANESTHESIA INDEMNITY BENEFIT PER DAY	20% OF SURGERY INDEMNITY
CRHWEL00 – WELLNESS INDEMNITY BENEFIT RIDER	
BENEFIT AMOUNT PER DAY	$100
MAXIMUM NUMBER OF DAYS PER CALENDAR YEAR PER COVERED PERSON OVER AGE 2	1
MAXIMUM NUMBER OF WELL BABY DAYS PER CALENDAR YEAR	
PER COVERED PERSON AGE NEWBORN TO 12 MONTHS	4
PER COVERED PERSON AGE 13 MONTHS TO 2ND BIRTHDAY	2

DEFINITIONS

Terms important to understanding this Certificate are defined below and are capitalized in this Certificate.

Accident or Accidental Injury – A sudden, unexpected, and unintended injury that:
1. Is independent of any Sickness;
2. Is caused by or is the result of external means; and
3. Takes place while the Covered Person's coverage is in force.

Active Service – Performing in the usual manner all of the regular duties of your occupation on a scheduled work day at the normal place of business or other location as directed by your employer.

You are considered to be in Active Service on a day which is not a scheduled work day only if you would meet the requirements above if it were a scheduled work day and you were in Active Service on the last preceding regular work day.

Active Service does not apply if employment is not an eligibility requirement.

Amendment, Endorsement, or Rider – Any form issued by us which adds, modifies, changes, or deletes any Policy or Certificate provision or benefit.

Application – The form completed and signed to apply for this insurance coverage.

Calendar Year – The period from January 1 through December 31 of the same year.

Child – A Child of yours who is under the age of 26 and is:
1. A natural Child; or
2. A legally adopted Child or a Child who has been placed for adoption with you; or
3. A stepchild or foster Child; or
4. A Child for whom you have been appointed legal guardian; or
5. A Child for whom you are legally required to provide support.

If applicable, Child will also include children of your Other Adult Dependent in the same manner as a stepchild.

Child also includes a Child who is incapable of self-support due to a mental or physical impairment. If a Child has reached age 26, but is incapable of self-support because of mental or physical impairment, we will continue the Child's coverage under the following conditions:
1. The Child must be incapacitated;
2. We must receive proof of incapacity within 31 days after coverage would otherwise terminate;
3. We may require additional proof of such incapacity from time to time, but not more often than once a year after the Child attains age 26; and
4. Your coverage must remain in force.

Confinement or Confined - That period of time the Covered Person is admitted into a Hospital as a resident bed patient. Confinement does not include that period of time during which a Covered Person is in a Hospital emergency room, an observation room, a freestanding surgical facility or an outpatient facility.

Covered Person - You and your Dependents who have been accepted for coverage.

Dependent – Your Spouse or Other Adult Dependent or Child covered under this Certificate.

Evidence of Insurability – The correct and complete answers to the questions in the Application and medical history, if necessary, which will be used by us to base our acceptance of any proposed Covered Person.

Hospital - A licensed institution that has on its premises or in facilities available to the Hospital on a contractually prearranged basis and under the supervision of a staff of one or more duly licensed Physicians:
1. Laboratory, X-ray equipment and operating rooms where major surgical operations may be performed by licensed Physicians;
2. Permanent and full-time facilities for the care of overnight resident bed patients under the supervision of a licensed Physician;
3. 24-hour-a-day nursing service by graduate registered nurses; and

4. A patient's written history and medical records.

Notwithstanding the above, Hospital does not include an institution or that part of an institution operated as:
1. A nursing home;
2. An extended care facility;
3. A skilled nursing facility;
4. A mental institution or a facility for the treatment of mental disorders;
5. A rest home or home for the aged;
6. A rehabilitation center; or
7. A place for alcoholics or drug addicts.

Immediate Family Member – Anyone related to a Covered Person in the following manner: spouse, daughter, son, stepchild, father, mother, stepparent, sister, brother, stepsister, stepbrother, grandchild, grandparent, father-in-law, mother-in-law, or the spouse of any of these. The term "spouse" includes a common law marriage partner, domestic partner, or civil union partner, if legally recognized in the governing jurisdiction.

Insured, you, or your – The employee or member covered for this insurance.

Observation Unit – A specialized area within a Hospital, apart from the emergency room, where a patient can be monitored following outpatient surgery or treatment in the emergency room by a Physician. Such a unit must:
1. Be under the direct supervision of a Physician or registered nurse;
2. Be staffed by nurses assigned specifically to that unit; and
3. Provide care seven days per week, 24 hours per day.

Other Adult Dependent – Your common law marriage partner, domestic partner, or civil union partner, if legally recognized in the governing jurisdiction or as otherwise agreed upon between the Policyholder and us.

Physician - A person who is providing services within the scope of his or her license, and is either:
1. Licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
2. Legally qualified and licensed as a medical practitioner and is required to be recognized, according to the insurance statutes or the insurance regulations of the governing jurisdiction.

Such person must not be an Immediate Family Member of any Covered Person. Practitioners of homeopathic, naturopathic and related medicines are not considered eligible Physicians under the Policy.

Policy – The complete contract of insurance, which includes the Policy as issued to the Policyholder, the Policyholder Application, the Certificate Provisions, and any Amendments, Endorsements, and Riders.

Policyholder – The entity named on the Schedule of Benefits to whom the Policy is issued.

Sickness – Illness or disease which first manifests itself while the Covered Person's coverage is in force and is the direct cause of the loss.

Spouse – Your legally married Spouse.

Transamerica Life Insurance Company, the Company, we, us, or our – The insurer that underwrites this coverage.

ELIGIBILITY AND EFFECTIVE DATE

Coverage will take effect at 12:01 a.m. at the main place of business of the Policyholder.

Employee or Member Eligibility – To be eligible for coverage under the Policy, you must:
4. Meet the eligibility requirements listed on the Policyholder Application;
5. Be in Active Service; and
6. Provide satisfactory Evidence of Insurability to us, if required.

Employee or Member Effective Date - Your insurance will take effect on the later of: (1) the Policy Effective Date; or (2) the first day of the calendar month which coincides with or next follows the date you are accepted for coverage; provided you are: (a) an eligible employee or member on such date; and (b) we have received your first premium payment.

If you do not meet the eligibility requirements on the date your coverage is to take effect, your coverage will take effect on the first day of the calendar month which coincides with or next follows the date you satisfy the requirements.

Dependent Eligibility, if available under the Policy – To be eligible under the Policy, a Dependent must:

5. Meet the definition of an eligible Dependent;
6. Be able to perform a majority of the normal activities of a person of like age in good health;
7. Not be eligible as an employee or member under the Policy; and
8. Provide satisfactory Evidence of Insurability to us, if required.

Dependent Effective Date – Insurance on each Dependent will take effect on the later of: (1) the date your coverage becomes effective; or (2) the first day of the calendar month which coincides with or next follows the date the Dependent is accepted for coverage, provided that: (a) the Dependent is an eligible Dependent on such date; and (b) we have received any additional premium.

If a Dependent does not meet the eligibility requirements on the date his or her coverage is to take effect, coverage on that Dependent will take effect on the first day of the calendar month which coincides with or next follows the date the Dependent satisfies the requirements.

If you and your Spouse or Other Adult Dependent are both eligible as an employee or member, any Children may be insured as a Dependent of either you or your Spouse or Other Adult Dependent, but not both.

Coverage for Newborn Child or Newly Adopted Child - Coverage for a newborn, a newly adopted Child, or a Child for whom you are appointed the legal guardian, will become effective automatically on the day he or she is born, the day the Child is placed for adoption or the day a court enters an order appointing you the legal guardian of the Child. The Child will be automatically covered for 31 days. In order to continue the Child's coverage, you must notify us by the end of the 31-day period and pay any additional premium, if applicable.

Coverage for a newly born or newly adopted Child will consist of coverage for Accident and Sickness including confinements for medically diagnosed congenital defects and birth abnormalities within the scope of the Policy.

DAILY IN-HOSPITAL INDEMNITY BENEFIT

We will pay the Daily In-Hospital Indemnity Benefit amount shown in the Schedule of Benefits for each day the Covered Person is Confined to a Hospital as the result of a covered Accident or Sickness. This benefit is limited to any maximums shown in the Schedule of Benefits.

We will not pay this benefit for an emergency room stay, an outpatient stay, or a stay in an Observation Unit.

Confinement for the same or related condition within 30 days of discharge will be treated as a continuation of the prior Confinement. Successive Confinements separated by more than 30 days will be treated as a new and separate Confinement.

EXCLUSIONS AND LIMITATIONS

With respect to benefits provided under this Certificate, no benefits will be payable as the result of:

1. A Covered Person's suicide or attempted suicide, while sane or insane.
2. A Covered Person's intentionally self-inflicted injury.
3. Rest care or rehabilitative care and treatment.
4. Immunization shots and routine examinations such as: physical examinations, mammograms, Pap smears, immunizations, flexible sigmoidoscopy, prostate-specific antigen tests and blood screenings. This exclusion does not apply to coverage under the optional Wellness Indemnity Benefit Rider, if attached as part of the contract.
5. Any pregnancy of a Dependent Child, including Confinement rendered to her Child after birth.
6. Routine newborn care. This exclusion does not apply to coverage under the optional Wellness Indemnity Benefit Rider, if attached as part of the contract.
7. A Covered Person's abortion, except for medically necessary abortions performed to save the mother's life.
8. The treatment of:
   a. A Covered Person's mental or emotional disorder. This exclusion does not apply to coverage under the optional Inpatient Mental and Nervous Disorder Indemnity Benefit Rider, if attached as part of the contract.
   b. A Covered Person's alcoholism or drug addiction. This exclusion does not apply to coverage under the optional Inpatient Drug and Alcohol Addiction Indemnity Benefit Rider, if attached as part of the contract.
9. A Covered Person's participation in a riot, or insurrection.

10. Dental care or treatment, except for such care or treatment due to Accidental Injury to sound natural teeth within 12 months of the Accident and except for dental care or treatment necessary due to congenital disease or anomaly.
11. Any Accident caused by the participation in any activity or event, including the operation of a vehicle, while under the influence of a controlled substance (unless administered by a Physician or taken according to the Physician's instructions) or while intoxicated (intoxicated means that condition as defined by the law of the jurisdiction in which the Accident occurred).
12. A Covered Person's sex change, reversal of tubal ligation or reversal of vasectomy.
13. Artificial insemination, in vitro fertilization, and test tube fertilization, including any related testing, medications or Physician's services, unless required by law.
14. Committing, attempting to commit, or taking part in a felony or assault, or engaging in an illegal occupation.
15. Traveling in or descending from any vehicle or device for aerial navigation, except as a fare-paying passenger in an aircraft operated by a commercial airline (other than a charter airline) on a regularly scheduled passenger trip.
16. Any loss incurred while a Covered Person is on active duty status in the armed forces. (If you notify us of such active duty, we will refund any premiums paid for any period for which no coverage is provided as a result of this exception.)
17. An Accident or Sickness arising out of or in the course of any occupation for compensation, wage or profit or for which benefits may be payable under an Occupational Disease Law or similar law, whether or not application for such benefits has been made.
18. A Covered Person's involvement in any war or act of war, whether declared or undeclared.

PREMIUMS

All premiums are payable on or before the date they are due.

Premium Changes - We have the right to change the premium rates on any premium due date in accordance with the terms of the Policy. If the rates are changed, we will give at least a 60-day advance written notice to the Policyholder.

If the premiums increase because a change in benefits increases our liability, premium rates may be changed on the date that our liability is increased, without regard to any premium rate guarantee. If such premium increase takes place on a date other than a premium due date, a pro rata premium for the increase will be due on the next premium due date. The pro rata premium will be for the period from the date of the increase to the next premium due date. If such premium is not paid when due, the coverage will automatically be terminated as of the date the pro rata premium was due. Any partial payment of premium will be refunded.

Premium Refunds - If your Spouse or Other Adult Dependent is covered and you divorce or legally terminate the Other Adult Dependent relationship or such Dependent dies and we are notified in writing at our Administrative Office, we will refund premiums for the period of time following the date of divorce/dissolution or death of such Dependent. Premiums will not be refunded for any period prior to 30 days before such notification is received in our Administrative Office.

If your Children are covered and coverage for all Children ends, we will refund premiums for the period of time following the last day of coverage. We must be notified in writing at our Administrative Office. Premiums will not be refunded for any time period prior to 30 days before such notification is received in our Administrative Office.

Unpaid Premiums - Any premium due and unpaid may be deducted from a claim payment.

TERMINATION OF INSURANCE

Subject to the Portability Option, your insurance will cease on the earliest of:
1. The date the Policy terminates, subject to the Portability Option;
2. The date you cease to be eligible for coverage;
3. The date of your death;
4. The premium due date on which we fail to receive your premium, subject to the Grace Period provision; or
5. The date you send us a written notice that you want to cancel coverage.

The insurance on a Dependent will cease on the earliest of:
1. The date your coverage terminates;
2. The premium due date on which we fail to receive your premium, subject to the Grace Period provision;
3. The date the Dependent Child no longer meets the definition of Child;
4. The date a Covered Spouse or Other Adult Dependent no longer meets the definition of same;
5. The date the Policy is modified so as to exclude Dependent coverage; or
6. The date you send us a written notice that you want to cancel coverage on your Dependent.

We will have the right to terminate the coverage of any Covered Person who submits a fraudulent claim under the Policy.

Termination of your insurance will not affect any claim which begins before the date of termination.

PORTABILITY OPTION

If you lose eligibility for this insurance for any reason other than nonpayment of premiums, you will have the option to continue this Certificate (including any Riders, if applicable) by paying the premiums directly to us at our Administrative Office within 31 days after this insurance terminates. We will bill you for these premiums after you notify us to continue this coverage. The premiums you pay directly to us may exceed the premiums that were paid through the Policyholder due to increased administrative costs for direct billing. If you stop paying the premiums under this option, this coverage will cease, subject to the terms of the Grace Period.

This Portability Option is only available for the Insured and the Insured's Dependents; it is not available for the Insured's Dependents without the Insured.

CLAIM PROVISIONS

Notice of Claim – Written notice of claim must be given to us at our Administrative Office, or to our agent. Such notice should be made within 30 days after any loss covered by the contract. If it is not reasonably possible to give notice within that time, the claim may not be denied or reduced due to the delay, so long as notice is given as soon as reasonably possible.

Claim Forms – Claim forms should be used for filing Proof of Loss. We will send such form to the claimant within 15 days of receipt of notice of claim. If we fail to supply the proper claim forms within 15 days, you can give proof in writing, setting forth the nature and extent of the loss within the time stated in the Proof of Loss provision. You or a personal representative may obtain a claim form by calling our toll-free telephone number listed on the cover page.

Proof of Loss – Due written Proof of Loss must be given to us at our Administrative Office. In case of a claim for loss for which a periodic payment is provided contingent upon continuing loss, such satisfactory written Proof of Loss must be sent within 90 days after the termination of the period for which we are liable. For any other loss, proof must be sent within 90 days after the date of such loss.

Failure to furnish such proof within such time will not invalidate nor reduce any claim if it was not reasonably possible to furnish such proof and it was furnished as soon as reasonably possible. In any event, the proof required must be given no later than one year from the time of loss, unless the claimant was legally incapacitated.

Payment of Claim Benefits – All benefits payable under your Certificate will be paid to you, unless you have assigned such benefits. Any benefits that are not paid at your death will be paid to your Spouse or Other Adult Dependent or if there is no Spouse or Other Adult Dependent, then to your estate. We may pay up to $1,000 of such benefit to one of your relatives at our discretion. Such payment fully discharges us to the extent of the payment.

Physical Examinations And Autopsy - We have the right to have a Covered Person examined by a Physician of our choice as often as reasonably necessary while a claim is pending. In case of death, we may request an autopsy where it is not forbidden by law. We will pay for such examination or autopsy.

Time of Payment of Claims – Benefits for a covered loss will be paid as soon as we receive due written Proof of Loss.

GENERAL PROVISIONS

Clerical Error – A clerical error by us will not invalidate insurance otherwise in force, nor continue insurance otherwise not validly in force.

Conformity with State Laws – A provision of the Policy or Certificate that conflicts with a law of the governing jurisdiction is hereby changed to meet the minimum standards of that law.

Entire Contract; Changes – The Entire Contract consists of the Policy as issued to the Policyholder, the Policyholder Application, the Certificate Provisions, and any attached Amendments, Endorsements, and Riders. Only our President, Vice President, Secretary, or an Assistant Secretary may make any changes to the Policy or this Certificate and then only in writing.

No agent or Policyholder has authority to change the Policy or this Certificate or to waive any of its provisions. Any changes are subject to the laws of the governing jurisdiction.

Grace Period – A Grace Period of 31 days will be allowed for each premium payment after the first premium. Coverage will stay in force during this time. The coverage under the Policy and/or Certificate will terminate at the end of the Grace Period if the premium has not been paid. You must still pay all unpaid premium. This includes the premium due for the Grace Period.

If coverage is canceled on a premium due date and the premium has been paid through that date, the Grace Period will not apply. If cancellation is during the Grace Period, you will be liable for any unpaid premium including the pro rata premium for that part of the Grace Period during which coverage was in force. Benefits may be reduced by the amount of any due but unpaid premiums.

Legal Action – No legal action may be brought to recover under the Policy or Certificate within 60 days after written Proof of Loss has been provided to us as required nor more than three years from the time written Proof of Loss is required to be furnished.

Misstatement of Age – If the Covered Person's age has been misstated, the Covered Person's true age will be used to adjust the premium or adjust the benefits paid.

Other Insurance With Us - If you have more than one hospital indemnity policy, certificate, or similar coverage with us, only the one chosen by you will remain in effect. We will refund all premiums paid for any other such coverage.

Time Limit on Certain Defenses
Misstatements in the Application - We will not use any statement, except fraudulent statements, to void or reduce benefits after coverage has been in effect for two years. Any such statement would have to be in a signed form. This also applies to all Riders. Any increase in benefit amounts is subject to a new two year contestable period for the increased amount only.

All statements made are considered representations and not warranties. No such statement will be used in any contest, unless a copy of such statement has been furnished to you.

Notices Given by Us – Any notice to you will be sent to your last known address.

TRANSAMERICA LIFE INSURANCE COMPANY

Home Office: Cedar Rapids, Iowa 52499
Administrative Office: P.O. Box 310, Grapevine, Texas 76099-0310
(Hereinafter called "the Company," "we," "us," or "our")

NEVADA AMENDMENT

This Amendment is part of the contract to which it is attached. The contract is amended as follows for the contracts issued in the State of Nevada.

The following right to file a complaint notice and contact information applies to the Policy and the Certificate:

YOU HAVE THE RIGHT TO PROVIDE AN ORAL COMPLAINT OR TO FILE A WRITTEN COMPLAINT
Any time that we deny a claim for a health care service or we limit coverage of such service to you, we will notify you in writing within 10 working days after denial of such coverage. Such notice will provide the reason for denying coverage of the service. We will provide the criteria used in determining whether to authorize or deny coverage of the health care service. You have the right to provide an oral complaint or to file a written complaint to our Administrator listed on the Policy's cover page.

CONTACT INFORMATION
If you have any questions or concerns, please contact our Administrative Office. If you wish to contact the Nevada Department of Insurance, you may contact them online for instructions on submitting a Consumer Complaint Form:

Nevada Division of Insurance – Consumer Services Section
http://doi.nv.gov

Schedule of Benefits – The Inpatient Drug and Alcohol Addiction Indemnity Benefit Rider, CRDA0400, and the Inpatient Mental and Nervous Disorder Indemnity Benefit Rider, CRMN0400, are not optional benefit riders. They are mandated benefit riders that are included in the base coverage of the Policy and/or the Certificate to which this Amendment is attached.

Exclusions and Limitations section is deleted and replaced as follows:

EXCLUSIONS AND LIMITATIONS

With respect to benefits provided under this Certificate, no benefits will be payable as the result of:

1. A Covered Person's suicide or attempted suicide, while sane or insane.
2. A Covered Person's intentionally self-inflicted injury.
3. Rest care or rehabilitative care and treatment.
4. Immunization shots and routine examinations such as: physical examinations, mammograms, Pap smears, immunizations, flexible sigmoidoscopy, prostate-specific antigen tests and blood screenings. This exclusion does not apply to coverage under the optional Wellness Indemnity Benefit Rider, if attached as part of the contract.
5. Any pregnancy of a Dependent Child, including Confinement rendered to her Child after birth.
6. Routine newborn care. This exclusion does not apply to coverage under the optional Wellness Indemnity Benefit Rider, if attached as part of the contract.
7. A Covered Person's abortion, except for medically necessary abortions performed to save the mother's life.
8. A Covered Person's participation in a riot, or insurrection.
9. Dental care or treatment, except for such care or treatment due to Accidental Injury to sound natural teeth within 12 months of the Accident and except for dental care or treatment necessary due to congenital disease or anomaly.
10. A Covered Person's sex change, reversal of tubal ligation or reversal of vasectomy. (However, hospitalization resulting from complications of sexual reassignment would be covered.) "Sex change" is defined as the usage of hormone treatment and surgery to alter the biological sex of an individual to those of the opposite sex.

11. Artificial insemination, in vitro fertilization, and test tube fertilization, including any related testing, medications or Physician's services, unless required by law.
12. Committing, attempting to commit, or taking part in a felony or assault, or engaging in an illegal occupation.
13. Traveling in or descending from any vehicle or device for aerial navigation, except as a fare-paying passenger in an aircraft operated by a commercial airline (other than a charter airline) on a regularly scheduled passenger trip.
14. Any loss incurred while a Covered Person is on active duty status in the armed forces. (If you notify us of such active duty, we will refund any premiums paid for any period for which no coverage is provided as a result of this exception.)
15. An Accident or Sickness arising out of or in the course of any occupation for compensation, wage or profit or for which benefits may be payable under an Occupational Disease Law or similar law, whether or not application for such benefits has been made.
16. A Covered Person's involvement in any war or act of war, whether declared or undeclared.

Grace Period provision – This provision is replaced in the Policy and Certificate as follows:

Grace Period – A Grace Period of 31 days will be allowed for each premium payment after the first premium. Coverage will stay in force during this time. The Policy and/or Certificate will then terminate retroactively to the end of the day next preceding the Grace Period. We will not be required to pay claims incurred during the Grace Period while a required premium remains unpaid and may seek reimbursement for any such claim erroneously paid during the Grace Period. We are liable for any claims incurred during the Grace Period if the required premium payment is received during the Grace Period.

The Grace Period will not apply if coverage is canceled on a premium due date and the premium has been paid through that date.

Policy – Policy Changes and Termination section – **Termination** provision – item 1 – the requirement for a 60-day advance written request is removed. It now reads as:

Termination – This Policy will end on the earliest of the following events:

1. If the Policyholder submits a written request to us to terminate this Policy, this Policy will terminate on the date specified in that request.

This Amendment does not waive, alter, or extend any conditions or provisions of the contract except to the extent shown. It is subject to all the terms and limitations of the contract. This Amendment takes effect and expires concurrently with the contract to which it is attached.

This Amendment is signed for the Company at our Home Office to take effect on the contract's Effective Date.

Craig D. Vermeer

General Counsel and Secretary

TRANSAMERICA LIFE INSURANCE COMPANY

Home Office: Cedar Rapids, Iowa 52499
Administrative Office: P.O. Box 310, Grapevine, Texas 76099-0310
(Hereinafter called "the Company," "we," "us," or "our")

AMBULANCE INDEMNITY BENEFIT RIDER

This Rider is attached to and made part of the contract as of the Rider Effective Date. It is issued in consideration of the Application and payment of any required initial premium. All provisions of the contract not in conflict with the provisions of this Rider apply to this Rider.

BENEFIT

We will pay the Ambulance Indemnity Benefit amount shown in the Schedule of Benefits for each day a Covered Person receives ambulance transportation to a Hospital or emergency center as the result of a covered Accident or Sickness. Ambulance service must be provided by a licensed ambulance company within 96 hours of the Accident or onset of Sickness. Benefits are subject to the maximums shown in the Schedule of Benefits.

RIDER EFFECTIVE DATE

This Rider becomes effective on the same date as the contract unless we inform the Insured in writing of a different date.

TERMINATION

This Rider will terminate on the earliest of the following dates or events:

1. The date the Rider or contract lapses for failure to pay premiums, subject to the Grace Period of the contract;
2. The date the Insured requests termination;
3. The date of the Insured's death; or
4. The date the contract terminates.

This Rider is signed for the Company at our Home Office to take effect on the Rider Effective Date.

Craig D. Vermie — General Counsel and Secretary

Brenda Cleary — President

CRAMB400

THIS PAGE INTENTIONALLY LEFT BLANK

TRANSAMERICA LIFE INSURANCE COMPANY

Home Office: Cedar Rapids, Iowa 52499
Administrative Office: P.O. Box 310, Grapevine, Texas 76099-0310
(Hereinafter called "the Company," "we," "us," or "our")

CRITICAL ILLNESS INDEMNITY BENEFIT RIDER

NOTICE: This Rider only pays a benefit for the specified diseases defined below.

This Rider is attached to and made part of the contract as of the Rider Effective Date. It is issued in consideration of the Application and payment of any required initial premium. All provisions of the contract not in conflict with the provisions of this Rider apply to this Rider.

DEFINITIONS

In addition to the definitions contained in the contract, the following definitions apply to this Rider.

Carcinoma In Situ – Cancer that is confined to the site of origin without having invaded neighboring tissue.

End Stage Renal Failure – The end stage failure which presents a chronic irreversible failure of both kidneys due to kidney disease and which requires treatment by renal dialysis or kidney transplant.

Heart Attack – The ischemic death of a portion of heart muscle as a result of obstruction of one or more of the coronary arteries. A positive diagnosis must be supported by either of the following criteria:

a. The presence of three or more of the following indicators:
   i. pain, pressure, fullness, discomfort or squeezing in the center of the chest;
   ii. radiating pain to shoulder(s), neck, back, arm(s) or jaw;
   iii. new EKG changes indicative of myocardial infarction;
   iv. diagnostic increase of specific cardiac markers typical for Heart Attack; and
   v. confirmatory imaging studies.
b. In the event of death, an autopsy confirmation identifying Heart Attack as the cause of death will be accepted.

Invasive Cancer – A Cancer which is evidenced by the presence of a malignant tumor characterized by uncontrolled and abnormal growth and spread of malignant cells, and the invasion of tissue. Leukemia, Hodgkin's Disease (except Stage 1 Hodgkin's Disease), and malignant melanoma will be considered Invasive Cancer.

Invasive Cancer does not include:

a. Carcinoma in Situ;
b. Pre-malignant conditions or conditions with malignant potential;
c. Prostatic Cancers which are histologically described as TNM Classification T1 (including T1(a) or T1(b), or of other equivalent or lesser classification);
d. Any malignancy associated with the diagnosis of HIV; or
e. Skin Cancer.

Major Organ Failure – The irreversible failure of a Covered Person's heart, lung, pancreas, entire kidney or any combination for which a Physician has determined that the complete replacement of such organ with an entire organ from a human donor is necessary. It can also be the irreversible failure of a Covered Person's liver for which a Physician has determined that the complete or partial replacement of the liver or liver tissue from a human donor is necessary. The need for a transplant must be due to severe organ disease.

Skin Cancer – Basal cell epithelioma or squamous cell carcinoma. Skin Cancer does not include malignant melanoma or mycosis fungoides which are not considered skin cancers under this Rider for the purpose of paying benefits.

Stroke – A cerebrovascular event resulting in permanent neurological damage, including infarction, hemorrhage or embolization of brain tissue from an extracranial source. The diagnosis must be based on:

a. Documented neurological deficits; and
b. Confirmatory neuron-imaging studies.

Stroke does not include cerebral symptoms due to:
a. Transient ischemic attack (TIA);
b. Reversible neurological deficit;
c. Migraine;
d. Cerebral injury resulting from trauma or hypoxia; or
e. Vascular disease affecting the eye, optic nerve or vestibular functions.

BENEFITS

Each of the following benefits is payable only one time per Covered Person and is payable in addition to any other benefit in the contract or this Rider. Diagnosis must be made after the Effective Date of this Rider.

Critical Illness Benefit – We will pay the Critical Illness Benefit amount shown in the Schedule of Benefits when a Covered Person is diagnosed with Invasive Cancer, a Heart Attack, a Stroke, End Stage Renal Failure or Major Organ Failure.

Subsequent Critical Illness Benefit – We will pay the Subsequent Critical Illness Benefit amount shown on the Schedule of Benefits when a Covered Person is subsequently diagnosed with a specified disease different from that for which we have already paid the Critical Illness Benefit, as follows. The subsequent specified disease must be Invasive Cancer, a Heart Attack, a Stroke, End Stage Renal Failure or Major Organ Failure. The subsequent specified disease must first manifest itself and be diagnosed more than 60 days after the specified disease diagnosis for which we have already paid the Critical Illness Benefit. The Subsequent Critical Illness Benefit is NOT payable for Skin Cancer or Carcinoma In Situ.

Skin Cancer Benefit – We will pay the Skin Cancer Benefit amount shown in the Schedule of Benefits when a Covered Person is diagnosed as having Skin Cancer.

Carcinoma In Situ Benefit – We will pay the Carcinoma In Situ Benefit amount shown in the Schedule of Benefits when a Covered Person is diagnosed as having Carcinoma In Situ.

NOTE: Invasive Cancer, Carcinoma In Situ and Skin Cancer must be diagnosed by a pathological or clinical diagnosis. We will accept a clinical diagnosis in lieu of a pathological diagnosis only when:
a. A pathological diagnosis cannot be made because it is medically inappropriate or life-threatening;
b. There is medical evidence to support the diagnosis; and
c. A Physician is treating a Covered Person for Cancer.

RIDER EFFECTIVE DATE

This Rider becomes effective on the same date as the contract unless we inform the Insured in writing of a different date.

TERMINATION

This Rider will terminate on the earliest of the following dates or events:
1. The date the Rider or contract lapses for failure to pay premiums, subject to the Grace Period of the contract;
2. The date the Insured requests termination;
3. The date of the Insured's death; or
4. The date the contract terminates.

This Rider is signed for the Company at our Home Office to take effect on the Rider Effective Date.

Craig D. Vermie
General Counsel and Secretary

Linda Clancy
President

TRANSAMERICA LIFE INSURANCE COMPANY

Home Office: Cedar Rapids, Iowa 52499
Administrative Office: P.O. Box 310, Grapevine, Texas 76099-0310
(Hereinafter called "the Company," "we," "us," or "our")

HOSPITAL CONFINEMENT INDEMNITY BENEFIT RIDER

This Rider is attached to and made part of the contract as of the Rider Effective Date. It is issued in consideration of the Application and payment of any required initial premium. All provisions of the contract not in conflict with the provisions of this Rider apply to this Rider.

BENEFIT

We will pay the Hospital Confinement Indemnity Benefit amount shown in the Schedule of Benefits for each day a Covered Person is Confined to a Hospital as the result of a covered Accident or Sickness. Confinement must begin while this Rider is in force and must last a minimum of 24 continuous hours from time of admission as a resident bed patient. Each stay in a Hospital must meet the definition of Confinement. Benefits are limited to the maximums shown in the Schedule of Benefits.

We will not pay this benefit for an emergency room stay, an outpatient stay, or a stay in an Observation Unit.

Confinement for the same or related condition within 30 days of discharge will be treated as a continuation of the prior Confinement. Successive Confinements separated by more than 30 days will be treated as a new and separate Confinement.

RIDER EFFECTIVE DATE

This Rider becomes effective on the same date as the contract unless we inform the Insured in writing of a different date.

TERMINATION

This Rider will terminate on the earliest of the following dates or events:
1. The date the Rider or contract lapses for failure to pay premiums, subject to the Grace Period of the contract;
2. The date the Insured requests termination;
3. The date of the Insured's death; or
4. The date the contract terminates.

This Rider is signed for the Company at our Home Office to take effect on the Rider Effective Date.

Craig D. Vermie — General Counsel and Secretary

Linda Clancy — President

THIS PAGE INTENTIONALLY LEFT BLANK

TRANSAMERICA LIFE INSURANCE COMPANY

Home Office: Cedar Rapids, Iowa 52499
Administrative Office: P.O. Box 310, Grapevine, Texas 76099-0310
(Hereinafter called "the Company," "we," "us," or "our")

INPATIENT DRUG AND ALCOHOL ADDICTION INDEMNITY BENEFIT RIDER

This Rider is attached to and made part of the contract as of the Rider Effective Date. It is issued in consideration of the Application and payment of any required initial premium. All provisions of the contract not in conflict with the provisions of this Rider apply to this Rider.

BENEFIT

We will pay the Inpatient Drug and Alcohol Addiction Indemnity Benefit amount shown in the Schedule of Benefits for each day a Covered Person is confined, on an inpatient basis, to a Hospital or residential treatment facility as the result of alcohol or drug addiction. Confinement must begin while this Rider is in force and last for a minimum of 24 continuous hours. Benefits are subject to the maximums shown in the Schedule of Benefits.

RIDER EFFECTIVE DATE

This Rider becomes effective on the same date as the contract unless we inform the Insured in writing of a different date.

TERMINATION

This Rider will terminate on the earliest of the following dates or events:
1. The date the Rider or contract lapses for failure to pay premiums, subject to the Grace Period of the contract;
2. The date the Insured requests termination;
3. The date of the Insured's death; or
4. The date the contract terminates.

This Rider is signed for the Company at our Home Office to take effect on the Rider Effective Date.

Craig D. Vermie — General Counsel and Secretary

Brenda Clancy — President

THIS PAGE INTENTIONALLY LEFT BLANK

TRANSAMERICA LIFE INSURANCE COMPANY

Home Office: Cedar Rapids, Iowa 52499
Administrative Office: P.O. Box 310, Grapevine, Texas 76099-0310
(Hereinafter called "the Company," "we," "us," or "our")

INPATIENT MENTAL AND NERVOUS DISORDER INDEMNITY BENEFIT RIDER

This Rider is attached to and made part of the contract as of the Rider Effective Date. It is issued in consideration of the Application and payment of any required initial premium. All provisions of the contract not in conflict with the provisions of this Rider apply to this Rider.

DEFINITIONS

In addition to the definitions contained in the contract, the following definition applies to this Rider.

Mental or Nervous Disorder - Includes neurosis, psychoneurosis, psychopathy, psychosis, or other mental or emotional disease or disorder of any kind.

BENEFIT

We will pay the Inpatient Mental and Nervous Disorder Indemnity Benefit amount shown in the Schedule of Benefits for 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. Confinement must begin while this Rider is in force and last for a minimum of 24 continuous hours. Benefits are subject to the maximums shown in the Schedule of Benefits.

RIDER EFFECTIVE DATE

This Rider becomes effective on the same date as the contract unless we inform the Insured in writing of a different date.

TERMINATION

This Rider will terminate on the earliest of the following dates or events:
1. The date the Rider or contract lapses for failure to pay premiums, subject to the Grace Period of the contract;
2. The date the Insured requests termination;
3. The date of the Insured's death; or
4. The date the contract terminates.

This Rider is signed for the Company at our Home Office to take effect on the Rider Effective Date.

Craig D. Vermie — General Counsel and Secretary

Linda Clarke — President

THIS PAGE INTENTIONALLY LEFT BLANK

TRANSAMERICA LIFE INSURANCE COMPANY

Home Office: Cedar Rapids, Iowa 52499
Administrative Office: P.O. Box 310, Grapevine, Texas 76099-0310
(Hereinafter called "the Company," "we," "us," or "our")

OFF-THE-JOB ACCIDENTAL INJURY INDEMNITY BENEFIT RIDER

This Rider is attached to and made part of the contract as of the Rider Effective Date. It is issued in consideration of the Application and payment of any required initial premium. All provisions of the contract not in conflict with the provisions of this Rider apply to this Rider.

DEFINITIONS

In addition to the definitions contained in the contract, the following definition applies to this Rider.

Off-the-Job Accidental Injury - An injury which is caused by an Accident that does not occur while in the course of any legal or illegal occupation, activity, or employment for pay, benefit or profit.

BENEFIT

We will pay the Off-the-Job Accidental Injury Indemnity Benefit amount shown in the Schedule of Benefits for each day a Covered Person receives treatment for a covered Accident. Treatment must be provided by a Physician in the Physician's office, clinic, urgent care facility or Hospital emergency room within 96 hours of the Accident. Benefits are limited to the maximums shown in the Schedule of Benefits.

RIDER EFFECTIVE DATE

This Rider becomes effective on the same date as the contract unless we inform the Insured in writing of a different date.

TERMINATION

This Rider will terminate on the earliest of the following dates or events:
1. The date the Rider or contract lapses for failure to pay premiums, subject to the Grace Period of the contract;
2. The date the Insured requests termination;
3. The date of the Insured's death; or
4. The date the contract terminates.

This Rider is signed for the Company at our Home Office to take effect on the Rider Effective Date.

Craig D. Vermie — General Counsel and Secretary

Brenda Cleary — President

CRACIN00

THIS PAGE INTENTIONALLY LEFT BLANK

TRANSAMERICA LIFE INSURANCE COMPANY

Home Office: Cedar Rapids, Iowa 52499
Administrative Office: P.O. Box 310, Grapevine, Texas 76099-0310
(Hereinafter called "the Company," "we," "us," or "our")

OUTPATIENT ADVANCED STUDIES DIAGNOSTIC TEST INDEMNITY BENEFIT RIDER

This Rider is attached to and made part of the contract as of the Rider Effective Date. It is issued in consideration of the Application and payment of any required initial premium. All provisions of the contract not in conflict with the provisions of this Rider apply to this Rider.

DEFINITIONS

In addition to the definitions contained in the contract, the following definition applies to this Rider.

Advance Studies Diagnostic Test - Includes the following tests performed on an outpatient basis.

1. Computer tomography scan (CT);
2. Magnetic resonance imaging (MRI);
3. Myelogram;
4. Positron emission tomography (PET);
5. Angiogram;
6. Arteriogram; and
7. Thallium stress test.

BENEFIT

We will pay the Outpatient Advance Studies Diagnostic Test Indemnity Benefit amount shown in the Schedule of Benefits for each day a Covered Person undergoes an Advance Studies Diagnostic Test for the purpose of diagnosing a covered Accident or Sickness. Benefits are subject to the maximums shown in the Schedule of Benefits.

RIDER EFFECTIVE DATE

This Rider becomes effective on the same date as the contract unless we inform the Insured in writing of a different date.

TERMINATION

This Rider will terminate on the earliest of the following dates or events:
1. The date the Rider or contract lapses for failure to pay premiums, subject to the Grace Period of the contract;
2. The date the Insured requests termination;
3. The date of the Insured's death; or
4. The date the contract terminates.

This Rider is signed for the Company at our Home Office to take effect on the Rider Effective Date.

Craig D. Vermie — General Counsel and Secretary

Brenda Cleary — President

THIS PAGE INTENTIONALLY LEFT BLANK

TRANSAMERICA LIFE INSURANCE COMPANY

Home Office: Cedar Rapids, Iowa 52499
Administrative Office: P.O. Box 310, Grapevine, Texas 76099-0310
(Hereinafter called "the Company," "we," "us," or "our")

OUTPATIENT DIAGNOSTIC LABORATORY TEST INDEMNITY BENEFIT RIDER

This Rider is attached to and made part of the contract as of the Rider Effective Date. It is issued in consideration of the Application and payment of any required initial premium. All provisions of the contract not in conflict with the provisions of this Rider apply to this Rider.

BENEFIT

We will pay the Outpatient Diagnostic Laboratory Test Indemnity Benefit amount shown in the Schedule of Benefits when for each day a Covered Person undergoes a diagnostic laboratory test, on an outpatient basis, for the purpose of diagnosing a covered Accident or Sickness. Benefits are subject to the maximums shown in the Schedule of Benefits.

This Rider does not pay a benefit for any tests covered by any other Rider attached to the contract.

RIDER EFFECTIVE DATE

This Rider becomes effective on the same date as the contract unless we inform the Insured in writing of a different date.

TERMINATION

This Rider will terminate on the earliest of the following dates or events:
1. The date the Rider or contract lapses for failure to pay premiums, subject to the Grace Period of the contract;
2. The date the Insured requests termination;
3. The date of the Insured's death; or
4. The date the contract terminates.

This Rider is signed for the Company at Our Home Office to take effect on the Rider Effective Date.

Craig D. Vermie — General Counsel and Secretary

Linda Clancy — President

THIS PAGE INTENTIONALLY LEFT BLANK

TRANSAMERICA LIFE INSURANCE COMPANY

Home Office: Cedar Rapids, Iowa 52499
Administrative Office: P.O. Box 310, Grapevine, Texas 76099-0310
(Hereinafter called "the Company," "we," "us," or "our")

OUTPATIENT PHYSICIAN OFFICE VISIT INDEMNITY BENEFIT RIDER

This Rider is attached to and made part of the contract as of the Rider Effective Date. It is issued in consideration of the Application and payment of any required initial premium. All provisions of the contract not in conflict with the provisions of this Rider apply to this Rider.

DEFINITIONS

In addition to the definitions contained in the contract, the following definition applies to this Rider.

Urgent Care Center – An ambulatory care facility that provides immediate medical care by a Physician on an unscheduled, walk-in basis to patients for extended hours. The center must have on-site diagnostic X-ray and laboratory equipment and can be located within a Hospital or as a freestanding facility. Emergency rooms and walk-in primary care offices are not considered Urgent Care Centers.

BENEFIT

We will pay the Outpatient Physician Office Visit Indemnity Benefit amount shown in the Schedule of Benefits for each day a Covered Person receives outpatient treatment in a Physician's office or Urgent Care Facility as the result of a covered Accident or Sickness. Benefits are subject to the maximums shown in the Schedule of Benefits.

RIDER EFFECTIVE DATE

This Rider becomes effective on the same date as the contract unless we inform the Insured in writing of a different date.

TERMINATION

This Rider will terminate on the earliest of the following dates or events:
1. The date the Rider or contract lapses for failure to pay premiums, subject to the Grace Period of the contract;
2. The date the Insured requests termination;
3. The date of the Insured's death; or
4. The date the contract terminates.

This Rider is signed for the Company at Our Home Office to take effect on the Rider Effective Date.

Craig D. Vermie — General Counsel and Secretary

Brenda Cleary — President

THIS PAGE INTENTIONALLY LEFT BLANK

TRANSAMERICA LIFE INSURANCE COMPANY

Home Office: Cedar Rapids, Iowa 52499
Administrative Office: P.O. Box 310, Grapevine, Texas 76099-0310
(Hereinafter called "the Company," "we," "us," or "our")

OUTPATIENT SELECT DIAGNOSTIC TEST INDEMNITY BENEFIT RIDER

This Rider is attached to and made part of the contract as of the Rider Effective Date. It is issued in consideration of the Application and payment of any required initial premium. All provisions of the contract not in conflict with the provisions of this Rider apply to this Rider.

DEFINITIONS

In addition to the definitions contained in the contract, the following definition applies to this Rider.

Select Diagnostic Test – Includes the following tests performed on an outpatient basis.

1. X-rays;
2. Ultrasound;
3. Electroencephalogram (EEG); and
4. Sleep Studies

BENEFIT

We will pay the Outpatient Select Diagnostic Test Indemnity Benefit amount shown in the Schedule of Benefits for each day a Covered Person undergoes a Select Diagnostic Test for the purpose of diagnosing a covered Accident or Sickness. Benefits are subject to the maximums shown in the Schedule of Benefits.

RIDER EFFECTIVE DATE

This Rider becomes effective on the same date as the contract unless we inform the Insured in writing of a different date.

TERMINATION

This Rider will terminate on the earliest of the following dates or events:
1. The date the Rider or contract lapses for failure to pay premiums, subject to the Grace Period of the contract;
2. The date the Insured requests termination;
3. The date of the Insured's death; or
4. The date the contract terminates.

This Rider is signed for the Company at our Home Office to take effect on the Rider Effective Date.

Craig S. Vernon — General Counsel and Secretary

Brenda Clancy — President

CRSDT400

THIS PAGE INTENTIONALLY LEFT BLANK

TRANSAMERICA LIFE INSURANCE COMPANY

Home Office: Cedar Rapids, Iowa 52499
Administrative Office: P.O. Box 310, Grapevine, Texas 76099-0310
(Hereinafter called "the Company," "we," "us," or "our")

PRESCRIPTION DRUG INDEMNITY BENEFIT RIDER

This Rider is attached to and made part of the contract as of the Rider Effective Date. It is issued in consideration of the Application and payment of any required initial premium. All provisions of the contract not in conflict with the provisions of this Rider apply to this Rider.

BENEFIT

We will pay the Prescription Drug Indemnity Benefit amount shown in the Schedule of Benefits for each day a Covered Person fills a prescription for drugs as a result of a covered Accident or Sickness. Such drugs must be prescribed by a Physician. Benefits are limited to the maximums shown in the Schedule of Benefits.

RIDER EFFECTIVE DATE

This Rider becomes effective on the same date as the contract unless we inform the Insured in writing of a different date.

TERMINATION

This Rider will terminate on the earliest of the following dates or events:
1. The date the Rider or contract lapses for failure to pay premiums, subject to the Grace Period of the contract;
2. The date the Insured requests termination;
3. The date of the Insured's death; or
4. The date the contract terminates.

This Rider is signed for the Company at our Home Office to take effect on the Rider Effective Date.

Craig D. Vermie — General Counsel and Secretary

Brenda Clancy — President

THIS PAGE INTENTIONALLY LEFT BLANK

TRANSAMERICA LIFE INSURANCE COMPANY

Home Office: Cedar Rapids, Iowa 52499
Administrative Office: P.O. Box 310, Grapevine, Texas 76099-0310
(Hereinafter called "the Company," "we," "us," or "our")

SURGICAL AND ANESTHESIA INDEMNITY BENEFIT RIDER

This Rider is attached to and made part of the contract as of the Rider Effective Date. It is issued in consideration of the Application and payment of any required initial premium. All provisions of the contract not in conflict with the provisions of this Rider apply to this Rider.

DEFINITIONS

Outpatient Minor Surgical Procedure – Those surgical procedures performed on an outpatient basis that are in the following CPT Code ranges:

- Skin – Debridement, Biopsy, Excisions/Removals: (10021 - 11001); (11042 - 11313); (11400 - 11442)
- Nails: (11719 – 11740)
- Injection – Intralesional, Intradermal, Subcutaneous: (11900 - 11954)
- Destruction Of Lesions: (17000 - 17286)
- Injection, Removal, Aspiration: (20500 - 20612)
- Casts And Strapping (29000 – 29750)
- Venous, Arterial (36430 - 36680)
- Bone Marrow, Stem Cell (38204 - 38221)
- Mouth – Incision, Excision, Destruction (40800 - 40820
- Tongue, Floor Of Mouth (41000 - 41010)
- Tongue, Floor Of Mouth – Incisioin/Excision (41100 - 41110)
- Dentoalveolar – Incisions/Excisions (41800 - 42106)
- Excision/Endoscopy (46320 - 46615)
- Destruction, Lesions Of Anus & Liver Needle Biopsy (46900 – 47001)
- Antepartum & Fetal Invasive Services (59000 – 59051)
- Nerve Blockers (64400 – 64550)
- Eyelids – Incisions, Excisions, Closure (67700 – 67875)
- External Ear – Incisions/Excision (69000 – 69105)
- Middle Ear – Incision (69400 – 69436)

Venipuncture, CPT codes 36400 – 36425, is NOT considered surgery.

All other surgical procedures performed on an outpatient basis will be covered under the "Outpatient Surgical Indemnity Benefit" described below.

BENEFITS

The following benefits are limited to the maximums shown in the Schedule of Benefits.

Surgical Indemnity Benefit

We will pay the **Inpatient Surgical Benefit** amount shown on the Schedule of Benefits for each day a Covered Person undergoes surgery while Confined to a Hospital as the result of a covered Accident or Sickness.

We will pay the **Outpatient Surgical Benefit** amount shown in the Schedule of Benefits for each day a Covered Person undergoes surgery, on an outpatient basis, as the result of a covered Accident or Sickness. This benefit is not payable for an Outpatient Minor Surgical Procedure.

We will pay the **Outpatient Minor Surgical Benefit** amount shown in the Schedule of Benefits for each day a Covered Person undergoes an Outpatient Minor Surgical Procedure as the result of a covered Accident or Sickness.

Anesthesia Indemnity Benefit

For each day a surgical benefit, as outlined above, is paid and anesthesia is administered, we will also pay the **Anesthesia Indemnity Benefit** amount shown in the Schedule of Benefits

EXCLUSIONS AND LIMITATIONS

The Exclusions listed in the Contract will apply to this rider; however, the following exception applies to exclusion 10 of the Contract with regards to this Rider:

Benefits under this Rider will be paid for the following dental or oral surgery procedures:

- Excision of impacted third molars; or
- Closed or open reduction of fractures or dislocation of the jaw.

RIDER EFFECTIVE DATE

This Rider becomes effective on the same date as the contract unless we inform the Insured in writing of a different date.

TERMINATION

This Rider will terminate on the earliest of the following dates or events:

1. The date the Rider or contract lapses for failure to pay premiums, subject to the Grace Period of the contract;
2. The date the Insured requests termination;
3. The date of the Insured's death; or
4. The date the contract terminates.

This Rider is signed for the Company at our Home Office to take effect on the Rider Effective Date.

Craig D. Vermie — General Counsel and Secretary

Linda Clancy — President

TRANSAMERICA LIFE INSURANCE COMPANY

Home Office: Cedar Rapids, Iowa 52499
Administrative Office: P.O. Box 310, Grapevine, Texas 76099-0310
(Hereinafter called "the Company," "we," "us," or "our")

WELLNESS INDEMNITY BENEFIT RIDER

This Rider is attached to and made part of the contract as of the Rider Effective Date. It is issued in consideration of the Application and payment of any required initial premium. All provisions of the contract not in conflict with the provisions of this Rider apply to this Rider.

DEFINITIONS

In addition to the definitions contained in the contract, the following definition applies to this Rider.

Health Screening Test includes any of the following tests performed under the supervision of or recommendation by a Physician:

Blood test for triglycerides
Bone marrow testing
Breast ultrasound
CA 125 (blood test for ovarian cancer)
CA 15-3 (blood test for breast cancer)
CEA (blood test for colon cancer)
Chest X-ray
Colonoscopy
Fasting blood glucose test
Flexible sigmoidoscopy
Hemocult stool analysis
Immunizations
Mammography
Pap test
Physical Examinations
PSA (blood test for prostate cancer)
Serum cholesterol test to determine HDL/LDL level
Serum Protein Electrophoresis (blood test for myeloma)
Stress test on a bicycle or treadmill
Thermography

BENEFIT

Wellness Benefit
We will pay the Wellness Indemnity Benefit amount shown in the Schedule of Benefits for each day a Covered Person undergoes a Health Screening Test. Benefits are limited to the maximums shown in the Schedule of Benefits.

RIDER EFFECTIVE DATE

This Rider becomes effective on the same date as the contract unless we inform the Insured in writing of a different date.

TERMINATION

This Rider will terminate on the earliest of the following dates or events:
1. The date the Rider or contract lapses for failure to pay premiums, subject to the Grace Period of the contract;
2. The date the Insured requests termination;
3. The date of the Insured's death; or
4. The date the contract terminates.

This Rider is signed for the Company at our Home Office to take effect on the Rider Effective Date.

Craig D. Vermie — General Counsel and Secretary

Lynda Clary — President

CRHWEL00

THIS PAGE INTENTIONALLY LEFT BLANK

Limited Medical

TRANSAMERICA LIFE INSURANCE COMPANY

Transamerica Life Insurance Company
Home Office: Cedar Rapids, IA
Administrative Office: P.O. Box 8063
Little Rock, Arkansas 72203-8063

Life and Health Group Application and Agreement

Multi-State Version

Name of Group (*you, your*): MDC RESTAURANTS, LLC	Tax ID Number: 91-2132382	SIC Code:	Website Address: N/A
Street Address: 313 PILOT ROAD	City: LAS VEGAS	State: NEVADA	ZIP Code: 89119
Contact Name: VINCE EUPIERRE	Email Address: VINCE@MANCHADEV.com	Phone #: 702 420-4515	Fax #:
Nature of Group: RESTAURANT	# of Employees/Members: 116	# Eligible for Coverage: 1000	# of Years In Existence: 10
Billing Address: (*if different*) 2276 SAMPSON AVENUE #201	City: CORONA	State: CA	ZIP Code: 92879
Billing Contact Name: (*if different*) YVETTE GALINORE	Email Address: YGALINORE@MANCHADEV.COM	Phone #: (951) 271-4813	Fax #: (951) 271-4107

Billing Address Is For: ☒ Group Policyholder ☐ Third Party Administrator ☐ Premium Collection Agency *(Requires a Premium Collection Agreement)*

You hereby authorize Transamerica Life Insurance Company, our authorized agents or our enrollers (collectively referred to as we, us, or our) to offer each of your eligible employees/members the opportunity to purchase insurance coverage as described in this form. This authorization is based upon the following agreements:

1. We customarily conduct an annual enrollment program for your eligible employees/members. You will provide us with census data if needed for us to determine proper enrollment eligibility.
2. The initial enrollment shall take place from 12/15/13 to 12/31/13. You will provide us direct access to your employees/members to obtain applications through group meetings and individual interviews in a suitable location on your property during normal business hours, or through other means mutually agreed upon between you and us. Participation in your group must meet our minimum participation requirements. We reserve the right to withdraw from the enrollment and cancel any applications already obtained if these conditions are not satisfied.
3. Unless otherwise agreed upon by you and us, you will collect premium contributions from your participating employees/members and forward to us when due. We customarily bill you each month. You will forward the premiums due to us within 15 days of the receipt of the monthly bill. You will maintain records of all premium contributions from your employees/members while this agreement remains in force and for two years after it terminates. These records will remain open to inspection and audit by us during normal business hours during this time.
4. In the event of any misappropriation by you, your employees or your agents, of funds owed to us, you will reimburse us for our entire loss including attorney fees and expenses incurred in collection, and any benefits we would not have had to pay but for such misappropriation.
5. Do benefit selections vary by class? ☒ No ☐ Yes *(define classes below)* Contribution levels vary

Definition of Class 1:	Nevada employees
Definition of Class 2:	CA Employees
Definition of Class 3:	NV managers
Definition of Class 4:	CA managers

6. Eligibility for Insurance:

	Class 1	Class 2	Class 3	Class 4	
a. Employer Groups - eligible employees are defined as those who work at least	30	30	30	30	hours per week for you,
and have been so employed for at least	1	1	30	30	days.

b. Member Groups - eligible members are defined as members of an eligible class of members, who are in good standing in accordance with your by-laws, who are not currently disabled and are able to perform the normal activities of a person of like age and gender.

7. Is dependent coverage being offered? ☒ Yes ☐ No
If yes, do you include same-sex partners? ☐ No ☐ Yes, state mandate *(Not applicable in TX)* ☐ Yes, corporate decision *(attach eligibility requirements)*

Billing Information

Pay periods per year: 24	Payments will be remitted: ☐ After each deduction ☒ Monthly ☐ Other
Payroll deductions per year: 24	Premium amount on bill should reflect: ☐ Levelized amount over 12 months ☒ Actual amount of deductions occurring each month
First payroll deduction date:	Preferred billing sequence: ☒ Alphabetical ☐ Social Security Number ☐ Employee/Member ID ☐ Other BY DIVISION
First bill due date:	Preferred Billing Method: ☐ Paper ☐ Electronic *(via website)* ☒ Self-Bill — Multiple Billing Locations: ☐ No ☐ Yes *(attach listing)*

Name of Section 125 Plan Administrator *(if applicable)*	Plan Start Date	Plan Anniversary Date
	1/1/14	1/1/15

Fraud Warning

District of Columbia, Louisiana, Maryland, and Rhode Island
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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

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

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

New Jersey
I understand that any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties. I represent that all statements made to or attached to this application are true and complete to the best of my knowledge and belief.

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

Puerto Rico
Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

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

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

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

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

I understand and agree that this application will be made part of each group master policy issued as a result of this application. The Group listed above will be named as the Policyholder for each group master policy. I agree that no insurance will be effective until approved by us at our administrative office.

Signed in (City/State) LAS VEGAS, NV This 17 Day of (Month/Year) DECEMBER 2013

Signature of Officer — VinceQ MANCHADEV.com (Email Address)

VINCE EUPIERRE, MANAGING MEMBER
Print Name and Title of Officer

Signature of Licensed Agent/Producer — SherriG@Benebizworksite.com (Email Address)

Sherri Guedea — CP5033
Print Name of Licensed Agent/Producer — Agent/Producer Number — License Number

Insurance Selections

(Product and Rider availability subject to state approval)

Participation Requirement: Each group master policy requires a minimum of 2 covered lives or the state minimum, whichever is greater, in order to be issued and remain in force. Any group master policy that falls below this requirement may be terminated, subject to the notice requirements in the master policy. Special underwriting offers may require higher participation in order to continue receiving the special underwriting offer for new insureds.

☐ Group Universal Life Insurance – TransLegacy *Product not available in PR.* *Available as an individual policy in PA and VT.*	Group Contribution? ☐ Yes ☐ No *If yes, list amount or %:*	Requested Effective Date:

Coverage: ☐ High Face Amount ☐ High Accumulation Value "**Attach a copy of the Rate Sheet**"
Accelerated Death Benefit for Terminal Illness/Condition included in all states except MA.
Waiver of Monthly Deductions for Layoff included in all states except MA, MD, PA, TN, VT, and WA.

Accept	Decline	
☐	☐	Accelerated Death Benefit for Critical Care: ☐ 25% ☐ 50% ☐ 75% ☐ 100% *(Not available in CT, FL, MA, or NJ)*
☐	☐	Accelerated Death Benefit for Long Term Care *(Not available in MA or UT) (Only available to large group (51+) in FL)*
☐	☐	Extension of Benefits Rider *(Not available in CT, FL, MA, NC, NJ, PA, TX, UT, or VT)*
☐	☐	Accidental Death & Dismemberment *(Accidental Death in VT)*
☐	☐	Automatic Face Amount Increase Option: ☐ $1 ☐ $2 for ☐ 3 ☐ 5 years ☐ All Employees ☐ Employee Option
☐	☐	Child Level Term Insurance Rider *(Not available in VA)*
☐	☐	Level Term Insurance Rider: ☐ Employee Choice ☐ 10 year term only ☐ 20 year term only
☐	☐	Waiver of Monthly Deductions for Total Disability

Replacement: Are you replacing existing coverage? ☐ No ☐ Yes
IRS Type: ☐ Welfare Benefit Plan ☐ ERISA ☐ 5500 Required ☐ Other *(please explain)*

☐ Group Interest Sensitive Whole Life – Trans$ure *Product not available in PR.* *Available as an individual policy in VT.*	Group Contribution? ☐ Yes ☐ No *If yes, list amount or %:*	Requested Effective Date:

Coverage: ☐ Money Purchase ☐ Defined Benefit "**Attach a copy of the Rate Sheet**"
Accelerated Death Benefit for Terminal Illness/Condition included in all states except MA.
Waiver of Premium for Layoff included in all states except MA, MN, PA, and VT.

Accept	Decline	
☐	☐	Accelerated Death Benefit for Critical Care: ☐ 25% ☐ 50% ☐ 75% ☐ 100% *(Not available in CT, FL, MA, or NJ)*
☐	☐	Accelerated Death Benefit for Long Term Care *(Not available in MA or UT) (Only available to large group (51+) in FL)*
☐	☐	Extension of Benefits Rider *(Not available in CT, FL, MA, NC, NJ, PA, TX, UT or VT)*
☐	☐	Accidental Death & Dismemberment *(Not available in MN) (Accidental Death in VT)*
☐	☐	Child Level Term Insurance Rider *(Not available in VA)*
☐	☐	Waiver of Premium for Total Disability

Replacement: Are you replacing existing coverage? ☐ No ☐ Yes
IRS Type: ☐ Welfare Benefit Plan ☐ ERISA ☐ 5500 Required ☐ Other *(please explain)*

☐ Group Term Life Insurance – TAC$-Advantage *Product not available in VT.*	Group Contribution? ☐ Yes ☐ No *If yes, list amount or %:*	Requested Effective Date:

Coverage: Continuation of Coverage and Waiver of Premium included in all states.
Terminal Illness/Condition Accelerated Death Benefit included in all states except OR.

Accept	Decline	
☐	☐	Accelerated Death Benefit for Critical Care: ☐ 25% ☐ 50% ☐ 75% ☐ 100% *(Not available in CT, FL or OR)*
☐	☐	Accidental Death & Dismemberment

Replacement: Are you replacing existing coverage? ☐ No ☐ Yes
IRS Type: ☐ Section 125 ☐ Welfare Benefit Plan ☐ ERISA ☐ 5500 Required ☐ Other *(please explain)*

☐ Group Term Life Insurance – Trans Select *Product not available in IL, PR, or VT.*	Group Contribution? ☐ Yes ☐ No *If yes, list amount or %:*	Requested Effective Date:

Coverage: Accelerated Death Benefit for Terminal Illness/Condition included in all states except MA.
Waiver of Premium included in all states.
Waiver of Premium Due to Layoff or Strike included in all states except CT, MA, MD, NJ, TN, and VA.

	☐ 5 Year Term	☐ 10 Year Term	☐ 20 Year Term
Accelerated Death Benefit for Critical Care: *(Not available in CT, FL or MA)*	☐ 25% ☐ 50% ☐ 75% ☐ 100%	☐ 25% ☐ 50% ☐ 75% ☐ 100%	☐ 25% ☐ 50% ☐ 75% ☐ 100%
Accelerated Death Benefit for Long Term Care with Extension of Benefits *(Not available in CO, MA, MD, NV, TX, UT or WA) (Extension of Benefits not available in FL, NJ, or PA)*	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Accidental Death & Dismemberment *(Not available in MN or OH)*	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Replacement: Are you replacing existing coverage? ☐ No ☐ Yes
IRS Type: ☐ Section 125 ☐ Welfare Benefit Plan ☐ ERISA ☐ 5500 Required ☐ Other *(please explain)*

☐ Self-Administered Basic Term Life Insurance
Product not available in CA.

Group Contribution? ☑ Yes
Policyholder pays 100% of Basic Life Insurance

Requested Effective Date:

Coverage: ☐ With Benefit Reduction ☐ Without Benefit Reduction		Class 1	Class 2	Class 3	Class 4
Basic Life Insurance: ☐ Flat Amount ☐ Multiple of Salary/not to exceed					
☐ Supplemental Life Insurance: ☐ Flat Amount ☐ Multiple of Salary	Minimum				
	Maximum				
	In Increments of				
☐ Dependent Life Insurance: Child Coverage is always $10,000	Minimum				
	Maximum				
	In Increments of				
☐ Optional Accidental Death & Dismemberment? *(Not available in FL or MN)*		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Optional Critical Illness? *(Not available in CT, FL, MA, MO, NJ, SD, VA, VT, WA)*		$	$	$	$

Accelerated Death Benefit for Terminal Illness/Condition included in all states except MA and OH.
Waiver of Premium included in all states.
Replacement: Are you replacing existing coverage? ☐ No ☐ Yes
IRS Type: ☐ Section 125 ☐ Welfare Benefit Plan ☐ ERISA ☐ 5500 Required ☐ Other *(please explain)*

☐ Group Term Life and Accident Package - myPack
Product not available in VT.

Group Contribution? ☐ Yes ☐ No
If yes, list amount or %:

Requested Effective Date:

Coverage: *This is a package containing 2 separate products in a combined safe to offer simplified rates and special underwriting.*

Group Term Life Base: Ages 18-39: $50,000, Ages 40-49: $30,000, Ages 50-64: $15,000
Accelerated Death Benefit for Critical Care (25%) included for all states except CT, FL or OR.
Continuation of Coverage included in all states.
Terminal Illness/Condition Accelerated Death Benefit included in all states except OR.
Waiver of Premium included in all states.

Accept	Decline	
☐	☐	Optional Dependent Coverage
☐	☐	Group Term Life Buy-up: Ages 18-39: $25,000, Ages 40-49: $15,000, Ages 50-64: $7,500
☐	☐	TransAccident Accident-Only Insurance *(not available in CT, FL, GU, ID, MD, NV, NH, NM, PA, PR or WA)* Off-the-Job Accident Disability Rider with 6-Month Benefit Included. Sickness Disability Rider with 14-Day Elimination Period and 6-Month Benefit Included.

Replacement: Are you replacing existing coverage? ☐ No ☐ Yes
IRS Type: ☐ Section 125 ☐ Welfare Benefit Plan ☐ ERISA ☐ 5500 Required ☐ Other *(please explain)*
Workers' Compensation: Are all employees/members covered under Workers' Compensation? ☐ Yes ☐ No *(explain below)*

☐ Group Accident Insurance – AccidentAdvance
Product not available in MN, PR, VT, or WA.
Available as an individual policy in FL.

Group Contribution? ☐ Yes ☐ No
If yes, list amount or %:

Requested Effective Date:

Coverage: ☐ 24-Hour Coverage ☐ Off-the-Job Only Coverage ☐ HealthPak AccidentAdvance *(No Sickness DI Rider)*

			Plan 1	Plan 2	Plan 3
Module 1 – Accident Emergency Treatment Benefits			Units	Units	Units
Module 2 – Follow-Up Visits and Physical Therapy Benefits			Units	Units	Units
Module 3 – Initial Accident Hospitalization			Units	Units	Units
Accept	Decline	Optional Riders			
☐	☐	Accidental Death and Dismemberment Rider	Units	Units	Units
☐	☐	Accident Hospital & ICU Income Rider	Units	Units	Units
☐	☐	Expanded Benefits Rider	Units	Units	Units
☐	☐	Wellness Benefit Rider *(Not available in CO, CT, DC, MA, or NH)*	Units	Units	Units
☐	☐	Accident Only Disability Income Rider *(Not available in CA)*	Elimination Period-0 Days Benefit Period: ☐ 6 ☐ 12 Months		
☐	☐	Sickness Only Disability Income Rider *(Not available in CA, CT or NH)*	Elimination Period: 14 Days Benefit Period: ☐ 6 ☐ 12 Months		
☐	☐	Spouse/Off-the-Job Accident Only Disability Income Rider *(Not available in CA)*	Elimination Period-0 Days Benefit Period: 6 Months		

Replacement: Are you replacing existing coverage? ☐ No ☐ Yes
IRS Type: ☐ Section 125 ☐ Welfare Benefit Plan ☐ ERISA ☐ 5500 Required ☐ Other *(please explain)*
Workers' Compensation: Are all employees/members covered under Workers' Compensation? ☐ Yes ☐ No *(explain below)*

☐ Group Accident Insurance – TransAccident
Product not available in FL, GU, ID, MH, NH, NM, PA, PR, VT, or WA.

Group Contribution? ☐ Yes ☐ No
If yes, list amount or %:

Requested Effective Date:

Coverage: ☐ Total Plan ☐ Select Plan ☐ Custom Plan *(Attach Plan Design)* ☐ HealthPak TransAccident *(No Sickness DI Rider)*

Accept	Decline	
☐	☐	Accident Only Disability Income Rider Elimination Period-14 Days Benefit Period: ☐ 6 ☐ 12 Months
☐	☐	Sickness Only Disability Income Rider *(N/A in MO)* Elimination Period-14 Days Benefit Period: ☐ 6 ☐ 12 Months
☐	☐	Wellness Rider *(Not available in CT, IN or MA)*

Replacement: Are you replacing existing coverage? ☐ No ☐ Yes
IRS Type: ☐ Section 125 ☐ Welfare Benefit Plan ☐ ERISA ☐ 5500 Required ☐ Other *(please explain)*_____
Workers' Compensation: Are all employees/members covered under Workers' Compensation? ☐ Yes ☐ No *(explain below)*

☐ Individual Accident Insurance – AccidentSelect
Accident AnswerSelect in MN
Product not available in CT, FL, GU, MA, NJ, OR, VT, or WV.

Group Contribution? ☐ Yes ☐ No
If yes, list amount or %:

Requested Effective Date:

Coverage: ☐ Plan I ☐ Plan II

Accept	Decline	
☐	☐	Accident Only Disability Income Rider *(Not available in PA)*
☐	☐	Sickness Only Disability Income Rider *(Not available in MD, SC or VA) (Accident & Sickness Disability Rider in MN and OR)*

Replacement: Are you replacing existing coverage? ☐ No ☐ Yes
IRS Type: ☐ Section 125 ☐ Welfare Benefit Plan ☐ ERISA ☐ 5500 Required ☐ Other *(please explain)*_____
Workers' Compensation: Are all employees/members covered under Workers' Compensation? ☐ Yes ☐ No *(explain below)*

☐ Group Cancer Insurance – CancerSelect Plus
Product not available in MN, NH, PR, or VT.
Available as an individual policy in CT, FL, ID, MD, NJ, UT, WA.

Group Contribution? ☐ Yes ☐ No
If yes, list amount or %:

Requested Effective Date:

Coverage: ☐ CancerSelect Plus ☐ LIVESTRONG Cancer
☐ Assignment Offered (Blood Profile Option)

Accept	Decline		Plan 1	Plan 2	Plan 3
		Module 1 – Hospital Benefits	Units	Units	Units
		Module 2 – Surgery Benefits	Units	Units	Units
		Module 3 – Radiation and Chemotherapy Benefits	Units	Units	Units
		Module 4 – Wellness and Miscellaneous Benefits	Units	Units	Units
		Module 5 – Drug-Related Expense Benefits	Units	Units	Units
Accept	Decline	Optional Riders			
☐	☐	First Occurrence Rider *(Lump Sum Diagnosis Rider in SD)*	Units	Units	Units
☐	☐	Intensive Care Rider *(Not available in CT, NJ or WA) (Module 6 in TN)*	Units	Units	Units
☐	☐	Specified Disease Rider *(Not available in OR, SD or WA)*	Units	Units	Units

Replacement: Are you replacing existing coverage? ☐ No ☐ Yes
IRS Type: ☐ Section 125 ☐ Welfare Benefit Plan ☐ ERISA ☐ 5500 Required ☐ Other *(please explain)*

☐ Group CI Insurance – CriticalAssistance Advance
Product not available in CA, CO, FL, GA, MN, NJ, PR and WA.
Available as an individual policy in CT and MD.

Group Contribution? ☐ Yes ☐ No
If yes, list amount or %:

Requested Effective Date:

Coverage: ☐ CriticalAssistance Advance ☐ LIVESTRONG CI Advance
☐ Assignment Offered (Blood Profile Option)

Accept	Decline			
☐	☐	Cancer Benefit Rider		
☐	☐	Occupational HIV Benefit Rider *(Not available in OR)*		
☐	☐	Quality of Life Benefit Rider *(Not available in CT, HI, MA, NC, NH, OR, PA, SD, TN, or UT)*		
☐	☐	Recurrent Critical Illness Benefit Rider *(Not available in MA)* Benefit: ☐ 25% ☐ 50% ☐ $75%		
		Benefit Amount Paid For By:	Policyholder	Employee
☐	☐	Intensive Care Rider *(Not available in MD, NH, or VT)*		
☐	☐	Initial Hospitalization for Accidental Bodily Injury Benefit Rider *(Not available in CT, MA, MD, NH, PA, or VT)*		
☐	☐	Accident Emergency Treatment Benefit Rider *(Not available in CT, MA, MD, NH, PA, VT)*		
☐	☐	Wellness Benefit Rider		

Replacement: Are you replacing existing coverage? ☐ No ☐ Yes
IRS Type: ☐ Section 125 ☐ Welfare Benefit Plan ☐ ERISA ☐ 5500 Required ☐ Other *(please explain)*

☐ Group CI Insurance – CriticalAssistance Plus
Product not available in CT, GA, MN or PR.
Available as an Individual policy in FL, MD, NJ, TN, UT and WA.

Group Contribution? ☐ Yes ☐ No
If yes, list amount or %:

Requested Effective Date:

Coverage: ☐ CriticalAssistance Plus ☐ LIVESTRONG CI Plus
☐ Assignment Offered (Blood Profile Option)

Accept	Decline	
☐	☐	Cancer Benefit Rider *(Includes $50 Wellness)*
☐	☐	Occupational HIV Benefit Rider *(Not available in CA, FL or OR)*
☐	☐	Quality of Life Benefit Rider *(Not available in FL, HI, MA, NC, NJ, OR, PA, SD, TN, UT or WA)*
☐	☐	Cancer Screening Wellness Benefit Rider Additional Benefit: ☐ $50 ☐ $100

Replacement: Are you replacing existing coverage? ☐ No ☑ Yes
IRS Type: ☐ Section 125 ☐ Welfare Benefit Plan ☑ ERISA ☐ 5500 Required ☐ Other *(please explain)*

☐ Group CI Insurance – CriticalAssistance Select
Product not available in CT, GU, MA, MH, NH, PR or WA.
Available as an Individual policy in FL and MD.

Group Contribution? ☐ Yes ☑ No
If yes, list amount or %:

Requested Effective Date:

Coverage: ☐ With Benefit Reduction ☐ Without Benefit Reduction ☐ HealthPak CI ☐ LIVESTRONG CI Select *(Only available in GA)*

☐ Option A – Cancer, Heart Attack, Stroke, End Stage Renal Failure, and Major Organ Transplant
☐ Option B – Heart Attack and Stroke Only *(Not available in GA)*
☐ Option C – Cancer Only *(Not available in GA)*
☐ Option B and C – Heart Attack, Stroke, and Cancer Only *(Not available in GA)*

Replacement: Are you replacing existing coverage? ☐ No ☐ Yes
IRS Type: ☐ Section 125 ☐ Welfare Benefit Plan ☐ ERISA ☐ 5500 Required ☐ Other *(please explain)*

☐ Self-Administered Basic Critical Illness Insurance
Product not available in CA, CO, CT, FL, GA, GU, MD, MN, NH, NJ, PR, UT, VA, VT, or WA.

Group Contribution? ☑ Yes
Policyholder pays 100% of Basic CI Insurance

Requested Effective Date:

Coverage:

		Class 1	Class 2	Class 3	Class 4
Basic CI Insurance	Insured	$	$	$	$
	Dependents	$	$	$	$
☐ Cancer Benefit Rider		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Occupational HIV Benefit Rider *(Not available in OR)*		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Quality of Life Benefit Rider *(Not available in AK, MA, NC, OH, OR, PA, SD, TN)*		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Recurrent Critical Illness Benefit Rider *(0%, 25%, 50%, or 75%)* *(Not available in MA or SD)*		%	%	%	%
☐ Intensive Care Rider *($100-$1000)*	Policyholder Paid	$	$	$	$
	Insured Paid	$	$	$	$
☐ Optional CI Insurance *(Insured Paid)*	Minimum	$	$	$	$
	Maximum	$	$	$	$
	In Increments of	$	$	$	$
☐ Optional Dependent CI Insurance *(Insured Paid)* *(Cannot exceed 50% of Insured's Benefit)*	Minimum	$	$	$	$
	Maximum	$	$	$	$
	In Increments of	$	$	$	$

Replacement: Are you replacing existing coverage? ☐ No ☐ Yes
IRS Type: ☐ Section 125 ☐ Welfare Benefit Plan ☐ ERISA ☐ 5500 Required ☐ Other *(please explain)*

☐ Group Limited Benefit Indemnity – TransConnect
Product not available in CT, GU, MH, NH, NJ, PR and WA.
Large Employer Group Only (51+) in MA.

Group Contribution? ☐ Yes ☑ No
If yes, list amount or %:

Requested Effective Date:

Coverage: ☐ TransConnect ☐ HealthPak
Do you continuously maintain a medical plan? ☐ Yes ☐ No *(Product only available while you continuously maintain an underlying medical plan)*
How many plans are in force? ____ *(Attach a copy or plan summary of each plan and the most recent billing statement)*

	Class 1	Class 2	Class 3	Class 4
Hospital Inpatient Benefit Amount				
Underlying Medical Plan Deductible				

Replacement: Are you replacing existing coverage? ☐ No ☐ Yes
IRS Type: ☐ Section 125 ☐ Welfare Benefit Plan ☐ ERISA ☐ 5500 Required ☐ Other *(please explain)*

☐ Identity Theft Protection – LifeLock®
Services provided by LifeLock, Inc.

Group Contribution? ☐ Yes ☐ No
If yes, list amount or %:

Requested Effective Date:

☐ Group Short-Term Disability – TransDI Plus IncomeSelect in FL. *Product not available in CA, GU, PR or VT. Available as an individual policy in WA.*	Group Contribution? ☐ Yes ☐ No *If yes, list amount or %:*	Requested Effective Date:

Coverage: Accelerated Benefit For Terminal Illness Rider included in all states except CT.

		Class 1	Class 2	Class 3	Class 4
Maximum Monthly Benefit is the lesser of: *(Cannot exceed 60% or $5,000)*	Percentage of Salary	%	%	%	%
	Dollar Amount	$	$	$	$
Maximum Benefit Period (3, 6, 12 or 24 Months)		Months	Months	Months	Months
Accident Elimination Period (0, 7, 14, 30, 60, 90 or 180 Days)		Days	Days	Days	Days
Sickness Elimination Period (0, 7, 14, 30, 60, 90 or 180 Days)		Days	Days	Days	Days

Accept	Decline	Optional Riders/Benefits *(Optional Riders/Benefits are not available in FL)*
☐	☐	Accidental Death & Dismemberment Benefit Rider
☐	☐	Hospital Indemnity Benefit Rider
☐	☐	Survivor Benefit Rider
☐	☐	Limited Pre-existing Condition Benefit (25% of the Disability Benefit for up to 6 weeks)

Replacement: Are you replacing existing coverage? ☐ No ☐ Yes
IRS Type: ☐ Section 125 ☐ Welfare Benefit Plan ☐ ERISA ☐ 5500 Required ☐ Other *(please explain)* _____
Workers' Compensation: Are all employees/members covered under Workers' Compensation? ☐ Yes ☐ No *(explain below)*

☐ Group Short-Term Disability – TransDI Elite *Product not available in CA, FL, GU, PR, VT or WA.*	Group Contribution? ☐ Yes ☐ No *If yes, list amount or %:*	Requested Effective Date:

Coverage:

Maximum Monthly Benefit Amount	Guaranteed Issue up to $2,600; Simplified Issue $2,600 to $5,000
Not to exceed	60% of Salary
Maximum Benefit Period	6 Months or 12 Months (Employee Option)
Accident Elimination Period	0 Days
Sickness Elimination Period	14 Days
Accidental Death Benefit Rider	$2,000 Benefit
Occupational Benefit Rider	25% of the Disability Benefit Amount
Limited Pre-existing Condition Benefit	60% of the Disability Benefit Amount for up to 12 Weeks of Disability

Replacement: Are you replacing existing coverage? ☐ No ☐ Yes
IRS Type: ☐ Section 125 ☐ Welfare Benefit Plan ☐ ERISA ☐ 5500 Required ☐ Other *(please explain)* _____
Workers' Compensation: Are all employees/members covered under Workers' Compensation? ☐ Yes ☐ No *(explain below)*

☐ Self-Administered Basic Short-Term Disability *Product only available in TN and TX.*	Group Contribution? ☑ Yes Policyholder pays 100% of Basic Disability Ins.	Requested Effective Date:

Coverage: ☐ Monthly Benefit ☐ Weekly Benefit

		Class 1	Class 2	Class 3	Class 4
Basic Benefit is the lesser of: *Cannot exceed 60%, 66⅔% if pre-tax, or $5,000*	Percentage of Salary	%	%	%	%
	Dollar Amount	$	$	$	$
Supplemental Benefit ☐ % of Salary ☐ Dollar Amount	Minimum				
	Maximum				
	In Increments of				
Total Basic & Supplemental Benefits Can't Exceed *60 or 66⅔% of Salary*		%	%	%	%
Maximum Benefit Period *(3, 6, 12 or 24 Months)*		Months	Months	Months	Months
Accident Elimination Period *(0, 7, 14, 30, 60, 90 or 180 Days)*		Days	Days	Days	Days
Sickness Elimination Period *(0, 7, 14, 30, 60, 90 or 180 Days)*		Days	Days	Days	Days

Replacement: Are you replacing existing coverage? ☐ No ☐ Yes
IRS Type: ☐ Section 125 ☐ Welfare Benefit Plan ☐ ERISA ☐ 5500 Required ☐ Other *(please explain)* _____
Workers' Compensation: Are all employees/members covered under Workers' Compensation? ☐ Yes ☐ No (explain below)

Mailing Instructions:
Send your completed application for the products listed above to:

Transamerica Worksite Marketing
Attention Account Management
P.O. Box 8083
Little Rock, AR 72203-8083

Insurance Selections

(Product and Rider availability subject to state approval)

Participation Requirement: Each group master policy requires a minimum of 6 covered lives or the state minimum, whichever is greater, in order to be issued and remain in force. Any group master policy that falls below this requirement may be terminated, subject to the notice requirements in the master policy. Special underwriting offers may require higher participation in order to continue receiving the special underwriting offer for new insureds.

☑ Hospital Indemnity – TransChoice Advance
Check with Account Management for current state approval information

Group Contribution? ☑ Yes ☐ No
If yes, list amount or %: Varies by class

Requested Effective Date: 1/1/14

Coverage: (Attach Plan Design)	Class 1	Class 2	Class 3	Class 4
Base: Daily In-Hospital Indemnity Benefit Maximum of 31 Days per Confinement	$ 100	$ 300	$ 300	$
☑ Hospital Confinement Indemnity Benefit Rider Maximum of 1 Day per Confinement	$ 500	$ 1,000	$ 1,000	$
Calendar Year Maximum	2 Days	2 Days	2 Days	___ Days
☐ Intensive Care Indemnity Benefit Rider *(Can't exceed 2 times the Base Benefit)*	$	$	$	$
Calendar Year Maximum	___ Days	___ Days	___ Days	___ Days
☑ Inpatient Miscellaneous Indemnity Benefit Rider Maximum of 31 Days per Confinement	$ 500	$ 1,000	$ 1,000	$
☑ Off-The-Job Accidental Injury Indemnity Benefit Rider Maximum of 1 Day per Accident, Calendar Year Maximum 5 Days	$ 0	$ 0	$ 700	$
☑ Critical Illness Indemnity Benefit Rider	$ 0	$ 0	$ 5,000	$
Dependent Benefit Percentage	0 %	0 %	50 %	%
☐ AmeriDoc ☑ Healthiestyou	☐ Yes ☑ No	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No
☐ Inpatient Surgical Indemnity Benefit Rider *(Requires confinement)*	$ 500	$ 1,000	$ 1,000	$
Calendar Year Maximum	___ Days	___ Days	___ Days	___ Days
Anesthesia Benefit Percentage	20 %	20 %	20 %	%
☑ Outpatient Surgical Indemnity Benefit Rider	$ 250/50	$ 500/100	$ 500/100	$
Calendar Year Maximum	___ Days	___ Days	___ Days	___ Days
Anesthesia Benefit Percentage	20 %	20 %	20 %	%
☑ Surgical and Anesthesia Indemnity Benefit Rider Daily Inpatient Surgical Benefit Amount: Daily Outpatient Surgical Benefit Amount: 50% of Inpatient Amount Daily Minor Outpatient Surgical Benefit Amount: 10% of Inpatient Amt. Calendar Year Maximum: 1 Day per category	$ 500	$ 1000	$ 1000	$
Anesthesia Benefit Percentage	20 %	20 %	20 %	%
☑ Ambulance Indemnity Benefit Rider – Daily Ground Benefit Daily Air Ambulance pays 3 times the Daily Ground Benefit Calendar Year Maximum: 3 Days, Lifetime Maximum: 6 Days	$ 0	$ 200	$ 350	$
☑ Inpatient Drug & Alcohol Addiction Indemnity Benefit Rider Calendar Year Maximum: 31 Days, Lifetime Maximum: 60 Days	$ 100	$ 100	$ 100	$
☑ Inpatient Mental & Nervous Disorder Indemnity Benefit Rider Calendar Year Maximum: 31 Days, Lifetime Maximum: 60 Days	$ 100	$ 100	$ 100	$
☐ Skilled Nursing Indemnity Benefit Rider Calendar Year Maximum: 60 Days, Lifetime Maximum: 120 Days	$	$	$	$
☑ Outpatient Physician Office Visit Indemnity Benefit Rider	$ 50	$ 70	$ 70	$
Calendar Year Maximum	6 Days	6 Days	6 Days	___ Days
☑ Outpatient Diagnostic Laboratory Test Indemnity Benefit Rider	$ 10	$ 15	$ 15	$
Calendar Year Maximum	2 Days	4 Days	4 Days	___ Days
Outpatient Select Diagnostic Test Indemnity Benefit Rider	$ 50	$ 75	$ 75	$
Calendar Year Maximum	1 Days	2 Days	2 Days	___ Days
Outpatient Advance Studies Diagnostic Test Indemnity Benefit Rider	$ 200	$ 300	$ 300	$
Calendar Year Maximum	1 Days	2 Days	2 Days	___ Days
☐ Emergency Room Sickness Indemnity Benefit Rider	$	$	$	$
Calendar Year Maximum	___ Days	___ Days	___ Days	___ Days
☑ Prescription Drug Indemnity Benefit Rider – Daily Generic Drug Benefit Daily Brand Name Drugs are paid at twice the Daily Generic Drug Benefit	$ 10 - $20	$ 15 - $30	$ 25 - $30	$
☐ Maximum Days per Month ☑ Calendar Year Maximum	12 Days	12 Days	36 Days	___ Days
☐ Wellness Indemnity Benefit Rider	$ 100	$ 100	$ 100	$
Calendar Year Maximum	1 Days	1 Days	1 Days	___ Days

Replacement: Are you replacing existing coverage? ☐ No ☑ Yes

IRS Type: ☑ Section 125 ☐ Welfare Benefit Plan ☐ ERISA ☐ 5500 Required ☐ Other *(please explain)* _____

Additional Coverage for TransChoice Advance

Check with Account Management for current state approval information

Additional Policies		Class 1	Class 2	Class 3	Class 4
☑ Group Term Life Insurance with AD&D Rider – Employee Benefit		$ 10K	$ 10K	$ 10K	$
	Spouse Benefit	$ 5K	$ 5K	$ 5K	$
	Child Benefit	$ 2500	$ 2500	$ 2500	$
☐ TransDI Plus Disability Income Insurance – Monthly Benefit Amount		$	$	$	$
	Elimination Period	___ Days	___ Days	___ Days	___ Days
	Benefit Period	___ Months	___ Months	___ Months	___ Months
☐ TransSmile Dental Insurance		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Non-Insurance Benefits					
☒ PPO Network: MultiPlan		☐ Yes ☒ No	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No
☐ AmeriDoc ☐ Healthiestyou		☐ Yes ☒ No	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No

☐ Group Dental Insurance – TransSmile
Product not available in GU, NH, NJ, or PR.

Group Contribution? ☐ Yes ☐ No
If yes, list amount or %:

Requested Effective Date:

Coverage: Attach Plan Design ☐ Freedom Network (Passive PPO-DentoMax Network) ☐ Select Network (MAC Network)

	Class 1	Class 2	Class 3	Class 4
Annual Individual Maximum	$	$	$	$
Annual Deductible per Person	$	$	$	$
Annual Family Maximum	$	$	$	$
Type 1 – Preventative & Diagnostic Services (Covered %)	%	%	%	%
Type 2 – Basic Restorative Services (Covered %)	%	%	%	%
Type 1 & 2 Waiting Period	Months	Months	Months	Months
☐ Type 3 – Major Restorative Services (Covered %)	%	%	%	%
Waiting Period	Months	Months	Months	Months
☐ Implants Benefit Rider (Covered %)	%	%	%	%
Waiting Period	Months	Months	Months	Months
☐ Orthodontic Expense Rider (Covered %)	%	%	%	%
Waiting Period	Months	Months	Months	Months
☐ TMJ Benefits Rider (Covered %)				
Waiting Period	Months	Months	Months	Months

Replacement: Are you replacing existing coverage? ☐ No ☐ Yes

IRS Type: ☐ Section 125 ☐ Welfare Benefit Plan ☐ ERISA ☐ 5500 Required ☐ Other *(please explain)*