needs to.

Q Fair enough. But it says that the 2014/2015 plans failed to meet that.

They wouldn't fail to meet it. You're just saying that the particular consequences or the need to meet it may be --

A We would have to look elsewhere, yeah.

Q Okay. I understand.

Let's see.

A Another thing that he may want -- frankly, I didn't put a whole lot of thought until all of the things that maybe he didn't consider, because to me it is just really irrelevant to the analysis. But as we sit here today, another example would be if he's saying these plans are violative or not compliant with the ACA, I don't know that he knows whether these individuals would be eligible for Medicaid, which would have an impact on which, if any, ACA requirements why. It doesn't appear he did that analysis, so that would be another thing that he's lacking.

Q Under an ACA analysis?

A Right.

Q Okay. Understood.

Which, as we have already said, is not

really to the point in this case?

A Exactly.

Q Okay. Two more things.

You say in your plan -- or in your report that "Employers rely exclusively on the insurers to insure coverage requirements are met. This is because insurers do not have -- because insurers have not only the burden to ensure compliance, but also the expertise required to do so, not employers."

Do you remember writing that?

A Yep.

Q Okay. Now, I think I understand what you're saying. It's because 689B, for example, regulates what an insurer does. It's the insurer's responsibility to make sure that the plans they're offering meet the particular statute, whether it's 689A or B or C or some other one, that there's some -- that they are -- under which they are selling the particular product; correct? That's a long way of saying it.

A Can you just say it again?

Q It's the insurer's responsibility to make sure that the things they're selling met law?

A That's correct.

Q Okay. This is a different situation, though, with the issues presented here and in the case itself. Because do you have any information that insurers would know that an employer is purchasing this product for the purpose of qualifying for what is basically a wage credit under the Minimum Wage Amendment? It's a strange situation.

A What is the question? I understand everything you said.

What is your question?

Q Is it -- would an insurer, in your experience, know that that is why MDC was buying these health insurance plan?

A More often than not, yeah.

Q So they would be sort of on notice that there's some compliance requirement, whatever it is, and that it's the insurer's responsibility to make sure that the thing they're selling them functions for the purpose MDC is providing it?

A Well, where you and I, or at least Milone and I disagree, I think, we need to distinguish here. So I believe that an insurance plan being offered, if it's been blessed by the insurance company -- excuse me, the insurance

commissioner.

Q They're all blessed by the companies.

A Right. Right.

-- that satisfies the Minimum Wage Amendment -- if that's what we're saying, satisfies -- they can pay the lower amount if it is made available because the commissioner approved it, blessed it. Okay.

Q For whatever purpose, for any purpose?

A Correct.

Q It's a legal product?

A If it's health insurance that the commissioner says you can sell in Nevada, my position is that requires -- that meets any requirements of the health insurance component of the Minimum Wage Amendment.

Q Got it.

A Now, we still have to talk about the 10 percent.

Q Sure, sure, sure.

A But that's -- so that's why I make that distinction.

Q I understand that.

A So we don't -- we don't get to the point of would the employer or the insurance company be

aware of the purpose that's being -- because it doesn't matter.

Q I understand.

A But to answer your question, I said sometimes that might be the case, the employer -- or, excuse me, the insurer may know why they're doing it.

Employers that I work with oftentimes are very closely -- have close relationships with their broker or brokers, and there is a constant dialogue between them about what benefits they're going to -- especially when they're putting together a benefits package.

Q That makes sense.

I mean, you're an employer, and you want to take advantage of the opportunity to pay the dollar less under the Minimum Wage Amendment. So you call up your insurance guy and say, "I need to offer health insurance to my employees in order to take advantage of this opportunity under the amendment. What do you got?"

A Yeah.

Q And in that sense, the insurer now knows, more or less, what the purpose is?

A Yeah. So with the Minimum Wage

Amendment, that conversation would be much less, but I'm not saying it couldn't happen, so yeah. Just functionally --

Q But in this paragraph --

A -- they have the dialogue.

Q But in this paragraph, where we're saying that the burden is on the insurer and they get relied upon, I mean, you're basically saying that because for the insurer to bring that thing to market to offer it to the employer anyway, they would have had the responsibility to insure compliance to begin with, so it doesn't then fall upon the employer to know whether this thing is compliant as insurance?

A You got it.

Q Got it. See, I'm with you on that. I understand what you're saying.

Okay. So what you're not saying, and correct me if I'm wrong, let's imagine a hypothetical where the health insurance that was offered by MDC is determined not to qualify MDC to pay less than 825 to their employees. Just imagine --

A But how? Like what do you mean not qualify?

Q That Milone is right.
A Okay.
Q Just imagine a world in which he's right and you're wrong.
A Okay. There is one. It's not here, but --
Q Right. Right.
A So you're not saying the plan doesn't meet the requirements of 689A, B, or C? That's not your question?
Q Well, you can -- you can sell the insurance as a product.
A Okay.
Q But it's determined that it should have complied with this aspect of state law or -- or whatever, and it doesn't, so you can't use it within the Minimum Wage Amendment to pay less money.
A I believe I understand the basis for your hypothetical.
Q Okay. In that situation, you're not saying -- by this sort of relied exclusively and it's the insurer's responsibilities, you wouldn't be saying in that situation that's the insurer's fault? Is it not the employer's responsibility to

meet the -- the requirements, whatever they are, under the Minimum Wage Amendment?

A I just can't answer that, because it's -- it's not a world that we live in. It's not how those things function. I can't say who's fault it is under a situation that would not happen. I just can't.

Q Well, the situation wouldn't happen, as in there's no way you're wrong? Because that's a world we're going to have live with for a couple of seconds.

A Well, let's say -- I don't mind being wrong. It's just, look, we've been doing this for ten years under the Minimum Wage Amendment. It's not the world as it's been for that decade.

Q Okay. But that doesn't really get to my question. I mean, we sort of talked about what you did mean about employers relying exclusively on insurers, and that insurers have the burden to ensure compliance.

Do insurers have the burden to ensure compliance with the Minimum Wage Amendment, or is that the employer's responsibility?

A Ensure compliance by offering -- if there were particular requirements that the

employer would have to see to and they didn't see to them with the --

Q If the health insurance fails, you don't get to pay a dollar less because of X, Y, Z. The whole range of theoretical possibilities as to why you might be wrong and he might be right -- and "he" being Milone -- that was the employer's responsibility; right?

A Okay. So while you disagree with me, I think you understand why I'm hesitant and just think I can't explain. Another reason, though, is, I mean, it's just -- functionally, it's not how it would work, because the insurance commissioner would have to address that question.

Q Okay. But you're not really -- I mean, maybe I'm not understanding well. Let me try --

A I understand your question. I just don't think I can answer it, but --

Q It kind of seems like you don't want to answer it.

A No. Okay. I'll answer it in that I don't think it's ever the employer's fault. But in a hypothetical, it's -- it's difficult. I mean, you're -- it's a hypothetical that I cannot imagine existing. So giving an unequivocal answer

to a hypothetical that I'm struggling with is difficult.

Q Okay. To answer a hypothetical you don't have to necessarily agree that it's -- I mean, because you not agreeing that it's possible is based upon your opinion that -- I mean, your theory of the case, really.

A Well, I don't have a theory of the case, but --

Q You do by extension. I could tease one of your report, but it's not important. Not important. It doesn't matter. None of this matters.

You say insurers have the burden to insure compliance. You mean compliance with Nevada insurance laws for selling their products?

A Okay. Yes. I'm trying to work with you.

Q Okay. The insurer would not have the burden of ensuring compliance with the minium wage scheme under the amendment; is that accurate?

A And what -- what would that compliance be?

Q That the insurance that they have offered, or the benefits, the plan, the thing that

they told to MDC.

A If there are some insurance plans that would satisfy that amendment --

Q Yeah, yeah.

A -- then I can -- I can see why you would believe that the insurer would have no responsibility there. And I guess in that hypothetical, I know what you mean.

Q I guess that's about as close as we're going to get. I'm fine with that.

Okay. The last thing has to do with this discrepancy between whether these plans are individual or group plans. And you have already, said, okay, the 2014 and 2015 plans, those are group plans.

As I understand your position regarding 2010 and 2013, that they're individual plans, is that MDC was the plan sponsor, correct, not the policyholder?

A Which plan?

Q 2010 through 2013, which you've said those can't fall under 689B, because 2010 to 2013 were actually individual plans.

A The employer was not the policyholder I believe. Yes, that's correct.

Q Okay. And is that the only criteria under which you determined whether those plans were individual or group policies?

A No.

Q What are the other ones?

A The language of the plan documents.

Q Now, when you say "language of the plan documents," if in the plan documents or the marketing materials the insurer itself called the 2010 or 2013 plans group plans, would that change your opinion?

A So if there's language within the 2010 to 2013 that says "This is group coverage," I would have to see the context it was used. It would curious to me, but I don't know that it would, like, rock my world and change my opinion.

Q It could still be something else, even though it was marketed as a group policy.

What if the employer was given a group policy number for those plans?

A What if what? I mean, what if --

Q Would that change your opinion as to whether that plan was an individual or group plan? Or are you saying it doesn't matter what you call it, it doesn't matter what skin you put on it, it

doesn't matter how you market it. What matters are the guts, and to me, the guts on this thing --

A The last one. I believe this is an insurance -- or, excuse me, an individual plan because it provides insurance to the individual rather than a group plan, where the contract is with the employer, and the employees are beneficiaries and have -- you know, they have their own relationship with the insurer, as well. But that doesn't exist here.

Q So you understand the 2010 to 2013 consisting of hundreds of individual contracts?

A I don't know whether it does or not. I've looked at one contract, and that is an individual plan. I'm not being difficult. I just can't say -- you say hundreds, and I don't know.

Q Was that to an individual employee?

A I'm sorry?

Q Was the contract you're talking about, was that between the insurer and an individual employee?

A I don't understand the question.

Q Well, you're saying it's an individual plan --

A Yes.

Q -- and the contracts are between the insurer and the employee. And you're saying you only looked at one contract. I mean, I'm not entirely sure which contract to which you're referring.

A And I'm not sure which one you're referring to. So what I was saying --

Q I'm referring to the one you're referring to.

A Well, I'm saying in a group plan, there is a contract between the insurance company and the employer.

Q Okay.

A That contract doesn't exist in the 2010 to 2013 plan. I'm not saying there isn't a contract, but that contract does not exist, from what I can tell.

Q So the contract that you looked at for 2010 to 2013 was not between Cigna and MDC?

A Well, let's look at '10, and I can show you what you mean. '10, '11 or --

Q There is '10.

A Thank you.

Q Actually, '10 to '12, and by extension, '13.

A And your question, just to be clear, is what? Is there any contract between the employer and the --

Q -- and the insurer here. Because you were using that as a basis for -- for saying these are individual plans, because there's no contracted between MDC and Cigna here.

A No. I'm saying the contract that exists in a group plan doesn't exist here.

Q Okay. Well, let's apply -- well, that -- how is that different?

A So the whole thing is structured differently. If we look at the 2014 plan, there is a particular type of contract as between the insurance company and the employer. They're not just a sponsor. The language I believe is that they are the named insured.

Q A plan participant, is that a phrase?

A It's a phrase, but I can't believe that's what it would be here. Plan participants are the employees that participate in the plan offered by the employer.

Q Okay. So if the employer was a plan participant, it would be a group policy; correct?

A No.

Q Okay. I mean, if I look at those policies or these things and there are group policy numbers, there are references to this being a group policy, either, you know, that's what the employer asked for or -- or that's what the insurer sent to them, you're saying that doesn't control whether it's actually a group policy; is that true?

A It doesn't matter what you call it, it is what it is?

Q Yes.

A Yes.

Q Okay. And you're saying this is an individual policy?

A From what I've been provided, I believe this is absolutely an individual policy.

Q Okay. Now, I can go and buy an individual policy any day of the week, right, just in my private capacity?

A Yes.

Q Now, when I do that, I could -- for example, I could compare 15 different policies. I could negotiate with the insurer. I mean, I, as an individual, I could do all of those things. I could -- I could call Aetna and Cigna and

Transamerica and all of these different place, and I could get quotes and talk to them about insurance. I could choose the one I wanted; correct?

A I agree with all of that except the negotiate with the insured. If you figure that out, yeah --

Q Okay. You called me.

A Everything else, yes, I see what you're saying.

Q Okay. But the employees here didn't have that opportunity, correct? Mancha went out -- Mancha being the parent company for MDC -- went out and arranged for one specific plan of their choosing and offered that to their employees in this instance.

Is that your understanding?

A I don't know that to be the case. I don't have that background. I just have this policy. And I'm not trying to avoid an answer. I do want to show you, though, look at MDC ending in 95. This does have a level one and a level two, so it leads me to believe that the -- excuse me, the employer may have made both available. I don't know, though.

Q That's different from, you know, we've got six different policies from six different companies, and you can choose between those?

A Well, insurer?

Q Yeah.

A Yeah.

So if you're asking me the employees, if they want to get insurance that is being offered or made available by their employer, they don't get a chose the insurance company, I agree with that. I believe that's the case with all insurance, no matter what employer.

Q Well, not individual insurance. Individual insurance, I can go buy whatever I want.

A I'm saying employer sponsored.

Q Employer sponsored individual insurance?

A Yeah. Because MDC appears to have paid a portion of the premium here, so it's not as though --

Q Sometimes. And sometimes -- I mean, when the premium costs for any particular pay period or particular year went above 10 percent of the employee's gross taxable income from the employer, that is sort of built into the

amendment. But the amendment doesn't say the premiums of the plan can only cost 10 percent of your income. It says the employee can only be forced to pay that; right? Well, it doesn't matter.

A Okay.

An explanation for why an individual policy pre-'13 policy might have group --

Q Qualities?

A -- language, yeah, or numbers, remember the concept of the converted policy that I told you about? That would be an explanation, in my mind.

Q Do you know if any of these are converted policies?

A If they are basic or simple health benefit plans, then, yes, they are.

Q I thought it was standard.

A You made me say simple. You're right, basic and standard.

Q Okay. So that may be an explanation.

You have no information that that would be the explanation in this case?

A I don't know. I believe these things very well may be the -- Cigna's basic and standard

health benefit plans. And if they are, if I'm right on that, then yes, they are -- they would be a contested policy. They're all the same, because, remember, I said they're issued for three reasons.

MR. SCHRAGER: Right. I remember. I remember.

I think I have reached the end of my yarn. I'll pass the witness.

MR. WIECZOREK: I don't have any questions, but I did want to point out that when Mr. Mulliner got this report to us, there were certain technical exigencies that went into it. So this has many typos and grammatical errors in it, which I believe he intend to correct, and we may issue a revised report that removes some of the typos.

Substantively, it won't change, and I'll make the same offer to you, if there's something in the amended report that strikes your fancy, then we can talk about that.

MR. SCHRAGER: No, that's fine. And I saw some of those. I didn't press him on it. I could tell from the context what he meant even when those arose.

THE WITNESS: When we're off the record, I'll give you the background on that.

MR. WIECZOREK: So other than much, I have nothing. Thank you.

MR. SCHRAGER: That's it. You're done. Thank you for coming in.

(Whereupon, the deposition concluded at 12:57 p.m.)

* * * * *

EXHIBIT G

EXHIBIT G

EXHIBIT G

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CLERK OF THE COURT

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DISTRICT COURT

CLARK COUNTY, NEVADA

CHRISTOPHER MCLAUGHLIN, an individual, on behalf of himself and all similarly situated individuals, Plaintiff, vs. DELI PLANET, INC., a Nevada limited liability company, d/b/a/ JASON'S DELI, and DOES 1 through 100, Inclusive Defendant.	) CASE NO.: A-14-703656-C) DEPT NO.: XXXI

ORDER GRANTING DEFENDANT'S MOTION TO DISMISS

Defendant's Motion to Dismiss having come on regularly for hearing on November 25, 2014 at 9:30 a.m. in Department XXXI of the above-entitled Court, the Honorable Joanna Kishner presiding, Plaintiff being represented by Bradley Schrager, Esq., and Defendant being represented by Anthony B. Golden, Esq. and David B. Dornak, Esq., the Court having considered the briefs of the parties, the arguments of

counsel and otherwise being fully advised in the premises and good cause appearing therefor,

IT IS HEREBY ORDERED, ADJUDGED AND DECREED that Plaintiff's Motion to Dismiss is granted and that Plaintiff's Complaint shall be dismissed without prejudice to file an amended Complaint;

DATED this 12th day of December 2014.

JOANNA S. KISHNER
DISTRICT COURT JUDGE

Approved as to Form and Content:

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DISTRICT COURT

CLARK COUNTY, NEVADA

CHRISTOPHER MCLAUGHLIN, an individual, on behalf of himself and all similarly situated individuals, Plaintiff, vs. DELI PLANET, INC., a Nevada limited liability company, d/b/a/ JASON'S DELI, and DOES 1 through 100, Inclusive Defendant.	) CASE NO.: A-14-703656-C) DEPT NO.: XXXI

ORDER GRANTING DEFENDANT'S MOTION TO DISMISS PLAINTIFF'S FIRST AMENDED CLASS ACTION COMPLAINT

Defendant's Motion to Dismiss First Amended Class Action Complaint having come on regularly for hearing on March 3, 2015 at 9:30 a.m. in Department XXXI of the above-entitled Court, the Honorable Joanna Kishner presiding, Plaintiff being represented by Bradley Schrager, Esq. and Daniel Bravo, Esq., and Defendant being

represented by Anthony B. Golden, Esq., the Court having considered the briefs of the parties, the arguments of counsel and otherwise being fully advised in the premises and good cause appearing therefor finds, concludes, and orders as follows:

FINDINGS OF FACT

1. On December 17, 2014, Plaintiff filed his First Amended Class Action Complaint ("Amended Complaint"). The Amended Complaint contained one claim for relief. That claim was an alleged violation of Nevada Constitutional Article XV, Section 16 (the "Minimum Wage Amendment"). According to Plaintiff, Defendant violated the Minimum Wage Amendment by paying him less than $8.25 per hour despite Defendant not offering Plaintiff a qualifying health insurance plan. As alleged by Plaintiff, Defendant's health insurance plan was not "comprehensive in its coverage" for Defendant to qualify to pay anything less than the higher-tier minimum wage rate. Plaintiff is not maintaining that the premiums he paid for any health insurance exceeded 10 percent of his gross taxable income from Defendant.

2. On January 29, 2015, Defendant filed its Motion to Dismiss. Plaintiff filed his Opposition to the Motion to Dismiss on February 18, 2015, and Defendant filed its Reply in Support of Motion to Dismiss on February 24, 2015. A hearing on the Motion to Dismiss was then held on March 3, 2015.

3. In its Motion and as argued at the hearing, Defendant maintained that the Amended Complaint should be dismissed because it only challenged the quality of Defendant's health insurance and not the cost of such insurance. According to Defendant, the Nevada Supreme Court in *Thomas v. Yellow Cab Corp.*, 130 Nev. Adv. Op. No. 52 at p. 8, 327 P.3d 518 (2014) requires the Court to apply the clear textual meaning of the Minimum Wage Amendment. Because the Minimum Wage Amendment defines health benefits as "making insurance available to the employee for the employee and the employee's dependents at a total cost to the employee for premiums of not more than 10 percent of the employee's gross taxable income from the employer", Defendant took the position that the Minimum Wage Amendment does not require its health plan to

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cover certain categories of health care expenses in order for Defendant to pay the lower minimum wage rate. Based upon a strict reading of the Minimum Wage Amendment, Defendant argued the Minimum Wage Amendment only addresses the cost and not quality of health insurance necessary to pay less than the $8.25 per hour.

4. Defendant further argued that, in order for Plaintiff to challenge the quality of its health plan, Plaintiff must first seek relief with the Nevada Labor Commissioner. As advanced by Defendant, the Nevada Labor Commissioner promulgated NAC 608.102 to address the type of health care expenses that employers' health insurance plans must cover to allow employers to pay the lower minimum wage rate. Although Defendant recognizes that the Minimum Wage Amendment created a private right of action for violations of the amendment, Defendant maintained that Plaintiff cannot rely upon that private right of action to challenge NAC 608.102. Relying on *Baldonado v. Wynn Las Vegas, LLC*, 124 Nev. 951, 194 P.3d 96 (2008), Defendant asserted that the Court should not imply a private cause of action when one is not expressly provided and that the Nevada Labor Commissioner is best tasked to interpret and enforce her regulations. As articulated by Defendant, if complaints addressing the quality requirement are not first brought before the Nevada Labor Commissioner, multiple judges throughout Nevada would have to decide on a case by case basis when a particular health plan meets the minimum coverage requirement to pay the lower minimum wage rate. This would render NAC 608.102 irrelevant.

5. In its Opposition, Plaintiff took the position that Defendant's health plan is "junk insurance" and, therefore, does not satisfy the requirements of the Minimum Wage Amendment. Plaintiff also argued that the Minimum Wage Amendment contains a broad and express right of access to Nevada courts for remedial enforcement. Plaintiff also asked the Court to determine the intent of the drafters' of the Minimum Wage Amendment regarding the remedy and enforcement provisions contained in the Minimum Wage Amendment. According to Plaintiff, the drafters never intended for plaintiffs to first have to resolve quality of coverage issues with the Nevada Labor

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Commissioner. Plaintiff further stated that *Baldonado v. Wynn Las Vegas, LLC*, 124 Nev. 951, 194 P.3d 96 (2008) does not apply because that case "is about whether and how Nevada courts should imply private rights of action in statutes where no express right is evident." Unlike *Baldonado*, Plaintiff maintained that his right of action is manifested in the Minimum Wage Amendment.

6. At the hearing, Plaintiff raised a new argument. Specifically, Plaintiff claimed that the Minimum Wage Amendment defines "health benefits" as offering "health insurance." As such, Plaintiff argued that the Minimum Wage Amendment goes from a general representation to a more specific requirement. Because the Minimum Wage Amendment requires "health insurance", Plaintiff claimed that Defendant's alleged "junk insurance" does not satisfy the requirements of the Minimum Wage Amendment to pay less than $8.25 per hour. Plaintiff also argued that nothing in the Minimum Wage Amendment "carves out for the Labor Commissioner" a claim based upon the quality of insurance offered by an employer.

CONCLUSIONS OF LAW

1. *Thomas v. Yellow Cab Corp.*, 130 Nev. Adv. Op. No. 52 at p. 8, 327 P.3d 518 (2014) requires the Court to apply the clear textual meaning of the Minimum Wage Amendment. In doing so, the Court should consider what the Minimum Wage Amendment actually states and not what the drafters who drafted the language in or the voters who voted for the Minimum Wage Amendment might have intended.

2. The Minimum Wage Amendment requires employers like Defendant to offer health benefits as described in the Minimum Wage Amendment in order to pay employees less than the higher minimum wage rate.

3. The Minimum Wage Amendment defines offering health benefits as "making health insurance available to the employee for the employee and the employee's dependents at a total cost to the employee for premiums of not more than 10 percent of the employee's gross taxable income from the employer." The Minimum

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Wage Amendment does not address the quality of insurance that Defendant must offer to pay lower minimum wage rate.

4. The Labor Commissioner created NAC 608.102 to fill the gap regarding what is not covered by the Minimum Wage Amendment. That administrative code – titled "Minimum wage: Qualification to pay lower rate to employee offered health insurance" – specifically addresses what categories of health care expenses an employer must cover in order to pay the lower minimum wage rate. Unlike NAC 608.102, the Minimum Wage Amendment addresses the premium cost and not coverage requirements.

5. Plaintiff is not challenging the premium costs he paid for Defendant's health insurance and has not alleged that such costs exceeded 10 percent of his gross taxable income from Defendant. Instead, Plaintiff is only claiming that Defendant's health insurance did not provide sufficient coverage to pay less than the higher minimum wage rate. Such a claim, however, is not a claim for violation of the Minimum Wage Amendment. It is in reality a violation of the interpretation by the Labor Commissioner under the governing regulations and clearly falls within the scope of the Labor Commissioner to interpret and to provide remedies.

6. Because Plaintiff's claim is fundamentally an alleged violation of the administrative code, there is no private right of action for the specific claim contained in the Amended Complaint. Plaintiff must first seek recourse with the Labor Commissioner. Such a finding is in line with *Baldonado v. Wynn Las Vegas, LLC*, 124 Nev. 951, 194 P.3d 96 (2008).

7. Any findings of fact that are really conclusions of law shall be considered as such and any conclusions of law that are really findings of fact shall be considered as such.

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ORDER

Based on the foregoing findings of fact and conclusions of law, IT IS HEREBY ORDERED, ADJUDGED AND DECREED that Defendant's Motion to Dismiss is granted and that Plaintiff's Amended Complaint shall be dismissed with prejudice.

DATED this 19th day of March 2015.

JOANNA S. KISHNER
DISTRICT COURT JUDGE

Approved as to Form and Content:

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EXHIBIT H

EXHIBIT H

EXHIBIT H

MEMBERS PRESENT:

Chairman John DuBois
Vice Chairman Robert Thomas
Mr. Bruce Bogaert
Mr. Gene Collins
Mr. Joe Dini
Mr. Jerry Fairchild
Mr. Steven C. Francis
Mr. John E. Jeffrey
Mr. Bob Kerns
Mr. James W. Schofield
Mr. Terry Tebbs
Mr. Danny L. Thompson
Mrs. Myrna Williams

MEMBERS ABSENT:

None

GUESTS PRESENT:

See attached guest list.

Chairman DuBois called the meeting to order at which time the Committee considered SB 295.

SB 295 - Summary - Revises various provisions regulating practice of homeopathic medicine. (BDR 54-418)

Chairman DuBois presented Amendment #948 to SB 295. This amendment is attached to these minutes as EXHIBIT A. The Committee reviewed the amendment.

Mrs. Williams moved to amend and do pass SB 295. Mr. Thomas seconded the motion. The motion carried with Mr. Thompson, Mr. Dini and Mr. Tebbs not present at the time of the vote.

The Committee then listened to a statement by county assessors regarding SB 131 which was heard before the Commerce Committee on May 17, 1985.

SB 131 - Summary - Vests enforcement of certain provisions concerning landlords and tenants of mobile home parks with manufactured housing division. (BDR 10-396)

Ms. Barbara Byington, Douglas County Assessor and Mr. Kit Weaver, Carson City Assessor, came forward to testify against the proposal to have the county assessor's office collect the proposed fee for mobile home park tenants as proposed in SB 131.

Ms. Byington stated that due to the system that her assessor's office uses, this proposal would cause a hardship on the office. Ms. Byington stated that at this time she has no way of knowing if a mobile home is in a mobile home park or on a residential lot. This is due to the definition of a mobile hom

park which states that a mobile home park is any place where there is two or more mobile homes. Ms. Byington explained problems with the proposal in having difficulty knowing where recreational mobile homes are. It was explained that the cost of providing the service would be about $6 to $8 for each billing. This is more than the $3 that is being proposed to charge the mobile home tenant.

Chairman DuBois placed SB 131 into a subcommittee for further study. The subcommitte appointed was Mr. Schofield and Mr. Collins.

AB 647 - Summary - Makes various changes in provisions relating to practitioners of healing arts. (BDR 54-1411)

Mr. Jim Wadhams, representing the Nevada Dental Association, came forward to testify on AB 647. Mr. Wadhams proposed amending AB 647. These proposed amendments are attached to these minutes as EXHIBIT B.

Mr. Wadhams reviewed AB 647 with the Committee. AB 647 would allow oral surgeons to perform histories and physicals on patients. Mr. Wadhams stated that Section 4 of AB 647 concerns cost containment relating to the procedure of pre-authorization by insurers.

Mr. Wadhams explained that, in Section 6, it is requested that the language referring to discount plans be dropped. It was explained that Section 5 of AB 647 refers to Health Maintenance Organizations (HMO's). HMO's can make periodic pre-payment to the dentist or can pay by a plan called a modified fee for services plan. In order to alleviate confusion, the amendment contained in EXHIBIT B is proposed. The proposal would make it clear that what triggers the regulation is the pre-payment. If there are no periodic pre-payment by the enrollees there is no need to regulate this business.

Finally, there is a proposal to allow the Insurance Commissioner to employ a health maintenance organization coordinator to assist in the execution of the Commissioner's duties as it relates to HMO's.

Mr. Kerns presented another proposed amendment to AB 647. This is attached to these minutes as EXHIBIT C. The amendment relates to self insuring employers.

Mr. David Gates, Insurance Commissioner, came forward to explain the proposal for a HMO coordinator. It was stated that the reason for an assessment request is due to the closed budget. This request should be a regular general budget position for years after this session paid out of the state general fund.

Mr. John Aebi, representing Health Plan of Nevada, and Mr. Mike Milner and Ms. Mary McDonald of Health Plan of Nevada, (HPN) came forward to testify against AB 647.

Mr. Aebi stated that HPN opposses Section 5 and the proposed amendments. This section would amend the definition of HMO's. This change would affect the HMO Act by changing the definition of an HMO.

Mr. Milner stated that at the inception of HMO's, he was the Director of Commerce. Then, there were two HMO's in southern Nevada that had failed. This is the reason for the present HMO Act. The proposed change in Section 5 would make HMO's just another insurance company. Mr. Milner explained that where pre-payment is in HMO Statutes, is specifically that the risk is shared by the providers and the HMO. To get the provider to share the risk, to get the HMO to work, the provider is paid a fixed fee to provide services. These services must be brought within the fee. The proposed change would define pre-payment as when the person pays his premium in advance. This is just insurance. HMO's are a different concept than insurance. Mr. Milner stated that the proposed amendment for Section 5 of AB 647 would drive health care costs up because it would take away the incentive to share the risks with physicians.

Mr. Wadhams came forward again with Mr. Mike West of Americare, an HMO applicant. Mr. Wadhams explained that risk sharing is the key but it does not require that every provider be on a fixed salary basis. The problem is that alternative providers see different ways of meeting the definition of the statute. Mr. Wadhams disagreed with Mr. Milner's statement that the proposal would drive up health care costs. Mr. Wadhams stated that increased competition tends to create a reduction in health care costs. The risk sharing is the key. The reason for the proposed change in Section 5 is to eliminate the need for this type of discussion and make the Insurance Commissioner's job easier.

Mr. Wadhams stated that the distinction between an HMO and a regular insurance provider is that the provider is selected and contracted with for the HMO insured, while under a regular insurance policy the insured can go to any provider and the policy is still good.

Mr. West stated that this is an escoteric area and for that reason Americare supports the position of HMO Coordinator under the Insurance Commissioner. Mr. West explained how the modified fee for service program works. Mr. West stated that the intent behind 42 states and the federal government establishing HMO's was to ensure the highest quality care; to provide the care at the lowest possible cost; and to shift the risks of financial burden of health care from patients to the organizations that provide the care. It does this by setting up contracts with the providers.

Mr. West explained that the difference between capitation (fixed fees) and fee for service is important to competition because the modified fee for service allows more flexibility in dealing with providers. More providers will sign up for fee for service plan that for the capitation plan.

Ms. McDonald came forward to respond to comments by Mr. West and Mr. Wadahams. Ms. McDonald reiterated statements made by Mr. Milner.

There being no further testimony on AB 647 the hearing was c1035d.

AB 598 - Summary - Allows indefinite term for installment loan. (BDR 56-1496)

Mr. Ken Scruggs, representing Household Finance Corporation, came forward to testify in favor of AB 598. Mr. Scruggs stated that AB 598 would allow finance companies to extend open-end credit to borrowers. This would apply to installment loans of $10,000 or less that are not secured by real property. Open-end credit, in AB 598, would work in that a line of credit would be established for a qualifying customer. That line of credit would represent the amount for which the customer would be eligible. It would not be easier to get credit. The customer would still have to apply and be approved for the credit limit for which he is qualified. The customer would be able to borrow any amount under the limit by means of a credit card, share draft or come into the company and request the money. The customer could never go beyond the limit for which he qualified.

Mr. Scruggs explained that with AB 598 it would make it easier for the consumer to get money. The customer would apply once and then would have access to the money if it is needed at a later date. In addition, if the rate changes after the customer has gotten approval for the loan, the new rate can apply only to advances made after the date of the rate change.

Mr. Dini moved to do pass AB 598. Mr. Fairchild seconded the motion. The motion carried with nine members voting yea, three nea and one not present. The nea votes were cast by Mr. Jeffrey, Mr. Collins and Mrs. Williams. Mr. Francis was not present at the time of the vote.

There being no further time, the hearings for SB 223 and SB 144 were postponed for a later date.

The meeting was adjourned at 3:30 p.m.

Respectfully submitted,

Deborah Redican

Deborah Redican, Secretary
Assembly Commerce Committee

AMENDMENTS FOR A.B. 647

1. Delete Section 1 in its entirety.

2. Amend Section 2 by deleting existing language and substituting:

"NRS 631 is hereby amended by adding the following section:

A qualified dentist is authorized to take complete case histories and perform complete physical evaluations which may be used for the purpose of admitting patients to hospitals for the practice of dentistry, to the extent such activities are necessary in the exercise of due care in conjunction with the practice of dentistry as defined by this chapter, provided further that no dentist shall be automatically entitled to membership on the medical staff or to the exercise of any clinical privileges at a hospital merely because he has a license to practice dentistry or because he is authorized to take case histories and perform physical evaluations as stated herein nor shall any dentist be denied membership on the medical staff or the right to the exercise of any clinical privileges at a hospital on the ground that the dentist holds a license to practice dentistry in this state rather than a license to practice medicine in this state."

3. Delete Section 3 in its entirety.

4. Amend Section 5 as follows:

on line 33 after the word "enrollees" add the phrase "to the person who arranges for the provisions of these services"

drop the bracket on line 36
drop the bracket on line 41
drop all new language on lines 41, 42 43 and 44

5. Amend Section 6 as follows:

drop brackets in line 6
on line 6 add bracket before "or arrange for a ..."
on line 7 add bracket after "discount of"
on line 8 add "or" between "payments" and "pay"
on line 8 add bracket before "or accept"
on line 9 add bracket after "discount"

This Section will then read as follows:

"Plan for dental care" means any agreement in which a person agrees to provide or arrange for dental care or pay for or reimburse any part of of the cost of that care and the member agrees to prepay, make periodic payments or pay through insurance for that care.

SECOND SET
AMENDMENT FOR A.B. 647

1. Add new section as follows:

The commissioner may employ or contract for a health maintenance organization coordinator to assist in the execution of his duties under this code relating to health maintenance organizations. All expenses related to the coordinators duties will be met by an assessment proportionate to premiums written, levied upon all authorized health maintenance organizations, which assessment shall not exceed the amount of $70,000.00 for the fiscal years 1985-1986 and 1986-1987 and which shall terminate at the end of such period.

2. add language to Section 5 at line 33 after the words "of the enrollees ..." as follows:

"to the arranger of those services as the operator of the health care plan"

3. delete italicized language at lines 41 through 44 of subsection 7 of Section 5.

Chapter 608 of NRS shall be amended by adding thereto the provisions set forth below:

1) An employer providing a health benefit to his employees must provide the same benefits and pay health care providers in the same fashion as an insurance company pursuant to Chapters 689A and 689B of NRS.

EXHIBIT I

EXHIBIT I

EXHIBIT I

MINUTES OF THE NEVADA STATE LEGISLATURE

SIXTY-SECOND Session

Senate Committee on Human Resources & Facilities

Date: March 14, 1983

Page: 1

The Senate Committee on Human Resources & Facilities was called to order by Chairman Joe Neal at 1:40 p.m. on Monday, March 14, 1983, in Room 213 of the Legislative Building, Carson City, Nevada. Exhibit A is the Meeting Agenda. Exhibit B is the Attendance Roster.

COMMITTEE MEMBERS PRESENT:

Senator Joe Neal, Chairman
Senator Donald A. Mello, Vice-Chairman
Senator Richard E. Blakemore
Senator Nicholas J. Horn
Senator Wilbur Faiss
Senator Helen A. Foley
Senator Bob Ryan

OTHER GUESTS PRESENT:

Mr. Frank W. Daykin, Legislative Counsel
Mr. Samuel F. Hohmann, Ph.D., Senior Research Analyst, Legislative Counsel Bureau, State of Nevada.

ASSEMBLY BILL NO. 141 - EXHIBIT C

Mr. James Stone, Assemblyman, District 30, sponsor of Assembly Bill Number 141, stated as now written, this bill would allow the Dairy Commission to grant to a retailer the authority to discount dairy products to senior citizens, and urged its passage.

Mr. Eric Stoval, serving as Assemblyman Erik Beyer's intern, stated Mr. Beyer was co-sponsor of this bill, and also urged its passage by this Committee.

The Chairman asked for questions. There being no further discussion, the hearing was closed on Assembly Bill Number 141.

SENATE BILL NO. 166 - EXHIBIT D

Senator William J. Raggio, Washoe District I, testified as the sponsor of this bill. Senator Raggio read from an eight page document (see EXHIBIT E). He also referred the Committee to proposed amendments (see EXHIBIT F), which he felt would be necessary to make this bill workable.

Discussion continued with Senator Raggio, Chairman Neal and committee members regarding the amendments (see EXHIBIT F) which, if adopted, would make the bill a mandatory inclusion for the purpose of health treatment for insurance coverage for alcoholism and drug abuse.

Virgil Getto, Assemblyman, gave testimony in strong support of this bill. He felt that in the area of insurance, alcoholism was not treated as a disease, and therefore there was no coverage. He felt alcoholism was an illness and should be treated in its early stages in a treatment center designed to deal with this illness. He urged legislation to pass a law enabling insurance coverage for all persons who might be in need of such care from one of the many treatment centers available for this purpose.

Robert E. Price, Assemblyman, District 17, lent his support to the concept of this bill. Mr. Price stated he had done a prior study on this same subject with essentially the same scheme as now outlined in Senate Bill Number 166.

Ms. Ruth Jagodzinski, R.N., a member of the Governor's Advisory Committee on Alcohol and Drug Abuse, testified on behalf of this bill. She felt that mandatory insurance coverage of alcoholism in particular, (and drug abuse), would cut insurance and hospital costs in the long run.

Mr. Robert Bunker, Claims Manager for Aetna Life & Casualty Co., State Chairman for the Health & Insurance Association of America, & Nevada State Certified Substance Abuse Counselor, testified in agreement with Senator Raggio. He felt there were now tremendous costs to the state and the nation with regards alcoholism, and insurance coverage for the treatment of this disease would actually lower the cost of the insurance.

Discussion followed with Senator Ryan and Mr. Bunker regarding employee-assistance programs, percentages of rehabilitation levels, and how people who sought treatment through followup, responded to these courses.

Senator Raggio gave a brief statement regarding the people who do not respond to treatment the first time, but surprisingly enough, do respond the second or third time to become totally productive individuals.

Mr. Samuel P. McMullen, Associate General Counsel for Harrah's, gave his support to the philosophy of this bill. He stated he had not been aware, however, of the mandatory coverage, and declined comment in this regard.

Mr. McMullen felt some changes were necessary in the language of the bill, and that some options should be left open regarding insurance coverage for inpatient and outpatients. Discussion continued with Mr. McMullen and committee members regarding Harrah's present employee program.

Mr. Nicholas Stuparich, also from Harrah's of Reno, verified an internal awareness program, which consists of educating the supervisors, management, and people in general who need to know how to deal with these types of drug problems. Mr. Stuparich stated there were no drug counselors at the present time, but only employee-relations counselors.

Mr. Richard Ham, Chief of the Bureau of Alcohol & Drug Abuse for the State of Nevada, stated he felt Senator Raggio and Assemblymen Price and Getto had gotten to the heart of this whole problem. Mr. Ham felt there was still not enough information today regarding these particular costs, however; but from information he had gathered from other states who had enacted similar laws such as this bill was proposing, these states were having no problems. Mr. Ham also cited the public programs available in this State where one could go for treatment for considerably less money, and these places were licensed and accredited by the Bureau of Alcohol & Drug Abuse, their counseling staffs and administration all being certified by the Bureau.

Discussion proceeded with Mr. Ham by committee members. Senator Foley specifically was concerned that insurance companies would be paying for a person not being treated for a specific disease, but only a "drying out" period. She felt this would happen if a person went to a hospital that did not have a specific treatment program for this disease, and therefore they would only be treated for their "drying out".

Mr. Joseph Strolin, Statewide Program Coordinator for Alcohol & Drug Abuse, responded to Senator Foley's statements. He felt she was going beyond what could be expected of this bill to cover in that regard. Mr. Strolin further stated the intent of this bill was to provide two basic streams by which hospitals and health-care facilities would be eligible for alcohol and drug abuse coverage under insurance policies. He cited the first eligibility criteria that these institutions be licensed and accredited by the Bureau of Alcohol & Drug Abuse as a drug and treatment center. The other way this criteria could be met would be through the Joint Commission on Accreditation of Hospitals, the major National Hospital Accreditation Association. Mr. Strolin stated the Joint Commission has a separate accreditation period for alcoholism and drug abuse treatment centers, and by tying the Joint Commission on Accreditation of Hospitals criteria with the Bureau for Alcohol & Drug Abuse Treatment Programs together, this could solve a lot of problems.

Discussion followed with Senator Raggio, Mr. Strolin and Senator Foley. Senator Foley stated she didn't want someone going to a hospital just to dry out for five days and have no treatment for a specific disease, just so their insurance would cover this.

Mr. Strolin replied that as the bill would be amended, coverage would be provided wherever these people were sent, but it would have to be a facility which was approved and accredited by the Joint Commission on Accreditation of Hospitals.

Chairman Neal asked for further questions. There being no discussion, the Chairman asked for those in opposition to testify.

Mr. James Wadhams, representative of the Health Insurance Association of America, stated he was generally in opposition, but not specifically. Mr. Wadhams brought up two problems with the bill -- "people who don't drink would be paying for coverage they don't need, and, an insurance company could not deny benefits even if the hospital did not have a treatment program."

Mr. Dave Bianchi, Nevada Association of Life Underwriter's, a group of life and health insurance agencies in the State of Nevada, was also opposed to Senate Bill Number 166. Mr. Bianchi felt this bill may be duplicating the efforts of Assembly Bill Number 273, which is authorizing a health care cost specialist in the insurance division. He suggested the Committee might want to look into this aspect. Mr. Bianchi further stated it was becoming more and more difficult to find companies who would even write individual health insurance coverage.

Mr. Wayne Carlson, Senior Risk Management Analyst for Washoe County, stated the County was not opposed to the concept of treatment for alcohol and drug abuse, but felt there was a problem with the mandatory coverage. He stated his reasons for this.

1. There is only a time limit of 60 days, whereas outpatient programs are limited to $1500. Therefore, a 60-day period could cost up to $22,500 for treatment of alcohol or other substance abuse.
2. The other problem with the bill is that there is no consideration given for the existence of current employee-assistance programs, which the County now offers.

Chairman Neal asked Mr. Carlson what language he would suggest to this bill.

Mr. Carlson suggested that the employer have the right to require that an employee go through an employee-assistance program prior to being referred to one of these treatment centers, and if he failed to do that, his benefits could be reduced. Mr. Carlson stated his preference was not to make the coverage mandatory, but to leave that option open, in order to structure the benefit as the need for coverage is seen.

Senator Foley stated she could see where some type of drug or alcohol abuse would be extremely embarrassing.

Mr. Carlson stated his employee-assistance program was done on an outpatient counseling basis, at no cost to the employee.

Senator Foley still questioned who would know if this person sought this type of counseling or assistance.

Mr. Carlson stated that only the employee who was seeking the name of an organization knows. He would go through the Personnel Department to find out who he could contact for counseling, but does not have to divulge what he needs or wants counseling for.

Senator Foley then stated to Mr. Carlson that under his proposed amendment, these people must go through counseling.

Mr. Carlson replied this was the case, and that some of the difficulties with this would be that if these people go into a treatment center first, and are not truly motivated, this treatment will fail.

Senator Foley disagreed with this, in that she felt if someone made the big step to motivate themselves to go, instead of being mandated to go by a counselor, that was the biggest motivation of all.

Mr. Carlson stated they were not saying a counselor would demand these people to go, merely would screen them.

Senator Raggio then gave his final statement to the Committee, following Mr. Carlson's testimony. Senator Raggio stated this bill was not introduced so that hospitals could collect $20,000 for treatment, but was designed to insure that the poor person would be able to get treatment when he needed it.

Chairman Neal recessed the hearing on Senate Bill Number 166.

Mr. Virgil Wedge, Attorney at Law, Reno, Nevada, wished the Committee to consider a Bill Draft Request (see EXHIBIT G), which he handed out to all committee members.

Chairman Neal asked what the Committee's pleasure was regarding this Bill Draft Request.

Senator Ryan moved to accept this Bill Draft Request.

Senator Faiss seconded the motion.

A I have -- if you have one, that would be great.

Q I'm sure I do.

MR. SCHRAGER: Why don't we mark this as Exhibit 4.

(Exhibit No. 4 was marked.)

BY MR. SCHRAGER:

Q Okay. I very much appreciated the succinctness and focused nature of your report. And I note that on page one of your report -- which I guess is MDC001374 -- you may want to flip to it. I know you have the whole report there --

A Okay. I'm there.

Q -- you lay out what Milone's report characterizes as -- or I guess what you also characterize as the issues presented; correct?

A Yes.

Q Okay. And you have two of them here, A and B. You say the first issue, A, the standards that exist to determine what is, quote, health insurance, end quote, as that term is used in Article 15, Section 16, of the Nevada Constitution. And a second one, B, an analysis of, quote, plan documents, end quote, produced in this case in light of these standards; correct?

A Yes. I -- I say that that is how Milone has characterized the issues presented in his report.

Q Okay. And you were asked to respond and act as a rebuttal expert regarding his report; is that correct?

A That's correct.

Q Would you characterize the issues presented any differently than he did?

A I guess I don't know what was presented to him, because he said these are the issues that were asked of me, presented to me by the plaintiffs.

Q Okay.

A So I don't really know what was. I have no reason to think that they were other than what he characterized them as.

Q These -- I mean, these issues presented in your report -- because you also refer to, as a defined term, the issues presented for the rest of your report. That basically sums up what we're talking about in both of these reports; right? Those are the questions we're after.

A The focus of my report was in rebuttal to Milone's report and the issues presented within

that report as he defined them.

Q Okay. Very good. I think that's a yes.

Okay. So as we start out, as I said, I only have four or five or six sort of issue areas I want to go over with you, so I think we'll be brief. But what I want to do at the outset, is just sort of generally characterize each of your positions, at least to the things that are most important to me as the plaintiffs' counsel.

And after I do that, if you think I've been, I don't know, unfair, incomplete, or somehow not characterized your position properly, I want you to tell me. That's why I'm doing this. I want to get to a sense of a "Here are the main issues we're talking about. Here are the basic positions of each side's experts regarding those issues, the issues presented.

So let me characterize Mr. Milone's position first, at least as to -- well, actually, to both A and B of the issues presented.

Mr. Milone, as I understand his report, his position is the minimum wage amendment -- which you understand to be Article 15, Section 16 of the Nevada constitution -- doesn't -- though it uses the term health insurance, it doesn't itself

specify what that means or what coverage maybe necessary to satisfy health insurance under the amendment to qualify a Nevada employer to pay less than 8.25 per hour to their employees.

His position is that in order to determine what health insurance means in the minimum wage amendment, it is necessary or useful to look at sources of law, like Nevada state law, Nevada regulations, federal law, federal regulations, sources of that nature. And when he does that -- whether it's to state law, state regulations, or to federal law -- he finds these plans wanting under the amendment. That's the Milone position.

As I understand your position, your position is you acknowledge or state that the minimum wage amendment does not itself specify, beyond saying health insurance must be provided -- the lights have just gone out. Are we okay?

You acknowledge in your report that the minimum wage amendment does not specify what health insurance means, it doesn't contain within it coverage requirements or anything of that sort. But in contrast to Mr. Milone, your position is that we don't need to look at the sources of state

law, state administrator regulations, or federal law that he looks at, because the 2010 to 2015 plans that you reviewed qualify, under your definition, as health insurance plans, and that that's all the minimum wage amendment requires.

Is that an accurate statement of both of your positions?

A I don't want to be difficult, but the -- with respect to the first part, I believe that actually everything we need to determine what is required of an employer to pay the lower of the two minimum wage amounts is all self-contained within the constitutional amendment. I don't believe it's lacking in any descriptions of what an employer must provide.

However, you said that it doesn't explain coverage requirements and so on. I guess I would agree with that. I just don't agree that it needs to or that it would make sense for it to do so.

Q So if I can recharacterize that -- because I respect what you just said -- you said that the amendment says health insurance, even though we would still need to define what health insurance is, and you provided a definition, that

because it says health insurance, it is basically self-contained in the amendment itself?

A I think that's fair.

Q Okay. Fair enough.

Now, you provided a definition of health insurance, I think --

A You had -- your last question to me said that I characterized your two positions correctly, and I said the first one was, and I tried to clarify a little bit.

Was there a second one that I needed to address?

Q Well, I characterized Mr. Milone's and yours, and I wanted to give you a chance to respond as to whether I was being fair about both of them.

A Understood. Okay. Thank you.

Q So nothing further there?

A Okay. Thank you.

Q That was a yes, nothing further?

A If my response addressed the full question, then, no, I have nothing further.

Q Okay. So the Nevada Minimum Wage Amendment, in your opinion, requires employers to provide health insurance. And the conclusion of

your report -- I'll skip to the end, and we'll work through the details in a minute.

The conclusion of your report is that all five of the plans that you looked at, 2010 through 2015, qualify as health insurance or health insurance plans and, therefore, they meet the requirement of the Nevada Minimum Wage Amendment; correct?

A Yes, I believe that all five plans are health insurance plans.

Q Okay. You know, I don't want to have you sort of shooting from the hip when I have your definition in my report, so I'm going to go ahead and read to you what I think your definition of health insurance is. It is -- and I'm reading from MDC001378, which is Section 6A of your report.

Are you there?

A I am.

Q And it's the second sentence -- where I'm starting at the second sentence of that paragraph. "It is common among lawyers, scholars, and other professionals specializing in these areas to generally refer to health insurance as any contract for insurance between an employer and

third-party insurer pursuant to which an employee health benefit plan is administered. All employee health benefit plans are comprised of two basic parts: One, an employer's plan to offer its employees health benefits, usually as part of a larger benefits package made available by the employer to the employee; and, two, someone to administer the plan through the payment of claims submitted to employers under the plan."

Would you agree that that's your definition of health insurance in the report?

A It is, though I think I have a typo.

Q Which one?

A The very last portion of what you read there, it says "Claims submitted by employers under the plan." It would be the employees who are submitting claims.

Q For the insured, I guess?

A Correct.

Q Yeah. Okay. That's fine.

A Employees, or their deponents who are insured.

Q No, exactly. Yeah, I didn't even note that, so I wouldn't have made anything of it, but I thank you for the correction.

But aside from that, this is your definition of what health insurance is?

A It is a definition, yeah.

Q Well, I mean, are there other definitions?

A There are all kinds of definitions on state and federal laws and regulations.

Q Okay. But this is the definition we're sort of going with as the basis of your opinions regarding plans at issue in this case; correct?

A Yes.

Q Okay.

A I'm sorry, I don't -- to me, it's not so much a definition as a way of understanding what is insurance within the context of an employee health benefit plan. That component, as I described it here, within the parts that comprise an employee benefit plan, it's that contract of insurance which provides indemnity or otherwise provides payment for claims, that part is a health insurance contract. I don't know that I would say that's a definition, because it's very nuanced and specific to what we're talking about today.

Q I mean, I'm trying to understand the distinction you're making for purposes of the

opinions you've rendered.

I mean, frankly, all I'm trying to get to is, you know, you're saying, in general, these plans are health insurance. The Minimum Wage Amendment says health insurance is all you need. I'm trying to find out what you think health insurance is comprised of.

And it's seems that this is -- in your report, this is the basis for it; correct?

A What I'm saying is if that part that I described exists, there is an insurance company involved who provides a contract of insurance for the payment of health claims by employees and their dependents, that is health insurance. So if these five plans that we're going to look at are that part, then those are health insurance contracts.

Q Are they that?

A Yes.

Q Okay. And, in fact, on the next page, you have another definition -- we can quibble over whether it's a definition. We're just trying to get to what you mean by health insurance. Okay?

And on the next page in the middle of the paragraph, you say "In other words, health

insurance simply refers to an insurance plan which provides coverage for services related to one's health, such as medical, dental, surgical, and many other forms of treatment"; right?

A Right.

Q So that sort of adds to or perhaps simplifies the definition that I read earlier on the page previously; correct?

A Yeah, I think they say the same thing.

Q Okay. And you go on and say "Any insurance plan which provides coverage for those expenses" -- meaning the health expenses you mentioned in the sentence before -- "incurred in connection with such services is a health insurance plan and commonly referred to as health insurance."

Do you see that?

A I do. Well, where are you at?

Q It's actually the next sentence from the one I read regarding -- that's started "In other words."

A Yes, you read that correctly and, yes, that's my -- my opinion.

Q Okay. So if I can -- and I know there are tremendous levels of nuance to this.

You're saying that lawyers, professionals, industry custom considers the five plans you looked at to be health insurance, therefore, they qualify as health insurance under the Minimum Wage Amendment; correct?

A I'm sorry. I think it was a good question, but could you just say it again?

MR. SCHRAGER: Can you read it back for me?

(Whereupon, the record was read.)

THE WITNESS: No, I'm not sure what you -- what you mean. I'm sorry. Could you --

BY MR. SCHRAGER:

Q Well, you know, you opine that it is common among lawyers, scholars, and other professionals to generally refer to health insurance as, and then you lay out your definition.

The next link in the chain is, these plans do that, therefore, they are considered by lawyers, scholars, and other professionals specializing in these areas -- and I'll even add industry, custom, whatever you want to that -- to be health insurance; correct?

A That's correct.

Q Therefore, in your opinion, it qualifies under the Minimum Wage Amendment to pay the lower wage, these plans do?

A If it otherwise satisfies the requirements of the Minimum Wage Amendment --

Q Correct.

A -- such as the 10 percent threshold and the provision being, you know, offered/made available to employees within six months.

Q And all of their dependents?

A Correct.

Q And, actually, the six-month things comes in the regulations.

A So I believe that it is a -- it is a health insurance plan if it otherwise satisfies those requirements, and then, yes, it would entitle the employer to pay the lower of the two wage amounts.

Q Okay. I think that's well said.

It is a health insurance under your opinion, but to satisfy the Minimum Wage Amendment, it would need to satisfy these other things, as well?

A That's correct.

Q Okay. Just sort of a point of

clarification, so that we have a mutual understanding of what the Minimum Wage Amendment requires other than a health insurance plan, but those other requirements, you know that the 10 percent premium cost cap is related to AGI, by which I assumed you mean adjusted gross income?

A I would -- yes.

Is AGI in my report, is that what you're saying?

Q Yes.

A Yes. That's what I would mean by AGI, yes.

Q Just to clarify in case it comes up later, it's my understanding under the amendment, is that the 10 percent relates to the gross taxable income from the employer, as opposed to everything somebody would put on their -- you know, someone may have two or three jobs, someone may have other income or household income or filed married, whatever; right? Do you -- are you aware of that?

A Do we that have that Minimum Wage Amendment language?

Q I'm sure we do.

MS. FORBUSH: I have it here.

THE WITNESS: I'm not sure what exists there and what exists in the regs, and minor differences in the phrasing can make a difference.

BY MR. WIECZOREK:

Q And, frankly, it's just a point of clarification. It's not important. It doesn't really touch upon your opinion. It's just a point of clarification.

A Yes. So it says more than 10 percent of the employee's gross taxable income from the employer.

Q Right.

A So, yeah, that is -- you're correct, this is actually structured in the way you describe it, which is a little different. Kind of like federal law, which talks about the --

Q It doesn't change anything in your --

A That's correct.

Q Okay. So as you understand the requirement of the Minimum Wage Amendment, apart from the 10 percent or the availability to dependents -- we're just talking about the health insurance part -- the requirements of the thing itself, the health insurance that must be provided in order to pay less than 8.25, those have nothing

to do with the contents of the plan in question itself, meaning specific coverages or levels of coverage or limitations. It is, in fact, more of a structural or mechanistic requirement that it be part of an employee health benefit plan, that someone administers the plans through payment of claims submitted by the insured under the plan; is that correct?

A Well, they impose -- "they" being the Minimum Wage Amendment or the regulations issued pursuant thereto -- they impose no coverage requirements. They just say insurance. However, each state, including Nevada, depending on what type of insurance product it is, type of insurance contract it is, there are other things that dictate what coverage must be.

So it's almost that they require certain coverages by reference, you know, to the -- the statutes. Put another way, these things don't impose any requirements at all.

Q "These things" being?

A Minimum wage amendment and the regs.

Q Got it.

A They just say health insurance. However, health insurance in Nevada has its own

requirements. There's all kinds of things that would be health insurance, are health insurance, but are not and cannot be offered in Nevada, because the statutes and regs of insurance don't allow it.

The statutes and regs also say the products of health insurance that are issued and made available in Nevada have coverage requirements. Some of them actually don't, but I'm saying there are coverage requirements depending on the requirement, but those are not imposed by the amendments or the regs.

Q Okay. I think that's a fascinating point, because it reveals, I think, the different conceptions of the Minimum Wage Amendment on the part of the two experts, yourself and Mr. Milone, regarding what I'll call slippage, in that -- in that Mr. Milone obviously believes that health insurance plans, even under the Minimum Wage Amendment, need to be held to the standards that you're talking about, coverage requirements for -- as a product -- as insurance products sold in Nevada.

What you're describing is that that exists, those coverage requirements exist for

certain health insurance products, but not for health insurance products offered or provided by an employer in an attempt to pay less than 8.25; is that accurate?

A No.

Q Okay.

A I don't know how I can say it another way. I mean -- and I'm not saying that you just don't get it.

Q No, no, no.

A I must not be explaining it well.

Q Trust me, I have very thick skin. There are so many names you can call me, and I probably heard them from my wife this morning. Don't worry about it.

A No, I don't do that.

What I'm saying is the Minimum Wage Amendment and the regs say health insurance. I'm not saying that -- quoting it, but for purpose of what we're saying, it just says health insurance.

Q Sure. Right.

A Okay. Only certain types of health insurance can be offered or made available in Nevada.

Q Okay.

A So an employer can't just make any type of insurance product available to its employees. It has to make available one which is offered by insurance companies authorized to do business in Nevada. That's a smaller universe than what is otherwise insurance.

Q Sure.

A So each of those products have their own requirements within the insurance code and -- and regulations as enforced by the insurance commissioner. So every -- every product does have coverage requirements, and an employer has to offer a plan that mets the requirements of a particular product, not because of the amendment or the regs or any onus on the employer, but because that's all that they have available to them. Only plans that can be issued in Nevada are available to employers.

Q Okay. So -- and I want to follow this logic out. So, for example, MDC wants to pay less than 8.25; right? MDC, being the defendants, wants to pay their employees less than 8.25.

There's a universe of products that they can offer that are health insurance; correct?

A Right.

Q Some of those products, I think it follows from what you just said, would be subject to coverage requirements under Nevada statutes; correct?

A All of those products.

Q All of those products would.

So there are no products that MDC could offer that are not subject to some coverage requirements under Nevada law?

A They are either subject to specific coverage requirements or they are specifically exempted from those coverage requirements by statute, and nothing else. I mean, they have to -- every product has to be blessed, so to speak, by the insurance commissioner. And it will only be blessed if it meets the coverage requirements applicable to that product or if that product is exempted from some or all coverage requirements that would otherwise exist.

Q Does the Minimum Wage Amendment function to exempt any health insurance products from coverage requirements under Nevada law?

A No. The minute wage -- no.

Q Okay. So I'm sort of getting crossed signals here, and I want to be clear myself.

Because it seems as though -- and I may be confusing this entirely -- is that your report suggests that products offered under the Minimum Wage Amendment to qualify an employer to pay less than currently 8.25 are not subject to coverage requirements. But now you're telling me that's not true.

What you're saying merely is that the Minimum Wage Amendment doesn't provide those coverage requirements, but they exist; is that accurate?

A Yeah. I'm saying the Minimum Wage Amendment does not itself impose any type of coverage requirements.

Q Okay. But the health insurance products that are being offered in an attempt to satisfy the conditions of the Minimum Wage Amendment to pay someone less than 8.25, those are subject to certain coverage requirements, depending on what kind of product they are; correct?

A Yes, or they must be specifically exempted by those coverage requirements by statute.

Q Okay. Just for my general knowledge, are the five -- which is the -- let's see.

There's three -- actually four, right, because there's 2010, '11, '12 and '13 are the Cigna Starbridge offered by MDC.

You remember that; correct?

A Yes. And are the 2012 one thing, and then it changed a little bit in '13, from what I recall.

Q You know, what from I understand -- that's a good question. They are the same plan in all respect, except the benefit limits are different. But in all other respects, as far as I can tell, they are identical products.

A I can tell you, how I've been treating it as the '10, '11, and '12 insurance product is one thing. It changed a little bit in '13, so it's -- it's its own thing. And then '14 is a different type, and '15 is a different type.

Q Okay. So I should think of them in four different categories? I mean, is '13 different enough that it's a different kind of product, for the purpose we're talking about, about subjecting it to whatever exemptions or coverage requirements, or are they similar enough that the limitations are really the only difference?

A I believe they would be the same,

although we would have to look at the laws that existed in 2013 versus '12, yeah.

Q Sure. Understood.

Now, you opine that health insurance is a broad enough term that it takes in medical, dental, surgical, many other forms of treatment; right?

A That it takes in?

Q Well, I'll just read what you said. "Health insurance simply refers to an insurance plan which provides coverage for services related to one's health such as medical, dental, surgical, and many other forms of treatment."

A That's correct.

Q Okay. So dental insurance, for example, would be considered health insurance?

A That's a -- that's a difficult question. It would be considered health insurance in that if it truly is insurance, you know, some form of indemnity. It would be health insurance, though statutes and regs may not let it be marketed or sold as an insurance product.

So, yes, it is a dental plan related to health claims. Okay. However, whether that is a type of insurance plan that can be and is offered

depends on statutes and regs, if the commissioner says you can sell this and market it in Nevada.

Q Okay. But so --

A Conceptually, it is, yes.

Q Okay. Sure. Because it sort of follows on that it's a part of an employer's plan to offer health benefit, and there's someone to administer the plan if, for example, I have a basic dental plan in which I pay $10 a month, and for that I get insurance benefits regarding dental care; right?

A Yes. So the context within -- which I use the language that you read, I believe was when I'm talking about reference to the -- well, it's the Nevada regulation that references 26 USC --

Q 213.

A Is that -- am I correct that what you read -- I'm not sure where you're at, but --

Q No, actually.

A Okay. Where are you at?

Q This is at that -- actually, the same paragraph -- we were just looking at the top of MDC001379. Where you're basically saying -- you know, you're still dealing with what is health insurance. And you say "Health insurance simply

refers to an insurance plan which provides coverage for services related to one's health, medical, dental, surgical, many other forms of treatments.

A Gotcha.

Q It's where you're establishing sort of the broadness of what is considered health insurance; correct?

A That is correct.

Q Okay. And so under that, medical would be considered health insurance. Dental would be considered health insurance. Surgical, if it met these other qualities; correct? Meaning someone to administer the plan through payment of claims submitted by the insured under the plan, part of a larger benefit package, those kinds of things, dental would be health insurance?

A Yeah, I would say that the answer I just gave is the same response. And I'm happy to give it again, I just don't want to -- I kind of clarified I think what I'm saying, in that conceptually it is, yes. It provides coverage for a health claim, but that doesn't necessarily mean you can go out and get a, quote, unquote, insurance contract for just dental in Nevada. It

depends whether the insurance commissioner has blessed that plan.

Q Blessed that plan or blessed that plan for a particular purpose?

A Both.

Q Both.

And does the insurance commissioner bless particular plans for a particular purpose as "You can use this dental plan for X, but you can't just it for Y. You can sell it. It's a legal product, but you can't just use it for Y and Z, because that's right out"?

A Specifically the dental, I don't know that it does that.

Q Just an example.

A Okay. But other examples, yes, they say exactly that.

Q So our point in this case, does the insurance commissioner, to your knowledge, bless particular plans for the use at issue in this case, which is to qualify under the minimum wage amendment to pay less than 8.25 an hour?

A Yes.

Q Yes.

And what -- what is that process?

Because I have never seen the certified plan or letter or bulletin or any of those things from the insurance commissioner saying MDC or anyone else, "Your plan, you are good with paying 7.25, because that plan qualifies."

Where do you see those?

A Perhaps I misunderstood your question.

The insurance commissioner blesses any plan that an employer could even make available to its employees. It's not -- the law doesn't function like you described it. The insurance commissioner doesn't go tell employers whether they can pay the lower minimum wage. It's not within their jurisdiction, and it wouldn't, to me, make sense for them to do that.

The labor commissioner, you know, on the other side of the coin, doesn't look at coverage requirements and the reticulated requirements of various chapters of insurance law to say "This plan meets those, so you can or can't pay the Minimum Wage Amendment," which is I think what you were saying. That somebody would bless the employer making those available such that they are then allowed to pay the lower -- it doesn't function that way.

Q Right. Right. I mean, I guess what I'm getting at -- and you have actually brought up a juncture that I think is also interesting in your report, and I'll get to it in a second.

But I guess what I'm getting at is, you know, you said -- okay. All plans are subject to regulations and coverage requirements or whatever insurance products are.

But it depends on the context whether or not a particular insurance product or plan is appropriate and lawful for use for that purposes; correct?

A Yeah. Can I give you an example.

Q Sure.

A Okay. So within 689A, B, or C, or maybe all of them, the statutes will say what a health benefit plan is, and it will say it is this, provides a definition, pretty broad. Everything we have talked about today, I think we can just supplant what our definition, if that's what we're at calling it, in there for the statutes.

The statutes say "A health benefit plan is this, unless it is" and then there are a number of exemptions that say "It is not a health benefit plan and cannot be offered, marketed, and sold as

a health benefit plan if" ...

And I know that some of those kind of carve outs are if it's offered as a supplement. For example, if medical payments are offered as a supplement to accident insurance, that itself -- like car accidents -- that is not a health benefit plan as defined in the statutes.

Q Right.

A So that concept is there, but it doesn't necessarily apply to everything. I just -- it answers your question, I think, of -- I'm trying not to overcomplicate this.

Q It's insurance. It's too late.

A I don't want to ask you questions, but has -- has what I've said so far made sense on this answer?

Q It does. I mean, maybe it's a function of the way I'm asking the questions. Maybe I need to be a little more concrete or at least launch more concrete hypotheticals, and your answers, we can sort of whittle down the issues of what we're talking about.

A Fair enough.

Q Where I was going with this is, you know, you've laid out what health insurance is,

and we've sort of talked about regulation, coverage requirements for particular purposes or particular products. But you've also said that dental insurance, seen the right way, is health insurance. So through this hypothetical, I think we can get to some of the questions and answers that I'm interested in.

Under the Minimum Wage Amendment, could an employer provide merely dental insurance as health insurance and qualify to pay less than 8.25 an hour?

A If the insurance commissioner had approved a plan to be marketed and sold in Nevada as insurance, yes.

Q As insurance or as health insurance?

A Same thing, but -- health insurance, that's how it would be blessed, yes.

Q So if the thing is legal, if you can sell it -- I mean, I think that's where I'm getting now. It seems like now you're bleeding into if a product is legal in Nevada, can be sold in Nevada as an insurance product, as a health insurance product at all, it satisfies the Minimum Wage Amendment's requirement that you provide health insurance plan?

A Yes.

Q Okay. So a dental plan, I mean, I guess -- I don't know, do vision plans count with that?

A Vision is a health benefit, yes.

Q Okay. So the logic of what you're saying -- and this is just stemming from the language of the Minimum Wage Amendment itself, not having to do with any other statute or regulations. I want to sort of isolate this.

For purposes of the Minimum Wage Amendment, an employer could offer or provide his or her employees a dental insurance plan that was legal to be sold in Nevada, and that would qualify them as having provided health insurance under the Minimum Wage Amendment, and they could pay less than 8.25 an hour?

A And we're talking specifically about dental?

Q Yeah. That's the only thing X employer offered, was a dental plan that was legal in Nevada.

A If 26 USC Section 213 includes as a category of expenses dental, and I believe it does, then the answer is yes.

Q Okay. Now, you're tying it to the regulations.

Do you consider NAC 608.100 through 108 -- you know, the ones that cover the Minimum Wage Amendment -- do you consider those to be determinative as an interpretation of what's required under the Minimum Wage Amendment?

A It is certainly an interpretation.

Q Is it determinative?

A When you say "determinative," what do you mean? Is it the authority?

Q Yeah.

A Does it impose its own requirements?

Q Yeah.

A I don't believe that that regulation would impose any requirements that don't exist within the Minimum Wage Amendment; however --

Q That's not exactly what I'm asking.

What I'm asking you is the weight and force of the regulations as opposed to -- I mean, I understand your position that 608, I think it's 102(a)(1) -- you know, the one that says 26 USC 213.

A Yeah.

Q I understand your position is that that

doesn't impose coverage requirements, that it describes health insurance basically?

A That's correct.

Q Right. I understand that. Let's step back with -- from that and get some sort of meta context was, does the fact that the insurance commissioner said that control our interpretation of the Minimum Wage Amendment? You understand what I'm asking now?

A Control, yes. I can't just say yes without a qualifier, although I think we're saying the same thing. The whole purpose of regulations are not to impose additional requirements that don't exist within statutes or, here, constitution. Regulations are typically intended to assist in the enforcement and interpretation of those statutes.

Sometimes that looks like additional requirements. It depends what those things are, whether they're additional requirements or just the interpretation and the way of enforcing what the actual law says.

Q Because it cannot exceed statutory or constitutional authority?

A That's correct.

Q So, I mean, you know, sometimes the complexity or noncomplexity of the regulation is a function of the complexity or noncomplexity of the authorized statute or constitution. Because if there's more of the statute, you may need less in the regulation.

A I think that's fair.

Q I think that's right.

But what I asked you could an employer just offer a dental plan, legal in Nevada, all of those things I said, you didn't just say yes. You qualified it by saying if it met the requirements of 608.102. You said if it's under 26 USC 213, and I think it is, were your words, then it would; right?

A Yes.

Q Okay. So you were interpreting what the Minimum Wage Amendment requires through the regulation?

A Not -- not really. I just -- you accurately described what my opinion is. The reference to that statute is a way of describing health benefits. What is health? It's medical, it's dental, it's vision, it's a lot of things. Dental I believe is a health benefit.

I made that qualification because I want to make sure that specifically here, dental is one of those things that nobody would disagree with me.

Q I understand. I understand.

A Dental is a health benefit. It -- my answer was ultimately yes, because it is a health benefit.

Q Understood.

So you were sort of using the regulation not as the final word on the interpretation of the amendment. You were using the amendment -- or the regulations as, "Here is one definition of health benefits. Dental meets that. That's what you need under the amendment, and therefore it meets the amendment"?

A That's correct.

Q Okay. See, we work these things out as we go. We get to where we need to be.

So you looked at all six plans, 2010 through 2015. And, you know, this may set off an entire lengthy discussion, but I'll throw this question out there, and you can deal with it the best you can.

Are you all right?

A Yeah.

Q Now, we talked about every product has coverage requirements or particular regulation, depending what the product is, depending what you're using it for, depending on a number of things.

Having looked at all five of the plans, could an insurer -- not an employer, just an insurer, an insurance company -- Cigna, Transamerica. I don't even know who does the MVP plan. It's kind of fairly mysterious.

Can an insurer sell those plans on their own as health insurance in Nevada -- and I know you're going to break it down by the year that they were offered; right? So, you know, feel free to go ahead and do that.

But I want to get into the discussion of -- not the employer. Because you make a distinction of who is regulated under 689 A and B, who is regulated under 608, who's responsible for compliance under --

A That's correct.

Q I completely respect that, and we'll -- we'll get to all of that at some point.

Can an insurer sell each of these six

plans at the time they were sold as health insurance in Nevada?

A Yes.

Q Okay. Every single one of them qualifies under the particular coverage requirements to be sold as health insurance in Nevada?

A Or are exempted from those requirements by statute, yes.

Q Okay. Which is which? Out of the six plans, which were exempted when they were sold, and which ones meet the requirements when they were sold?

A Well, every product has requirements. Some of those requirements are coverage requirements. There are requirements who can they be offered to, when can they be offered, how can they be marketed, all kinds of things. But specific to coverage, every product has a set of coverage requirements or is specifically exempted from some or all of those requirements.

Q Right.

A Okay. So you're asking which of these plans is exempted and which of these --

Q Well, you said these are all good.

A And they're all good.

Q They're all good, meaning they are -- there's a --

A Fair.

Q -- they're compliant.

Some of them maybe compliant because they're exempted from the standards you're talking about. Some of them may be good or compliant because they meet whatever coverage requirements there are. So they're good or compliant for one of those two reasons. I'm asking you to go through for me -- if you can, go through them and say which is which.

A Okay. So 2010 to 2012, if we look at those plans, it's -- it's a little difficult at this point, frankly -- and I think we need to talk about this, but with the Affordable Care Act and the state counterparts that Nevada instituted between 2011 and now -- 2013 specifically, the requirements I'm talking about now -- it changed what types of plans can be offered and are offered, because we have the marketplace now.

Prior to that change, there were a number of products that could be and were offered that I think are no longer offered. 2010 to 2012

plans I believe would -- were something that could be offered then, may not be offered now. Okay? So that is -- I mean, we can go a lot of directions that with. Tell me where you want me to go from there.

Q I mean, I understand the 2010 through -- actually, 2013, if I can include that in the same package, because they're similar products.

A Yeah.

Q There were limited benefit health plans; correct?

A That's --

Q The Starbridge limited benefits?

A Yeah, I don't know that that is, like, a thing, a definition within the statutes, but that language is used on the plan documents.

Q Right. And it's my understanding that those were discontinued perhaps from a -- from an economic perspective, but also from a legal perspective. Because after a certain point in the maturity or -- or effectiveness of the Affordable Care Act, an insurer could no longer offer health insurance that, for example, had -- help me here -- capped payouts; is that --

A Among other things.

Q Among other things having to do with --

A Yeah, so -- I don't want to get too far afield from your question.

Q Sure.

A If I do, cut me off.

Q Okay. Stop. I'm kidding.

A You're joking? Okay.

Talking specifically about prior to '13, there were what are called basic health benefit plans and standard health benefit plans, each of those things having their own definition.

Q In state law?

A Yes. 689A and 689C, both provided for those things.

Q Okay.

A Standard and basic health benefit plans.

Q And just to be clear, 689A regulates individual health insurance?

A That's correct.

Q And 689C is offered by small employers?

A That's correct.

Q Okay. You know, just so we're clear, do you understand any of the defendants in this case to meet the definition of a small employer?

A I do not believe so.

Q Okay. So you're saying this for illustration, but it -- but anything having to do with 689C would have no actual direct and legal impact on the parties in this case?

A If it were so easy. You would think that's the case, however, what I'm go going to tell you actually implicates 689C by reference and applies it to individual plans.

Q Okay.

A Okay. So basic and -- so in 1997 when federal law, HIPAA, was enacted, there were things that states had to do to comply, as well. Nevada opted to do -- I forget the terminology, but it was a -- an alternative method of making coverage available to individuals who loose coverage under a group plan. Okay. So HIPAA is -- the portable part is what we're talking about.

Q Portable. I got that.

A So I'm working for an employer that has a group plan. I leave the group plan. Prior to HIPAA, people have a problem getting insurance after that. HIPAA wanted to change that, and the way that they changed it at the state level was to set up a whole system whereby there are products that that individual can, as a matter of right, if

he's eligible, purchase immediately and have the coverage that HIPAA wanted individuals to have.

Okay. Nevada did that by saying providers must make available a basic and standard health benefit plan.

Q To people in this situation who had -- who have left their employ and lost their group health insurance?

A Yes. Yes. So those basic and standard health benefits plans are offered for, I believe, three reasons -- or in three context: One, can people -- the people I've just been talking about that leave their employer and then want individual coverage; two, lose group coverage under 689B, but could get it under 689C, so small employer.

Q So they go from a large employer to a small employer, or the employer shrinks? How do you explain the lost 689B coverage, but now you go to 689C?

A Switching jobs.

Q Okay. Go to a small employer that qualifies under 689C?

A Yeah.

Q Okay.

A So those plans were the three context in

which they were to be made available: To individuals as part of a small group, small employer scheme under 689C, and as what are called converted policies from group health plans.

So if I had coverage under a group health plan and I quit, the -- these regulations and statutes said the insurance company -- let's say I had Aetna for that large group. When I leave, Aetna has to have an individual plan that I can -- that I can grab, that I can sign up for, and those that -- those are called converted policies. You're within a group, it's converted to individual.

Those converted policies were these basic and standard health benefit plans. So that's the third way in which they, you know, interacted here with pre-2013 Nevada state law.

Q Got it.

A Okay. So --

Q Let me just say -- let me just add -- and I don't mean to interrupt your flow. I just want to say as a public policy matter, this seems to be -- this seems to be something we want, because it -- it increases access or keeps people insured who would otherwise maybe lose their

insurance?

A Yeah. The Feds did. I mean, under HIPAA -- and then we have state requirements, yeah, as a result thereof.

So those are what I'm referring to as basic standard -- excuse me, basic and standard health benefit plans. Those are defined in 689C and 689A.

Q Were or still are?

A Were.

Q Okay.

A In 2013 it changed. So you've got to go back, and as a practical matter, you have to look at 2011, because our statutes are only published every two years. So you go look at the 2011 statutes. Those health benefit plans are defined and addressed in 689C and A.

Okay. So you said 689C would have no application, and I was a pain, because not really.

Q In this instance, it may?

A In this instance, 689C includes a statute that says these basic and standard health benefit plans are not subject to coverage requirements found elsewhere in the statutes. Okay. "A" does not have a similar provision.

689A does not have a similar provision.

Q Okay.

A What it says is that statute within 689C applies.

Q I see. So it -- so it incorporates --

A Incorporation by reference.

Q I understand what you're saying.

A Okay.

Q So these basic and standard plans you're talking about in pre-'13, they did have coverage requirements?

A When you say "coverage requirements," you mean what --

Q I mean, from a layman's perspective, you're saying, all right, you leave Aetna or wherever you work, and you had this group plan, but these other plans now are going to be available to you. Under the policy, you know, increasing or continuing health insurance coverage, you can have these basic or standard plans, which must be offered to you by virtue of the statute; correct?

A Yes.

Q Okay. Did those plans have coverage requirements -- I mean, did they have to have

qualities about them to be the things you're talking about, basic and standard plans offered to people?

A Okay. So I was just stumped by what you mean by coverage.

Do you mean certain services have to be covered, or they have to cover a certain portion of the actual charge? Do you mean both? Anything?

Q Yeah, yeah, yeah.

A Okay. So, yes. So how it worked was when the laws -- it was AB 521 in 1997 that put together and rolled out this state counterpart to HIPAA that I've been talking about.

Q Right.

A It established that -- AB 521 established a committee, a health benefit plan committee whose duties were to, among other things, get together and come up with what should be the requirements -- coverage requirements -- any requirements of these basic and standard health benefit plans.

Q Which were new in '97?

A That's correct.

Q -- as a statutory --

A They were called something new. Whether they existed before, I don't know.

Q That's fair. That's fair.

A Okay. But the committee did that, and I believe they had to issue that report every three years. So if -- if all of this weren't done away with, we would probably be able to go back and find a report from '98, 2001, '4, '7, '10; right?

Q Probably still could. Probably out there somewhere.

A I've looked.

Q Oh, okay. Well, you would know where to look better than I.

A Well, I've looked a lot, and I can't find all of them. But, for example, you can go find -- and it's included in my work file. You can go find that report from 2001 and I believe 2004, and that report has in exhibits "This is what standard and basic health benefit plans must provide."

Q Must contain. Okay.

A So if those are coverage requirements, yes. All of the requirements of those plans are set forth in those exhibits.

Q And were those codified in statute?

Regulations? You're saying these reports. Was it more like a bulletin like the insurance commissioner puts out now? How do you characterize the thing?

A They weren't in bulletins. They -- again, because so much of this has gone away, I can't access it. The reports were not authoritative themselves, of course. The committee was to report its recommendation to the commissioner. That much I know. I believe then -- though I can't confirm, because these things aren't available -- the commissioner would accept and issue regulations adopting them.

Q Okay. You expect that's true, but you don't know for sure?

A Yes.

Q Maybe we could look at the regulations from that period.

A I've tried, and --

Q Also difficult?

A Also difficult, but that I think is possible. And I believe that to be the case, because, yeah, the reports themselves have no authority.

Q Okay. This was a long way -- but I

appreciate everything you said, because I followed it. This is a long way of sort of getting back to -- well, let me ask this question first: What you're talking about does not implicit 689B. The standard and basic plans you're telling me were -- were created or referenced regulated under, I guess, 689A and 689C; correct?

A Yeah. Primarily A, yes.

Q Okay. Now, the question that started all of this was, can an insurer sell 2010 to 2015 plans as health insurance in Nevada? You said that for 2010 to 2012, yes, they could; correct?

A I think we're saying '13.

Q That's fine. You can add that, as well.

A But, yes. '12, '13, yes, those three -- four years -- first four years, yes.

Q Yeah, which -- you know, the complexity of how they change and everything, we've already talked about.

But do you base that opinion because those plans met the requirements for a basic and standard plan as you just described?

A From what I have access to now, yes. That is part of the -- I believe that they more than likely were what Cigna was required to

provide as basic and standard health benefit plans during the relevant time periods and would be subject to those reports as adopted.

Q Okay. But you would agree that the 2012 through 2010 plans sold by Cigna, offered by MDC, were not offered in the situation or circumstances you're talking about. They weren't offered to individuals who had just left their job and lost their group health insurance. They were offered as insurance, however else you want to characterize it, as insurance plans to employees at their certain job.

A Right.

Q So why does the -- why did the standards for basic or standard plan -- which as you've described to me, apply to the circumstances we just discussed -- why do those support that an insurer can sell -- well, that's because I asked that question; right? Can an insurer sell it?

So let me ask you this: Could an insurer sell these plans as health insurance in Nevada in 2010 through 2013 as a plan, other than a simple or basic plan under those circumstances?

A It's standard and basic. Not to correct you, but just for the record.

Q What did I say?

A Simple and basic. Kind of the same thing.

Q Oh, okay.

A I believe so. I don't -- I just cannot go -- I don't have available to me a definitive answer on that, because I don't have, as it existed, what was required of those plans at this time.

Q Okay.

A Also, the online access that used to exist where I could go look and see what plans has Cigna produced as its standard and basic. We could have answered it very easily before if I had access to that system that's no longer available.

So I believe that to be the case; however, the other reason that I think they could be offered as health insurance here is, frankly, because they were. I believe -- I believe the health -- the insurance commissioner blessed these things. They were approved and were allowed to be sold as health insurance plans.

Q Okay. I mean, do you know whether they were blessed as standard and basic plans under the scheme you're talking about, or some other?

A I don't know.

Q Okay. And so I'm clear -- and I know this is going to open a can of worm that we'll get to in a minute. You're not talking about group health plans in this context; right? The standard and basic plans -- because you're basically analogizing; right? You're saying, okay, because there were these standard and basic plans under 689A and 689C, these could be legally sold, probably by analogy, to the coverage requirements necessary for those.

None of those applies if these plans are group plans. You would have to find another basis for why these -- the 2010 and '13 or '12 plan could be sold in Nevada if it's group insurance?

A So just to make sure I understand your question, if the 2010 to '13 plans were subject to group plan requirements --

Q Correct.

A -- then would this concept of basic and standard health benefit plans apply?

Q Yes.

A Not outside of the context that I have already talked about, when you're leaving one of those.

Q Right. But if you're just in your job?

A Those plans are not part of the group plan market. That's the terminology that the commissioner would use.

Q I understand that's your position.

A Oh, okay.

Q Right. I mean, it is your position. You understand that there is a discrepancy, or at least a disagreement, between yourself and Mr. Milone as to whether all of these plans -- not just 2010 or 2012, but all of the plans are properly or would properly be regulated or defined or covered as either individual health insurance under 689A or group health insurance under 689B?

A That I do understand and agree with, yes.

Q Okay. That there's a discrepancy?

A Correct.

Q All right. We will get to that.

Okay. So the 2014 plan, the Transchoice advance plan, do you remember this plan?

A Yeah.

Q Okay.

A I don't remember that language, but I was looking at a 2014 plan.

What did you say? Transchoice?

Q I think the formal name is Transchoice Advanced or something like that. It was sold by Transamerica.

A Yes.

Q Do you recall that it's a health -- it's a hospital indemnity plan?

A I believe that's correct.

Q Okay. You know what a hospital indemnity plan is?

A I do.

Q Is that considered group health benefits under state and federal law?

A That plan is, in my opinion, unquestionably group insurance and would be subject to 689B.

Q Okay. Right.

But it also is group health insurance?

A It is.

Q It is, number one, health insurance?

A It is.

Q And the kind of health insurance, you're saying it is group health insurance --

A It is.

Q -- regulated by 689B?

A It is.

Do you mind if I just stand up and get a bottle of water?

Q No, no, no.

A We don't need to take a break.

Q Okay. So having just said that, that the 2014 plan, the hospital indemnity plan is unquestionably, in your mind, group health insurance regulated by 689B, I'm trying to square that with your opinion, you know, that's in your report.

What you seem to be saying is that if an insurer sells it, it's regulated under 689B and needs to meet all these things. But if the employer offers it to their employees as health insurance, it doesn't have to meet the coverage requirements in 689B; is that correct?

A No. No, I'm saying 2010 through 2013 were individual plans, and 689A applied. 2014 was a different animal. That was a different plan altogether, and that was a group plan, as well was the '15 plan, so those things are subject to 689B.

Q Understood.

A Which is what my position has always been.

Q But you don't actually contend that the 2014 and 2015 plans meet all of the requirements of 689B, do you? I mean, that's -- that doesn't appear to be contestable. There are a myriad of coverage requirements and other things in 689B that are just -- it's clear on its case that the 2014 plan doesn't meet them.

A Like what?

Q Well, for example, you know, the autism spectrum disorder or the -- or the coverage for alcohol and drug dependency. I mean, there are -- food for metabolic disorders, all of those things, none of those things are covered under the 2014 plan, as far as I can tell. At least that's what Mr. Milone says.

I didn't see anything in your report that said, "Okay. Yes" -- I mean, you did say that the 2014 plan is a group plan.

A Yes.

Q I absolutely saw that.

I did not see you say, "And it meets all of the requirements of 689B." In fact, what you said was it doesn't have to. It doesn't apply.

A Can you tell me where I said that?

Q Well, it goes along with your idea that

all you have to offer under the Minimum Wage Amendment is health insurance in order to pay less than $8.25; right?

A Right.

Q So the fact that the 2014 plan is health insurance, what I got from your report was that's enough. It doesn't have to comply additionally with 689B.

A 689B has a slew of requirements. It's a very long statute.

Q Sure. Yeah.

A Not all of those are going to apply to all group plans. For example, regulations made clear that if a policy existed prior -- so, for example, if we had a 2013 plan that was renewed prior to 2014 and a new requirement came in 2014, it didn't have to comply. That would be an example of --

Q This is grandfathered, in essence?

A Yes.

Q But you're not talking about -- or that's the concept under the ACA?

A The reason I hesitated is because "grandfathered" is specifically the terminology used in the ACA. I'm not sure it was the same

terminology used in the state statutes, but the consent is the same, yes.

If it was a plan that was blessed by the insurance commissioner prior to some new coverage requirements, depending on what those requirements were, regulations would say you can continue to offer them if they meet the requirements of being what is a grandfathered plan, although they may not have called it a grandfathered plan.

Q And what in Nevada were the requirements for being a grandfathered plan?

A It depends. Within 689B, we would have to look.

Q I mean, I'm having a hard time thinking that this is sort of endless, that you could have a plan that was fine, you know, a long time ago, you utterly updated all of the requirements, but you get to stick with the old one because we made changes later. I mean, it would seem that you have to update your coverage as the statutes change.

A It always does. I don't know -- I think it probably depends what requirement we're talking about. We could get into 689B NRS and the NAC to look at one, but I think we're on the same page.

I can just give you by analogy. So, like, the ACA has grandfathered plans. It doesn't say you can continue to offer them into perpetuity, but you don't have to comply in 2014, and then they were further exempt in 2015, I believe, but that doesn't go on forever. It's either a sunset law where -- do you know what that is?

Q Yeah.

A Okay. So it's either a sunset law or --

Q You get a certain amount of time, and it expired on its own terms or whatever.

A Yes. Or it's something that is not exempted until we say it is. So it might be exempted in 2014, and it's not grandfathered and exempted in 2015 until we say it is. So it's not perpetuity.

Q And is this -- help me understand this. Because as I understand -- just as an analogy, grandfathering under the ACA, if you -- that that had to do with the employer having the plan, as opposed to simply the product itself is grandfathered forever. That if an employer switched plans, you didn't get the benefit of the grandfathering of that particular plan you're

taking on. Because you're buying a new plan, you have to -- you have to meet the new requirements.

Is that your understanding?

A I don't know that that's correct. My understanding of a grandfathered plan under the ACA is a plan that was offered prior to January 1 of 2010 on terms that have not been substantially modified since that time. So it's that they were offered prior to a date certain -- and in this instance, that date certain was 2010 -- and it hasn't changed.

So it's not the employer was offering that to its employees. It's that the insurer had this product that was available, and it could continue to make it available.

Q It could continue to make it available, but could the -- so it had nothing to do with the renewal? For example, the employer says, "I'm going to renew this grandfathered plan, 2011, 2013, 2013, and then I'm going to switch to something else in 2014, and I don't get the benefit of grandfathering the old one. I have to get a plan that is no longer grandfathered, but meets the new requirements"?

A Yes, I believe what you said is correct.

Q I think so.

So, I mean, going back, do you know if that's how it worked in Nevada? I mean, we're talking about the ACA. Under the system you're talking about -- which I guess is a Nevada version of grandfathering -- did it work the same way as far as renewal and grandfathering and how you got grandfathered?

A That an employer could -- could the employer -- is your question could an employer in Nevada offer a plan which it did not previously offer as a grandfathered plan?

Q Yeah. That's essentially it, yeah.

A Okay. I believe so.

Q Okay. Where can you point me so I can learn more about this? Because I need to know, rather than having you believe it.

A The 689 -- well, we're talking about B here, NRS and NAC, in 2011.

Q Okay.

A Some of which is on that disk.

Q Okay. Excellent.

A In fact, the NRS I gave you the full -- it's the whole chapter. The NAC, I don't know, but I think I have access to an archived version

of it.

Q I actually have them all here.

A Actually, '11 --

Q Oh, okay. Understood.

A If you need to find them online, Justia.com has the archived version.

Q Okay. I appreciate that.

You know, we talked a little bit about ACA, mostly by analogy. Obviously Mr. Milone talks about ACA, because it seems that when he's searching for ways to define health insurance, he's sort of reaching for various standards from various sources of state law, but also federal and the ACA being one of those things; correct?

A Mr. Milone's report?

Q Yes.

A Yes.

Q You actually don't do that. In fact -- I just want to be clear. Your position appears to be that the ACA is irrelevant to the issues presented.

A It is certainly irrelevant to the Minimum Wage Amendment and whether a particular insurance would entitle an employer to pay a lower minimum wage. I just want to look at the issues

presented and make sure I can say that uncategorically, too, or categorically.

So the first issue presented, which is the standards used to exist what is health insurance as used in the Minimum Wage Amendment, yes, it's my opinion that the ACA is completely and totally irrelevant to that analysis.

Q Okay.

A The second issue presented is in analysis of plan documents produced in this case in light of those standards. So I'm not sure --

Q Well, if the standards don't have anything to do with the ACA, it's hard to say that the plan documents need to be applied to the standards.

A Yeah. The ACA doesn't have anything to do with -- so the first issue presented, which then I think the second one doesn't make any sense.

Q Logically, yeah.

Okay. So it's irrelevant to the issues in the case, as far as you're concerned?

A Absolutely.

Q That doesn't mean that it can't have value for understanding particular terms or any

context, but for the -- but I understand what you're saying. In fact, you say it a couple of times in your report.

And sort of following on from that, does it not follow, then, that in your opinion, the Minimum Wage Amendment having been enacted in 2006, the Affordable Car Act having been enacted in 2010 but having various dates of effectiveness over the years, the Affordable Care Act did not change the duties and responsibilities of a Nevada employer under the Minimum Wage Amendment?

A That's correct.

Q Okay.

A You said it could be useful for other purposes. I don't think you asked me to confirm that. I frankly don't think it could be useful for any purposes. I just want to be clear.

Q You know, the only thing that crossed my mind -- and I'll be perfectly open with you about this, is that there's a -- you know, there's a definition of health insurance coverage in the ACA, as there is in HIPAA and as there is in lots of different places.

A Right.

Q One of the things that the ACA says --

and actually I think this may be a Nevada statute, as well, or at least one of them -- is this notion of accepted benefits, which I know is an ACA term. It may not be a -- a Nevada term, a state law term.

You know what excepted benefits are?

A I do.

Q Okay?

A But usually, as that term is used in the ERISA world, the employee benefits world, we refer to it as being part of the Public Health and Welfare Act, so not -- it's not part of the ACA, though --

Q I think it is.

A Well, it's implicated by. But excepted benefits are defined within the Public Health and Welfare Act. Okay?

Q Okay. I mean, they may be defined either for the same purpose or for different purposes in each, but I'm pretty sure that there's a -- there's a definition of accepted benefits in the ACA pretty close to the definition of what health insurance coverage is.

A My recollection is that it refers to the Public Health and Welfare Act as to what is

excepted benefits.

Q It's actually neither here nor there, we don't need to quibble over this, but when we're talking about the how the ACA can shed light or context on definitions, concepts, and ideas, is that excepted benefits are not considered under the ACA to be benefits for medical care; is that correct?

A I would have to get the statute out.

Q Sure.

A What the import of excepted benefits are is that if an insurance product or anything is an excepted benefit, it's not subject to the Affordable Care Act's requirements.

Q As a result?

A Of being excepted.

Q Well, being excepted, because it's not considered benefits for medical care.

A That's what you're saying. I don't --

Q That's what I think the statute says.

A I would have to look at it. I'm not disagreeing with you, but I just can't take that position.

Q Sure. And it can be easily confirmed by --

A Right.

Q -- by referring to the statute, so there's no need for us to -- you know, someone to say uncle.

A Right. Right.

Q What I will say is that it's my recollection, if I'm right by excepted benefits not being treated as benefits for medical care, is that fixed indemnity or hospital indemnity policies fall under excepted benefit and are specifically not considered benefits for medical care under ACA.

Do you have any recollection of that?

A Yes. In fact, there's quite a bit of discussion about that. And you can't say it categorically, because people were issuing things as hospital indemnity plans that weren't technically meeting all the requirements, so they, therefore, weren't excepted benefits.

Q Because they called them that, but they weren't that thing, so by definition, they fell under not excepted benefits?

A They weren't excepted, yes.

Q Right. But it wasn't that hospital indemnity plans were not excepted benefit. That

had to do with the specific circumstances of that plan?

A You got it.

Q Okay. Got it.

So you do recall what I'm talking about?

A I do.

Q Okay. I just want to get some -- some language questions from you.

A couple of times you used the -- you used the terminology or the phrasing when you're talking about the requirements for health insurance under the Minimum Wage Amendment, and you say, "The amendment doesn't create any heightened or changed or increased coverage benefits under its own terms."

Do you remember using that phrase a couple of times?

A It doesn't create any. Not increased or additional, it doesn't create any.

Q That's what I wanted to clarify. Because that was my question after you say it doesn't create any heightened, is heightened from what?

A Right.

Q But you're saying it doesn't create

any --

A Right.

Q -- so you may have inartfully stated it, but that's what you mean?

A If -- yeah.

Q Okay. I'm actually fairly close to the end.

You don't understand the 2010 through 2015 plan to be employer sponsored plans, do you?

A Which plan?

Q Any of them.

A Yeah, I do.

Q Okay. By "employer sponsored," I mean -- you know, you draw the distinction of employer sponsor plan being different from a contractor insurance with a third-party insurer whereby -- okay. I'm being inexact in my language, but I think you know what I'm getting at.

A I don't. I'm sorry. I'm not being difficult, but --

Q Okay. You draw the distinction of an employer sponsored plan, meaning they're self-insured in a way.

A No. So a plan sponsor doesn't mean

who's paying claims.

Q Okay.

A So no.

Q I mean, it's -- you do make this distinction --

A There is certainly the --

Q Self-funded. That's the word I'm looking for. I'm sorry. Self-funded health benefits plans do not create a policy of insurance; correct?

A Do not create a policy of insurance? Self-funded or self-insured health benefit plans do not have a contract of insurance as between the employer and an insurance company. It doesn't exist. They're paying them themselves. That doesn't mean that the benefits provided to the individual isn't itself an insurance.

Q Understood. That's an important distinction. Thank you for that.

But the 2010 through 2015 plans are not what you would call self-funded?

A I don't believe any of these are self-funded, though I don't know that I have all of the information to be 100 percent certain on that. But if you were asking me to -- my -- I

don't even want to say "guess," because I'm more sure than that. I do not believe that they are self-insured. There's one thing I would like to look at.

Q But it stands to reason, you know, they bought four plans or entered into a contract with four plans from Cigna, the Starbridge, next from Transamerica, next was the MVP plan. I mean, those appear to be contracts with insurers to provide health insurance benefits to their employees, correct, which created an insurance policy.

A So I can tell you unequivocally 2010 through 2013 were not self-insured plans. 2014 I believe is the case -- that's the case, as well. But either the 2014 or the 2015 plan was lacking in some information that I think I would need to make a conclusive "No questions asked, this is not self-insured."

All of that said, I still don't think they are.

Q What's the piece of information you would --

A So can we look at the 2015 plan?

Q Sure. If you want, we can mark that as

Exhibit 5.

MR. SCHRAGER: Will you mark that as Exhibit 5, please.

(Exhibit No. 5 was marked.)

BY MR. WIECZOREK:

Q Okay. You have before you what I have had marked as Deposition Exhibit 5.

Do you recognize that?

A Yes.

Q What is that? What is that document?

A Let me just read all the way through it, please.

So I believe this is -- well, it's plan documents for the -- for what was offered in 2015. What type of plan document, I don't know. For example, I -- I have -- I was provided for the 2014 plan a proposal, a summary, and the actual plan. 2015, this is a plan document for what was offered.

Q That's fair.

Okay. So we were talking about your consideration of whether there was a self-funded plan, and you said you needed a piece of information, that maybe looking at this would help you --

A Yeah.

Q -- to determine.

What do you think?

A Was there -- I'm sorry, I just -- I've got my own documents, I just -- as a deponent, I don't want to go looking through my own stuff, unless you tell me to.

Was there any other documentation provided for the '15 plan other than this?

Q You got what I got. I would like to have more documentation.

A At the risk of twerking you out, can we look at the '14 plan? Because --

Q Oh, sure. It's a completely different plan, both in character and --

A What I want to see is -- it's going to be at the front of the plan document, whether the summary or proposal. It describes who the players, the sponsor, the --

Q Policies holder, I know exactly what you're talking about.

A Right.

Q And you don't have that for this?

A I don't have that for this, but one of them that I looked at I thought was lacking and

made me have just a little bit of an inkling that maybe this could be possibly -- maybe, maybe be self-insured. And I can tell you what made me think that and what additional information I would need, but it wasn't this document that made me think that.

Q Okay. But your instinct tells you there's nothing on here that indicates it is a self-funded plan, but you can't say definitively, because you don't have particular pieces of information that would confirm that?

A So, in other words, I said 2014 may be. 2015 is the one I have questions on. I'm saying I think maybe it was 2014 I had questions on. If we can look at that --

Q It's really not that important.

A Okay.

Q Frankly, I mean, it's -- there's nothing -- I'll represent to you that there's nothing that would indicate to us in our analysis that any of the plans are self-funded.

A Okay. Self-funded is a very broad definition, and it doesn't mean large employers anymore. So you -- a lot of times you would assume that they're not self-funded, but they are.

Q Real quickly, just to clear up a couple of things, and then we'll get to the last thing. So there's two quick questions, and then the last thing.

I know you say that the ACA is more or less irrelevant to the issues presented in the case. But you do mention that -- you know, Milone talks about essential health benefits and minimal essential coverage. And it says the '14 and '15 plans don't meet those standards, because his opinion is, at best, unreliable, as Milone simply does not have all of the information required to make this determination, the determination being they don't meet those particular standards. That's on 001375 of your --

A Thank you.

Q -- of your report.

A I'm there.

Q It's at the -- it's the next to the last paragraph or the last full paragraph in the middle.

A Starting with "Note"?

Q Yes.

A Okay.

Q And sort of in the middles of that

paragraph, it says -- well, actually it says what it says.

A Yep. I'm there.

Q What information would you have needed to make that requirement -- or would he have needed to make that determination?

A Well, I say, "For example, if any of the plans analyzed under the ACA have grandfathered status," that's one thing. He, I don't think, looked at that. I believe the 2014 plan did have grandfather status.

Q Well, it said here you think 2013 does; right? Is that what you mean?

A Yes.

Q Okay. I actually think 2013 doesn't have grandfather status, and I only say that because it says it doesn't have grandfather status.

Is there some circumstance in which a plan would say this is not a grandfathered plan under the Affordable Care Act, but would still get grandfathered status? I'm not trying to trip you up here.

A No, it's a fair question, and one that occurred to me as I was looking at these things.

So if it's not grandfathered, they have to tell you. Just disclosure requirements, they have to say a statement as to whether it is or it isn't. But they maybe seeking grandfather status at the time that they have to make that disclosure, so sometimes that could provide conflicting information that it isn't, but we think it is.

Q Okay.

A Does that make sense?

Q Well, it's like pending. We are sort of -- "We are finding out whether it has grandfather status"?

A Yeah, but they -- a little more affirmative in that we think it is. It technically isn't, but we think it is, and we have submitted and are waiting.

Q Okay. Well, actually, why don't we have a quick look at it.

A But --

Q This is the --

A Okay. We're going to look at the '13 plan, because you -- I don't know that I was slipping up and may have confused them. I'm just saying 2014, I don't know if he analyzed that.

But you know what, yeah, there was one that actually I think was actually grandfathered, and I think it may be the '13 plan.

Q I just want to clear that up.

A Can I take a bathroom break in the future? Not immediately. Let's finish the thought.

Q We're probably 15 minutes from walking out of here. Can you make it?

A Yeah.

Q How about if I don't enter this. Is that okay with you? How about if I show you this?

A Show me?

Q This is my copy of the '10 to 2013 plan, which is -- which is added to by the -- by this version of the 2013 plan.

Here is what I'm looking at. This is also on the front of this, as well.

A Forgive me, if you will. My vision is not that great.

Q Join the club.

A Well, I'm one of the few people that surgery went horribly wrong. I was better off before.

Okay. So you were -- I thought this was

98, right? Is that --

Q That's MDC 98, yeah. No, this is a different --

A Yeah.

Q This was the --

A Oh, so you're asking me to look at this? I don't have it here?

Q Right.

A Got it.

May I?

Q Sure, sure, sure.

And the only reason I say this, you noted that you thought 2013 was grandfathered. And the only thing I know is it says on there it's not, and I just want to know the circumstances of which --

A The very next page ending in 99, that -- there's a paragraph that says "Notice of grandfathered plan status," so that's what I was referring to.

Q Okay.

A I agree that those are conflicting in some way.

Q It's confusing.

A And as is often the case, when you

compile insurance plan documents five years after the fact, I don't know that they were -- how they were compiled, whether they are in the sequence that they were offered originally. I couldn't square those two things myself either.

Q Okay. That's fine.

A But when I read this, it's seemed unequivocal that it was grandfathered. In a vacuum, admittedly, if you don't look at the prior page.

Q Right.

Same thing, I guess, on this one, which also has the -- I don't know if inside it has language like you showed me in here.

A Right.

Q But it also says the same thing on the -- on the front. I mean, I don't know how to square it up, either.

A A possibility is that these things were compiled at different times. I mean, same plan but, for example, an employee in January 1 of 2013 may have a different document than somebody in February gets, because that pending status has changed.

Q Understood.

A And these things have been meshed.

Q Those copies may not be --

A Possibly.

Q Understood. That makes sense to me.

Okay. So the reason we brought that up was because, you know, you listed that aspect of an example of how Milone's opinion regarding the 2014 and '15 being -- failing to meet essential health benefits or minimum essential coverage doesn't take that sort of thing, as one example, into account?

A Right.

Q I mean, one of the things we can take into account is a lot of these plans on their face say this is not minimal essential coverage under the Affordable Care Act?

A But that doesn't mean that it's violative of the Affordable Care Act.

Q Right. Well, no, it actually means that it doesn't meet those standards. What you're saying is that you may not be open as an employer to penalties because of it because of other circumstances?

A It says it doesn't meet those requirements, but it says nothing about whether it

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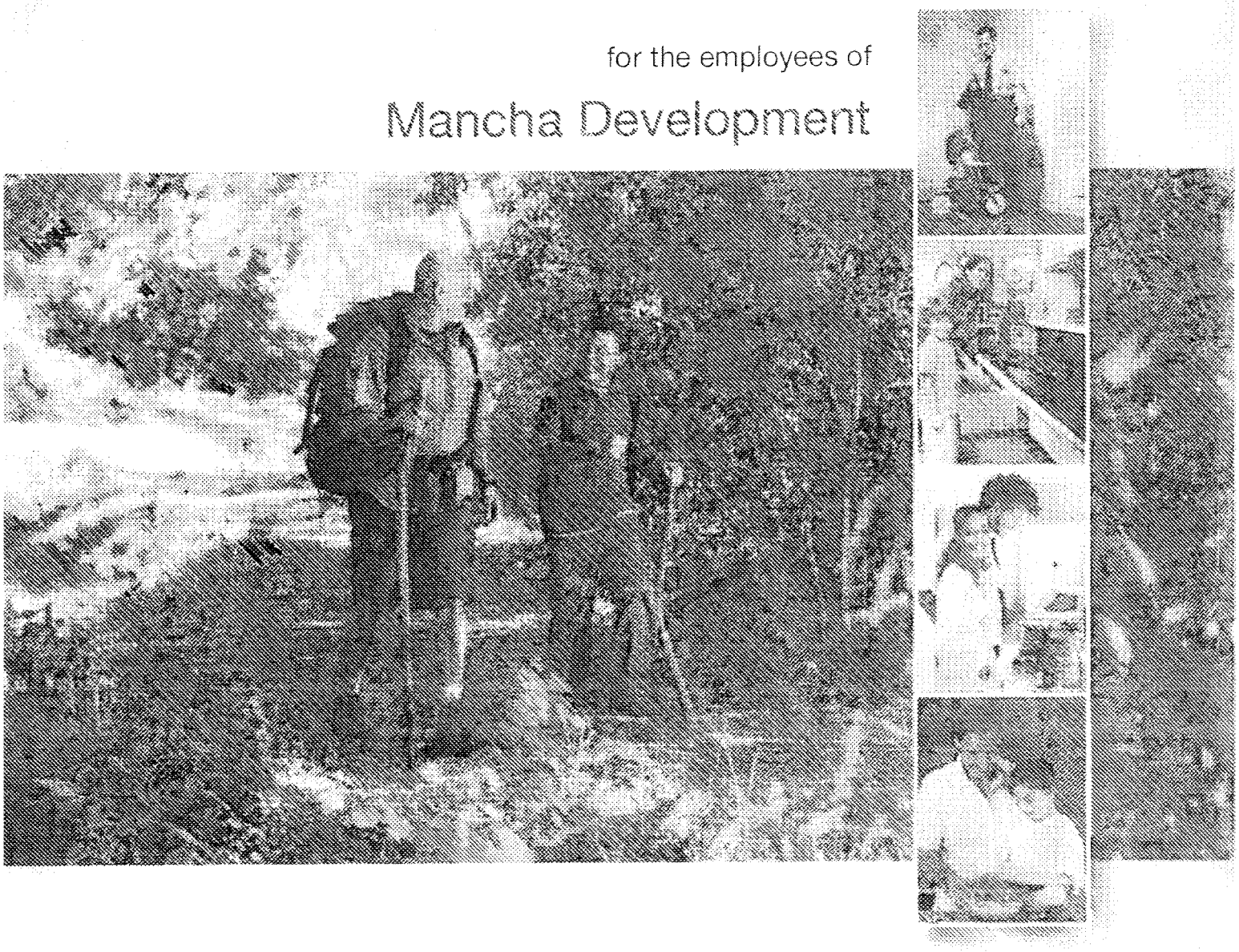

presented by

Sherri Guedea

proposal date

November 15, 2013

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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

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 MetaTM*	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.

[illegible]

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 [illegible] Life Insurance Company, [illegible]

Policy form series GP100200 and [illegible] Term series [illegible]. Forms and form numbers may vary.
Coverage may not be available in all jurisdictions. Limitations and exclusions apply. Refer to the actual 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.

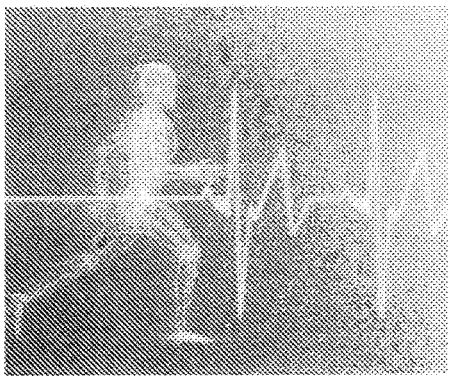
If more than one covered loss is sustained as a result of the same accidental bodily injury, payment shall be made for only the one loss for which the largest amount is payable.

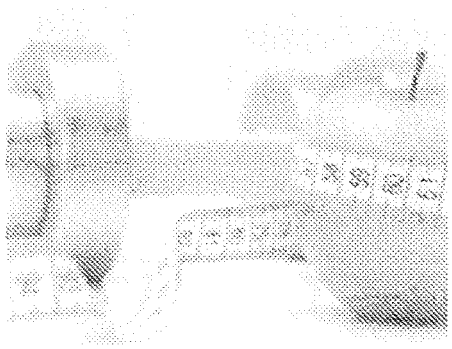
EXHIBIT E

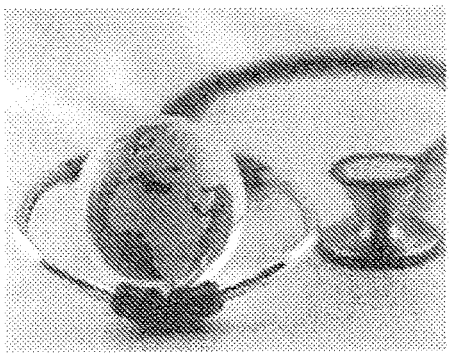
EXHIBIT E

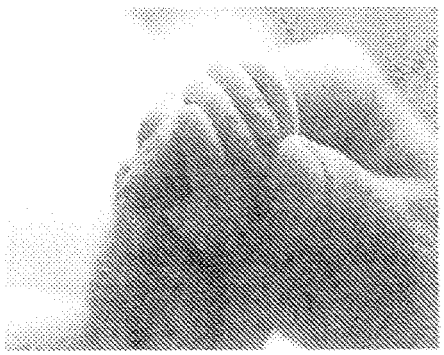
EXHIBIT E

Mancha Companies









2015 Employee Benefit Guide

January 1, 2015 – December 31, 2015

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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 0898

EXHIBIT F

EXHIBIT F

EXHIBIT F

I. Introduction and Overview

I have been retained to provide my opinions in connection with the Expert Report of Matthew T. Milone dated October 12, 2015 (the "Milone Report", "Milone's Report" or the "Report") and the issues presented therein. Milone's Report characterizes the issues on which plaintiffs have requested his opinions as follows (hereafter, the "Issues Presented"):

a. The standards that exist to determine what is "health Insurance" as that term is used in Article 15, Section 16 of the Nevada Constitution; and

b. An analysis of "plan documents" produced in this case in light of these standards.

II. Qualifications and Disclosures

I have previously submitted my Curriculum Vitae and all other information required to be disclosed pursuant to N.R.C.P. 16.1, and will supplement all such information at the request of any party, or on my own initiative, as may be appropriate.

My fee schedule is attached hereto as Exhibit A, reflecting my compensation in connection with this matter at the generally applicable rate of $350 per hour for work in connection with this report and providing testimony, and $300 per hour in connection with my initial review and consideration of the case materials provided to me.

III. Documents and Materials Considered

In preparing this report and forming the opinions expressed herein, I have reviewed the documents, materials and other information set forth in the list of "Data or Other Information Considered" attached hereto as Exhibit B.

IV. Discussion of Relevant Authority

a. Enforcement of Insurance Versus Employment Laws

Milone's Report appears to misunderstand the boundary that exists at the state level with regard to the enforcement of health insurance laws (i.e., those within NRS Chapters 689A, 689B and 689C) versus employment laws (i.e., those within NRS Chapter 608). For example, the Report concludes that employers subject themselves to insurance coverage and payment requirements of NRS Chapters 689A and 689B upon making health insurance available to employees. In fact, each of Milone's opinions within the Report is premised on the notion that employers are personally responsible for ensuring that the insurance plans made available to employees are in compliance with insurance regulations.

However, unlike the federal administrative system providing for the dual enforcement of employee benefits laws (for example, making the Department of Labor responsible for the enforcement of laws governing group health insurance), Nevada's system assigns those distinct duties to either the Insurance Commissioner or the Labor Commission, not both. Under Milone's theory that employers have direct obligations under insurance coverage laws, the Insurance Commissioner would have to assert jurisdiction over the employer for purposes of enforcing those laws. Similarly, under Milone's theory that insurers must issue plans providing specific coverage for plans offered in connection with the Minimum Wage Amendment, the Labor Commissioner

would be in the same position. Under Nevada law, however, each Commissioner is vested with exclusive jurisdiction to enforce the laws of his or her respective field.

Milone's suggestion that employers must select specific insurance plans in connection with the Minimum Wage Amendment also contradicts the pattern and practice of employers and insurers in employee benefits market. Having counseled hundreds of employers regarding their benefits practices, it has been universally true in my experience that employers do not participate in assembling their plans, but instead rely exclusively on the insurers to ensure coverage requirements are met. This is because insurers have not only the burden to ensure compliance, but also the expertise required to do so, not employers

b. Current Versus Prior Law

Milone's report fails to consider any authority other than that which exists today to determine compliance of plans that existed between one and six years ago. This flawed methodology appears to be responsible for some of the most significant false conclusions within the report. For example, Milone's analysis is based on Nevada insurance laws within NRS Chapters 689A, 689B and 689C exclusively (and almost exclusively just 689B), however he appears to have failed to consider the significantly different statutes that existed within those chapters prior to 2013. In other words, Milone applies the wrong law to his analysis of at least four (2010 through 2013) of the six plans at issue because Chapters 689A, 689B and 689C are markedly different now from what they were at relevant times. In fact, the statutes which authorized the 2010 and 2013 plans and exempted them from most coverage requirements no longer exist at all after amendments implementing the state's insurance exchange under the ACA.

c. State Versus Federal Law

While state law counterparts to the ACA have some relevance to the Issues Presented, the ACA itself provides no guidance whatsoever. Milone fails to provide any explanation or link between the federal law and Nevada's Minimum Wage Amendment to its Nevada Constitution[1] Yet, notwithstanding its inapplicability, Milone's report devotes a considerable amount of discussion to the ACA without offering any explanation of its perceived relevance.

Note: While Milone's analysis of essential health benefits ("EHB"), minimum essential coverage ("MEC"), annual and lifetime limits, and other features of the ACA have no bearing on the Issues Presented, his opinion that the 2014 and 2015 plans fail to meet EHB, MEC and other ACA requirements is misguided in any event. This opinion is at best unreliable, as Milone simply does not have all the information required to make this determination. For example, if any of the plans analyzed under the ACA have "grandfather" status, as does the 2013 plan, it is exempted from the requirements Milone claims are not met. More importantly, however, the analysis simply has no bearing on the issues of this case.

Note: Milone's suggestion that the 2014 plan fails to meet also-irrelevant requirements of COBRA is similarly false. Milone claims the plan is deficient because: (1) it provides a period of only 31-days to elect continuation coverage, whereas COBRA requires a 60-day period; and (2) it

[1] Additionally, Milone's report focuses exclusively on coverage requirements under the ACA that were not even effective until 2014.

states that the cost of continuation coverage will include unstated "administrative cost"; whereas COBRA permits a maximum charge of only 102% of the total premium.

As for the first issue, the 2014 plan actually provides a period of at least 62 days after coverage ends for the insured to elect continuation coverage, not 31 days. This is because the plan includes a "grace period" of 31 days during which coverage will continue automatically even if a premium is missed. The 31-day period Milone refers to does not start to run until after the grace period expires, effectively providing a total period of 62 days. As for the cost of continuation coverage, the additional 2% of the cost (for a total of 102% the premium amount) is permitted specifically to cover the administrative costs no longer borne by an employer. Thus, the plan language is entirely consistent with COBRA.

d. ERISA Preemption

Milone's discussion of federal preemption under the Employee Retirement Income Security Act of 1974 ("ERISA") addresses only part of what must be considered. The preemptive effect that ERISA has on state laws, and on state insurance laws in particular, is a complex topic, a lengthy discussion of which is neither necessary nor beneficial to the expert reports produced in this case. However, in order to form correct opinions concerning the Issues Presented, and especially to explain them, it is critical that any expert consider at least three major components effecting the issue of preemption, as follows: (1) ERISA's general preemption of state laws that "relate to" employee benefit plans[2]; (2) the "savings clause" which provides the only exception to ERISA preemption, saving state laws that "regulate insurance" from preemption; and (3) the "deemer clause" which limits the scope of the savings clause, thereby limiting insurance laws which can survive preemption Milone's report addresses only the first two.

An understanding of the third component, the "deemer clause", is of critical importance in forming an opinion as to the effect of state insurance laws whenever those laws potentially apply employer-sponsored benefit plans. While this area alone has been the subject of entire treatises, it is only necessary to understand two concepts that belie the opinions in Milone's Report to understand why those opinions are inaccurate. First, the "deemer clause" states that self-insured employers cannot be deemed insurers, and thus be subjected to state insurance regulations, simply because they provide benefits in the same manner as insurance companies under benefit plans. The second fundamental concept of the deemer clause is provided through the Supreme Court's 1985 opinion in Metropolitan Life Ins. Co. v. Massachusetts, holding that state insurance laws are not entirely preempted simply because they "relate to" employee benefit plans, but will only apply to the extent benefits are provided by an insurer, i.e. a third-party providing a policy of insurance. Conversely, benefit plans that are self-funded are not subject to state laws because there is not an insurance policy to regulate.

V. Issues Common to All Deficiencies of the Reoprt

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[2] Lawyers and laypersons alike often refer to only a portion of employer-sponsored benefit plans as "ERISA plans", most commonly those relating to pensions rather than health benefits, those associated with the Act's more complex provisions, and/or those maintained for the benefit of members of a labor organization under the terms of a collective bargaining agreement. In reality, all employer-sponsored plans providing benefits to an employee (i.e. including both pension benefit plans and employee health and wellness plans) are governed by ERISA, however only some of them are shielded from preempted regulation at the state-level.

a. The Report Does Not Apply Factors or Standards as Promised

Milone's report claims to resolve the Issues Presented by applying industry standards to determine whether the plans provide "health insurance" as that term is used in the Minimum Wage Amendment. However, the "standards" Milone applies are not industry standards at all, but a mere recitation of the coverage requirements found in 689B that he believes apply. This methodology presents at least two significant problems with each of Milone's opinions.

First, I do not consider Milone's application of statutory requirements in checklist fashion to be an expert opinion. This methodology does not require any heighted level of expertise and assist in providing an understanding of the issues beyond that which other similarly situated persons could provide. Secondly, because this the statutory requirements Milone applies in his analysis are inapplicable, the conclusions provided after performing his analysis are necessarily inaccurate as a result.

b. Apparent Biases

While this report focuses primarily on the substantive flaws of Milone's Report, the apparent biases that are evident throughout the Report cannot be overlooked. These biases are so pervasive, and appear to drive Milone's analysis so significantly, that they demonstrate more than merely the unreliability of Milone's opinions – they explain the very bases upon which he reached many of his conclusions.

As an example, Milone's analysis relies heavily on NAC 608.104 to support his conclusion that the term "health insurance", as used within the Nevada Minimum Wage Amendment, means only insurance policies which provide coverage for every category of health care expense that would otherwise be tax-deductible by an individual. Milone reaches this result through his own gratuitous additions to the language of NAC 608.104(a)(1) which merely servers to identify a "health insurance plan" as an insurance plan which covers "those categories of health care expenses generally deductible by an employee on his individual federal income tax return." NAC 608.104(a)(1). Specifically, Milone's report alters this language when quoting the regulation in his analysis of the health insurance plans at issue in this case, concluding that the plans are not "health insurance" because they do not cover "all of the 'categories of health care expenses' referred to in the regulation." This significant alteration of NAC 608.104 is either a gross misunderstanding of the import of the regulation or a means of reaching pre-determined conclusions that serve his and/or plaintiff's own interests. Either way, Milone's conclusions premised on his alternate form of the regulation are unfounded.

Milone's apparent bias in favor of requiring employers to pay the higher minimum wage within Nevada's two-tier system are also demonstrated through his characterization of that system. For example, Milone refers to this higher amount as "the standard minimum wage" and the lower amount "the reduced minimum wage", yet these terms are not found anywhere within the actual language of the amendment.[3] In case this nomenclature is not telling enough, Milone's report also

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[3] The actual language of the Minimum Wage Amendment provides, in relevant part,

> The rate shall be five dollars and fifteen cents ($5.15) per hour worked, if the employer provides health benefits as described herein, or six dollars and fifteen cents ($6.15) per hour if the employer does not provide such benefits.

describes the operation of the two-tier system in a manner clearly favoring the plaintiffs' interests in this case. To that end, Milone's Report includes the following statements:

> [A]n employer earns the privilege of paying employees a minimum wage of $1.00 less than the standard minimum wage if the 'employer provides health benefits.
>
> [T]he employer must offer a health insurance plan in order to earn the privilege identified in Article XV, section 16 of the Nevada Constitution[.]
>
> This report addresses the requirement in Article XV, Section 16 of the Nevada Constitution that "health insurance" be provided to the employee in order for the employer to obtain the benefit of paying a reduced minimum wage[.]"[4]

Just as the terms "standard rate" or "reduced minimum wage" are absent from the Minimum Wage Amendment, the Amendment similarly does not include reference to any "privilege" or "benefit" which must be "earned" or for which an employer must "qualify." "right under the cons under the of paying either amount,

VI. Additional, Specific Errors of the Report

a. Health Insurance is Health Insurance – It Does Not Imply Coverage Details

The Minimum Wage Amendment does not create a heightened level of coverage for "health insurance" that must accompany Nevada's lower minimum wage rate. It is common among lawyers, scholars and other professionals specializing in these areas to generally refer to "health insurance" as any contract for insurance between an employer and third-party insurer pursuant to which an employee health benefit plan ("EHBP") is administered. All EHBP's are comprised of two basis parts: (1) an employer's plan to offer its employees' health benefits, usually as part of a larger benefits package made available by the employer to the employee; and (2) someone to administer the plan through the payment of claims submitted by employers under the plan. When the employer pays these claims directly, the plan is considered self-insured and a health insurance plan is not present. However, when the employer contracts a third-party, an insurer, to pay the claims, that contract is considered a "health insurance plan" among industry professionals.

Based on my knowledge and experience in the employee benefits and health care industries, the term "health insurance" does not describe any details about the plan or its coverage other than as described above. It is my opinion that the term "health insurance" is used within the Minimum

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Notably, neither of the rates provided are discussed in terms of a "standard" or "reduced" wage.

[4] To the contrary, the actual language of the Minimum Wage Amendment describing the rates of its two-tier system could not be more matter-of-fact:

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

Wage Amendment in the same manner and has the same meaning as I have described, and that the term "health insurance" does not impose or imply any coverage requirements for specific health services. In other words, health insurance simply refers to an insurance plan which provides coverage for services related to one's health, such as medical, dental, surgical, and many other forms of treatment. Any insurance plan which provides coverage for these expenses incurred in connection with such services is a "health insurance plan" and commonly referred to as "health insurance."

The Minimum Wage Amendment does not itself require any particular form of health insurance or specify any particular coverage requirements. To the contrary, the Amendment uses the more general term "health benefits" then describes the particular form of health benefits to which it refers, specifically a health insurance plan which is made available to a specific group of people (employees and their dependents) at a specific cost (no more than 10% of the employee's AGI). Given the specificity provided for those other aspects of the "health insurance plan", it is not reasonably to conclude that the voters intended, but failed to include, specificity as to the coverage which must be provided.

Each of the 2010 through 2015 plans are "health insurance plans" suitable and permissible in connection with the Nevada Minimum Wage Amendment.

b. Neither the NAC nor NRS Chapter 608 Requires A Heightened Level of Coverage

NAC 608.102 does not mandate specific coverage for health insurance plans under the Minimum Wage Amendment. Milone's opinion to the contrary – that the Labor Commissioner intended to insert coverage requirements of his own – is not reasonable. This is especially true given the disparity in the level of authority as between the Nevada Constitution and administrative rule making. Milone's opinion is therefore further unreasonable in that it requires one to adoption the notion that neither the Legislature nor the language chosen to amend the Constitution saw fit to impose requirements about the coverage which must be required, but then-Commissioner Michael Tanchek did. Based on my considerable dealings with Commissioner Tanchek on employee benefits issues, I know this position to be untenable.

Milone's opinion in particular – that health insurance plans must cover "each of the" the categories of health care expenses described in 26 U.S.C. § 213 – would compel the absurd result that employers are required to provide the most expansive coverage imaginable, and coverage which was not required under identical statutes and regulations previously, at a cost to the employee of less than 10% of his AGI. In my opinion, very few employers would be able to meet these requirements and even fewer would likely make the decision to do so. In fact, given the cost the employer would be required to bear in order to provide this level of insurance, the employer would be far better off paying an additional $1.00 per hour to its minimum wage employees.[5] It is unreasonable to conclude that this was the intent of NAC 608.102.

Further, based on my considerable dealings with Commissioner Tanchek and each of the Commissioners since, I am certain that Milone's view is contrary to the Office of the Labor

[5] Employers would likely attribute as much of the cost of this insurance to the employee, assuring that the insurance would only be available to employees at a cost of 10% of their total gross income for the year. Milone's interpretation of NAC 689C.102 would thus also make insurance unaffordable for many of those workers, the individuals who were intended to benefit from the Minimum Wage Amendment in the first place.

Commissioner's interpretation of NAC 689C.102(a)(1). As explained above, the regulation's reference to those categories of health care expenses" set forth in the Tax Code is not a coverage mandate, but a means of identifying "health insurance", as opposed to myriad other types of insurance, by providing a fixed reference to the types of services which fall under the umbrella of "health" or "health care" services. Thus, if an insurance plan covers those types of expenses generally, it is "health insurance" for purposes of the Minimum Wage Amendment. This is not only my opinion based on my experience and expertise in this area, but also consistent with the view of the Labor Commissioner's Office since the Minimum Wage Amendment was enacted.

In sum, neither the Minimum Wage Amendment nor NAC 608.102 increased or otherwise changed the coverage requirements applicable to health insurance plans that are made available by employers to their employees.

c. NRS 608.1555 Does Subject All Health Insurance Plans to Chapters 689A and 689B – In Fact, the Statute Does Not Apply at All

Milone's suggestion that NRS 608.1555 applies to all health benefits plans, including health insurance plans, is also untenable. Upon reviewing the statute, it is clear that it was never intended to apply to benefit plans which are already administered through an insurance plan. To the contrary, the purpose of this statute was to compel self-insured employers to pay providers and otherwise administer the plan in the manner preferred by doctors and dentists, the manner utilized by insurance companies.

Second, the legislative history of the act creating NRS 608.1555 confirms this result. Third, any suggestion that this statute enacted 21 years before the Minimum Wage Amendment explains what coverage must be provided in connection with the Amendment. Fourth, if you attempt to apply NRS 608.1555 to insurance plans, as opposed to self-insured plans, the result is illogical, essentially mandating that insurance policies issued pursuant NRS Chapters 689A or 689B are subject to those chapters. Finally, it is my opinion that NRS 608.1555 is not enforceable against self-insured plans, the only plans to which its application could have been intended because it is preempted by ERISA. This opinion is further supported by the fact the statute was enacted in 1985, as case law making its preemption clear had not yet been issued.

d. The 2010 through 2013 Plans Are Individual, Not Group, Plans and Are Exempt from Coverage Requirements

Coverage requirements are not derived from the Minimum Wage Amendment at all, but rather from the statutes and regulations which govern the terms of a particular plan. This is where Milone's report is most flawed, as his opinions are based entirely on the premise that Chapter 689B governs each of the policies at issue when it does not.

Though his reasons for doing so are unclear, Milone determined that each of the policies at issue are "group health plans" and thus governed by NRS Chapter 689B when in reality the 2010, 2011, 2012 and 2013 plans are all "individual health plans" governed by NRS Chapter 689A. To the extent this conclusion is an opinion rather than verifiable fact, I have based it on a comparison of the terms set forth in the plan documents against the definitions provided in Chapter 689A, the express terms of the policies which reference individual coverage throughout, and by observing who is the "policyholder" under those policies. Unlike group plans under which the employer is the policyholder, the employees are the policyholders under individual plans such as the 2010 through 2013 policies. Further, where individual plans are made available to individuals through thei

employer, the employer is identified as the plan "sponsor" as defendants are listed just as sponsors under the 2010 through 2013 plans.

In my opinion, that the plans offered by MDC changed from individual plans to a group plan after 2013 because of significant changes to NRS Chapters 689A, 689B and 689B, among others at that time as the state's health insurance exchange was implemented in connection with the ACA. Most significant of those changes for purposes of addressing the Issues Presented is the Legislature's repeal of individual health benefit plans originally introduced to Nevada's insurance market in 1997 under HIPAA and Assembly Bill 521. Under AB 521, and Chapter 689A as it existed from 1997 to 2013, employers had the option to make "individual health benefit plans" available to employees. Insurers providing such coverage were required to make two types available to individuals in Nevada: (1) its basic plan, and (2) its standard plan. These plans were in all respect health insurance plans under Nevada law.

The 2010 through 2013 plans are "basic health benefit plans" as defined by NRS 689A.480. As such, they are not subject to coverage requirements pursuant to the express terms of NRS 689C 950, as follows:

> Notwithstanding any specific statute to the contrary, a statute that requires the coverage of a specific health care service or benefit, or the reimbursement, utilization or inclusion of a specific category of licensed health care practitioner, is not applicable to a basic health benefit plan delivered or issued for delivery to small employers or eligible persons in this state pursuant to this chapter or chapter 689A of NRS.

The entirety of Milone's report analyzing the compliance of the 2010 through 2013 plans is inapplicable. These plans are health insurance plans and comply with Nevada law in all respects including in connection with the Minimum Wage Amendment.

e: The 2014 and 2015 Plans Meet All Applicable Coverage Requirement

Milone's report resorts exclusively to the irrelevant discussion of the ACA because these plans comply with all applicable coverage requirements. I have personally reviewed these plans to confirm this result.

VII. Conclusion

Each of the 2010 to 2015 plans at issue in this case are "health insurance plans" providing "health insurance" as those terms are used in Nevada, including in connection with the Nevada Minimum Wage Amendment. It is my opinion that, if an employer made these policies available to employees during their respective plan years on the terms set forth in the Nevada Minimum Wage Amendment and NAC 608.102 (i.e. for a cost of 10 percent or less of the employees AGI, etc.), the applicable minimum wage would be the lesser of the two rates in Nevada's two-tier system.

Dated this 14th day of March 2016

Timothy R. Mulliner Signed 3/14/16

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PROFESSIONAL EXPERIENCE

Mulliner Law Group, Chtd., Las Vegas, Nevada
Managing Partner — 2016-Present

Duane Morris LLP, Las Vegas, Nevada
Special Counsel, *Employment, Labor, & Benefits* and *Insurance Groups* — 2015-2016

Ballard Spahr LLP, Las Vegas, Nevada
Associate, *Labor & Employment* and *Health Care Practice Groups* — 2011-2015

Lionel Sawyer & Collins, Las Vegas, Nevada
Associate, Litigation Department, *Labor & Employment Sub-Group* — 2007-2011

EDUCATION

University of Nebraska College of Law, Lincoln, NE
Juris Doctor *conferred "with Distinction"* — 2007
Executive Editor, *Nebraska Law Review*
Student of the Year, *Civil Litigation Program*
Honors Graduate

University of Nebraska, Kearney, NE
Bachelor of Science, Criminal Justice *conferred "with Honors"* — 2004
Scholarship Recipient, *Dale and Ellen Schroeder Scholarship* — 2000-2004

AWARDS & ACHIEVEMENTS

AV® Preeminent™ Peer Review Rating, *Martindale-Hubbell*
Southern Nevada's Top Attorneys, *Nevada Business* magazine's Legal Elite — 2011-2015
"Super Lawyer", *Mountain States* Super Lawyers — 2013-2016
"Rising Star", *Mountain States* Super Lawyers — 2011

MEMBERSHIPS & ASSOCIATIONS

American Bar Association, Litigation and Employment Law Sections
American Health Lawyers Association
Executive Committee, Insurance & Health Law Section, Nevada Bar Association
Vice-Chairman (Executive Committee) — 2015-Present
CLE Chair (Executive Committee) — 2013-2015
Society for Human Resource Management
Southern Nevada Human Resources Association

SELECTED PUBLICATIONS

"Guide to the Patient Protection and Affordable Care Act", *Nevada Bar Association Publication* (Not Yet Published), Five Chapters	Publication Pending
CHALLENGING IRS TAX PENALTIES UNDER THE ACA	
REPORTING AND NOTICE REQUIREMENTS	
THE EMPLOYER "PLAY-OR-PAY" MANDATE	
THE INDIVIDUAL MANDATE	
CHANGES TO WELLNESS PROGRAMS	
"The Who, What, and When of the Employer Mandate: ***An Overview of Employer Obligations under the Affordable Care Act***", *Nevada Lawyer Magazine*	2014
"Proposed IRS Regulations Address Community Health Needs Assessment for Tax-Exempt Hospitals", *J.D. Supra Business Advisor*	2013
"NLRB's Third Report on Social Media Policies Urges Employers to Provide Specific Examples of Activity", *Association of Corporate Counsel Online Journal*	2012
"Proposed DOL Rule Could Require Employers Report Agreements with Their Attorneys", *Employee Benefit News*	2011

SELECTED SPEAKING ENGAGEMENTS

"Nevada Minimum Wage after *Terry v. Sapphire Gentlemen's Club*: *The More Things Stay the Same, the More They Change*", *Southern Nevada Business Resource Group*, Las Vegas, Nevada	2015
"Hot Topics in Nevada Employment Law", *Southern Nevada Business Resource Group*, Las Vegas, Nevada	2015
"Health Care Fraud & Abuse in the U.S.", *Nevada State Medical Association*, Las Vegas, Nevada	2014
"Health Care Reform and Employer Wellness Programs: ***What Does It All Mean?***", *Global Media Dynamics*, Las Vegas, Nevada	2014
Moderator and Keynote Speaker, *Global Media Dynamics 2014 Health & Wellness Congress for Employers*, Las Vegas, Nevada	2014
"Health Care Reform: ***What Employers Need to Know***", *Association of* ***Health & Insurance Law*** *Corporate Counsel*, Las Vegas, Nevada	2013
"Nevada Health & Insurance Law Changes: ***A Legislative Update:***", *Nevada Bar Association*, Las Vegas, Nevada	2013

ADDENDUM A

ADDENDUM A

Hourly Fee Schedule — Expert Witness

Timothy R. Mulliner[†]

Task Performed - Active Litigation	Hourly Rate[††]	Minimum/Cancellation
Review background materials; legal research; communicate with client and others as directed	$300	$1,500 (minimum charge after instructed to begin)
Prepare written reports	$350	$1,500 (minimum charge after instructed to begin)
Prepare supplemental reports, affidavits, declarations or other written discovery	$350	N/A
Provide testimony at deposition or trial; prepare for the same	$350	$1,500 (amount due if cancelled within five business days)
Travel as required (applicable only if destination is more than 25 miles from Clark County Courthouse)	$200	N/A

[†] All fees are payable to Mulliner Law Group, Chtd. (within 30 days of receipt)

[††] All tasks billed at 1/4-hour increments, subject to minimum or cancellation amount

Tasks which the expert and client cannot agree fall within one of the above categories will be billed at a "Miscellaneous" rate of $300/hour with no minimum.

*** ROUGH DRAFT *** ROUGH DRAFT ***

ROUGH DRAFT TRANSCRIPT

DEPOSITION OF

TIMOTHY MULLINER

March 31, 2016
10:55 a.m.

* * * * *

The following transcript of proceedings, or any portion thereof, is being delivered UNCERTIFIED by the court reporter.

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Heidi K. Konsten, RPR, CCR # 845

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DEPOSITION OF TIMOTHY MULLINER

March 31, 2016

* * * * * *

TIMOTHY MULLINER,

having been first duly sworn, was examined and testified as follows:

MR. SCHRAGER: Okay. We're on the record.

My name is Bradley Schrager, and I am counsel for the plaintiffs in this case. And with me today is my colleague, Jordan Butler, from my firm.

Counsel, would you like to make your appearances for the record?

MR. WIECZOREK: Yeah, Nick Wieczorek on behalf of MDC and the related entities.

MS. FORBUSH: Deanna Forbush on behalf of the defendants.

EXAMINATION

BY MR. SCHRAGER:

Q **Okay. And, Mr. Deponent, would you state your name for the record, please?**

A Full legal name is Timothy Richard

Mulliner. Timothy Richard, spelled normally, M-U-L-L-I-N-E-R.

Q Okay. Mr. Mulliner, you're here today by virtue of a notice of taking deposition and subpoena duces; is that correct?

A That's correct.

Q Okay. I'm going to ahead, just for formality sake, and mark each of those as exhibits for our deposition.

(Exhibit Nos. 1 & 2 were marked.)

BY MR. SCHRAGER:

Q Mr. Milliner, I'm going to hand you Exhibit 1. That's the notice of taking deposition.

You've seen that, yes, sir?

A I have.

Q Okay. And Exhibit No. 2 is a subpoena duces tecum, if I can hand that to you.

Do you recognize that?

A Yes, I do.

Q Okay. Now, the subpoena -- well, Exhibit 1 asks you to come here today so we can conduct your deposition as a retained expert for the defense in this case, and Exhibit 2 asks you to bring with you and produce certain documents;

is that correct?

A That's correct.

Q Have you done that?

A I have.

Q Okay. Can you go ahead and give me the documents?

A Yes. So it's a voluminous production, about 5,000 pages of a work file and e-mail, so I've burnt disks.

Q Perfect. In fact, thank you. I usually like to walk out of depositions with less paper than I came in with.

A Okay. Great. Well, I didn't want to come in with a banker's box.

Q I appreciate that.

A And Nick is representing me today; right?

MR. WIECZOREK: Yeah.

THE WITNESS: I didn't do any kind of a written disclosure, you know, or -- in response to your subpoena. I thought I would talk to Nick about whether he wants to do that.

MR. SCHRAGER: That's fine. I mean, I don't think there were any objections that were made to broadening that --

MR. WIECZOREK: No. He brought his whole file, as I understand it.

MR. SCHRAGER: Yeah, that's fine. I'm sure it's fine.

And as we discussed yesterday in Mr. Regal's deposition, it's unlikely, but if there's something in the production for today, we can talk about getting together again.

MR. WIECZOREK: Understood, yeah.

THE WITNESS: I do have one for the court reporter, as well. I don't know if you plan on doing anything with it today. But I'll give you two copies, and if you want to give one to --

MR. SCHRAGER: Well, just for safekeeping, so someone has it, maybe we'll mark that as so Exhibit 3 and give it to you. So Exhibit 2 will be Mr. Mulliner's produced file pursuant to the subpoena duces tecum.

(Exhibit No. 3 was marked.)

BY MR. SCHRAGER:

Q Okay. Have you been deposed before?

A I have not.

Q Okay. Have you conducted depositions?

A I have.

Q Okay. So you're familiar with what is

known as sort of the standard admonitions at the start of a deposition?

A I don't use that vernacular, because I don't think everyone knows and agrees on it, so I'm not sure what you would mean by that.

Q Okay. Well, I was going to ask you whether we could dispense with the standard instructions. For example, you want to speak clearing, because everything is being taken down. You have taken the same oath you would in court, therefore everything you say is sworn testimony. We need to be careful not to talk over each other, because it's being transcribed, you know, things of that nature. Just the basic instruction of how this is going to work.

Your counsel is free to object to any questions I have, but unless he informs you not to answer, I'm going to ask you to go ahead and answer. If you need a break at any time, all you have to do is say so. I'm happy to accommodate that at any point during the -- during the deposition.

What I will ask is that if there's a question pending when you ask for a break, I'm going to ask you to finish answering the question

prior to us taking the break, and then we can have the break.

Is there any reason -- medical, illness, medication -- any reason you can't give your best testimony here today?

A No.

Q Okay. Those are the standard admonitions. I don't think I left any out, have I? If I have --

A Those are all understood.

Q Okay. Very good.

So this is your first ever deposition?

A First time being deposed.

Q Yeah. Well, I'm actually quite honored. It's actually fairly pleasant. We're just going to have a conversation. I'm not here to try trap you into anything. I have questions about things you wrote, how they compare with things that are in the Milone report.

The whole purpose of an expert deposition is to assist the trier of fact and the parties and counsel to answer certain questions about evidence, about facts, about things that will eventually determine the outcome of a lawsuit. Right? So that's really why we're here

today.

So it is adversarial in nature, but it's also, you know, me talking to you and you talking to me about issues that I raise in your report. Okay?

A Okay.

Q Okay. Have you ever been an expert witness before in a case?

A A testifying witness?

Q Yes.

A No.

Q Okay. Have you been a consulting expert in a case before?

A I have.

Q Okay. How many cases, roughly?

A On one occasion, I was retained as a consulting expert for three related cases.

Q Okay.

A If that makes sense.

Q So sort of like a package of cases?

A It was.

Q And they had related cases?

A That's correct.

Q What sort of issues were you retained to discuss?

A Nevada prevailing wage issues.

Q Okay. And so there were three cases in which that arose, and a particular party retained you to consult on all of them, but you were not deposed and you didn't testify?

A That's correct.

Q Okay. Very good.

A Nor was I disclosed as a testifying --

Q Sure. Okay.

You understand that Matthew Milone was retained by the plaintiffs as a testifying expert, much in the same way you've been retained as a testifying expert by the defense; correct?

A Yes.

Q Okay. And you produced a rebuttal report to Mr. Milone's original expert report on or about March 14th of this year; correct?

A Yes.

Q Okay. And that was produced to us as part of the defendant's tenth supplement to disclosure of witnesses and production of documents pursuant to NRCP 16.1. I have lots of copies of things here.

Do you need it a copy of your own report?

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 5 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
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Attorneys for Defendants and Petitioners
MDC RESTAURANTS, LLC; LAGUNA RESTAURANTS, LLC; INKA, LLC.

Chronological Index

Alphabetical Index

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

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
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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.

General Counsel and Secretary

TRANSAMERICA LIFE INSURANCE COMPANY

Home Office: Cedar Rapids, Iowa 52499
Administrative Office: P.O. Box 310, Grapevine, Texas 76099-0310
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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. Vermeer — General Counsel and Secretary

Linda Clancy — President

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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

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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. Vermilion — General Counsel and Secretary

Brenda Clancy — President

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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

Linda Clarey — President

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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

Brenda Clancy — President

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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

Linda Clancy — President

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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. Vermaas — General Counsel and Secretary

Linda Clancy — President

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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

Brenda Clancy — President

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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

Linda Clancy — President

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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

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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

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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. Vermeer — General Counsel and Secretary

Brenda Clancy — President

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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. Vrooman — General Counsel and Secretary

Linda Cleary — 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. Vermeer — General Counsel and Secretary

Lynda Clancy — President

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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 EMPIERRE	Email Address: VINCE@MANCHADEV.com	Phone #: 702 420-4515	Fax #:
Nature of Group: RESTAURANT	# of Employees/Members: 116	# Eligible for Coverage: 1600	# of Years In Existence: 10
Billing Address: (*if different*) 2275 SAMPSON AVENUE #201	City: CORONA	State: CA	ZIP Code: 92879
Billing Contact Name: (*if different*) YVETTE GALIMORE	Email Address: YGALIMORE@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 — VINCE@MANCHADEV.COM Email Address

Print Name and Title of Officer — VINCE EMPIERRE, MANAGING MEMBER

Signature of Licensed Agent/Producer — SherriG@Benebizworksite.com Email Address

Print Name of Licensed Agent/Producer — Sherri Guedea — CP5033 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, MD, 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 sale 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, MN, 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 MD)* 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 *(Lum 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		Benefit Amount Paid For By:	Policyholder	Employee
☐	☐	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%			
☐	☐	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, LA, 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, MN, 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 AR, 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, MN, 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 80% 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 $2,500; Simplified Issue $2,600 to $5,000
Not to exceed	60% of Salary
Maximum Benefit Period	3 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	50% 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%, 80% if pre-tax, or $5,000*	Percentage of Salary	%	%	%	%
	Dollar Amount	$	$	$	$
Supplemental Benefit ☐ % of Salary ☐ Dollar Amount	Minimum				
	Maximum				
	Increments of				
Total Basic & Supplemental Benefits Can't Exceed *60 or 80% 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 8063
Little Rock, AR 72203-8063

Insurance Selections

(Product and Rider availability subject to state approval)

Participation Requirement: Each group master policy requires a minimum of 5 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 6 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	$ 250/150	$ 500/300	$ 500/300	$
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	$ 10 - $ 20	$ 15 - $ 30	$ 25 - $ 30	$
Daily Brand Name Drugs are paid at twice the Daily Generic Drug Benefit				
☐ Maximum Days per Month ☑ Calendar Year Maximum	12 Days	12 Days	30 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 ☐ RealMedYou	☐ 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 IndMdual 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)*