IN THE SUPREME COURT OF THE STATE OF NEVADA

BARRY JAMES RIVES, M.D.; and LAPAROSCOPIC SURGERY OF NEVADA, LLC, Appellants/Cross-Respondents, vs. TITINA FARRIS and PATRICK FARRIS, Respondents/Cross-Appellants.	Case No. 80271
BARRY JAMES RIVES, M.D.; and LAPAROSCOPIC SURGERY OF NEVADA, LLC, Appellants, vs. TITINA FARRIS and PATRICK FARRIS, Respondents.	Case No. 81052

APPELLANTS' APPENDIX
VOLUME 5

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CHRONOLOGICAL INDEX TO APPELLANTS' APPENDIX

[1] These additional documents were added after the first 29 volumes of the appendix were complete and already numbered (6,493 pages).

EXHIBIT "1"

RTRAN

DISTRICT COURT

CLARK COUNTY, NEVADA

TITINA FARRIS and PATRICK FARRIS, Plaintiffs, vs. BARRY RIVES, M.D.; LAPAROSCOPIC SURGERY OF NEVADA, LLC., ET AL., Defendants.	CASE#: A-16-739464-C DEPT. XXXI

BEFORE THE HONORABLE JOANNA S. KISHNER
DISTRICT COURT JUDGE
MONDAY, OCTOBER 7, 2019

RECORDER'S TRANSCRIPT OF PENDING MOTIONS

APPEARANCES:

For the Plaintiffs:	KIMBALL JONES, ESQ. JACOB G. LEAVITT, ESQ.
For the Defendants:	THOMAS J. DOYLE, ESQ. CHAD C. COUCHOT, ESQ.

RECORDED BY: SANDRA HARRELL, COURT RECORDER

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INDEX OF EXHIBITS

FOR THE PLAINTIFF	MARKED	RECEIVED
None		

FOR THE DEFENDANT	MARKED	RECEIVED
None		

Las Vegas, Nevada, Monday, October 7, 2019

[Case called at 8:34 a.m.]

THE COURT: Okay. Ferris v. Rives, 739464. Can I have appearance of counsel, please?

MR. JONES: Kimball Jones and Jacob Leavitt for the Plaintiffs, Your Honor.

MR. DOYLE: And Tom Doyle and Chad Couchot for the Defendants.

THE COURT: Okay. As you know, today is the day of the continuation. Got a couple of different matters on for today.

[Court and Clerk confer]

THE COURT: Okay. So today is a continuation of the Plaintiff -- it was Plaintiffs' motion for sanction under Rule 37 for Defendant's intentional concealment of Defendant Rives' history of negligence and litigation. And then -- and motion to file leave to amend complaint to add claim for punitive damages on order shortening time. Now, as you know, this was originally on hearing last week. During that hearing, the -- was a motion. There was -- the Court has signed the order shortening time.

Now, the Court did not get the appropriate courtesy copies, which was the Court's having to go through this pile again. Okay. So at the end of that hearing -- I'm restating part of this for the benefit of counsel that was not here at the last hearing. So with regards to the last hearing, the Court specifically stated and offered the opportunity only --

because although it was not in Defendant's opposition to motion for sanctions, there was no affidavit, no declaration, nothing with regards to Dr. Rives. So it gave the Court no basis as to have any understanding whatsoever about whether or not -- what his position was.

Okay. So in light of that, I obviously -- of course Supreme Court precedent, including *Young v. Ribeiro*, *Johnny Young v. Ribeiro* as well as *State Farm v. Hansen* this Court used to evaluate various factors and of course *Valley Health* as well as *v. Doe* in making certain determinations. And so in order to do, the Court offered the opportunity to do a hearing under *Johnny Ribeiro*, although as that case cites and cases subsequently have cited, the Court's not required to do so, but offered a hearing.

There was no objection. I believe Plaintiff's counsel specifically said that -- I don't want to misstate your words. It wasn't -- they seem to have concurred. They definitely did not raise an objection, but they seemed to have concurred that it would be a good idea. Defense counsel was giving the opportunity, if they chose, if that felt after consultation with their client and obviously, they know their obligations under Nevada Supreme Court precedent, including specifically *State Farm v. Hansen* and hopefully -- I'm going to have to confirm that was fully complied with. Was that fully complied with?

MR. COUCHOT: I'm sorry, Your Honor?

THE COURT: Was Nevada law, *State Farm v. Hansen* fully complied with? I'm not asking about the content of any of your conversations with regards to your client, but because of the serious

nature of this hearing, including terminating sanctions, this Court just wants to ensure -- because I see just the two of you all here, and of course it's a public courtroom. Anyone's more than welcome to be here, but I'm going to -- individual in the last row, are you counsel or are you just an observer probably from the appropriate insurance company? I'm not asking who you are. You're more than welcome to be here, whoever you are, but I'm only asking if you're here in a private capacity as counsel for Dr. Rives. Are you?

UNIDENTIFIED SPEAKER: No.

THE COURT: That's all I was asking. Okay. In light of that, then of course, the Court always asks just to confirm that applicable state law has been complied with. So I'm just asking Defense counsel. I wanted to make sure. The reason -- one of the reasons why the Court set the hearing for today is to give Defense counsel full opportunity to speak with Dr. Rives directly, coordinate among yourselves and determine whether or not A, you wanted the evidentiary hearing, B, who you wanted to call for the evidentiary hearing, including Dr. Rives.

As the Court specifically stated at the last hearing, no one was requiring Dr. Rives to testify, provide an affidavit, provide a declaration or do anything. It was completely up to you. I just needed confirmation, A, you wanted the hearing and B, if you were -- if you did want the hearing, whether Dr. Rives would or would not be testifying, we could do scheduling, because you all specifically stated you only wanted an hour.

And the Court, in light of that, as I told you I would be doing,

because there was other cases that needed time, would be scheduling something specifically based on your requirements and the Court has done so. So I have another matter starting at 10:00, because you all said you needed an hour, which got the 8:30 to 9:30. In an abundance of caution, I scheduled the next one at 10:00, knowing that probably be a few minutes of preliminary time period and scheduling another one from 1:00 to 5:00. So some of these other cases, I told you that needed this Court's time, so today was three different, special settings.

So in light of that, I wanted to give everyone enough time that they could speak with whomever they deemed that they needed to speak with to ensure that you had a full opportunity to be heard. So today is the continuation of that motion for sanctions, without going into -- it's the long version. I'm just going to call it motions for sanctions. In addition, as you all know, the Court had also set for the prior hearing date the Court's own order, because of the two separate issues.

One, both counsel, in providing documents to this Court, which on more than when occasion that were violative of multiple rules, even after the Court notifying the parties and/or their offices, as detailed in that Court's order, which you all know, because you had notice of, and it was set for last week and it was continued to today. You have the order of which I speak with regards to that. In the intervening time, unfortunately, there has been additional inappropriate, impermissible conduct by Defense counsel and continuing violations of the rules, some of which has prompted the Court to do an additional order, which was

set for today to be heard as well as even subsequent to that order -- didn't think this one was possible.

Looks like there's even more conduct, which the Court has to address as well and see -- since that most recent conduct happened on Friday, and I don't even have a judicial day, I'm not sure -- well, the Court's going to decide whether it's -- how it's going to address that most recent issue, because that ties is not only to today's first prong, the evidentiary hearing, but the Court's continued concern, despite specific citation to case law rules, rules of professional conduct, NRCPs, statutory authority, case authority, local rules, you name it.

In writing, in minute orders, in memos, there continues to be, it seems, a blatant disregard of many of the Court rules. Any being probably a little strong, since I guess some of them are followed. They actually do get filed electronically, but there has been numerous -- I would use the term numerous. I won't use the term many. I'll say numerous.

When I use Court rules, I'm not talking specific Department 31. I'm talking Supreme Court. Lot of rules of civil procedure is also created by, obvious, the Supreme Court and a whole bunch of others that I've named and subsequently put forth in writing, stated in court, including blatant statements that are not accurate in declarations. So the Court has to address those as well.

Whether we will have time for all of that today in the slotted hour, stay tuned. We don't know. If not, looks like you may be coming back on Thursday or Friday this week, after you have your calendar call,

which of course, everything is due at the calendar call, depending on what the Court's ruling is today. If not, remember, everything's still due, depending on the Court's ruling today.

Okay. When I say depending on the ruling today, meaning unless the Court's rule is that it strikes everything, then you all knew, and you all knew when this date was set, and you all knew with everything that everything is still due. So I'm sure everyone's intending to comply. Nothing was alleviated with regards to everything that's due at the calendar call tomorrow.

Is that clear to everyone?

MR. DOYLE: Yes, Your Honor.

MR. JONES: Yes, Your Honor.

THE COURT: Okay. Just making sure. So and then also, we had the order shortening time on the striking of the supplemental witnesses, which I don't know if we're going to be able to get to that today or not, but we also have that, Plaintiffs on the supplemental witnesses, the 18 recorded witnesses that was asserted.

So going to the evidentiary hearing portion, since like I said, it's -- obviously, it's counsel's obligation, not the Court's obligation, but the Court always does want to make sure that everything is complied with and that you know, we don't have people that don't have law degrees getting on the stand and some things like that about things being fully noticed.

So in that regard, since today's evidentiary hearing was solely to provide Defense to the wish -- to the extent the Defense wish to

call any witnesses, even though they have not requested such in their opposition, to the extent that they wish to call any witnesses, because of the fact there was terminating sanctions being sought and also lesser sanctions as well being sought. Give them an opportunity, if they wish to call any witnesses in response to that, that was the sole thing that this Court allowed. And I believe this Court was abundantly clear. Does anyone think that this Court said anything else, other than evidentiary hearing today, in which witnesses could be called, if Defense chose to do so?

MR. JONES: I understand it was a Barry hearing, Your Honor, where the Defense was going to have the opportunity.

THE COURT: Was that your understanding as well?

MR. COUCHOT: I understand, yes, Your Honor.

THE COURT: Okay. The Court did not -- and the reason why the Court was asking that question is because we're now going to go into what happened on Friday. Contrary to this Court's express, multiple times stated and in fact, clearly stated so much that I even said does everyone understand the process was you can choose to have the hearing or not. You can choose whether you wanted somebody to testify or not and that you then needed to provide this Court written confirmation.

The only written paper this Court was supposed to get was a written confirmation of whether A, Defense wanted the hearing to take place and B, whether or not Dr. Rives was going to testify. And the reason why the Court needed that, as the Court clearly said, is because I

needed to know if there was going to be a hearing, so that everyone could be prepared and knew if they had a need to be here at 8:30 or not and I could schedule other matters. And two, in fairness to everyone, they needed to know who the witness or witnesses would be, so that people could prepare.

Okay. This Court did not implicitly, explicitly or in any manner whatsoever tell anyone they could do supplemental briefing. And I don't think anyone's going to say that this Court said anyone could do supplemental briefing. Counsel for Plaintiff, did this Court say anyone could do supplemental briefing?

MR. JONES: No, Your Honor --

MR. LEAVITT: No, Your Honor.

MR. JONES: -- you did not.

THE COURT: Counsel for Defense, you were here. Did the Court say you could do supplemental briefing?

MR. COUCHOT: No, Your Honor.

THE COURT: So contrary to the Court's express statements, express limited to try and allow, because Defense counsel did not even put it in their opposition, to allow that one aspect, if they wished to call a witness or witnesses, whoever they wished to call for an evidentiary hearing to take place this morning and they only stated one, so that's the only reason why the Court used the singular, is that there was, instead, it appears, Friday -- and I need to get on my system.

Friday there was a pleading filed, a rogue pleading filed, a pleading in direct violation of yet another Court's specific order that

occurred, which the Court has to address first. The Court's going to address it in two manners. The Court's going to address it first, just procedurally, for today's sanction hearing. Then the Court's going to have to address it second with regards to the Court's own orders on what sanctions need -- may be imposed, up to, including terminating sanctions, up to and including all sanctions, as the Court specifically put in is order.

Fully on notice under *Valley Health Systems v. Doe* and all the RPC aspects, all the Rule 37s, the whole panoply is all included in the Court's order. That's going to be have to be taken into account, because of the pattern of conduct. This is not the first, second, third or -- if I remember, it may be, but definitely not the first or second time this has happened. So when I say this, meaning the disregard of the Court's specific directive with regards to this case by Defense counsel, who was present in court, their law firm present in court.

So from a procedural standpoint, with regards to the hearing, the Court's question is this. Was there any express agreement by Plaintiff's counsel, albeit in contravention of the Court's specific directive, to allow under EDCR 7.50, some additional briefing by Defense?

MR. JONES: Not at all, Your Honor. No, we were very upset about it.

THE COURT: Okay. Do you waive or -- do you waive or wish the Court to consider the briefing filed by Defendants?

MR. JONES: We do, Your Honor. We agree that it's --

THE COURT: Excuse -- I said --

MR. JONES: Oh.

THE COURT: -- do you waive the fact that -- do you waive, and do you wish the Court to consider their briefing?

MR. JONES: No, not at all, Your Honor.

THE COURT: I just need --

MR. JONES: We don't --

THE COURT: -- to know if you're raising an objection or not. I just need to know your position, so --

MR. JONES: Your Honor, we object to the briefing. In fact, we pro -- I produced a motion to strike, but because I couldn't get it on OST, there was --

THE COURT: What do you mean --

MR. JONES: -- no way for me to --

THE COURT: -- you couldn't get on OST?

MR. JONES: -- to produce it, since it was filed on Friday, so no, we do not think it's appropriate to be considered, Your Honor.

THE COURT: Okay. So I'm going to address that portion first. Counsel for Defense?

MR. DOYLE: Your Honor, after consultation with appellate counsel, a decision was made to file the supplemental brief to --

THE COURT: Excuse me. Appellate counsel told you to disregard as -- what appellate counsel in the State of Nevada told you to specifically disregard a Court's directive, and why is that appellate counsel not here?

MR. DOYLE: The appellate counsel did not advise us to

disregard a Court's directive.

THE COURT: Did you tell the appellate counsel that there was a specific Court directive of the only thing that could occur, because of your failure to even include on behalf of your client anything about his own position in your opposition?

MR. DOYLE: Well, I --

THE COURT: I'm not asking about the content. I'm only asking did you advise --

MR. DOYLE: No.

THE COURT: Okay. So you did not advise them that the Court gave a specific directive of the only thing that could be taken into account additionally?

MR. DOYLE: Well, that -- I guess that's an overly narrow interpretation. That was not -- I read the transcript, and it was my impression that if -- erroneously so, that I thought it would be helpful to have the supplemental opposition --

THE COURT: Counsel -- my question. I'm interrupting you. It's very narrow, because you do have limited time, and I have another case at 10:00, okay, because of the specific request of your co-counsel, how much time he needed, okay? My specific request was who's the name of the counsel that you are saying told you to file this brief? If you're saying it's not you, then I'm going to have to consider that counsel for sanctions, too. So I want to know.

MR. DOYLE: His name is Robert Eisenberg. He did not tell us to --

THE COURT: Okay. Robert Eisenberg I'm very familiar with. I would be very surprised under this scenario, that Robert Eisenberg, if fully aware of all the facts -- did you provide him a copy of the transcript?

MR. DOYLE: No.

THE COURT: Okay.

MR. DOYLE: Oh, wait. I take that back. He did have a copy of the transcript. I'm sorry. I did provide it to him.

THE COURT: Your -- so, Mr. Eisenberg needs to be here for sanctions as well, because you are saying that on his advice and counsel, you chose to disregard this Court's specific directive?

MR. DOYLE: No, I -- it's not on his advice and counsel. We were talking about the issues raised in the motion, the issues raised in our --

THE COURT: I'm not asking about the content.

MR. DOYLE: I --

THE COURT: I'm just trying to get a specific -- you understand what the Court's specific question is. This Court is asking -- okay -- Mr. Couchot was here. This Court was try -- because of the pattern of what you all have been filing, this Court set out a specific procedure, a specific procedure of do you want an evidentiary hearing. Mr. Couchot said that you, Mr. Doyle, would be handling it, not him.

To give you all benefits of the doubt, the best possible opportunity, so that everyone could speak about it and make a determination, people were not having to make a determination in court, to give you a full opportunity to speak with both your clients in a

tripartite relationship, okay? To make a full, well-reasoned determination. This Court wasn't requiring that anybody make the determination in court. The Court was offering, but then giving you time in which you could fully consult with whomever you wished to do, if you wished an evidentiary hearing.

Johnny Ribeiro says what -- *Young v. Johnny Ribeiro* says what it says in subsequent case law. The Court doesn't need to offer it. You didn't even request it. You didn't even request it during the hearing. And I say you, meaning your firm, didn't on behalf of Dr. Rives. The Court just offered it.

The Court offered it, but did not require anyone to have it. Okay. I had no objection. So full waiver issue on the Plaintiffs, so I had no issues there, so it was just an offer to Defense if they wished to have any witnesses of their choosing in the time period they chose for today's date at 8:30. Based on this statement it was going to be an hour.

So with that in mind, then the Court wanted a specific writing from Defense counsel CC'ed to all parties and to the Court by a time period that Mr. Couchot and Ms. Newberry, who are here, Ms. Clark Newberry, seemed to be in agreement with, that that was sufficient time. Nobody asked me for any more time to consult with whomever they needed to consult with, to find out A) if they wanted the hearing, and B) if Dr. Rives or anybody else was going to be testifying so it would be put in just purely for a scheduling statement. No substance.

There was no request in that letter. There was no request by motion. There is a proper procedure if somebody wishes to file a

motion, right? If you wish to file a motion, there is a procedure if you wish to file a supplemental brief in the State of Nevada and under our local rules. No such procedure was followed. There was not even an OST submitted to the Court to request a supplemental brief. There was no oral request in Court. There wasn't even an improper request in the letter for a supplemental brief. There was nothing.

Then it came on Friday, less than a judicial day before today's hearing. That is the reason why this Court has to ask under that factual scenario, since none of those rules were followed, and you said it was just filed, okay, and gave no chance whatsoever, because Mr. Couchot knew, and Ms. Aimee Clark Newberry knew, because they were here in court, that counsel for Plaintiffs even stated that they would be out of town on Friday, because they were all aware that my JA came into court.

Because inadvertently, I started to say I could do the hearing on Friday, and then my JA came into court, and I believe I made some statement like, oops, I have this tendency to try and schedule things because I'm so -- try to help the parties out and try and schedule things, when JA has to remind me that I, too, scheduled to be at that same conference for -- CLE conference, right? And that both counsel were willing not to attend that conference if the Court was specifically scheduling, because they said that they both were going to be out of town.

So counsel for Defense who were here, I'm paraphrasing, it may have been shorter than that, my JA came in, so that's why I said

Monday, so you can give more time to Defense. So we knew that Plaintiffs were out -- Plaintiffs' counsel were out of town, and the Court was out of town on Friday, and yet still filed something in Friday. I'm not saying that -- no one is sneaking in the door. Obviously, the Court had backup in the court. My team knows how much I was calling, texting, and on the phone, and everyone at the conference saw how much I was on the phone.

Anyway, so obviously, the Court was fully available and could handle anything if it came in the door, but nothing did come in the door, because the Court was more than checking on this and every one other of its cases to ensure that everyone was fully taken care of, albeit while I was out of the jurisdiction at a CLE conference with several of our justices, Court of Appeals, et cetera. So, you know, we all were fully available to take care of our work, as well as obviously get our required, continuing legal education.

So that being said, that's why the Court has to ask the question is you didn't follow any of the procedures. So if you're telling me you didn't follow any of those procedures or you didn't file an OST or request supplemental briefing in any manner whatsoever because Robert Eisenberg told you not to, then of course, in fairness, I'd give him due process and give him an opportunity to explain.

MR. DOYLE: Okay. I'm not sure what the question is, but the decision to file the supplemental brief was mine after speaking to Bob Eisenberg about various issues. He did not say we shouldn't file it, and the decision was mine.

THE COURT: Okay. And a decision not to file any request or permission to seek leave to file a supplemental brief from me, that determination, please?

MR. DOYLE: I made that determination, and I didn't feel it was necessary under the circumstances given the significant and serious nature of the sanctions being requested. The fact that it's on an order shortening time, that's not a lot of time to deal with this to try and corral all the information and figure out what happened, and to get all the, what I believe to be, the necessary information in front of the Court so that it could make an informed decision, I proceeded in that fashion.

THE COURT: But, counsel, you had a full opportunity to put all that same information in your opposition and you chose to do so; did you not?

MR. DOYLE: No. It was done on a --

THE COURT: You knew about --

MR. DOYLE: -- it was done on an order shortening time.

THE COURT: And was there any request --

MR. DOYLE: We had been --

THE COURT: -- with regards to the ordering shortening time to extend the hearing date? It was at the Court's own decision that we gave the evidentiary hearing. Anything in the opposition to request additional time, either for briefing, to continue the hearing to a different date, this Court received nothing from Defense counsel, nor the information that you sought, which has its own issues on hearsay which the Court hasn't even gotten to. But that information, you could have

easily picked up the phone, if you wanted to, and called Mr. Hand any day you chose to do so, correct?

MR. DOYLE: I did --

THE COURT: And that could've been before the opposition was filed, correct?

MR. DOYLE: I did call Mr. Hand and left him a message last week, and he did not return my call, because I wanted to discuss with him my conversation with Mr. Brenske, and Mr. Hand did not return my telephone call.

THE COURT: And you could have picked up the phone and called Mr. Brenske at any time whatsoever when they first filed their motion, right, way back? And they discussed it with you before they filed the motion. I believe it was back around September 12th or 13th, correct? Which is --

MR. DOYLE: And I did -- I did call Mr. Brenske and talked to him, and that was the basis for the statement that I put in my declaration.

THE COURT: Counsel, this Court's question is -- let's walk through dates, please. Okay. Plaintiffs' motion for sanctions was submitted to this Court on order shortening time by its date -- well, it's dated September 16th. It was submitted to the Court for signature. The Court dated it on the 18th, and it shows it was personally served on the 19th of September, okay?

Now, the Court does not have available to it when it was electronically filed to Defendants. I don't know if it was filed before it was submitted to the Court on order shortening time, but in the affidavit

on that motion, it said that it had spoken -- prior to filing OST in accordance with the EDCR, they need to reach out to opposing counsel.

The affidavit sets forth that it did reach out to opposing counsel and that they spoke with opposing counsel so that there would have been -- even if the -- if the declaration is accurate and the pleading date is accurate, at the latest, based on what is presented here, at the latest, September 16th, Defense counsel would have been aware of the allegations contained in the motion. Based on the purported rogue document filed without the Court's permission, you did not contact Mr. Brenske until on or about October 2nd.

MR. DOYLE: That is correct.

THE COURT: That means between September 16th and October 2nd, you had the full opportunity to contact Mr. Brenske, put that information in your opposition to the original motion for order shortening time or B) request of this Court or first opposing counsel, or this Court, to have continued the original motion, requested additional time to have done opposition to the original motion for order shortening time, or like I said, to have continued the hearing in the first place, or to have even addressed the fact that you were in the process of trying to reach out to Mr. Brenske or some such information somewhere in your opposition, but instead, there was nothing about that whole topic area in your opposition.

And in fact, it wasn't until the Court even set -- offered you the opportunity to even have the evidentiary hearing, it's like you didn't seem to address that issue. So that's why the Court's asking you the

question. I'm not seeing how your statement that you can disregard the rules has any basis whatsoever when you would've had, at the latest, at least from September 16th to have a full opportunity to do this way before your opposition to the original motion, or you had several remedies that you could have taken place way back in September, but you chose not to do any of those, nor was there any request made at the hearing, in the letter after the hearing, or before the supplemental brief. That's why the Court is asking you that question.

MR. DOYLE: And I wish I had a crystal ball, or I could take a time machine and put myself back a couple of weeks and do things differently, but given the exigent circumstances and the significant relief being sought by Plaintiffs, we proceeded in what I believe to be an expeditious manner, trying to gather all the information necessary. Frankly, I didn't know we could request an extension of an order shortening time. I've never seen that happen. We just -- we assumed, given that we had the impending trial date and the terminating sanctions --

THE COURT: Well, counsel, therein lies part of the challenge that this Court is going to have to address with you, right? Please read the rules. Please stop violating all the rules. Please actually read the rules when the Court sends you memos that sets it forth, right, because they're there. They're there for you to read and to comply with, and you would have found it there, if you had read them.

And as an experienced litigator, you know you can't say you didn't know it existed, so you just were going to violate them and do

what you wanted to do. Plus, as you know, you even stated in your statement that your alleged conversation, which you know the Court can't take into account substantively because it's pure hearsay, even regardless of all the procedural issues is pure hearsay. Is Mr. Brenske here in court? No. Did you subpoena him? No. Did you have a full opportunity to do so if you chose to do so? Yes. You were not limited in the number of witnesses. Any witnesses you chose to could be here at 8:30. There was no limitation. It's whoever you wanted. He's not here, the Court can't take it into account, as you know. It's hearsay.

You know it shouldn't have been in your declaration in the first place because you know it's not personal knowledge as an experienced litigator, so there would be no basis to have any exigent circumstances. There's nothing -- as you know, the Court can't, by law, take it into account, so there would be no reason to even file it in the first place. So there would be no basis to violate the rules because you know the underlying substances. You can't ask this Court to violate its oath of office by taking into account hearsay.

So at this juncture, this Court cannot take into account, procedurally or substantively, a "supplement" that was A) filed in direct -- and these are all independent bases, so it's not the totality. The totality meets it. It independently meets it. The Court specifically -- you did not request it -- offered the additional -- the hearing was supposed to be over that day, but for the fact that the Court was concerned with the lack of what was in that opposition with the extent of the nature of the sanctions against one of your clients, okay, to ensure that both of your clients'

interests were represented so that -- okay, the Court offered the evidentiary hearing. Otherwise, that hearing would have been over that day.

So what you filed on Friday is a rogue document that the Court cannot consider procedurally because A) it was filed less than a judicial day, B) filed in direct contravention of this Court's specific -- without any leave, which could have easily been sought, was not sought. There's no good cause for it not to be sought, even the very "looking at the document" so that you had the conversation on the 2nd, but you still chose to wait until a date of the 4th to even file the document, giving no time whatsoever, fully prejudice to Plaintiffs, who have specifically objected, any opportunity to respond, knowing even independently, if you forgot that they were out of town -- they did state in open court that they were out of town, but that's even a non-sequitur. Even if they were in town or out-of-town, they could've done work over the weekend, I guess. So I'm not taking into account they were out of town.

I just -- that is not a factor that the Court is legally stating, but it just presents an even different concern, but that's not something that the Court is taking into account legally, but you did know that. So procedurally, it's a per se violation of the rules in and of itself. It's even more so a violation of the rules because the Court specifically said what could be done. You had full opportunity to ask for relief while you were here in court last week, and no one did so. Not in your brief, did not ask in open court, did not ask in a follow-up letter the Court did, and did not ask in any other motion before the Court, but instead -- and then even on

the alleged conversation you did it on the 2nd, you then waited until Friday to even file it, giving no chance for Plaintiffs to have any opportunity to respond.

That all procedurally is detrimental to Plaintiffs, a violation of the rules, a violation of specific court directive procedurally, all cannot be done independently. The violation aspect is going to have to be addressed separately shortly, with regards to the substantive aspect, even if the Court somehow could overlook all of those procedural hurdles, which it cannot, but independently, I would, to give you the benefit of the doubt, the Court said is there any way, I can give you the benefit of the doubt and look at it from a substantive manner. But the Court even looking at it -- if it tried to even look at a substantive manner, the Court can't, because it's pure hearsay.

It's pure hearsay because it was based -- supposedly, based upon any purported conversation with another individual who is not present in court when you had a full opportunity today on the evidentiary hearing to have any witnesses you chose to bring. If you chose to have Mr. Brenske present here in court, you could have asked him to be here either by subpoena or by request. He is not here. It is now 9:10, and I need to get you all started with the actual other portion, so --

MR. DOYLE: And I guess the impetus for my phone call with Mr. Brenske was the fact that there was nothing, and still today, there's nothing from George Hand who was the only --

THE COURT: Counsel. Counsel. This is not a time -- the

Court's doing its ruling of why I'm not considering it, okay? So substantively, pure hearsay. Counsel who is an experienced litigator knew the procedural aspects fully available, and because -- it's more egregious in this case, because of the numerous times that this Court has, in open court, with three separate attorneys from your firm, or your associated firms, plus the memos you've gotten in writing and served onto you, plus the two orders the Court has, and in those orders where the Court has referenced all the other -- not all -- actually, let me be very clear. It wasn't all.

I only gave you EGs. I gave you examples of other occasions where you've been specifically reminded to read the rules and given specific examples of not following the rules, and the Court even -- you're pending dispositive striking for your failure to follow the rules and litigation tactics and then you do another one?

That presents a huge challenge, okay? And particularly, since this just -- this Court had just done another order where it had just outlined it. You were subject to having the Court evaluate Rules of Professional Conduct, a whole panoply to do this again. Can't do it on all of that. Substantively, it's hearsay. Pure and simple. Cannot be considered, will not be considered, should have never been filed, and the Court has to evaluate, in addition under Rule 11 if there's any good basis, in addition to all the other factors, that unfortunately -- but the Rule 11 factor is not to be taken into account for this dispositive hearing. That is for the Court's other hearing that the Court has already set up because of Defense counsel, and potentially their client's pattern of

conduct in this case.

So with that being said, the Friday document that was filed shall not be considered by this Court because it cannot be considered by this Court, either procedurally or substantively under any basis. And there was nothing even in the document that even -- in the document itself, even provided any support on how the Court could hear it. There was nothing in the pleading itself on another substantive alternative basis that even said why the Court could consider the supplement. There was nothing even procedurally that addressed the procedural nature of it being filed on Friday, or any basis for the Court to consider it.

So it can't be considered, it won't be considered. The law does not allow me to consider it, and I've gone through all the prejudicial nature. The impropriety of it being filed will be addressed in the Court's portion, which it has to do because of the conduct as stated in the two court orders.

So getting to the -- now, that takes care of that Friday pleading, so we are back to where we were, which is what the Court provided. You have the pending motion for dispositive, which was Plaintiffs' motion. Everyone had had a full opportunity to argue everything is what this Court had been told, other than -- and people who were ready for the Court to rule, and then the Court then offered the evidentiary hearing in regards to the witness testimony because the Court asked some questions of Defense counsel, simple questions like whether or not they provided things to their client, which Defense counsel couldn't answer, or stated he didn't know.

So at this juncture, to the extent that Defense wishes to call any witnesses, the Court will now provide that opportunity. Realize any witnesses you call, you have to ensure that you fully advise your client everything that you need to advise your client under Nevada law. I've already cited a couple of the cases. You know the case law. If he chooses -- if you're advising him to take the stand, even if there's no RPC issues or anything like that, no conflict issues, no -- I don't know if I said *State Farm v Hansen* issues.

So if you wish to call whatever witnesses you wish to call, Defense counsel, and remember, there's cross-examination by Plaintiffs' counsel, and the Court may have some questions if the parties don't address the issues that the Court had. And then the Court will make a ruling on Plaintiff's outstanding motion. So counsel for Defense, if there's any witnesses you'd like to call, feel free to all your first witness.

MR. DOYLE: I'd like to call Dr. Barry Rives and then when his testimony is finished, I'd like to make some closing remarks.

THE COURT: That was not part of it. It was just -- it was just to call any witnesses.

MR. DOYLE: So I'm not --

THE COURT: It was not requested by anybody last week. Your co-counsel -- neither of your co-counsel made that request. That was not the scope of this. Nobody requested that. You all requested the time period for the one hour just for the questioning, and the only person that was discussed was Dr. -- now if you brought somebody else,

of course, the Court didn't limit it to that. I said any witnesses because I wanted to get everyone a full chance for any counsel to discuss with anybody, any counsel that may not have been present in court that day. But no such request was made. There is --

[Court and Clerk confer]

THE COURT: I don't recall, I was going to go see if we have a copy. I don't recall if the letter said that request, but this Court is not aware of any said request for any closing response.

All oral argument was taken care of. It was only the witness testimony that -- that was what -- the only thing that --

MR. DOYLE: The witness testimony necessarily requires some comment by me --

THE COURT: No, it --

MR. DOYLE: -- when the witness is done testifying.

THE COURT: Well, then your --

MR. DOYLE: And --

THE COURT: -- counsel should have asked that last week. Nobody asked that -- the Court was not -- okay, at this juncture, you may call your first witness.

MR. DOYLE: All right. Dr. Rives.

THE COURT: Okay.

BARRY RIVES, DEFENDANT, SWORN

THE CLERK: Thank you, please be seated. Could you please state and spell your name for the record?

THE WITNESS: Barry James Rives, R-I-V-E-S.

THE CLERK: Thank you.

DIRECT EXAMINATION

BY MR. DOYLE:

Q Good morning, Dr. Rives.

A Good morning.

Q Over the years, have you given a number of depositions?

A Yes, I have.

Q Have you testified at trial several times?

A Yes, I have.

Q Did you take an oath each time?

A Yes, I did.

Q And do you understand you took an oath this morning?

A Yes.

Q Do you understand you took an oath before -- or at the beginning of the Farris deposition?

A Yes.

Q And your understanding of the oath that you took at the time of the Farris deposition and today means what to you?

A To tell the truth, the whole truth, and nothing but the truth. So help me God.

Q And anything else?

A That's it.

Q Do you understand -- at the time you gave the Farris deposition, did you understand the penalties that you could face, if you did not carry out that oath?

A Yes.

Q Did you understand the penalties that you faced if you lied, or were deceitful at the Farris deposition?

A Of course.

Q And what did you understand those to be?

A I could be guilty of perjury.

Q And at the Farris deposition, did you -- in response to any of the questions at the time of the deposition, did you lie?

A No.

Q Were you deceitful?

A No.

Q Did you withhold information?

A Not at all.

Q I want to ask you some questions about the discovery responses, the request to produce documents and the interrogatories. There was a set of each to you individually and then as well as to your professional corporation, Laparoscopic Surgery of Nevada. Did we send those to you on April 12, 2017?

A I believe so, yes.

Q Did we send you a copy of the request to produce documents with draft responses we had prepared?

A Yes.

Q Did we send you the two sets of interrogatories with draft responses we had prepared?

A Yes.

Q. Had you talked to anyone in my office before you received those draft responses, either Mr. Couchot, myself, or anyone else, about the interrogatories or request to produce documents?

THE COURT: The Court's going to interject here, because the Court is being clear. The Court is not asking that anyone disclose any attorney-client communications. If your client is going to waive that, I need -- then (a) this Court needs to know that; and (b), this Court needs to have a clear understanding that he has been advised clearly of what that means, the impact of it, the full extent of what he's doing, because there's a distinction between how that can be handled.

And you, as his counsel, I just want to ensure that the Court is not asking any of that. The Court just needs to know if you're trying to elicit communications between Dr. Rives and your office, that he has (a) been advised of his rights, and the attorney-client privilege, and if he's waiving it, what that impact is. The Court just wants to make sure that he has been fully advised of such.

MR. DOYLE: And my client has been fully advised, and I think the answer to the question will show that there is no attorney-client privilege to violate.

THE COURT: No worries. The Court just --

MR. DOYLE: Thank you for that.

THE COURT: -- to ensure that everyone has a full opportunity, and there's nothing done inadvertently. Thank you, so much.

MR. DOYLE: Thank you.

BY MR. DOYLE:

Q Doctor, before you received on April 12th, 2017, the request to produce documents and the special interrogatories, was there a conversation between you and someone in my office about preparing the draft responses?

A No.

Q Was it your understanding my office had prepared those draft responses with no input from you?

A Correct.

Q Is it your understanding that we prepared those draft responses based on information that we had obtained over the years representing you in other cases?

A That is correct.

Q And --

THE COURT: Counsel, I've got to -- I'm hearing your questions, but by the very nature of your questions, this Court's not getting the nexus of how you said this is not eliciting attorney-client communication. How can a person have an understanding of your office's practices without having a communication with someone from your office, and know specifically about how your office did his interrogatories --

MR. DOYLE: Okay.

THE COURT: -- without having some conversation with someone in your office? That's why this Court was -- it's not the first hearing this Court has done, that's why this Court was very specific in

trying to give that step.

MR. DOYLE: I'm going to go on. Let me -- let me --

THE COURT: That's fine, counsel.

MR. DOYLE: Okay. Thank you, Your Honor.

THE COURT: The Court's concerned about waiver issues right now. The Court's just saying that. Okay.

BY MR. DOYLE:

Q Doctor, concerning the special interrogatories that were sent to you as an individual and the draft responses that we prepared, did you review those draft responses?

A No.

Q Why not?

A I believe when I looked at the email, I opened up the first PDF, which had to do with, I believe disclosure of materials, and it looked like a bunch of legalese, and I assumed everything else was the same.

Q Did you rely on my office to -- for the information contained in the responses to those interrogatories?

A Yes.

Q Before -- after you received the draft responses to the special interrogatories directed to you, did you and I have a conversation about those draft responses back in April or May of 2017, before they went out?

A No.

Q Did you have a conversation about them with anyone else in my office?

A No.

Q The first time that you saw the responses to those interrogatories, was that recently?

A Within the last week or two, yes.

Q And did you sign and return to us a verification for the special interrogatories that were directed to you personally?

A To me personally, no.

Q Doctor, if you had reviewed the draft interrogatory answers, do you believe you would have noticed that they contained an old office address?

A Yes.

Q Do you believe you would have noticed that Center was not on the list of cases?

A Yes.

MR. JONES: Your Honor, I'm just going to object. I don't know when the last time it was that the Doctor testified and wasn't just led into a question with a yes or no.

THE COURT: I'm sorry, so what's -- I'm not hearing your --

MR. JONES: Every question -- every question has been leading, Your Honor, and I would just request that he actually elicit --

THE COURT: Okay.

MR. JONES: -- testimony from the Doctor.

THE COURT: Sustained because this is your witness.

MR. DOYLE: Okay.

BY MR. DOYLE:

Q Doctor, when you looked at the answers to interrogatories

recently, were supplemental responses prepared?

A Yes, I believe so.

Q And what was corrected based upon the information in the draft responses, that we had prepared, and you had not seen? What was changed, or amended?

A I noticed that the existing office address was incorrect. So that had to be amended. That the Center case wasn't in there, so that had to be amended. That there was a response to whether I'd been on any medical committees, regarding the hospital, that was left either blank, or that was -- didn't include my chief of surgery, and all of the other stuff that I had done for the hospitals. So I believe that had to be amended as well.

Q Okay. Now, when you sat for your deposition in Farris, what did you review to prepare for the deposition?

A My office notes and the medical notes.

Q When you prepared for the deposition in Farris, did you review any of the interrogatory responses, either by you, or by your professional corporation?

A No.

Q Did you review, to prepare for the deposition, the request to produce documents that had been prepared -- or the responses prepared on your behalf and your anticipated --

MR. JONES: Your Honor, I'm going to just object again. I would appreciate it if he'd elicit something from the Doctor, rather than telling the Doctor the answer, and asking for a yes or no.

THE COURT: Counsel, I need that in the form of a proper objection, if that's an objection.

MR. JONES: Your Honor -- leading, Your Honor.

THE COURT: Sustained.

BY MR. DOYLE:

Q Doctor, did you review any discovery responses to prepare for your deposition in Farris?

A No.

Q At the deposition, who was the attorney that was present for the Farrises?

A George Hand, I believe.

Q Did George Hand mark as an exhibit for the deposition a copy of the interrogatory responses from you --

MR. JONES: Objection, Your Honor. Leading.

THE COURT: Sustained. That's going to leading. Counsel, three sustains on the same basis. Please stop it.

BY MR. DOYLE:

Q What did Mr. Hand mark and show you at the deposition concerning interrogatory answers?

THE COURT: Counsel --

MR. JONES: Objection, Your Honor. Foundation. Leading.

THE COURT: -- that's a leading question, please. You've already been admonished. I already just advised you on the very last question, please do not do it indirectly what the Court has just admonished you not to do directly. I am sustaining the objection and

you will be -- have sanctions against you if you do it a third time. Are we clear?

MR. DOYLE: Yes.

THE COURT: Thank you.

BY MR. DOYLE:

Q What did Mr. Hand show you?

A I believe at one point during the deposition he handed me a set of the interrogatories and my CV.

Q And what did he ask you to do when he handed you those documents?

A He asked me to review my CV and see if it was up to date.

Q What did you do in response to his question?

A I think there was some dates, like in the medical -- my medical license, the expiration date wasn't updated. There were some small little factors like that, that I said needed to be updated. And then he asked me to hand it back to him.

Q What do you mean by he asked you to hand it back to him?

A He asked the CV and the interrogatories be handed back to him.

Q What did you do when he asked you that?

A I handed it to him.

Q Do you recall at the deposition whether you were asked questions about interrogatory number 3?

A Yes, I was.

Q What do you recall about interrogatory number 3? What was

that about?

A I believe that's when he went through a list of my prior cases and asked me for information regarding those cases.

Q Did you answer his questions?

A Yes.

Q Can you tell us if your answers were accurate?

A Yes, they were.

Q When Mr. Hand got to the end of asking you about cases where you had been a Defendant, did he ask you about the Center case?

A No, he --

MR. JONES: Leading, Your Honor, again.

THE COURT: Counsel that is leading 101.

MR. DOYLE: Okay.

THE COURT: Sustained.

MR. DOYLE: Did --

THE COURT: And counsel, what did I say?

MR. DOYLE: Okay.

THE COURT: Counsel?

MR. DOYLE: I understand.

THE COURT: But you're not listening.

MR. DOYLE: I --

THE COURT: You're hearing me, but --

MR. DOYLE: I thought it was not a leading question, I apologize, Your Honor. I'm not doing this intentionally. Let me try again. I'm sorry.

BY MR. DOYLE:

Q Were you asked a question about the Center case?

A Regarding the interrogatories?

Q Yes.

A No.

Q Were you asked whether there were any other cases?

A I was asked if I had been deposed as an expert witness for either a patient or for a defendant doctor.

Q And how did you respond to that question?

A I gave him two examples that I could remember at that time, where I had been deposed or went to Court as an expert witness.

Q Did the Center case come up?

A The Center case did come up, yes.

Q How did it come up?

A Right at the end of that particular question, he asked me -- he, being Mr. Hand, asked me regarding that question, were there any others that I could think of at that time. I could not recall any other time that I did an expert witness for either a patient or a defendant doctor, and Chad at that time mentioned Center's not on there. And I didn't really understand what he was referring to, because Center is a case where I was a Defendant, not an expert witness or something else to another matter. And I think from there, we then talked about the Center case.

Q Did you answer all of Mr. Hand's questions about the Center case?

A Yes.

Q Were your answers accurate?

A Yes, they were.

Q At that time, Doctor, did you have any reason to hide from Mr. Hand the Center case?

MR. JONES: Your Honor, leading, again.

THE COURT: Did you have any reason to hide the Center case?

MR. DOYLE: Did you --

THE COURT: Counsel, would you consider that a leading question?

MR. DOYLE: No, I don't, actually.

THE COURT: Doesn't it presuppose the answer to the question? Did you have any reason to hide the Center case? That is a leading question, counsel. You're an experienced litigator, you know that. That is sustained.

MR. DOYLE: Okay.

THE COURT: Please ensure that you ask open ended questions. This Court is very concerned about how you're asking these questions. They do not appear to be open ended to your client.

MR. DOYLE: Okay.

BY MR. DOYLE:

Q Doctor, at the time of the Farris deposition, what thoughts were going through your head about the Center case?

A None.

Q Why not?

A A) to me, they weren't material to the issue at hand. I was focused on my care and my medical responsibilities to Mrs. Farris in my deposition -- or my answers to questions in that regard.

Q The deposition transcript in Farris, did you -- tell us whether you received it.

A I received a letter and transcript within the last week or two, regarding that.

Q Did you receive the deposition transcript before then?

A No, I did not.

MR. DOYLE: That's all I have then. Thank you.

THE COURT: Thank you. Any questions by Plaintiff's counsel?

MR. JONES: Yes, Your Honor.

THE COURT: And since there's two of you, only one will be asking questions, correct.

MR. LEAVITT: That is correct.

MR. JONES: That is correct, Your Honor.

THE COURT: I appreciate it. Thank you.

MR. JONES: Your Honor, I have some binders here that just have some exhibits that I know I'll reference a couple of them, but I may reference several.

THE COURT: Are they exhibits that have been introduced in this case and are already on your pretrial through your joint pretrial memorandum? What I'm trying to get clear is that they were exhibits that have been produced in this case, they were at your 2.67, you know

what I mean, exchanged as proposed exhibits, et cetera. Meaning they're not new exhibits coming in for the first time today.

MR. JONES: Yes, with the exception of a couple, Your Honor. So what we have is the answer and complaint, and then we have the Answers to Interrogatories by Dr. Rives for his corporation and for himself personally. There's three sets of those each. Right? So there's six.

THE COURT: Okay. So they're --

MR. JONES: Our 2.67 --

THE COURT: So they've been E-served. Okay. So what you're talking about --

MR. JONES: They have been E-served, Your Honor.

THE COURT: -- the pleadings that have been E-served. I just want to ensure that there's no surprises that come up from either side. Right? Fairness --

MR. JONES: Correct.

THE COURT: -- to both sides forward -- forward and fair to both sides in each and every case.

MR. JONES: That -- that is correct, Your Honor. And we have disclosed the deposition that the doctor gave in the *Center* case. That is also included here.

THE COURT: That was attached to the pleadings with your Exhibit 3, I think.

MR. JONES: That is correct, Your Honor.

THE COURT: Okay. So let's see, the Court's not taking any

position. We'll see what I hear from the other side --

MR. DOYLE: Yeah.

THE COURT: -- as you go through. So the Court's not taking a position until you do what you do. I just --

MR. JONES: And --

THE COURT: With that representation --

MR. JONES: -- Your Honor, may I approach to provide --

THE COURT: Of course.

MR. JONES: -- a copy to the Court?

THE COURT: Right.

MR. JONES: And also to the --

THE COURT: Like I said, the Court's not going to take any position until I hear what you're saying and what you're asking.

MR. JONES: Yeah. Thank you, Your Honor.

[Counsel confer]

CROSS-EXAMINATION

BY MR. JONES:

Q All right. Doctor, the binder that you have in front of you, I'd just like to go through it with you relatively quickly. If you can look -- turn to Tab 1. This is the complaint of the Farrises against yourself in this case and against the Laparoscopic Surgery of Southern Nevada. Does that appear correct?

A It does.

Q Okay. Have you seen this document before?

A I believe I have, yes.

Q Okay. Let's go ahead and turn to Tab 2. This is your answer to the Plaintiff's complaint in this matter. Have you seen this document before?

A I believe so, yes.

Q All right. Turn to Tab 3, please. This is Defendant Barry Rives -- Dr. Barry Rives' response to Plaintiff Titina Farris' first set of interrogatories. And you can see up in the top right-hand corner it says, "Electronically served 4/17/2017 at 1:20 and 37 seconds, p.m."?

A Yes.

Q Okay. Have you seen this document before?

A A couple weeks ago, yes.

Q Okay. So you did not see this document prior to April 17th, 2017; is that correct?

A That is correct.

Q Okay. If you turn to Tab 4, this document was electronically served on September 13th, 2019, and it's entitled, "Defendant Dr. Barry Rives' supplemental response to Plaintiff Titina Farris' first set of request for production of documents." Have you seen this document before?

A Yes, I have.

Q Okay. And when did you first see this document?

A Just about that time.

Q About the 13th of September?

A Sometime in that frame, yeah.

Q Okay. When you say, "that frame," what are the parameters of the frame that you would provide?

A Maybe within one or two weeks of it being filed.
Q Either --
THE COURT: Counsel, can you re-ask that question? I didn't --
MR. JONES: Yes. I'm trying to establish the time frame whereby the doctor identified it.
BY MR. JONES:
Q Doctor --
THE COURT: Which tab is that? I was trying -- I --
MR. JONES: Oh. Tab 4, Your Honor.
THE COURT: One or two weeks -- can you please re-ask the question? I was trying to --
MR. JONES: Certainly.
THE COURT: -- get the date --
MR. JONES: Yes.
THE COURT: -- that you got listed. Please. Thank you.
BY MR. JONES:
Q So I asked you when it was that you first observed this document, Doctor. And -- go ahead?
A "Defendant Dr. Rives' supplemental response to Plaintiff Titina Farris' first set of requests for production of documents." The supplemental response --
Q Yes.
A -- was sometime in September.
Q Okay. Do you have any -- anymore narrower parameters

than sometime in September to identify when it was that you saw this document for the first time?

A No, I don't.

Q Okay. All right. Did you ever see either of these documents, whether it be Exhibit 3 or Exhibit 4, prior to September 2019, Doctor?

A The supplemental response and -- hold on one second -- Defendant response to first set -- no.

Q Okay.

A The first time I saw these was sometime in September of this year.

Q Okay. Thank you, Doctor.

THE COURT: So that question was Tabs 3 and 4? When you're doing it by tabs rather than titles, I'm trying to make sure I've got the correct --

MR. JONES: Thank you.

THE COURT: -- titles of what you're saying. So --

MR. JONES: I appreciate it, Doctor -- Your Honor.

THE COURT: Because the Court needs to be clear.

MR. JONES: Right.

BY MR. JONES:

Q And to be clear, Doctor, the tabs we were talking about were 3 and 4, which would have been the initial responses and the supplemental responses, correct?

A The supplemental response to request for production of documents and the response to Plaintiff's first set of interrogatories,

correct.

Q. Okay. And those were the documents that one -- the first was served 4/17/2017, and the second was served 9/13/2019, correct?

A. Correct.

Q. Okay. And those were -- you saw those for the first time both in September of 2019. Fair?

A. That is correct.

Q. All right. Turn to Tab 5. So this document is titled, "Defendant Dr. Barry Rives' first supplemental response to Plaintiff Titina Farris' first set of interrogatories." And this is dated 9/25/2019, correct?

A. That is correct.

Q. Have you ever seen this document before?

A. I have.

Q. Okay. And when did you first see this document?

A. Sometime in September.

Q. Okay. Did you see it before, after, or concurrently with the -- the document that was served 9/13/2019, the supplemental response, versus the first supplemental response?

A. I don't have an independent recollection of that.

Q. You don't have an independent recollection of when you saw each?

A. No. I got a number of emails in the last couple of weeks, all through September, with different interrogatories, different supplements asking me to review, and then verify, get it notarized, and resigned.

Q. Okay.

A So which one came in one email versus the other, I'd have to review my emails for that.

Q Based on your recollection, did you see them all at one time or did you see them on multiple occasions?

A I saw them on multiple vacation -- multiple occasions.

Q Okay. And as we sit here today, you couldn't tell like me or the Court when it was that you saw one versus the other. Is that fair?

A Exactly, no.

Q Okay. All right. All of them in September 2019 for the first time?

A I believe September or possibly even late August, but sometime in the last four to six weeks, yes.

Q Okay. Let's go ahead and -- I want to be very brief with the next three. If you took at Tabs 6, Tabs 7, and Tabs 8, these are essentially the mirror responses or -- the responses are different, and the questions are different, but these were served at the exact same times as the aforementioned three that we went through. And these are with respect to Defendant Laparoscopic Surgery Center of Southern Nevada -- Surgery of Nevada, LLC's responses.

And so the first, which is Tab 6, was electronically served 4/17/2017, the seventh tab is your supplemental responses, and the eighth tab is the first supplemental responses. Again, these are for your corporation. Correct?

A Correct.

Q All right. Tab Number 6, have you ever seen this before?

A Yes, I have.
Q When did you see this, Doctor?
A Within the last couple weeks.
Q Okay. The same timeline as the aforementioned three that we just went through?
A Correct.
Q Okay. Number 7?
A Same timeline.
Q Okay. Number 8?
A Same timeline.
Q Okay. Now, Doctor, are you sure that you have not seen these before, any of these six that we just went through, prior to September of 2019?
A Yes.
Q Okay. Why are you so sure of that, Doctor?
A Because when I had a chance to review them, there were errors on there that I needed to have them corrected.
Q And that's true both for the ones for your corporation as well as for your Answers to Interrogatories for yourself personally?
A I'd have to go through them again to verify that.
Q Please do so.

[Witness reviews document]

THE WITNESS: Yeah, I reviewed them in September of this year, because I needed to correct the address on my corporation's responses as well.

BY MR. JONES:

Q Okay. So because of that, you can say with certainty for the Court that this is the first time you saw them, was September 2019, correct?

A Or sometime in September, yes.

Q Right. Sometime in September 2019?

A Oh, 2019. Yes.

Q Okay. And that you've never seen either one before, correct?

A That is correct.

Q All right. Doctor, who is Teresa Duke?

A Teresa Duke is head of credentialing at St. Rose -- actually St. Rose, all campuses.

MR. JONES: Your Honor, I have another exhibit that I didn't think I was going to be needing to attach. We received this from Defense counsel within the last week or so, two weeks perhaps. One through paralegals. We reached out to them for a copy of the verification in this case. I'd like to distribute verifications signed by Dr. Rives that we've received within the last week.

THE COURT: Is that the one that came in the night before the last --

MR. JONES: No, Your Honor.

THE COURT: -- hearing?

MR. JONES: This is one that -- that we happened to receive by email within the last week or so.

THE COURT: All right. But what I'm asking is, I think at the

original hearing set on order shortening time in this case on 9/26 on the 10 a.m., you all disclosed to me at the hearing on 9/26 that -- I believe you said the evening before, you received a verification. Is that the verification you're talking about that's in your hand, or is this a different verification? I'm just trying to get an understanding of --

MR. JONES: Absolutely.

THE COURT: -- what verification is this.

MR. JONES: Yes. And, Your Honor, I'll -- so after we got Defendant's opposition, we asked them if they had a verification, and their paralegal sent us this, which is a verification of Dr. Rives for his surgery center.

THE COURT: Okay. So --

MR. JONES: It appears to contradict what Dr. Rives just testified to, Your Honor.

THE COURT: Okay. Well, let's see it, and see what people's position is. So you're saying you got this from the paralegal of the Doyle firm? I'm just trying to get an understanding who you got it from, when you got, and where you got it, if you don't mind, please.

MR. JONES: Absolutely, Your Honor. When we saw Defendant's opposition, much of it said, well --

THE COURT: Okay.

MR. JONES: -- it's really not that bad because there wasn't a verification, I reached out to Mr. Hand and I said, is there a verification? And he said, oh, let me check. And his paralegal sent an email to the paralegal asking for verification from Mr. Doyle's office, and they sent

over this verification.

THE COURT: Okay.

MR. JONES: And so we received this in the last week or two, is my --

THE COURT: Okay.

MR. JONES: -- understanding, Your Honor.

THE COURT: So time frame -- just so the Court has an understanding here, just -- because you all are talking about a lot of different time frames. Defendant filed their opposition. Since I don't have the final stamped copy -- I'm looking at the date on page 22. Okay? It says September 24, 2019. Okay? So your understanding is you got this verification some point between September 24 and when the hearing took place on September 26, or you got it -- I'm just --

MR. JONES: No. That's --

THE COURT: I'm trying to chronology it.

MR. JONES: Right.

THE COURT: I'm trying to get the correct chronology here, please.

MR. JONES: My understanding is right around that time, Your Honor.

THE COURT: Okay.

MR. JONES: That's my understanding.

Now, to be clear, the -- at the hearing, I didn't mention this because it didn't seem directly on point at all, since this is only a verification of the company, not of his individual responses.

THE COURT: Okay. Okay.

BY MR. JONES:

Q Dr. Rives, what is this document that I've just handed you?

A It's a verification regarding Laparoscopic Surgery of Nevada's response to Plaintiff Titina Farris' first set of interrogatories.

Q All right. And can you read -- it says verification. And can you please read what it says below that?

A "I, the undersigned, declare I have read the foregoing document, and know the contents thereof. I am informed and believe that the matters stated therein are true. And on that ground, I allege that the matters stated therein are true. I declare under penalty of perjury that the foregoing is true and correct. Executed on the 27th of 2017 at Henderson, Nevada."

Q Is that your signature, Doctor?

A That is.

Q All right. And Teresa Duke is a notary at St. Rose?

A She's head of medical credentialing, but she's a notary, yes.

Q Okay. And she's notarized documents for you before?

A Yes, she has.

Q And you don't doubt -- you don't deny that you signed in document, that it was notarized?

A No, I don't.

Q Okay. All right. So, Doctor, what you testified to before, a moment ago, that you had never seen this document up until September of 2019, that's not true, is it?

A No. It is true.

Q So, Doctor, you had this verification notarized when?

A The 27th, 2000- -- April 27th, 2017.

Q Okay. And you did that without looking at the document that it attached to?

A The documents came as an email. The first PDF I pulled up was for something regarding discovery. I read it as a bunch of legalese. They asked me, can you approve these? So I printed out the last verification, had it signed and notarized.

Q Okay. So -- and you didn't go back to read what you were swearing under penalty of perjury was true?

A You mean the other documents?

Q Right.

A No.

Q Okay. What did you believe this related to, Doctor, at the time that you swore under penalty of perjury that the answers were true?

A To the documents prepared by my legal counsel.

Q Okay. All right. And you did so. It says, "I have read the foregoing document and know the contents thereof." That was not true when you signed this?

A No.

Q Okay. And you have no idea whether or not the information stated therein was true or not, did you, because you hadn't reviewed any of it?

A I did not review it. Having been with this counsel for many years and seeing these in the past, half the time I can't make sense of them, so I assume what their due diligence has been is true. Yes.

Q Okay. All right. But you certainly did not verify that any of the statements therein were true, correct?

A I did not review them sentence by sentence, no.

Q And your understanding when you signed this was that you were affirming that everything they had sent to you was true, correct?

MR. DOYLE: Objection. It mischaracterizes the evidence.

MR. JONES: I don't think it does at all.

THE COURT: Okay. I need an answer -- I need a further -- since this is me and an evidentiary -- I don't have a jury -- I need a further explanation. I don't want --

MR. DOYLE: This is --

THE COURT: -- it in his presence though because I do not want to -- in light of the issues that were raised with these leading questions, I need this done in a manner that explains to the Court. So we have a couple of ways of doing that.

MR. DOYLE: Can we approach?

THE COURT: But I want to ensure that you are fine with your client, because we have those mixed interests because he is a client who is also entitled to hear things.

So, counsel, what do you suggest? You're his counsel.

MR. DOYLE: I'd like to just point out what's wrong with the question. And the suggestion in the question is inaccurate about this

document.

MR. JONES: Your Honor, I'm happy to rephrase the question and see if I can accomplish what I'm attempting to accomplish --

THE COURT: Okay.

MR. JONES: -- with something that is --

THE COURT: Since it's rephrased, the Court will --

BY MR. JONES:

Q Doctor, a moment ago you testified --

THE COURT: -- not address it.

Go ahead.

MR. JONES: Oh, sorry.

BY MR. JONES:

Q Doctor, a moment ago you testified that you got all of these documents from counsel, and that you knew that they wanted a verification signed, so you printed off the very last page of all of them and signed that, correct?

A That is correct.

Q Okay. And you did that believing that this was a verification saying that everything they had sent you was true. Is that fair?

MR. DOYLE: Objection. It mischaracterizes the evidence.

THE COURT: The Court's going to overrule the objection because he said, "Is that fair."

THE WITNESS: I'm sorry. You're going to have to -- I got lost in all this, quite honestly.

MR. JONES: You bet, Doctor.

BY MR. JONES:

Q You printed off this last page, and you signed it as a verification that you were saying that everything they had sent you was true --

A Correct.

Q -- is that -- all right, Doctor. Now, I want to go through -- you've been deposed numerous times, and that dealt with previously, and you were under oath in each occasion; isn't that true?

A That is true.

Q And you've answered interrogatories in numerous cases, and you would know that you -- that those are under penalty of perjury as well, correct, when you answered those?

A My counsel has answered those interrogatories for me, yes.

Q But you knew -- but you signed verifications for those interrogatories, correct?

A I believe so, yes.

Q And the verifications to those interrogatories were sworn under penalty of perjury, were they not?

A I believe so, yes.

Q And you're the one swearing under penalty of perjury that they're true, aren't you?

A Yeah, I guess. Yeah.

Q Okay. All right. Now, Doctor, during your deposition, you stated that -- in this case, you stated that Mr. Hand provided you with some documents, including your CV and including interrogatory

responses; is that true?

A Rereading the deposition and the best of my recollection, yes.

Q Okay. When did you reread that deposition, Doctor?

A Sometime in the last week or two.

Q Okay. Any time before that since the time of your deposition?

A I do not -- I don't think I even had the deposition. No.

Q Okay. So you believe the first time you saw that deposition since the deposition was sometime last week or two?

A I believe so, yes.

Q We can agree that that deposition as taken October 24th, 2018?

A I have no reason to quibble with that.

Q Okay. Let's just flip over to Exhibit 10.

MR. JONES: Your Honor, I have a few more questions still. Is there --

THE COURT: Here's what we're going to -- how much time do you estimate that you still need?

MR. JONES: Maybe ten minutes. Something like that.

THE COURT: Okay. And how much do you need for your final rebuttal or your final -- are you going to do redirect?

MR. DOYLE: So far, no.

THE COURT: Okay.

MR. DOYLE: But I haven't heard everything.

THE COURT: Okay. Then Tena says I'm fine for the other case that's waiting, estimate we're probably more likely to start closer to 10:15 just to let you know, best estimate. Okay. So if you need to be doing something, we won't call -- you know what I mean? We won't start without you, let's put it that way. But more likely 10:15. Okay. Thank you.

Go ahead, counsel.

BY MR. JONES:

Q Now, Doctor, the -- when he handed those to you, did he give you the impression that you weren't really permitted to really look through those answers?

A Say that again?

Q Well, I'll say it the other way. Was it clear that he wanted you to review what he was handing you?

A He asked me to review the CV part, yes.

Q Okay. But he handed you both things?

A Yes.

Q Did he say, please review your CV, but don't review the interrogatories?

A He asked me only to review the CV.

Q Okay. All right. Did you, at any time, review the interrogatories at that time?

A No, I don't believe I did.

Q Did you even look at them as -- during the course of that deposition?

A I don't believe I did.

Q Okay. Do you have an actual recollection of either looking at them or not looking at them during that deposition?

A To the best of my recollection is that I did not.

Q Okay. So I just want to ask you again. Do you have an independent recollection of that? Do you actually recall answering his questions about interrogatories without them in front of you versus with them in front of you?

A In -- you mean independent of all other information like rereading the deposition?

Q I'm asking you right now, do you have a memory in your mind of the deposition that is so clear that you can tell the Court with certainty, based on your memory, whether or not you answered the questions with the deposition -- or interrogatories in front of you?

A To the best --

MR. DOYLE: Objection. Argumentative.

THE COURT: Court's going to overrule that.

THE WITNESS: Am I allowed to answer?

BY MR. JONES:

Q Yes.

A To the best of my recollection, to the best memory I have as I sit here today is that I did not have those when he asked me about them.

Q Okay. Do you have a recollection of answering those questions --

THE COURT: Bless you.

BY MR. JONES:

Q -- and that the interrogatories were not in front of you?

A Yeah, I believe I just stated that.

Q Okay. All right. Okay. If you can turn to page 10 of Exhibit 10, down at the very bottom of that page, beginning line 25, there's a question. It says,

> "If I could direct you to response number 3. And the question is if you had ever been named as a defendant in any case arising from alleged malpractice or negligence? So I'm just going to go over these with you. We are on page 2."

So are you saying that as he's saying that to you that you did not have that document in front of you?

A That's correct because he asked for it back on page 10, around question -- line 1 or 2 where he says, "Can I see those interrogatories again for a second. Thank you."

Q Okay. And so you're saying that when he did that there was only one set of interrogatories, and he was just talking to you only at that time?

A Correct.

Q Okay. So when he was asking -- when he was saying if he could direct you to response number 3, he was holding the only set of interrogatories himself and not directing you to anything?

A He was holding the interrogatories and going through the list that he was reading. I was listening to him as he was reading the list of cases.

Q Okay. Doctor, have you looked at any portion of the deposition of the *Center* case within the last month?

A Yes.

Q When was that?

A Within the last two weeks maybe.

Q Was that also in relation to this hearing?

A Yes, it was.

Q Okay. In the *Center* case, do you recall being asked about prior medical malpractice cases in which you had been involved?

A I believe so, yes.

Q And you'd agree that when you were under oath in the *Center* case, you also had taken an oath to tell the truth, and as you stated, the whole truth and nothing but the truth, correct?

A That is correct.

Q And that was true for today, at the deposition in the Farris case, and the deposition in the *Center* case, correct?

A That covers all aspects of my life, yes.

Q Okay. Let's go ahead and go to Exhibit 9. And you'd agree this is a copy of your deposition in the *Center* case, correct?

A It appears to be, yes.

Q Okay. Now, in the *Center* case, you also failed to mention the Farris case when you were asked about medical malpractice cases you'd been involved in, correct?

MR. DOYLE: Objection. Mischaracterizes the evidence.

THE COURT: The Court can't make a ruling on that because

you're referencing a hundred plus page document. So the Court's going to have reserve and hear what the answer is and then rule afterwards and let you each provide what you want to provide afterwards.

Go ahead.

BY MR. JONES:

Q. Go ahead, Doctor. Answer.

A. I'm sorry; you're going to have to remind me.

Q. Yes, Doctor. You'd agree that you failed to name the Farris case when you were asked about medical malpractice cases in which you had been involved during your *Center* deposition?

A. When I reviewed my deposition I realized that I had left off both pending cases, Brown and Farris.

Q. Okay. So you failed to disclose that you had the Farris case, and you failed to disclose that you had the Brown case during your *Center* deposition?

A. No, I misunderstood the question. I thought it was related to matters that had been settled. So I talked about the four cases that had been settled. I didn't realize that included the three pending cases, which would have been *Brown, Center, and Farris* at that time.

Q. Okay. But you would agree in retrospect, having reviewed this in the last two weeks, that the question required you to be candid even about the Farris and the *Brown* case, correct?

A. In retrospect, yes.

Q. Okay. And so you're just saying at the time, you misunderstood it, correct?

A That is correct.

Q And because of that, you gave incomplete testimony, correct?

A That is correct.

Q Okay. Now, you'd agree that your attorney understood the call of the question in the Farris case to require you to mention the *Center* case when you were being deposed in the Farris case?

MR. DOYLE: Objection. Speculation.

THE WITNESS: I'd say you'd have to ask Chad.

THE COURT: Wait just a second. Hold on. Can you repeat that question? You understood --

BY MR. JONES:

Q During your deposition --

MR. JONES: I think it's a fair objection, Your Honor. I think it is speculative. I'm going to move on.

THE COURT: Okay. You're going to rephrase. Since it's been withdrawn, then the Court need not rule?

MR. JONES: Yes, I'll withdraw --

THE COURT: Okay.

MR. JONES: -- the question, Your Honor.

BY MR. JONES:

Q Now, do you recall if Mr. Brenske, after you failed to divulge the Farris case during the *Center* case, if Mr. Brenske, the attorney in the *Center* case, reminded you of the Farris case at some point?

MR. DOYLE: I'm going to object. It mischaracterizes his

testimony.

THE COURT: I'm going to overrule that objection because it's a do you recall if this happened, so it's not testimony.

THE WITNESS: You mean do you -- do I recall after having read the deposition?

BY MR. JONES:

Q I asked if you recalled.

A Well, does that include rereading my deposition? Because something jogs your memory or --

Q Answer it the way you see fit, Doctor.

A Rereading my deposition on *Center*, Mr. Brenske readdresses me towards the two pending cases. Yes.

Q Okay. So after he asked you and you hadn't mentioned those cases, he later brought those cases up to you?

A He did. Yes.

Q Okay. All right. And do you recall providing Mr. Brenske an explanation about what happened in the Farris case?

A I'd have to review that.

Q Doctor, can you give a short description about what happened in the Farris case?

A Right now?

Q Yeah.

A Oh, Ms. Farris came to me because she had a recurrent eventual hernia. I recommended surgery for that. Went through all the risks, benefits, alternatives regarding the surgery. We did a presumed to

be outpatient surgery. During that surgery, there were injuries to the transverse colon that are repaired at that time. Subsequently, she developed sepsis and had a prolonged hospital course.

Q Okay. Now, Doctor, when you were asked to provide a description from Mr. Brenske, you don't recall what it is that you stated?

A Not without reviewing the record, no.

Q All right. I'll refer you to page 18 of your deposition in this case. This is Exhibit 9, beginning at line 3, going through 12.

"Q With regard to the next case, Farris --

A Wait, I'm not there yet.

Q Oh, okay.

A Hold on.

Q My apologies, Doctor.

A Where are we at? Page 18 --

Q Page 18.

A Oh, there are four pages to a page. Okay.

Q Yes. Yeah. I apologize. That's the only version I have at this time.

A No worries.

Q Page 18, beginning at line 3. Tell me when you're ready.

A Go ahead.

"Q With regard to the next case, Farris v. Reeves, is that case still ongoing?

"A Yes.

"Q In ten words or less, can you -- you don't have to do it in ten

words or less, but can you just give us a brief description of what that -- the allegations in that case?"

And then your answer is there. Doctor, can you read your answer?

"A The patient had a laparoscopic hernia repair and resulted in oculocutaneous fistula postoperatively that required subsequent surgery."

Q That's not accurate, is it, Doctor?

A It -- yeah, it is.

Q That is accurate?

A Yeah.

Q When was she diagnosed with oculocutaneous fistula by you?

A It was when she had her CT scan showing the extravasation, and she had to go -- be taken back to surgery. I don't recall the exact date of that.

Q And you're saying that you diagnosed her with that condition?

A I diagnosed her with that -- I don't know --

Q With oculocutaneous fistula?

A Well, it hadn't fistulized yet, but it was a leak, so it was going to be oculocutaneous fistula, effectively, yes.

Q Did she develop oculocutaneous fistula, Doctor?

A She went to surgery.

Q She did go to surgery.

A Right.

Q Did she develop oculocutaneous fistula, Doctor?
A No.
Q She did not?
A No.
Q Okay. Now, you testified under oath here on page 18 that it resulted in oculocutaneous fistula.
A Correct.
Q Isn't that what your testimony was?
A It was.
Q Okay. And in fact, you never diagnosed her with oculocutaneous fistula, did you?
A We diagnosed her with oculo -- we diagnosed her with a perforation to the colon. That's the development of oculocutaneous fistula. Whether you want to say it's matured and she's leaking stool out of her skin or whether you want to say she has a perforation and that's going to be the subsequent outcome of it, whichever part of that time frame you want to be definitive, depends upon your definition, I guess.
Q Okay. In any event, you would agree with me that she was never diagnosed with oculocutaneous fistula; isn't that true?
A She was not diagnosed with oculocutaneous fistula.
Q And she was not diagnosed by you or by anyone else, was she?
A She didn't develop oculocutaneous fistula because she went back to surgery --
Q Okay.

A -- on that day or the day after, I should say.
Q On -- you mean like 13 days after the original surgery?
A When Dr. Hamilton [phonetic] did the surgery.
Q Okay.
A Correct.
Q Got it. Is there any reason that you didn't tell Mr. Brenske that she developed bilateral foot drop?
A No.
Q Is there any reason that you didn't tell Mr. Brenske that she became septic post-op day one?
A No.
Q Is there any reason you didn't tell Mr. Brenske that she remained septic, and you didn't recommend surgery for more than 11 days?
A No.
Q Okay. You knew that those were all issues, allegations made against you in the *Center* case, though, correct?
A Correct. He asked me to summarize, not allege what the allegations against me were.
Q Okay. And you agree that all of those are commonalities in this case, correct?
A No.
Q No?
A Not at all.
Q Those that I just mentioned are not?

A With the *Center* case?
Q That's correct, those three things.
A But Center never had foot drop.
Q Okay. Her feet were amputated instead, correct?
MR. DOYLE: Your Honor, relevance.
THE COURT: The Court's going to sustain for the purpose of today's evidentiary hearing.
MR. JONES: Okay.
THE COURT: I'll sustain his objection.
MR. JONES: All right.
BY MR. JONES:
Q Doctor, you agree that the documents that you received in April of 2017 failed to list the *Center* case, correct?
A That is correct.
Q Okay. And you agree that you signed a verification that you believed was attesting to the truthfulness of those documents, although you never reviewed them yourself?
A Basically, yes.
Q Okay. And you'd agree that during your deposition, you never provided information about the *Center* case until after your attorney stepped in and mentioned what has come into the transcript as *Center*, correct?
A Yeah. I was never asked about the *Center* case. No.
Q You ultimately were asked about the *Center* case, weren't you?

A In the part that you were talking about, no. But later, yes.

Q Okay. After your attorney mentioned the case, you were then asked about it?

A That is correct.

Q Okay. And when you were asked about the *Center* case, you didn't mention that she developed sepsis post-op day one, correct?

A I don't recall what I said. I'd have to review it on the deposition.

Q Okay. Let's go ahead to page 10.

MR. JONES: Your Honor?

THE COURT: A few more moments, Counsel.

MR. JONES: Okay.

THE COURT: You went into an area that was outside, so you --

MR. JONES: That's fair enough. I can shut it down, Your Honor, if you'd like me to.

THE COURT: We've got a moment or two, and then --

MR. JONES: Okay.

THE COURT: -- I'm going to see if counsel has an understanding of the case.

MR. JONES: I will be finished in one minute.

BY MR. JONES:

Q Page 13, Doctor, of Exhibit 10.

A Okay.

Q Are you there?

A Yes, I am.

Q Let's see. Okay. It's actually on page 14. Sorry, beginning line 3 says, "Can you tell me what that case involved?" And your answer?

A "Patient had diaphragmatic tear laparoscopically. She aspirated and became septic."

Q Okay. And while those are things that you may have argued in your trial in that case, you'd agree with me that the allegations were that she became septic post-op day one?

A That was an allegation, yes.

Q Right. And you agreed that that was the case, in fact, did you not?

A Yeah.

Q And also, that there was an 11-day period in which she remained septic without surgical --

MR. DOYLE: Objection. Relevance. Relevance.

THE COURT: I'm going to sustain it as to that's a substantive question not for purposes of today's evidentiary hearing.

MR. JONES: Thank you, Your Honor. I'll move on.

BY MR. JONES:

Q Doctor, is it your practice to swear under oath without knowing or reviewing information you're swearing to?

A No.

Q It just happened in this case?

A That is correct.

MR. JONES: That's all, Your Honor.

THE COURT: Thank you. Counsel?

MR. DOYLE: I don't have any questions.

THE COURT: Okay. The Court has a few follow-up questions. I'm going to tell you what the Court's questions are and it's really going to be up to -- if either counsel does not wish the Court to ask any of these questions, then I won't. It's really as simple as that, okay?

So I'm going to tell you what the question is. Well actually, there's a few of them, okay? First question is the Court would like to have a better clarification of how Dr. Rives knew in April 2017 to get into the email to find the verification, to sign the verification.

MR. DOYLE: No objection.

MR. JONES: No objection, Your Honor.

THE WITNESS: I was sent an email from my attorneys with --

THE COURT: And the Court's not asking about the content of any communications, but the way you described it --

THE WITNESS: Okay.

THE COURT: -- I'm trying to just get an understanding of how you knew -- you said you opened up --

THE WITNESS: An email.

THE COURT: -- an email, the last page and to find the verification on the last document, in the last page of the last document. So I'm trying to have an understanding of how you knew which document --

THE WITNESS: There's --

THE COURT: -- to know, to find a verification.

THE WITNESS: So there's a list of pdf files, and there's a truncated title to each pdf file. It doesn't give the complete title. And I believe the last one says verification, so I clicked on that one to print it out, have it signed and notarized.

THE COURT: Okay. So the Court's follow up question is was there only -- I'm trying to get an understanding of what this email looked like to the extent without in any way invading the attorney client privilege. Was there only one truncated document that said verification? That's the next question. Anyone that doesn't want the Court to ask it, then the Court won't.

MR. DOYLE: No objection.

MR. JONES: No objection, Your Honor.

THE WITNESS: There were -- if I recall correctly, six pdf files. And as I scanned through them that was the one that came out of in my mind that said verification on them.

THE COURT: So the Court doesn't feel that that answered the Court's direct question of whether or not there was only one that said verification. As there were six, was there only one that said verification is really the question the Court was asking. I was trying to get an understanding if there was one or more than one that had the word verification on it.

THE WITNESS: I can't remember, Your Honor.

THE COURT: Okay. And I'll tell you the Court's next question would be is whether or not this witness has signed other interrogatories

in the past and understands what the verification is, without in any way asking from any communications with any counsel, but understands what a verification is from the past, so he's got an understanding of how he knew to look for the verification in this case from the email. Not getting into content or any communications, of course. Just trying to get a background.

MR. DOYLE: No objection.

MR. JONES: No objection.

THE WITNESS: In the email, it asked me if I approve, to sign the verification.

THE COURT: Okay. The Court's question was a little different about whether or not there had been any prior signing of --

THE WITNESS: Oh. My apologies.

THE COURT: -- interrogatories and verifications or was this the first time. Does anyone have any objection to that question being re-asked so that it clarifies?

MR. DOYLE: No, Your Honor.

MR. JONES: No objection.

THE WITNESS: My apologies, Your Honor. I misunderstood. I'm sure that in the past, I've been asked to verify these before.

THE COURT: Okay. Okay. Those were the Court's questions. So it is 10:16. Dr. Rives came on the stand, Madam Court Reporter, what time?

COURT REPORTER: 9:16.

THE COURT: 9:16. An hour. Just what you all asked for. So,

you all being provided the exact amount of time that you specifically requested on 9/26 to having today for the totality of today's hearing, the Court finds that it has provided you. And that hour was supposed to take into account also really the Court's ruling as well, so the Court's given you a full hour to give you an opportunity. It's offered direct examination, cross-examination, offered but did not wish any response. So the witness can feel free to go off the stand.

So the Court's position at this juncture is the Court did exactly what the parties asked for, after the Court offered the evidentiary hearing. In the intervening time, the Court did go and ask -- just let my Law Clerk leave to make sure -- I wanted to make sure I reread the letter of September 30th, 2019, just to see if there was any request for any additional argument, oral argument, because the Court knows it did not receive anything subsequent to that. There's no request in this letter. It just says, you know -- it just says whether he was intending to testify at the hearing scheduled at 8:30. Correspondence via the Court and counsel, Dr. Rives will testify.

So there's no request for any additional oral argument. The Court gave you all extensive oral argument to the extent everybody wished to do as much as you wanted to. In fact, the Court even, on 9/26, gave you a partial inclination to one portion of Plaintiff's motion and that was as to the punitive damages portion, to give you some indication so that to the extent that was of assistance, so that you could fully prepare for tomorrow's calendar call, but said that the other requested sanction aspects were still on the table for today's evidentiary hearing to really

allow you to narrow where you were going for today.

So while I heard Defense counsel mention that you'd like to do some kind of summation at the end, the Court doesn't see that that was requested previously by anyone. This was set up specific when I had counsel -- Plaintiff's table on 9/26, whoever you all chose to come at the hearing date, which was supposed to be the total final only hearing date. I had two counsel on Defense. Nobody asked on 9/26. Nobody asked in any of the intervening time, either in the letter -- I even double-checked the inappropriately -- which is now stricken, by the way.

The Court specifically ordered stricken the improperly rogue documents filed on 9/30, specifically contrary for all the reasons that the Court said previously, obviously, the quote supplemental and that declaration, post -- and for supplemental, because -- for all the reasons the Court stated. It's not even there, a request for oral argument, so I double-checked that just to see by chance, even if it was. So even giving the benefit of the doubt with regards to -- the Court even -- if by implication, somebody may have intended that somewhere, the Court can't take that into consideration, because that is -- for all the reasons, it's impermissible.

The Court's not reiterating everything it said for the first time period this morning at 8:30, so that can't be considered. Those we're striking, but in any event, there was nothing on the face of that document that requested specific additional oral argument, and I've given the other side an opportunity to do so. And the Court -- you all knew I was scheduling something right after you. In fact, you all thought

I was scheduling right after I gave some time.

So here's what the Court's going to do. The Court is going to say as follows. We didn't get to the motion to strike the affirmative defenses, did not get to the other motions that were also going to be taken care of, because I wanted to ensure -- we went longer on the testimonial portion, so I wanted to ensure everyone had a full opportunity to have that taken care of.

So the Court's going to do the following. The Court's going to give you its ruling on the 10th, but here's what we're going to do. I'm going to tell you the first part of the Court's ruling, okay? Because that's going to be important for tomorrow's purposes. For tomorrow's purposes, here's what you're going to hear. The first portion of the requested ruling was for terminating sanctions, okay? For terminating sanctions. And I will give you my longer analysis on Thursday.

But the short version of its for there to be terminating sanctions, those terminating sanctions would need to be due, as you know, to the conduct of Dr. Rives, okay? Under *Young v. Ribeiro*, well, I'm just going to short-version it. All analysis setting forth, citing *Young v. Ribeiro*, I will cite all the different provisions of the other applicable case law, NRCP 37 -- 7.60, all the different basis I -- actually, your motion's really on 37, but when listening, while there is egregious conduct, the one mitigating factor for reason why this Court doesn't find solely on this motion alone -- not taking into account everything else that the Court needs to address -- for counsel's conduct, for all the other issues that the Court still needs to address.

But for Plaintiff's motion alone, the Court doesn't find that terminating sanctions under the applicable case law and the rules, would be appropriate, because Dr. Rives' conduct in and of itself would not rise to the level for terminating sanctions, based on his testimonial evidence presented today, taking into account the following. The Court -- after I get through the whole analysis, what I'll give you further on Thursday, when you're coming back is the prejudice to Plaintiff issue.

By Plaintiff's own declaration in their motion, they acknowledge that they did not look at some of this information, until, I'm going to put it, summer of this year. Whereas, this deposition, or some of this information was clear, was October 2018. So the prejudice aspect, solely for this motion only, Plaintiff's motion only, I do have to look at prejudice. Prejudice under *Johnny Ribeiro* is that some of that prejudice, this Court finds, could have been mitigated, if it had been looked at earlier.

There could have been some additional things the Court would have had the ability potentially to have done. And that -- taking that into account, which was one of the factors the Court does specifically need to take into account. I'm not in any way minimizing the egregious conduct, which will be discussed later, by both counsel and client, okay, which the Court will be evaluating and going through. But the reason why the Court doesn't find it merits at this juncture purely on Plaintiff's motion only, which is the only thing I'm addressing right now, is because by Plaintiff's own declaration, this information was available.

I'm not in any way adopting the oppositions' position that

you needed to look at Odyssey. They had an -- sorry. Yeah. They had an affirmative -- Defense had an affirmative obligation to give you the correct information. I'm in no way adopted their position. However, some of this information was available to Plaintiffs in a manner that it could have been evaluated, because there was enough in that October deposition that a reasonable inquiry could have gotten you some information and gotten some relief requested from the Court in a more timely manner that could have alleviated some of the prejudice, which is a factor this Court does have to consider under *Johnny Ribeiro*, and that's why the Court doesn't find it to be appropriate to do terminating sanctions.

All other sanctions up to that are on the table and will be further discussed on Thursday. The reason why I needed -- important to tell you the terminating was not happening is because you have your calendar call tomorrow. So I want to make it clear, I would expect to see everything tomorrow, as you have been told all along, okay? Since January, not since September, as improperly stated in people's declarations. So we will be seeing you tomorrow at your calendar call. Thank you so very much.

MR. DOYLE: Your Honor, if I may --

THE COURT: That's -- this hearing is now over. We'll be seeing you tomorrow at your calendar call. I need to get to my next case that's patiently -- you're already taking 25 of their minutes.

MR. DOYLE: A quick question. I was going to be traveling on Thursday. The Court hasn't set a time for the hearing on Thursday,

but could I do that by telephone, rather than physically being present?

THE COURT: How important you think this --

MR. DOYLE: I'll be here personal --

THE COURT: -- is for you, that's up to you.

MR. DOYLE: I'll be here personally on Thursday.

THE COURT: That's up to you.

MR. DOYLE: All right.

THE COURT: The Court's not requiring, because there's no evidentiary basis. Thursday is we're going to go over that. We're going to go over all the other sanction components against you and your firm, so it's however important you feel it is. If you want a telephonic request, you can have a telephonic.

MR. DOYLE: Okay.

THE COURT: It's up to you. The Court's not requiring people to be here in person. I was going to suggest 1:30 on Thursday the 10th. See you all. But I was going to discuss that further tomorrow? Okay. But anticipated time is going to be Thursday the 10th at 1:30. If you want to be here telephonically, telephonically is fine. Plaintiff's counsel, if one of you want to be here telephonically, once again, it's your choice.

MR. JONES: We will be here, Your Honor.

THE COURT: That's up to you.

MR. LEAVITT: We'll be present.

THE COURT: The Court's not requiring somebody to be here in present [sic]. The Court's going to go over all those issues. It's how you wish to be here.

MR. JONES: Your Honor, would you like to retain a copy of the binder that I dropped --

THE COURT: I am going to just for purposes that you -- easy way, instead of me having to click on the system, I've got mine. I'll keep it until Thursday. But I'll see you tomorrow, okay?

MR. JONES: Okay.

THE COURT: Thank you so much.

MR. JONES: Absolutely, Your Honor.

[Proceedings concluded at 10:26 A.M.]

ATTEST: I do hereby certify that I have truly and correctly transcribed the audio-visual recording of the proceeding in the above entitled case to the best of my ability.

Jessica B. Cahill

Maukele Transcribers, LLC
Jessica B. Cahill, Transcriber, CER/CET-708

EXHIBIT "2"

Farris v. Rives
Eighth Judicial District Court No.
Laparoscopic Surgery of Nevada's Response to Plaintiff Titina Farris' First Set of Interrogatories

VERIFICATION

I, the undersigned, declare:

I have read the foregoing document and know the contents thereof.

I am informed and believe that the matters stated therein are true and on that ground I allege that the matters stated therein are true.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on April 27, 2017, at Henderson, Nevada.

BARRY RIVES, M.D.

SUBSCRIBED and SWORN to before me this 27 day of April, 2017, by BARRY RIVES, M.D., personally known to me or proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

TERESA M. DUKE
NOTARY PUBLIC
STATE OF NEVADA
My Commission Expires: 03-03-18
Certificate No: 98-1756-1

NOTARY PUBLIC

(seal)

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Attorneys for Defendants BARRY RIVES, M.D. and LAPAROSCOPIC SURGERY OF NEVADA, LLC

DISTRICT COURT

CLARK COUNTY, NEVADA

TITINA FARRIS and PATRICK FARRIS, Plaintiffs, vs. BARRY RIVES, M.D.; LAPAROSCOPIC SURGERY OF NEVADA, LLC, et al., Defendants.	CASE NO. A-16-739464-C DEPT. NO. 31 **DEFENDANTS' TRIAL BRIEF IN SUPPORT OF THEIR POSITION REGARDING THE PROPRIETY OF DR. RIVES' RESPONSES TO PLAINTIFFS' COUNSEL'S QUESTIONS ELICITING INSURANCE INFORMATION**

Defendants BARRY J. RIVES, M.D. and LAPAROSCOPIC SURGERY OF NEVADA, LLC ("Defendants") hereby submit the following trial brief in support of their position regarding the propriety of Dr. Rives' response plaintiffs TITINA FARRIS' and PATRICK FARRIS' ("Plaintiffs") counsel's questions eliciting insurance information. As outlined in more detail below, Dr. Rives' testimony related to the fact Ms. Farris had health insurance was proper

Case Number: A-16-739464-C

because Plaintiffs' opened the door to such evidence, there was no motion in limine filed by Plaintiffs to exclude evidence of insurance and Plaintiffs have not met their burden of proof that Ms. Farris' health plan was a self-funded ERISA plan.

Dated: October 22, 2019

SCHUERING ZIMMERMAN & DOYLE, LLP

By */s/ Thomas J. Doyle*

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Attorneys for Defendants BARRY RIVES, M.D. and LAPAROSCOPIC SURGERY OF NEVADA, LLC

DECLARATION OF THOMAS J. DOYLE

I, THOMAS J. DOYLE, declare as follows:

1. I am an attorney at law licensed to practice in the state of Nevada. I am a partner of the law firm of Schuering Zimmerman & Doyle, LLP, attorneys of record for Defendants. I am making this declaration based upon my personal knowledge and I could testify competently to the matters asserted herein.

2. Attached hereto as **Exhibit 1** is a true and correct copy of my firm's file copy of a document entitled MGM Resorts Health & Welfare Benefit Plan, which was produced by Plaintiffs on July 5, 2019 in connection with their 7th Supplemental NRCP 16.1 Disclosure. I am not aware of any evidence produced by Plaintiffs in this case that establishes that Ms. Farris' health plan was a self-funded health plan under ERISA.

3. Attached hereto as **Exhibit 2** is a true and correct copy of all case law cited herein.

I declare under penalty of perjury under the laws of the State of Nevada that the foregoing is true and correct, and if called to testify, I could competently do so.

Executed this 22nd day of October, 2019, at Las Vegas, Nevada.

/s/ Thomas J. Doyle
THOMAS J. DOYLE

MEMORANDUM OF POINTS AND AUTHORITIES

I.

BACKGROUND

This medical malpractice action arises from the care and treatment Defendants provided to Ms. Farris in connection with a laparoscopic hernia repair. Ms. Farris claims past medical expenses.

Ms. Farris had health insurance at the time of the care at issue claimed in her past medical expenses. Plaintiffs contend it was a health plan subject to ERISA. During the course of discovery, Plaintiffs did not meet their burden of establishing that the ERISA health plan at issue was a self-funded plan.

On July 5, 2019, Plaintiffs produced the MGM Resorts Health & Welfare Benefit Plan ("Benefit Plan"). Exhibit 1. The Benefit Plan does not state unambiguously that Ms. Farris' health plan through MGM Resorts was a self-funded plan under ERISA.

For example, section 20.17 of the Benefit Plan suggests the acquisition of insurance by the plan as opposed to a self-funded plan.

> 20.17 Limitations on Liability for Benefits.
>
> (a) Source of Benefits For Fully Insured Benefits. All Benefits that are fully insured shall be paid or provided for under the Plan *solely by the insurance company or other entity contractually responsible to pay for or to provide such benefits*. The Employer assumes no liability or responsibility with respect to any obligor and does not guarantee that such Benefits shall be payable or paid, or that any Benefit shall be funded. Benefits provided under a fully insured Plan shall be provided only to the extent any Benefit continues to be maintained.

Exhibit 1, p. PLTF 11557, *emphasis added.*

As the court is well aware, no motions in limine were filed in this case. Specifically, there was no motion in limine filed by Plaintiffs to exclude evidence of the fact that Ms. Farris had health insurance.

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On October 21, 2019, during the testimony of Dr. Rives, Plaintiffs' counsel asked questions to Dr. Rives that elicited evidence of the fact Ms. Farris had health insurance. The Court asked Defendants' counsel to provide authorities for their position as to the propriety of Dr. Rives testimony regarding Ms. Farris' health insurance.

II.

ARGUMENT

A. Plaintiffs Opened the Door to Evidence of Ms. Farris' Health Insurance.

One party may open the door to the introduction of otherwise inadmissible evidence by the other party. *See*, *Sprowson v. State*, 2019 WL 2766854 *3 (Nev.; July 1, 2019; No. 73674; unpublished decision), citing *Cordova v. State*, 116 Nev. 664, 670, 6 P.3d 481, 485 (2000). Here, Plaintiffs' line of questioning of Dr. Rives opened the door to evidence of Ms. Farris health insurance because the questions necessarily required a response that included evidence of Ms. Farris' health insurance.

On October 21, 2019, during the testimony of Dr. Rives, Plaintiffs' counsel asked Dr. Rives a series of questions regarding his billing for his services to Ms. Farris. He was asked a question regarding whether he paid back or offered to pay back the money he received for his treatment of Ms. Farris. Dr. Rives testified that he did not think he could give back the money, and Plaintiffs' counsel asked why he did not think he could do so. Given Plaintiffs' knowledge that the billing of Dr. Rives' services and the payment therefor went through Plaintiffs' health insurance company, Plaintiffs' counsel's questioning of Dr. Rives as to whether he paid back the money he received for his services rendered to Ms. Farris and his reasons for thinking that he could not do so, necessarily invoked a response that included evidence of the fact Ms. Farris had health insurance. Accordingly, Plaintiffs opened the door to evidence of Ms. Farris' health insurance.

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B. Dr. Rives Did Not Violate Any Court Order in Testifying about Ms. Farris' Health Insurance.

There is no Order in this case that prevents Dr. Rives from testifying about Ms. Farris' health insurance. Plaintiffs did not file a motion in limine to preclude such evidence. Additionally, Plaintiffs did not discuss the need for such an exclusion at the EDCR 2.67 conference, at the October 8, 2019 calendar call, or at any other time before this issue arose. Dr. Rives' testimony regarding Ms. Farris' health insurance therefore was proper and not in violation of any Order excluding such evidence.

C. Plaintiffs Have Not Met Their Burden of Establishing NRS 42.021 Does Not Apply to this Case.

Nevada has provided specific protections for health care provider defendants in terms of the abrogation of the collateral source rule in an action for medical malpractice. NRS 42.021 provides in relevant part:

> In an action for injury or death against a provider of health care based upon professional negligence, if the defendant so elects, the defendant may introduce evidence of any amount payable as a benefit to the plaintiff as a result of the injury or death pursuant to the United States Social Security Act, any state or federal income disability or worker's compensation act, any health, sickness or income-disability insurance, accident insurance that provides health benefits or income-disability coverage, and any contract or agreement of any group, organization, partnership or corporation to provide, pay for or reimburse the cost of medical, hospital, dental or other health care services. If the defendant elects to introduce such evidence, the plaintiff may introduce evidence of any amount that plaintiff has paid or contributed to secure his right to any insurance benefits concerning which the defendant has introduced evidence.

As is evident from the clear language of NRS 42.021, defendants in a professional negligence case may elect to introduce evidence of collateral sources, if they so choose. The public policy behind permitting collateral evidence to be introduced is clear upon a consideration of the history of NRS 42.021. It was part of an Act proposed by Initiative Petition and approved by the Nevada voters in the 2004 general election. The Initiative, on the Ballot as Question 3 and entitled "Keep Our Doctors in Nevada" ("KODIN"),

contained several sections which made various changes to the statutory framework of a medical malpractice action in Nevada. Section 9 amended Chapter 42 of the Nevada Revised Statutes so that, in an action for medical malpractice, the defendant may introduce evidence at trial of any amount payable as a benefit to the plaintiff as a result of injury or death. The Initiative was placed on the ballot to address "skyrocketing medical malpractice insurance costs [which] have resulted in a potential breakdown in the delivery of health care for the medically indigent, a denial of access to health care for the economically marginal, and the depletion of physicians such as to substantially worsen the quality of health care available to the residents of this state." When the Initiative passed, Section 9 was codified at NRS 42.021.

The default rule in a medical malpractice action therefore is that pursuant to NRS 42.021, Defendants are permitted to introduce any and all benefits paid as a result of the Plaintiffs' alleged injuries. Dr. Rives' testimony regarding Ms. Farris' health insurance therefore was proper under NRS 42.021.

While Plaintiffs argue the application of NRS 42.021 is preempted by federal law because Ms. Farris was insured by an ERISA plan, Plaintiffs' analysis and the evidence put forward by Plaintiffs relative to that issue falls short of such a conclusion. Federal preemption does not apply to any and all ERISA plans; it applies solely to employer self-funded plans. *Coast Plaza Doctors Hosp. v. Blue Cross of Cal.*, 173 Cal.App.4th 1179, 1189, 93 Cal. Rptr. 3d 479, 486-87 (2009.) ERISA plans that are not-self funded, but rather, are ERISA insurance plans, are subject to ERISA's insurance savings clause, which subjects the plans to state regulation such as NRS 42.021. Id., citing *FMC Corp. v. Holliday*, 498 U.S. 52, 61, 111 S. Ct. 403, 409 (1990).

The federal preemption of NRS 42.021 pursuant to *McCrosky v. Carson Tahoe Reg'l Med. Ctr.*, 408 P.3d 149 (Nev. 2017) applies only to self-funded ERISA plans. In this case, there is insufficient evidence that Ms. Farris' health plan was a self-funded ERISA plan. In

fact, Plaintiffs have not provided Defendants or this Court with any evidence sufficient to establish that the default rule in a medical malpractice action, NRS 42.021, does not apply in this case because Ms. Farris' health plan was a self-funded ERISA and not an ERISA insurance plan.

Section 20.17 of the Benefit Plan suggests the acquisition of insurance by the plan as opposed to a self-funded plan.

20.17 Limitations on Liability for Benefits.

> (b) Source of Benefits For Fully Insured Benefits. All Benefits that are fully insured shall be paid or provided for under the Plan solely *by the insurance company or other entity contractually responsible to pay for or to provide such benefits*. The Employer assumes no liability or responsibility with respect to any obligor and does not guarantee that such Benefits shall be payable or paid, or that any Benefit shall be funded. Benefits provided under a fully insured Plan shall be provided only to the extent any Benefit continues to be maintained.

Exhibit 1, p. PLTF 11557, *emphasis added.*

In the absence of Plaintiffs providing this Court and Defendants with evidence sufficient to meeting their burden of proof that NRS 42.021 does not apply to this case, because Ms. Farris' health plan was a self-funded ERISA plan and not an ERISA insurance plan, Dr. Rives' testimony regarding the existence of health insurance is proper under NRS 42.021.

III.

CONCLUSION

For the reasons stated in more detail above, Dr. Rives' testimony related to the fact Ms. Farris had health insurance was proper because Plaintiffs' opened the door to such evidence, there was no motion in limine filed by Plaintiffs to exclude evidence of

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insurance and Plaintiffs have not met their burden of proof that Ms. Farris' health plan was a self-funded ERISA plan.

Dated: October 22, 2019

SCHUERING ZIMMERMAN & DOYLE, LLP

By */s/ Thomas J. Doyle*

THOMAS J. DOYLE
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Attorneys for Defendants BARRY RIVES, M.D. and LAPAROSCOPIC SURGERY OF NEVADA, LLC

CERTIFICATE OF SERVICE

Pursuant to NRCP 5(b), I certify that on the 22nd day of October, 2019, service of a true and correct copy of the foregoing:

DEFENDANTS' TRIAL BRIEF IN SUPPORT OF THEIR POSITION REGARDING THE PROPRIETY OF DR. RIVES' RESPONSES TO PLAINTIFFS' COUNSEL'S QUESTIONS ELICITING INSURANCE INFORMATION

was served as indicated below:

☒ served on all parties electronically pursuant to mandatory NEFCR 4(b);

☐ served on all parties electronically pursuant to mandatory NEFCR 4(b) , exhibits to follow by U.S. Mail;

☐ by depositing in the United States Mail, first-class postage prepaid, enclosed ;

☐ by facsimile transmission; or

☐ by personal service as indicated.

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an employee of Schuering Zimmerman & Doyle, LLP
1737-10881

EXHIBIT 1

MGM RESORTS
HEALTH AND WELFARE BENEFIT PLAN

As Amended and Restated Effective January 1, 2012

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MGM RESORTS
HEALTH AND WELFARE BENEFIT PLAN

As Amended and Restated Effective January 1, 2012

ARTICLE I

INTRODUCTION

MGM Resorts International (the "Company") maintains the MGM Resorts Health and Welfare Benefit Plan (the "Plan") to provide certain health and welfare benefits to eligible Employees, as defined herein.

The Company now desires to amend and restate the Plan effective January 1, 2012 in order (i) to reflect the provisions of all prior amendments to the Plan, (ii) to make certain benefit design changes and clarifications, and (iii) to make certain changes as required by law and as may be recommended by counsel.

Accordingly, this document sets forth the Plan, as amended and restated effective January 1, 2012. This document, as it may be duly amended, together with any other documents incorporated herein by reference ("Incorporated Documents") as each may be amended, constitutes the Plan in its entirety.

The Plan has been established and shall be maintained with the intention of meeting the requirements of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), and any other pertinent laws and regulations. The Plan is also intended to qualify as a cafeteria plan under the provisions of section 125 of the Internal Revenue Code of 1986, as amended (the "Code") and applicable regulations issued and effective thereunder.

The Company reserves the right to alter, amend, modify or terminate the Plan in whole or in part, at any time and for any reason, in a manner consistent with the provisions of Article XIX.

In the event that the provisions of a document describing or governing a Benefit conflict with the provisions of this document or any other documents governing the Benefits, the Plan Administrator shall use its discretion to interpret the terms and purpose of the Plan consistent with applicable law to resolve any conflict. However, the terms of this document shall not enlarge the rights of a Participant or his or her beneficiary to Benefits.

ARTICLE II

DEFINITIONS

Whenever used in the Plan, the following words and phrases shall have the respective meanings specified in this Article unless the context plainly requires a different meaning, or the

documents describing or governing a Benefit contain a definition applicable to that Benefit. When a defined meaning is intended, the term shall be capitalized in the Plan.

2.1 Affordable Care Act means together the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, which was signed into law on March 23, 2010; and H.R. 4872, the Health Care and Education Reconciliation Act of 2010, which was signed into law on March 30, 2010, as amended, and the applicable regulations issued and effective thereunder.

2.2 Benefit(s) means the health and welfare benefits as described herein and within each Incorporated Document.

2.3 Claims Administrator means a person or persons, or entity or entities appointed by the Company to serve as the administrator of claims under the Plan with the responsibility for review and payment of claims and recordkeeping related thereto and, to the extent directed by the Company, to exercise its discretionary authority in the review of claim payments (including eligibility for benefits claimed) and claim denials under the terms of the Plan. In the case of any Plan benefits provided under a group insurance contract, the insurance company shall be the Claims Administrator for the benefits provided under that group insurance contract unless otherwise provided in the contract. If no Claims Administrator is authorized to act under the terms of a Benefit's governing documents, the Plan Administrator shall be the Claims Administrator.

2.4 COBRA means the coverage rights which are conferred by Code section 4980B, *et seq.*, and ERISA section 601, *et seq* (as such statutes were created by the Consolidated Omnibus Budget Reconciliation Act of 1985, and amended thereafter), and the applicable regulations issued and effective thereunder.

2.5 Code means the Internal Revenue Code of 1986, as amended from time to time, and the applicable regulations issued and effective thereunder.

2.6 Company means MGM Resorts International and any successor or assign thereof which adopts the Plan by action of its Board of Directors (or that Board's designee).

2.7 Dependent means a Spouse, Domestic Partner or dependent child of an Employee who is eligible for coverage under the terms of the Benefit's Incorporated Documents.

2.8 Domestic Partner means, for purposes of the Plan, a same-sex partner as defined in the Company's affidavit, including a same-sex spouse or civil union partner as recognized by state law.

2.9 Effective Date means (except as otherwise set forth herein) January 1, 2012, the general effective date of the provisions of this amended and restated Plan.

2.10 Employee means a person who is classified by the Employer as a common law employee of the Employer. The term "Employee" does not include (i) any employee of the Employer who is a member of a collective bargaining unit and is covered under a collective

bargaining agreement unless the collective bargaining agreement provides for the employee's participation in the Plan, (ii) any contract employees, or leased employees of the Employer as defined in Code section 414(n), or (iii) any person who is not classified by the Employer as a common law employee of the Employer, notwithstanding any later reclassification by a court or any regulatory agency of the person as a common law employee of the Employer. Classification of persons as Employees shall be determined by the Employer in its discretion.

2.11 Employer means the Company and each subsidiary or affiliate that employs Employees and is a member of the Company's controlled group, as described in Code sections 414(b) or (c), other than MGM Grand Detroit, LLC and Mandalay Employment, LLC.

2.12 ERISA means the Employee Retirement Income Security Act of 1974, as amended from time to time, and the applicable regulations issued and effective thereunder.

2.13 FMLA means the Family and Medical Leave Act of 1993, as amended.

2.14 Full-Time Employee means an Employee who is designated to work full-time by the Employer.

2.15 Health Care Components means the Benefits that provide medical, wellness program, prescription drugs, dental, vision, employee assistance benefits and health care spending account benefits under the Plan.

2.16 HIPAA means the Health Insurance Portability and Accountability Act of 1996, as codified under Code section 9801, *et seq.*, and ERISA section 701, *et seq.*

2.17 Incorporated Document means each written arrangement incorporated under this Plan, including each insurance policy, administrative services agreement, HMO agreement and Summary Plan Description, that constitutes part of an "employee welfare benefit plan" within the meaning of Section 3(l) of ERISA and that provides Benefits under the Plan. The insurance policy governing any insured Benefit shall constitute the official plan document for the purpose of benefit determinations and shall supersede the provisions of any Summary Plan Description with respect to such Benefit.

2.18 Participant means any Employee, and where applicable, eligible Dependent, who participates in the Plan in accordance with the terms of the Benefits.

2.19 Participation Date means, with respect to any Participant, the date on which his or her participation in the Plan commences, as provided in Article III.

2.20 Plan means the MGM Resorts Health and Welfare Benefit Plan, as set forth herein, and as may be amended from time to time, together with any and all appendices and supplements.

2.21 Plan Administrator means the Company or such other person or committee of one or more persons (which may include employees, officers or directors of the Company) as

may be designated by the Company in writing to administer the Plan as provided herein. The "Plan Administrator" shall be the "named fiduciary" of the Plan within the meaning of ERISA Section 402(a).

2.22 **Plan Year** means the twelve (12) month period beginning on January 1 and ending on the next following December 31.

2.23 **Qualifying Life Event** means any event, which qualifies as a status change or other event under Code section 125, which permits an Employee to make a pre-tax election change.

2.24 **Required Contribution** means the contribution, if any, required to be paid by a Participant for Benefits, as determined by the Plan Administrator.

2.25 **Spouse** means a person of the opposite sex who is legally married (other than by common-law) to the Participant. A Spouse does not include a former spouse following legal separation, final decree of dissolution or divorce, or a common law spouse.[1]

2.26 **Summary Plan Description** means the most recent version of each summary plan description for each Benefit, as amended from time to time with a summary of material modifications or a new summary plan description, each of which forms a part of the Plan, and which sets forth the terms and conditions relating to eligibility for coverage, the levels and types of Benefits, any Required Contributions and the source of benefit payments and funding, if applicable.

2.27 **USERRA** means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

ARTICLE III

ELIGIBILITY AND PARTICIPATION

3.1 Employee Eligibility.

(a) Full-Time Employees. Except as provided below, each Employee who is a Full-Time Employee is eligible to participate hereunder as of his or her Participation Date, which is the first day after the Employee completes ninety (90) calendar days of active continuous employment with the Employer as a Full-Time Employee. Each Employee who is designated by the Employer as an "on-call," "part-time," or "temporary" employee is not eligible to participate hereunder.

(b) Full-time Flex or Part-time with Benefits. Each Employee who is classified by the Employer as a "full-time flex" or "part-time with benefits" Employee shall be eligible to participate hereunder as of his or her Participation Date, which is the first day after the Employee

[1] BHFS question/comment: Please confirm that the Plan excludes separated spouses?

completes ninety (90) calendar days of active continuous employment with the Employer during which such Employee completes an average of thirty (30) hours of work for the Employer per week determined by an audit conducted every calendar quarter.

(c) Employees who Become Non-Bargaining. The Participation Date of an Employee who becomes a Full-Time Employee in a non-bargaining position after being a Full-Time Employee covered by a collective bargaining agreement that does not provide for coverage hereunder shall be the first business day of the week following the date on which the employment status change (transfer transaction) is entered in the Employer's Human Resource system, provided that the Employee has completed ninety (90) calendar days of active continuous employment with the Employer starting from his or her original date of hire.

(d) Change in Employment Status from Part-time or On-call or Temporary to Full-Time or Full-time Flex or Part-time with Benefits Status. The Participation Date of an Employee who becomes a Full-Time, "full-time flex," or "part-time with benefits" Employee after being a "part-time," "on-call," or "temporary" Employee shall be the first business day of the week following the date on which the employment status change (transfer transaction) is entered in the Employer's Human Resource system, provided that, as of such date, the Employee has completed ninety (90) calendar days of active continuous employment for the Employer during which such Employee completes an average of thirty (30) hours of work for the Employer per week determined by an audit conducted every calendar quarter.

(e) The Signature Condominiums, LLC Employees. The Participation Date of an Employee who is treated as a "new hire" by The Signature Condominiums, LLC ("Signature") on or after March 1, 2006, and who is covered under the PPO or HMO[2] [Benefits under the Plan on the day before his or her date of new hire, shall be the Employee's date of new hire by Signature. The Participation Date of an Employee who is treated as a "new hire" by Signature on or after March 1, 2006, and who is covered under a collectively bargained health plan on the day before his or her date of new hire, shall be the first day after the Employee completes ninety (90) calendar days of active continuous employment as a Full-Time Employee with Signature starting from his or her date of new hire.

(f) Circus Circus Reno Employees. The following provisions apply to Employees of Circus Circus Reno only.

(i) New Employees. To be eligible to participate in the Plan, new Employees of Circus Circus Reno must satisfy subparagraphs (A) and (B) below.

(A) Waiting Period Required. The Employee must complete ninety (90) calendar days of active continuous employment with the Employer. If the Employee meets the requirements of subparagraph (B) below, then the Employee shall be eligible to become a Participant as of his or her Participation Date, which is the first day after the Employee's completion of this waiting period.

[2] BHFS question: Should the DCHP be included here?

(B) Full-time Employment Required. The Employee must be employed by the Employer on a full-time basis, as determined by the Plan Administrator, in its sole discretion, immediately preceding the Employee's Participation Date.

(I) Initial Full-time Test. An Employee shall be deemed to be employed on a "full-time basis" if he is Actively Employed, at his customary place of employment, for an average of thirty (30) or more hours per week (or such other number of hours as may be established by the collective bargaining agreement covering his or her employment with the Employer). The computation period shall be determined by the Plan Administrator in its sole discretion, but shall be selected so as to facilitate obtaining the necessary data, making the necessary computations, and notifying Employees of their options in a timely manner.

(II) Failure of Initial Full-time Test. If an Employee does not meet the requirements of the initial full-time employment test during his applicable computation period determined pursuant to subparagraph (I), the Employee's hours worked shall be reviewed each subsequent calendar quarter and the Employee shall be deemed to be employed on a "full-time basis" if he or she is Actively Employed, at his or her customary place of employment, for an average of thirty (30) or more hours per week (or such other number of hours as may be established by the collective bargaining agreement covering his or her employment with the Employer) for the three (3) month period immediately preceding the first day of any calendar quarter thereafter.

(ii) Continuing Employees. To remain eligible to participate, an Employee must continue to be Actively Employed for an average number of hours (the "Average Hours Requirement") as specified below, so as to continue to be considered a Full-Time Employee.

(iii) Computation of Full-Time Employment.

(A) Except in the case of the Initial Full-Time Test applied to new Employees as described in subparagraph (f)(i)(B)(I), an Employee's status as a Full-Time Employee shall be measured on a calendar quarter basis as set forth in subsection (B).

(B) An Employee shall be deemed to be employed on a "full-time basis" if he or she is Actively Employed, at his or her customary place of employment, for an average of thirty (30) or more hours per week (or such other number of hours as may be established by the collective bargaining agreement covering his or her employment) for the three (3) month period immediately preceding the first day of any calendar quarter thereafter.

(iv) Loss of Coverage.

(A) So long as all requirements for coverage other than the Average Hours Requirement continue to be met, a Participant whose Active Employment throughout a calendar quarter fails to meet the Average Hours Requirement shall not lose

coverage hereunder until the end of the first calendar quarter coinciding with the date that he or she has failed to meet the Average Hours Requirement for two consecutive calendar quarters.

(B) If an Employee's Active Employment is less than necessary to meet the Average Hours Requirement for two (2) consecutive calendar quarters, then he or she shall not be eligible to participate for the following calendar quarter; provided, however, that if an Employee fails to meet the Average Hours Requirement solely as a result of a leave taken pursuant to the FMLA, or any other leave of absence approved by the Company, generally not to exceed sixty (60) days, such person shall not cease to be an eligible Employee, and upon his return from such leave, shall have his or her eligibility for coverage measured based on the calendar quarter ended immediately prior to his leave of absence.

(C) An Employee whose Plan coverage is terminated solely because of his or her failure to meet the Average Hours Requirement for two (2) consecutive calendar quarters may again become eligible to participate on the first day of the first calendar quarter following the first calendar quarter during which his or her Active Employment throughout such calendar quarter meets the Average Hours Requirement.

For purposes of this subparagraph (f), "Active Employment" or "Actively Employed" shall mean that an Employee is: (1) actively at work at the Employer's regular place of business or another location to which the Employee may be required to travel to perform the duties of his or her employment with the Employer; (2) on an approved vacation or is absent due to a hospital confinement or other health factor; (3) on an approved military leave of absence; or (4) on an approved leave of absence and receiving workers' compensation benefits.

(g) For purposes of this Section 3.1, an Employee shall also be treated as in active continuous employment with the Employer during any period of absence from work due to any health factor.

3.2 Dependent Eligibility. A Dependent shall be eligible for coverage under the terms of the Benefit's Incorporated Documents.

3.3 Qualified Medical Child Support Orders. The Plan shall honor any qualified medical child support order ("QMCSO") that provides for Plan coverage for an alternate recipient, in the manner described in Section 609 of ERISA and in accordance with the Plan's QMCSO procedures.

3.4 Participation. Each Employee and Dependent shall become a Participant on the Employee's Participation Date provided that (i) the Employee has commenced work by such date and completed the applicable waiting period, and (ii) the Employee completes the enrollment process as prescribed by the Plan Administrator, including submitting all required documentation, no later than thirty-one (31) days after such date, except as provided in Section 3.9.

3.5 Termination of Participation/Continuation During Certain Leaves of Absence. This Section shall apply only to the Health Care Components. A Participant's

coverage under other Benefits shall terminate or be continued in accordance with the terms of the applicable Benefit's Incorporated Documents.

(a) Termination of Participation/Death of Participant.

(i) A Participant's participation shall terminate as of the date the Participant ceases to be an eligible Employee (or Dependent, as applicable) hereunder, except as may be otherwise provided in Section 3.1(f) and this Section.

(ii) A Participant must provide to the Plan Administrator notice of a legal separation, divorce, or a Dependent's loss of dependent status within thirty-one (31) days after such event. If this notice is not provided within sixty (60) days after such event, COBRA coverage shall not be available to the former Spouse or Dependent whose coverage terminates as a result of such event.

(iii) If a Participant dies while actively employed by an Employer, the Participant's Dependents shall continue to be covered hereunder as provided in the applicable Incorporated Document.

(b) Continuation During Certain Leaves of Absence.

(i) Approved Personal Leave of Absence. If a Participant is on an approved personal leave of absence from the Employer, the Employer shall continue coverage hereunder for thirty (30) days provided that the Participant pays the applicable premium contribution. Coverage under the Plan shall terminate on the thirty-first (31st) day after the start of the Participant's leave of absence.

(ii) FMLA/Medical Leave. If a Participant is on FMLA or other approved medical leave from the Employer, as described in the Employer's leave policy, the Employer shall continue coverage hereunder for the Participant for a period not to exceed eighty-four (84) days in a rolling twelve-month period (or such longer period if required by law) only if the Participant pays for coverage for that period at the Plan's rates that would apply if the Participant was not on FMLA leave.

(iii) Workers' Compensation Leave. If a Participant is on a qualified Employer-approved workers' compensation leave, the Employer shall continue coverage hereunder for the Participant during that leave only if the Participant pays for coverage for that period at the Plan's rates that would apply if the Participant was not on leave.

(iv) Military Leave. Subject to all conditions set forth in the Company's military leave policy, the Employer shall continue coverage for a Participant who is an Employee and his or her enrolled Dependents at no cost to the Employee during the Employee's military leave of absence from the Employer.

(c) Continuation During Other Events. The Plan may provide continuation coverage during certain layoffs or other leaves in accordance with the Employer's personnel policies and as communicated to Participants.

3.6 Rehired/Reinstated and Transferred Employees.

(a) Rehired/Reinstated Employees. An Employee who is rehired by an Employer shall be eligible to participate in the Plan and make new benefit elections, provided such Employee satisfies the eligibility requirements of Section 3.1. Notwithstanding the foregoing, if a former Employee is rehired by an Employer during the same Plan Year and within six (6) months of the date his or her prior participation ended, his or her elections shall be reinstated. If an Employee is considered by the Employer as "reinstated" under the Employer's personnel policies, the provisions of those policies with respect to eligibility shall apply for purposes of this Plan and Benefits.

(b) Transferred Employees. A Participant who transfers from one Employer to another Employer shall retain coverage hereunder. An Employee who transfers from an affiliate or subsidiary of the Company that is not an Employer to an Employer shall be credited with past service with that prior employer for purposes of eligibility hereunder.

3.7 Enrollment.

(a) Initial Enrollment. An eligible Employee must enroll for coverage hereunder for himself or herself and any Dependents by completing the enrollment process as prescribed by Plan Administrator within thirty-one (31) days after his or her Participation Date. To complete the enrollment process, the Employee must provide to the Plan Administrator documentation of dependent status of any Dependents (such as marriage certificates or birth certificates) as prescribed by the Plan Administrator. The Participant's initial coverage period is the period beginning on his or her Participation Date and ending on December 31 of that year. An eligible Employee who fails to complete the enrollment process timely may become a Participant on a later date as provided in this Section.

(b) Annual Enrollment. The Employer shall have an annual enrollment period during which an Employee may change his or her benefit elections. Benefit elections made during this period shall generally become effective January 1st and shall remain in effect through the next December 31st. A Participant's enrollment elections shall remain in effect each subsequent Plan Year unless changed during annual enrollment or in connection with a Qualifying Life Event; provided, however, that a Participant contributing on a post-tax basis due to late enrollment, as described in Section 3.9, shall be automatically re-enrolled in the subsequent Plan Year on a pre-tax basis. Notwithstanding the foregoing, the Participant must affirmatively re-enroll each year in the Health Care Spending Account and Dependent Care Spending Account. To complete the enrollment process, the Employee must provide to the Plan Administrator documentation of dependent status of any Dependents (such as marriage certificates or birth certificates) as prescribed by the Plan Administrator.

(c) Special Enrollment. An eligible Employee may enroll himself or herself and his or her Dependent(s) in health coverage under the Plan if: (i) the Employee or Dependent was covered under a group health plan or had health insurance coverage from another source at the time coverage hereunder was made available to the individual, (ii) the Employee or Dependent certifies that other health coverage was the reason for declining coverage, (iii) the loss of such coverage was due to exhaustion of COBRA, or due to loss of eligibility for coverage or employer contributions toward coverage were terminated, and (iv) the Employee or Dependent requests enrollment no later than thirty-one (31)[3] days after the loss of such other coverage. Provided these requirements have been met, coverage hereunder shall be effective the first day following the loss of other coverage. If an Employee or Dependent loses other coverage due to his or her failure to pay Required Contributions or for "cause," as determined by the Plan Administrator, such individual shall not have any special enrollment rights hereunder.

In addition, to the extent required by HIPAA, an eligible Employee with a new Dependent as a result of marriage, birth, adoption, or placement for adoption, may be permitted to enroll himself or herself and his or her Dependents in health coverage under the Plan within sixty (60) days after the marriage, birth, adoption, or placement for adoption.

Each Employee or Dependent, who is eligible for coverage under the group health coverage under the Plan, but not enrolled, may enroll for group health coverage under the terms of the Plan if either:

(i) the Employee or Dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or under a State Children's Health Insurance Program ("CHIP") under Title XXI of the Social Security Act and (a) coverage of the Employee or Dependent under such a plan is terminated as a result of loss of eligibility for such coverage, and (b) the Employee requests coverage under the group health coverage under the Plan no later than 60 days after the date such coverage terminates; or

(ii) the Employee or Dependent becomes eligible for assistance, with respect to group health coverage under the Plan, under a Medicaid plan or State CHIP (including under any waiver or demonstration project conducted under or in relation to such a plan), and the Employee requests coverage under the group health coverage under the Plan no later than 60 days after the date the Employee or Dependent is determined to be eligible for such assistance.

3.8 Qualifying Life Event Enrollments and Required Enrollment Changes.

Except as otherwise provided in Section 3.7, in the case of a Qualifying Life Event that permits adding a Dependent to coverage under the Plan, for coverage to be effective for such Dependent, the Participant must enroll the eligible Dependent within sixty (60) days of the event. In the case a Participant changes status from Employee to Dependent or from Dependent to Employee, the person must re-enroll under the new status within thirty-one (31)[4] days of the change. Enrollment must be completed in the manner required by the Plan Administrator. If

[3] BHFS Question: Should this be 60 days also?
[4] BHFS Question: Should this be 60 days also?

enrollment is not completed by the deadlines provided herein, the enrollment shall be considered a "late enrollment," as described in Section 3.9.

Notwithstanding the foregoing, an Employee who undergoes an employment status change and therefore becomes newly eligible to participate in the Plan must complete the enrollment process as prescribed by the Plan Administrator, including submitting all required documentation, no later than sixty (60) days after the date that the Employee satisfies the eligibility requirements.

3.9 Late Enrollment.

(a) The provisions of this subsection (a) apply to Employees and Dependents other than Employees and Dependents of Employees of Circus Circus Reno. If an Employee, other than a Circus Circus Reno Employee, does not enroll within the time period provided for an initial enrollment, as a special enrollment, or during the time periods provided for Qualifying Life Event enrollments, the enrollment shall be considered a "late enrollment." If the Employee enrolls and it is a "late enrollment," coverage hereunder shall be effective as of the first day of the month after enrollment is completed, and premium payments shall be made after-tax.

(b) Employees of Circus Circus Reno must enroll within the time periods provided under the Plan, and shall not be permitted to enroll late as described in subsection (a) above. If the Employee does not timely enroll, the Employee shall not be permitted to enroll until the next open enrollment period or unless the Employee experiences a special enrollment pursuant to Section 3.7(c) or Qualifying Life Event.

ARTICLE IV

CLAIMS ADMINISTRATION AND PROCEDURE

The Plan may contract with a Claims Administrator to administer the benefits hereunder. The Participant must follow the Plan's claims procedure, as provided in the Incorporated Documents or as provided by the Plan Administrator or Claims Administrator and communicated to Participants, to be eligible for a Benefit hereunder. All claims must be submitted to the Claims Administrator for payment and must contain such information as is required by the Claims Administrator.

Appeals of adverse benefit determinations shall be processed in accordance with the claims and appeals procedures set forth in Incorporated Documents (including the Summary Plan Descriptions) of the applicable Benefits. The Plan Administrator shall have no authority with respect to any matter as to which a Claims Administrator under any Summary Plan Description is empowered to make final claim determinations. If, however, a Claims Administrator is not empowered to make final claim determinations for a Benefit, then the Plan Administrator shall be the claims administrator and shall make such determinations in accordance with the procedures set forth in the applicable Incorporated Document.

In the event that (i) the Incorporated Documents governing the Benefit do not prescribe a claims procedure for Benefits that satisfies the requirements of Section 503 of ERISA or (ii) the Plan Administrator determines that the procedures described above with respect to a particular Benefit do not apply, the claims procedures described in the final regulations issued by the U.S. Department of Labor regulations at 29 C.F.R. Section 2560.503-1 shall apply with respect to the Benefit.

With respect to the non-grandfathered Medical Benefits, the claims, appeals and external review procedures shall be administered in compliance with the Affordable Care Act.

ARTICLE V

MEDICAL BENEFITS

Medical Benefits are described in the applicable Incorporated Documents.

ARTICLE VI

WELLNESS PROGRAM BENEFITS

Wellness Program Benefits are described in the applicable Incorporated Documents

ARTICLE VII

DENTAL BENEFITS

Dental Benefits are described in the applicable Incorporated Documents.

ARTICLE VIII

VISION BENEFITS

Vision Benefits are described in the applicable Incorporated Documents.

ARTICLE IX

LIFE INSURANCE AND AD&D BENEFITS

Life Insurance and Accidental Death and Disability Benefits are described in applicable Incorporated Documents.

ARTICLE X

LONG-TERM DISABILITY BENEFITS

Long-Term Disability Benefits are described in applicable Incorporated Documents.

ARTICLE XI

SHORT-TERM DISABILITY BENEFITS

Short-Term Disability Benefits are described in the applicable Incorporated Documents.

ARTICLE XII

EMPLOYEE ASSISTANCE PROGRAM BENEFITS

Employee Assistance Program Benefits are described in the applicable Incorporated Documents.

ARTICLE XIII

SEVERANCE PAY PROGRAM BENEFITS

Severance Pay Program Benefits are described in the applicable Incorporated Documents.

ARTICLE XIV

LEGAL PLAN BENEFITS

Legal Plan Benefits are described in the applicable Incorporated Documents.

ARTICLE XV

SUPPLEMENTAL INSURANCE BENEFITS

Supplemental Insurance Benefits are described in the applicable Incorporated Documents.

ARTICLE XVI

CAFETERIA PLAN BENEFITS

This Article XVI contains the terms that are applicable only to the Health Care Spending Account ("Health Care FSA") and Dependent Care Spending Account ("Dependent Care FSA") and the premium conversion benefits under the Plan. To the extent this Plan provides permitted taxable benefits and qualified benefits under Code section 125, it is intended to qualify as a cafeteria plan under Code section 125. This document is intended to satisfy the written plan documents requirements of Proposed Treasury Regulations section 1.125-1. The cafeteria plan is for Employees only.

16.1 Definitions. Capitalized terms used in this Article XVI are defined as follows, or if not defined herein, as defined elsewhere in the Plan:

(a) **Dependent** means, (1) for purposes of the Health Care FSA, an individual (as defined in Code section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof), and any child (as defined in Code section 152(f)(1)) of the taxpayer who as of the end of the taxable year has not attained age 27; and (2) for purposes of the Dependant Care Spending Account, a qualifying individual as defined in Code section 21(b)(1).

(b) **Dependent Care Expenses** means expenses that are considered to be employment-related expenses under Code section 21(b)(2) relating to expenses for the care of a qualifying individual, as defined in Code section 21(b)(1) paid for by the Participant provided, however, that this term shall not include any expenses for which the Participant or other person incurring the expense is reimbursed for the expense through insurance or any other plan.

(c) **Earned Income** means all income derived from wages, salaries, tips, self-employment, and other Employee compensation (such as disability or wage continuation benefits), but does not include any amounts received pursuant to any dependent care assistance program under Code section 129, any amounts received as a pension or annuity, or any amounts received pursuant to workers compensation). Earned Income is computed without considering community property laws. Earned Income of a Spouse who is a full-time student, as defined in Code section 21(e) or who is Physically or Mentally Incapable of Self-Care is deemed to be not less than $250 per month for Participants with one Dependent or $500 per month for Participants with two or more Dependents.

(d) **Physically or Mentally Incapable of Self-Care** means incapable of caring for ones hygienic or nutritional needs, or requires full time attention of another person for ones own safety or the safety of others.

(e) **Medical Care Expense** means, for purposes of the Health Care FSA, a Participant's and a Dependent's expenses incurred during the Plan Year for medical care, as defined in Code sections 213(d)(1)(A) and (B). To be a Medical Care Expense, the medical care must be essential to diagnose, cure, mitigate or prevent a disease or disorder or to affect an unsound structure or function of the mind or body. Incurred refers to the date the medical is provided – not to the date charged, billed, or paid.

(f) **Period of Coverage** means the Plan Year, with the following exceptions: (i) for Employees who first become eligible to participate, it shall mean the portion of the Plan Year following the date participation commences, and (ii) for Employees who terminate participation, it shall mean the portion of the Plan Year prior to the date participation terminates.

(g) **Qualified Reservist Distribution** means a taxable distribution to a Participant of all or a portion of the balance in the Participant's Health Care FSA if:

(i) the Participant was (by reason of being a member of a reserve component (as defined in section 101 of title 37, United States Code)) ordered or called to active duty for a period of one hundred and eighty (180) days or more or for an indefinite period, and

(ii) the distribution is requested during the period beginning on the date of such order or call and ending on the last day of the Plan Year which includes the date of such order or call.

(h) **Salary Reduction** means the amount by which the Participant's compensation is reduced and applied by the Employer under this Plan to pay for one or more of the Benefits provided under this Plan.

16.2 Health Care Spending Account. The Health Care FSA allows Participants to receive benefits in the form of pre-tax reimbursement for Medical Care Expenses. A notational account is established on behalf of each Employee who elects the Health Care FSA to which the Participant allocates Salary Reduction contributions for the reimbursement of Medical Care Expenses. The Health Care FSA is an employee welfare benefit plan, as defined in ERISA and is intended to qualify as a health plan under Code section 105(e). This document is intended to satisfy the written plan document requirement of Treasury Regulation section 1.105-11(b)(1)(i). To the extent necessary, other provisions of the Plan are incorporated by reference herein.

(a) Eligibility. All Employees who meet the eligibility requirements of Section 3.1, with the exception of Employees of Circus Circus Reno, may enroll and make elections for Health Care FSA in accordance with the Plan's procedures.

(b) Account Minimum. The minimum annual contribution is the $120.

(c) Account Maximum. The maximum annual contribution is $2,000. If an Employee and Spouse both work for the Employer, each may contribute the maximum to separate accounts. Medical Care Expenses for each covered Dependent may be claimed once. If an Employee is hired mid-year, the account maximum shall be prorated based on the number of pay periods remaining in the Participant's Period of Coverage. If a Participant elects to participate in the Health Care FSA, he or she must determine the total amount of his or her annual contribution during the Employee's initial or annual enrollment.

(d) Uniform Coverage and Irrevocability. A Participant has immediate access to the total amount of the annual contribution on the first day that the Participant's election is effective. The entire annual election may be reimbursed for Medical Care Expenses (minus any amounts already reimbursed), regardless of the amount actually in the Participant's account at the time. An election to participate in the Health Care FSA is irrevocable for the duration of the Plan Year except as permitted in connection with a Qualifying Life Event.

(e) Tax Considerations. The amount allocated to this account may be used to reimburse Medical Care Expenses which may also qualify for a medical deduction for federal income tax purposes. A Participant who participates in this account cannot claim any Medical Care Expenses that are reimbursed through this account as a deduction on his or her federal income tax return.

(f) Health FSA Exclusions. The following items are not considered Medical Care Expenses under the Code and/or for purposes of the Health Care FSA:

(i) Drugs obtained in an illegal way.

(ii) Controlled substances if the substance violates federal law, even if prescribed by a physician.

(iii) Vitamins or dietary nutritional supplements available without prescription.

(iv) Insurance premiums of any kind including those for health maintenance organizations, life insurance, long term care, loss of earnings, accidental death or dismemberment, automobile insurance, and group medical or other health insurance.

(v) Cosmetic surgery or other similar procedures unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or disfiguring disease.

(vi) Funeral or burial expenses.

(vii) Household and domestic help (even though recommended by a qualified physician due to the Participant's or Dependent's inability to perform physical housework).

(viii) Custodial care.

(ix) Massage therapy unless prescribed by a physician to treat a specific injury or trauma.

(x) Costs for sending a child to a special school for benefits the child may receive from the course of study and disciplinary methods.

(xi) Health club dues with respect to general membership.

(xii) Weight loss drugs or programs unless for a specified disease diagnosed by a physician such as: obesity, heart disease, or diabetes.

(xiii) Social activities, such as dance lessons, even if recommended by a qualified physician for general health improvement.

(xiv) Swimming lessons, even if recommended by a physician for general health.

(xv) Maternity clothes.

(xvi) Diaper service or diapers.

(xvii) Uniforms or special clothing, such as maternity clothing.

(xviii) Transportation expenses not primarily for and essential to medical care.

(xix) Home or automobile improvements or other similar capital expenses to the extent that they appreciate value of personal assets.

(xx) Teeth bleaching.

(xxi) Exercise equipment or programs unless prescribed by a doctor to treat a specific medical condition.

(xxii) Qualified long-term care services or nursing home services.

(xxiii) Capital expenses.

(xxiv) Household improvements to treat allergies.

(xxv) DNA collection and storage.

(xxvi) House improvements (i.e., exit ramps, widening doorways).

(xxvii) Mattresses, even if to treat a medical condition.

(xxviii)Personal use items (i.e., shampoo, hand lotion).

(xxix) Special foods needed to treat a special illness or ailment, even if prescribed by a physician and do not substitute normal nutritional requirements.

(xxx) Over-the counter or nonprescription drugs or items unless specifically permitted under applicable law, regulations, or other guidance issued by the relevant government agency(ies).

(xxxi) Other items not described in Code section 213(d).

(g) Funding. The Participant must complete a Salary Reduction agreement to specify the amount of his or her Health Care FSA contributions. Thereafter, the Participant's Health Care FSA shall be credited with the portion of compensation that the Participant has elected to forgo through Salary Reduction. These portions shall be credited as of each pay period.

(h) Claims Procedures for Health Care FSAs. The following claims procedures apply to the Health Care FSA, but do not supersede the claims procedures provided elsewhere in the Plan.

(i) Time to Submit Claims. All claims for reimbursement must be submitted on or before March 31 of the year following the end of the Plan Year. Amounts for which claims were not submitted by March 31 shall be forfeited.

(ii) Procedures for Submitting Claims. A Participant may elect automatic reimbursement, meaning that medical and/or dental expenses that are not covered by the Medical or Dental Plan in which the Employee is enrolled shall be forwarded for payment under the Health Care FSA. For all other Medical Care Expenses, the Participant must submit a claim form to the Claims Administrator and provide any required proof as requested. Claims may be submitted as Medicare Care Expenses are incurred during the Plan Year. Eligible Health Care FSA expenses shall be reimbursed as long as the amount requested is at least $25 and the amount does not exceed the limit of the Participant's contributions for the year, including any prior withdrawals and any availability restrictions. The $25 minimum claim requirement shall be waived at the end of the Plan Year to assure that the Participant receives the tax benefit of all eligible expenses, up to the contribution limit for the year.

(iii) Qualified Reservist Distributions. A Participant may make a written request to the Plan Administrator or its delegate for a Qualified Reservist Distribution.

A Qualified Reservist Distribution shall not be made based on an order or call to active duty of any individual other than the Employee. After a Participant requests a Qualified Reservist Distribution and before the Plan Administrator may distribute an amount, the Plan Administrator must first receive a copy of the order or call to active duty.

The balance that can be distributed is limited to the amount of the Participant's actual payroll deductions made as of the date of the request (i.e., the amount contributed to the Health Care FSA as of that date), less any amount that has already been disbursed for valid claims received as of the date of the request.

The Plan Administrator shall pay the Qualified Reservist Distribution to the Participant within a reasonable time, but not more than sixty (60) days, after the request for the Qualified Reservist Distribution has been made.

After requesting a Qualified Reservist Distribution in a Plan Year, the Participant may not, for that Plan Year, request any more Qualified Reservist Distributions or submit any further claims for reimbursement with respect to Medical Care Expenses incurred after the date the Qualified Reservist Distribution is requested.

(i) Termination of Participation. A Participant shall cease participation in the Health Care FSA when he or she is no longer eligible to participate, when the Participant revokes his or her election to participate in the Health Care FSA, or when the Participant terminates employment or dies unless the Participant elects continuation coverage.

16.3 Dependent Care Spending Account. The Dependent Care FSA allows a Participant to receive benefits in the form of pre-tax reimbursement for Dependent Care Expenses incurred on behalf of one or more of his or her Dependents. A notational account is established on behalf of each Employee who elects the Dependent Care FSA to which the Participant allocates Salary Reduction contributions for the reimbursement of Dependent Care Expenses. The Dependent FSA is not subject to ERISA. The Dependent Care FSA is intended to qualify as a dependent care assistance provision under Code section 129. This document is

intended to satisfy the written plan document requirement of Code section 129(d)(1). To the extent necessary, other provisions of the Plan are incorporated by reference herein.

(a) Eligibility. All Employees who meet the eligibility requirements of Section 3.1, with the exception of Employees of Circus Circus Reno, may enroll and make elections for the Dependent Care FSA in accordance with the Plan's procedures.

(b) Account Minimum. The minimum annual contribution is $120.

(c) Account Maximum. The maximum annual contribution is $5,000, subject to the limitations set forth below. The Participant may not be reimbursed in excess of the contributions made at any point in time. Once Dependent Care Expenses are incurred, the Participant may file a claim and be reimbursed for up to the maximum amount of the Participant's account balance. If a Participant elects to participate in the Dependent Care FSA, he or she must determine the total amount of his or her annual contribution amount during the Employee's initial or annual enrollment.

If the Participant's Spouse has a Dependent Care Spending Account through his/her Employer, the combined contribution cannot be more than the account maximum. If the Participant and Spouse both work for the same Employer, both may contribute to the account, but may not contribute more than the account maximum.

(d) Maximum Reimbursement Available. The Participant can be reimbursed for up to the least of the following amounts: (a) the year-to-date amount that has been withheld from the Participant's compensation for the Dependent Care FSA less any prior reimbursements for Dependent Care Expenses during the Period of Coverage; (b) $5,000 (or $2,500 for a married Participant filing a separate federal income tax return); or if less (c) the Participant's Earned Income (or if less, the Participant's Spouse Earned Income, if the Participant was married at the end of his or her tax year).

Reimbursements payable under the Plan to each highly compensated employee, as defined in Code section 414(q), are limited to the extent necessary to avoid violating Code section 129(d)(8).

(e) Irrevocability Rule. An election to participate in the accounts is irrevocable for the duration of the Plan Year except as permitted in connection with a Qualifying Life Event or a change in cost or coverage as provided in Section 16.3(i). The Participant cannot reduce his or her election for Dependent Care FSA to a point where the annualized contribution is less than the amount already reimbursed. Any change in an election affecting the Dependent Care FSA pursuant to this Section shall also change the maximum reimbursement benefit for the Period of Coverage remaining in the Plan Year. The maximum reimbursement benefit following an election change is calculated as follows:

	Balance (if any) remaining in the reimbursement account as of the end of the portion of the Plan Year immediately preceding the change in election.
+	Plus total contributions the Participant is scheduled to make for the remainder of the Plan Year as affected by the election change.
	Maximum reimbursement benefit for Period of Coverage remaining in the Plan Year.

(f) Dependent Care FSA Exclusions. The following items are not considered Dependent Care Expenses under the Code and/or for purposes of the Dependent Care FSA:

(i) Payments to the Participant's child who is under age 19 and who is caring for a younger child.

(ii) Tuition expenses for schooling in the first grade or higher.

(iii) Food or clothing expenses.

(iv) Overnight camp expenses.

(v) Expenses in excess of the Participant's taxable income or that of the Participant's Spouse, whichever is less.

(vi) Expenses incurred when the Participant is not working.

(vii) Expenses incurred prior to the coverage date or after the Plan Year ends.

(viii) Expenses claimed as a deduction or credit for federal or state tax purposes.

(ix) Expenses incurred if the Participant's Spouse is not engaged in gainful employment during the hours dependent care is needed, the Spouse is not a full-time student and the Spouse is not physically or mentally disabled or otherwise incapable of caring for Dependent(s).

(x) Any expenses that do not qualify under Code section 21.

(g) Funding. The Participant must complete a Salary Reduction agreement to specify the amount of his or her Dependent Care FSA contributions. Thereafter, the Participant's Dependent Care FSA shall be credited with the portion of compensation that the Participant has elected to forgo through Salary Reduction. These portions shall be credited as of each pay period.

(h) Claims Procedures for Dependent Care FSAs. The following claims procedures apply to the Dependent Care FSA.

(i) Time to Submit Claims. All claims for reimbursement must be submitted on or before March 31 of the year following the end of the Plan Year. Amounts for which claims were not submitted by March 31 shall be forfeited.

(ii) Procedures for Submitting Claims. When the Participant incurs a Dependent Care Expense, the Participant may submit a claim to the Claims Administrator on a claim form. The Participant must attach a receipt from the qualified caregiver indicating the services provided and the tax identification number or social security number of the caregiver.

(iii) Reimbursements After Termination. When a Participant terminates participation in the Dependent Care FSA, the Participant's Salary Reductions shall terminate. On and after the date the Participant terminates participation in the Plan, the Participant (or the Participant's estate) may claim reimbursement for any Dependent Care Expenses incurred during the Period of Coverage prior to his or her termination and may also claim reimbursement for any Dependent Care Expenses incurred after his or her termination and through the last day of the Plan Year of the termination.

(i) Change in Coverage or Cost. A Participant may make a prospective election change with respect to the Dependent Care FSA that is on account of and corresponds with a change by the Participant in the dependant care service provider. For example:

(i) If the Participant terminates one dependent care service provider and hires a new dependent care service provider, the Participant may change coverage to reflect the cost of the new service provider; and

(ii) If the Participant terminates a dependent care service provider because a relative becomes available to take care of the child at no charge, the Participant may cancel coverage.

The "Change in Cost" provision applies to Dependent Care FSA only if the cost change is imposed by a dependent care provider who is not a "relative" of the Employee. For this purpose, a relative is an individual who is related as described in Code section 152.

16.4 Premium Conversion. The premium conversion feature of the Plan allows Participants to elect to pay for his or her share of the premiums for medical, vision, dental, voluntary employee life, voluntary disability and supplemental insurance coverage under the Plan, on a pre-tax salary reduction basis or elect cash, in the manner prescribed by the Plan Administrator. An election to participate in the premium conversion feature of the Plan is irrevocable for the duration of the Plan Year except as permitted in connection with a Qualifying Life Event.

ARTICLE XVII

PLAN ADMINISTRATION

17.1 Plan Administrator. It shall be the principal duty of the Plan Administrator to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of Participants and by operating the Plan uniformly for similarly-situated individuals. The Company shall have the authority to remove itself as Plan Administrator and appoint a new Plan Administrator from time to time by action of the Company's Board of Directors.

17.2 Powers and Authority of Plan Administrator. The Plan Administrator shall have sole discretionary power to administer the Plan in all of its details, subject to applicable requirements of law. For this purpose, the Plan Administrator's powers shall include, but shall not be limited to, the discretion to do the following, in addition to any other powers provided by this Plan:

(a) To make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plan;

(b) the discretionary authority and the exclusive right to interpret the Plan and other documents, to decide questions and disputes, to supply omissions, and to resolve inconsistencies and ambiguities arising under the Plan and other documents, which interpretations and decisions shall be final and binding for the purposes of the Plan and to decide any matters arising in connection with the administration and operation of the Plan;

(c) To appoint such agents, counsel, accountants, consultants and other persons (regardless of whether they also provide services to the Employer) as may be required to assist in administering the Plan;

(d) To allocate and delegate its responsibilities under the Plan and to designate other persons from time to time to carry out any of its responsibilities under the Plan, any such allocation, delegation or designation to be in writing;

(e) To request and obtain information and records from the Participant or any other party as it deems necessary and proper in its sole discretion for any purpose under the Plan, and to require that Participants provide proof of eligibility for coverage or benefits under the Plan as a condition to being eligible for coverage or benefits, with such proof including, among other things, submission to an examination by a physician of the Plan Administrator's choice, evidence of marital status, dependent status, or other status, or other documentation or evidence, as determined in its sole discretion;

(f) To develop enrollment forms and any other forms or processes necessary for Plan administration; and

(g) To make such administrative or technical amendments to the Plan as may be reasonable necessary or appropriate to carry out the intent of the Company, including such

amendments as may be required or appropriate to satisfy the requirements of the Code and ERISA and the rules and regulations from to time in effect under any such laws, or to conform the Plan with other governmental regulations or policies. [5]

The Plan Administrator has sole and complete discretionary authority in the exercise of all of its powers and duties as to invoke the arbitrary and capricious standard of review as opposed to the de novo standard. All actions and determinations of the Plan Administrator shall be final and binding.

17.3 Plan Administrator and Claims Administrator Decisions Final. Except to the extent that a Claims Administrator has discretionary authority as provided below, the Plan Administrator shall have the discretionary authority to determine eligibility for benefits, to interpret the Plan, to make factual determinations under the Plan, and to decide claims under the terms of the Plan. A Claims Administrator shall have the discretionary authority to determine eligibility for benefits, to interpret the terms of any documents describing and/or governing the Benefits for which it has claims administration responsibility and to decide claims. Subject to applicable law, any interpretation of the provisions of the Plan (including any Summary Plan Description) and any decisions on any matter within the discretion of the Plan Administrator or the Claims Administrator, as the case may be, made in good faith shall be binding on all persons. A misstatement or other mistake of fact shall be corrected when it becomes known, and the Plan Administrator shall make such adjustment on account thereof as it considers equitable and practicable. Neither the Plan Administrator nor the Claims Administrator shall be liable in any manner for any determination of fact made in good faith.

17.4 Records and Reports. Subject to the provisions of Article XVII, the Plan Administrator shall direct the Employer to maintain such records of its activities and of Participants and operations as it deems necessary and appropriate, and shall comply with all reporting requirements. Plan records pertaining to the Employer or its Employees (subject to any confidentiality protections required by law or established by the Plan Administrator's rules) shall be available for examination by the Plan Administrator at reasonable times during normal business hours. Plan records pertaining to a Participant shall be available for examination by such Participant upon written request at reasonable times during normal business hours.

The Plan Administrator and its delegates shall make such reports to the Employer as the Employer or the Plan fiduciaries shall reasonably request, and such reports to government authorities as applicable law shall require.

17.5 Reliance on Information. The Plan Administrator, and any person or entity authorized to act on its behalf, shall be entitled to rely on the accuracy and genuineness of any written materials, directions or documents furnished by or on behalf of any Employee or the Employer (unless the Plan Administrator has actual knowledge that such written item is inaccurate or is not genuine) and shall be fully protected in acting or relying in good faith thereon. The Plan Administrator shall have no obligation to take any action upon the occurrence

[5] BHFS Comment: Please confirm it is the Company's intent for the Plan Administrator to make such amendments without the Board's or its designee's involvement.

of any event unless and until it has received proper and satisfactory evidence of such occurrence. The Benefits payable under the Plan to or on behalf of a Participant are conditioned on the Participant's furnishing full, true and complete documents, data or other information reasonably related to the administration of the Plan requested by the Plan Administrator.

17.6 Indemnification of Plan Administrator. The Plan Administrator and any person or entity authorized to act on its behalf, shall be indemnified by the Employer against any and all liabilities, damages, costs and expenses (including reasonable attorney's fees) incurred by it by reason of any act or failure to act of the Plan Administrator made in good faith and consistent with the provisions of the Plan in the administration of the Plan, including costs and expenses incurred in defense or settlement of any claim relating thereto.

ARTICLE XVIII

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

18.1 Use and Disclosure of Protected Health Information (PHI). The following provisions of this Article XVIII apply only with respect to any Health Care Component of the Plan that is a "covered entity" for purposes of HIPAA. The Plan and the Company shall use and disclose PHI to the extent of and in accordance with the uses and disclosures required and permitted by 45 C.F.R. Parts 160 and 164 of HIPAA. This includes the right to use or disclose PHI for payment, treatment and health care operations. The Plan shall disclose PHI to the Company only in accordance with 45 C.F.R. Section 164.504(f) and this Article XVIII.

18.2 Definitions. Whenever used in this Article XVIII, the following terms shall have the respective meanings set forth below.

(a) "Health Care Operations" include, but are not limited to, the following activities:

(i) conducting quality assessment and improvement activities;

(ii) population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;

(iii) rating provider and Plan performance, including accreditation, certification, licensing or credentialing activities;

(iv) underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess loss insurance);

(v) conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

(vi) business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies; and

(vii) business management and general administrative activities of the Plan, including, but not limited to:

(A) management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements;

(B) customer service, including the provision of data analyses for policyholders, plan sponsors or other customers provided that PHI is not disclosed to such policyholder, plan sponsor or customer;

(C) resolution of internal grievances;

(D) the sale, transfer, merger or consolidation of all or part of the Plan with another covered entity (as defined in 45 C.F.R. Section 160.103) or an entity that following such activity shall become a covered entity and due diligence related to such entity;

(E) creating de-identified health information in a limited data set, in accordance with 45 C.F.R. Section 1640.514; and

(viii) fundraising for the benefit Plan.

(b) "Individually Identifiable Health Information" means information that is a subset of health information, including demographic information collected from an individual, and: (i) is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (ii) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of the health care to an individual; and (iii) that identifies the individual; or (4) with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

(c) "Payment" includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of benefits under the Plan. These activities include, but are not limited to, the following:

(i) determination of eligibility or coverage (including coordination of benefits) and cost sharing amounts;

(ii) adjudication or subrogation of health benefit claims (including appeals and other payment disputes);

(iii) risk adjusting amounts due based on enrollee health status and demographic characteristics;

(iv) billing, claims management, collection activities, obtaining payment under a contract for reinsurance (including stop-loss insurance and excess loss insurance) and related health care data processing;

(v) review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care or justification of charges;

(vi) utilization review, including precertification and preauthorization of services, concurrent and retrospective review of services; and

(vii) disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed name and address, date of birth, social security number, payment history, account number and name and address of the provider and/or health plan).

(d) "Plan Administrative Functions" means administrative functions performed by the Company on behalf of the Plan, which are limited to those functions listed under the definition of "Payment" and "Health Care Operations." Plan Administrative Functions do not include functions performed by the Company in connection with any other benefit or benefit plan of the Company.

(e) "PHI" means Individually Identifiable Health Information that is transmitted or maintained electronically, or any other form or medium.

(f) "Privacy Official" shall mean the individual appointed by the Company pursuant to 45 C.F.R. Section 164.530(a)(1)(i) who is responsible for the development and implementation of the Company's privacy policies and procedures.

18.3 Disclosures of PHI to the Company. The Plan hereby incorporates the provisions listed in Section 18.4 below to enable it to disclose PHI to the Company and acknowledges receipt of written certification from the Company that the Plan has been so amended.

18.4 Company Compliance with Privacy Conditions. Pursuant to 45 C.F.R. Section 164.504(f)(2)(ii), the Company agrees to:

(a) not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law;

(b) ensure that any agents, including subcontractors, to whom it provides PHI received by the Plan agree to the same restrictions and conditions that apply to the Company with respect to such PHI;

(c) not use or disclose PHI for employment-related actions and decisions unless authorized by an individual;

(d) not use or disclose PHI in connection with any other benefit or employee benefit plan of the Company unless authorized by an individual;

(e) report to the Plan any use or disclosure of PHI that is inconsistent with the uses or disclosures provided for of which the Company becomes aware;

(f) make PHI available to an individual in accordance with the access requirements, as described in 45 C.F.R. Section 164.524;

(g) make PHI available for amendment and incorporate any amendments to PHI in accordance with 45 C.F.R. Section 164.526;

(h) make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. Section 164.528;

(i) make internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services for the purposes of determining the Plan's compliance with HIPAA; and

(j) if feasible, return or destroy all PHI received from the Plan that the Company still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

18.5 Company Compliance with Security Conditions. Pursuant to 45 C.F.R. Section 164.314(b)(1), the Company agrees to:

(a) implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of the Plan;

(b) ensure that adequate separation required by 45 C.F.R. Section 164.502(f)(2)(iii) is supported by reasonable and appropriate security measures;

(c) ensure that any agent or subcontractor to whom it provides PHI agrees to implement reasonable and appropriate security measures to protect the information; and

(d) report to the Plan any security incident of which it becomes aware.

18.6 Separation Between the Plan and the Company. The Plan shall only disclose PHI to the following employees: the Privacy Official and those individuals who assist in the administration of the Plan at the Employer.

18.7 Limitations on PHI Access and Disclosure. The persons described in this Article may only have access to and use and disclose PHI for Plan Administrative Functions and as required by law. Such access or use shall be permitted only to the extent necessary for these individuals to perform their respective duties for the Plan.

18.8 Noncompliance Issues. If the Company becomes aware of a violation of this Article XVIII, the Company shall inform the Privacy Official, who shall cause the violation to be investigated and shall determine in accordance with the Plan's privacy policies and procedures what sanctions, if any, shall be imposed.

ARTICLE XIX

AMENDMENT AND TERMINATION

19.1 Amendment of the Plan. The Company shall have the sole discretionary right to modify or amend the Plan in any respect, at any time and from time to time, retroactively or otherwise, by a written instrument adopted by its Board of Directors or the Board's designee and duly executed on behalf of the Company.

19.2 Termination of the Plan. The Company shall have the sole discretionary right to terminate the Plan at any time as designated by a written instrument adopted by its Board of Directors or the Board's designee and duly executed on behalf of the Company. With respect to any portion of the Plan that has been terminated, the rights of persons covered by the Plan at that time shall be limited to benefit claims incurred as of the date of Plan termination.

ARTICLE XX

MISCELLANEOUS PROVISIONS

20.1 Limitation of Rights. The establishment, maintenance and provisions of the Plan shall not be considered or construed: (a) as giving to any Employee any right to continue in the employment of the Employer; (b) as limiting the right of the Employer to discipline or discharge any of its Employees; (c) as creating any contract of employment between the Employer and any Employee; or (d) as conferring any legal or equitable right against the Plan Administrator or the Employer. No Employee or other person shall have any guaranteed or vested right to receive Plan benefits.

20.2 Subrogation and Right to Recovery.

(a) Definitions. The following defined terms are used in this subsection:

(i) "Covered Expenses" means any expenses or charges reimbursed or benefits paid under the Plan.

(ii) "Covered Person" means anyone covered under the Plan, including minor Dependents.

(iii) "Recoveries" means all monies paid to the Covered Person—or to any agent, attorney or beneficiary of, or trustee for, such Covered Person—by way of judgment, settlement, or otherwise to compensate for all losses caused by an injury or sickness, whether or not said losses reflect Covered Expenses. "Recoveries" further includes, but is not limited to, recoveries for medical, dental or other expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages and any other recovery of any form of damages or compensation whatsoever. All such payments received from any sources shall be deemed to be first for Covered Expenses regardless of whether the payments are so designated by the parties, and regardless of any limitations on the ability of the Covered Person to collect medical expenses from the Third Party. The Plan shall be reimbursed in full, regardless of whether the Covered Person has been made whole, before any amounts (including attorney fees and court costs) are deducted from such payments.

(iv) "Subrogation" means the Plan's right to pursue and lien upon the Covered Person's claims for medical, dental or other charges against the other person.

(v) "Third Party" means any third party including another person or a business entity.

(b) Intent and Purpose of the Plan. To the extent that conflicting Subrogation or Recovery provisions exist in an insurance contract which is an Incorporated Document, such provisions in the insurance contract shall govern. The intent and purpose of the Plan is to provide payment for those Covered Expenses not paid or payable by any Third Party. For example, a Covered Person may incur Covered Expenses due to an injury or sickness which may be caused by the act or omission of a Third Party or for which a Third Party may be responsible for payment. In such circumstances, any Recoveries or other payments due from or payable by Third Parties on account of Covered Expenses shall be the property of the Plan and, if paid directly to a Covered Person—or to an agent, attorney or beneficiary of, or trustee for, such Covered Person—up to the amount paid by the Plan, shall be held in trust for the benefit of the Plan. Failure to forward such sums received from Third Parties to the Plan shall constitute unjust enrichment of the Covered Person or other party converting such funds to its own benefit, shall create a constructive trust over such funds and shall subject such Covered Person or other constructive trustee, among other available remedies, to an equitable action by the Plan for disgorgement. Accepting benefits under this Plan for Covered Expenses automatically creates the trust for the benefit of the Plan and assigns to the Plan any rights the Covered Person may have to any Recoveries or related payments from any Third Party. To avoid unjust enrichment of any Third Party, the Plan shall be further entitled to pursue any claim that the Covered Person has against any Third Party, whether or not the Covered Person chooses to pursue that claim, and by accepting benefits under this Plan, the

Covered Person automatically assigns to the Plan the Covered Person's claims for Recoveries against such Third Party.

(c) Amount Subject to Plan's Rights to Payment. The Plan has equitable rights to receive amounts paid by Third Parties and to Subrogation and reimbursement. These rights provide the Plan with a 100%, first-dollar priority over any and all Recoveries and funds paid or payable by a Third Party to a Covered Person relative to an injury or sickness, including any amounts relating to any claim for non-medical or dental charges, attorney fees, or other costs and expenses. The Plan shall be reimbursed in full, regardless of whether the Covered Person has been made whole, before any amounts (including attorney fees and court costs) are deducted from such payments. The Plan's rights hereunder are limited to the extent to which the Plan has made, or shall make, payments for Covered Expenses and for its court costs and attorneys' fees if the Plan needs to file suit in order to avoid unjust enrichment of the Covered Person or any Third Party.

In the sole and absolute discretion of the Plan Administrator or its designated representative, payments under the Plan shall be reduced by any Recoveries paid or owed by a Third Party if a Covered Person resolves any claim for a Recovery prior to payment by the Plan. In the event the Plan is not reimbursed in full by the Third Party determined responsible for the Covered Expenses of the Covered Person, the Plan Administrator nonetheless may deduct any outstanding amounts from any and all future Plan benefit payments. The Covered Person shall be responsible for any and all attorneys' fees or other legal costs incurred by the Covered Person in an attempt to hold a Third Party liable for the Covered Expenses.

(d) Conditions Precedent to Coverage. In the event a Covered Person incurs Covered Expenses for which a Third Party is or may be liable, an advance of Plan benefits shall be provided contingent upon each of the following terms and conditions which are deemed agreed to by each Covered Person upon enrollment in the Plan:

(i) To the extent of Covered Expenses that are or may be incurred, the Covered Person transfers his rights to any Recoveries for which a Third Party may be liable to the Plan.

(ii) The Covered Person shall promptly notify the Plan Administrator or its designee of any legal or administrative proceeding or of any negotiations which could result in payments by any Third Party for injuries or sickness which resulted in Covered Expenses as well as any potential legal claims the Covered Person may have against any Third Party resulting from the acts which caused the Covered Expenses to be incurred.

(iii) The Covered Person shall have no legal or equitable right or title to Recoveries from Third Parties as payment for costs and expenses paid or payable by the Plan and shall hold such Recoveries, up to and including the total amount paid or payable by the Plan as Covered Expenses, in trust for the Plan. Any such funds, whether obtained by action at law, settlement or otherwise, up to the amount of Covered Expenses, are the property of the Plan and shall be remitted to the Plan at the earliest opportunity.

(iv) The Covered Person shall permit Subrogation for claims that the Covered Person may have against any Third Party and, in such event, the Covered Person shall cooperate with the Plan Administrator or its designated representative, acting in the Plan Administrator's sole and absolute discretion, to assist in the collection of such claim, whether by action at law or otherwise.

(v) When a right of Recoveries exists, the Covered Person shall execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the Plan's rights as a condition to having the Plan make payments. In addition, the Covered Person shall do nothing to prejudice the right of the Plan.

The Plan shall have no obligation whatsoever to a Covered Person if these terms and conditions are not satisfied. Further, in the event the Covered Person is a minor, the Plan shall have no obligation to pay any Covered Expenses incurred on account of injury or sickness caused by a Third Party until after the Covered Person or his authorized legal representative obtains valid court recognition and approval of the Plan's 100%, first-dollar rights hereunder, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.

(vi) Recovery from another Plan under which the Covered Person is Covered. The Plan's entitlement to funds recovered or recoverable from Third Parties also applies when a Covered Person recovers under any uninsured or underinsured motorist plan (which shall be treated as Third Party coverage when recovery or Subrogation is in order), school insurance plan, homeowner's plan, renter's plan, medical malpractice plan or any liability plan.

(e) Rights of Plan Administrator. The Plan Administrator has a right to request reports on and approve of all settlements.

20.3 COBRA. Notwithstanding any provision of the Plan to the contrary, the Plan shall provide Participants with all health care continuation rights to which they are entitled under COBRA and, to the extent applicable, any other similar state law.

20.4 USERRA. Notwithstanding any provision of the Plan to the contrary, the Plan shall provide Participants with coverage as required by USERRA, and the applicable regulations issued and effective thereunder.

20.5 FMLA. Notwithstanding any provision of the Plan to the contrary, the Plan shall provide Participants with coverage as required by FMLA, and the applicable regulations issued and effective thereunder.

20.6 Other Federal Laws. Notwithstanding any provision of the Plan to the contrary, the Plan shall be administered at all times in accordance with the preexisting condition limitation, creditable coverage, certificate of coverage delivery, special enrollment period, notification and other applicable requirements of HIPAA.

All elections and benefits under this Plan shall be subject to all applicable non-discrimination and other rules under the Code and other applicable law (including, effective January 1, 2010, the Genetic Information Nondiscrimination Act of 2008, and the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, and as applicable, the Affordable Care Act). The Plan shall be administered in compliance with such rules and the Company may take any actions it considers advisable to comply with such rules.

20.7 No Assignment. To the extent permitted by law, no Benefit payment under this Plan shall be subject in any way to alienation, sale, transfer, assignment, pledge, attachment, garnishment, execution, levy, lien or encumbrance of any kind, and any attempt to accomplish the same shall be void. Notwithstanding the foregoing, the Plan Administrator shall have the right, in its sole discretion, to accept a valid assignment for payment of Plan benefits made by a Participant to a hospital, doctor, dentist or other medical services provider.

20.8 Severability. Any provision of the Plan shall be severable, so that if any Plan provision is held to be invalid or unenforceable such invalid or unenforceable provision shall be severed from the Plan and the Plan shall operate without regard to such severed provision. In such event, the Plan shall be construed and enforced as if such severed provision had not been included herein.

20.9 Mistake or Misstatement of Fact. Any mistake of fact or misstatement of fact shall be corrected when it becomes known and proper adjustment made by reason thereof.

20.10 Governing Law. The Plan shall be construed in accordance with the laws of the State of Nevada, to the extent not preempted by federal law.

20.11 Provisions of Plan to Control. Summary Plan Descriptions shall be furnished to eligible Employees setting forth, in summary form, the essential features of the Benefits of the Plan and to whom such Benefits are payable. The Summary Plan Description may incorporate insurance documents which fully describe the various Plan Benefits. In the event of any inconsistency between the Summary Plan Description documents and the specific provisions of this document or other Plan documents (such as amendments or insurance contracts or policies maintained in conjunction with the Plan), this document and such contracts or policies shall govern.

20.12 Titles and Captions. All titles and captions used in this Plan are used as a matter of convenience and for reference only, and in no way shall they be considered in determining the scope or intent of the Plan or in interpreting or construing any Plan provisions.

20.13 Recovery of Benefit Overpayment and Effect of False Certifications. If any Plan Benefit paid to or on behalf of a Participant should not have been paid or should have been paid in a lesser amount, and the Participant or any other appropriate party fails to repay the amount promptly, the overpayment may be recovered by the Plan Administrator from the Participant, such party, or from any monies then payable by the Plan. Any such amounts that are not repaid when due may be deducted, at the direction of the Plan Administrator, from other benefits payable under this Plan with respect to the Participant or Dependent. The Plan

Administrator also reserves the right to recover any such overpayment by appropriate legal action. The Participant shall pay all costs of the Plan, including without limitation, attorneys' fees, should the Plan pursue any means available under the law to recover any amount owed to the Plan by the Participant. If an Employee falsely certifies eligibility for Plan participation or does not inform the Plan Administrator of termination of eligibility, the Employer reserves the right to take disciplinary action, including termination of employment, and the right to seek reimbursement for benefits paid on behalf of the ineligible individual. Coverage under the Medical Benefits shall not be rescinded unless the Participant performs an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the Plan. The Plan shall provide advance notice of any such rescission.

20.14 Funding. The amount and timing of any Required Contributions with respect to each Benefit shall be determined by the Employer from time to time. The Employer reserves the right to change the amount of Required Contributions at any time. Nothing herein requires any Employer to contribute with respect to any Benefit, or to maintain any fund or segregate any amount for the benefit of any Participant or beneficiary, except to the extent specifically required. Benefits under the Plan may be provided in the sole discretion of the Employer through a trust, one or more insurance contracts and/or HMO contracts, or directly from the assets of the Employer. The cost of each Benefit is paid by the Employer and/or Employees as determined by the Employer from time to time in the Employer's discretion.

20.15 Treatment of Certain Policy Payments. Where an insurance policy provides for payment of premiums directly from the Employer, unless the insurance policy states otherwise, payable dividends, retroactive rate adjustments, experience refunds or rebates are not plan assets. These dividends, retroactive rate adjustments, experience refunds or rebates are Employer property, which the Employer may retain to the extent they do not exceed the Employer's aggregate contributions to the Plan cost made from its own funds.

20.16 Benefits. Benefits shall be paid solely in the form, in the amount, and pursuant to the terms of the Plan including the Incorporated Documents.

20.17 Limitations on Liability for Benefits.

(a) Source of Benefits For Fully Insured Benefits. All Benefits that are fully insured shall be paid or provided for under the Plan solely by the insurance company or other entity contractually responsible to pay for or to provide such benefits. The Employer assumes no liability or responsibility with respect to any obligor and does not guarantee that such Benefits shall be payable or paid, or that any Benefit shall be funded. Benefits provided under a fully insured Plan shall be provided only to the extent any Benefit continues to be maintained.

(b) Benefits Limited. Nothing contained in this Plan is intended to obligate the Employer, the Plan, or the named fiduciaries to provide benefits or any other item of value other than as provided in accordance with the terms of the Benefit. Further, notwithstanding any provision in the Plan or of any documents governing the Benefits to the contrary, neither the Employer, the Plan, nor the named fiduciaries guarantee that benefits shall be provided at a level sufficient to satisfy any particular community or other standard of "medical necessity."

(c) Limitation of Rights to Benefits. No Employee, Participant, former Participant or other interested person shall acquire by reason of the Plan any right in or title to any assets, funds or property of the Plan or any Employer. No Employer, employee, officer, director, agent or member of the Employer guarantees in any manner the payment of Plan Benefits.

IN WITNESS WHEREOF, MGM Resorts International has caused this amended and restated Plan to be executed below by its duly authorized representative this _____ day of _____, 2013, to be effective as of the Effective Date set forth herein.

MGM RESORTS INTERNATIONAL

By:_____

Its:_____

ATTEST:

By:_____

Its:_____

APPENDIX A

INCORPORATED DOCUMENTS[6]

APPLICABLE DOCUMENT	APPLICABLE BENEFIT
Contract between the Company and Blue Cross Blue Shield	Medical Benefits
Summary Plan Description for the Direct Care Health Plan	Medical, Prescription Drug, Dental and Vision Benefits
Summary Plan Description for the Preferred Provider Organization	Medical, Prescription Drug, Dental and Vision Benefits
Summary Plan Description for the Health Maintenance Organization	Medical, Prescription Drug, Dental and Vision Benefits
Contract between the Company and Liberty Dental Plan of Nevada, Inc. and Evidence of Coverage	Dental Benefits
Contract between the Company and EyeMed Vision Care and Evidence of Coverage	Vision Benefits
Wellness Plan Policy Issued: May 21, 2012	Wellness Program
Contract between the Company and UMR Care Management	
Contract between the Company and ComPsych®	Employee Assistance Program
Contract between the Company and GuidanceResources	
Contract between the Company and CIGNA	
Contract between the Company and Harmony Healthcare	
Contract between the Company and Health Plan of Nevada, Inc.	
Insurance Policy issued by Sun Life Assurance Company of Canada and Certificates of Coverage for the	Life, Dependent Life, Accidental Death &

[6] CJW@BHFS comment: Please review and edit as needed.

Insurance Policy issued by Sun Life Assurance Company of Canada and Employee Group Benefits Booklets	Dismemberment, Short-Term Disability and Long-Term Disability Benefits
Insurance Policy issued by AFLAC	Supplemental Insurance Benefits

All references to the Contracts and Insurance Policies shall include all applicable amendments and riders.

This Appendix shall be subject to modification without formal amendment to the Plan.

EXHIBIT 2

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User Name: AIMEE LAMBERT
Date and Time: Tuesday, October 22, 2019 3:50:00 PM EDT
Job Number: 100804177

Document (1)

1. *Sprowson v. State, 2019 Nev. Unpub. LEXIS 733*
Client/Matter: Farris
Search Terms: 2019 WL 2766854
Search Type: Natural Language
Narrowed by:

Content Type	Narrowed by
Cases	-None-

Sprowson v. State

Supreme Court of Nevada

July 1, 2019, Filed

No. 73674

Reporter
2019 Nev. Unpub. LEXIS 733 *; 2019 WL 2766854

MELVYN PERRY SPROWSON, JR., Appellant, vs. THE STATE OF NEVADA, Respondent.

Prior History: **[*1]** This is an appeal from a judgment of conviction, pursuant to a jury verdict, of first-degree kidnapping; child abuse, neglect, or endangerment with substantial bodily and/or mental harm; and four counts of unlawful use of a minor in the production of pornography. Eighth Judicial District Court, Clark County; Stefany Miley, Judge. Appellant Melvyn Sprowson, Jr., raises six main contentions on appeal. Since the parties are familiar with the facts, we address only those relevant to our discussion of the issues presented.

Sprowson v. State, 2015 Nev. Unpub. LEXIS 1334 (Nov. 3, 2015)

Core Terms

district court, sexual, jurors, voir dire, argues, child pornography, photographs, portrayal, sex, prosecutorial misconduct, substantial rights, interaction, witnesses, grooming, reversal

Judges: Pickering, J., Parraguirre, J., Cadish, J.

Opinion

ORDER AFFIRMING IN PART, REVERSING IN PART, AND REMANDING

Structural error during voir dire

First, Sprowson contends that the district court committed structural error during voir dire and that given his pro se status he adequately preserved this issue for appeal. We conclude that Sprowson did not preserve the issue because his queries lacked the specificity required, even under a liberal construction. *See United States v. Gray, 581 F.3d 749, 752-53 (8th Cir. 2009)* (recognizing that although a pro se defendant's objections should be given a liberal construction, the defendant's complaint must be sufficiently specific to convey the objection); *Hudson v. Gammon, 46 F.3d 785, 786 (8th Cir. 1995)* (concluding that a pro se litigant's objections **[*2]** preserved error where they "sufficiently directed the district court to the alleged errors"); *Jeremias v. State, 134 Nev. Adv. Rep. 8, 412 P.3d 43, 48 (2018)* (concluding that generally a defendant must object, even to alleged structural error, so that the district court has an opportunity to correct it). Thus, we review for plain error.

To obtain relief under plain-error review, "an appellant must demonstrate that: (1) there was an 'error'; (2) the error is 'plain,' meaning that it is clear under current law from a casual inspection of the record; and (3) the error affected the defendant's substantial rights." *Jeremias, 134 Nev. Adv. Rep. 8, 412 P.3d at 48* (quoting *Green v. State, 119 Nev. 542, 545, 80 P.3d 93, 95 (2003)*). "[A] plain error affects a defendant's substantial rights when it causes actual prejudice or a miscarriage of justice (defined as a 'grossly unfair' outcome)." *Id. at 49* (citing *Valdez v. State, 124 Nev. 1172, 1190, 196 P.3d 465, 477 (2008)*).

The district court erred to the extent it delegated its duty to gather sworn information from potential jury members to its marshal. *See NRS 16.030(5)* (stating that "Nefore persons whose names have been drawn are examined as to their qualifications to serve as jurors, *the judge or the judge's clerk* shall administer an oath or affirmation to them" (emphasis added)); *NRS 16.030(6)* ("*The judge* shall conduct the initial **[*3]** examination of prospective jurors and the parties or their attorneys are entitled to conduct supplemental examinations which must not be unreasonably restricted." (emphasis added)). Nonetheless, the error does not qualify as plain because

it did not prejudice Sprowson or affect his substantial rights. The record demonstrates that Sprowson agreed to the release of all but one of the excused jurors and the one juror he did not consent to release was a noncitizen who was ineligible for jury duty. *See* Jeremias, 134 Nev. Adv. Rep. 8, 412 P.3d at 49-50 (concluding no prejudice resulted from the district court's voir dire errors that occurred in only one small part of the jury-selection process); Collins v. State, 133 Nev. 717, 724, 405 P.3d 657, 664 (2017) (recognizing a distinction between "administrative and preliminary voir dire" and "substantive voir dire"). Accordingly, we discern no plain error on this record entitling Sprowson to relief.

Exclusion of evidence

Second, Sprowson argues that the district court violated his constitutional right to present a defense and cross-examine witnesses by excluding evidence regarding the victim's interaction with other men—specifically, the resulting mental harm from those relationships. We review a district court's decision **[*4]** to exclude evidence for an abuse of discretion. Vega v. State, 126 Nev. 332, 341, 236 P.3d 632, 638 (2010). "An abuse of discretion occurs if the district court's decision is arbitrary or capricious or if it exceeds the bounds of law or reason." Crawford v. State, 121 Nev. 746, 748, 121 P.3d 582, 585 (2005) (internal quotation marks omitted). When the defendant has preserved the error, we will not reverse the judgment of conviction if the error is harmless. Newman v. State, 129 Nev. 222, 236-37, 298 P.3d 1171, 1181-82 (2013). We will deem an error affecting a defendant's constitutional right to present a complete defense harmless only when we can determine, beyond a reasonable doubt, that the error did not contribute to the verdict. Coleman v. State, 130 Nev. 229, 243, 321 P.3d 901, 911 (2014).

Before meeting Sprowson, the victim engaged with another older man she met online. He was ultimately convicted for sexually assaulting the victim. That incident caused the victim to begin therapy. The district court granted in part the State's motion in limine and excluded all evidence of the victim's interaction with the other man, ruling that Sprowson could explore the victim's emotional distress and her previous therapy, but not "the why" behind it.

Sprowson argues that the victim's interaction with the other man was relevant to the kidnapping charge because it showed her history of meeting men online and running away to be with them, **[*5]** which undermined the State's enticement theory. We are not convinced that the victim's past was relevant to whether Sprowson willfully enticed the victim to leave her mother's home and go to his because it says nothing about the defendant's actions and consent is not a defense to first-degree kidnapping of a person under the age of 18. NRS 200.350(2); *see* NRS 48.015 (defining relevant evidence). We also reject Sprowson's argument that the district court erred in precluding him from asking the victim about their online chat involving her virginity and liking sex. The answers to those questions were irrelevant because they did not tend to prove or disprove any fact of consequence. *See* NRS 48.015.

We conclude, however, that the evidence about the victim's relationship with the other man was relevant to the substantial-mentalharm element of the child abuse charge. *See* NRS 200.508 (defining abuse, neglect, or endangerment of a child and the penalties when substantial mental harm is involved). NRS 200.508(4)(e) defines "substantial mental harm" as "an injury to the intellectual or psychological capacity or the emotional condition of a child as evidenced by an observable and substantial impairment of the ability of the child to function within his or **[*6]** her normal range of performance or behavior." This language puts at issue the victim's state of mind when she met Sprowson. Yet, the district court precluded Sprowson from cross-examining the victim's doctor about the victim's past psychological damage after the doctor testified that only 5 to 10 percent of her patients require the type of long-term care that the victim required after her interaction with Sprowson. Further, the district court precluded Sprowson from impeaching the victim and her mother with medical documentation indicating that the victim's relationship with her 19-yearold boyfriend contributed to the victim's mental health issues subsequent to her interaction with Sprowson. *See* Lobato v. State, 120 Nev. 512, 518, 96 P.3d 765, 770 (2004) (noting that a witness's prior inconsistent statements may be used to impeach that witness). Indeed, the State's closing argument characterized the victim as a normal teenager with no issues until Sprowson came along and that he, alone, was responsible for any mental harm she suffered. NRS 200.508(4)(e). To assess the victim's "normal range of performance or behavior," the jury needed to know *why* the victim was in counseling, not just *that* she was in counseling. We cannot conclude, beyond a reasonable doubt, **[*7]** that these errors did not contribute to the verdict on the child abuse count. *See* Coleman, 130 Nev. at 243, 321 P.3d at 911. We therefore reverse the conviction for child abuse and

remand for a new trial on that charge.

Lastly, Sprowson argues that the district court abused its discretion in precluding him from asking the victim about her belief that he gave her a sexually transmitted disease. We conclude that Sprowson should have been permitted to cross-examine the victim about this highly prejudicial testimony that had little probative value to the State's case, especially since the State opened the door to it. *See* NRS 48.035(1); Cordova v. State, 116 Nev. 664, 670, 6 P.3d 481, 485 (2000) (explaining that one party may open the door to the introduction of otherwise inadmissible evidence). However, the error was harmless because the district court gave a limiting instruction and, in the context of the charges, we conclude the error did not contribute to the verdict.

Child pornography counts

Third, Sprowson argues that the child pornography convictions require reversal because (1) he did not "produce a performance," according to NRS 200.710,[1] with a photograph that he claimed was taken before he knew the victim; (2) the photographs did not show "sexual conduct" or involve a "sexual portrayal"; and/or (3) the **[*8]** child pornography statute is unconstitutional. We reject the first argument because Sprowson questioned the victim regarding the alleged preexisting photograph, she denied that it predated their relationship, and the jury was not required to credit Sprowson's conflicting testimony. We also reject the second argument because the photographs show the minor victim staged in sexually suggestive positions, thus depicting her "in a manner which appeals to the prurient interest in sex and which does not have serious literary, artistic, political or scientific value." NRS 200.700(4) (defining "sexual portrayal"); *see also* Shue v. State, 133 Nev. 798, 805, 407 P.3d 332, 338 (2017) (explaining that a "prurient" interest in sex involves "'a shameful or morbid interest in nudity, sex, or excretion,' or involving 'sexual responses over and beyond those that would be characterized as normal'" (quoting Brockett v. Spokane Arcades, Inc., 472 U.S. 491, 498, 105 S. Ct. 2794, 86 L. Ed. 2d 394 (1985)). Sprowson's argument that the photographs did not appeal to a prurient interest in sex because the victim was his girlfriend and was of legal age to consent to sex is without merit. *See* Shue, 133 Nev. at 805, 407 P.3d at 338 (reiterating that what is prurient depends on "the views of an average person applying contemporary community standards"); State v. Hughes, 127 Nev. 626, 630, 261 P.3d 1067, 1070 (2011) (rejecting the argument that a minor under the age of 18 but **[*9]** of legal age to consent cannot be the subject of child pornography). Because the jury could reasonably find that the photographs depicted the minor victim as the subject of a "sexual portrayal," the evidence is sufficient to support the child pornography convictions under NRS 200.710(2). Thus, we need not determine whether the evidence is sufficient to support those convictions on the alternative theory that the photographs showed "sexual conduct" for purposes of NRS 200.710(1).

Nor can we credit Sprowson's argument that Nevada's statutory definition of "sexual portrayal" is unconstitutionally vague or overbroad. *See* Shue, 133 Nev. at 805-07, 407 P.3d at 338-39 (concluding Nevada's statutes barring the sexual portrayal **[*10]** of minors are not overbroad because the type of conduct proscribed under NRS 200.700(4) does not implicate the First Amendment's protection and sufficiently narrows the statute's application to avoid vagueness). Sprowson's argument that *Shue* should be revisited because it did not discuss United States v. Stevens, 559 U.S. 460, 130 S. Ct. 1577, 176 L. Ed. 2d 435 (2010), is unavailing. *Stevens* does not stand for the proposition that only productions connected to independent criminal conduct will be considered child pornography, as Sprowson suggests. 559 U.S. at 470.

Procuring a witness's attendance

Fourth, Sprowson contends that the district court erred in denying him, an indigent defendant, the ability to call the victim as a witness in his case-in-chief unless he could pay for her travel expenses. The record shows that the district court allotted Sprowson defense costs and appointed standby counsel. And although it did not have the duty to do so, the district court advised

[1] NRS 200.710 states:

> 1. A person who knowingly uses, encourages, entices or permits a minor to simulate or engage in or assist others to simulate or engage in sexual conduct to produce a performance is guilty of a category A felony and shall be punished as provided in NRS 200.750.
>
> 2. A person who knowingly uses, encourages, entices, coerces or permits a minor to be the subject of a sexual portrayal in a performance is guilty of a category A felony and shall be punished as provided in NRS 200.750, regardless of whether the minor is aware that the sexual portrayal is part of a performance.

Sprowson of the procedures for procuring witnesses for trial. *See* Harris v. State, 113 Nev. 799, 803, 942 P.2d 151, 154-55 (1997) (noting that there is no duty that a district court inform a pro se defendant of their right to subpoena witnesses). Sprowson, however, did not subpoena the victim. We perceive no district court error in these circumstances.

Prosecutorial misconduct

Fifth, Sprowson argues that **[*11]** the State committed prosecutorial misconduct with statements made during voir dire and by improperly commenting on his constitutional rights. "When considering claims of prosecutorial misconduct, this court engages in a two-step analysis. First, we must determine whether the prosecutor's conduct was improper. Second, if the conduct was improper, we must determine whether the improper conduct warrants reversal." Valdez, 124 Nev. at 1188, 196 P.3d at 476 (footnotes omitted). Because Sprowson failed to object, reversal is warranted only if he demonstrates plain error that affected his substantial rights. Id. at 1190, 196 P.3d at 477.

Sprowson complains that the State's description of the case during voir dire was unduly inflammatory but we disagree. The language Sprowson complains about amounted merely to a factual recitation of the State's case. *See* Gomez v. United States, 490 U.S. 858, 874, 109 S. Ct. 2237, 104 L. Ed. 2d 923 (1989) (highlighting that "voir dire represents jurors' first introduction to the substantive factual and legal issues in a case"). Sprowson next assigns error to the State identifying and keeping jurors who had a strong reaction to its introduction. But the record shows the State did not seek a commitment and the jurors who reacted also expressed their ability to be fair and impartial. *See* Witter v. State, 112 Nev. 908, 914, 921 P.2d 886, 891 (1996) ("The critical concern **[*12]** of jury voir dire is to discover whether a juror 'will consider and decide the facts impartially and conscientiously apply the law as charged by the court.'" (quoting Adams v. Texas, 448 U.S. 38, 45, 100 S. Ct. 2521, 65 L. Ed. 2d 581 (1980))), *abrogated on other grounds by* Nunnery v. State, 127 Nev. 749, 263 P.3d 235 (2011).

As to voir dire, Sprowson contends that "[t]he State indoctrinated the jury about grooming." The record does not support this claim. The State's colloquy with the jury on grooming sought to elicit information from the jurors, not to indoctrinate them. *See* Khoury v. Seastrand, 132 Nev. 520, 528-29, 377 P.3d 81, 87-88 (2016) (concluding that questions aimed at discovering the jurors' feelings on a specific issue are not indoctrination).

Next, Sprowson argues that the State committed prosecutorial misconduct by using a juror's definition of grooming to argue in closing that Sprowson groomed the victim. We agree that the State's reference to this grooming definition was improper because it was not based on evidence adduced at trial. *See* Williams v. State, 103 Nev. 106, 110, 734 P.2d 700, 703 (1987) (reiterating that a prosecutor is not permitted to argue facts or inferences not supported by the evidence). But because Sprowson failed to object, plain-error review applies. The comment was brief and ample other evidence supports Sprowson's kidnapping conviction. *See* Valdez, 124 Nev. at 1190, 196 P.3d at 477. The error thus did not affect Sprowson's substantial **[*13]** rights as to require reversal based on plain-error review.

Lastly, Sprowson argues that the State erred in commenting on his constitutional rights. The record does not support Sprowson's contentions that (1) the State improperly inquired about the victim's fear of being cross-examined, (2) the State commented on Sprowson's right to confrontation when it highlighted the victim's reaction to Sprowson approaching her at trial, and (3) the State improperly urged the jury to hold Sprowson responsible. *See* Domingues v. State, 112 Nev. 683, 698-99, 917 P.2d 1364, 1375 (1996) (concluding there was no prosecutorial misconduct where the State reminded the jury that criminal defendants should be held accountable for their reprehensible acts).

Cumulative error

Finally, Sprowson argues that we should reverse the judgment of conviction based on cumulative error. The evidentiary errors related to the victim's mental health affected only the child abuse conviction, which we reverse. The quantity and character of the remaining errors we have identified above are not significant. Nor do those errors appear to have had a cumulative impact on the jury's verdict that warrants reversal where the issue of guilt was not close on the kidnapping and child pornography counts. ***[*14]*** *See* Valdez, 124 Nev. at 1195, 196 P.3d at 481 (when assessing cumulative error claims, this court considers "(1) whether the issue of guilt is close, (2) the quantity and character of the error, and (3) the gravity of the crime charged" (internal quotation marks omitted)). Accordingly, we

ORDER the judgment of conviction AFFIRMED IN PART AND REVERSED IN PART AND REMAND this matter to the district court for proceedings consistent with this order.

/s/ Pickering, J.

Pickering

/s/ Parraguirre, J.

Parraguirre

/s/ Cadish, J.

Cadish

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User Name: AIMEE LAMBERT
Date and Time: Tuesday, October 22, 2019 3:51:00 PM EDT
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Document (1)

1. *Coast Plaza Doctors Hospital v. Blue Cross of California, 173 Cal. App. 4th 1179*
   Client/Matter: Farris
   Search Terms: 173 Cal. App. 4th 1179
   Search Type: Natural Language
   Narrowed by:

Content Type	Narrowed by
Cases	-None-

Coast Plaza Doctors Hospital v. Blue Cross of California

Court of Appeal of California, Second Appellate District, Division One

May 11, 2009, Filed

B205892

Reporter
173 Cal. App. 4th 1179 *; 93 Cal. Rptr. 3d 479 **; 2009 Cal. App. LEXIS 714 ***; 46 Employee Benefits Cas. (BNA) 2658

COAST PLAZA DOCTORS HOSPITAL, Plaintiff and Appellant, v. BLUE CROSS OF CALIFORNIA et al., Defendants and Respondents.

Prior History: [***1] APPEAL from a judgment of the Superior Court of Los Angeles County, No. BC365740, William F. Fahey, Judge.

Disposition: Reversed.

Core Terms

insured, Patient, preemption, providers, state law, regulate insurance, saving clause, deemer, emergency care, employee benefit plan, superior court, emergency service, group health plan, Proceedings, self-funded, bargains, benefits, demurrer, enrollee, plans, health care service plan, pooling arrangement, district court, authorization, conditions, preempted

Case Summary

Procedural Posture

When defendant insurer did not reimburse plaintiff hospital for the cost of emergency care provided to a patient, the hospital sued the insurer. The Los Angeles County Superior Court, California, sustained the insurer's demurrer on the ground the hospital's state law claims deriving from *Health & Saf. Code, § 1371.4*, were subject to ordinary preemption under the Employee Retirement Income Security Act of 1974 (ERISA). The hospital appealed.

Overview

The instant court concluded that *Health & Saf. Code, § 1371.4*, was not subject to ordinary preemption under ERISA because *§ 1371.4* fell under the purview of ERISA's saving clause, *29 U.S.C. § 1144(b)(2)(A)*. It noted that it was not dealing with a self-funded plan. The insurer's representative averred in a declaration that the insurer and the employer of the patient's spouse were parties to a group healthcare plan, established or maintained by the employer for the purpose of providing medical, surgical, and hospital care benefits to plan participants. ERISA's deemer clause, *29 U.S.C. § 1144(b)(2)(B)*, did not apply because the patient's group health plan purchased insurance from the insurer in order to satisfy its obligations to plan participants, including the patient. Because the deemer clause did not apply, the saving clause saved *§ 1371.4* from preemption. Therefore, the trial court committed reversible error by sustaining the insurer's demurrer to the hospital's complaint.

Outcome

The judgment was reversed, and the case was remanded for further proceedings.

LexisNexis® Headnotes

Business & Corporate Compliance > ... > Regulators > State Insurance Commissioners & Departments > Rules & Regulations

Healthcare Law > ... > Insurance Coverage > Health Insurance > General Overview

HN1 **State Insurance Commissioners & Departments, Rules & Regulations**

In California, health care providers are statutorily required to provide emergency care to a patient without regard to the patient's ability to pay for such care. *Health & Saf. Code, § 1317*. If a patient who receives emergency care is an enrollee of a health care service

plan, *Health & Saf. Code, § 1371.4*, requires the plan to reimburse the provider for the cost of the emergency care, barring certain exceptions.

Civil Procedure > Dismissal > Involuntary Dismissals > Appellate Review

Civil Procedure > ... > Responses > Defenses, Demurrers & Objections > Demurrers

Civil Procedure > ... > Pleadings > Complaints > General Overview

Civil Procedure > Appeals > Standards of Review > General Overview

HN2 **Involuntary Dismissals, Appellate Review**

Where a plaintiff appeals from a judgment of dismissal after the trial court sustained a demurrer, the appellate court accepts as true the allegations of the complaint.

Civil Procedure > Dismissal > Involuntary Dismissals > Appellate Review

Civil Procedure > ... > Responses > Defenses, Demurrers & Objections > Demurrers

Civil Procedure > ... > Pleadings > Complaints > General Overview

Civil Procedure > Appeals > Standards of Review > De Novo Review

HN3 **Involuntary Dismissals, Appellate Review**

An appellate court reviews a trial court's ruling on a demurrer independently. The appellate court's task in reviewing a judgment of dismissal following the sustaining of a demurrer is to determine whether the complaint states a cause of action.

Healthcare Law > ... > Insurance Coverage > Health Insurance > ERISA

Insurance Law > ... > ERISA > Preemption Clause > General Overview

HN4 **Health Insurance, ERISA**

See *29 U.S.C. § 1144(a)*.

Healthcare Law > ... > Insurance Coverage > Health Insurance > ERISA

Insurance Law > ... > ERISA > Savings Clause > General Overview

HN5 **Health Insurance, ERISA**

See *29 U.S.C. § 1144(b)(2)(A)*.

Healthcare Law > ... > Insurance Coverage > Health Insurance > ERISA

Insurance Law > ... > Federal Regulations > ERISA > Deemer Clause

HN6 **Health Insurance, ERISA**

See *29 U.S.C. § 1144(b)(2)(B)*.

Healthcare Law > ... > Insurance Coverage > Health Insurance > ERISA

Insurance Law > ... > Savings Clause > Business of Insurance Test > Effects on Risk Pooling

HN7 **Health Insurance, ERISA**

A two-part test has been established to determine whether a state law regulates insurance within the purview of ERISA's saving clause, *29 U.S.C. § 1144(b)(2)(A)*: First, the state law must be specifically directed toward entities engaged in insurance. Second, the state law must substantially affect the risk pooling arrangement between the insurer and the insured.

Business & Corporate Compliance > ... > Regulators > State Insurance Commissioners & Departments > Rules & Regulations

Healthcare Law > ... > Insurance Coverage > Health Insurance > General Overview

HN8 **State Insurance Commissioners & Departments, Rules & Regulations**

Health & Saf. Code, § 1371.4, regulates insurance because it imposes conditions on the right of insurers to conduct their business in California. The language of the provision is mandatory and insurers who elect not to comply may not engage in the business of insurance within California. Thus, *§ 1371.4* is specifically directed toward the insurance industry.

Business & Corporate
Compliance > ... > Regulators > State Insurance Commissioners & Departments > Rules & Regulations

Healthcare Law > ... > Insurance Coverage > Health Insurance > ERISA

Insurance Law > ... > Savings Clause > Business of Insurance Test > Effects on Risk Pooling

HN9 **State Insurance Commissioners & Departments, Rules & Regulations**

Under the second prong of the Miller test for determining whether a state law regulates insurance within the purview of the Employee Retirement Income Security Act of 1974's saving clause, *29 U.S.C. § 1144(b)(2)(A)*, a statute substantially affects the risk pooling arrangement between the insurer and the insured by expanding the number of providers from whom an insured may receive services and altering the scope of permissible bargains between insurer and insured. A statute need not actually spread risk in order to affect the pooling arrangement between the insurer and insured. So long as the statute dictates to the insurance company the conditions under which it must pay for the risk that it has assumed, the second prong is satisfied.

Business & Corporate
Compliance > ... > Regulators > State Insurance Commissioners & Departments > Rules & Regulations

Healthcare Law > ... > Insurance Coverage > Health Insurance > General Overview

HN10 **State Insurance Commissioners & Departments, Rules & Regulations**

Health & Saf. Code, § 1371.4, requires an insurer to pay for emergency services rendered to the insured until the insured is stabilized. This is tantamount to dictating to the insurer the conditions under which the insurer must pay for the risk it has assumed, namely the risk that the insured may require emergency services.

Business & Corporate
Compliance > ... > Regulators > State Insurance Commissioners & Departments > Rules & Regulations

Healthcare Law > ... > Insurance Coverage > Health Insurance > General Overview

HN11 **State Insurance Commissioners & Departments, Rules & Regulations**

Health & Saf. Code, § 1371.4, alters the scope of permissible bargains between the insurer and insured by telling them what bargains are acceptable and what bargains are unacceptable. *Section 1371.4* tells the insurer and insured that they cannot enter into a bargain whereby the insurer only pays for emergency services rendered by providers inside the insured's network.

Business & Corporate
Compliance > ... > Regulators > State Insurance Commissioners & Departments > Rules & Regulations

Healthcare Law > ... > Insurance Coverage > Health Insurance > ERISA

Insurance Law > ... > ERISA > Savings Clause > General Overview

HN12 **State Insurance Commissioners & Departments, Rules & Regulations**

Health & Saf. Code, § 1371.4, meets Miller's two-part test for regulating insurance and, therefore, falls within the scope of the Employee Retirement Income Security Act of 1974's saving clause, *29 U.S.C. § 1144(b)(2)(A)*.

Healthcare Law > ... > Insurance Coverage > Health Insurance > ERISA

Insurance Law > ... > Federal Regulations > ERISA > Deemer Clause

Insurance Law > ... > ERISA > Preemption Clause > General Overview

HN13 **Health Insurance, ERISA**

Under the Employee Retirement Income Security Act of 1974's deemer clause, *29 U.S.C. § 1144(b)(2)(B)*, a state law that regulates self-funded Employee Retirement Income Security Act of 1974 plans, even if it regulates insurance within the meaning of the saving clause, is not saved from preemption. A self-funded employee benefit plan does not purchase an insurance policy from any insurance company in order to satisfy its obligations to its participants.

Healthcare Law > ... > Insurance Coverage > Health Insurance > ERISA

Insurance Law > ... > ERISA > Savings Clause > General Overview

Insurance Law > ... > ERISA > Preemption Clause > General Overview

HN14 **Health Insurance, ERISA**

Health & Saf. Code, § 1371.4, is not subject to ordinary preemption under the Employee Retirement Income Security Act of 1974 (ERISA) because it falls under the purview of ERISA's saving clause.

Headnotes/Summary

Summary

CALIFORNIA OFFICIAL REPORTS SUMMARY

A hospital provided emergency care to a patient, an enrollee of a group health plan. When the plan's insurer refused to reimburse the hospital for the cost of the emergency care, the hospital sued the insurer, alleging a number of state law claims that derived from *Health & Saf. Code, § 1371.4*. Because the plan qualified as an employee benefit plan subject to the Employee Retirement Income Security Act of 1974 (ERISA; *29 U.S.C. § 1001 et seq.*), the trial court sustained the insurer's demurrer on the ground the insurer's state law claims were subject to ordinary preemption under ERISA. (Superior Court of Los Angeles County, No. BC365740, William F. Fahey, Judge.)

The Court of Appeal reversed the judgment and remanded the matter for further proceedings. The court held that *Health & Saf. Code, § 1371.4*, is not subject to ordinary preemption under ERISA because *§ 1371.4* falls under the purview of ERISA's saving clause (*29 U.S.C. § 1144(b)(2)(A)*). The court noted that it was not dealing with a self-funded plan. The insurer's representative averred in a declaration that the insurer and the employer of the patient's spouse were parties to a group healthcare plan, established or maintained by the employer for the purpose of providing medical, surgical, and hospital care benefits to plan participants. ERISA's deemer clause (*29 U.S.C. § 1144(b)(2)(B)*) did not apply because the patient's group health plan purchased insurance from the insurer in order to satisfy its obligations to plan participants, including the patient. Therefore, the trial court committed reversible error by sustaining the insurer's demurrer to the hospital's complaint. (Opinion by Tucker, J.,* with Mallano, P. J., and Rothschild, J., concurring.) **[*1180]**

Headnotes

CALIFORNIA OFFICIAL REPORTS HEADNOTES

CA(1) **(1)**

Insurance Companies § 2—Regulation—ERISA's Saving Clause.

A two-part test has been established to determine whether a state law regulates insurance within the purview of the Employee Retirement Income Security Act of 1974's saving clause (*29 U.S.C. § 1144(b)(2)(A)*): First, the state law must be specifically directed toward entities engaged in insurance. Second, the state law must substantially affect the risk pooling arrangement between the insurer and the insured.

CA(2) **(2)**

Insurance Companies § 2—Regulation—Conditions on Right to Conduct Business.

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* Judge of the Orange Superior Court, assigned by the Chief Justice pursuant to *article VI, section 6 of the California Constitution*.

Health & Saf. Code, § 1371.4, regulates insurance because it imposes conditions on the right of insurers to conduct their business in California. The language of the provision is mandatory and insurers who elect not to comply may not engage in the business of insurance within California. Thus, *§ 1371.4* is specifically directed toward the insurance industry.

CA(3) **(3)**

Insurance Companies § 2—Regulation—ERISA's Saving Clause—Risk Pooling Arrangement—Permissible Bargains.

Under the second prong of the Miller test for determining whether a state law regulates insurance within the purview of the Employee Retirement Income Security Act of 1974's saving clause (*29 U.S.C. § 1144(b)(2)(A)*), a statute substantially affects the risk pooling arrangement between the insurer and the insured by expanding the number of providers from whom an insured may receive services and altering the scope of permissible bargains between insurer and insured. A statute need not actually spread risk in order to affect the pooling arrangement between the insurer and insured. So long as the statute dictates to the insurance company the conditions under which it must pay for the risk that it has assumed, the second prong is satisfied.

CA(4) **(4)**

Insurance Companies § 2—Regulation——Payment of—Emergency Services.

Health & Saf. Code, § 1371.4, requires the insurer to pay for emergency services rendered to the insured until the insured is stabilized. This is tantamount to dictating to the insurer the conditions under which the insurer must pay for the risk it has assumed, namely the risk that the insured may require emergency services.

CA(5) **(5)**

Insurance Companies § 2—Regulation—Payment of Emergency Services—Permissible Bargains.

Health & Saf. Code, § 1371.4, alters the scope of permissible bargains between an insurer and insured by telling them what bargains are acceptable and what bargains are unacceptable. *Section* ***[*1181]*** *1371.4* tells the insurer and insured that they cannot enter into a bargain whereby the insurer only pays for emergency services rendered by providers inside the insured's network.

CA(6) **(6)**

Insurance Companies § 2—Regulation—ERISA's Saving Clause.

Health & Saf. Code, § 1371.4, meets Miller's two-part test for regulating insurance and, therefore, falls within the scope of the Employee Retirement Income Security Act of 1974's saving clause (*29 U.S.C. § 1144(b)(2)(A)*).

CA(7) **(7)**

Insurance Companies § 2—Regulation—ERISA's Deemer Clause—Preemption.

Under the Employee Retirement Income Security Act of 1974's (ERISA; *29 U.S.C. § 1001 et seq.*) deemer clause (*29 U.S.C. § 1144(b)(2)(B)*), a state law that regulates self-funded ERISA plans, even if it regulates insurance within the meaning of the saving clause, is not saved from preemption. A self-funded employee benefit plan does not purchase an insurance policy from any insurance company in order to satisfy its obligations to its participants.

CA(8) **(8)**

Insurance Companies § 2—Regulation—ERISA's Saving Clause and Deemer Clause—Ordinary Preemption.

Health & Saf. Code, § 1371.4, is not subject to ordinary preemption under the Employee Retirement Income Security Act of 1974 (ERISA; *29 U.S.C. § 1001 et seq.*) because it falls under the purview of ERISA's saving clause (*29 U.S.C. § 1144(b)(2)(A)*). Thus, in a case in which a hospital sued an insurer of a group health plan after the insurer refused to reimburse the hospital for the cost of emergency care provided to an enrollee of the plan, the trial court committed reversible error by sustaining the insurer's demurrer to the hospital's complaint. ERISA's deemer clause (*29 U.S.C. § 1144(b)(2)(B)*) did not apply because the enrollee's group health plan purchased insurance from the insurer in order to satisfy its obligations to plan participants, including the enrollee.

[Cal. Forms of Pleading and Practice (2009) ch. 308, Insurance, § 308.379; 3 Witkin, Summary of Cal. Law (10th ed. 2005) Agency and Employment, § 411.]

[*1182]

Counsel: Hooper, Lundy & Bookman, Daron L. Tooch, Glenn E. Solomon, Suzanne S. Chou and John A. Mills for Plaintiff and Appellant.

Aileen F. Bruno for Defendant and Respondent Blue Cross of California.

Theodora Oringher Miller & Richman, Kenneth E. Johnson; Bird, Marella, Boxer, Wolpert, Nessim, Drooks & Lincenberg and Thomas R. Freeman for Defendants and Respondents Prospect Medical Group, Inc., and Nuestra Familia Medical Group.

Judges: Opinion by Tucker, J., with Mallano, P. J., and Rothschild, J., concurring.

Opinion by: Tucker

Opinion

[481]** **TUCKER, J.** *—*HN1*[↑] In California, health care providers are statutorily required to provide emergency care to a patient without regard to the patient's ability to pay for such care. (Health & Saf. Code, § 1317.) [1] If a patient who receives emergency care is an enrollee of a health care service plan, section 1371.4, a provision of the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene; § 1340 et seq.), requires the plan to reimburse the provider for the cost of the emergency care, barring certain exceptions inapplicable here.

In this case, Coast Plaza Doctors Hospital (Coast Plaza) provided emergency care to "Patient X," an enrollee of a group health plan insured by Blue Cross of California (Blue Cross). When Blue Cross did not reimburse Coast Plaza for the cost of the emergency care, Coast Plaza sued Blue Cross in superior court, alleging a number of state law claims derived from section 1371.4. Because Patient X's group health plan qualified as an employee benefit plan subject to the Employee Retirement Income Security Act of 1974 (ERISA; 29 U.S.C. § 1001 et seq.), the trial court sustained Blue Cross's demurrer **[**482]** on the ground that Coast Plaza's state law claims were subject to ordinary preemption under ERISA.

We conclude that section 1371.4 is a state law that regulates insurance within the purview of ERISA's saving clause. Therefore, we reverse the judgment in favor of Blue Cross and remand for further proceedings. **[*1183]**

FACTS AND PROCEEDINGS BELOW

A. *Alleged Facts*

HN2[↑] Because Coast Plaza appeals from a judgment of dismissal after the court sustained a demurrer, we accept as true the allegations of the complaint. (See Blank v. Kirwan (1985) 39 Cal.3d 311, 318 [216 Cal. Rptr. 718, 703 P.2d 58].)

Blue Cross **[***3]** is an insurance company licensed by the Department of Managed Health Care to operate a health care service plan pursuant to Knox-Keene. Prospect Medical Group (Prospect) provides medical care to patients, including those patients whom Blue Cross insures. Nuestra Familia Medical Group (Nuestra) is an affiliate of Prospect. [2]

Patient X is an insured of Blue Cross. [3] In 2006, Coast Plaza admitted Patient X for a partial removal of the thyroid gland. Because Coast Plaza was an "out-of-network provider" (i.e., it did not contract with Blue Cross to provide services to plan participants or beneficiaries), Patient X made a cash payment to Coast Plaza in advance of the surgery. The surgery proceeded without any complications and Patient X was transferred to Coast Plaza's postoperative care unit. A few days after the surgery, Patient X suddenly developed life-

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* Judge of the Orange Superior Court, assigned by the Chief Justice pursuant to article VI, section 6 of the California Constitution.

[1] Statutory **[***2]** references are to the Health and Safety Code unless otherwise specified.

[2] As defendants explain, Prospect and Nuestra are independent practice associations (IPA's) that contract with Blue Cross to provide professional medical care to specified patients, including Patient X.

[3] As defendants explain, Blue Cross insures Patient X through a group health plan sponsored by the employer of Patient X's spouse, thus making Patient X a beneficiary of the plan. Both parties agree the group health plan in this case is an "employee benefit plan" under ERISA. (29 U.S.C. § 1002(1), (3).)

threatening acute respiratory distress. An emergency room physician intubated Patient X, placed her on a ventilator, and transferred her **[***4]** to Coast Plaza's intensive care unit (ICU) for further treatment.

After Coast Plaza stabilized Patient X, Patient X informed Coast Plaza that she was insured by Blue Cross or Prospect, or both entities. Coast Plaza called Nuestra to have Patient X transferred to an "in-network provider." Nuestra would not authorize the transfer and refused to be involved with any decisions regarding Patient X's medical care. Patient X remained in Coast Plaza's ICU for approximately two months, after which time she was transferred to another medical facility.
[*1184]

On or about September 25, 2006, Coast Plaza electronically billed Blue Cross for $ 582,252.97, the amount of medical charges Coast Plaza claims it incurred providing emergency care to Patient X. [4] The next day, a representative from Nuestra informed Coast Plaza that Nuestra would not pay any portion of the bill. On or about October 2, 2006, Blue **[***5]** Cross followed up with correspondence stating: **[**483]** "In order to process this claim, we require an authorization from the patient's assigned medical group ... unless these services were rendered in connection with a medical emergency. If these services were rendered in connection with a medical emergency, please supply records, as an emergency condition could not be determined from the information that we have." The complaint contains no allegation as to whether Coast Plaza provided Blue Cross with any records. It simply alleges that Blue Cross and Prospect have refused to pay, and continue to refuse to pay, any money in connection with the services Coast Plaza provided to Patient X.

B. Coast Plaza's *Causes of Action*

Coast Plaza sued Blue Cross, Prospect, and Nuestra in Los Angeles Superior Court for (1) **[***6]** recovery of services rendered, (2) recovery on an open book account, (3) quantum meruit, (4) breach of implied-in-fact contract, (5) violation of Business and Professions Code section 17200, and (6) declaratory relief. Coast Plaza cited section 1371.4 in the general allegations portion of its complaint and relied on that provision, either expressly or by reference, as a basis for each cause of action. [5] Coast Plaza sought compensatory damages in the amount of $ 582,252.97, plus statutory interest, restitution in the same amount, attorney fees and costs, and a declaration that Blue Cross or Prospect, or both entities were obliged to pay Coast Plaza "all monies owed for services rendered to Patient X."

C. *Proceedings in Federal Court*

Defendants removed the action to federal district court on the ground that Coast Plaza was **[***7]** seeking benefits under an employee benefit plan governed by ERISA, and thus the action was completely preempted by ERISA section **[*1185]** 502(a). (29 U.S.C. § 1132(a).) [6] Defendants maintained that Patient X had assigned her right to benefits under the group health plan to Coast Plaza. Without confirming or denying the existence of an assignment, Coast Plaza maintained that it was not bringing the action as Patient X's assignee.

The district court concluded that ERISA section 502(a) did not completely preempt Coast Plaza's action because Coast Plaza was neither a participant in nor a beneficiary of Patient X's health plan. Without complete preemption under ERISA section 502(a), the district **[***8]** court concluded removal was improper and remanded the action to superior court. In its remand order, the district court left open the possibility that Blue Cross could raise ordinary preemption under ERISA section 514(a) (29 U.S.C. § 1144(a)) as a defense to the

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[4] Blue Cross contends that Patient's X's condition was not an "emergency medical condition." We must accept as true Coast Plaza's allegation that Patient X's condition was an "emergency medical condition" under the Health and Safety Code. (§ 1317.1, subd. (b).) We express no opinion, however, about whether Coast Plaza will or will not be able to prove the truth of this allegation at trial.

[5] On appeal, Coast Plaza also acknowledges that all of its "state law claims are based on the Knox-Keene Act provision which requires that a 'health care service plan shall reimburse *providers* for emergency services to its enrollees, until the care results in stabilization of the enrollee, except as provided in subdivision (c).' Cal. Health and Safety Code § 1371.4(b)."

[6] ERISA section 502(a) provides in relevant part: "A civil action may be brought ... [¶] ... by a participant or a beneficiary ... [¶] ... [¶] ... to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan ... ." Although codified at 29 U.S.C. § 1132(a), we will refer to this provision as "ERISA section 502(a)," a practice used by a majority of the courts, including the United States Supreme Court, addressing ERISA preemption.

action in superior court. [7]

[484]** D. *Proceedings in Superior Court After Remand*

Defendants demurred to the action in superior court, arguing that Coast Plaza's claims "related **[***9]** to" ERISA, and thus were subject to ordinary preemption under ERISA section 514(a). The trial court sustained the demurrer and granted Coast Plaza leave to amend its complaint. Coast Plaza elected not to amend the complaint and the trial court subsequently entered judgment in favor of defendants. Coast Plaza timely appealed from the final judgment.

DISCUSSION

I. *Standard of Review*

HN3[↑] "We review a trial court's ruling on a demurrer independently. [Citation.]" (*Liska v. The Ams Law Firm (2004) 117 Cal.App.4th 275, 281 [12 Cal. Rptr. 3d 21]*.) Our task in reviewing a judgment of dismissal following the sustaining **[*1186]** of a demurrer is to determine whether the complaint states a cause of action. (*Crowley v. Katleman (1994) 8 Cal.4th 666, 672 [34 Cal. Rptr. 2d 386, 881 P.2d 1083]*.)

II. *Ordinary Preemption* [8]

A. *Statutory Framework*

Three provisions of ERISA expressly address the issue of ordinary preemption:

1. The preemption clause: ***HN4***[↑] "Except as provided in [the saving clause], the provisions of **[***10]** this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan ... ." (ERISA § 514(a), as set forth in *29 U.S.C. § 1144(a)*.)

2. The saving clause: ***HN5***[↑] "Except as provided in [the deemer clause], nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." (ERISA § 514(b)(2)(A), as set forth in *29 U.S.C. § 1144(b)(2)(A)*.)

3. The deemer clause: ***HN6***[↑] "Neither an employee benefit plan ... nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies." (ERISA § 514(b)(2)(B), as set forth in *29 U.S.C. § 1144(b)(2)(B)*.)

For purposes of our analysis, we accept, without deciding, that *section 1371.4* relates to employee benefit plans so as to come under the preemption clause of ERISA section 514(a). (See, e.g., *Hewlett-Packard Co. v. Barnes (9th Cir. 1978) 571 F.2d 502*, **[***11]** which adopted in full the district court's decision in the same case, *Hewlett-Packard Co. v. Barnes (N.D.Cal. 1977) 425 F.Supp. 1294* (*Hewlett-Packard*).) Hence, we must determine the following: (1) **[**485]** whether *section 1371.4* regulates insurance so as to come under the saving clause of ERISA section 514(b)(2)(A), and (2) if *section 1371.4* does regulate insurance, whether it nonetheless is subject to preemption under the deemer clause of ERISA section 514(b)(2)(B).
[*1187]

B. ERISA Section 514(b)(2)(A)—Saving Clause

We turn to whether *section 1371.4* regulates insurance so as to fall under the purview of ERISA's saving clause.

CA(1)[↑] **(1)** In *Kentucky Assn. of Health Plans, Inc. v. Miller (2003) 538 U.S. 329 [155 L. Ed. 2d 468, 123 S. Ct. 1471]* (*Miller*), the Supreme Court established ***HN7***[↑] a two-part test to determine whether a state law

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[7] ERISA section 514(a) provides in relevant part: "Except as provided in subsection (b) of this section, the provisions of this [statute] shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan ..." covered by the statute. (*29 U.S.C. § 1144(a)*.) None of the exceptions in subsection (b) is directly at issue in this case. Although the provision is codified at *29 U.S.C. § 1144(a)*, we will refer to it as "ERISA section 514(a)" for the reasons stated in the preceding footnote. The parties refer to preemption under ERISA section 514(a) as "ordinary preemption," and we will do the same for consistency. We note for clarity, however, that some cases refer to preemption under ERISA section 514(a) as "defensive preemption."

[8] Coast Plaza contends that because it does not have standing either as a "participant" or "beneficiary" under ERISA, ERISA section 502, its claims under *Health and Safety Code section 1371.4* cannot be preempted under section 514(a). Because we decide this case on other grounds, we do not reach this issue.

regulates insurance within the purview of ERISA section 514(b): "First, the state law must be specifically directed toward entities engaged in insurance. [Citations.] Second ... the state law must substantially affect the risk pooling arrangement between the insurer and the insured." (*Miller, supra, 538 U.S. at p. 342*.) [9]

Under the first prong of the *Miller* test, a state law "must be 'specifically directed toward' the insurance industry in order to fall under ERISA's saving clause." (*Miller, supra, 538 U.S. at p. 334*.) In *Miller*, the court considered Kentucky's "Any Willing Provider" statute, which prohibited health insurers from discriminating against providers that were willing to meet the terms and conditions for participation established by the health insurers. (*Id. at p. 332*.) The insurers argued the statute was not "specifically directed" at the insurance industry because it did not regulate the relationship between insurers and insureds. The court rejected this argument, reasoning that the statute regulated insurance because it "impos[ed] conditions on the right to engage in **[***13]** the business of insurance" within Kentucky. (*Id. at p. 338*.)

CA(2)[↑] **(2)** Likewise, ***HN8***[↑] *section 1371.4* regulates insurance because it imposes conditions on the right of insurers, like Blue Cross, to conduct their business in California. The language of the provision is mandatory and insurers that elect not to comply may not engage in the business of insurance within California. (Accord, *Bell v. Blue Cross of California (2005) 131 Cal.App.4th 211, 215 [31 Cal. Rptr. 3d 688]* ["The Knox-Keene Act is a comprehensive system of licensing and regulation under the jurisdiction of the Department of Managed Health Care" and *section 1371.4* "compels [insurers] to reimburse emergency health care providers for emergency services to the plans' enrollees"].) Thus, we conclude *section 1371.4* is specifically directed toward the insurance industry. [10]

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[9] Blue Cross attempts to circumvent the two-part test announced in *Miller* altogether, arguing that **[***12]** under *Aetna Health Inc. v. Davila (2004) 542 U.S. 200, 217–218 [159 L. Ed. 2d 312, 124 S. Ct. 2488]* (*Davila*) "even a state law that can arguably be characterized as 'regulating insurance' will be pre-empted if it provides a separate vehicle to assert a claim for benefits outside of, or in addition to, ERISA's remedial scheme." But *Davila* is inapposite because in that case, the Supreme Court was addressing preemption under ERISA section 502(a), which is not at issue in this case.

[10] Defendants do not contend otherwise in their respondents' brief.

[*1188]

HN9[↑] ***CA(3)***[↑] **(3)** Under the second prong of the *Miller* test, a statute substantially affects the risk pooling arrangement between the insurer and the insured by "expanding the number of providers from whom an insured may receive health services" and "alter[ing] the scope of permissible bargains between insurer[] and insured[]." (*Miller, supra, 538 U.S. at pp. 338–339*.) A statute **[***14]** need not **[**486]** "actually spread risk" in order to affect the pooling arrangement between the insurer and insured. (*Id. at p. 339, fn. 3*.) So long as the statute "dictates to the insurance company the conditions under which it must pay for the risk that it has assumed," the second prong is satisfied. (*Ibid.*)

Defendants argue that "[o]n its face, *Section 1371.4* does not address risk pooling arrangements between insurer and insured." We disagree for a number of reasons.

CA(4)[↑] **(4)** First, ***HN10***[↑] *section 1371.4* requires the insurer to pay for emergency services rendered to the insured until the insured is stabilized. This is tantamount to dictating to the insurer the conditions under which the insurer must pay for the risk it has assumed, namely the risk that the insured may require emergency services. (*Miller, supra, 538 U.S. at p. 339, fn. 3*.)

Second, *section 1371.4* expands the number of providers from whom an insured may receive services. Under the statute, "a health care service plan shall not require a provider to obtain authorization prior to the provision of emergency services and care necessary to stabilize the enrollee's medical condition." (*§ 1371.4, subd. (b)*.) Absent *section 1371.4*, an insured requiring **[***15]** emergency care bears the risk of receiving delayed care, or no care at all, if an emergency care provider must obtain authorization from the insurer before treatment. By prohibiting an insurer from requiring authorization before a provider renders emergency care, *section 1371.4* expands the insured's access to hospitals "by removing [an] obstacle to treatment." (*Louisiana Health Service v. Rapides Healthcare (5th Cir. 2006) 461 F.3d 529, 545* [state law that removes an obstacle to treatment substantially affects risk pooling agreement between insurer and insured].)

CA(5)[↑] **(5)** Third, ***HN11***[↑] *section 1371.4* alters the scope of permissible bargains between the insurer and insured by telling them what bargains are acceptable

and what bargains are unacceptable. (*Miller, supra, 538 U.S. at p. 338*; *Benefit Recovery Inc. v. Donelon (5th Cir. 2008) 521 F.3d 326, 331* [state law that tells parties what bargains are acceptable in an insurance contract substantially affects risk pooling arrangement].) *Section 1371.4* tells the insurer and insured that they **[*1189]** cannot enter into a bargain whereby the insurer only pays for emergency services rendered by providers inside the insured's network.

CA(6)[↑] **(6)** Based on the **[***16]** foregoing, we conclude that ***HN12***[↑] *section 1371.4* meets *Miller*'s two-part test for regulating insurance and, therefore, falls within the scope of ERISA's saving clause.

C. ERISA Section 514(b)(2)(B)—Deemer Clause

We next turn to whether the "deemer clause" applies. If it applies in this case, then *section 1371.4* is preempted. If it does not, then *section 1371.4* is saved from preemption.

HN13[↑] ***CA(7)***[↑] **(7)** Under the "deemer clause," a state law that regulates "self-funded" ERISA plans, even if it regulates insurance within the meaning of the saving clause, is not "saved" from preemption. (*FMC Corp. v. Holliday (1990) 498 U.S. 52, 61 [112 L. Ed. 2d 356, 111 S. Ct. 403]* (*FMC*).) A "self-funded" employee benefit plan "does not purchase an insurance policy from any insurance company in order to satisfy its obligations to its participants." (*Id. at p. 54*.)

Here, we are not dealing with a self-funded plan. A representative of Blue Cross averred in a declaration that "Blue Cross and [employer] are parties to a group healthcare plan, Group Plan No. ... , **[**487]** established or maintained by [employer] for the purpose of providing medical, surgical and hospital care benefits to participants in this Group Plan." Thus, the "deemer clause" does not apply in this case **[***17]** because Patient X's group health plan purchased insurance from Blue Cross, an insurer, in order to satisfy its obligations to its participants, including Patient X. Because the "deemer clause" does not apply, the "saving clause" saves *section 1371.4* from preemption. [11]

CA(8)[↑] **(8)** For the foregoing reasons, we conclude that ***HN14***[↑] *section 1371.4* is not subject to ordinary preemption under ERISA because it falls under the purview of ERISA's saving clause. Thus, the trial court committed reversible error by sustaining Blue Cross's demurrer to Coast Plaza's **[***18]** complaint. **[*1190]**

DISPOSITION

The judgment is reversed and remanded for further proceedings consistent with this decision. [12] Coast Plaza shall recover its costs on appeal.

Mallano, P. J., and Rothschild, J., concurred.

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[11] Because the present case does not involve self-funded plans, we note that it appears to differ in that respect from the plans at issue in *Hewlett-Packard*. (*Hewlett-Packard, supra, 425 F.Supp. at p. 1295*.) To the extent that the *Hewlett-Packard* court concluded that the deemer clause applied without considering whether the plans were self-funded, we note that neither the district court nor the Ninth Circuit had the benefit of the Supreme Court's decision in *FMC* which clearly laid out the distinction between self-funded plans and non-self-funded plans as it related to the deemer clause. We, however, do have the benefit of the Supreme Court's analysis in *FMC* and are bound by it.

[12] We also grant both parties' requests for judicial notice but note that the documents submitted by them have no bearing on our analysis in this case.

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Document (1)

1. *Fmc Corp. v. Holliday, 498 U.S. 52*
Client/Matter: Farris
Search Terms: 498 U.S. 52
Search Type: Natural Language
Narrowed by:

Content Type	Narrowed by
Cases	-None-

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Fmc Corp. v. Holliday

Supreme Court of the United States

October 2, 1990, Argued ; November 27, 1990, Decided

No. 89-1048

Reporter
498 U.S. 52 *; 111 S. Ct. 403 **; 112 L. Ed. 2d 356 ***; 1990 U.S. LEXIS 6114 ****; 59 U.S.L.W. 4009; 12 Employee Benefits Cas. (BNA) 2689; 90 Cal. Daily Op. Service 8609

FMC CORPORATION, PETITIONER v. CYNTHIA ANN HOLLIDAY

Prior History: [**1]** CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT.

Disposition: *885 F. 2d 79*, vacated and remanded.

Core Terms

state law, deemer, plans, insurance company, regulate insurance, pre-emption, employee benefit plan, insurer, regulation, insurance contract, benefits, pre-empted, purporting, saving clause, subrogation, exempt, insurance business, benefit plan, self-insured, banking, investment company, trust company, provisions, insurance regulation, state regulation, reimbursement, purposes, legislative history, insurance law, antisubrogation

Case Summary

Procedural Posture

Petitioner employer sought certiorari to review a decision of the United States Court of Appeals for the Third Circuit, after it granted respondent's motion for summary judgment. The court of appeals held that *75 Pa. Cons. Stat. § 1720*, unless preempted by the Employee Retirement Income Security Act of 1974 (ERISA), *29 U.S.C.S. § 1001 et seq.*, prohibited petitioner's exercise of subrogation rights on respondent's tort recovery.

Overview

Petitioner employer provided an employee welfare benefit plan within the meaning of the Employee Retirement Income Security Act of 1974 (ERISA) for employees and their dependents. Respondent, dependent child of employee, was injured in an automobile accident. Respondent's father brought a negligence action, and petitioner attempted to seek reimbursement for the amounts it paid for respondent's medical expenses. The court vacated and remanded the court of appeals' decision, and held that ERISA preempted the application of Pennsylvania's Motor Vehicle Financial Responsibility Law, *75 Pa. Cons. Stat. § 1720*, to petitioner employer's welfare benefit plan for employees. The court held that ERISA's "deemer clause" was not directed solely at laws governing the business of insurance; it was directed at any law of any state that regulates insurance, while the saving clause protected state insurance regulation of insurance contracts purchased by employee benefit plans. A "deemer clause" that exempted employee benefit plans from only those state regulations would encroach upon ERISA's provisions and undermine Congress's desire to avoid endless litigation over the validity of a state action.

Outcome

The court vacated and remanded the decision of the court of appeals and held that he Employee Retirement Security Act of 1974 preempted the application of Pennsylvania's Motor Vehicle Financial Responsibility Law to petitioner employer's welfare benefit plan for employees.

LexisNexis® Headnotes

Business & Corporate Compliance > ... > Workers' Compensation & SSDI > Third Party Actions > Subrogation

Insurance Law > Claim, Contract & Practice

Issues > Subrogation > General Overview

HN1[] **Workers' Compensation, Subrogation**

See *75 Pa. Cons. Stat. § 1720* (1987).

Insurance Law > ... > Excess Insurance > Obligations > Indemnification Obligations

Insurance Law > Contract Formation > Policy Delivery

HN2[] **Obligations, Indemnification Obligations**

See *75 Pa. Cons. Stat. § 1719* (1987).

Civil Procedure > ... > Subject Matter Jurisdiction > Federal Questions > General Overview

Constitutional Law > Supremacy Clause > General Overview

HN3[] **Subject Matter Jurisdiction, Federal Questions**

In determining whether federal law pre-empts a state statute, the Supreme Court looks to congressional intent.

Pensions & Benefits Law > ERISA > Federal Preemption > General Overview

HN4[] **ERISA, Federal Preemption**

Preemption may be either express or implied, and is compelled whether Congress' command is explicitly stated in the statute's language or implicitly contained in its structure and purpose. A court begins with the language employed by Congress and the assumption that the ordinary meaning of that language accurately expresses the legislative purpose.

Pensions & Benefits Law > ERISA > Federal Preemption > Savings Clause

Pensions & Benefits Law > ERISA > Federal Preemption > General Overview

Pensions & Benefits Law > ERISA > Federal Preemption > State Laws

HN5[] **Federal Preemption, Savings Clause**

Except as provided in subsection (b) of this section, the saving clause, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan. § 514(a) of the Employee Retirement Income Security Act of 1974, *29 U.S.C.S. § 1144 (a)* (preemption clause).

Insurance Law > ... > Federal Regulations > ERISA > Deemer Clause

Pensions & Benefits Law > ERISA > Federal Preemption > Savings Clause

Pensions & Benefits Law > ERISA > Federal Preemption > General Overview

HN6[] **ERISA, Deemer Clause**

Except as provided in subparagraph (B), the deemer clause, nothing in this subchapter shall be construed to exempt or relieve any person from any law of any state which regulates insurance, banking, or securities. § 514(b)(2)(A), as set forth in *29 U.S.C.S. § 1144(b)(2)(A)* (saving clause).

Insurance Law > ... > Federal Regulations > ERISA > Deemer Clause

Pensions & Benefits Law > ERISA > Federal Preemption > Deemer Clause

Pensions & Benefits Law > ERISA > Federal Preemption > General Overview

HN7[] **ERISA, Deemer Clause**

Neither an employee benefit plan nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any state purporting to regulate insurance companies, insurance contracts, banks, trust

companies, or investment companies. § 514(b)(2)(B), *29 U.S.C.S. § 1144(b)(2)(B)* (deemer clause).

Insurance Law > Claim, Contract & Practice Issues > Subrogation > General Overview

HN8 **Claim, Contract & Practice Issues, Subrogation**

A law relates to an employee welfare plan if it has a connection with or reference to such a plan.

Pensions & Benefits Law > ERISA > Federal Preemption > State Laws

Pensions & Benefits Law > ERISA > Federal Preemption > General Overview

HN9 **Federal Preemption, State Laws**

Employee Retirement Security Act of 1974's preemptive scope is as broad as its language under *29 U.S.C.S. § 1144(b)(4)*.

Pensions & Benefits Law > ERISA > Federal Preemption > General Overview

HN10 **ERISA, Federal Preemption**

Where a patchwork scheme of regulation would introduce considerable inefficiencies in benefit program operation, the court applies the preemption clause to ensure that benefit plans will be governed by only a single set of regulations.

Business & Corporate Compliance > ... > Workers' Compensation & SSDI > Third Party Actions > Subrogation

Pensions & Benefits Law > Governmental Employees > State Pensions

Workers' Compensation & SSDI > Administrative Proceedings > Awards > Credits

Insurance Law > Claim, Contract & Practice Issues > Subrogation > General Overview

HN11 **Workers' Compensation, Subrogation**

Application of differing state subrogation laws to plans would frustrate plan administrators' continuing obligation to calculate uniform benefit levels nationwide. The most efficient way to meet these administrative responsibilities is to establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits.

Contracts Law > Contract Conditions & Provisions > General Overview

Insurance Law > ... > Federal Regulations > ERISA > Deemer Clause

Contracts Law > Third Parties > Subrogation

Insurance Law > Claim, Contract & Practice Issues > Subrogation > General Overview

Pensions & Benefits Law > ERISA > Federal Preemption > General Overview

HN12 **Contracts Law, Contract Conditions & Provisions**

75 Pa. Cons. Stat. § 1720 directly controls the terms of insurance contracts by invalidating any subrogation provisions that they contain. It does not merely have an impact on the insurance industry; it is aimed at it.

Antitrust & Trade Law > Exemptions & Immunities > McCarran-Ferguson Act Exemption

Insurance Law > ... > Federal Regulations > ERISA > Deemer Clause

Insurance Law > ... > Alternative Risk Transfers > Self Insurance > General Overview

Insurance Law > Industry Practices > General Overview

HN13 **Exemptions & Immunities, McCarran-Ferguson Act Exemption**

The business of insurance, and every person engaged therein, shall be subject to the laws of the several states which relate to the regulation or taxation of such

business. 15 U.S.C.S. § 1012(a). This includes not only direct regulation of the insurer but also regulation of the substantive terms of insurance contracts.

Insurance Law > ... > Federal Regulations > ERISA > Deemer Clause

Pensions & Benefits Law > ERISA > Federal Preemption > Deemer Clause

Insurance Law > Industry Practices > Federal Regulations > General Overview

Pensions & Benefits Law > ERISA > Federal Preemption

Pensions & Benefits Law > ERISA > Federal Preemption > General Overview

Pensions & Benefits Law > ERISA > Federal Preemption > Savings Clause

HN14[↓] ERISA, Deemer Clause

Congress intended by the Employee Retirement Security Act of 1974 to establish pension plan regulation as exclusively a federal concern.

Lawyers' Edition Display

Decision

Application of state statute, prohibiting exercise of subrogation rights on tort recovery, to employee welfare benefit plan held pre-empted by ERISA (29 USCS 1001 et seq.).

Summary

Section 514(a) of the Employee Retirement Income Security Act of 1974 (ERISA) (29 USCS 1144(a)), states that except as provided by 514(b), ERISA supersedes all state laws insofar as they may relate to any employee benefit plan. Section 514(b) contains a "saving clause" (29 USCS 1144(b)(2)(A)), which reserves to the states the power to enforce state laws regulating insurance, and a "deemer clause" (29 USCS 1144(b)(2)(B)), which provides that an employee benefit plan governed by ERISA shall not be deemed an insurance company, an insurer, or engaged in the business of insurance for the purposes of any state law purporting to regulate insurance companies or insurance contracts. A Pennsylvania statute provides that in actions arising out of the maintenance or use of a motor vehicle, there shall be no right of subrogation or reimbursement from a claimant's tort recovery with respect to benefits payable under any program, group contract, or other arrangement for the payment of benefits. The daughter of an employee covered by an employee welfare benefit plan was injured in an automobile accident, and the plan paid a portion of her medical expenses. The plan was self-funded and did not purchase any insurance policy to satisfy its obligations. The provisions of the plan included a subrogation clause under which a plan member agreed to reimburse the plan for benefits paid if the member recovered on a liability claim against a third party. The employee brought a negligence action in Pennsylvania state court against the driver of the automobile in which his daughter was injured. The claim was settled. While the action was pending, the employer notified the employee that it would seek reimbursement for the amounts the plan had paid for his daughter's medical expenses. The employee and his daughter contended that the Pennsylvania statute precluded such reimbursement. The employee's daughter filed a diversity action in the United States District Court for the Western District of Pennsylvania and obtained a declaratory judgment that the Pennsylvania statute prohibited the employer's exercise of subrogation rights. On appeal, the United States Court of Appeals for the Third Circuit affirmed, holding that (1) the Pennsylvania statute, unless pre-empted, barred the employer from enforcing the plan's subrogation provision; and (2) ERISA did not pre-empt the Pennsylvania statute, inasmuch as ERISA's deemer clause (a) was meant mainly to reach back-door attempts by states to regulate core ERISA concerns in the guise of insurance regulation, and (b) did not exempt the employer's plan from state subrogation laws (885 F2d 79).

On certiorari, the United States Supreme Court reversed and remanded. In an opinion by O'Connor, J., joined by Rehnquist, Ch. J., and White, Marshall, Blackmun, Scalia, and Kennedy, JJ., it was held that ERISA pre-empted the application of the Pennsylvania statute to the employer's plan, because (1) the Pennsylvania statute "relate[s] to" an employee benefit plan within the meaning of 514(a) of ERISA, inasmuch as (a) the Pennsylvania statute has a reference to benefit plans governed by ERISA, and (b) it also has a connection to ERISA benefit plans; (2) although the Pennsylvania statute falls within ERISA's saving clause permitting states to regulate insurance except as provided by the

deemer clause, the deemer clause, by forbidding states to deem an employee benefit plan to be an insurance company, an insurer, or engaged in the business of insurance, exempts self-funded ERISA plans from state laws regulating insurance, although plans that are insured are subject to indirect state insurance regulation insofar as such regulation applies to the plans' insurers; and (3) interpretations of the deemer clause as excepting from the saving clause only state insurance regulations that are pretexts for impinging upon core ERISA concerns, or only state statutes that apply to insurance as a business, are not supported by ERISA's language.

Stevens, J., dissented, expressing the view that (1) while ERISA's saving clause exempts from pre-emption all state laws that have the broad effect of regulating insurance, the deemer clause allows pre-emption of only those state laws that expressly regulate insurance; and (2) the Pennsylvania statute fits into the broader category of laws that fall within the saving clause only.

Souter, J., did not participate.

Headnotes

COURTS §775 > PENSIONS AND RETIREMENT FUNDS §1 > STATES, TERRITORIES, AND POSSESSIONS §46 > STATUTES §91 > state law prohibiting subrogation -- pre-emption by ERISA -- consistency with prior decision -- congressional intent -- > Headnote:
LEdHN[1A][1A] *LEdHN[1B]*[1B] *LEdHN[1C]*[1C] *LEdHN[1D]*[1D] *LEdHN[1E]*[1E] *LEdHN[1F]*[1F] *LEdHN[1G]*[1G]

The application of a state statute--which statute provides that in actions arising out of the maintenance or use of a motor vehicle, there shall be no right of subrogation or reimbursement from a claimant's tort recovery with respect to benefits payable under any program, group contract, or other arrangement for the payment of benefits--to a self-funded employee welfare benefit plan, which provides for reimbursement for benefits paid to a plan member if the member recovers on a claim in a liability action against a third party, is pre-empted by the Employee Retirement Income Security Act of 1974 (ERISA) (*29 USCS 1001 et seq.*), because (1) 514(a) of ERISA (*29 USCS 1144(a)*) states that except as provided by 514(b), ERISA supersedes all state laws insofar as they may relate to any employee benefit plan; (2) the state statute relates to an employee benefit plan, inasmuch as a law relates to an employee benefit plan if it has a connection with or reference to such a plan, and the state statute (a) has a reference to benefit plans covered by ERISA, and (b) also has a connection to ERISA benefit plans, because it (i) prohibits plans from being structured so as to require reimbursement in the event of recovery from a third party, and (ii) requires plan providers in that state to calculate benefit levels based on expected liability conditions that differ from those in states that have not enacted similar legislation; (3) application of different state subrogation laws to plans would frustrate plan administrators' continuing obligation to calculate uniform benefit levels nationwide; (4) although the state statute falls within the saving clause of 514(b)(2)(A) of ERISA (*29 USCS 1144(b)(2)(A)*), permitting states to regulate insurance except as provided by ERISA's deemer clause (*29 USCS 1144(b)(2)(B)*), the deemer clause, by forbidding states to deem an employee benefit plan to be an insurance company, an insurer, or engaged in the business of insurance, exempts self-funded ERISA plans from state laws regulating insurance, although plans that are insured are subject to indirect state insurance regulation insofar as such regulation applies to the plan's insurer; (5) this reading of the deemer clause (a) is consistent with a prior Supreme Court decision under ERISA which distinguished between insured plans and self-funded plans, and left the former, but not the latter, open to indirect state regulation, (b) is respectful of the presumption that Congress does not intend to pre-empt areas of traditional state regulation, and (c) protects employers from conflicting or inconsistent state and local regulation of employee benefit plans; and (6) interpretations of the deemer clause as excepting from the saving clause only state insurance regulations that are pretexts for impinging upon core ERISA concerns, or only state statutes that apply to insurance as a business, are not supported by ERISA's language, would be fraught with administrative difficulties, and would, contrary to congressional intent, lead to the expenditure of plan funds in litigation to define core ERISA concerns and what constitutes business activity. (Stevens, J., dissented from this holding.)

STATES, TERRITORIES, AND POSSESSIONS §22 > STATUTES §164 > pre-emption of state law -- congressional intent -- language used -- > Headnote:
LEdHN[2][2]

In determining whether federal law pre-empts a state statute, the United States Supreme Court looks to congressional intent; the court begins with the language employed by Congress and the assumption that the ordinary meaning of that language accurately expresses the legislative purpose.

STATES, TERRITORIES, AND POSSESSIONS §21 > federal law – express or implied pre-emption -- > Headnote:
LEdHN[3][3]

Federal pre-emption of a state statute may be either express or implied, and is compelled whether Congress' command is explicitly stated in the statute's language or implicitly contained in its structure and purpose.

PENSIONS AND RETIREMENT FUNDS §1 > STATES, TERRITORIES, AND POSSESSIONS §38 > STATUTES §110 > employee benefit plans -- state laws -- pre-emption by ERISA -- other provisions of statute -- > Headnote:
LEdHN[4][4]

The words "relate to" in 514(a) of the Employee Retirement Income Security Act (ERISA) (*29 USCS 1144(a)*)--which states that, except as provided by 514(b) (*29 USCS 1144(b)*), the provisions of ERISA "shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan"--are used in their broad sense, and do not mean to pre-empt only state laws specifically designed to affect employee benefit plans, as that interpretation would have made it unnecessary for Congress to enact 514(b)(4) of ERISA (*29 USCS 1144(b)(4)*), which exempts from pre-emption generally applicable criminal laws of a state.

PENSIONS AND RETIREMENT FUNDS §1 > STATES, TERRITORIES, AND POSSESSIONS §38 > pension plan regulation -- federal pre-emption -- > Headnote:
LEdHN[5][5]

The Employee Retirement Income Security Act (ERISA) (*29 USCS 1001 et seq.*) is intended to establish pension plan regulation as exclusively a federal concern.

Syllabus

After petitioner FMC Corporation's self-funded health care plan (Plan) paid a portion of respondent's medical expenses resulting from an automobile accident, FMC informed respondent that it would seek reimbursement under the Plan's subrogation provision from any recovery she realized in her Pennsylvania negligence action against the driver of the vehicle in which she was injured. Respondent obtained a declaratory judgment in Federal District Court that *§ 1720* of Pennsylvania's Motor Vehicle Financial Responsibility Law -- which precludes reimbursement from a claimant's tort recovery for benefit payments by a program, group contract, or other arrangement -- prohibits FMC's exercise of subrogation rights. The Court of Appeals **[****2]** affirmed, holding that the Employee Retirement Income Security Act of 1974 (ERISA), which applies to employee welfare benefit plans such as FMC's, does not pre-empt *§ 1720*.

Held: ERISA pre-empts the application of *§ 1720* to FMC's Plan. Pp. 56-65.

(a) ERISA's pre-emption clause broadly establishes as an area of exclusive federal concern the subject of every state law that "relate[s] to" a covered employee benefit plan. Although the statute's saving clause returns to the States the power to enforce those state laws that "regulate insurance," the deemer clause provides that a covered plan shall not be "deemed to be an insurance company or other insurer . . . or to be engaged in the business of insurance" for purposes of state laws "purporting to regulate" insurance companies or insurance contracts. Pp. 56-58.

(b) *Section 1720* "relate[s] to" an employee benefit plan within the meaning of ERISA's pre-emption provision, since it has both a "connection with" and a "reference to" such a plan. See *Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 96-97, 77 L. Ed. 2d 490, 103 S. Ct. 2890*. Moreover, although there is no dispute that *§ 1720* "regulates **[****3]** insurance," ERISA's deemer clause demonstrates Congress' clear intent to exclude from the reach of the saving clause self-funded ERISA plans by relieving them from state laws "purporting to regulate insurance." Thus, such plans are exempt from state regulation insofar as it "relates to" them. State laws directed toward such plans are pre-empted because they relate to an employee benefit plan but are not "saved" because they do not regulate insurance. State

laws that directly regulate insurance are "saved" but do not reach self-funded plans because the plans may not be deemed to be insurance companies, other insurers, or engaged in the business of insurance for purposes of such laws. On the other hand, plans that are insured are subject to indirect state insurance regulation insofar as state laws "purporting to regulate insurance" apply to the plans' insurers and the insurers' insurance contracts. This reading of the deemer clause is consistent with *Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 735, n.14, 747, 85 L. Ed. 2d 728, 105 S. Ct. 2380*, and is respectful of the presumption that Congress does not intend to pre-empt areas of traditional state **[****4]** regulation, see *Jones v. Rath Packing Co., 430 U.S. 519, 525, 51 L. Ed. 2d 604, 97 S. Ct. 1305*, including regulation of the "business of insurance," see *Metropolitan Life Ins. Co. v. Massachusetts, supra, at 742-744*. Narrower readings of the deemer clause -- which would interpret the clause to except from the saving clause only state insurance regulations that are pretexts for impinging on core ERISA concerns or to preclude States from deeming plans to be insurers only for purposes of state laws that apply to insurance as a business, such as laws relating to licensing and capitalization requirements -- are unsupported by ERISA's language and would be fraught with administrative difficulties, necessitating definition of core ERISA concerns and of what constitutes business activity, and thereby undermining Congress' expressed desire to avoid endless litigation over the validity of state action and requiring plans to expend funds in such litigation. Pp. 58-65.

Counsel: H. Woodruff Turner argued the cause for petitioner. With him on the briefs was Charles Kelly.

Deputy Solicitor General Shapiro argued the cause for the United States as amicus **[****5]** curiae urging reversal. With him on the brief were Solicitor General Starr, Christopher J. Wright, Allen H. Feldman, Steven J. Mandel, and Mark S. Flynn.

Charles Rothfeld argued the cause for respondent. On the brief were Thomas G. Johnson and David A. Cicola. *

* Briefs of amici curiae urging reversal were filed for the Central States, Southeast and Southwest Area Health and Welfare Fund by Anita M. D'Arcy, James L. Coghlan, and William J. Nellis; for the Chamber of Commerce of the United States of America by Harry A. Rissetto, E. Carl Uehlein, Jr., and Stephen A. Bokat; for the National Coordinating Committee for Multiemployer Plans by Gerald M. Feder, David R. Levin, and Diana L. S. Peters; for the Teamsters Health and Welfare Fund of Philadelphia & Vicinity et al. by James D. Crawford, James J. Leyden, Henry M. Wick, Jr., and Jack G. Mancuso; and for Travelers Insurance Co. by A. Raymond Randolph, M. Duncan Grant, and Waltraut S. Addy.

Briefs of amici curiae urging affirmance were filed for the American Chiropractic Association by George P. McAndrews and Robert C. Ryan; for the American Optometric Association by Ellis Lyons, Bennett Boskey, and Edward A. Groobert; for the National Conference of State Legislatures et al. by Benna Ruth Solomon and Charles Rothfeld; and for the Pennsylvania Trial Lawyers Association by John Patrick Lydon.

Briefs of amici curiae were filed for the American Podiatric Medical Association by Werner Strupp; and for the Self-Insurance Institute of America, Inc., by George J. Pantos.

[**6]**

Judges: O'CONNOR, J., delivered the opinion of the Court, in which REHNQUIST, C. J., and WHITE, MARSHALL, BLACKMUN, SCALIA, and KENNEDY, JJ., joined. STEVENS, J., filed a dissenting opinion, post, p. 65. SOUTER, J., took no part in the consideration or decision of the case.

Opinion by: O'CONNOR

Opinion

[*54] [*362] [**405]** JUSTICE O'CONNOR delivered the opinion of the Court.

LEdHN[1A][↑] [1A]This case calls upon the Court to decide whether the Employee Retirement Income Security Act of 1974 (ERISA), 88 Stat. 829, as amended, *29 U. S. C. § 1001 et seq.*, pre-empts a Pennsylvania law precluding employee welfare benefit plans from exercising subrogation rights on a claimant's tort recovery.

I

Petitioner, FMC Corporation (FMC), operates the FMC Salaried Health Care Plan (Plan), an employee welfare benefit plan within the meaning of ERISA, § 3(1), *29 U. S. C. § 1002(1)*, that provides health benefits to FMC employees and their dependents. The Plan is self-funded; it does not purchase an insurance policy from any insurance company in order to satisfy its obligations **[****7]** to its participants. Among its provisions is a subrogation clause under which a Plan member agrees to reimburse the Plan for benefits

[406]** paid if the member recovers on a claim in a liability action against a third party.

Respondent, Cynthia Ann Holliday, is the daughter of FMC employee and Plan member Gerald Holliday. In 1987, **[*55]** she was seriously injured in an automobile accident. The Plan paid a portion of her medical expenses. Gerald Holliday brought a negligence action on behalf of his daughter in Pennsylvania state court against the driver of the automobile in which she was injured. The parties settled the claim. While the action was pending, FMC notified the Hollidays that it would seek reimbursement for the amounts it had paid for respondent's medical expenses. The Hollidays replied that they would not reimburse the Plan, asserting that *§ 1720* of Pennsylvania's Motor Vehicle Financial Responsibility Law, *75 Pa. Cons. Stat. § 1720* (1987), precludes subrogation by FMC. *Section 1720* states that "in actions arising out of the maintenance or use of a motor vehicle, there shall be no right of subrogation or reimbursement from a claimant's tort recovery with respect **[***8]** to . . . benefits . . . payable under *section 1719*." [1] *Section 1719* refers to benefit payments by "any program, group contract or other arrangement." [2]

[*9] **[*56]** Petitioner, **[***363]** proceeding in diversity, then sought a declaratory judgment in Federal District Court. The court granted respondent's motion for summary judgment, holding that *§ 1720* prohibits FMC's exercise of subrogation rights on Holliday's claim against the driver. The United States Court of Appeals for the Third Circuit affirmed. *885 F.2d 79 (1989)*. The court held that *§ 1720*, unless pre-empted, bars FMC from enforcing its contractual subrogation provision. According to the court, ERISA pre-empts *§ 1720* if ERISA's "deemer clause," § 514(b)(2)(B), *29 U. S. C. § 1144(b)(2)(B)*, exempts the Plan from state subrogation laws. The Court of Appeals, citing *Northern Group Services, Inc. v. Auto Owners Ins. Co., 833 F.2d 85, 91-94 (CA6 1987)*, cert. denied, *486 U.S. 1017, 100 L. Ed. 2d 216, 108 S. Ct. 1754 (1988)*, determined that "the deemer clause [was] meant mainly to reach back-door attempts by states to regulate core ERISA concerns in the guise of insurance regulation." *885 F.2d at 86*. Pointing out that the parties had not suggested that the Pennsylvania antisubrogation **[***10]** law addressed "a core type of ERISA matter which Congress sought to protect by the preemption provision," *id., at 90*, the court concluded that the Pennsylvania law is not pre-empted. The Third Circuit's holding conflicts with decisions of other Courts of Appeals that have construed ERISA's deemer clause to protect self-funded plans from all state insurance regulation. See, *e.g., Baxter v. Lynn, 886 F.2d 182, 186 (CA8 1989)*; *Reilly v. Blue Cross and Blue Shield United of Wisconsin, **[**407]** 846 F.2d 416, 425-426* (CA7), cert. denied, *488 U.S. 856, 102 L. Ed. 2d 117, 109 S. Ct. 145 (1988)*. We granted certiorari to resolve this conflict, *493 U.S. 1068 (1990)*, and now vacate and remand.

II

LEdHN[1B] [1B]***LEdHN[2]*** [2]***LEdHN[3]*** [3]***HN3*** In determining whether federal law pre-empts a state statute, we look to congressional intent. '" **[***11]** ***HN4*** Pre-emption may be either express or implied, and "is compelled whether Congress' **[*57]** command is explicitly stated in the statute's language or implicitly contained in its structure and purpose."'" *Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 95, 77 L. Ed. 2d 490, 103 S. Ct. 2890 (1983)* (quoting *Fidelity Federal Savings & Loan Assn. v. De la Cuesta, 458 U.S. 141, 152-153, 73 L. Ed. 2d 664, 102 S. Ct. 3014 (1982)*, in

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[1] *Section 1720* of Pennsylvania's Motor Vehicle Financial Responsibility Law is entitled "subrogation" and provides:

HN1 "In actions arising out of the maintenance or use of a motor vehicle, there shall be no right of subrogation or reimbursement from a claimant's tort recovery with respect to workers' compensation benefits, benefits available under section 1711 (relating to required benefits), 1712 (relating to availability of benefits) or 1715 (relating to availability of adequate limits) or benefits in lieu thereof paid or payable under *section 1719* (relating to coordination of benefits)."

[2] *Section 1719*, entitled "coordination of benefits," reads:

HN2 "(a) General rule. -- Except for workers' compensation, a policy of insurance issued or delivered pursuant to this subchapter shall be primary. Any program, group contract or other arrangement for payment of benefits such as described in section 1711 (relating to required benefits), 1712(1) and (2) (relating to availability of benefits) or 1715 (relating to availability of adequate limits) shall be construed to contain a provision that all benefits provided therein shall be in excess of and not in duplication of any valid and collectible first party benefits provided in section 1711, 1712 or 1715 or workers' compensation.

"(b) Definition. -- As used in this section the term 'program, group contract or other arrangement' includes, but is not limited to, benefits payable by a hospital plan corporation or a professional health service corporation subject to 40 Pa. C. S. Ch. 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations)."

turn quoting *Jones v. Rath Packing Co., 430 U.S. 519, 525, 51 L. Ed. 2d 604, 97 S. Ct. 1305 (1977)*; see also *Chevron U. S. A. Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837, 842-843, 81 L. Ed. 2d 694, 104 S. Ct. 2778 (1984)* ("If the intent of Congress is clear, that is the end of the matter; for the court . . . must give effect to the unambiguously expressed intent of Congress" (footnote omitted)). We "begin with the language employed by Congress and the assumption that the ordinary meaning of that language accurately expresses the legislative purpose." *Park ' N Fly, Inc. v. Dollar Park and Fly, Inc., 469 U.S. 189, 194, 83 L. Ed. 2d 582, 105 S. Ct. 658 (1985)*. **[****12]** Three provisions of ERISA speak expressly to the question of pre-emption:

> ***HN5***[↑] " **[***364]** Except as provided in subsection (b) of this section [the saving clause], the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." § 514(a), as set forth in *29 U. S. C. § 1144 (a)* (pre-emption clause).
>
> ***HN6***[↑] "Except as provided in subparagraph (B) [the deemer clause], nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." § 514(b)(2)(A), as set forth in *29 U. S. C. § 1144(b)(2)(A)* (saving clause).
>
> ***HN7***[↑] "Neither an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, **[****13]** trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or **[*58]** investment companies." § 514(b)(2)(B), *29 U. S. C. § 1144(b)(2)(B)* (deemer clause).

LEdHN[1C][↑] [1C]We indicated in *Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 85 L. Ed. 2d 728, 105 S. Ct. 2380 (1985)*, that these provisions "are not a model of legislative drafting." *Id., at 739*. Their operation is nevertheless discernible. The pre-emption clause is conspicuous for its breadth. It establishes as an area of exclusive federal concern the subject of every state law that "relate[s] to" an employee benefit plan governed by ERISA. The saving clause returns to the States the power to enforce those state laws that "regulate insurance," except as provided in the deemer clause. Under the deemer clause, an employee benefit plan governed by ERISA shall not be "deemed" an insurance company, an insurer, or engaged **[****14]** in the business of insurance for purposes of state laws "purporting to regulate" insurance companies or insurance contracts.

III

LEdHN[1D][↑] [1D]***LEdHN[4]***[↑] [4]Pennsylvania's antisubrogation law "relate[s] to" an employee benefit plan. We made clear in *Shaw v. Delta Air Lines, supra*, that ***HN8***[↑] a law relates to an employee welfare plan if it has "a connection with or reference to such a plan." *463 U.S. 85, 96-97, 103 S. Ct. 2890, 77 L. Ed. 2d 490* (footnote omitted). **[**408]** We based our reading in part on the plain language of the statute. Congress used the words "'relate to' in § 514(a) [the pre-emption clause] in their broad sense." *Id., at 98*.It did not mean to pre-empt only state laws specifically designed to affect employee benefit plans. That interpretation would have made it unnecessary for Congress to enact ERISA § 514(b)(4), *29 U. S. C. § 1144(b)(4)*, which exempts from pre-emption **[****15]** "generally" applicable criminal laws of a State. We also emphasized that to interpret the pre-emption clause to apply only to state laws dealing with the subject matters covered by ERISA, such as reporting, disclosure, and fiduciary duties, would be incompatible with the provision's legislative history because the House and **[***365]** Senate versions of the bill that became ERISA **[*59]** contained limited pre-emption clauses, applicable only to state laws relating to specific subjects covered by ERISA. [3] These were rejected in favor of the present language in the Act, "indicating that the section's ***HN9***[

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[3] The bill introduced in the Senate and reported out of the Committee on Labor and Public Welfare would have pre-empted "any and all laws of the States and of political subdivisions thereof insofar as they may now or hereafter relate to the subject matters regulated by this Act." S. 4, 93d Cong., 1st Sess., § 609(a) (1973). As introduced in the House, the bill that became ERISA would have superseded "any and all laws of the States and of the political subdivisions thereof insofar as they may now or hereafter relate to the fiduciary, reporting, and disclosure responsibilities of persons acting on behalf of employee benefit plans." H. R. 2, 93d Cong., 1st Sess., § 114 (1973). The bill was approved by the Committee on Education and Labor in a slightly modified form. See H. R. 2, 93d Cong., 1st Sess., § 514(a) (1973).

[↑] pre-emptive scope was as broad as its language." *Shaw v. Delta Air Lines, 463 U.S. at 98*.

[**16]**

LEdHN[1E][↑] [1E]Pennsylvania's antisubrogation law has a "reference" to benefit plans governed by ERISA. The statute states that "in actions arising out of the maintenance or use of a motor vehicle, there shall be no right of subrogation or reimbursement from a claimant's tort recovery with respect to . . . benefits . . . paid or payable under *section 1719*." *75 Pa. Cons. Stat. § 1720* (1987). *Section 1719* refers to "any program, group contract or other arrangement for payment of benefits." These terms "include, *but [are] not limited to*, benefits payable by a hospital plan corporation or a professional health service corporation." *§ 1719* (emphasis added).

The Pennsylvania statute also has a "connection" to ERISA benefit plans. In the past, we have not hesitated to apply ERISA's pre-emption clause to state laws that risk subjecting plan administrators to conflicting state regulations. See, *e. g., Shaw v. Delta Air Lines, supra, at 95-100* (state laws making unlawful plan provisions that discriminate on the basis of pregnancy and requiring plans to provide specific benefits "relate to" benefit **[****17]** plans); *Alessi v. Raybestos-Manhattan, **[*60]** Inc., 451 U.S. 504, 523-526 (1981)* (state law prohibiting plans from reducing benefits by amount of workers' compensation awards "relate[s] to" employee benefit plan). To require plan providers to design their programs in an environment of differing state regulations would complicate the administration of nationwide plans, producing inefficiencies that employers might offset with decreased benefits. See *Fort Halifax Packing Co. v. Coyne, 482 U.S. 1, 10, 96 L. Ed. 2d 1, 107 S. Ct. 2211 (1987)*. Thus, ***HN10***[↑] where a "patchwork scheme of regulation would introduce considerable inefficiencies in benefit program operation," we have applied the pre-emption clause to ensure that benefit plans will be governed by only a single set of regulations. *Id., at 11*.

Pennsylvania's antisubrogation law prohibits plans from being structured in a manner requiring reimbursement in the event of recovery from a third party. It requires plan providers to calculate benefit levels in Pennsylvania based on **[****18]** expected liability conditions that differ from those in States that have not enacted similar antisubrogation legislation. **[**409]** ***HN11***[↑] Application of differing state **[***366]** subrogation laws to plans would therefore frustrate plan administrators' continuing obligation to calculate uniform benefit levels nationwide. Accord, *Alessi v. Raybestos-Manhattan, Inc., supra* (state statute prohibiting offsetting worker compensation payments against pension benefits pre-empted since statute would force employer either to structure all benefit payments in accordance with state statute or adopt different payment formulae for employers inside and outside State). As we stated in *Fort Halifax Packing Co. v. Coyne, supra, at 9*, "the most efficient way to meet these [administrative] responsibilities is to establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits."

There is no dispute that the Pennsylvania law falls within ERISA's insurance saving clause, which provides, **[****19]** "*except as provided in [the deemer clause]*, nothing in this subchapter **[*61]** shall be construed to exempt or relieve any person from any law of any State which regulates insurance," § 514(b)(2)(A), *29 U. S. C. § 1144(b)(2)(A)* (emphasis added). *Section 1720* ***HN12***[↑] directly controls the terms of insurance contracts by invalidating any subrogation provisions that they contain. See *Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. at 740-741*. It does not merely have an impact on the insurance industry; it is aimed at it. See *Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 50, 95 L. Ed. 2d 39, 107 S. Ct. 1549 (1987)*. This returns the matter of subrogation to state law. Unless the statute is excluded from the reach of the saving clause by virtue of the deemer clause, therefore, it is not pre-empted.

We read the deemer clause to exempt self-funded ERISA plans from state laws that "regulate insurance" within the meaning of the saving clause. By forbidding States to deem employee benefit plans "to be an insurance company **[****20]** or other insurer . . . or to be engaged in the business of insurance," the deemer clause relieves plans from state laws "purporting to regulate insurance." As a result, self-funded ERISA plans are exempt from state regulation insofar as that regulation "relate[s] to" the plans. State laws directed toward the plans are pre-empted because they relate to an employee benefit plan but are not "saved" because they do not regulate insurance. State laws that directly regulate insurance are "saved" but do not reach self-funded employee benefit plans because the plans may not be deemed to be insurance companies, other insurers, or engaged in the business of insurance for purposes of such state laws. On the other hand, employee benefit plans that are insured are subject to indirect state insurance regulation. An insurance company that insures a plan remains an insurer for

purposes of state laws "purporting to regulate insurance" after application of the deemer clause. The insurance company is therefore not relieved from state insurance regulation. The ERISA plan is consequently bound by state insurance regulations insofar as they apply to the plan's insurer.

[*62] Our reading of the **[****21]** deemer clause is consistent with *Metropolitan Life Ins. Co. v. Massachusetts, supra.* That case involved a Massachusetts **[***367]** statute requiring certain self-funded benefit plans and insurers issuing group health policies to plans to provide minimum mental health benefits. *471 U.S. 724, 734, 105 S. Ct. 2380, 85 L. Ed. 2d 728*. In pointing out that Massachusetts had never tried to enforce the portion of the statute pertaining directly to benefit plans, we stated, "in light of ERISA's 'deemer clause,' which states that a benefit plan shall not 'be deemed an insurance company' for purposes of the insurance saving clause, Massachusetts has never tried to enforce [the statute] as applied to benefit plans directly, effectively conceding that such an application of [the statute] would be pre-empted by ERISA's pre-emption clause." *Id., at 735, n.14* (citations omitted). We concluded that the statute, as applied to insurers of **[**410]** plans, was not pre-empted because it regulated insurance and was therefore saved. Our decision, we acknowledged, "results in a distinction between insured and uninsured plans, leaving the former **[****22]** open to indirect regulation while the latter are not." *Id., at 747*. "By so doing, we merely give life to a distinction created by Congress in the 'deemer clause,' a distinction Congress is aware of and one it has chosen not to alter." *Ibid.* (footnote omitted).

Our construction of the deemer clause is also respectful of the presumption that Congress does not intend to pre-empt areas of traditional state regulation. See *Jones v. Rath Packing Co., 430 U.S. at 525*. In the McCarran-Ferguson Act, 59 Stat. 33, as amended, *15 U. S. C. § 1011 et seq.*, Congress provided that ***HN13***[↑] the "business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business." *15 U. S. C. § 1012(a)*. We have identified laws governing the "business of insurance" in the Act to include not only direct regulation of the insurer but also regulation of the substantive terms of **[**411]** insurance contracts. *Metropolitan Life Ins. Co. v. Massachusetts, supra, at 742-744*. **[****23]** **[*63]** By recognizing a distinction between insurers of plans and the contracts of those insurers, which are subject to direct state regulation, and self-insured employee benefit plans governed by ERISA, which are not, we observe Congress' presumed desire to reserve to the States the regulation of the "business of insurance."

Respondent resists our reading of the deemer clause and would attach to it narrower significance. According to the deemer clause, "neither an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State *purporting* to regulate insurance companies [or] insurance contracts." § 514(b)(2)(B), *29 U. S. C. § 1144(b)(2)(B)* (emphasis added). Like the Court of Appeals, respondent would interpret the deemer clause to except from the saving clause only state insurance regulations that are pretexts for impinging upon core ERISA concerns. The National Conference of State Legislatures et al. as *amici curiae* in support of respondent **[****24]** offer an alternative interpretation of the deemer **[***368]** clause. In their view, the deemer clause precludes States from deeming plans to be insurers only for purposes of state laws that apply to insurance as a business, such as laws relating to licensing and capitalization requirements.

These views are unsupported by ERISA's language. Laws that *purportedly* regulate insurance companies or insurance contracts are laws having the " appearance of" regulating or "intending" to regulate insurance companies or contracts. Black's Law Dictionary 1236 (6th ed. 1990). Congress' use of the word does not indicate that it directed the deemer clause solely at deceit that it feared state legislatures would practice. Indeed, the Conference Report, in describing the deemer clause, omits the word "purporting," stating, "an employee benefit plan is not to be considered as an insurance company, bank, trust company, or investment **[*64]** company (and is not to be considered as engaged in the business of insurance or banking) for purposes of any State law that regulates insurance companies, insurance contracts, banks, trust companies, or investment companies." H. R. Conf. Rep. No. 93-1280, p. **[****25]** 383 (1974).

Nor, in our view, is the deemer clause directed solely at laws governing the business of insurance. It is plainly directed at "any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies." § 514(b)(2)(B), *29 U. S. C. § 1144(b)(2)(B)*. Moreover, it is difficult to understand why Congress would have included *insurance contracts* in the pre-emption clause if it

meant only to pre-empt state laws relating to the operation of insurance as a business. To be sure, the saving and deemer clauses employ differing language to achieve their ends -- the former saving, except as provided in the deemer clause, "any law of any State which regulates insurance" and the latter referring to "any law of any State purporting to regulate insurance companies [or] insurance contracts." We view the language of the deemer clause, however, to be either coextensive with or broader, not narrower, than that of the saving clause. Our rejection of a restricted reading of the deemer clause does not lead to the deemer clause's engulfing the saving clause. As we have pointed out, *supra, at 62-63*, the **[****26]** saving clause retains the independent effect of protecting state insurance regulation of insurance contracts purchased by employee benefit plans.

LEdHN[1F][1F] ***LEdHN[5]***[5] ***HN14***[1F][5] Congress intended by ERISA to "establish pension plan regulation as exclusively a federal concern." *Alessi v. Raybestos-Manhattan, Inc., 451 U.S. 504 at 523, 68 L. Ed. 2d 402, 101 S. Ct. 1895* (footnote omitted). Our interpretation of the deemer clause makes clear that if a plan is insured, a State may regulate it indirectly through regulation of its insurer and its insurer's insurance contracts; if the plan is uninsured, the State may not regulate it. As a result, employers will not face "'conflicting or inconsistent State and local regulation of employee benefit plans.'" **[*65]** *Shaw v. Delta Air Lines, Inc., 463 U.S. at 99* (quoting remarks of Sen. Williams). A construction of the deemer clause that exempts employee benefit plans from only those **[****27]** state regulations that encroach upon **[***369]** core ERISA concerns or that apply to insurance as a business would be fraught with administrative difficulties, necessitating definition of core ERISA concerns and of what constitutes business activity. It would therefore undermine Congress' desire to avoid "endless litigation over the validity of State action," see 120 Cong. Rec. 29942 (1974) (remarks of Sen. Javits), and instead lead to employee benefit plans' expenditure of funds in such litigation.

LEdHN[1G][1G] In view of Congress' clear intent to exempt from direct state insurance regulation ERISA employee benefit plans, we hold that ERISA pre-empts the application of *§ 1720* of Pennsylvania's Motor Vehicle Financial Responsibility Law to the FMC Salaried Health Care Plan. We therefore vacate the judgment of the United States Court of Appeals for the Third Circuit and remand the case for further proceedings consistent with this opinion.

It is so ordered.

JUSTICE SOUTER took no part in the consideration or decision of this case.

Dissent by: STEVENS

Dissent

JUSTICE STEVENS, dissenting.

The Court's construction **[****28]** of the statute draws a broad and illogical distinction between benefit plans that are funded by the employer (self-insured plans) and those that are insured by regulated insurance companies (insured plans). Had Congress intended this result, it could have stated simply that "all State laws are pre-empted insofar as they relate to any self-insured employee plan." There would then have been no need for the "saving clause" to exempt state insurance laws from the pre-emption clause, or the "deemer clause," which the Court today reads as merely reinjecting **[*66]** into the scope of ERISA's pre-emption clause those same exempted state laws insofar as they relate to self-insured plans.

From the standpoint of the beneficiaries of ERISA plans -- who after all are the primary beneficiaries of the entire statutory program -- there is no apparent reason for treating self-insured plans differently from insured plans. Why should a self-insured plan have a right to enforce a subrogation clause against an injured employee while an insured plan may not? The notion that this disparate treatment of similarly situated beneficiaries is somehow supported by an interest in uniformity is singularly unpersuasive. **[****29]** If Congress **[**412]** had intended such an irrational result, surely it would have expressed it in straightforward English. At least one would expect that the reasons for drawing such an apparently irrational distinction would be discernible in the legislative history or in the literature discussing the legislation.

The Court's anomalous result would be avoided by a correct and narrower reading of either the basic pre-emption clause or the deemer clause.

I

The Court has endorsed an unnecessarily broad reading of the words "relate to any employee benefit

plan" as they are used in the basic pre-emption clause of § 514(a). I acknowledge that this reading is supported by language in some of our **[***370]** prior opinions. It is not, however, dictated by any prior holding, and I am persuaded that Congress did not intend this clause to cut nearly so broad a swath in the field of state laws as the Court's expansive construction will create.

The clause surely does not pre-empt a host of general rules of tort, contract, and procedural law that relate to benefit plans as well as to other persons and entities. It does not, for example, pre-empt general state garnishment rules insofar **[****30]** as they relate to ERISA plans. *Mackey v. Lanier Collection Agency & Service, Inc., 486 U.S. 825, 100 L. Ed. 2d 836, 108 S. Ct. 2182 (1988)*. Moreover, the legislative history of the provision indicates that **[*67]** throughout most of its consideration of pre-emption, Congress was primarily concerned about areas of possible overlap between federal and state requirements. Thus, the bill that was introduced in the Senate would have pre-empted state laws insofar as they "relate to the subject matters regulated by this Act," [1] **[****31]** and the House bill more specifically identified state laws relating "to the fiduciary, reporting, and disclosure responsibilities of persons acting on behalf of employee benefit plans." [2] Although the compromise that produced the statutory language "relate to any employee benefit plan" is not discussed in the legislative history, the final version is perhaps best explained as an editorial amalgam of the two bills rather than as a major expansion of the section's coverage.

When there is ambiguity in a statutory provision preempting state law, we should apply a strong presumption against the invalidation of well-settled, generally applicable state rules. In my opinion this presumption played an important role in our decisions in *Fort Halifax Packing Co. v. Coyne, 482 U.S. 1, 96 L. Ed. 2d 1, 107 S. Ct. 2211 (1987)*, and *Mackey v. Lanier Collection Agency & Service, Inc., supra.* Application of that presumption leads me to the conclusion that the pre-emption clause should apply only to those state laws that purport to regulate subjects regulated by ERISA or that are inconsistent with ERISA's central purposes. I do not think Congress intended to foreclose Pennsylvania from enforcing the antisubrogation provisions of its state Motor Vehicle Financial Responsibility Law against ERISA plans -- most certainly, it did not intend to pre-empt enforcement of that statute against self-insured plans while preserving enforcement against insured plans.

[*68] II

[**32]** Even if the "relate to" language in the basic pre-emption clause is read broadly, a proper interpretation of the carefully drafted text of the deemer clause would caution against finding pre-emption in this case. Before identifying the key words in that text, it **[**413]** is useful to comment on the history surrounding enactment of the deemer clause.

The number of self-insured employee **[***371]** benefit plans grew dramatically in the 1960's and early 1970's. [3] The question whether such plans were, or should be, subject to state regulation remained unresolved when ERISA was enacted. It was, however, well recognized as early as 1967 that requiring self-insured plans to comply with the regulatory requirements in state insurance codes would stifle their growth:

> "Application of state insurance laws to uninsured plans would make direct payment of benefits pointless and in most cases not feasible. This is because a welfare plan would have to be operated as an insurance company in order to comply with the detailed regulatory requirements of state insurance codes designed with the typical operations of insurance companies in mind. It presumably would be necessary to form a captive **[****33]** insurance company with prescribed capital and surplus, capable of obtaining a certificate of authority from the insurance department of all states in which the plan was 'doing business,' establish premium rates subject to approval by the insurance department, issue policies in the form approved by the insurance department, pay commissions and premium taxes required by the insurance law, hold and deposit reserves established by the insurance department, make investments permitted under the law, and comply with all filing and examination requirements of the insurance department. The result would be to reintroduce **[*69]** an insurance company, which

[1] S. 4, 93d Cong., 1st Sess., § 609(a) (1973), reprinted at 1 Legislative History of the Employee Retirement Income Security Act of 1974 (Committee Print compiled by the Subcommittee on Labor of the Senate Committee on Labor and Public Welfare) 93, 186 (1976) (Leg. Hist.).

[2] H. R. 2, 93d Cong., 1st Sess., § 114 (1973); 1 Leg. Hist. 51.

[3] See Comment, State Regulation of Noninsured Employee Welfare Benefit Plans, 62 Geo. L. J. 339, 340 (1973).

the direct payment plan was designed to dispense with. Thus it can be seen that the real issue is not whether uninsured plans are to be *regulated* under state insurance laws, but whether they are to be *permitted*." Goetz, Regulation of Uninsured Employee Welfare Plans Under State Insurance Laws, 1967 Wis. L. Rev. 319, 320-321 (emphasis in original).

[**34]** In 1974 while ERISA was being considered in Congress, the first state court to consider the applicability of state insurance laws to self-insured plans held that a self-insured plan could not pay out benefits until it had satisfied the licensing requirements governing insurance companies in Missouri and thereby had subjected itself to the regulations contained in the Missouri insurance code. *Missouri* v. *Monsanto Co.*, Cause No. 259774 (St. Louis Cty. Cir. Ct., Jan. 4, 1973), rev'd, *517 S.W.2d 129 (Mo. 1974)*. Although it is true that the legislative history of ERISA or the deemer clause makes no reference to the Missouri case, or to this problem -- indeed, it contains no explanation whatsoever of the reason for enacting the deemer clause -- the text of the clause itself plainly reveals that it was designed to protect pension plans from being subjected to the detailed regulatory provisions that typically apply to all state-regulated insurance companies -- laws that purport to regulate insurance companies and insurance contracts.

The key words in the text of the deemer clause are "deemed," "insurance **[***372]** company," and "purporting." [4] It provides **[*70]** **[****35]** that an employee welfare plan shall not be *deemed* to be an *insurance company* or to be engaged in the business of insurance for the purpose of determining whether it is an entity that is regulated by any state law *purporting* to regulate *insurance companies* and insurance contracts.

[414]** Pennsylvania's insurance code purports, in so many words, to regulate insurance companies and insurance contracts. It governs the certification of insurance companies, *Pa. Stat. **[****36]** Ann., Tit. 40, § 400* (Purdon 1971), their minimum capital stock and financial requirements to do business, § 386 (Purdon 1971 and Supp. 1990-1991), their rates, *e.g.*, § 532.9 (Purdon 1971) (authorizing Insurance Commissioner to regulate minimum premiums charged by life insurance companies), and the terms that insurance policies must, or may, include, *e. g.*, § 510 (Purdon 1971 and Supp. 1990-1991) (life insurance policies), § 753 (Purdon 1971) (health and accident insurance policies). The deemer clause prevents a State from enforcing such laws purporting to regulate insurance companies and insurance contracts against ERISA plans merely by deeming ERISA plans to be insurance companies. But the fact that an ERISA plan is not deemed to be an insurance company for the purpose of deciding whether it must comply with a statute that purports to regulate "insurance contracts" or entities that are defined as "insurance companies" simply does not speak to the question whether it must nevertheless comply with a statute that expressly regulates subject matters other than insurance.

There are many state laws that apply to insurance companies as well as to other entities. Such laws **[****37]** may regulate some aspects of the insurance business, but do not require one to be an insurance company in order to be subject to their terms. Pennsylvania's Motor Vehicle Financial Responsibility Law is such a law. The fact that petitioner's plan is not deemed to be an insurance company or an insurance contract does not have any bearing on the question whether petitioner, **[*71]** like all other persons, must nevertheless comply with the Motor Vehicle Financial Responsibility Law.

If one accepts the Court's broad reading of the "relate to" language in the basic pre-emption clause, the answer to the question whether petitioner must comply with state laws regulating entities including, but not limited to, insurance companies depends on the scope of the saving clause. [5] In this case, I am prepared to accept the Court's broad reading of that clause, but it is of critical **[***373]** importance to me that the category

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[4] Section 514(b)(2)(B), as set forth in *29 U. S. C. § 1144(b)(2)(B)*, provides:

"Neither an employee benefit plan . . . nor any trust established under such a plan, shall be *deemed* to be an *insurance company* or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State *purporting* to *regulate insurance companies*, insurance contracts, banks, trust companies, or investment companies." (Emphasis added.)

[5] Section 514(b)(2)(A), as set forth in *29 U. S. C. § 1144(b)(2)(A)*, provides:

"Except as provided in subparagraph (B) nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities."

of state laws described in the saving clause is broader than the category described in the deemer clause. A state law "which regulates insurance," and is therefore exempted from ERISA's pre-emption provision by operation of the saving clause, does not necessarily have **[****38]** as its purported subject of regulation an "insurance company" or an activity that is engaged in by persons who are insurance companies. Rather, such a law may aim to regulate another matter altogether, but also have the effect of regulating insurance. The deemer clause, by contrast, reinjects into the scope of ERISA pre-emption only those state laws that "purport to" regulate insurance companies or contracts -- laws such as those which set forth the licensing and capitalization requirements for insurance companies or the minimum required provisions in insurance contracts. While the saving clause thus exempts from the pre-emption clause all state laws that have the broad effect of regulating insurance, the deemer clause simply allows pre-emption of those state laws that expressly regulate insurance and that would therefore be applicable to ERISA plans only if States were allowed to deem such plans to be insurance companies.

[**39]** **[*72]** Pennsylvania's Motor Vehicle Financial Responsibility Law fits into the broader category of state laws that fall within the saving clause only. The Act regulates persons in addition to insurance companies and affects subrogation and indemnity agreements that are not necessarily insurance contracts. Yet **[**415]** because it most assuredly is not a law "purporting" to regulate any of the entities described in the deemer clause -- "insurance companies, insurance contracts, banks, trust companies, or investment companies," the deemer clause does not by its plain language apply to this state law. Thus, although the Pennsylvania law is exempted from ERISA's pre-emption provision by the broad saving clause because it "regulates insurance," it is not brought back within the scope of ERISA pre-emption by operation of the narrower deemer clause. I therefore would conclude that petitioner is subject to Pennsylvania's Motor Vehicle Financial Responsibility Law.

I respectfully dissent.

References

60A Am Jur 2d, Pensions and Retirement Funds 115, 118, 124, 130

Federal Procedure, L Ed, Declaratory Judgments 23:41

29 USCS 1144 **[****40]** *(a), 1144(b)(2)(A), 1144(b)(2)(B)*

RIA Employment Coordinator B-10,715--B-10,718

RIA Pension Coordinator 80,120-80,123

US L Ed Digest, Pensions and Retirement Funds 1; States, Territories, and Possessions 38, 46

Index to Annotations, Employee Retirement Income Security Act; Insurance and Insurance Companies; Pre-emption; States

Annotation References:

Construction and application of pre-emption exemption, under Employee Retirement Income Security Act (*29 USCS 1001 et seq.*), for state laws regulating insurance, banking ,or securities (*29 USCS 1144(b)(2)*). *87 ALR Fed 797*.

Pre-emption of state fair employment laws under provisions of 514 of Employee Retirement Income Security Act (*29 USCS 1144*). *72 ALR Fed 489*.

Federal question jurisdiction in declaratory judgment suit challenging state statute or regulation on grounds of federal pre-emption. *69 ALR Fed 753*.

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DISTRICT COURT

CLARK COUNTY, NEVADA

TITINA FARRIS and PATRICK FARRIS, Plaintiffs, vs. BARRY RIVES, M.D.; LAPAROSCOPIC SURGERY OF NEVADA, LLC, et al., Defendants.	CASE NO. A-16-739464-C DEPT. NO. 31 **DEFENDANTS BARRY RIVES, M.D. AND LAPAROSCOPIC SURGERY OF NEVADA, LLC'S OPPOSITION TO PLAINTIFFS' RENEWED MOTION TO STRIKE**

I. INTRODUCTION

On Saturday October 19, 2019, at 9:58 p.m., Plaintiffs filed a renewed motion to strike defendants' answer. The motion contends, among other things, Dr. Barry Rives committed perjury, and defense counsel improperly attempted to impeach Dr. Michael Hurwitz with his prior deposition testimony. Dr. Rives did not commit perjury. Further, the

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attempt to impeach Dr. Hurwitz is not grounds to strike Defendants' Answer.[1]

DECLARATION BY THOMAS J. DOYLE

I, Thomas J. Doyle, declare as follows:

1. I am an attorney at law licensed to practice in the State of Nevada. I am a partner of the law firm of Schuering Zimmerman & Doyle, LLP, attorneys of record for Defendants BARRY J. RIVES, M.D.; LAPAROSCOPIC SURGERY OF NEVADA, LLC.

2. Amy Hanegan is a jury selection and witness preparation consultant retained by Defendants. My plan was for Ms. Hanegan to meet with Dr. Barry Rives to assist in preparing him to testify.

3. Ms. Hanegan did not meet with Dr. Rives to assist in preparing him to testify, because she and Dr. Rives could not find a convenient time to do so.

4. A declaration by Amy Hanegan, confirming she did not prepare Dr. Rives to testify, is attached hereto as Exhibit A.

5. I have no independent recollection of the discussion at side bar described in the Declaration of Kimball Jones. I cannot agree or disagree with Mr. Jones' characterization of my statements. If I stated that Ms. Hanegan helped prepare Dr. Rives to testify, that statement was a mistake.

6. A true and correct copy of the deposition of Dr. Michael Hurwitz, taken September 18, 2019, is attached hereto as Exhibit B.

7. A true and correct copy of the Recorder's Transcript of Pending Motions, pertaining to the hearing on October 7, 2019, is attached hereto as Exhibit C.

8. The transcript of the deposition of Dr. Hurwitz was delivered to my office in Sacramento, California, on the same day as the calendar call.

9. On the first day of trial, I offered the transcript of the deposition of Dr.

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[1] Plaintiffs' motion is based, at least in part, on NRCP 37. NRCP 37 addresses the failure to make disclosures or to cooperate in discovery. It does not address trial testimony, or trial procedure.

Hurwitz, and the Court did not permit it to be lodged, because it was not produced at calendar call.

10. I understood the Court's Order, pertaining to the transcript of the deposition of Dr. Hurwitz, as prohibiting Defendants from showing the deposition transcript to Dr. Hurwitz for the purpose of refreshing his recollection, or impeachment. I did not understand the Court's Order as prohibiting use of the transcript to ask Dr. Hurwitz questions, whether taken from the transcript verbatim or paraphrased.

I declare under penalty of perjury under the laws of the State of Nevada that the foregoing is true and correct, and if called to testify, I could competently do so.

Executed this 21st day of October, 2019, at Las Vegas, Nevada.

/s/ Thomas J. Doyle
THOMAS J. DOYLE

II. DR. RIVES DID NOT MEET WITH AMY HANEGAN TO PREPARE FOR HIS TESTIMONY.

Plaintiffs contend Dr. Rives committed perjury when he testified that Amy Hanegan did not help prepare him to testify in this case. Dr. Rives did not commit perjury. Amy Hanegan is a jury selection and witness preparation consultant retained by Defendants. (Declaration of Thomas J. Doyle ¶ 2.) The plan was for Ms. Hanegan to meet with Dr. Rives to assist in preparing him to testify. (*Id.*) Ms. Hanegan did not meet with Dr. Rives to assist in preparing him to testify, because she and Dr. Rives could not find a convenient time to do so. (*Id.* at ¶ 3.) The Declaration of Amy Hanegen confirms she did not prepare Dr. Rives for his testimony. (Declaration of Amy Hanegan ¶ 2.)

Dr. Rives did not commit perjury. To the contrary, Dr. Rives testified truthfully and accurately. His testimony does not warrant the imposition of sanctions. Additionally, Mr. Doyle does not recall representing to the Court that Ms. Hanegan had prepared Dr. Rives to testify. But if Mr. Doyle did say this, he was mistaken, because although the witness

preparation had been planned, it had not actually occurred (for the reason explained in Mr. Doyle's declaration).

III. DR. RIVES' TESTIMONY REGARDING INTERROGATORIES WAS NOT PERJURY.

Plaintiffs contend Dr. Rives' trial testimony appeared to lack candor, when he addressed the issue of verifying discovery responses. (Motion 4:4-15.) Specifically, plaintiffs contend "Dr. Rives initially vacillated and acted as though he did not understand whether or not Interrogatories are made under oath and under penalty of perjury." (*Id.*) Later in the motion, Plaintiffs describe Dr. Rives' testimony as perjury. (Motion 10:2-4.)

Plaintiffs cite Dr. Rives' testimony from the hearing on October 7, 2019, to support the contention Dr. Rives' trial testimony lacked candor or constituted perjury. During the hearing, Dr. Rives was asked whether he understood the verifications he signed were signed under penalty of perjury. Dr. Rives confirmed he did. (Exhibit C, 53: 8-57:22). During trial, Dr. Rives was asked a different question, "whether [he] understood that Interrogatories are made under oath and penalty of perjury." (Motion 4:7-8.) Plaintiffs contend that in response to that question at trial, "Dr. Rives initially vacillated and acted as though he did not understand whether or not Interrogatories are made under oath and under penalty of perjury."

It is reasonable for Dr. Rives, who is not an attorney, not to know whether responses to interrogatories are made "under oath and penalty of perjury," as opposed to "under penalty of perjury." Dr. Rives' "vacillation" in response to the question is understandable, considering the difference in the question posed during the October 7, 2019 hearing, versus the question posed at trial. The fact that Dr. Rives did not know whether interrogatory responses are made under oath and under penalty of perjury, does not demonstrate he committed perjury.

Whether Dr. Rives was candid in his testimony is an issue of his credibility. "Matters of fact, including the credibility of witnesses, are for jury resolution." *Anderson v. State*,

86 Nev. 829, 837, 477 P.2d 595, 600 (1970), citing *Graves v. State*, 82 Nev. 140-41. 137, 413 P.2d 503 (1966). Plaintiffs might argue to the jury that Dr. Rives' testimony appeared to lack candor. However, it is not grounds to strike Defendants' Answer.

IV. THE ATTEMPT TO IMPEACH DR. HURWITZ IS NOT GROUNDS TO STRIKE DEFENDANTS' ANSWER.

The Court ruled the deposition transcript of Dr. Hurwitz could not be opened and published to the jury. Defendants understood that they would be precluded from showing to the transcript to the jury, or the witness. Defendants did not understand the Court's order to preclude any reference to Dr. Hurwitz' prior sworn deposition testimony.

By analogy, in *Rish v. Simao*, 368 P.3d 1203, 1211 (Nev. 2016), the Nevada Supreme Court addressed when a violation of an order in limine justifies striking an answer. In applying the analysis of *BMW v. Roth*, 127 Nev. 122, 126, 252 P.3d 649, 652 (2011), the Court held that for violation of an order in limine to constitute attorney misconduct requiring case-ending sanctions, the order must be specific, the violation must be clear, and unfair prejudice must be shown.

In this case, defense counsel was prohibited from opening and publishing the transcript of the deposition, but only because the transcript had not produced at calendar call. Defense counsel understood the Court's verbal order to prohibit opening and publishing the transcript of Dr. Hurwitz' deposition to the jury or to Dr. Hurwitz, for the purpose of refreshing his recollection or impeachment, but not to prohibit any mention of the expert's deposition itself or his testimony. The oral order did not specifically or clearly prohibit anything other than opening and publishing the transcript, and the order did not specifically or clearly prohibit reference to deposition testimony. After the objection was raised, it became clear that the Court intended to prohibit the transcript to be used for any purpose. There was no prejudice to Plaintiffs; their timely objection was sustained.

V. THE REMAINING ISSUES RAISED ON PLAINTIFFS' MOTION WERE PREVIOUSLY ADDRESSED IN THE INITIAL MOTION FOR SANCTIONS.

Plaintiffs' renewed motion for sanctions addresses the conduct underlying the former Motion for Sanctions, filed September 18, 2019, primarily dealing with earlier discovery responses. Following the hearing, which included the testimony of Dr. Rives on October 7, 2019, the Court imposed a substantial and significant sanction, in the form of a permissible adverse inference instruction be given to the jury, similar to the instruction discussed in *Bass-Davis* 122 Nev. 442, 446, 1364 P.3d 103, 105 (2006). That sanction adequately addressed the discovery violations, and those discovery violations should not be grounds for further sanctions.

VI. CONCLUSION

There are no grounds to strike defendants' answer. Dr. Rives did not commit perjury. He did not meet with Ms. Hanegan to prepare to testify. What plaintiffs allege is an inconsistency between Dr. Rives' testimony at the October 7, 2019 hearing, and during trial, is a credibility issue for the jury to decide. Finally, defense counsel's reference to the deposition of Dr. Hurwitz does not justify the imposition of case terminating sanctions.

Dated: October 21, 2019

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EXHIBIT A

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DISTRICT COURT

CLARK COUNTY, NEVADA

TITINA FARRIS and PATRICK FARRIS, Plaintiffs, vs. BARRY RIVES, M.D.; LAPAROSCOPIC SURGERY OF NEVADA, LLC, et al., Defendants.	CASE NO. A-16-739464-C DEPT. NO. 31 **DECLARATION OF AMY B. HANEGAN**

I, AMY B. HANEGAN, declare as follows:

1. I was retained by counsel for Defendants BARRY RIVES, M.D. and LAPAROSCOPIC SURGERY OF NEVADA, LLC, to assist in jury selection for the *Farris v. Rives, et al.* case.

2. I did not prepare Dr. Rives for his testimony.

3. If called to testify to the matters asserted herein, I could do so competently.

I declare under penalty of perjury under the laws of the State of Nevada that the foregoing is true and correct, and if called to testify, I could competently do so.

Executed this 18th day of October, 2019 at Lake Forest Park, Washington.

AMY B. HAEGAN

State Washington
County King
Signed before me by Amy Beth Haegan on this 19th day of October 2019

EVERETTS BLANDINO
COMMISSION EXPIRES
NOTARY
PUBLIC
01-15-2020
STATE OF WASHINGTON

Everetts Blandino