IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE

KELLY B. KIVILAAN,	)	
Individually and on behalf of all	)	
others similarly situated,	)	
	)	
Plaintiff,	)	
	)	**Case No. 3:04-0814**
v.	)	
	)	**Judge Nixon**
AMERICAN AIRLINES, INC.,	)	**Magistrate Judge Bryant**
	)	
Defendant.	)	

PLAINTIFF'S MEMORANDUM OF LAW IN SUPPORT OF MOTION FOR CLASS CERTIFICATION

Under Federal Rule of Civil Procedure 23 and Local Civil Rule 23.01, Plaintiff Kelly B. Kivilaan (hereinafter "Kivilaan" or "Plaintiff") respectfully asks this Court to certify this case against American Airlines, Inc. (hereinafter "American Airlines" or "Defendant") for class treatment. This case involves an undisputed nation-wide policy that applies across the board to all putative class members: American Airlines singles out women for disadvantageous treatment by excluding prescription contraceptives[1] and related services from its employee benefit plans. [2] Thus, the same legal and factual issues are raised with respect to all these employees, making the

[1] Oral contraceptives (also called "birth control pills") are the most commonly known prescription contraceptive; prescription contraceptives also include Norplant, injectables, intra-uterine devices (hereinafter "IUD"), the diaphragm and the cervical cap. American Airlines excludes these drugs and medical devices from insurance coverage when they are prescribed for purposes of contraception. *See* American Airlines Employee Benefits Guide (excerpts) at AA/KIVILAAN 00046 (attached as Ex. A).

[2] The central issue here is a pure question of law, which Plaintiffs anticipate the Court will decide on summary judgment.

class action approach the most efficient and effective way to resolve them.

Kivilaan, an employee of American Airlines, alleges that American Airlines's policy denying its employees health insurance coverage for prescription contraceptives discriminates against women in violation of Title VII of the Civil Rights Act of 1964 (hereinafter "Title VII"), 42 U.S.C. § 2000e *et seq.*, as amended by the Pregnancy Discrimination Act (hereinafter "PDA"), 42 U.S.C. § 2000e(k). Plaintiff alleges that American Airlines's policy constitutes unlawful sex discrimination on its face because contraception is clearly "pregnancy-related" and, under the PDA, discrimination "on the basis of pregnancy, childbirth or related medical conditions" constitutes unlawful sex discrimination on its face.[3] Plaintiff further alleges that American Airlines's exclusion of prescription contraceptives has a disproportionate adverse impact on women and therefore constitutes unlawful "disparate impact" sex discrimination under Title VII.

This matter presents a classic case of system-wide sex discrimination, based on a written policy that applies uniformly to all class members. Kivilaan asserts a claim on behalf of herself and all others similarly situated and asks the Court to certify the following class: "All female employees nationwide who were covered, or have been covered, by Defendant's health insurance plans at any time between February 18, 2003 and the date of trial in this Action who used or sought coverage for prescription contraceptives not covered by the plans."[4] In addition, the principal

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[3] The exclusion of prescription contraceptives and related services from an employee health plan violates Title VII and specifically as amended by the PDA. *See Erickson v. Bartell Drug Co.*, 141 F. Supp. 2d 1266, 1277 (W.D. Wash. 2001); Equal Employment Opportunity Commission Decision (E.E.O.C. 2000) (attached as Exhibit B). Indeed, this exclusion creates "a gaping hole in the coverage offered to female employees, leaving a fundamental and immediate healthcare need uncovered." *Erickson*, 141 F. Supp. 2d at 1277.

[4] Plaintiff has requested that Defendant identify and produce all employee health

relief Kivilaan seeks - injunctive and equitable relief ending the practice of excluding prescription contraceptives from American Airlines health benefits plans - will benefit all class members alike. In these circumstances, the requirements of Rule 23 are easily satisfied, as shown below. Accordingly, the proposed class should be certified.

I. STATEMENT OF FACTS

Plaintiff Kivilaan has been a full-time employee of American Airlines, eligible for employee health insurance, since June 3, 1987. Complaint ¶ 14. As a term and condition of employment, Kivilaan was offered enrollment in an American Airlines health plan (hereinafter, referred to as "the Plan") and enrolled. Under the Plan, her benefits included coverage of prescription drugs and devices. *Id.*

The Plan is a written policy that is applied equally and uniformly to all eligible American Airlines employees. American Airlines's benefits include coverage of many "preventative" drugs and devices, such as mammograms, drugs to prevent allergic reactions and drugs to prevent blood clotting. *Id*. ¶ 15. The Plan, however, specifically excludes from coverage contraceptive drugs and devices and related services. *Id*. *See also* Employee Benefits Guide, Ex. A, at AA/Kivilaan 00046. Kivilaan believes American Airlines has a nationwide uniform policy to exclude prescription contraceptives and related services from coverage under the Plan. Complaint ¶ 19.

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care benefit programs for all of its employees. Defendant, however, has objected to the scope of these discovery requests and produced only those plans offered to or selected by Kivilaan – namely, variations of the Employee Benefits Guide for American Airlines Flight Attendants.

In order to avoid an unplanned pregnancy, Kivilaan has used oral contraceptives, a reversible method of contraception. *Id.* ¶ 17. As a result of American Airlines's exclusion of prescription contraceptives from its employee health plan, Kivilaan has paid $37.59 a month out-of-pocket for her oral contraceptives. *Id*. ¶ 18.

III. ARGUMENT

A motion for class certification is not an occasion for examination of the merits of the case. *Reeb v. Ohio Dep't of Rehab. & Corr*., 81 F. App'x 550, 555 (6th Cir. 2003); *Caridad v. Metro-N. Commuter R.R.*, 191 F.3d 283, 291 (2d Cir. 1999); *see also Moore v. Hughes Helicopters, Inc.*, 708 F.2d 475, 480 (9th Cir. 1983). There is "nothing in either the language or history of Rule 23 that gives a court any authority to conduct a preliminary inquiry into the merits of a suit in order to determine whether it may be maintained as a class action." *Eisen v. Carlisle & Jacquelin*, 417 U.S. 156, 177 (1974). Instead, the Court must determine if the plaintiffs and the proposed class can meet each of the requirements of Rule 23. No weighing of competing evidence is appropriate at this stage of the litigation, *Caridad*, 191 F.3d at 293; rather, a court should accept the complaint's allegations as true for the purpose of deciding a class certification motion. *Reeb*, 81 F. App'x, at 555.

Here, Plaintiff states claims under both the disparate treatment and disparate impact analyses of Title VII and the PDA. As discussed below, this class meets all the requirements of Rule 23(a): numerosity, commonality, typicality and adequacy of representation. In addition, since Plaintiff seeks injunctive and other equitable relief, certification of this class is appropriate under Rule 23(b)(2).

A. Civil Rights Litigation Is Well-Suited to Class Action Treatment

Civil rights actions and, in particular, actions brought under Title VII, represent the paradigm for appropriate use of the class action device:

> Employment discrimination is particularly amenable to class treatment . . . . Institutional discrimination, often difficult to detect and enforce, avoids prompt remedial action through the often onerous litigation process available to the individual plaintiff. The widespread utilization of class actions and judicial recognition that invidious discrimination is by its very nature a public, not private, wrong have served to correct the traditional imbalance of the litigation process.

5 Herbert B. Newberg & Alba Conte, Newberg on Class Actions § 24.1, at 5, 7 (4th ed. 2002) (hereinafter "Newberg on Class Actions"). Courts have traditionally recognized that claims of discrimination against a class of plaintiffs are particularly well-suited to class action treatment. *Gore v. Turner*, 563 F.2d 159, 166 (5th Cir. 1977) ("by definition, discrimination on the basis of race is a class wrong"); *Gay v. Waiters' & Dairy Lunchmen's Union*, 549 F.2d 1330, 1333 (9th Cir. 1977) ("Since the purpose of Title VII is to eliminate such class based discrimination, class actions are favorable in Title VII actions for salutary policy reasons."); *Oatis v. Crown Zellerbach Corp.*, 398 F.2d 496, 499 (5th Cir. 1968) ("Racial discrimination is by definition class discrimination.").

In this case, Kivilaan challenges an unambiguous, written, company-wide policy, which by definition affects an entire class of employees. Class certification is routinely granted - or conceded by the defendant - in similar cases involving a uniform written company policy. *E.g.*, *Int'l Union, UAW v. Johnson Controls*, 499 U.S. 187, 192-93 (1991) (parties stipulated to class certification in a Pregnancy Discrimination Act and Title VII case challenging an employer's "fetal protection policy"); *Frank v. United Airlines, Inc.*, 216 F.3d 845, 848-49 (9th Cir. 2000), *cert. denied*, 532 U.S. 914 (2001) (parties stipulated to class certification in Title VII case where policy at issue related to sex-based weight requirements for flight attendants); *Gerdom v. Cont'l*

Airlines, 648 F.2d 1223, 1228 (9th Cir. 1981) (class of female flight attendants certified as Title VII class challenging sex-based weight restrictions); *Waldrip v. Motorola, Inc.*, 85 F.R.D. 349, 351 (N.D. Ga. 1980) (certifying class challenging mandatory pregnancy leave policy).

Moreover, various courts have certified classes challenging policies nearly identical to that challenged here. *See, e.g., Stocking v. AT&T Corp.*, 436 F. Supp. 2d 1014 (W.D. Mo. 2006) (granting summary judgment to plaintiffs and certifying case challenging the exclusion of prescription contraceptives from the employee benefits plan); *Mauldin v. Wal-Mart Stores, Inc.*, No. Civ. A. 1:01-CV2755JEC, 2002 WL 2022334 (N.D. Ga. Aug. 23, 2002) (certifying a class of nation-wide employees challenging the exclusion of prescription contraceptives from the employee benefits program) (attached as Ex. C); *Erickson v. Bartell Drug Co.*, No. C00-1213L, slip op. (W.D. Wash. Dec. 14, 2000) (same) (attached as Ex. D). In all three cases, the courts certified classes under Rule 23(b)(2) of female employees who alleged that their employers' exclusion of prescription birth control from their health benefits plan constituted sex discrimination in violation of Title VII.

Class certification is likewise appropriate here. Plaintiff alleges that American Airlines's exclusion of prescription contraceptives from an otherwise comprehensive health insurance plan constitutes sex discrimination against an entire class of employees. If liability is found, only class certification will ensure that the injured parties will secure meaningful equitable and injunctive relief.

B. <u>The Requirements of Rule 23(a) Are Satisfied</u>

Fed. R. Civ. P. 23(a) provides that a case may proceed as a class action if:

> (1) [T]he class is so numerous that joinder of all members is impracticable, (2) there are questions of law or fact common to the class, (3) the claims or defenses of

> the representative parties are typical of the claims or defenses of the class, and (4) the representative parties will fairly and adequately protect the interests of the class.

Rutherford v. City of Cleveland, 137 F.3d 905, 909 (6th Cir. 1998).

Each of these requirements has been specifically pleaded in this case, and each is manifestly satisfied. In determining whether a class action will be allowed, the substantive allegations of the complaint should be taken as true, and all factual disputes arising at the hearing and in the pleadings are to be resolved in the plaintiff's favor. *Blackie v. Barrack*, 524 F.2d 891, 901 nn.16 & 17 (9th Cir. 1975); *Drayton v. W. Auto Supply Co.*, 203 F.R.D. 520, 524 (M.D. Fla. 2000).

1. The Class Is So Numerous That Joinder of All Members Is Impracticable

American Airlines has between 100,000 and 150,000 employees in the United States. Complaint ¶ 11. Given the number of qualifying employees[5] and the well-documented utilization rates for prescription contraceptive drugs and devices, Kivilaan believes that the class consists of at least thousands of women. The "sheer number of potential litigants in a class, especially if it is more than several hundred, can be the only factor needed to satisfy Rule 23(a)(1)." *Bacon v. Honda of Am. Mfg., Inc.*, 370 F.3d 565, 570 (6th Cir. 2004), *cert denied*, 543 U.S. 1151 (2005). Therefore, the numerosity requirement is satisfied here. *Cox v. Am. Cast Iron Pipe Co.*, 784 F.2d

[5] Despite Plaintiff's requests, American Airlines has refused to identify the number of employees covered by its health insurance plans during the class period. Defendant has objected to the scope of this request and indicated that it will identify only the number of flight attendants covered by the 2006 health benefit plans that were applicable to Kivilaan, though this lawsuit was filed in 2004 on behalf of all female employees. *See generally* Complaint. Such unreasonable limitations on discovery are untenable and, to the extent the parties are unable to reach an agreement, the Plaintiffs will move this Court to compel Defendant to provide responsive answers to Plaintiff's requests for interrogatories and production of documents.

1546, 1553 (11th Cir. 1986) ("while there is no fixed numerosity rule, 'generally less than twenty-one is inadequate, more than forty adequate, with numbers between varying according to other factors'"); *Kilgo v. Bowman Transp., Inc.*, 789 F.2d 859, 878 (11th Cir. 1986) (affirming certification where there were at least 31 class members). Further, the numerosity requirement should be read liberally when certification is sought for a civil rights use. *Jones v. Diamond*, 519 F.2d 1090, 1100 (5th Cir. 1975).

2. There are Questions of Law and Fact Common to the Class

Rule 23(a)(2) requires that there be questions of law or fact common to the class. The commonality requirement, however, is "qualitative rather than quantitative, that is, there need only be a single issue common to all members of the class." *In re Am. Med. Sys. Inc.*, 75 F.3d 1069, 1080 (6th Cir. 1996) (citation omitted). Rule 23 does not require that *all* questions of law and fact raised be common. *Cox*, 784 F.2d at 1557. The claims actually litigated in the suit must simply be those fairly represented by the named plaintiffs. *Id.* "Indeed, Rule 23(a)(2) has been construed permissively . . . . The existence of shared legal issues with divergent factual predicates is sufficient, as is a common core of salient facts coupled with disparate legal remedies within the class." *Hanlon v. Chrysler Corp.*, 150 F.3d 1011, 1019 (9th Cir. 1998); *see also Jackson v. Motel 6 Multipurposes, Inc.*, 175 F.R.D. 337, 342 (M.D. Fla. 1997). Moreover, even when individual factual circumstances are present among the class members, "the commonality requirement is satisfied where it is alleged that the defendants have acted in a uniform manner with respect to the class." *Buford v. H&R Block, Inc.*, 168 F.R.D. 340, 349 (S.D. Ga. 1996), *aff'd*, 117 F.3d 1433 (11th Cir. 1997) (quoting *Int'l Molders' & Allied Workers' Union No. 164 v. Nelson*, 102 F.R.D. 457, 462 (N.D. Cal. 1983)).

The commonality requirement is satisfied when a class of employees challenges company-wide policies. *Cox*, 784 F.2d at 1557-59 (court certified class challenging compensation, promotion and training policies); *Shipes v. Trinity Indus.*, 987 F.2d 311, 316 (5th Cir. 1993) (commonality satisfied in class of employees who work at two different plants because the plants used the same insurance plan and the same employee handbook); *Ingram v. Coca-Cola Co.*, 200 F.R.D. 685, 697 (N.D. Ga. 2001) ("commonality exists where plaintiffs allege that company-wide policies and practices . . . discriminate against a class"); *see also Erickson*, No. C00-1213L (W.D. Wash. Dec. 14, 2000) (commonality and typicality not challenged by defendant where company had a written policy specifically excluding prescription contraceptives from employee plan) (Ex. D); *Mauldin v. Wal-Mart Stores, Inc.*, 2002 WL 2022334 (Ex. C). Thus, the commonality requirement is satisfied here, where a company-wide policy of excluding prescription birth control from its health benefits plan affects Kivilaan and class members in the same way.

Numerous questions of law and fact raised by the Complaint are common to the Plaintiff and the class, including:

- Whether American Airlines's conduct violates Title VII, as amended by the PDA, which prohibits discrimination based on "pregnancy, childbirth or related medical conditions;"
- Whether American Airlines's conduct - its exclusion of contraceptives from its health benefits plans - constitutes disparate treatment on the basis of sex in violation of Title VII;
- Whether American Airlines's conduct has a disparate impact on women and therefore constitutes unlawful "disparate impact" sex discrimination under Title VII;
- The nature and scope of declaratory relief appropriate in this case;
- The nature and scope of injunctive relief necessary to prevent further violations of federal law; and,

- The nature and scope of equitable relief appropriate to complement any injunctive relief awarded by the Court.

Complaint ¶ 32. Given these common questions that go to the heart of this litigation, the claims of Kivilaan and the class have more than enough in common to satisfy the commonality prong of Rule 23(a).

3. Plaintiff's Claims are Typical of Those of the Other Class Members

The commonality and typicality requirements of Rule 23(a) tend to merge. Indeed, "[b]oth serve as guideposts determining whether under the particular circumstances maintenance of a class action is economical and whether the named plaintiff's claim and the class claims are so interrelated that the interests of the class members will be fairly and adequately protected in their absence." *Gen. Tel. Co. of SW. v. Falcon*, 457 U.S. 147, 157 n.13 (1982); *see also Prado-Steiman ex rel. Parado v. Bush*, 221 F.3d 1266, 1279 (11th Cir. 2000), *Buford*, 168 F.R.D. at 350.

Kivilaan's claims are typical of the claims of the class members as a whole. The typicality requirement is satisfied where a plaintiff's claims "arise[] from the same event or practice or course of conduct that gives rise to the claims of the other class members, and if his or her claims are based on the same legal theory." *Am. Med. Sys.*, 75 F.3d at 1082 (citation omitted). The typicality threshold is low, *Buford*, 168 F.R.D. at 351, and may be satisfied even if there are substantial factual distinctions between the claims of the named plaintiff and other class members, *Senter v. General Motors Corp.*, 532 F.2d 511, 524 (6th Cir. 1976) ("Factual identity between the plaintiff's claims and those of the class he seeks to represent is not necessary."); *Larkin v. Pullman-Standard Div.*, 854 F.2d 1549, 1573 (11th Cir. 1988), *vacated on other grounds*, 493 U.S. 929 (1989).

Kivilaan's experience and claims are typical of the class. Like every other class member, Kivilaan has been employed by American Airlines during the relevant period, is enrolled in the Plan, and was denied coverage for prescription contraceptives. This same fact pattern is shared by all other class members. Consequently, the typicality requirement is satisfied.

4. Plaintiff and Her Attorneys Are Adequate Representatives

Rule 23(a)(4) requires that the named representative "will fairly and adequately protect the interests of the class." Fed. R. Civ. P. 23(a)(4). Adequate representation requires that: "1) The representative must have common interests with unnamed members of the class, and 2) it must appear that the representatives will vigorously prosecute the interests of the class through qualified counsel." *Senter*, 532 F.2d at 525 (citing *Gonzales v. Cassidy*, 474 F.2d 67, 73 (5th Cir. 1973)).

Here, the interests of the class and the interests of Kivilaan coincide completely. The class members and Kivilaan all suffer from the same problem: American Airlines's Plan fails to cover their basic health need for prescription contraceptives. All seek to prove that American Airlines's conduct violate Title VII, as amended by the PDA, because it constitutes unlawful disparate treatment on the basis of sex, as well as unlawful disparate impact on a protected class (women) in violation of Title VII. Furthermore, Kivilaan and other class members would benefit from the same injunctive and declaratory relief because they would no longer have to choose between paying for prescription contraceptives out-of-pocket or forgoing their use altogether. Kivilaan is willing to vigorously prosecute the case on behalf of the class and she has selected class counsel who are prepared to do the same. Accordingly, the proposed class representative meets the adequacy requirement for class certification. *Gonzales*, 474 F.2d 67.

In addition, Plaintiff has retained counsel who have the resources and expertise to

prosecute this action vigorously on behalf of the class. Plaintiff's counsel are experienced in representing plaintiffs in complex class action litigation, including civil rights and employment discrimination cases.[6]

C. Because the Class Seeks Primarily Injunctive and Equitable Relief, Class Certification is Proper Under Rule 23(b)(2)

In addition to satisfying the four factors of Rule 23(a), a plaintiff seeking class certification must show that the action is maintainable as a class action under either Rule 23(b)(1), (2) or (3). *Amchem Prods., Inc. v. Windsor*, 521 U.S. 591, 613 (1997). Rule 23(b)(2) permits a class action to be brought if the requirements of Rule 23(a) are met, and:

> [T]he party opposing the class has acted or refused to act on grounds generally applicable to the class, thereby making appropriate final injunctive relief or corresponding declaratory relief with respect to the class as a whole.

Fed. R. Civ. P. 23(b)(2).[7] "Lawsuits alleging class-wide discrimination are particularly well suited for 23(b)(2) treatment since the common claim is susceptible to a single proof and subject to a single injunctive remedy." *Senter*, 532 F.2d at 525.

This case falls squarely within the requirement of Rule 23(b)(2). American Airlines has "acted or refused to act on grounds generally applicable to the class" by implementing an across-the-board written policy denying its employees prescription contraceptive benefits, despite providing coverage for other prescription drugs and devices. Various courts have certified cases challenging nearly identical practices under Rule 23(b)(2). *See, e.g, Mauldin*, 2002 WL 2022334,

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[6] *See* firm resumes (attached as Ex. E).

[7] Since the modern class action rule was amended in 1966, the Advisory Committee has cited civil rights actions as illustrative of the Rule 23(b)(2) model. *See* Fed. R. Civ. P. 23, Advisory Committee Notes, 1966 Amendment.

at *16-17 (Ex. C); *Erickson*, No. C00-1213L (W.D. Wash. Dec. 14, 2000) (Ex. D); *In re Union Pac. R.R. Employment Practices Litig.*, No. MDL 1597, 803CV437, 2005 WL 1027078, at *4-5 (D. Neb. Mar. 31, 2005) (attached as Ex. F).[8] Similar treatment is appropriate here.

The predominant relief requested by the class is a declaratory judgment that American Airlines's policy violates Title VII and an injunction preventing American Airlines from engaging in the challenged discriminatory conduct. *See* Complaint at 11. Above all, this case seeks to alter Defendant's discriminatory conduct.

Furthermore, Plaintiff's only monetary claim seeks equitable relief; that is, back pay or nominal damages to reimburse class members for the out-of-pocket expenditures for prescription contraceptives and related services during the class period. As such, "[t]his is not a case where individualized inquiry needs to be made to determine back pay or fringe benefits other than those related to the coverage of prescription contraceptives." *In re Union Pac. R.R. Litig.*, 2005 WL

[8] Furthermore, courts have consistently found civil rights cases compatible with class treatment under Rule 23(b)(2); *See e.g. Amchem Prods.*, 521 U.S. at 614 ("Civil rights cases against parties charged with unlawful, class-based discrimination are prime examples"); *Cox*, 784 F.2d at 1558 (Rule 23(b)(2) class certified where plaintiffs alleged pattern and practice of sex discrimination); *Kilgo*, 789 F.2d at 859 (certifying a Rule 23(b)(2) class of present and future employees and deterred job applicants); *Holmes v. Cont'l. Can Co.*, 706 F.2d 1144, 1152 (11th Cir. 1983) ("Civil rights class actions . . . are generally treated under subsection (b)(2) of Rule 23."); *Robinson v. Metro-N. Commuter R.R. Co.*, 267 F.3d 147, 167 (2d Cir. 2001) (finding 23(b)(2) certification appropriate in civil rights cases in which monetary damages were sought); *Linney v. Cellular Ala. P'ship*, 151 F.3d 1234, 1240 (9th Cir. 1998) (Rule 23(b)(2) class certification granted in civil rights case in which injunctive or declaratory relief was the predominant remedy sought); *Shores v. Publix. Super Mkts, Inc.*, No. 95-1162-CIV-T-25(E), 1996 U.S. Dist. LEXIS 3381, at *27 (M.D. Fla. Mar. 12, 1996) (finding hybrid Rule 23(b)(2) certification the appropriate mechanism for resolving an employment discrimination action) (attached as Ex. G); *Drayton*, 203 F.R.D. at 528 ("Civil Rights cases . . . are prime examples of Rule 23(b)(2) actions."); *Waldrip*, 85 F.R.D. at 349 (certifying Rule 23(b)(2) class in sex discrimination suit challenging mandatory maternity leave); *Ingram*, 200 F.R.D. at 699 (approving certification of Title VII injunctive and equitable relief under Rule 23(b)(2) and compensatory and punitive damages under 23(b)(3)).

1027078, at *5 (Ex. F). Indeed, the damages owed to class members will be determined through objective data – by receipts and market prices for prescription contraception over the class period. Courts have long recognized back pay as an equitable remedy compatible with Rule 23(b)(2) class certification. *See Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 218 n.4 (2002); *Coleman v. Gen. Motors*, 286 F.3d 433, 450 (6th Cir. 2005) (acknowledging that back pay is an equitable remedy compatible with certification under Rule 23(b)(2); *Eubanks v. Billington*, 110 F.3d 87, 95 (D.C. Cir. 1997) (same); *In re Monumental Life Ins. Co.*, 365 F.3d 408, 418 (5th Cir. 2004) (same), *cert. denied*, 534 U.S. 870 (2004) (No. 04-27); *Holmes*, 706 F.2d at 1152 (class action based on Title VII discrimination claim seeking equitable, injunctive or declaratory relief, including back pay, was properly certified as Rule 23(b)(2) class action); *Probe v. State Teachers' Ret. Sys.*, 780 F.2d 776, 780 (9th Cir. 1986) ("Class actions certified under Rule 23(b)(2) are not limited to actions requesting only injunctive or declaratory relief, but may include cases that also seek monetary damages"); *EEOC v. Gen. Tel. Co.*, 599 F.2d 322, 334 (9th Cir. 1979) ("Even if the suit contains a request for back pay the case continues to be properly certifiable under Rule 23(b)(2)."); *Orlowski v. Dominick's Finer Foods*, 172 F.R.D. 370 (N.D. Ill. 1997); *Butler v. Home Depot*, 70 Fair Empl. Prac. Cas. (BNA) 51 (N.D. Cal. 1996) (attached as Ex. H). [9]

Furthermore, the overwhelming authority makes plain that compensation for lost employment fringe benefits constitutes "back pay" and is consequently available as equitable relief. *Crabtree v. Baptist Hosp. of Gadsden, Inc.*, 749 F.2d 1501, 1502 (11th Cir. 1985)

[9] The very language of Title VII makes clear that back pay is an integral part of equitable relief. 42 U.S.C. § 2000e-5(g) ("the court may enjoin the respondent from engaging in [an] unlawful employment practice, and order such affirmative action as may be appropriate, which may include, but is not limited to, reinstatement or hiring of employees, with or without *backpay . . . or any other equitable relief* as the court deems appropriate") (emphasis added).

("Because the object of the backpay provisions of Title VII is to make employees whole for losses suffered on account of unlawful discrimination, fringe benefits should be included in back pay." (citation omitted)); *Cox*, 784 F.2d at 1562 (As a matter of law, back pay awards consist of more than straight salary and should include fringe benefits); *E.E.O.C. v. Wilson Metal Casket Co.*, 24 F.3d 836, 841 (6th Cir. 1994) (back pay awards may include fringe benefits such as compensation for medical expenses incurred); *Metz v. Merrill Lynch, Pierce, Fenner & Smith Inc.*, 39 F.3d 1482, 1493 (10th Cir. 1994) (lost fringe benefits are available under the back pay and equitable relief provisions of Title VII); *Brooks v. Hilton Casinos, Inc.*, 959 F.2d 757, 768, n.11 (9th Cir. 1992) (court awarded compensation for lost retirement benefits as an equitable remedy in a Title VII action); *O'Neal v. Thomas*, No. 1:89-CV-218-RHH, 1990 U.S. Dist. LEXIS 19038, at *9 (N.D. Ga. Oct. 15, 1990) (awarding lost fringe benefits as part of back pay in a Title VII case) (attached as Ex. I); *EEOC v. Emerson Elec. Co.*, No. 81-862C(2), 1986 U.S. Dist. LEXIS 30537, at *1-3 (E.D. Mo. Jan. 13, 1986) (in Title VII action challenging lack of coverage for pregnancy-related expenses, the award of lost insurance benefits deemed appropriate as analogous to back pay) (attached as Ex. J); *see generally* 2 Barbara Lindemann & Paul Grossman, *Employment Discrimination Law* 1779-83 (3d ed. 1996).

Accordingly, class certification is appropriate under Rule 23(b)(2).

V. CONCLUSION

For the foregoing reasons, Plaintiff respectfully submits that this case should be certified as a class action pursuant to Fed. R. Civ. P. 23(a) and 23(b)(2). This is a classic case of system-wide sex discrimination, based on a written policy that applies uniformly to all class members. As a remedy, Plaintiff seeks predominantly injunctive and declaratory relief. The

merits of this claim, and any defenses that American Airlines may present, should be determined in a unified, class-wide proceeding.

Respectfully submitted,

/s/ Victoria S. Nugent_____

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CERTIFICATE OF SERVICE

I hereby certify that on November 16, 2006, I served the foregoing Memorandum in Support of Motion for Class Certification through the Court's CMECF system upon:

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Employee Benefits Guide

AMERICAN AIRLINES

FLIGHT ATTENDANTS

How To Use This Guide

This guide is divided into several comprehensive sections to allow you quick access to the information about your benefits. Refer to the *Table of Contents* as well as the *Index*, starting on page 139, to find the appropriate section. Below are some suggestions on where to look for answers to commonly asked questions.

TO LOOK FOR ...	SEE ...
Who is eligible for coverage?	**Eligibility**, page 11, for information about who can be covered by your plan.
What are my benefits options?	**Your Benefits Options**, page 10, for brief descriptions of the options.
What kinds of changes can I make if my work or personal situation changes?	**Important Events at a Glance**, page 4, and **Life Events**, page 16, for helpful guidelines about what changes can be made.
What kinds of expenses are covered?	The individual plan descriptions for each plan (such as **Medical** and **Dental**), starting on page 22.
How do I file a claim?	**Filing Claims**, page 101, for information on filing claims under each plan.
Who do I call if I have questions?	**Important Contacts**, page 133. The contact may vary, depending on your particular question, so be sure to check the plan description for details before calling.

This Employee Benefits Guide is effective January 1, 1999, and supersedes all prior versions.

IMPORTANT TERMS

Throughout this guide, important terms are *italicized*. Italicized terms are defined in the Glossary of Terms, beginning on page 125.

Table of Contents

Important Events at a Glance

HOW LIFE EVENTS AFFECT YOUR BENEFITS

Whenever you experience a change in your life, consider how it affects your benefits. The table below lists a number of these important life events. For details, see the Life Events section beginning on page 16 and refer to the plan descriptions of each affected benefit.

IF	THEN
you become eligible for company-provided benefits (see page 11)	■ you will automatically receive a personalized enrollment kit.
you get married	■ you may add your spouse to medical, dental, and accident coverages within 60 days of your marriage. Contact the Employee Service Center for a Life Event Change Form. ■ review your life and accident insurance beneficiary designations.
you get divorced or legally separate from your spouse	■ you must submit a Life Event Change Form to the Employee Service Center within 60 days to delete your spouse from your coverage. You are responsible for repayment of any benefits paid for an ineligible person if you fail to notify the company of your divorce or legal separation. ■ provide an address on your Life Event Change Form so the Employee Service Center can send information to your former spouse about continuing coverage. ■ review your life and accident insurance beneficiary designations.
you or your spouse becomes pregnant	■ contact QuickReview before the 16th week of pregnancy if you are covered by the Standard Medical Plans. Contact your plan's prenatal care program if you are covered by the Point-of-Service Plan or an *HMO*. ■ see page 62 for information on the AMR Medical Department's prenatal program. ■ contact the maternity coordinator in your Flight Service Administration office.
you or your spouse give birth or adopt a child	■ you may add the child to your medical, dental, and accident coverages within 60 days of the birth or adoption. Filing a maternity claim does not add the child to your medical coverage. See Life Events, page 16. ■ review your life and accident insurance beneficiary designations.
you have a covered dependent who no longer meets the plan's definition of eligibility	■ submit a Life Event Change Form to the Employee Service Center so the dependent will be deleted from coverage and will receive information about electing continuation of coverage under COBRA.

QUESTIONS?

Call the Employee Service Center at:

ICS or (817) 967-1770

or (800) 888-1696.

IF . . .	THEN . . .
you, your covered spouse, or child needs surgery and/or *hospitalization*	■ if you are enrolled in the Standard Medical Plans, contact CheckFirst to determine if the recommended procedure is covered. Then, contact QuickReview to determine *medical necessity* and pre-authorize the hospitalization. ■ if you are using *network* providers under the Point-of-Service Plan or an HMO, contact your *primary care physician (PCP)* for network coverage. ■ if you are using out-of-network providers under the Point-of-Service Plan, contact your network administrator.
you move to a new home address	■ contact the Employee Service Center to change your address for benefits, submit a revised W-4 for payroll tax purposes, and contact other organizations such as the Credit Union or C. R. Smith Museum directly. ■ if you are enrolled in the Point-of-Service Plan or an HMO, check to be sure a similar option is offered in your new location. If not, you will need to select a new medical option. ■ update your Personal Information Notice (PIN) with your supervisor to ensure your emergency contacts are current.
you become disabled	■ notify your supervisor, who will request a Disability Claim Form from the Employee Service Center. ■ complete and file your claim for disability benefits.
you take a leave of absence	■ you receive a personalized Leave of Absence Worksheet from the Employee Service Center when your payroll authorization placing you on unpaid leave is processed. It lists your options during the leave, cost for coverages, and enrollment deadline. Your cost depends on the type of leave.
you change from part-time to full-time or full-time to part-time	■ you may change your elections in a manner consistent with this life event. Contact the Employee Service Center within 60 days of the event for a Life Event Change Form.
you die	■ your dependents should contact your supervisor, who will coordinate with Survivor Support Services to assist them with all benefits and privileges available to them, including electing continuation of coverage, if eligible. See N*EMPLOYEE DEATH in SABRE.
your dependent dies	■ submit a Life Event Change Form to the Employee Service Center to change your benefits. ■ if death is due to an accident and your dependent is covered under the family VPAI plan, see page 105 for filing a claim.
you end your employment with the company or are eligible to retire	■ review this guide for information on when coverage ends. ■ you will be sent information on electing continuation of coverage under COBRA. ■ for information on retirement, contact the Employee Service Center.
you transfer to another work group or subsidiary of AMR Corporation	■ contact your supervisor, the Employee Service Center, or the new subsidiary to determine benefits available to you and make new benefit elections.

Benefits Plan for Flight Attendants

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Your Benefits

The company recognizes that employees have different needs for benefits based on their personal situations. Some factors that may affect your need for benefits include your age, marital status, number of children, other coverage, and general financial circumstances. The Benefits Plan for Flight Attendants gives you the ability to tailor your benefits to your needs.

COMPANY-PROVIDED BENEFITS

All employees are provided with basic benefits protection as a hidden part of your paycheck. These benefits include:

- Medical coverage. You can choose from four Standard Medical Plan options, a Point-of-Service Plan, or an *HMO* (if available in your area). If you select the "richest" coverage, you contribute about 10% of the cost and the company pays the remaining 90%. However, the lowest level of coverage is available to you at no cost.
- Two Dental plan options. The high option (Plan 1) requires you to contribute a small portion of the cost, and the low option (Plan 2) is available at no cost (see page 65).
- Basic Life Insurance coverage based on your annual salary (up to a maximum of $70,000).
- Accidental Death and Dismemberment coverage of $10,000.
- Short Term Disability pay.

EMPLOYEE-PAID BENEFITS

In addition to these company-provided benefits, you can select from a number of optional benefits for which you pay the full cost. These include:

- Contributory Term Life Insurance for yourself
- Voluntary Personal Accident Insurance for you alone or for you and your family
- Long Term Disability coverage
- A Health Care Reimbursement Account
- A Dependent Day Care Reimbursement Account.

PAYING FOR BENEFITS

The amount indicated on your Enrollment Form and deducted from your paycheck is your contribution to the cost of coverage. Depending on your pay cycle, here is how payroll deductions work. (The amount may vary by a few cents due to rounding.) If you are paid:

Monthly (part-time Flight Attendants): You only receive one paycheck per month, so benefit deductions are taken from that paycheck.

Semi-monthly (full-time Flight Attendants): You receive two paychecks per month, and the same amount is deducted equally from both paychecks each month.

TAXATION OF BENEFITS

You pay for most benefits on a before-tax basis, which means the cost of your benefits is deducted from your pay before taxes are calculated. Tax withholding is calculated only on the remaining amount. Therefore, your contributions for before-tax benefits actually reduce your taxable income, and the amount of taxes withheld from your pay is also lower. However, a few benefits must be paid on an after-tax basis.

Here are a few important points about before-tax and after-tax benefits:

- You purchase Long Term Disability coverage on an after-tax basis. Because you have already paid taxes on the money used to purchase the coverage, any benefits you would receive in the event of your disability would not be taxable.

- Each before-tax dollar you contribute to your Dependent Day Care Reimbursement Account reduces the eligible amount you may claim on your federal income tax return for the dependent care tax credit. Consult your tax advisor to determine whether you would benefit more from the Dependent Day Care Reimbursement Account or the federal dependent care tax credit.

- When you calculate your federal income tax deduction for medical expenses, you may not include any money contributed before-tax to the Health Care Reimbursement Account. If you anticipate having medical expenses of more than 7.5% of your adjusted gross income, you should consult your tax advisor before signing up for the Health Care Reimbursement Account.

- You do not pay federal (or most state or local) taxes or Social Security (FICA) taxes on your pay used to purchase before-tax benefits. Because this reduces your Social Security wages, before-tax benefits could reduce your future Social Security benefits by a small amount. If your taxable pay remains above the Social Security wage base ($68,400 for 1998), your before-tax benefits do not affect future Social Security benefits.

Your Benefits Options

The following table summarizes options available to eligible employees under the Benefits Plan for Flight Attendants. The second column shows whether you pay for the benefit before-tax. The third column indicates whether you may waive coverage (choose no coverage) for this benefit option. Be sure to refer to the pages indicated for details about these plans.

TYPE OF BENEFIT	BEFORE TAX?	MAY WAIVE?	DESCRIPTION OF BENEFIT	SEE PAGE
Medical	Yes	No	Four Standard Medical Plan options cover the same medical care, but they vary in the amounts of deductibles, out-of-pocket maximums, and employee contributions. The Point-of-Service Plan (available in most locations) gives participants the choice of using *network* providers and receiving higher benefits or using out-of-network providers and receiving lower benefits. Health Maintenance Organizations (available in most locations) provide medical care coordinated through a *primary care physician* and cover medical services only when provided through network providers.	22
Dental	Yes	No	Two options provide coverage for the same eligible expenses and have the same deductibles and maximum benefits. Options differ in employee contributions and the percentage of covered expenses they reimburse.	65
Contributory Term Life Insurance	No	Yes*	You may choose from three contributory plans, based on the amount of your Basic coverage, to be paid to your beneficiary in the event of your death.	70
Voluntary Personal Accident Insurance	No	Yes	You may elect Employee or Family coverage from $10,000 to $500,000. If you die as the result of an accident, benefits are paid to your beneficiary. If you are dismembered as a result of an accident, benefits are paid to you. If a covered family member dies or suffers a loss, benefits are paid as a percentage of the total coverage amount, based on the composition of your family. This coverage is in addition to your basic Accidental Death & Dismemberment coverage of $10,000 which is provided by the company.	78
Long Term Disability	No	Yes*	Provides a continuing source of income during your period of disability, up to 50% of your pre-disability salary.	89
Health Care Reimbursement Account	Yes	Yes	This account allows you to set aside tax-free money to pay predictable out-of-pocket medical, dental, vision, and hearing expenses. You decide how much you want deducted throughout the year and then submit claims for reimbursement of eligible expenses. Claims are paid from your account with money that is never taxed. If you don't use all the money in your account for eligible expenses incurred during the year, you lose it.	96
Dependent Day Care Reimbursement Account	Yes	Yes	This account allows you to set aside tax-free money to pay your dependent day care expenses for children under age 13 or dependent adults. You decide how much you want deducted throughout the year and then submit claims for reimbursement of eligible day care expenses. Claims are paid from your account with money that is never taxed. If you don't use all the money in your account for eligible day care expenses incurred during the year, you lose it.	99

* Requires proof of good health any time you increase your level of coverage or if you waive coverage and later decide to elect it.

Eligibility for Benefits

You are eligible to enroll in benefits as an active employee and may elect coverage for you and your eligible dependents if you meet the eligibility requirements described in this section.

ACTIVE EMPLOYEES

As a regular employee who is a Flight Attendant on the U.S. payroll of American Airlines, Inc., you are eligible for coverage on your enter-on-duty date.

If you are not at work on the date coverage would otherwise begin, coverage is effective on the date you are actively at work.

If you do not return an enrollment form to the Employee Service Center, you will receive "default" coverage (see page 16).

ELIGIBLE DEPENDENTS

An eligible dependent is an individual (other than the employee covered by the plan) who lives in the United States, Puerto Rico, the U.S. Virgin Islands, or who accompanies an employee on a company assignment outside of the U.S. and is related to the employee in one of the following ways:

- **Spouse,** not employed by the company
- **Unmarried child under age 19** (See definition of "child" on this page.)
- **Unmarried incapacitated child age 19 or over** (See page 12 for definition of *incapacitated child.*)
- **Unmarried child age 19 through 22,** if the child is registered as a full-time student at an educational institution in a program of study leading to a degree or certification (proof of continuing eligibility will be required from time to time) and either:
  - The child maintains legal residence with you and is wholly dependent on you for maintenance and support
  - You are required to provide coverage under a Qualified Medical Child Support Order (QMCSO, as explained in this section) that is issued by the court or a state agency.

  If, for medical reasons, the child is required to reduce or terminate his or her studies, coverage will be continued for up to nine months. The child must be under a *physician's* care and statements must be provided from the attending physician and educational institution. After nine months, coverage will end unless the child returns to *school* full-time or meets the definition of an incapacitated child (explained on the next page).

Child

For the purpose of determining eligibility, "child" includes your:

- Natural child
- Legally adopted child
- Stepchild or *special dependent* (as defined on page 131), if the child lives with you and you claim the child as a dependent on your federal income tax return.

Incapacitated Child

An "incapacitated child" age 19 or over is eligible if all of the following criteria are met:

- The child was covered as your dependent under this plan before reaching age 19 (or age 23 if registered as a full-time student before reaching age 23).
- The child is mentally or physically incapable of self-support.
- You file an application with United HealthCare to continue the child's coverage within 31 days of the date coverage would otherwise end. United HealthCare must approve the application in order for coverage to be continued under either the Standard Medical Plans, the Point-of-Service Plan, or an *HMO*. Call the Employee Service Center to request an application.
- The child continues to meet the criteria for dependent coverage under this plan.
- You provide additional medical proof of incapacity as may be required by United HealthCare from time to time. Coverage will be terminated and cannot be reinstated if you cannot provide proof or if United HealthCare determines the child is no longer incapacitated. If you elect to drop coverage for your child, you may not later reinstate it.
- And either:
  - The child maintains legal residence with you and is wholly dependent on you for maintenance and support
  - You are required to provide coverage under a Qualified Medical Child Support Order (QMCSO) that is issued by the court or a state agency.

Qualified Medical Child Support Order (QMCSO)

Federal law authorizes state courts and administrative agencies to issue Qualified Medical Child Support Orders (QMCSOs). A QMCSO may require you to add your child as a dependent for health and dental benefits in some situations, typically a divorce. If you are subject to a QMCSO, your choice of plans may be affected. For example, if the child doesn't live in the same location as you, you may not be eligible for an HMO.

Parents and Grandchildren

Neither your parents nor grandchildren are eligible as dependents, regardless of whether they live with you or receive maintenance or support from you (unless you are the grandchildren's legal guardian). However, you may be eligible for reimbursement of their eligible expenses under the Reimbursement Accounts if you claim your parent or grandchild as a dependent on your federal income tax return.

EMPLOYEES MARRIED TO EMPLOYEES

If both you and your spouse are company employees, you are each covered as single employees and neither of you may be covered as a dependent under the other's health coverage. Your eligibility may change under certain circumstances. Following are situations when your eligibility could change:

Change in spouse's employment: If one spouse ends his or her employment with the company or moves to a subsidiary that does not offer the Benefits Plan for Flight Attendants, the Benefits Plan for Crewmembers, or Flexible Benefits, the spouse who changes may be eligible for coverage as a dependent, if he or she waives coverage under the subsidiary's health plan. However, if an employee is discharged for gross misconduct, he or she cannot be covered as a dependent of the active employee spouse.

Spouse not eligible for full benefits: During the six-month waiting period required for some work groups to be eligible for benefits, the new employee may be covered as the spouse of the active employee who already has benefits. (This does not apply during the six-month employment probation for Flight Attendants. You have your own coverage during this time.) If your spouse is working as a part-time extendible, part-time non-extendible, or job share employee, he or she may waive medical coverage and be covered as a dependent under your coverage.

Retirees married to active employees: Retirees married to active employees are eligible for coverage as dependents. The benefits available and *medical maximum benefit* limits are defined by the active employee's coverage. The retiree's individual maximum benefit is limited to the maximum benefit allowed for dependents, less any claims filed under company-sponsored plans before or during his or her retirement. When the actively working spouse retires, each retiree is covered under his or her own retirement benefit.

Spouse on leave of absence: For leaves such as a personal leave of absence, when company-provided benefits terminate, a spouse on a leave of absence may continue to purchase coverage as an employee on leave or elect to be covered as the dependent of the actively working spouse, but not both.

The actively working spouse's health coverage determines the health benefit coverage for all dependents. Because a leave of absence is a life event, the actively working spouse may make changes to his or her other coverages.

The actively working spouse may elect to:
- Add the spouse on leave as a dependent
- Cover only eligible dependent children
- Cover both the spouse and children.

If an employee elects to be covered as a dependent during a leave of absence, the following conditions apply:
- Optional coverages the person elected as an active employee end, unless payment for these coverages is continued while on leave.
- Proof of good health may be required to re-enroll or increase optional coverage upon the employee's return to work.

Company-provided coverage automatically continues for a period of time for employees on family, sick, injury-on-duty, or maternity leave. These employees cannot be covered as dependents.

Other Information

Eligible dependent children: If both spouses are covered under the Benefits Plan for Flight Attendants or the Benefits Plan for Crewmembers, eligible dependent children are covered as dependents of the parent whose birthday occurs first in the calendar year, unless the parents elect otherwise by writing to the Employee Service Center. If one spouse is covered under the Flexible Benefits Plan, the children are covered under the parent with the Flexible Benefits Plan. Children cannot be covered under both parents' health plans.

Contributions: If both you and your spouse are covered under the Benefits Plan for Flight Attendants, the Benefits Plan for Crewmembers, or Flexible Benefits and select exactly the same medical or dental plan at the same cost, your contributions will be adjusted to ensure you pay approximately the same for your total family coverage as you would if your spouse worked elsewhere. The savings will be divided equally and applied to both your paychecks.

Family deductibles: Family deductibles apply if both employees choose the same medical plan option (if you elect the Point-of-Service Plan, both employees must be enrolled in the same *network*). If the parents choose different options, the family *deductible* applies to the employee covering the children and the individual deductible applies separately to the other parent.

HMO participation: If you and your spouse enroll in the same HMO, the entire family unit is covered in the male employee's name because of HMO administrative procedures.

Accident coverage: Each of you may enroll for yourself. Neither of you may elect coverage for your spouse. Only the parent who elects medical coverage for the dependent children may elect family accident coverage.

Reimbursement accounts: Deposits to the Health Care and Dependent Day Care Reimbursement Accounts may be made by one or both spouses. Either of you may submit claims to the account. However, if only one spouse is making deposits to the account, claims must be submitted under that person's Social Security number. If you both make deposits, you may only contribute the maximum amount the law permits for a couple filing a joint tax return.

ELIGIBILITY DURING LEAVES OF ABSENCE AND DISABILITY

Subject to the specific rules governing leaves of absence, you may be eligible to continue benefits for yourself and eligible dependents for a period of time during a leave. The type of leave you take determines whether you must pay for benefits while on leave and what the cost will be.

When you begin a leave of absence, the Employee Service Center will send you a personalized Leave of Absence Worksheet listing your options and the cost to continue coverage during your leave. If you haven't received this worksheet within 10 days of being placed on unpaid leave, contact the Employee Service Center immediately to be sure you can continue coverage during the leave.

During the first two years of a sick or injury-on-duty leave of absence, you may keep the same benefits you had while actively working. You are responsible for paying your share of the cost for coverage. After this period, your coverage ends. If you have at least 10 years of company seniority and have qualified for Social Security Disability Benefits at the end of two years, you are eligible to terminate from the company and elect coverage under the Retiree Medical and Life Plans. Otherwise, you may elect continuation of coverage, as explained on page 112.

For detailed descriptions of leaves of absence, refer to AA REGS, consult your supervisor, or contact the Employee Service Center.

ELIGIBILITY AFTER AGE 65

As an active employee, your medical coverage continues after you reach age 65 (or your spouse reaches age 65), unless you (or your spouse) notify the company in writing that you want Medicare to be your only coverage.

If you elect Medicare as your only coverage, your company-sponsored medical coverage will terminate, including coverage for your dependents. If your spouse elects Medicare as his or her only coverage, your spouse's company-sponsored coverage will terminate.

RETIREE MEDICAL AND LIFE INSURANCE COVERAGE

You are eligible for Retiree Medical and Life Insurance coverage if you:

- Have at least 10 years of company seniority and
- Are age 55 or older or are receiving Social Security Disability Benefits.

Age 50 to 55 Rule

If you terminate employment after you reach age 50 (but before age 55) and you have at least 10 years of company seniority, you become eligible for the Retiree Medical Plan and Retiree Life Insurance coverage when you elect to receive your pension benefits.

Article 30

If you terminate employment after you reach age 45, but before age 55, and you have at least 20 years of company seniority, you are eligible for Article 30 early retirement, which provides limited Retiree Medical and Life Insurance coverage.

DEPENDENTS OF DECEASED EMPLOYEES

If you have elected medical coverage for your spouse and children and you die as an active employee, your covered dependents continue to have the same medical coverage they had before you died for 90 days at no cost. At the end of the 90-day period, covered dependents may purchase continuation of coverage through COBRA (as explained on page 112).

This 90-day extension applies only to medical coverage. Covered dependents may continue certain other benefits, such as dental, through COBRA starting at the time of your death.

Enrolling and Changing Your Selections

You may enroll or request changes in your benefits elections only at the following times:

- When you initially become eligible
- During annual enrollment
- Within 60 days following a life event.

Company-provided coverage begins when you are first eligible for benefits, as explained on page 11. To elect optional coverage after your initial eligibility, some coverage requires proof of good health.

NEWLY ELIGIBLE EMPLOYEES

As a newly-hired employee:

- You receive a personalized enrollment kit shortly after you begin working. You elect coverages you want for yourself and your eligible dependents.
- Between your hire date and the date your enrollment is received by the Employee Service Center, you are enrolled in the following "default" coverages: Standard Medical Plan 1, Dental Plan 1, Basic Employee Term Life Insurance, $10,000 of Accidental Death & Dismemberment coverage, and Long Term Disability coverage.

After the Employee Service Center processes your enrollment, your selected coverage (if different from default coverage) is retroactive to your hire date and your paycheck is adjusted as necessary.

If you select the Point-of-Service Plan or an *HMO* and need medical care during this interim period, you must select a *network* provider to receive network coverage. If you don't, you will be covered at the out-of-network level under the Point-of-Service Plan or have no HMO coverage.

ANNUAL ENROLLMENT

Each fall, the company conducts an annual enrollment period. You will receive information on the exact dates. During the annual enrollment period, you have the opportunity to enroll, make changes to your elections, or continue your previous elections. With the exception of specific life events (as explained later in this section), annual enrollment is the only time you can change your coverage. Any selections you make during annual enrollment are generally effective the following January 1. If proof of good health is required, the effective date may be later to allow for review and approval of your Statement of Health Form.

LIFE EVENTS

After you enroll, IRS rules specify that only under certain circumstances may you change your elections at any time other than the annual enrollment period. These circumstances are called life events and are listed in the chart on pages 19 and 20. You may only make changes consistent with the life event, and only if your request is received by the Employee Service Center within 60 days of the event.

If you experience a life event and wish to make a change, complete a Life Event Change Form and return it to the Employee Service Center within 60 days of the life event. Be sure to keep a copy for yourself. To request the form, call the Employee Service Center.

For information on how life events affect your benefits, see pages 4 and 5.

If you return your form to the Employee Service Center within 60 days, your changes are retroactive to the date of the life event (or date proof of good health is approved, if applicable). Any change in your cost for coverage is also retroactive to the date the change is effective, so catch-up contributions or deductions will be taken from one or more paychecks after your election is received. You will receive a confirmation statement outlining your selections.

If you miss the 60-day deadline, you may add or delete dependents from the medical or dental coverage you previously elected, but you may not make other changes. Changes in your covered dependents are effective on the day your Life Event Change Form is received by the Employee Service Center. However, in the event of a divorce or a dependent child losing eligibility for coverage, coverage terminates as of the date of the event.

If you have had the opportunity to add a dependent during an annual enrollment, but you did not add the person, you may not add the dependent through late enrollment.

When you experience a life event, you should always review your life and accident insurance beneficiary designations. You can make beneficiary changes at any time by contacting the Employee Service Center and requesting a Beneficiary Designation Form.

SPECIAL CONSIDERATIONS

Birth or adoption of a child: To add a natural child to coverage, you may use *hospital* records or an unofficial birth certificate as documentation of the birth. You should not wait to receive the baby's Social Security number or official birth certificate. Those documents may take more than 60 days to arrive, preventing you from starting coverage as of the baby's birthdate.

To add an adopted child to coverage, you must supply a copy of the placement papers or actual adoption papers. Coverage for an adopted child is effective with the date the child is placed in your home and is not retroactive to the child's birthdate.

Special dependent: To cover a *special dependent* (foster child or child for whom you are the legal guardian), you must complete a special dependent statement and return it to the Employee Service Center along with a copy of the court decree or guardianship papers.

Relocation: If you are enrolled in the Point-of-Service Plan or an HMO, and you move out of your plan's service area, you must choose another medical plan. However, your deductibles and out-of-pocket maximums do not transfer to the new plan. If the Employee Service Center does not receive your election, you will be enrolled in another medical plan and will receive a confirmation statement indicating your new coverage.

If you are enrolled in one of the Standard Medical Plans, you may stay in that plan or elect the Point-of-Service Plan or an HMO.

Contributory Term Life Insurance: You may only increase this coverage by one level per year with approved proof of good health.

Reimbursement Accounts: If you change the amount of your deposits during the year, claims from your Health Care Reimbursement Account for eligible health care expenses incurred before the change are payable up to the original amount you elected to deposit. Claims for expenses incurred after the change are payable up to your newly elected deposit amount. You forfeit part of your balance when the deposits before your change are greater than your claims before the change. Your Dependent Day Care Reimbursement Account reimburses based on the deposits in your account at the time of the claim.

COVERAGE NOT AFFECTED BY LIFE EVENTS

Medical Plan: You may not change medical plans unless you relocate. You may not change from one Standard Medical Plan option to another because of relocation.

Dental Plan: You may only change dental plans during the annual enrollment period.

WHEN COVERAGE ENDS

Coverage for you and your dependents ends when you terminate employment, cancel coverage, or stop paying for coverage, or if you become ineligible for the coverage (for example, due to a change in your job classification). In addition, your dependent's coverage ends if the dependent no longer meets the eligibility requirements, as explained on page 11.

If you die as an active employee, your covered dependents continue to receive the same medical coverage they had before you died for 90 days at no cost. This 90-day extension applies only to medical coverage. All other coverages end at the time of your death.

Certain benefits can be continued through COBRA. See page 112 for information about continuation of coverage.

WHEN YOU RETIRE

If you retire and are immediately eligible for Retiree Medical and Life Insurance coverage:

- Your Retiree Medical and Life Insurance coverage begins on the first of the month on or after your retirement date. You are covered as an active employee under your medical and life insurance coverages until your retiree coverage takes effect.

  If you die within the first 31 days of Retiree Life Insurance coverage, your beneficiary will receive a death benefit based on the amount of life insurance you had as an active employee.

- All other active employee coverages end on your last day on active payroll.

LIFE EVENTS	ALLOWABLE CHANGES IN COVERAGE (if received within 60 days)				
	MEDICAL AND DENTAL	LONG TERM DISABILITY	CONTRIBUTORY TERM LIFE INSURANCE**	VOLUNTARY PERSONAL ACCIDENT INSURANCE	REIMBURSEMENT ACCOUNTS
Marriage	Add coverage for spouse; no change allowed in coverage options	Start or stop Long Term Disability coverage*	Increase or decrease existing coverage*	Start or stop coverage for yourself or family; increase or decrease existing coverage	Start/increase or stop/decrease Dependent Day Care Account and/or Health Care Account
Divorce or legal separation	Stop coverage for spouse; no change allowed in coverage options	Start or stop Long Term Disability coverage*	Increase or decrease existing coverage*	Start or stop coverage for yourself; stop coverage for family; increase or decrease existing coverage	Stop/decrease Health Care Account; start/increase or stop/decrease Dependent Day Care Account
Birth or adoption of a child	Start coverage for dependent; no change allowed in coverage options	Start or stop Long Term Disability coverage*	Increase or decrease existing coverage*	Start or stop coverage for yourself or family; increase or decrease existing coverage	Start/increase or stop/decrease Dependent Day Care Account and/or Health Care Account
Adding some other eligible dependent to your household	Start coverage for eligible dependent; no change allowed in coverage options	Start or stop Long Term Disability coverage*	Increase or decrease existing coverage*	Start or stop coverage for yourself or family; increase or decrease existing coverage	Start/increase or stop/decrease Dependent Day Care Account and/or Health Care Account
Death of a covered dependent	Stop coverage for dependent; no change allowed in coverage options	Start or stop Long Term Disability coverage*	Increase or decrease existing coverage*	Start or stop coverage for yourself or family; increase or decrease existing coverage	Stop/decrease Health Care Account; start/increase or stop/decrease Dependent Day Care Account
Dependent child no longer qualifies	Stop coverage for dependent; no change allowed in coverage options	Start or stop Long Term Disability coverage*	Increase or decrease existing coverage*	Start or stop coverage for yourself or family; increase or decrease existing coverage	Stop/decrease Health Care Account; start/increase or stop/decrease Dependent Day Care Account

* Starting or increasing coverage may require proof of good health.
** You may increase your Contributory Term Life Insurance coverage by only one level per year.

LIFE EVENTS	ALLOWABLE CHANGES IN COVERAGE (if received within 60 days)				
	MEDICAL AND DENTAL	LONG TERM DISABILITY	CONTRIBUTORY TERM LIFE INSURANCE**	VOLUNTARY PERSONAL ACCIDENT INSURANCE	REIMBURSEMENT ACCOUNTS
Return from an unpaid leave of absence	Resume coverage; no change allowed in coverage options	Start or stop Long Term Disability coverage*	Increase or decrease existing coverage*	Start or stop coverage for yourself or family; increase or decrease existing coverage	Start/increase or stop/decrease Dependent Day Care Account
Change from full-time to part-time or vice-versa, for you or your spouse	Start or stop coverage for spouse; no change allowed in coverage options	Start or stop Long Term Disability coverage*	Increase or decrease existing coverage*	Start or stop coverage for yourself or family; increase or decrease existing coverage	Stop/decrease Health Care Account; start/increase or stop/decrease Dependent Day Care Account
Change in spouse's employment or other health coverage, or loss of employer contributions toward coverage	Start or stop coverage for spouse or dependent; no change allowed in coverage options	Start or stop Long Term Disability coverage*	Increase or decrease existing coverage*	Start or stop coverage for yourself or family; increase or decrease existing coverage	Stop/decrease Health Care Account; start/increase or stop/decrease Dependent Day Care Account
Relocation	May select the Point-of-Service Plan or an HMO if available in new location, or elect one of the Standard Medical Plan options	Start or stop Long Term Disability coverage*	Increase or decrease existing coverage*	Start or stop coverage for yourself or family; increase or decrease existing coverage	Stop/decrease Health Care Account; start/increase or stop/decrease Dependent Day Care Account
Dependent care provider changes	Not applicable	Not applicable	Not applicable	Not applicable	Start/increase or stop/decrease Dependent Day Care Account

* Starting or increasing coverage may require proof of good health.
** You may increase your Contributory Term Life Insurance coverage by only one level per year.

Group Health Plan

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Medical Coverage

The company offers eligible employees the opportunity to elect medical coverage that provides protection for you and your covered dependents in the event of an illness or injury. You may choose one of four Standard Medical Plans, a Point-of-Service Plan, or a Health Maintenance Organization *(HMO)*. The Point-of-Service Plan and HMOs are not offered in all locations.

Here is how the plans are funded and administered:

- The Standard Medical Plans and the Point-of-Service Plan are self-funded by the company. Each of these plans has a claims processor or network administrator (listed on page 134), but reimbursements for covered health care expenses are paid from the general assets of the company—not by an insurance company.

- HMOs are insured programs whose covered services are paid by the HMO organization. The company pays a flat monthly premium and the HMO pays for all covered services. HMOs are offered in many locations, but their coverage and features vary by location. If you live in a location where an HMO is offered, it will be listed as an option on your annual benefits enrollment form.

Regardless of the medical coverage you select, you may take advantage of the wellness programs described on page 62 and the Employee Assistance Program *(EAP)* described on page 64.

Standard Medical Plans

The Standard Medical Plans pay benefits to plan participants for *eligible medical expenses.* When you enroll, you may elect Plan 1, Plan 2, Plan 3, or Plan 4. All four plans require you to satisfy an annual *deductible* before they begin paying a percentage of the cost of covered medical care, up to the annual out-of-pocket maximum. You may use any qualified *physician.*

United HealthCare is the claims processor for the Standard Medical Plans. When you enroll, you will receive an ID card to present whenever you or a covered family member receives medical care. The differences in Plan 1, Plan 2, Plan 3, and Plan 4 are in the amount of the individual and family deductibles and the maximum out-of-pocket amount you pay each year, as shown in the table below. The costs of the options also vary. All four plans have the same features and cover the same eligible expenses. In this section, the term "the plan" refers to all four Standard Medical Plans.

HOW THE STANDARD MEDICAL PLANS WORK

When you or a covered dependent needs medical care, you may use any licensed physician. Each covered person must satisfy an annual deductible before the plan begins paying a percentage of his or her eligible, *medically necessary* expenses.

After you meet the annual deductible, the plan pays 80% of eligible expenses up to *usual and prevailing fee limits* for medically necessary services. Your *coinsurance* would be 20%. *Outpatient* mental health care is covered at 50% and is not included in the annual out-of-pocket maximum. Your coinsurance is 50% for outpatient mental health care. After you meet the annual out-of-pocket maximum, eligible medical services are covered at 100% for the remainder of the year.

For a detailed explanation of the plan's eligible expenses and exclusions, see pages 37 - 47.

FEATURES	STANDARD MEDICAL PLAN OPTIONS			
	PLAN 1	PLAN 2	PLAN 3	PLAN 4
Individual annual deductible	$150	$250	$500	$1,000
Family annual deductible	$400	$750	$1,350	$3,000
Individual annual out-of-pocket maximum*	$1,000	$1,500	$2,000	$2,500

* This maximum does not include your annual deductible, expenses that are not covered or exceed the usual and prevailing fee limits, or any expenses incurred for outpatient mental health care which are reimbursed at 50%.

Italicized terms are defined in the Glossary of Terms beginning on page 125.

PROVISIONS OF THE STANDARD MEDICAL PLANS

The plan has the following special features:

Accidental injury benefit: If you and/or a covered dependent are injured in a non-work related accident, the plan pays 100% of the first $250 of *hospital* and physician charges per person each calendar year. Treatment must be received within 24 hours of the accident. After the first $250, you must satisfy a deductible.

If two or more members of your family are injured in the same accident, only one individual deductible applies to all injured family members for expenses in connection with that accident during the year in which the accident occurs. Individual annual deductibles (up to the family maximum) still apply to each person for expenses not related to the accident.

Medical Discount Program: The Standard Medical Plans offer a voluntary *preferred provider organization (PPO)*, which is a *network* of over 315,000 physicians, hospitals, and other medical service providers that have agreed to charge discounted fees for medical services. The Medical Discount Program helps save you and the company money when you or a covered dependent needs medical care and chooses a participating provider.

This discount is automatic when you present your ID card to a PPO provider. PPO providers are available in most locations. PPO network providers have agreed to keep their negotiated rates within the usual and prevailing fee limits. Please keep in mind that some providers charge more than others for the same services. For this reason, using a participating provider may not always be the least expensive alternative. However, you will always receive a discount off that provider's normal fees. And, PPO providers' fees are always within the usual and prevailing fee limits of the plan.

In addition to the fee discounts from PPO providers, you receive another advantage. You pay nothing to the physician at the time of service and the physician's office files your claim for you. You receive a bill for only the remaining amount which you are responsible for paying, such as your deductible or coinsurance amounts.

Call United HealthCare to request a directory of PPO providers in your area or to learn more details about this plan feature. Because PPO network providers may change, you should confirm that your physician is part of the network whenever you make an appointment.

Please keep in mind the following situations when using PPO providers:

- If you go to a PPO hospital but receive services from a physician who is not a PPO provider, you receive the PPO discount for hospital charges, but the physician's fee is not eligible for the discount.
- If you use a PPO physician or hospital, charges for your lab services may not be eligible for the PPO discount if your physician or hospital uses a lab that is not part of the PPO network.

Whenever possible, be sure to check with your provider in advance to ensure you receive the maximum discount.

Preventive care: Under the Standard Medical Plans, well-child care (for children up to age 2) and mammograms (according to the guidelines on page 39) are covered.

Point-of-Service Medical Plan

The Point-of-Service Plan is an alternative to the Standard Medical Plans. The Point-of-Service Plan offers a *network* of *physicians* and *hospitals* that have agreed to provide medical services to Point-of-Service Plan participants at preferred rates. In this section, the term "the plan" refers to the Point-of-Service Plan.

Advantages of the Point-of-Service Plan include:

- The choice of using a network or out-of-network provider each time you need medical care
- Greater benefits when you use network providers
- A *primary care physician* who coordinates network services for you
- Low *copayments* or *coinsurance* for services provided by network providers
- Covered preventive care from network providers
- No claims to file when you use network providers.

The Point-of-Service Plan is currently offered in most locations. If you live in a location where the Point-of-Service Plan is offered, it will be listed as an option on your benefits enrollment form. Eligibility is based on your home ZIP code.

Each Point-of-Service Plan network is administered by a network administrator. These vary by location, and may either be United HealthCare, Prudential HealthCare, or Aetna U.S. Healthcare, depending on the area. The health care providers in each network are carefully screened and selected by the network administrator.

HOW THE POINT-OF-SERVICE PLAN WORKS

You may use physicians and other service providers who are part of the network, or you may use providers who are not part of the network. However, when you use network providers, you receive a higher level of benefits, called the network benefit level. At the network benefit level, you pay only a small copayment or coinsurance and no *deductible*.

When you enroll, you must contact the network's Member Services to select a primary care physician (PCP) from a group of physicians who participate in the network. Your PCP is your partner in the services you receive under the Point-of-Service Plan. He or she:

- Coordinates all phases of your network medical care to be sure the services you receive are necessary and appropriate for your condition
- Provides referrals to other network providers when the care of a specialist is necessary
- Oversees, coordinates, and authorizes *hospitalization* and surgery.

PCPs practice in pediatrics, family practice, general practice, or internal medicine. When your medical care is provided by or authorized by your PCP, you receive the network level of benefits.

You can change your PCP at any time by calling Member Services.

To receive the network level of benefits for care from a specialist, you need a referral from your PCP. However, you are not required to have a referral from your PCP to receive the network level of benefits when you use a network chiropractor or obstetrician/gynecologist for these specialized services.

If you need the care of a specialist and the network in your area does not offer any providers in that specialty, your PCP can provide a referral to an out-of-network specialist. In these rare instances, your out-of-network care is covered at the network benefit level.

If you go to a provider who is not part of the network, you are still covered for eligible, *medically necessary* services, but at a lower level of benefits, called the out-of-network benefit level. At the out-of-network benefit level, you pay a deductible and higher out-of-pocket amounts. For most services, the plan pays 70% and you pay the remaining 30% of covered out-of-network charges after you satisfy the $300 deductible. Each time you or your covered dependent needs medical care, you choose whether to use a network or out-of-network provider.

After you have enrolled, you will receive a Point-of-Service Plan ID card from the network administrator indicating that you and your covered dependents are covered by the plan. The card lists your PCP and important phone numbers. Present the ID card each time you go to a network physician, *hospital*, or pharmacy.

PROVISIONS OF THE POINT-OF-SERVICE PLAN

Following are some of the important features of the Point-of-Service Plan:

Preventive care: You and each covered family member are eligible to receive benefits for annual routine physical exams, well-child exams, and well-woman exams provided by your PCP or a network obstetrician/gynecologist.

No claims to file: When you use network providers, they file your claims for you.

Copayments vs. coinsurance: What you pay for eligible medical services depends on where you receive those services. At the network benefit level, you pay a fixed copayment for services such as office visits to your PCP or specialists, including any tests or treatment received during that office visit. You pay coinsurance (a percentage of the cost) for services received in a hospital-based setting (see below). For out-of-network services, you must first satisfy a deductible, then you pay the higher out-of-network coinsurance amount.

Hospital out-of-pocket maximum: Under the Point-of-Service Plan, you pay 10% coinsurance, up to a maximum of $750 per covered person per year for network hospital-based services, including: hospital facility charges, *free-standing surgical facilities*, physician charges, room and board, diagnostic testing, x-ray and lab fees, anesthesia, dialysis, chemotherapy, MRIs, and mammograms. Fixed copayments for office visits to your PCP or specialist are not included in this out-of-pocket maximum.

Emergency care: If you have a medical *emergency*, go directly to an emergency facility. You or a family member must call your PCP or Member Services within 48 hours of your emergency care to be eligible for the network benefit level. You should arrange any follow-up treatment through your PCP.

Care while traveling: If you have an emergency, acute illness, or injury while traveling, get medical attention immediately. Then call your PCP within 48 hours of your emergency care. In this case you must submit a claim form, but are eligible for the network benefit level. If you are enrolled in the United HealthCare or Aetna U.S. Healthcare network, call the Member Services number on your ID card. If you are enrolled in the Prudential HealthCare network and need immediate or *urgent care* while traveling, call them at (800)526-2963 for referral to an appropriate facility or physician.

Urgent care: If you need urgent care but you do not have an actual emergency, call your PCP. He or she will direct you to the appropriate place for treatment. You are eligible for the network benefit level if you follow these procedures.

Continuing care: In the event you are newly enrolled in the Point-of-Service Plan and you or a covered family member has a serious illness or you or your spouse are in the 20th (or later) week of pregnancy, you may ask the plan administrator to evaluate your need for continuing care. You may be eligible to continue with your current care provider at the network benefit level, even if that provider is not part of the network. Call the Member Services number on your ID card.

Network administrator: The network administrator (either Aetna U.S. Healthcare, Prudential HealthCare, or United HealthCare, depending on your location; see page 134) establishes standards for participating providers, including physicians, hospitals, and other service providers. They carefully screen providers and verify their medical licenses, board certifications, hospital admitting privileges, and medical practice records. They also periodically monitor whether participating providers continue to meet network standards. The network administrator performs all these selection and accreditation activities.

Exclusions and limitations: Exclusions and limitations are listed on pages 45 - 47.

Dependents living in different cities: If your spouse does not live in the same city as you, and you wish to cover your spouse under the Point-of-Service Plan, your spouse must select a PCP and receive medical services in your city to receive the network level of benefits.

If you have a child who is living away from home (such as a student or a child you are required to cover under a Qualified Medical Child Support Order), your child must select a PCP and receive medical services in your city to receive the network level of benefits. Your dependents may receive care in their location at the out-of-network benefit level.

Special programs: In addition to the coverage available to all Point-of-Service Plan participants, each of the network administrators offers special programs. Although these programs vary by network administrator, examples of special programs include prenatal, diabetes, and asthma programs. Not all of these are available in each network. Call your network administrator for information.

Leaving the service area: With the exception of the annual enrollment period, the only other time you may change your election for coverage under the Point-of-Service Plan is if you relocate out of your plan's network service area.

If you move out of your Point-of-Service Plan's network service area, you may enroll in another Point-of-Service Plan network or an *HMO* (if either is available in your new location) or select one of the Standard Medical Plans. You must submit a Life Event Change Form to the Employee Service Center and make another election within 60 days of your move. If the Employee Service Center does not receive your election, you will be enrolled in the Point-of-Service Plan in your new location (if available) or in Standard Medical Plan 1 (if the Point-of-Service Plan is not available) and will receive a confirmation statement indicating your new coverage.

Key Plan Features

Following are key features of the Standard Medical Plans and the Point-of-Service Plan. See page 37 for specific covered expenses.

Medically necessary: Medical care is covered by the Standard Medical Plans when it is *medically necessary* as defined on page 129. The Standard Medical Plans also cover certain well-child care and periodic mammograms. Under the Point-of-Service Plan, the same *medical necessity* requirements apply. However, some services, such as routine physical exams and preventive care, are covered if performed by *network* providers.

Please note that just because a *physician* orders a service does not mean it is medically necessary. See page 50 for information on QuickReview.

Usual and prevailing fee limits: The amount of benefits paid for eligible expenses is based on the *usual and prevailing fee limits* for a particular service or supply in that geographic location. Because participating providers in the Standard Medical Plan Medical Discount Program (the *PPO*) and the Point-of-Service Plan's network have agreed to discounted fees, their charges are always within the usual and prevailing fee limits.

Individual annual deductible: Your annual *deductible* under the Standard Medical Plans and out-of-network services under the Point-of-Service Plan is the amount you must pay each year before the plan will start reimbursing you. After you satisfy the deductible, the plan pays the appropriate percentage of the usual and prevailing fee for eligible covered medical services. There is no annual deductible for network services under the Point-of-Service Plan. Expenses incurred for network services under the Point-of-Service Plan do not apply to the out-of-network deductible.

Family annual deductible: After satisfying the family deductible, all members of your family are eligible for reimbursement of eligible medical expenses, regardless of whether they have satisfied individual annual deductibles. The family annual deductible is available if three or more family members are covered.

Claims: Under the Standard Medical Plans, you must file a claim for services unless you use a provider who participates in the Medical Discount Program PPO. Participating PPO providers file claims for you.

Under the Point-of-Service Plan, your network provider files claims for you. You must only file a claim if you receive services from an out-of-network provider, receive *emergency* care, or need medical care while traveling.

Annual out-of-pocket maximum: After you satisfy the annual out-of-pocket maximum for eligible expenses under the plan, the plan pays 100% of eligible expenses within usual and prevailing fee limits for the rest of the year.

- For the Standard Medical Plans and out-of-network services under the Point-of-Service Plan, all *coinsurance* amounts (except *outpatient* mental health care amounts) apply to the annual out-of-pocket maximum.
- For network *hospital* services under the Point-of-Service Plan, coinsurance amounts for hospital-based services apply to the annual out-of-pocket maximum. However, *copayments* do not apply toward the annual out-of-pocket maximum.

Medical maximum benefit: $1,000,000 is the most any participant can receive in medical benefits during the entire period the person is covered. All expenses incurred under the Standard Medical Plans, the Point-of-Service Plan, and the Mail Service Prescription Program are included in the maximum.

Each January 1, part of your *medical maximum benefit* is automatically restored. The amount restored is $3,500, or the amount necessary to restore your full $1,000,000, whichever is less.

CheckFirst: Under the Standard Medical Plans, you should contact CheckFirst to determine whether a proposed medical service is covered under the plan and if your provider's fee falls within the usual and prevailing fee limits. When you use the Medical Discount Program (PPO) under the Standard Medical Plans, those services are always within the usual and prevailing fee limits. However, you may still need to use CheckFirst to determine whether the procedure is covered. When using network services under the Point-of-Service Plan, your PCP handles these determinations. If you are using out-of-network services under the Point-of-Service Plan, contact your network administrator.

See page 48 for more information on CheckFirst.

QuickReview: Under the Standard Medical Plans, you are required to request pre-authorization before *hospitalization*. QuickReview authorizes the medical necessity of your hospitalization as well as the length of your *hospital stay*. It is also recommended that you pre-authorize any outpatient surgery. For more information on QuickReview, see page 50.

QuickReview is not necessary if you are covered by the Point-of-Service Plan or an *HMO* and your PCP has arranged your hospitalization through network providers. If you need emergency care under the Point-of-Service Plan, you must contact your PCP within 48 hours to receive the network benefit level.

If you are using out-of-network providers under the Point-of-Service Plan, contact your network administrator to pre-authorize any surgery or hospitalization.

SHARE: Share Health Audit Results Effectively (SHARE) may pay you a reward if you discover a provider has overcharged on any of your medical bills. The reward is 50% of the amount of any savings to the plan, up to a maximum reward of $1,000 per claim. SHARE is explained on page 57.

Prescription drug benefits: The Standard Medical Plans cover *prescription drugs* purchased at any retail pharmacy and offer discounted prescriptions at participating PAID Prescriptions network pharmacies. The Point-of-Service Plan covers prescriptions at low copayments when purchased at your network's participating pharmacies.

A special mail service program is available to participants of the Standard Medical Plans and the Point-of-Service Plan. It allows you to purchase drugs you take on an ongoing basis, such as medications to treat chronic illnesses, at a discount. Covered prescription drugs are described on page 41. See page 52 for a description of the prescription program.

Comparison of Plan Features and Your Cost

The following table provides a summary of plan features under the Standard Medical Plans (Plan 1, Plan 2, Plan 3, and Plan 4) and the Point-of-Service Plan. It shows the amount or percentage you pay for covered services. Benefits are available for covered medical services that are *medically necessary* and within the *usual and prevailing fee limits*. You pay any amounts not covered by the plan. If you are covered under Plans 1, 2, 3, or 4, or you use out-of-network services under the Point-of-Service Plan, you must satisfy the individual annual *deductible* before the plan pays benefits for covered medical services. For details on how specific services are covered and which are excluded, refer to pages 37 and 45.

FEATURE	WHAT YOU PAY UNDER THE STANDARD MEDICAL PLANS				WHAT YOU PAY UNDER THE POINT-OF-SERVICE PLAN	
	PLAN 1	PLAN 2	PLAN 3	PLAN 4	NETWORK	OUT-OF-NETWORK
Individual annual deductible	$150	$250	$500	$1,000	None	$300
Family annual deductible	$400	$750	$1,350	$3,000	None	$900
Individual annual out-of-pocket maximum (This does not include deductible or expenses incurred for *outpatient* mental health care covered at 50% or non-covered expenses.)	$1,000	$1,500	$2,000	$2,500	$750 per person for *hospital*-based services that require you to pay 10% of the cost	$2,000
Individual *medical maximum benefit*	$1,000,000 per covered individual					
PREVENTIVE CARE						
Annual routine physical exams	Not covered				$10 per visit* to *PCP*	Not covered
Well-child care	20% for children up to age 2, for initial *hospitalization* following birth, all immunizations, and up to 7 well-child care visits				$10 per visit* to PCP, with no age limit	30% for children up to age 2, for initial hospitalization following birth, all immunizations, and up to 7 well-child care visits

*These copayment amounts do not apply to the annual $750 out-of-pocket maximum.

FEATURE	WHAT YOU PAY UNDER THE STANDARD MEDICAL PLANS	WHAT YOU PAY UNDER THE POINT-OF-SERVICE PLAN	
	(PLAN 1, PLAN 2, PLAN 3, PLAN 4)	NETWORK	OUT-OF-NETWORK
	MEDICAL SERVICES		
Physician's office visits	20%	$10 per visit* to PCP	30%
Specialist's office visits	20%	$20 per visit* with PCP referral (including x-rays and lab work done in office)	30%
Urgent care clinic	20%	$25 per visit*	30%
Gynecological care:	20% if medically necessary; preventive care not covered (except for mammograms, as listed below)	$10 per visit* to *network* OB/GYN (no PCP referral required to OB/GYN)	30% if medically necessary; preventive care not covered (except for mammograms, as listed below)
■ Pap tests	20% if medically necessary; not covered if routine	No cost if part of office visit	30% if medically necessary; not covered if routine
■ Mammograms (See page 39 for guidelines.)	20% if medically necessary; routine mammograms are covered beginning at age 35	No cost if part of office visit; 10% if hospital outpatient	30% if medically necessary; routine mammograms are covered beginning at age 35
Pregnancy (This includes physician's charges only; hospital charges are same as for any hospitalization.)	20%	$100 per pregnancy* includes pre- and postnatal visits and delivery	30%
Second surgical opinions (No cost if ordered by the plan administrator.)	20% if elected by participant	$20 per visit* with PCP referral, if elected by participant	30% if elected by participant
Chiropractic care	20%	$20 per visit* (no PCP referral required)	30%
		Maximum 20 chiropractic visits per person per year combined network and out-of-network	
Speech, physical, occupational, restorative, and rehabilitative therapy	20%	$20 per visit* with PCP referral; maximum copayment of $100 per person per year; then covered at 100%	30%

*These copayment amounts do not apply to the annual $750 out-of-pocket maximum.

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FEATURE	WHAT YOU PAY UNDER THE STANDARD MEDICAL PLANS (PLAN 1, PLAN 2, PLAN 3, PLAN 4)	WHAT YOU PAY UNDER THE POINT-OF-SERVICE PLAN NETWORK	WHAT YOU PAY UNDER THE POINT-OF-SERVICE PLAN OUT-OF-NETWORK
MEDICAL SERVICES (continued)			
Allergy care:			
■ Physician's office visit (PCP)	20%	$10 per visit* to PCP	30%
■ Physician's office visit (specialist)	20%	$20 per visit* with PCP referral; maximum copayment of $100 per person per year	30%
■ Allergy testing, shots, or serum	20%	No cost if administered in physician's office	30%
OUTPATIENT SERVICES			
Diagnostic x-ray and lab	20%	10% at hospital; no cost if received at a network lab with PCP referral or in a physician's office	30%
Outpatient surgery in physician's office (Pre-authorization is recommended to ensure *medical necessity;* see page 50.)	20%	$20 per visit* (PCP will obtain pre-authorization for you)	30%
Outpatient surgery in a hospital or free-standing surgical facility (Pre-authorization is recommended to ensure medical necessity; see page 50.)	20%	10% (PCP will obtain pre-authorization for you)	30%
Pre-admission testing	20%	10%	30%
HOSPITAL SERVICES			
Inpatient room and board, including intensive care unit or special care unit	20%	10%	30%

*These copayment amounts do not apply to the annual $750 out-of-pocket maximum.

FEATURE	WHAT YOU PAY UNDER THE STANDARD MEDICAL PLANS (PLAN 1, PLAN 2, PLAN 3, PLAN 4)	WHAT YOU PAY UNDER THE POINT-OF-SERVICE PLAN NETWORK	WHAT YOU PAY UNDER THE POINT-OF-SERVICE PLAN OUT-OF-NETWORK
HOSPITAL SERVICES (continued)			
Ancillary services (This includes radiology, pathology, operating room, and supplies.)	20%	10%	30%
Newborn nursery care (Considered under the baby's coverage, not the mother's. Be sure to enroll your baby in your health plan as soon as possible. Payment of a maternity claim does not automatically enroll your baby. For a Life Event Change Form, call the Employee Service Center.)	20%	10%	30%
Surgery and related expenses such as anesthesia and medically necessary assistant surgeon	20%	10%	30%
Blood transfusions	20%	10% (No cost if performed in physician's office)	30%
Organ transplants	20%	10%	30%
Emergency ambulance	20%	No cost	30%
Emergency room	20% – however, accidents are covered at no cost and with no deductible for the first $250 in covered expenses or with only one deductible if two or more family members are injured in the same accident	$50 copayment;* copayment is waived if admitted	30%
OUT-OF-HOSPITAL CARE			
Convalescent and skilled nursing facilities following hospitalization	50%, maximum of 60 days	10%	30%
		Maximum of 60 days for network and out-of-network combined	
Home health care	20%	No cost when approved by the network administrator	30%
Hospice care	20%	10%	30%

*These copayment amounts do not apply to the annual $750 out-of-pocket maximum.

FEATURE	WHAT YOU PAY UNDER THE STANDARD MEDICAL PLANS (PLAN 1, PLAN 2, PLAN 3, PLAN 4)	WHAT YOU PAY UNDER THE POINT-OF-SERVICE PLAN — NETWORK	WHAT YOU PAY UNDER THE POINT-OF-SERVICE PLAN — OUT-OF-NETWORK
OTHER SERVICES			
Tubal ligation or vasectomy (Reversals are not covered.)	20%	$20 copayment* in physician's office; 10% in hospital	30%
Infertility treatments (This includes in-vitro fertilization.)	Not covered	Not covered	Not covered
Radiation therapy and chemotherapy	20%	No cost in physician's office; 10% in hospital	30%
Kidney dialysis (If the dialysis continues more than 12 months, participant must apply for Medicare.)	20%	No cost in physician's office; 10% in hospital	30%
Supplies, equipment, and durable medical equipment (DME)	20%	No cost if purchased from a network supply house; 10% if purchased from the hospital	30%
MENTAL HEALTH AND CHEMICAL DEPENDENCY CARE			
Inpatient mental health care	20%	10%	50%** up to a maximum of 30 days per year
Alternative mental health care center	50%**	10%	50%** up to a maximum of 30 days per year
Outpatient mental health care	50%**	$20 per visit*	50%** up to a maximum of 60 visits per year
Marriage counseling	Not covered	Not covered	Not covered
Detoxification (See page 38.)	20%, must be approved by QuickReview	10% if approved by the network administrator	30% if not approved by the network administrator, even if a network facility is used

*These copayment amounts do not apply to the annual $750 out-of-pocket maximum.

FEATURE	WHAT YOU PAY UNDER THE STANDARD MEDICAL PLANS (PLAN 1, PLAN 2, PLAN 3, PLAN 4)	WHAT YOU PAY UNDER THE POINT-OF-SERVICE PLAN NETWORK	WHAT YOU PAY UNDER THE POINT-OF-SERVICE PLAN OUT-OF-NETWORK
MENTAL HEALTH AND CHEMICAL DEPENDENCY CARE (continued)			
Chemical dependency:	No inpatient or outpatient chemical dependency rehabilitation is covered without prior approval from the Employee Assistance Program *(EAP)* or the AMR Medical Department. Only one rehabilitation, combined inpatient and outpatient, is covered during the entire time a person is covered by the plan.		
■ Inpatient chemical dependency rehabilitation	20% (hospital benefits apply if approved by the EAP)	10% if approved by the EAP	Not covered unless approved by the EAP
■ Outpatient chemical dependency rehabilitation	20% (if approved by the EAP)	$20 per visit,* if approved by the EAP, up to a maximum copayment of $100	Not covered unless approved by the EAP
PRESCRIPTION MEDICATIONS			
Retail pharmacies (Typically up to a 30-day supply; oral contraceptives and fertility drugs are not covered.)	20% for most drugs; 50% for psychotherapeutic drugs;** PAID Prescriptions network pharmacies offer discounts on prescriptions.	$5 for generic drugs,* $10 for brand names* at participating network pharmacies; includes psychotherapeutic drugs	30% for most drugs; 50% for psychotherapeutic drugs**
Mail-order program (90-day supply)	$7 copayment for generic drugs, $15 copayment for brand name drugs, up to a 90-day supply of prescription for treatment of chronic medical conditions; 50%** *coinsurance* for psychotherapeutic drugs; oral contraceptives available at full discounted cost.		
Over-the-counter medications	Not covered	Not covered	Not covered
OTHER INFORMATION			
Hospital pre-authorization (QuickReview, as explained on page 50.)	Required for hospitalizations and recommended before outpatient surgeries	PCP obtains pre-authorization	Required for hospitalizations and recommended before outpatient surgeries
Pre-determination of benefits (CheckFirst, as explained on page 48.)	Recommended before hospitalization and surgery	PCP obtains pre-determination	Recommended before hospitalizations and surgery

*These copayment amounts do not apply to the annual $750 out-of-pocket maximum.
**Amounts covered at 50% do not apply to the annual out-of-pocket maximum.

How the Plans Differ

Your choice of health plan can dramatically affect the amount you pay for medical care. Because each employee's situation is different, sometimes it's difficult to decide which plan is right for you. To illustrate what an average employee might pay in a hypothetical situation, consider the following example:

An employee living in Dallas requires knee surgery and his doctor refers him to a specialist. The surgical procedure will be performed on an *outpatient* basis, and he'll need pain medication for a period afterwards. At the right is a breakdown of typical charges involved in this type of procedure. The table below illustrates what you might pay under the various medical plan options. Remember, these are only examples. Actual charges would vary depending on the choice of physician, discounts negotiated with the provider, and area of the country where surgery is performed.

OFFICE VISIT TO DOCTOR	**$70**
OFFICE VISIT TO SPECIALIST	**$120**
SURGERY:	
Surgeon's Fees	**$2,400**
Facility Charge	**$2,000**
Anesthesiologist	**$500**
PRESCRIPTION	**$50**
TOTAL AVERAGE COST	**$5,140**

	STANDARD MEDICAL PLANS				POINT-OF-SERVICE	
	PLAN 1	PLAN 2	PLAN 3	PLAN 4	NETWORK	OUT-OF-NETWORK
Pre-authorization...	Call QuickReview	Call QuickReview	Call QuickReview	Call QuickReview	Your *network* physician handles for you	Call your network administrator
You pay:						
Deductible or copayment...	$150 *deductible*	$250 deductible	$500 deductible	$1,000 deductible	$10 copay - *PCP* $20 copay - Specialist $10 copay - Prescription	$300 deductible
Coinsurance...	$998 (20% *coinsurance* on remaining $4,990)	$978 (20% coinsurance on remaining $4,890)	$928 (20% coinsurance on remaining $4,640)	$828 (20% coinsurance on remaining $4,140)	$490 (10% coinsurance on $4,900 for the surgery)	$1,452 (30% coinsurance on remaining $4,840)
Your total cost is...	**$1,148**	**$1,228**	**$1,428**	**$1,828**	**$530**	**$1,752**

Covered Medical Expenses

Following is a description of eligible expenses (listed alphabetically) that are covered under the Standard Medical Plans and the Point-of-Service Plan when *medically necessary*. Benefits for some of these eligible expenses vary depending on whether you are covered under the Standard Medical Plans or the Point-of-Service Plan. See page 45 for a list of items that are excluded from coverage.

If you are covered under the Point-of-Service Plan, your benefits also vary depending on whether you use *network* or out-of-network providers. The table on pages 30 - 35 compares how most services are covered.

Acupuncture: Under the Standard Medical Plans and out-of-network care under the Point-of-Service Plan, up to 10 treatments for each episode of an illness or injury are covered when performed by a Certified Acupuncturist. Additional, medically necessary treatments may be approved by the claims processor. Under the Point-of-Service Plan, treatment ordered by your *primary care physician* (*PCP*) and received from a network acupuncturist are covered without pre-determined limits.

Allergy Care: Charges for medically necessary *physician's* office visits, allergy testing, shots, and serum. See page 45 for excluded allergy care.

Ambulance: Professional ambulance services and air ambulance once per illness or injury to and from:

- The nearest *hospital* qualified to provide necessary treatment in the event of an *emergency*
- The nearest hospital or *convalescent or skilled nursing facility* for *inpatient* care
- A network hospital if you are covered under the Point-of-Service Plan and the network administrator authorizes the transfer.

Ambulance services are only covered in an emergency and only when care is required en route to or from the hospital.

Air ambulance services are covered when medically necessary services cannot be safely and adequately performed in a local facility and the patient's medical condition requires immediate medical attention for which ground ambulance services might compromise the patient's life.

Ancillary charges: *Ancillary charges* include charges for hospital services, supplies, and operating room use.

Anesthesia expenses: Anesthetics and administration of anesthetics. Expenses are not covered for an anesthesiologist to remain available when not directly attending to the care of a patient.

Assistant surgeon: The Standard Medical Plans and out-of-network care under the Point-of-Service Plan only cover assistant surgeon's fees when the procedure makes it medically necessary to have an assistant surgeon. To determine whether an assistant surgeon is considered medically necessary, use the pre-determination procedure described on page 48.

If you are using network providers in the Point-of-Service Plan, your PCP ensures that any medically necessary assistant surgeon's fees are authorized.

Blood: Coverage includes blood, blood plasma, and expanders. Benefits are paid only to the extent there is an actual expense to the participant.

Chiropractic care: Coverage includes medically necessary services of a *restorative or rehabilitative* nature provided by a chiropractor practicing within the scope of his or her license. Under the Point-of-Service Plan, you are limited to 20 visits per year for combined network and out-of-network *chiropractic care.* Additional visits are not covered. A referral from your PCP is not required for chiropractic care.

Convalescent or skilled nursing facilities: These facilities are covered at 50% of the most common semi-private room rate for inpatient hospital expenses for up to 60 days per illness (for the same or related causes) after you are discharged from the hospital for a covered inpatient hospital confinement of at least three consecutive days. To be eligible, the confinement in a convalescent or skilled nursing facility must begin within 15 days after release from the hospital and be recommended by your physician for the condition which caused the *hospitalization.*

Eligible expenses include room and board, as well as services and supplies (but not personal items) that are incurred while you are confined to a convalescent or skilled nursing facility, are under the continuous care of a physician, and require 24-hour nursing care. Your physician must certify that this confinement is an alternative to a hospital confinement and your stay must be approved by QuickReview or your network administrator. Your stay is not covered if it is for *custodial care.*

Cosmetic surgery: Medically necessary expenses for cosmetic surgery are only covered if they are incurred under either of the following conditions:

- As a result of a non-work related injury
- For replacement of diseased tissue surgically removed.

Other cosmetic surgery is not covered under this plan because it is not medically necessary.

Dental care: Dental expenses covered as medical care are limited to physician's services or x-ray examinations involving one or more teeth, the tissue around them, the alveolar process, or the gums only when the care is for:

- Accidental injuries to sound natural teeth caused by external means
- Services for treatment of fractures and dislocations of the jaw
- Cutting procedures of the mouth (other than extractions, dental implants, and repair or care of the teeth and gums).

Detoxification: *Detoxification* is covered as a medical condition when alcohol and drug addiction problems are sufficiently severe to require immediate inpatient medical and nursing care services. If you are covered under the Standard Medical Plans, contact QuickReview for authorization. If you are enrolled in the Point-of-Service Plan, you must request approval for detoxification from the network administrator within 48 hours of an emergency.

Dietician services: Under the Point-of-Service Plan, coverage includes services recommended by your PCP and provided by a licensed network dietician. Dietician services are not covered under the Standard Medical Plans or out-of-network under the Point-of-Service Plan.

Durable medical equipment (DME): Reimbursement for the rental of *DME* is limited to the maximum allowable equivalent of the purchase price. The plan may, at its option, approve the purchase of such items instead of rental.

Replacement of DME is covered only when medically necessary for a change in a patient's condition (improvement or deterioration) or the natural growth of a child. Replacement of DME resulting from normal wear and tear is not covered.

Coverage includes only the initial purchase of eye glasses or contact lenses required because of cataract surgery.

Emergency room: Charges for services and supplies provided by a hospital emergency room to treat medical emergencies. Under the Standard Medical Plans, you must call QuickReview within 48 hours of an emergency resulting in admission to the hospital. Under the Point-of-Service Plan, you must call your PCP or Member Services within 48 hours of an emergency.

Facility charges: Charges for the use of an *outpatient* surgical facility are covered when the facility is either an outpatient surgical center affiliated with a hospital or a *free-standing surgical facility*.

Hearing care: Covered expenses include medically necessary hearing exams and up to one hearing aid for each ear per year. Cochlear implants are covered if medically necessary.

Hemodialysis: Removal of certain elements from the blood through selective diffusion for treatment of kidney failure.

Home health care: *Home health care* is covered when your physician certifies that the visits are medically necessary for the care and treatment of a covered illness or injury. It is subject to review by the claims processor or network administrator, who requires the physician to provide an approved treatment plan before paying benefits, and may periodically review the plan.

Under the Standard Medical Plans, you should call QuickReview to be sure home health care is considered medically necessary. Custodial care is not covered.

Hospice care: *Hospice care* is covered by the Standard Medical Plans when approved by QuickReview. It is covered under the Point-of-Service Plan when approved by your network administrator. If not approved by your network administrator, it is covered at the out-of-network level. Expenses in connection with hospice care include both facility and outpatient care.

Benefits are payable for eligible medical expenses necessary for the care and treatment of a terminally ill plan participant if they are included in an approved written treatment plan and are provided by a hospice agency or hospice center.

Inpatient room and board expenses: Under the Standard Medical Plans, hospital room and board charges are covered at 80% up to the most common semi-private room rate plus $4.00. If the hospital does not have semi-private rooms, the plan considers the eligible expense to be 90% of the hospital's lowest private room rate plus $4.00. The Point-of-Service Plan pays based on the negotiated rates with that particular hospital.

Intensive care, coronary care, or special care units (including isolation units): Coverage includes room and board and medically necessary services and supplies.

Mammograms: Medically necessary diagnostic mammograms are covered regardless of age.

Coverage for routine mammograms under the Standard Medical Plans for female employees and dependents is based on the following guidelines:

- Once between ages 35 and 39 to serve as a baseline against which future mammograms will be compared
- Once every one to two years for women ages 40 to 49 as recommended by your physician
- Once every year for women age 50 and over.

Under the Point-of-Service Plan, mammograms are covered if ordered by your PCP or network obstetrician/gynecologist.

Medical supplies: Covered medical supplies include, but are not limited to:

- Oxygen, blood, and plasma
- Sterile items including sterile surgical trays, gloves, and dressings
- Needles and syringes
- Colostomy bags.

Non-sterile or disposable supplies such as band-aids and cotton swabs are not covered.

Newborn nursery care: Under the Standard Medical Plans and the Point-of-Service Plan, hospital expenses for a healthy newborn baby are considered under the baby's coverage, not the mother's.

Be sure to call the Employee Service Center to request a Life Event Change Form and enroll your baby in your medical plan within 60 days of birth. Payment of a maternity claim does not automatically enroll the baby.

Nursing care: Coverage includes medically necessary private duty care by a licensed *nurse* if it is of a type or nature not normally furnished by hospital floor nurses.

Oral surgery: Hospital charges in connection with oral surgery involving teeth, gums, or the alveolar process are covered only if it is medically necessary to perform oral surgery in a hospital setting rather than in a dentist's office. If medically necessary, the plan will pay room and board, anesthesia, and miscellaneous hospital charges. Oral surgeons' and dentists' fees are not covered under the medical plan. However, they may be covered under the dental plan (see page 65).

Outpatient surgery: Charges for services and supplies for a medically necessary surgical procedure performed on an outpatient basis at a hospital, free-standing surgical facility, or physician's office. If you are covered under the Standard Medical Plans, you should pre-authorize outpatient surgery through QuickReview to ensure the procedure is medically necessary. If you use a network physician under the Point-of-Service Plan, that physician will pre-authorize the surgery for you. With out-of-network providers, contact your network administrator for pre-authorization.

Physical or occupational therapy: Coverage includes medically necessary *restorative and rehabilitative care* by a licensed physical or occupational therapist when ordered by a physician (your PCP if you are enrolled in the Point-of-Service Plan).

Physician's services: Covered services include office visits and other medical care, treatment, surgical procedures, and post-operative care for medically necessary diagnosis or treatment of an illness or injury. Both the Standard Medical Plans and the Point-of-Service Plan cover office visits for certain preventive care, as explained on page 41.

Pregnancy: Charges in connection with pregnancy are covered only for female employees and spouses of male employees. Prenatal care and delivery are covered when provided by a physician or midwife who is registered, licensed, or certified by the state in which he or she practices.

Within the first 16 weeks of pregnancy, you should call to pre-authorize your hospitalization and take advantage of the healthy pregnancy program your plan offers. If you are covered by the Standard Medical Plans, pre-authorization is handled by QuickReview, as explained on page 50. If you are covered by the Point-of-Service Plan, your network provider will arrange pre-authorization. With out-of-network providers, contact your network administrator for pre-authorization.

Delivery may be in a hospital or birthing center. Birthing center charges are covered when the center is certified by the state department of health or other state regulatory authority. Prescription prenatal vitamin supplements are covered by all plans.

Federal law prohibits the plan from limiting your length of stay to less than 48 hours for a normal delivery or 96 hours for a cesarean delivery, or from requiring your provider to obtain pre-authorization for a longer stay.

Charges in connection with pregnancy for covered dependent children are covered only if due to certain complications of pregnancy, for example, ectopic pregnancy, hemorrhage, toxemia, placental detachment, and sepsis.

Prescription drugs: Medically necessary *prescription drugs* that are approved by the FDA for treatment of your condition are covered. See page 52 for details of the prescription drug program. Prescriptions related to *infertility treatment,* weight control, and oral contraceptives are not covered. See page 45 for additional exclusions.

Medications are also covered for the following special situations:

- Medications administered and entirely consumed in connection with care rendered in a physician's office are covered as part of the office visit.
- Medications which are to be taken by or administered while you are covered as a patient in a licensed hospital, extended care facility, convalescent hospital, or similar institution which operates an on-premises pharmacy are covered as part of the facility's ancillary charges.

Preventive care: The Point-of-Service Plan covers preventive care, including well-child care, immunizations, mammograms, pap smears, male cancer screenings, and annual routine physical exams for participants of all ages. Non-routine tests for certification, sports, or insurance are not covered unless medically necessary. Preventive care covered under the Standard Medical Plans and out-of-network care under the Point-of-Service Plan includes mammograms (see page 39 for guidelines), and well-child care for children up to age 2 (including initial hospitalization following birth, all immunizations, and up to seven well-child care visits).

Prostheses: Coverage includes prostheses (such as a leg, foot, arm, hand, or breast) necessary because of illness, injury, or surgery. Replacement of a prosthesis is only covered when medically necessary because of a change in the patient's condition (improvement or deterioration) or the natural growth of a child. Replacement of a prosthesis resulting from normal wear and tear is not covered.

Radiology (x-ray) and laboratory expenses: Covered services include examination and treatment by x-ray, radium, or other radioactive substances, diagnostic laboratory tests, and annual *mammography* screenings for women (see page 39 for guidelines). Please note that under the Point-of-Service Plan, your network coverage depends on whether the care is received in a hospital-based setting or a physician's office or laboratory facility. (See page 26 for details.)

Reconstructive surgery: Surgery following an illness or injury, including contralateral reconstruction to correct asymmetry of bilateral body parts, such as breasts or ears.

Secondary surgical procedures: Under the Standard Medical Plans and out-of-network Point-of-Service Plan, reimbursement for these procedures is at a reduced rate because surgical preparation fees are included in the fee for the primary surgery. To determine the amount of coverage under the Standard Medical Plans, and to be sure the charges are within the *usual and prevailing fee limits,* use the CheckFirst pre-determination program described on page 48. For out-of-network care under the Point-of-Service Plan, contact your plan administrator for pre-determination. Under the Point-of-Service Plan, your network provider will contact the plan administrator for you to ensure medically necessary procedures are authorized.

Speech therapy: Restorative and rehabilitative care and treatment for *loss or impairment of speech* are covered when the treatment is medically necessary because of an illness (other than a mental, psychoneurotic, or personality disorder), injury, or surgery. If the loss or impairment is caused by a congenital anomaly, surgery to correct the anomaly must have been performed before the therapy.

Surgery: Covered when medically necessary and performed in a hospital, free-standing surgical facility, or physician's office. If you are hospitalized for surgery, see page 50 for details about pre-authorization.

Temporomandibular joint dysfunction (TMJ): Eligible expenses under the medical plan include the following, if medically necessary:

- Injection of the joints
- Bone resection
- Application of splints, arch bars, or bite blocks if their only purpose is joint stabilization and not orthodontic correction of a malocclusion
- Manipulation or heat therapy.

Crowns, bridges, or orthodontic procedures are not covered for treatment of TMJ.

Transplants: Expenses for transplants or replacement of tissue or organs are covered if they are medically necessary and not *experimental services.* Benefits are payable for natural or artificial replacement materials or devices.

Donor and recipient coverage is as follows:

- If the donor and recipient are both covered under the plan, expenses for both individuals are covered by the plan.
- If the donor is not covered under the plan and the recipient is covered, the donor's expenses are covered to the extent they are not covered under any other medical plan, and only if they are submitted as part of the recipient's claim.
- If the donor is covered under the plan but the recipient is not covered under the plan, no expenses are covered for the donor or the recipient.

The total benefit paid under this plan for the donor's and recipient's expenses will not be more than any plan maximums applicable to the recipient.

If you are covered by the Standard Medical Plan or the Point-of-Service Plan, you may arrange to have the transplant at a network transplant facility rather than a local network hospital. Although using a network transplant facility is not required, these centers specialize in transplant surgery and may have the most experience, the leading techniques, and a highly qualified staff.

Under the Standard Medical Plans, you must contact QuickReview as soon as possible for pre-authorization before contemplating or undergoing a proposed transplant. If you are using out-of-network services under the Point-of-Service Plan, contact your network administrator.

Transportation expenses: Regularly scheduled commercial transportation by train or plane is covered when necessary for your emergency travel to and from the nearest hospital that can provide inpatient treatment not locally available. Only one round-trip ticket is covered for any illness or injury and will be covered only if medical attention is required en route. For information on ambulance services, see page 37.

Tubal ligation and vasectomy: These procedures are covered; however, reversal of these procedures is not covered.

Urgent care: Charges for services and supplies provided at an *urgent care* clinic. Under the Point-of-Service Plan, you must contact your PCP for authorization before seeking care at an urgent care clinic. If you are traveling and need urgent medical care, contact Member Services if you are enrolled in an Aetna U.S. Healthcare or United HealthCare network. If you are enrolled in a Prudential Healthcare network, call the Prudential Hotline (see page 134).

Well-child care: Under the Standard Medical Plans and out-of-network coverage under the Point-of-Service Plan, children up to age two are covered for initial hospitalization following birth, all immunizations, and up to seven well-child care visits. There is no age limitation when you use network providers under the Point-of-Service Plan.

Wigs and hairpieces: Active employees and eligible dependents are covered up to a $350 lifetime maximum for an initial synthetic wig or hairpiece, if purchased within six months of hair loss. The wig must be prescribed by a physician for a covered medical condition causing hair loss. These conditions include, but are not limited to: chemotherapy, radiation therapy, alopecia areata, endocrine disorders, metabolic disorders, cranial surgery, or severe burns. This benefit is subject to the usual and prevailing fee limits, deductibles, *copayments*, *coinsurance*, and out-of-pocket limits of your plan.

Replacement wigs or hairpieces are not covered, regardless of any change in the patient's physical condition. Hair transplants, styling, shampoo, and accessories are also excluded.

COVERED MENTAL HEALTH AND CHEMICAL DEPENDENCY CARE

In addition to covered medical expenses, the Standard Medical Plans and the Point-of-Service Plan cover certain medically necessary mental health and chemical dependency care. The following expenses are covered under the Standard Medical Plans and the Point-of-Service Plan for mental health and chemical dependency care.

Mental Health Care

Covered expenses include medically necessary inpatient care (in a *psychiatric hospital*, acute care hospital, or an *alternative mental health care center*) and outpatient care for a *mental health disorder*.

Under the Point-of-Service Plan, to receive network mental health care benefits, you or your covered dependent should call the toll-free number listed on your ID card for an authorization or referral. Your PCP may also refer you for mental health care.

Inpatient mental health care: When you are hospitalized in a psychiatric hospital for a mental health disorder, expenses during the period of hospitalization are covered the same as inpatient hospital expenses (see page 39), up to plan maximums.

If you are covered by the Point-of-Service Plan and use out-of-network providers for mental health care, your benefits are limited to 30 days of inpatient confinement per calendar year.

Alternative mental health care center: Treatment in an alternative mental health care center is covered at 50% under the Standard Medical Plans. Under the Point-of-Service Plan, such treatment is covered at 90% when using network providers, and at 50% when using out-of-network providers. A day of treatment is defined as not more than 8 hours in a 24-hour period. This may also be called alternative hospitalization.

Outpatient mental health care: Expenses for outpatient mental health care are covered at 50% under the Standard Medical Plans and out-of-network Point-of-Service Plan. Your 50% coinsurance for outpatient mental health care is not included in the annual out-of-pocket maximum. Out-of-network Point-of-Service Plan benefits for outpatient mental health care are limited to 60 visits per year. For network care under the Point-of-Service Plan, the copayment is $20 per visit.

Chemical Dependency Care

Chemical dependency rehabilitation: Covered chemical dependency rehabilitation expenses for treatment of drug or alcohol dependency can be inpatient, outpatient, or a combination. You are covered for one chemical dependency rehabilitation program during the entire time you are covered by the plan (regardless of whether the program is inpatient or outpatient). The plan does not cover expenses for a family member to accompany the patient being treated, although many treatment centers include family care at no additional cost.

To be eligible for reimbursement under the plan, the chemical dependency rehabilitation program must be approved in advance by the Employee Assistance Program *(EAP)* or the AMR Medical Department and be considered medically necessary. See page 64 for information on the EAP. You will not be reimbursed for treatment without this advance approval.

Detoxification: Chemical dependency rehabilitation does not include detoxification (although the EAP may arrange detoxification before rehabilitation). Detoxification is considered a medical procedure and is reimbursed under the plan's regular medical provisions. However, the following provisions apply:

- If you are covered by the Standard Medical Plans, you must call QuickReview for approval of detoxification.
- To receive the network benefit level under the Point-of-Service Plan, detoxification treatment must be approved by the network administrator within 48 hours of admission for detoxification.
- If you are covered by the Point-of-Service Plan and you do not receive network administrator approval for detoxification, it is covered at the out-of-network benefit level, even if you use a network facility.

Exclusions

No benefits are paid for expenses in connection with the following items (listed alphabetically):

Allergy testing: Excluded under the Standard Medical Plans is specific testing (called provocative neutralization testing or therapy) which involves injecting a patient with varying dilutions of the substance to which the patient may be allergic.

Alternative medicine: Charges for herbal, holistic, and homeopathic medicine are excluded from coverage.

Claim forms: The plan will not pay the cost for anyone to complete your claim form.

Cosmetic treatment: Excluded are the following:

- Medical treatments solely for cosmetic purposes (such as treatments for hair loss, acne scars, liposuction, and sclerotherapy for varicose veins or spider veins)
- Cosmetic surgery, unless required as a result of *accidental injury* or surgical removal of diseased tissue.

Counseling: All forms of marriage and family counseling are excluded from coverage.

Custodial care and custodial care items: Excluded are *custodial care* and items such as incontinence briefs, liners, diapers, and other items when used for custodial purposes, unless provided during an *inpatient* confinement in a *hospital* or *convalescent or skilled nursing facility.*

Developmental therapy for children: Excluded are charges for all types of *developmental therapy.*

Dietician services: Dietician services are not covered under the Standard Medical Plans or out-of-network under the Point-of-Service Plan. If you are enrolled in the Point-of-Service Plan, contact your *network* administrator to determine what services are covered.

Drugs: The following are excluded from coverage:

- Drugs, medicines, and supplies that do not require a *physician's* prescription and may be obtained *over-the-counter,* regardless of whether a physician has written a prescription for the item. (This exclusion does not apply to diabetic supplies, which are limited to insulin, needles, chem strips, lancets, and test tape.)
- Drugs which are not required to bear the legend "Caution - Federal Law Prohibits Dispensing Without Prescription"
- Covered drugs in excess of the quantity specified by the physician or any refill dispensed after one year from the physician's order
- Contraceptive drugs, patches, or implants when used for family planning or birth control. (Even though they are not covered, you may order these drugs through the mail service prescription program and receive a discount. See page 54.)
- Drugs requiring a prescription under state law, but not federal law
- Medications or products which promote general well-being such as vitamins or food supplements (except for prenatal vitamins, which are covered)
- Drugs prescribed for cosmetic purposes (such as Minoxidil)
- Medications used primarily for the purpose of weight control
- Infertility drugs
- Drugs labeled "Caution - Limited by Federal Law to Investigational Use," drugs not approved by the FDA, or *experimental* drugs, even though the individual is charged for such drugs
- Any and all medications not approved by the FDA as appropriate treatment for the specific diagnosis.

Educational testing or training: Testing or training that does not diagnose or treat a medical condition is not covered. For example, testing for learning disabilities is excluded.

Ecological and environmental medicine: Excluded are diagnosis, testing, treatment, and care.

Eye care: Eye exams, refractions, eye glasses or the fitting of eye glasses, radial keratotomy or surgeries to correct refractive errors, visual training, and vision therapy.

Experimental treatment: Medical treatment, procedures, drugs, devices, or supplies which are generally regarded as experimental or unproven, including, but not limited to:

- Treatment for Premenstrual Syndrome, Chronic Fatigue Syndrome, and Epstein-Barr Syndrome
- Hormone pellet insertion
- Plasmapheresis.

Foot care: Diagnosis and treatment of weak, strained, or flat feet including corrective shoes or devices or the cutting or removal of corns, calluses, or toenails. (This exclusion does not apply to the removal of nail roots.)

Free care or treatment: Excluded are care, treatment, services, or supplies for which payment is not legally required.

Government-paid care: Excluded are care, treatment, services, or supplies provided or paid by any governmental plan or law when the coverage is not restricted to the government's civilian employees and their dependents. (This exclusion does not apply to Medicare or Medicaid.)

Infertility treatment: Excluded are expenses or charges for *infertility treatment or testing* and charges for treatment or testing for hormonal imbalances which cause male or female infertility, regardless of the primary reason for hormonal therapy.

Items not covered include (but are not limited to) the following: medical services, supplies, procedures for or resulting in impregnation, including in-vitro fertilization, artificial insemination, embryo transfer, embryo freezing, gamete transfer, and reversal of tubal ligations or vasectomies. Drug therapy, such as treatment for ovarian dysfunction, and infertility drugs such as Clomid or Pergonal, are also excluded.

Only the initial tests are covered to diagnose systemic conditions such as infection or endocrine disease. Also, the repair of reproductive organs damaged by an accident or certain medical disorders are eligible for coverage.

Lenses: No lenses are covered except the first pair of *medically necessary* contact lenses following cataract surgery.

Massage therapy: Excluded are all forms of massage and soft-tissue therapy, regardless of who performs the service.

Medical necessity: Services and supplies considered not medically necessary are not covered.

Medical records: The plan does not cover charges for requests of medical records.

Missed appointments: If you incur a charge for missing an appointment, the plan will not pay any portion of the charge.

Nursing care: Excluded are the following:

- Care, treatment, services, or supplies received from a *nurse* which do not require the skill and training of a nurse
- Private duty nursing care which is not medically necessary, or if medical records establish that such care is within the scope of care normally furnished by hospital floor nurses
- Certified nurse's aides.

Organ donation: Expenses incurred as an organ donor when the recipient is not covered under the plan.

Pregnancy for dependents: Prenatal care and delivery charges are excluded for covered dependent children unless the charges are due to certain complications. Examples of covered complications include ectopic pregnancy, hemorrhage, toxemia, placental detachment, and sepsis.

Relatives: You are not covered for treatment by a medical practitioner (including, but not limited to: a nurse, physician, physiotherapist, or speech therapist) who is a close relative (spouse, child, brother, sister, parent, or grandparent of you or your spouse, including adopted and step relatives).

Sleep disorders: Treatment of sleep disorders is not covered unless it is considered medically necessary. If you are covered by the Standard Medical Plans, contact QuickReview. If you are covered under the Point-of-Service Plan, contact your network administrator to determine if treatment is covered.

Sex changes: Sex changes or transsexual and related operations are not covered.

Speech therapy: Expenses are not covered for losses or impairments caused by mental, psychoneurotic, or personality disorders or for conditions such as learning disabilities, developmental disorders, or progressive loss due to old age. Speech therapy of an educational nature is not covered.

TMJ: Except as described on page 42, diagnosis or treatment for temporomandibular joint (TMJ) disease or syndrome by a similar name, including adult orthodontia to treat TMJ, is not covered.

Transportation: Transportation by regularly scheduled airline, air ambulance, or train for more than one round trip per illness or injury. However, under certain circumstances, the plan may consider covering this transportation. If you are enrolled in the Standard Medical Plans, contact CheckFirst. Point-of-Service Plan participants should contact your network administrator for assistance.

Usual and prevailing: Any portion of fees for physicians, hospitals, and other providers that exceed the *usual and prevailing fee limits* are not covered by the plan.

War-related: Services or supplies are excluded when received as a result of a declared or undeclared act of war.

Weight reduction: Excluded are *hospitalization,* surgery, treatment, and medications for weight reduction other than for approved treatment of morbid obesity. If you are covered by the Standard Medical Plans, contact CheckFirst. If you are enrolled in the Point-of-Service Plan, contact your network administrator to determine if treatment is covered.

Wellness items: Items which promote well-being and are not medical in nature, and which are not specific for the illness or injury involved (such as massage therapy, dehumidifiers, air filtering systems, air conditioners, bicycles, exercise equipment, whirlpool spas, and health club memberships).

Also excluded are:

- Services or equipment intended to affect high levels of performance (primarily in sports-related activities), including strengthening and physical conditioning
- Services related to vocation, including but not limited to: physical exams, performance testing, and work hardening programs.

If you are covered under the Point-of-Service Plan, contact your network administrator to determine if your program covers a specific wellness item for a particular medical condition.

Work-related: Medical services and supplies for treatment of any work-related injury or illness sustained by you or your covered dependent, whether or not covered by Workers' Compensation, occupational disease law, or other similar law.

CheckFirst for Pre-determination of Benefits

If you are covered by the Standard Medical Plans or plan to use an out-of-network provider under the Point-of-Service Plan, CheckFirst allows you to find out if:

- The recommended service or treatment is covered by the plan.
- Your *physician's* proposed charges fall within the plan's *usual and prevailing fee limits.*

You do not need to use CheckFirst if you are covered by the Point-of-Service Plan or an *HMO* and you use *network* services arranged by your *primary care physician (PCP).* If you are covered by the Standard Medical Plans and are using a *PPO* provider, that provider's fees will always be within usual and prevailing fee limits, but you may want to contact CheckFirst to determine if the proposed services are covered under the plan.

For out-of-network care under the Point-of-Service Plan, call your network administrator for pre-determination.

To use CheckFirst under the Standard Medical Plans, you may either submit a CheckFirst Pre-determination Form to United HealthCare before your proposed treatment or call (800)638-9599 to receive pre-determination over the phone. If you choose to receive pre-determination of benefits over the phone, ask for written confirmation.

If you wish to submit a CheckFirst Pre-determination Form, request a form by calling United HealthCare or the Employee Service Center. Before calling or completing the form, you will need the following information from your physician:

- Diagnosis
- Clinical name of the procedure and the CPT code
- Description of the service
- Estimate of the charges
- Physician's name and office ZIP code
- Name and ZIP code of the *hospital* or clinic where surgery is scheduled.

Even if you use CheckFirst, the claims processor reserves the right to make adjustments upon receipt of your claim if the actual treatment or cost is different from the information you submitted for pre-determination.

For hospital stays, CheckFirst can pre-determine the amount payable by the plan, but you still need to call QuickReview for pre-authorization (see page 50). A CheckFirst pre-determination does not pre-authorize the length of a *hospital stay* or determine *medical necessity.*

For *outpatient* surgery only, United HealthCare will coordinate with Health International (HI) to determine the medical necessity of your proposed surgery before making a pre-determination of benefits. Both United HealthCare and HI will mail you a written response.

Although you may find CheckFirst beneficial whenever you need medical treatment, there are two circumstances when you may especially benefit by using CheckFirst. Use this pre-determination procedure if your physician recommends either of the following:

Assistant surgeon: A fee for an assistant surgeon is only covered when there is a demonstrated medical necessity. To determine if there is a medical necessity, you must use the CheckFirst procedure.

Multiple surgical procedures: If you are having multiple surgical procedures performed at the same time, the procedures that are not the primary reason for surgery are covered at a reduced reimbursement rate because surgical preparation fees are included in the fee for the primary surgery. You must use CheckFirst to find out how the plan reimburses the cost for the additional procedures.

QuickReview for Hospital Pre-authorization

If you are enrolled in the Standard Medical Plans, you are required to call QuickReview to request pre-authorization of any *hospital* admission, or within 48 hours (or the next business day) following *emergency* care. If you do not call QuickReview, your expenses are still subject to review and will not be covered under the plan if they are not considered medically necessary.

QuickReview is not required for *hospitalization* if you are covered by the Point-of-Service Plan or an *HMO* and your *primary care physician (PCP)* has arranged for your *network* hospitalization. However, if you are covered by the Point-of-Service Plan and wish to use an out-of-network provider, you must request pre-authorization by calling your network administrator.

QuickReview or your network administrator will tell you:

- Whether the proposed treatment is considered *medically necessary* and appropriate for your condition
- The number of approved days of hospitalization.

QuickReview does not determine whether you are eligible for benefits under the plan or how much you will be reimbursed. For information on eligibility or coverage, call CheckFirst, as explained on page 48.

Any portion of a stay that has not been approved is considered not medically necessary. The plan does not pay charges for any portion of a stay that is not medically necessary. For example, if QuickReview determines that five hospital days are medically necessary for your condition and you stay in the hospital seven days, charges for the extra two days will not be covered.

Under the Standard Medical Plans, QuickReview is administered by Health International (HI). For out-of-network care under the Point-of-Service Plan, it is administered by your network administrator.

You are required to call QuickReview in the following situations:

- Before you are admitted to the hospital for an illness, injury, surgical procedure, or pregnancy.
- Within 48 hours after an emergency hospital admission (or the next business day if you are admitted on a weekend).

It is also recommended that you call QuickReview:

- Before *outpatient* surgery to ensure that the surgery is considered medically necessary.
- During the first 16 weeks of pregnancy to participate in your medical plan's healthy pregnancy program.

If your *physician* recommends surgery or hospitalization:

- Ask your physician for the following information:
  - Diagnosis
  - Clinical name of the procedure and the CPT code
  - Description of the service
  - Estimate of the charges
  - Physician's name and telephone number
  - Name and telephone number of the hospital or clinic where surgery is scheduled.

- If you are enrolled in the Standard Medical Plans, call QuickReview at (800) 638-9599 as soon as possible, with the information provided by your physician. If you are enrolled in Point-of-Service and are using out-of-network services, call your network administrator (see page 134). Under both plans, in the event of an emergency hospital admission, call within 48 hours after the admission (or the next business day if you are admitted on a weekend).

- If your illness or injury prevents you from personally contacting QuickReview, any of the following may contact QuickReview for you:
  - A family member or friend
  - Your physician
  - The hospital.

- QuickReview authorizes the medically necessary length of your *hospital stay*. In some cases, they may refer you for a consultation before surgery or hospitalization is authorized. To avoid any delays in surgery or hospitalization, notify QuickReview as far in advance as possible.

- Be sure to write down the reference number given to you when you call. You will need that number if you call QuickReview back at a later time.

- If you receive pre-authorization of a hospital stay over the phone, ask for written confirmation of the pre-authorization.

After you are admitted to the hospital, the QuickReview program provides case management services to monitor your stay. If you are not discharged from the hospital within the authorized number of days, QuickReview consults with your physician and hospital to verify the need for any extension of your stay. Contact QuickReview again if you are discharged from the hospital and then readmitted or transferred to another hospital for treatment of the same illness.

If you are scheduled for *outpatient* surgery, you should also call QuickReview. If you do not call, you may be subject to a retrospective review of the surgery to determine whether it was medically necessary. This means you may be asked to provide medical documentation to support the *medical necessity* of your surgery before any claim will be paid.

QuickReview does not guarantee that benefits will be paid. The claims processor reserves the right to make adjustments upon receipt of the final claim papers if the actual service differs from the pre-authorization information you submitted.

Prescription Drug Benefits

Prescription drugs may either be purchased at retail pharmacies or through the mail service program. The Standard Medical Plans and the Point-of-Service Plan each offer retail prescription drug benefits; however, their programs are different. The optional mail service program is available to participants of the Standard Medical Plans and the Point-of-Service Plan.

For information on which drugs are covered, see page 41. For excluded drugs, see page 45. Prescription drug coverage under the HMOs is administered by the HMOs and is not described in this section (see page 60).

RETAIL DRUG PROGRAM FOR THE STANDARD MEDICAL PLANS

As a participant in the Standard Medical Plans, you may have your prescriptions filled at any pharmacy. However, if you present your PAID Prescriptions ID card at a *network* pharmacy, you will have access to negotiated discount prices at those pharmacies. PAID Prescriptions, administered by Merck-Medco, has over 51,000 network pharmacies throughout the United States, Puerto Rico, and the U.S. Virgin Islands. The network includes nine out of 10 retail pharmacies nationwide.

To request a list of participating pharmacy chains, call Merck-Medco Member Services at (800)988-4125.

When you fill your prescription at a network pharmacy, you pay the discounted price for the prescription. For most covered drugs, you are reimbursed at 80% of the discounted price after satisfying your *deductible*. So, you generally pay less for prescription drugs when you present your card at a network pharmacy.

Psychotherapeutic drugs for treatment of mental health or substance abuse are covered at 50% after your annual deductible and the cost is not applied toward your annual out-of-pocket maximum.

Filling Prescriptions

Follow these steps to fill prescriptions at a network pharmacy and file for reimbursement:

- Present your PAID Prescriptions ID card to the pharmacy when you order your prescription from a network pharmacy.
- Pay the discounted price for the prescription and obtain a receipt when you pick up your prescription.
- File a claim with PAID Prescriptions for reimbursement of your covered expenses, as explained on page 103.

If you fill your prescription at an out-of-network pharmacy, you will follow the same procedures, but will not receive a discount. You pay the full retail price for your prescription and file the claim in the same manner.

PAID Prescriptions reports the claim to United HealthCare (the claims processor for the Standard Medical Plans). United HealthCare then mails you an *explanation of benefits (EOB)* advising you of the total charges you submitted, any amounts not covered and the reason, and the amounts eligible and paid under the medical plan.

If you participate in the Health Care Reimbursement Account, your retail drug claim automatically rolls into your account for reimbursement of eligible amounts, unless you inform United HealthCare that you want to discontinue the automatic rollover feature. For further information on the Health Care Reimbursement Account, see page 96.

If you have questions concerning this program, call the Merck-Medco Member Services number on your PAID Prescriptions ID card.

Prior Authorization

To be eligible for benefits, certain prescriptions require *prior authorization* to determine *medical necessity* before you can obtain them at a participating pharmacy or through the mail service program. Medications requiring prior authorization include (but are not limited to) the following:

- Growth hormones
- Imitrex
- Contraceptives for medical conditions.

When you submit your prescription, the pharmacist will receive a message from Merck-Medco instructing him or her to call Merck-Medco.

A Merck-Medco pharmacist will then contact your *physician* to review the request for approval. Both you and your physician will be sent a letter about the authorization review. If authorization is approved, the system will automatically allow refills for the original approved time. When a renewal date for an authorization approaches, you will be sent a letter notifying you of the upcoming expiration with instructions on how to obtain a new authorization.

To request prior authorization, ask your physician to write a letter on his or her letterhead to Merck-Medco Member Services at the address on page 135 or call (800) 841-5345. Your physician should provide the following information:

- The name of the drug, strength, and supply being prescribed
- The medical condition for which the drug is being prescribed
- The proposed treatment plan
- Any other information your physician believes is pertinent.

Member Services will advise you whether prior authorization is approved or denied. If it is denied, they will explain the reason for denial.

RETAIL DRUG PROGRAM FOR THE POINT-OF-SERVICE PLAN

As a participant in the Point-of-Service Plan, you may have your prescriptions filled at any pharmacy. However, you receive greater benefits when you use your network's participating pharmacies. To request a network directory, call your network administrator.

When you use network pharmacies, you pay $5 for generic drugs or $10 for brand name drugs for up to a 30-day supply of any medically necessary prescription, including psychotherapeutics.

If you fill your prescription at an out-of-network pharmacy, eligible prescription drugs are covered at 70% after you satisfy your annual deductible, and you pay 30% *coinsurance.* Psychotherapeutic drugs for treatment of mental health or substance abuse are covered at 50% after your annual deductible and the cost is not applied toward your annual out-of-pocket maximum.

Filling Prescriptions

Follow these steps to fill prescriptions:

Network pharmacies:

- Present your Point-of-Service Plan ID card to the pharmacy.
- Pay the $5 or $10 *copayment* for the prescription and obtain a receipt when you pick up your prescription.
- There is no claim form to file for your prescription. However, if you also participate in the Health Care Reimbursement Account, your copayment for the prescription is eligible for reimbursement under the account. You must file a Health Care Reimbursement Account claim form (see page 107).

Out-of-network pharmacies:

- You must pay the full retail price of the prescription at the time you receive it.
- File a claim for reimbursement of eligible expenses. Complete an out-of-network claim form and attach the receipt for your prescription, as explained on page 103.
- If you elected to participate in the Health Care Reimbursement Account, you may file a claim for reimbursement of the part of your prescription that is not paid by the plan. For further information, see page 107.

MAIL SERVICE PRESCRIPTION DRUG PROGRAM

As a participant in the Standard Medical Plans or the Point-of-Service Plan, you and your covered dependents are eligible for the mail service program through Merck-Medco Rx Services. You may use the mail service program for prescription drugs you take on an ongoing basis to treat chronic medical conditions such as allergies, arthritis, diabetes, emphysema, heart disease, high blood pressure, thyroid disease, and ulcers. Injectible drugs which are FDA approved for self-administration may be purchased through the mail service program.

Under the mail service program, you may order up to a 90-day supply of your prescription drug (but no more than the number of days prescribed by your physician). You pay a minimum copayment (with no annual deductible) for each prescription or refill. *Copayments,* which are subject to change, are currently:

- $7 for generic drugs
- $15 for brand name drugs.

In two cases you pay a coinsurance amount instead of a copayment. You pay:

- 50% for psychotherapeutic drugs
- 100% for oral contraceptives.

A registered pharmacist fills your prescription. Generally, your order is shipped within three working days of receipt. All orders are sent by United Parcel Service (UPS) or first class mail. UPS delivers to rural route boxes but not to post office (P.O.) boxes. If you have only a P.O. box address, your order is sent by first class mail.

You may use the mail service program to fill prescriptions for treatment of mental health conditions. You pay 50% of the discounted rates for these drugs. If you are covered by the Point-of-Service Plan, you should compare the cost of a 90-day supply of psychotherapeutic drugs through the mail service program to the cost of three copayments for a 30-day supply from a retail pharmacy to determine which will cost you less.

You and your covered dependents may purchase oral contraceptives through the mail service program. Because these are not covered by the Medical Plan, you pay the full cost of the prescription. However, the mail service program offers a significant discount compared to retail prices.

Generic Drugs

Many drugs are available in generic form. Your prescription will be substituted with a generic when available and your physician considers it appropriate. A-rated generic drugs are used because they generally cost less and have the same therapeutic effect and composition as their brand equivalents. By using A-rated generic drugs, you save money for yourself and the company. If a brand name drug is not specified, your prescription will be filled with the generic.

Ordering Mail Service Prescriptions

Initial order: To place your first order for a prescription through the mail service program, follow these steps:

- Provide the information requested on the back of your mail service order envelope, and complete and enclose the patient profile. (The profile will not be necessary on refills or future orders unless your health changes significantly.)
- Insert the original written prescription signed by your physician.
- If the prescription is for a psychotherapeutic drug or oral contraceptive, call Merck-Medco Member Services to find out how much you must pay for the prescription.
- Indicate the desired method of payment on the mail service order envelope. You may charge your payment to a major credit card (MasterCard, VISA, or Discover) or pay by personal check or money order. If paying by check or money order, enclose your payment with the order. Do not send cash.
- Mail your order to the address on the order envelope.

Refills: To order refills, follow these steps:

- Place your refill order at least two weeks before your current supply runs out.
- Call Merck-Medco Member Services to request a refill. They will need your member ID number (employee Social Security number), current mailing address, and Merck-Medco Rx Services prescription number. If you prefer to order by mail, complete a mail service order envelope and attach your Merck-Medco refill prescription label to the form or write the prescription refill number on the envelope.

To request a mail service order envelope, call Merck-Medco Member Services at (800)988-4125 or the Employee Service Center at ICS or (817)967-1770 or (800)888-1696.

Internet Refill Option: The Internet gives you access to Merck-Medco 24 hours a day, seven days a week. Using Merck-Medco Online, you can order prescription drug refills, check on the status of your order, and request additional forms and envelopes.

To access Merck-Medco Online:

- Go to http://www.merck-medco.com
- Click on Member Services
- Select the service you would like to use:
  - refill your current prescription
  - check the status of your recent order
  - request mail service envelopes and claim forms
  - find the location of the pharmacy nearest you.

To refill a prescription online, you will simply need to supply your member number (Social Security number), and the prescription (Rx) numbers you want to refill. Verify your address on file and review your order. When you order online, you will receive a detailed summary of your order, including costs. Please allow up to 14 days for delivery of your prescription.

Medical Maximum Benefit

Merck-Medco Rx Services sends you a statement with each prescription they fill. The statement advises you of your copayment, and the amount the company paid. The amount the company paid is applied to your *medical maximum benefit* (as explained on page 28).

Reimbursement of Copayments

Your mail service copayments for prescription drugs are not eligible for reimbursement under the Standard Medical Plans or the Point-of-Service Plan. However, if you elected to participate in the Health Care Reimbursement Account, you may submit your copayment for reimbursement under your account. For information on filing for reimbursement under a Health Care Reimbursement Account, see page 107.

SHARE Program

The plan rewards you for finding and correcting errors on your medical and dental bills. This program is called Share Health Audit Results Effectively (SHARE). You will receive a reward of 50% of the amount of savings generated from your review of the bills for services received by you or your covered dependents. The maximum reward is $1,000 per claim. The SHARE program is available to participants of the Standard Medical Plans, the Point-of-Service Plan, and the Dental Plan, but not the HMOs.

If you review your *explanation of benefits (EOB)* from the claims processor and discover an overcharge or error, obtain a corrected bill from the provider. Send a copy of the original bill, the corrected bill, and your EOB to the Employee Service Center.

You must report any overcharges or errors within three months of final payment of the original claim. The bill must have been paid and the claims processor must have performed all audits before the overcharge can be considered under the SHARE program. After the company verifies that the bill has been corrected and the provider has issued a credit, the SHARE program pays you the reward.

The company sends you a confirmation letter notifying you of the reward. A copy is also sent to the payroll department to authorize your reward payment. The IRS considers the reward taxable compensation that is subject to payroll taxes. Taxes are withheld from the reward amount and the reward is reported as part of your income on the Form W-2 you receive from the company.

A reward is only paid if detection of the error actually results in a savings to the company. Also, you are not eligible for a reward if the claims processor, company, or service provider discovers the error or if the error was caused by the claims processor.

If the amount of the error or overcharge is $50 or less, no SHARE reward is paid because of the expense of re-processing the claim. AAchiever awards are given instead of cash.

The SHARE program is designed to reward the identification of errors or overcharges on medical and dental bills. The prices you see on your hospital or doctor bills may be significantly higher than the negotiated rates that are actually paid by your medical plan. A reduction in your bill as a result of negotiated discounts will occur automatically and is not eligible for a SHARE award.

Coordination of Benefits

If you or any covered dependents have primary coverage (explained later in this section) under any other group medical plan or other group dental plan, your medical and dental plans will coordinate benefits to avoid duplication of payment for the same expenses. The Benefits Plan for Flight Attendants will take into account all payments you have received under any other plan and will only supplement those payments up to the amount you would have received if it was your only coverage.

If your dependent is covered by another plan and the Point-of-Service Plan is his or her secondary coverage, the Point-of-Service Plan only pays up to the maximum benefit amount payable under the Point-of-Service Plan, and only after the primary plan (explained later in this section) has paid. The maximum benefits payable depend on whether *network* or out-of-network providers are used.

If you or a dependent is hospitalized before coverage begins, your prior coverage is responsible for medical services until you are released. If you have no prior coverage, this plan will only pay benefits for the portion of your stay occurring after you became eligible under this plan.

OTHER PLANS

The term "other group medical plan" or "other group dental plan" in this section includes any of the following:

- Employer-sponsored plans under which the employer pays all or part of the cost or takes payroll deductions, regardless of whether the plans are insured or self-funded
- Government or tax-supported programs, including Medicare or Medicaid
- Property or homeowner's insurance or no-fault motor vehicle coverage, except if the plan participant has purchased this coverage.

WHICH PLAN IS PRIMARY

When a person is covered by more than one plan, one plan is the primary plan and all other plans are considered secondary plans. The primary plan pays benefits first and without consideration of any other plan. The secondary plans then determine whether any additional benefits will be paid after the primary plan has paid. Proof of other coverage will be required from time to time.

The following determines which plan is primary:

- Any plan that does not have a coordination of benefits provision is automatically the primary plan.
- A plan that has a coordination of benefits provision is the primary plan if it covers the individual as an employee.
- A plan that has a coordination of benefits provision is the secondary plan if it covers the individual as a dependent or as a laid-off or retired employee.

- Any benefits payable under this plan and Medicare are made according to federal regulations. In case of a conflict between plan provisions and federal law, federal law prevails.

- If the coordination of benefits is on behalf of a covered child:
  - For a natural child or adopted child, the plan of the parent whose birthday occurs earlier in the calendar year pays before the plan of the parent whose birthday occurs later in the year, regardless of the parents' ages. If the parents have the same birthday, the plan that has been in effect the longest is the primary plan and pays benefits before the other plan. If the parents are divorced, these rules still apply, unless the divorce decree specifies otherwise (see QMCSO on page 12).
  - For a stepchild or *special dependent*, the plan of the parent whose birthday occurs earlier in the calendar year pays before the plan of the parent whose birthday occurs later in the year, regardless of the parents' ages. If the parents are divorced, the plan of the parent with custody is primary unless the divorce decree specifies otherwise (see QMCSO on page 12).

Health Maintenance Organizations (HMOs)

In many locations you may elect an *HMO* instead of the Standard Medical Plans or the Point-of-Service Plan. HMOs are insured programs whose covered services are paid by the HMO. HMOs are offered in many locations, but the plans offered vary by location. You are eligible for HMOs based on your home ZIP code. If you live in an area that offers one or more HMOs, the names of those HMOs appear as options on your annual enrollment form.

HMOs include a *network* of *physicians*, hospitals, and other medical service providers. Your medical care is only covered when you use network providers. When you enroll in an HMO, a *primary care physician (PCP)* usually coordinates your medical care. Most HMOs require you to obtain a referral from your PCP before receiving care from a specialist.

Advantages of HMOs include:

- A network of providers when you need health care
- A primary care physician who coordinates your covered medical care
- Low *copayments* for covered services provided by network providers
- Covered preventive care from network providers
- No claims to file.

If you elect an HMO, your HMO coverage replaces medical coverage offered through the Standard Medical Plans or the Point-of-Service Plan. Your benefits, including *prescription drugs* and mental health care, are covered according to the rules of the HMO you select.

Under most HMOs, chemical dependency rehabilitation for HMO participants will be coordinated by the Employee Assistance Program *(EAP)*, and will be covered as described for the Standard Medical Plans on page 44. However, some HMOs provide their own chemical dependency rehabilitation programs to comply with state insurance laws. *Detoxification* is covered under the HMO.

HMOs provide their members with comprehensive health care services for a fixed monthly payment. HMOs are completely independent of the company. Because each HMO is an independent organization, the benefits, restrictions, and conditions of coverage vary from one HMO to another and the company cannot influence or dictate the coverage provided.

BENEFITS

If you enroll in an HMO, you will receive information from the HMO describing the services and exclusions of that HMO. Review that material carefully. Benefits provided by the HMO may differ from benefits provided under the other medical plans offered by the company.

PROBLEMS AND COMPLAINTS

Each HMO has a grievance procedure or policy to appeal claims or other issues involving the HMO. Consult your HMO information or call your HMO representative for information on filing complaints or grievances.

IF YOU AND YOUR SPOUSE WORK FOR THE COMPANY

If you and your spouse enroll in the same HMO, the entire family unit is covered in the male employee's name because of HMO administrative procedures.

CHILDREN LIVING OUTSIDE THE SERVICE AREA

If your child does not live with you, either because the child is a student or because you are providing the child's coverage under a Qualified Medical Child Support Order (QMCSO), you must contact the HMO to find out whether the child can be covered. If the HMO cannot cover the child, you should select one of the Standard Medical Plans or the Point-of-Service Plan. If you select the Point-of-Service Plan, the child will receive out-of-network benefits unless he or she selects a PCP and receives medical services in your area.

TERMINATION OF COVERAGE

Your HMO coverage terminates on the date your employment terminates or you move out of the HMO service area. If your employment terminates, you may be eligible to have your HMO coverage continue under COBRA. You may also apply for individual HMO coverage.

Following is special information about termination of coverage that applies to HMOs:

Leaving the service area: With the exception of the annual enrollment period, the only other time you may change your election for HMO coverage is if you move out of the HMO's service area.

If you move out of your HMO's service area, you may enroll in another HMO or the Point-of-Service Plan (if available) or select one of the Standard Medical Plans. You must notify the Employee Service Center and make another election within 60 days of your move. If the Employee Service Center does not receive your election, you will be enrolled in another medical plan and will receive a confirmation statement indicating your new coverage.

Active employees over age 65: If you or your covered spouse reaches age 65 and becomes eligible for Medicare while covered under an HMO, most HMOs allow you to continue coverage. Coordination of benefits applies. The HMO is primary and Medicare is secondary (as explained on page 58) as long as you are an active employee. You are encouraged to enroll in Medicare Parts A and B to maximize your protection.

Retirement: If you retire while covered by an HMO, your coverage is transferred to the Retiree Medical Plan coverage if you are eligible. HMO membership is not currently available to retirees through the company.

Wellness Programs

The company offers a number of prevention programs designed to help your overall health and well-being. The AMR Medical Department coordinates these programs.

Some of these programs may require a separate fee which may or may not be covered by the Medical Plan you have selected. Many may also be eligible for reimbursement under a Health Care Reimbursement Account. Programs and schedules vary by location, and can be accessed in SABRE at N*PREVENTION TAKES FLIGHT or through your local AMR Medical Department.

Prenatal education: This program offers a $100 savings bond to expectant parents who complete an educational program and pre-authorize their *hospital stay* during the first trimester. The program's goal is to reduce premature births and health care costs. Classes are free. Look for more information in SABRE at N*PRENATAL INFORMATION. Please contact your local AMR Medical Department for prenatal class schedules and program eligibility rules.

Susan G. Komen Breast Health Awareness Program & mammography: This program provides instruction on breast self-examination and guidelines for detecting breast cancer at an early and treatable phase. Mobile *mammography* units are scheduled at various locations during the year.

Male health screening: This program provides worksite cancer screenings, including physical exams, blood pressure checks, cholesterol testing, and the PSA blood test. Employees and spouses are eligible to participate. See N*PREVENTION TAKES FLIGHT for further information.

Other health screenings: The cholesterol program includes screening for cholesterol, triglyceride levels, and HDL/LDL ratios, as well as educational materials explaining the different levels. It includes prevention tips to improve your health. Diabetes and glaucoma screening programs are also available.

Stress management: These brown bag seminars emphasize strategies and techniques for dealing with stress at home and in the workplace.

HIV/AIDS awareness: This program is designed to provide education, alleviate fears, and promote understanding of the disease. A segment of the class includes a video narrated by a former Pan Am flight attendant which provides stirring and compelling personal insight into the life of a person with AIDS. The video is available only upon request. Please contact your local AMR Medical Department for further information.

Immunizations: You can obtain immunizations from your local AMR Medical Department before you travel. Available immunizations include Larium tablets, Hepatitis A or B vaccines, Typhoid vaccines, Yellow Fever vaccines, and Tetanus vaccines. Flu shots are available in October, November, and December. The AMR Medical Department can also provide travel advisory information from the federal government's Centers for Disease Control and Prevention (CDC).

Smoking cessation: Although treatment isn't covered under the Medical Plan, this program reimburses you for 100% of the cost of the treatment, up to $350, including medication for smoking cessation (such as Nicoderm, Habitrol, and Nicorette gum) subject to the limitations listed on the next page.

- You and your eligible dependents are each covered for only one smoking cessation treatment during the entire time you are employed by the company. You may choose a combination of prescription medication and other treatments. The Employee Assistance Program *(EAP)* can provide more information about smoking cessation programs. Contact your local EAP office.
- You or your eligible dependent remains smoke-free for six months from the date treatment ends. Smoke-free means you don't use one cigarette, pipe, cigar, or other tobacco product.
- You and your eligible dependents may choose the Merck-Medco Smoking Cessation Patient Support Program. To enroll in the program, call 1-800-SMOK-FREE (1-800-766-5373).

The Employee Service Center administers the smoking cessation program. When you file your claim for reimbursement, you must include a statement that you (or your eligible dependent who received treatment) have remained smoke-free for six months following completion of the medication or program.

You file claims for smoking cessation directly with the company. To request a claim form, call the Employee Service Center.

Traveler kits: The AMR Medical Department has domestic and international traveler kits available at all medical hub locations. These packaged ready-to-go kits contain 23 items to help protect the health and safety of travelers. Contact your local AMR Medical Department for more information.

Osteoporosis screening: When detected early, osteoporosis is a treatable, preventable disease. The AMR Medical Department offers this vital screening to women over age 35, including employees, spouses, retirees, parents of employees, and covered adult females with a family history of osteoporosis, regardless of age.

Body fat testing: This service, brought to you by the AMR Medical Department, is available at CP4 Medical and ORD Medical. It includes an in-depth analysis of your current body fat composition and identifies what you can do to modify exercise and diet programs to improve your overall body fat composition.

Other medical services: The AMR Medical Department also offers allergy shots, blood pressure checks, chemistry profiles, FAA exams, Laerdal masks, lithium levels, prostate screenings, pulmonary function tests, and retirement physicals.

EXHIBIT B

The U.S. Equal Employment Opportunity Commission

The following Commission Decision finds reasonable cause to believe that discrimination occured under Title VII of the Civil Rights Act of 1964, as amended, in two charges challenging the exclusion of prescription contraceptives from a health insurance plan. The Decision is a formal statement of Commission policy as applied to the facts at issue in these charges.

Decision

Summary of Charge

The Charging Parties, female employees of Respondents, allege that Respondents have engaged in an unlawful employment practice in violation of Title VII of the Civil Rights Act of 1964, as amended, 42 U.S.C. 2000e *et seq.* (Title VII). Specifically, Charging Parties challenge Respondents' failure to offer insurance coverage for the cost of prescription contraceptive drugs and devices.

Jurisdiction

Respondents are employers within the meaning of Section 701(b) of the Act. All other jurisdictional requirements have also been met.

Summary of Investigation

Charging Party A, a registered nurse, began working for Respondent A in 1997. Under its health insurance plan, Respondent A covers numerous medical treatments and services, including prescription drugs; vaccinations; preventive medical care for children and adults, including pap smears and routine mammograms for women; and preventive dental care. Respondent A also covers the cost of surgical means of contraception, namely vasectomies and tubal ligations. However, Respondent A's plan excludes coverage for prescription contraceptive drugs and devices, whether they are used for birth control or for other medical purposes.

Charging Party A wishes to use oral contraceptives for birth control purposes. Based on her medical history, Charging Party A also wishes to use oral contraceptives to alleviate the symptoms of dysmenorrhea and pre-menstrual syndrome and to prevent the development of ovarian cancer.

Charging Party B, a registered nurse, began her employment with Respondent B on May 1, 1999. Respondent B is commonly owned with Respondent A, and offers to its employees the same health insurance policy that Respondent A offers to its employees. As a result, Charging Party B is subject to the same exclusions from health coverage as Charging Party A. Charging Party B wishes to use Depo Provera, an injectible prescription contraceptive, for birth control purposes.

Charging Parties both allege that Respondents' failure to offer coverage for prescription contraceptive drugs and devices constitutes discrimination on the bases of sex and pregnancy in violation of Title VII. Respondents deny that the exclusion of prescription contraceptives, which on its face does not distinguish between men and women, is discriminatory.

Discussion

Based on current medical knowledge, individuals who wish to avoid conception may choose from a range of contraceptive alternatives. These alternatives include surgical procedures, like vasectomies and tubal ligations; non-prescription birth control, like condoms; and prescription contraceptive drugs and devices, like birth control pills, diaphragms, intra-uterine devices, and Norplant implants. Prescription contraceptives are available only to women.

Oral contraceptives are also widely recognized as effective in treating certain medical conditions that

exclusively affect women, such as dysmenorrhea (menstrual cramps) and pre-menstrual syndrome.(1) Contraceptives are also sometimes prescribed to prevent the development of ovarian cancer. Respondents' insurance plan excludes contraceptives "regardless of intended use."(2)

The Commission concludes that Respondents' exclusion of prescription contraceptives violates Title VII, as amended by the Pregnancy Discrimination Act,(3) whether the contraceptives are used for birth control or for other medical purposes.

I. Exclusion of Prescription Contraceptives Used for Birth Control Purposes

A. The Pregnancy Discrimination Act Applies to Prescription Contraception

To clarify its long-standing intent with regard to Title VII, Congress enacted the Pregnancy Discrimination Act (PDA) to explicitly require equal treatment of women "affected by pregnancy, childbirth, or related medical conditions" in all aspects of employment, including the receipt of fringe benefits.(4) This language bars employers from treating women who are pregnant or affected by related medical conditions differently from others who are similarly able or unable to work. It also prohibits employers from singling out pregnancy or related medical conditions in their benefit plans.

As the Supreme Court has made clear, the PDA's prohibitions cover a woman's potential for pregnancy, as well as pregnancy itself. Recognizing that the PDA prohibits "discrimination on the basis of a woman's ability to become pregnant," the Court concluded that an employment policy that excluded women capable of bearing children from certain jobs was an impermissible classification because it was based on the potential for pregnancy. As the Court held, "[u]nder the PDA, such a classification must be regarded, for Title VII purposes, in the same light as explicit sex discrimination."(5) Under the Court's analysis, the fact that it is women, rather than men, who have the ability to become pregnant cannot be used to penalize them in any way, including in the terms and conditions of their employment.

Contraception is a means by which a woman controls her ability to become pregnant. The PDA's prohibition on discrimination against women based on their ability to become pregnant thus necessarily includes a prohibition on discrimination related to a woman's use of contraceptives. Under the PDA, for example, Respondents could not discharge an employee from her job because she uses contraceptives. So, too, Respondents may not discriminate in their health insurance plan by denying benefits for prescription contraceptives when they provide benefits for comparable drugs and devices.

This conclusion is supported by additional language in the PDA that specifically exempts employers from any obligation to offer health benefits for abortion in most circumstances.(6) Congress understood that absent an explicit exemption, the PDA would require coverage of medical expenses resulting from a woman's decision to terminate a pregnancy.

The same analysis applies to the question of whether the PDA covers prescription contraceptives. As just discussed, the PDA's prohibition of discrimination in connection with a woman's ability to become pregnant necessarily includes the denial of benefits for contraception. Had Congress meant to limit the applicability of the PDA to contraception, therefore, it would have enacted a statutory exemption similar to the abortion exemption. Such an exemption, of course, does not exist for contraceptives.

Further, construing the PDA to cover contraception implements Congress' clearly expressed intent in enacting the PDA. Congress wanted to equalize employment opportunities for men and women, and to address discrimination against female employees that was based on assumptions that they would become pregnant.(7) Congress thus prohibited discrimination against women based on "the whole range of matters concerning the childbearing process,"(8) and gave women "the right ... to be financially and legally protected before, during, and after [their] pregnancies."(9) It was only by extending such protection that Congress could ensure that women would not be disadvantaged in the workplace either because of their pregnancies or because of their ability to bear children.

In sum, the Commission concludes that the PDA covers contraception based on its plain language,

the Supreme Court's interpretation of the statute, and Congress' clearly expressed legislative intent.

B. The PDA Requires Coverage of Prescription Contraceptives in this Case

The PDA requires that expenses related to pregnancy, childbirth, or related medical conditions be treated the same as expenses related to other medical conditions.(10) Because Respondents have failed to provide such equal treatment in this case, they are liable for discrimination under the PDA.

Contraception is a means to prevent, and to control the timing of, the medical condition of pregnancy. In evaluating whether Respondents have provided equal insurance coverage for prescription contraceptives, therefore, the Commission looks to Respondents' coverage of other prescription drugs and devices, or other types of services, that are used to prevent the occurrence of other medical conditions. In Respondents' plan, such drugs, devices, and services include:

- vaccinations;
- drugs to prevent development of medical conditions, such as those to lower or maintain blood pressure or cholesterol levels;
- anorectics (weight loss drugs) for those 18 years of age and under;
- preventive care for children and adults, including physical examinations; laboratory services in connection with such examinations; x-rays; and other screening tests, like pap smears and routine mammograms; and
- preventive dental care (including oral examinations, tooth cleaning, bite wing x-rays, and fluoride treatments).(11)

Respondents have made three arguments to justify their exclusion. First, Respondents allege that their plan covers treatment of medical conditions only if "there is something abnormal about [the employee's] mental or physical health,"(12) and thus that the above-listed drugs and services are not appropriate comparators for evaluating Respondents' coverage of contraceptives. However, this argument reflects a misunderstanding about the nature of pregnancy. It is widely recognized in the medical community that pregnancy is a medical condition that poses risks to, and consequences for, a woman.(13)

In addition, Respondents' argument is also belied by the explicit terms of their health plan, which is not, in fact, restricted to coverage of "abnormal" conditions. First, Respondents cover contraception through surgical forms of sterilization - vasectomies and tubal ligations -- without requiring any showing of the reasons individuals are undergoing the procedures. More broadly, Respondents cover numerous treatments and services that are designed to maintain current health and prevent the occurrence of future medical conditions, whether or not there is something "abnormal" about the employee's current health status. It is appropriate, for example, to compare Respondents' coverage of vaccinations or physical examinations to that of contraceptives, because both serve the same preventive purposes. Because Respondents have treated contraception differently from preventive treatments and services for other medical conditions, they have discriminated on the basis of pregnancy.(14)

Respondents also claim that Charging Parties' claims are preempted by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1144(a), 1191.(15) This claim is without merit. ERISA preempts certain *state* laws that regulate insurance, but explicitly exempts federal law from preemption.(16) Moreover, the fact that ERISA does not require health plans to "provide specific benefits" does not mean that other statutes - namely Title VII - do not impose such requirements where necessary to avoid or correct discrimination.

Finally, Respondents state that they have excluded contraception for "strictly financial reasons."(17) Respondents' motivation is, however, legally irrelevant. Although Congress clearly anticipated that an employer's insurance costs would likely increase once the PDA required employers to cover pregnancy and related medical conditions,(18) it wrote no cost defense into the law.(19)

II. Exclusion of Prescription Contraceptives Used for Birth Control and/or Other Medical Purposes

The analysis set forth above applies to Charging Parties' claims that Respondents' exclusion unlawfully interferes with their ability to use prescription contraceptives for birth control purposes. Charging Party A has further claimed that Respondents' exclusion applies not only to her use of contraceptives for birth control purposes, but also to her use of contraceptives to treat dysmenorrhea and menstrual cramps. Respondents have violated Title VII's basic nondiscrimination principles regardless of the purpose of Charging Parties' use of contraceptives.

Respondents assert that their exclusion does not constitute sex discrimination because it does not explicitly distinguish between men and women.(20) However, prescription contraceptives are available *only* for women. As a result, Respondents' explicit refusal to offer insurance coverage for them is, by definition, a sex-based exclusion. Because 100 percent of the people affected by Respondent's policy are members of the same protected group - here, women -- Respondent's policy need not specifically refer to that group in order to be facially discriminatory.(21)

Moreover, Respondents' other efforts to mount a defense are unavailing. Respondents may not rely on arguments that coverage of contraception is precluded by ERISA or may be denied based on cost concerns. Nor can Respondents successfully argue that contraception is not medically necessary, whether used for birth control or other medical purposes. *See* Section I(B), *supra*.

The inequality in treatment is apparent whether Charging Parties wish to use contraceptives to prevent conception or for other medical purposes. This is because Respondents have circumscribed the treatment options available to women, but not to men. Respondents' health plan effectively covers approved, non-experimental treatments for employees' medical conditions *unless* those treatments involve contraceptives. This is unlawful.(22)

Conclusion

There is reasonable cause to believe that Respondents have engaged in an unlawful employment practice in violation of Title VII of the Civil Rights Act of 1964, as amended by the Pregnancy Discrimination Act, by failing to offer insurance coverage for the cost of prescription contraceptive drugs and devices. Charging Parties are entitled to reimbursement of the costs of their prescription contraceptives for the applicable back pay period. In addition, the District Office is instructed to determine whether any cognizable damages have resulted from Respondents' actions.

In order to avoid violating Title VII in the future:

- Respondents must cover the expenses of prescription contraceptives to the same extent, and on the same terms, that they cover the expenses of the types of drugs, devices, and preventive care identified above. Respondents must also offer the same coverage for contraception-related outpatient services as are offered for other outpatient services. Where a woman visits her doctor to obtain a prescription for contraceptives, she must be afforded the same coverage that would apply if she, or any other employee, had consulted a doctor for other preventive or health maintenance services. Where, on the other hand, Respondents limit coverage of comparable drugs or services (*e.g.,* by imposing maximum payable benefits), those limits may be applied to contraception as well.

- Respondents' coverage must extend to the full range of prescription contraceptive choices. Because the health needs of women may change -- and because different women may need different prescription contraceptives at different times in their lives -- Respondents must cover each of the available options for prescription contraception. Moreover, Respondents must include such coverage in each of the health plan choices that it offers to its employees. *See* 29 C.F.R. part 1604, App. Q&A 24; *Arizona Governing Committee v. Norris*, 463 U.S. 1073, 1081-82 n.10 (1983).

The charges are remanded to the field for further processing in accordance with this decision.

FOR THE COMMISSION:

12/14/00
Date

/s/
Executive Officer
Executive Secretariat

1. *See, e.g.*, Kaunitz, *Oral Contraceptive Health Benefits: Perception v. Reality*, Contraception 1999, 59:29S-33S (January 1999); Sulak, *Oral Contraceptives: Therapeutic Uses and Quality -of-Life Benefits - Case Presentations*, Contraception 1999, 59:35S-38S (January 1999).

2. Letter from Respondents to EEOC, June 22, 2000.

3. Numerous states have also addressed policies like Respondents'. To date, thirteen states have passed legislation mandating insurance coverage of contraception where a policy covers prescription drugs or devices. *See* Cal. Ins. Code 10123.196 (California); Del. Code Ann., title 18, 3559 (Delaware); 1999 Conn. Acts 99-79 (June 3, 1999) (Connecticut); Ga. Code Ann. 33-24-59.6 (Georgia); Hawaii Rev. Stat. 431:10A-116.6, 431:10A-116.7, 432:1-604.5 (Hawaii); Iowa Code 514C.19; Me. Rev. Stat. Ann., title 24, 2332-J, Me. Rev. Stat. Ann., title 24-A, 2756, 2847-G, 4247 (Maine); Md. Code Ann., Ins., 15-826 (Maryland); Nev. Rev. Stat. Ann. 689A.0415 *et seq.* (Nevada); N.H. Rev. Stat. Ann., title 37, 415:18-i (New Hampshire); 1999 N.C. Sess. Laws 90 (June 30, 1999) (North Carolina); R.I. Gen. Laws 27-18-57, 27-19-48, 27-20-43, 27-41-59 (Rhode Island); 8 Vt. Stat. Ann. 4099c (Vermont). Insurance plans offered to federal employees must meet similar requirements. P.L. 106-58, 113 Stat. 430 (Sept. 29, 1999).

4. 42 U.S.C. 2000e(k).

5. *Int'l Union, UAW v. Johnson Controls*, 499 U.S. 187, 199, 211 (1991).

6. 42 U.S.C. 2000e(k).

7. H.R. Rep. No. 948, 95th Cong., 2d Sess. 3 (1978) ("[t]he assumption that women will become pregnant and leave the labor force leads to the view of women as marginal workers, and is at the root of the discriminatory practices which keep women in low-paying and dead-end jobs"); *see also id.* at 6-7; 123 Cong. Rec. 29,385 (1977) (statement of Senator Williams, chief sponsor of the Senate bill that led to the PDA) ("[b]ecause of their capacity to become pregnant, women have been viewed as marginal workers not deserving of the full benefits of compensation and advancement . . .").

8. H.R. Rep. No. 948, 95th Cong., 2d Sess. 5 (1978).

9. 124 Cong. Rec. H38,574 (daily ed. October 14, 1978) (statement of Rep. Sarasin, a manager of the House version of the PDA).

10. *See, e.g.*, 29 C.F.R. Part 1604, App. Introduction ("any health insurance provided must cover expenses for pregnancy-related conditions on the same basis as expenses for other medical conditions").

11. *See* Respondents' Summary Plan Description at, *e.g.*, pp. 87, 90, 112, 137.

12. Letter from Respondents to EEOC, June 22, 2000.

13. *See, e.g., Equity in Prescription Insurance and Contraceptive Coverage Act 1998: Hearings on S. 766 before the Senate Committee on Labor and Human Resources*, 105th Cong., 2d Sess. 25 (1998) (statement of Richard H. Schwarz, M.D.); 144 Cong. Rec. S9,194 (daily ed. July 29, 1998) (statement of Senator Snowe) (there is "nothing 'optional' about contraception. It is a medical necessity for women during 30 years of their lifespan. To ignore the health benefits of contraception is to say that the alternative of 12 to 15 pregnancies during a woman's lifetime is medically acceptable.") (quoting statement by American College of Obstetricians and Gynecologists).

14. In addition, Respondents cover Viagra where patients complain about "decreased sexual interest or energy," whether or not the individual has been diagnosed as impotent. Letter from Respondents

to EEOC, August 25, 2000. Respondents' assertion that their plan covers treatments only for abnormal medical conditions is not credible in light of these facts.

15. Letter from Respondents to EEOC, June 22, 2000.

16. 29 U.S.C. 1144(a) (setting forth basic rule of preemption of state law); 1144(d) ("[n]othing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States . . . or any rule or regulation issued under any such law"); *see also Shaw v. Delta Airlines*, 463 U.S. 85 (1983) (state laws that are co-extensive with federal laws are not preempted by ERISA).

17. Letter from Respondents to EEOC, April 19, 2000.

18. *See, e.g.*, Statement of Senator Williams, floor manager of the PDA, *reprinted in* "Legislative History of the Pregnancy Discrimination Act of 1978," at 63, 64 (1980) (identifying "significant cost factor[s]" that would be incurred by employers, but noting that "the committee found that the cost of equal treatment of pregnancy has been greatly exaggerated"); H. Rep. No. 95-948, 95th Cong., 2d Sess. 10 (1978) (discussing anticipated costs of complying with PDA). In any event, the costs of contraception are low. *See* Alan Guttmacher Institute, *Cost to Employer Health Plans of Covering Contraceptives* (June 1998) (estimating that average added cost to employers of covering contraceptives is $1.43 per employee per month). Moreover, studies -- and common sense -- show that the financial costs associated with childbirth are much greater than the costs of many years of contraception. *See* Law, *Sex Discrimination and Insurance for Contraception*, 73 Wash. L. Rev. 363, 365 & n. 13 (1998) (citing studies). Even if a cost defense were available as a matter of law, therefore, Respondents would be unlikely to be able to cost-justify the exclusion of contraceptives.

19. *See Arizona Governing Committee v. Norris*, 463 U.S. 1073, 1085 n. 14 (1983) (in enacting the PDA, Congress decided "to forbid special treatment of pregnancy despite the special costs associated therewith . . ."); *Newport News Shipbuilding and Dry Dock Co. v. EEOC*, 462 U.S. 669, 683 n. 26 (1983) ("no [cost] justification is recognized under Title VII once discrimination has been shown").

20. Letter from Respondents to EEOC, June 22, 2000.

21. This is the rationale that was set forth by the dissenters in *General Electric Co. v. Gilbert*, 429 U.S. 125 (1976), and adopted by Congress in passing the PDA. *See Gilbert*, 429 U.S. at 149 (Brennan, J., dissenting) ("it offends common sense to suggest that a classification revolving around pregnancy is not, at the minimum, strongly 'sex related'"); *id.* at 162 (Stevens, J., dissenting) (special treatment of pregnancy is sex discrimination because it is "the capacity to become pregnant which primarily differentiates the female from the male"); H.R. Rep. No. 948, 95th Cong., 2d Sess. 2 (1978) (adopting reasoning of dissenters). *See also Newport News Shipbuilding and Dry Dock Co. v. EEOC*, 462 U.S. 669, 676 (1983) ("Congress, by enacting the [PDA], not only overturned the specific holding in [*Gilbert*], but also rejected the test of discrimination employed by the Court in that case"); *California Federal Savings & Loan Ass'n v. Guerra*, 479 U.S. 272, 284 (1987) (in enacting the PDA, Congress "unambiguously expressed its disapproval of both the holding and the reasoning of the Court in" *Gilbert*) (citation omitted).

22. Of course, as has been recognized by legal commentators, an employer's exclusion of contraceptives can also be challenged on disparate impact grounds. Law, *Sex Discrimination and Insurance for Contraception*, 73 Wash. L. Rev. 363, 373-76 (1998). Based on the analysis in text, however, it is unnecessary to address application of the disparate impact theory here.

This page was last modified on December 14, 2000.

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EXHIBIT C

Mauldin v. Wal-Mart Stores, Inc.N.D.Ga.,2002.
United States District Court,N.D. Georgia.
Lisa Smith MAULDIN, Individually and on behalf of all others similarly situated, Plaintiff,
v.
WAL-MART STORES, INC., Defendant.
No. Civ.A.1:01-CV2755JEC.

Aug. 23, 2002.

ORDER

CARNES, J.

***1** This case is before the Court on plaintiff's Motion for Class Certification [13]. The Court has reviewed the record and the arguments of the parties and, for the reasons set forth below, concludes that plaintiff's Motion for Class Certification [13] should be GRANTED in part.

BACKGROUND

Plaintiff, an employee of defendant Wal-Mart Stores, Inc. ("Wal-Mart"), filed the instant action against Wal-Mart on October 16, 2001. Plaintiff alleges that Wal-Mart's policy of denying its employees health insurance coverage for prescription contraceptives discriminates against women, and thus violates Title VII of the Civil Rights Act of 1964 ("Title VII"), 42 U.S.C. § 2000e *et seq .*, as amended by the Pregnancy Discrimination Act ("PDA"), 42 U.S .C. § 2000e(k). She has asserted a claim under Title VII and the PDA on behalf of herself and all others similarly situated, which she defines in her Complaint [1] as "all women nationwide who are covered, or have been covered, by Defendant's health insurance plan at any time during the applicable period and who use or wish to use prescription contraceptives not covered by the plan." (Compl. at ¶ 30.) She has thus asserted a claim on behalf of this entire class as a class action pursuant to Rule 23 of the Federal Rules of Civil Procedure. (*Id.*)

Plaintiff alleges in her Complaint that she began working for Wal-Mart on August 29, 1996. (Compl. at ¶ 14.) She further alleges that Wal-Mart provides its employees with a health insurance plan (the "Plan") as a benefit of employment. (Compl. at ¶ 14.) According to the plaintiff, at the time she first enrolled in the Plan in 1996, and continuing until the present, the Plan has included comprehensive coverage of prescription drugs and devices, including "preventative" drugs, such as drugs to lower blood-cholesterol levels and drugs to prevent allergic reactions and blood clotting. (*Id.*) The Plan specifically excludes coverage of prescription drugs, services, and devices for the prevention of pregnancy, however, including oral contraceptives (the "birth control pill") and other prescription contraceptives, including Norplant, injectables, intrauterine devices ("IUD's"), the diaphragm, and the cervical cap, all of which are available for use only by women. (*Id.* at ¶ 21.) [FN1]

FN1. According to the version of the Plan presented by the plaintiff, the following services are under the section of "Charges Not Covered":
Reproductive Systems.
Charges for, or relating to, any treatment or service for abortions, sexual dysfunction, impotence, infertility, birth control (birth control pills/injectives are not covered for any reason), sterilization or reversal of sterilization procedures, artificial inseminations, in-vitro fertilizations or embryo transfers, and any complications arising therefrom.
(Pl. Mot. for Class Cert. [13], Ex. B at D13; *see also* Def. Ex. A-1 [28].)

Plaintiff contends that she currently pays $29.84 per month for birth control pills, and argues that Wal-Mart discriminates against her, and against all women, by failing to include health insurance coverage for prescription contraceptives as part of its employee benefits program. (*Id.* at ¶ ¶ 18-19.) She has asserted two counts in her Complaint for sex discrimination under Title VII: in Count I, she asserts a claim for disparate treatment on the basis of sex, on the ground that Wal-Mart singles out female employees for disadvantageous treatment in its provision of employee benefits; in Count II, she asserts a claim for disparate impact, on the ground that Wal-Mart's facially neutral policy of excluding coverage for prescription contraceptives in the Plan has an adverse disparate impact on women, because only women use prescription contraceptives. (*Id.* at ¶ ¶ 41-47.)

*2 Plaintiff seeks declaratory and injunctive relief on behalf of herself and other similarly situated, including a declaratory judgment that defendant's exclusion of coverage for prescription contraceptives violates Title VII and an order requiring defendant to provide comprehensive health insurance coverage for prescription contraceptives. In its Answer, defendant does not dispute that the Plan excludes coverage for prescription contraceptives, but contends that the Plan applies equally to all employees and that the exclusion of prescription contraceptives does not constitute unlawful sex discrimination. (*See* Answer [23] at 8-9.)

On January 14, 2002, the plaintiff filed a Motion for Class Certification [13], seeking to certify a class defined as follows:
All women nationwide who are covered, or have been covered, by Defendant's health insurance plan at any time after September 5, 1999 and who use or wish to use prescription contraceptives not covered by the plan.

(Pl. Mot. for Class Cert. [13] at 1.) The plaintiff argues that this action should be allowed to proceed as a class action under Rule 23 of the Federal Rules of Civil Procedure, because defendant's policy of excluding health insurance coverage for prescription contraceptives constitutes unlawful sex discrimination on its face and, therefore, any declaratory or injunctive relief entered against defendant will benefit all members of the class.

Defendant has opposed the plaintiff's Motion for Class Certification on the ground that the plaintiff has failed to establish that this action meets the requirements for class actions under Rule 23(a) or Rule 23(b) of the Federal Rules of Civil Procedure. Specifically, defendant argues that the class members can not be identified by reference to any objective standard; individualized issues related to monetary damages would predominate over the injunctive relief; the plaintiff's claim is time-barred and the class would include other people whose claims are time-barred; the plaintiff's claim is not typical of the claims of other class members; and the plaintiff would not adequately represent the interests of the class as a whole.

DISCUSSION

I. *Standards for Class Actions under Rule 23*

Class actions serve three essential purposes: (1) promoting judicial economy by avoiding multiple suits alleging the same or similar claims; (2) providing a feasible means for asserting the rights of those who would have no realistic opportunity to have their claims heard absent the class action mechanism; and (3) avoiding inconsistent results in claims premised on the same legal theories or same wrongful conduct. *Buford v. H & R Block, Inc.,* 168 F.R.D. 340, 345-346 (S.D.Ga.1996); *see also Phillips Petroleum Co. v. Shutts,* 472 U.S. 797, 809, 105 S.Ct. 2965, 86 L.Ed.2d 628 (1985); *Am. Pipe & Constr. Co. v. Utah,* 414 U.S. 558, 550 (1974); *First Fed. of Michigan v. Barrow,* 878 F.2d 912, 919 (6th Cir.1989). " 'The class action is a powerful procedural device, offering enormous savings in time and judicial resources while opening up opportunities for both new forms of litigation and potential abuse by litigants." ' *Buford,* 168 F.R.D. at 346 (quoting Richard L. Marcus & Edward F. Sherman, Complex Litigation 233 (1985)).

*3 Plaintiff has moved for this action to be certified as a class action pursuant to Fed. R. Civ. P. 23, which governs the class certification process.

Rule 23(a) provides as follows:
(a) Prerequisites to a Class Action. One or more members of a class may sue or be sued as representative parties on behalf of all only if (1) the class is so numerous that joinder of all members is impracticable, (2) there are questions of law or fact common to the class, (3) the claims or defenses of the representative parties are typical of the claims or defenses of the class, and (4) the representative parties will fairly and adequately protect the interests of the class.

Fed. R. Civ. P. 23(a).

Rule 23(b) provides as follows:
(b) Class Actions Maintainable. An action may be maintained as a class action if the prerequisites of subdivision (a) are satisfied, and in addition:
(1) the prosecution of separate actions by or against individual members of the class would create a risk of
(A) inconsistent or varying adjudications with respect to individual members of the class which would establish incompatible standards of conduct for the party opposing the class, or
(B) adjudications with respect to individual members of the class which would as a practical matter be dispositive of the interests of the other members not

parties to the adjudications or substantially impair or impede their ability to protect their interests; or
(2) the party opposing the class has acted or refused to act on grounds generally applicable to the class, thereby making appropriate final injunctive relief or corresponding declaratory relief with respect to the class as a whole; or
(3) the court finds that the questions of law or fact common to the members of the class predominate over any questions affecting only individual members, and that a class action is superior to other available methods for the fair and efficient adjudication of the controversy. The matters pertinent to the findings include: (A) the interest of members of the class in individually controlling the prosecution or defense of separate actions; (B) the extent and nature of any litigation concerning the controversy already commenced by or against members of the class; (C) the desirability or undesirability of concentrating the litigation of the claims in the particular forum; (D) the difficulties likely to be encountered in the management of a class action.

Fed. R. Civ. P. 23(b).

Thus, in order to establish that this action should proceed as a class action under Rule 23, the plaintiff must first establish that all four of the prerequisites of Rule 23(a)-numerosity, commonality, typicality, and adequacy of representation-are met. *See Amchem Prods., Inc. v. Windsor,* 521 U.S. 591, 613, 117 S.Ct. 2231, 138 L.Ed.2d 689 (1997); *Prado-Steiman v. Bush,* 221 F.3d 1266, 1278 (11th Cir.2000). After establishing that all four of the factors of Rule 23(a) are present, the plaintiff must then establish that *one* of the three requirements of Rule 23(b) is met: (1) that the prosecution of separate actions by the individual class members would create a risk of inconsistent judgments or would impair the ability to protect their interests; (2) that the defendant has acted on grounds generally applicable to the class, making appropriate final injunctive or declaratory relief with respect to the class as a whole; *or* (3) that questions of law or fact common to the members of the class predominate over any questions affecting only individual members, and a class action is superior to other available methods for the fair and efficient adjudication of the controversy. Fed.R.Civ.P. 23(b); *see Amchem,* 521 U.S. at 614.

***4** In considering all these factors, a district court has considerable discretion in deciding whether to certify an action as a class action. *See, e.g., Griffin v. Dugger,* 823 F.2d 1476, 1486 (11th Cir.1987); *Walker v. Jim Dandy Co.,* 747 F.2d 1360, 1363 (11th Cir.1984); *Freeman v. Motor Convoy, Inc.,* 700 F.2d 1339, 1347 (11th Cir.1983). In making its determination, the court may consider the allegations of the complaint, as well as any supplemental evidentiary submissions from the parties. *Buford v. H & R Block, Inc.,* 168 F.R.D. 340, 346 (S.D.Ga.1996) (citing *Blackie v. Barrack,* 524 F.2d 891, 901 n. 17 (9th Cir.1975)). Class certification is strictly a procedural matter, however, and courts are not to consider the merits of the plaintiffs' claims in determining whether the action should be allowed to proceed as a class action. *Eisen v. Carlisle & Jacquelin,* 417 U.S. 156, 177, 94 S.Ct. 2140, 40 L.Ed.2d 732 (1974). Furthermore, any doubts are to be resolved in favor of certification, because class certification is conditional only and the court may amend the certification order or decertify the class at any time prior to a final judgment on the merits. Fed. R. Civ. P. 23(c)(1); *Prado-Steiman,* 221 F.3d at 1273.

II. *Plaintiff's Motion for Class Certification*

The plaintiff has filed a motion for class certification pursuant to Rule 23. She argues that she has presented sufficient evidence that this action meets all four of the prerequisites for class actions required by Rule 23(a), and also that it meets the requirements of Rule 23(b)(2): that the defendant has acted or refused to act on grounds generally applicable to the class, thereby making declaratory and injunctive relief appropriate with respect to the class as a whole. In the alternative, she argues that this action meets the requirement of Rule 23(b)(3), in that common questions of law predominate over issues related to individual class members. Defendant has opposed the plaintiff's motion on numerous grounds.

A. *Prerequisites of Rule 23(a)*

As discussed above, the Supreme Court has held that plaintiffs seeking to assert class actions under Title VII must first comply with all the prerequisites established by Rule 23. "An individual litigant seeking to maintain a class action under Title VII must meet 'the prerequisites of numerosity, commonality, typicality, and adequacy of representation' specified in Rule 23(a). These requirements effectively 'limit the class claims to those fairly encompassed by the named plaintiff's claims." ' *General Tel. Co. v.. Falcon,* 457 U.S. 147, 156, 102 S.Ct. 2364, 72 L.Ed.2d 740 (1982)

(citations omitted); *see Prado-Steiman,* 221 F.3d at 1278. The *Falcon* Court held that "actual, not presumed, conformance with Rule 23(a) [is] indispensable." *Falcon,* 457 U.S. at 160. Thus, a class action brought under Title VII "may only be certified if the trial court is satisfied, after a rigorous analysis, that the prerequisites of Rule 23(a) have been satisfied." *Falcon,* 457 U.S. at 161; *see also Griffin v. Dugger,* 823 F.2d 1476, 1486 (11th Cir.1987).

***5** Accordingly, the Court must first determine whether the plaintiff has established that this action fulfills the four prerequisites of a class action under Rule 23(a): numerosity, commonality, typicality, and adequacy of representation.

1. *Numerosity*

The first requirement of Rule 23(a) is that the class be so large that joinder of all members is impracticable. Fed. R. Civ. P. 23(a)(1). "Practicability of joinder depends on many factors, including for example, the size of the class, ease of identifying its numbers and determining their addresses, facility of making service on them if joined and their geographic dispersion." *Kilgo v. Bowman Transp., Inc.,* 789 F.2d 859, 878 (11th Cir.1986). When a class is extremely large, the numbers alone may presume that joinder is not feasible. *See Buford,* 168 F.R.D. at 348. The size of the individual claims is another factor courts may consider, because joinder is less likely when individual claims are so small as to inhibit individuals from pursuing their own separate claims. *See Buford,* 168 F.R.D. at 348.

Plaintiff contends that defendant Wal-Mart employs over 900,000 people nationwide, with over 600,000 participants enrolled in the Plan. (Pl. Br. [13] at 9; Compl. [1] at ¶ 11.) She alleges that the total number of persons covered by the Plan, including covered dependents, exceeds 1,000,000 people. (Pl. Br. [13] at 9.) She argues that, given the "well-documented utilization rates for prescription contraceptive drugs and devices, plaintiff believes that the class consists of at least thousands of women." (*Id.*) Defendant does not dispute that the class, as it is defined by the plaintiff, is so numerous as to make joinder impracticable.

In addition to the sheer size of the class, however, a second element of the numerosity requirement is that the proposed class meet a minimal standard of identifiability.[FN2] *In re Polypropylene Carpet Antitrust Litig.,* 178 F.R.D. 603, 612 (N.D.Ga.1997) (Murphy, J.). Indeed, it is "elementary" that a class must be adequately defined so that all members of the class are clearly ascertainable before a class action can be certified under Rule 23. *See DeBremaecker v. Short,* 433 F.2d 733, 734 (5th Cir.1970). Although "[i]t is not necessary that the members of the class be so clearly identified that any member can be presently ascertained, ... [Plaintiffs] must establish that there exists a legally definable 'class' that can be ascertained through reasonable effort." *In re Polypropylene Carpet Antitrust Litigation,* 178 F.R.D. at 612 (quoting *Earnest v. General Motors Corp.,* 923 F.Supp. 1469, 1473 & n. 4 (N.D.Ala.1996) (quotations and citations omitted)). The class must meet a "minimum standard of definiteness which will allow the trial court to determine membership in the proposed class." *Id.*

FN2. Some courts have held that the adequacy of the definition of the class is not part of the numerosity analysis of Rule 23(a), but instead is an independent question that must be considered *before* the court addresses the four prerequisites of Rule 23(a). *See, e.g., Buford v. H & R Block, Inc.,* 168 F.R.D. 340, 346 (S.D.Ga.1996) ("Before considering the requirements of Rule 23, however, a court must determine whether a class exists that can adequately be defined.... Thus, class definition is an implicit requirement which must be met before a Rule 23 analysis can be undertaken by the district court.") In any event, whether the class definition is addressed by the court before the Rule 23 analysis, or as part of the numerosity analysis required by Rule 23(a), the law is clear that a class must be adequately and clearly defined before the class action may be certified. *DeBremaecker v. Short,* 433 F.2d 733, 734 (5th Cir.1970).

Establishing a precise definition of the class early in the litigation serves two functions: (1) it allows the court to determine whether the case is suitable for certification as a class action and (2) it " 'insures that those actually harmed by defendants' wrongful conduct will be recipients of the relief eventually provided." ' *Buford v. H & R Block, Inc.,* 168 F.R.D. 340, 346 (S.D.Ga.1996) (quoting *Simer v. Rios,* 661 F.2d 655, 670 (7th Cir.1981)).
***6** Class definition is of critical importance because it identifies the persons (1) entitled to relief, (2) bound

by a final judgment, and (3) entitled to notice in a Rule 23(b)(3) action. It is therefore necessary to arrive at a definition that is precise, objective, and presently ascertainable.

Manual for Complex Litigation, Third § 30.14 at 235 (2002); *see also Buford,* 168 F.R.D. at 346.

In her Motion for Class Certification, the plaintiff has moved the Court to certify a class defined as follows: All women nationwide who are covered, or have been covered, by Defendant's health insurance plan at any time after September 5, 1999 and who use or wish to use prescription contraceptives not covered by the plan.

(Pl. Mot. for Class Cert. [13] at 1.) Defendant argues that this definition is far too vague and indefinite to be certified as a class: "Plaintiff's proposed class in this case is both amorphous and incapable of a reasonably precise definition." (Def. Br. [28] at 9.) Defendant's objection is based on the plaintiff's proposed inclusion of women who merely "wish to use" prescription contraceptives, arguing that such a definition would require the Court to delve into the state of mind of every woman covered by the Plan in order to determine whether she "wished" to use prescription contraceptives at some time during the relevant time period. Defendant argues that the Court must deny the plaintiff's motion for class certification because the plaintiff's proposed definition of the class is fatally flawed.

Although neither the Supreme Court nor the Eleventh Circuit has ever ruled on the precise issue of whether the exclusion of prescription contraceptives in an employee benefit plan violates Title VII, the plaintiff has cited a district court decision from Washington that addressed a claim nearly identical to the claim asserted by plaintiff in the instant action. She argues that this Court should certify this action as a class action, just as the Washington court certified that class action. In *Erickson v. Bartell Drug Co.,* 141 F.Supp.2d 1266 (W.D.Wash.2001), the court concluded that an employer violated Title VII by providing its employees with a health insurance plan that excluded coverage of prescription contraceptives. *Id.* at 1276-1277. The *Erickson* court noted a recent decision from the Equal Employment Opportunity Commission ("EEOC"), the federal agency charged with enforcing the regulations of Title VII, that such an exclusion violates Title VII because any health insurance policy that excludes prescription contraceptives, which are used by a large percentage of women, provides less comprehensive health care coverage for women than for men. *Id.* at 1275-1276. (*See* EEOC decision dated December 14, 2000, Pl. Mot. for Class Cert. [13], Ex. A.) The court concluded that the EEOC's position on the matter was a reasonable interpretation of Title VII and was thus entitled to deference. It, therefore, held that the employer's policy violated Title VII. *Id.* at 1276-1277.

*7 The plaintiff contends that the *Erickson* court certified a class action "in which the facts were identical to the instant case," but the Court notes that the *Erickson* court did *not* certify a class including women who merely "wished to use" prescription contraceptives. *See Erickson,* 141 F.Supp.2d at 1268 n. 2. Instead, the *Erickson* court certified a class that included only female employees who were enrolled in their employer's health insurance plan "while using prescription contraceptives." *Id.* (certified class of plaintiffs included "[a]ll female employees of Bartell who at any time after December 29, 1997, were enrolled in Bartell's Prescription Benefit Plan for non-union employees while using prescription contraceptives."). (*See also* Pl. Mot. for Class Cert. [13], Ex. C at 1.)

The Court agrees with the *Erickson* court that a class including only female employees who were covered by their employer's health insurance plan and were "using" prescription contraceptives during a specific time period is adequately defined and would provide an objective standard for determining membership in the class. The Court agrees with defendant, however, that including women who merely "wish to use" prescription contraceptives is such a vague definition that it would present significant difficulties in determining class membership. Does this definition include only women who actually received prescriptions for contraceptives by their doctors during the relevant time period, but never purchased them because they could not afford to do so under the Plan's policy of excluding coverage? Does this definition also include women who never even discussed contraceptives with their physicians, because they knew of the Plan's policy excluding coverage? Does it include women who claim that they "wish to use" prescription contraceptives, but who are unable to use them for medical reasons? What about women who "wish to use" prescription contraceptives, but failed to obtain a prescription for them because of their religious beliefs or for any other reason completely unrelated to the Plan's policy of excluding coverage?

In sum, any woman covered by the Plan during the

relevant time period would potentially be a member of the class, without any objective showing of actual injury resulting from the Plan's policy of excluding prescription contraceptives from coverage. Such a definition would allow a woman to become a member of the class by claiming to be a member of the class and would thus require an individualized inquiry into the "state of mind" of each potential class member without any objective standards for identification of the class members. *See, e.g., DeBremaecker,* 433 F.2d at 734 (class composed of residents "active in the Peace movement" was too vague and indefinite for the class members to be ascertained by any objective standard). Furthermore, by including within the class any women claiming that they "wish to use" prescription contraceptives, the class would conceivably include women who had medical conditions that would have contraindicated the use of prescription contraceptives or women who were otherwise inappropriate candidates for prescription contraceptives for a myriad of reasons completely unrelated to Wal-Mart's policy of excluding insurance coverage for them.[FN3]

FN3. In her reply brief, plaintiff states: "Plaintiff obviously does not seek to include persons for whom a particular prescription contraceptive is medically contraindicated and such a person is unlikely to be able to obtain a prescription under these circumstances." (Pl. Reply Br. [33] at 20-21.) That is precisely the problem: plaintiff *does* seek to include those persons within her proposed class, as she defines it in her motion for class certification. By including women who "wish to use" prescription contraceptives within the definition of the class, the plaintiff seeks to include women who were not even able to obtain a prescription for contraceptives from their doctors because of their age or a health condition or other reason that contraindicated the use of prescription contraceptives. The Court agrees with defendants that including women in the class who never obtained a prescription for contraceptives could result in thousands of mini-trials on issues related to the health of the individual and whether certain prescription contraceptives were medically appropriate for them.

***8** Moreover, the Court notes that the plaintiff has withdrawn all claims for compensatory and punitive damages and seeks only equitable relief for the individual class members, including back pay: "Plaintiff only requests equitable relief in the form of reimbursement for costs which she and the class would not have had to pay but for defendant's discriminatory Plan." (Pl. Reply Br. [33] at 7.) By including women who only "wish to use" prescription contraceptives, however, but who never actually obtained prescriptions, purchased or used contraceptives during the relevant time period, the plaintiff has not shown that these putative class members would be entitled to back pay for reimbursement for costs they never actually incurred.[FN4] Furthermore, any injunctive relief requiring the defendant to include health insurance coverage for prescription contraceptives in the future would automatically benefit all women covered under the Plan who used contraceptives in the future, regardless of whether they had ever used them in the past.[FN5]

FN4. Thus, including these women within the class definition might present problems with the typicality requirement discussed *infra.*

FN5. Indeed, plaintiff concedes this point in her reply brief: "Class members who 'wish to use' prescription contraceptives will benefit from the injunction automatically if Wal-Mart is forced to cover prescription contraceptives because anyone who wishes to use contraceptives will then be able to submit claims for coverage from the date of the injunction forward." (Pl. Reply Br. [33] at 31.) Although the plaintiff contends that this is the very reason she has chosen to include such women in the definition of the class, because they will automatically benefit from any injunctive relief in the future, the Court finds that including such women in the definition of the class if they will "automatically" benefit is superfluous. If the plaintiff seeks to include women who actually file claims for reimbursement of prescription contraceptives at some date in the future, she should so define the class by reference to the relevant time period, not by reference to what a woman might "wish" to do.

Accordingly, the Court concludes that the plaintiff's definition of the class is overbroad and that women who merely "wish to use" prescription

contraceptives, without actually having purchased them or using them at any time during the relevant time period, should not be included within the definition of the class. *See, e.g., Earnest v. General Motors Corp.,* 923 F.Supp. 1469, 1473 & n. 4 (N.D.Ala.1996) ("Because the class definition offered by the plaintiffs could potentially mean anything the plaintiffs want it to mean at any particular time, it would be virtually impossible to determine membership in the class.").

Nevertheless, the Court does not agree with the defendant that the plaintiff's motion for class certification should be denied in its entirety on the ground that her proposed class is too vague. Instead, the Court finds that her definition is merely too *broad,* because she proposes to include both women who actually used prescription contraceptives, as well as women who merely "wish to use" them, without ever actually obtaining a prescription for them, purchasing them, or using them. Defendant does not argue that a class composed of women covered by the Plan who actually used prescription contraceptives is too vague or indefinite to be certified as a class. Furthermore, the Eleventh Circuit has held that Rule 23(c)(1) grants district courts broad discretion to alter or amend the definition of the class at any time throughout the litigation, prior to a final decision on the merits of the action. *Prado-Steiman v. Bush,* 221 F.3d 1266, 1273 (11th Cir.2000).

In light of the Court's broad discretion to fashion a workable definition of the class, the Court concludes that it would be waste of judicial resources to deny the plaintiff's motion for class certification on the grounds that *part* of her proposed class is too vaguely defined and to require her to refile another motion for class certification with a revised definition of the proposed class excluding those women who merely "wished to use" prescription contraceptives. Thus, the Court will limit its discussion herein to a potential class including only those women who were covered by the Plan after September 5, 1999 and who *used* prescription contraceptives during the relevant time period. The Court will discuss defendant's further objections below as they apply to a class so defined.

2. *Commonality*

*9 The second requirement of Rule 23(a) is that "there are questions of law or fact common to the class." Fed. R. Civ. P. 23(a)(2). This requirement is generally considered very easy to satisfy because the "threshold of 'commonality' is not high." *Jenkins v. Raymark Indus., Inc.,* 782 F.2d 468, 472 (5th Cir.1986.) It is not required that the claims of all putative class members be absolutely identical, only that they share questions of either law or fact in common. *See Johnson v. Am. Credit Co. of Georgia,* 581 F.2d 526, 532 (5th Cir.1978); *Buford,* 168 F.R.D. at 349. Moreover, even when individual factual circumstances are present among the class members, "the commonality requirement is satisfied where it is alleged that the defendants have acted in a uniform manner with respect to the class." *Buford,* 168 F.R.D. at 349 (quoting *Int'l Molders' & Allied Workers' Union No. 164 v. Nelson,* 102 F.R.D. 457, 462 (N.D.Cal.1983)).

In the instant action, the claims of all the class members clearly share a common question of law, as defendant's liability on every claim is premised on the same question: does the Plan's policy of excluding prescription contraceptives from coverage violate Title VII? Accordingly, the Court finds that the plaintiff has established that this action meets the commonality requirement of Rule 23(a)(2).

3. *Typicality*

In order to meet the third prerequisite for class actions under Rule 23(a), the plaintiff must establish that the claims or defenses of the representative parties are typical of the claims or defenses of the class. Fed. R. Civ. P. 23(a)(3). As the plaintiff is the only named plaintiff in this action, she must therefore show that her claims are typical of those of the other putative members of the class. *Kornberg v. Carnival Cruise Lines, Inc.,* 741 F.2d 1332, 1337 (11th Cir.1984).

As the Supreme Court has explained, "[w]e have repeatedly held that a class representative must be part of the class and possess the same interest and suffer the same injury as the class members." *General Tel. Co. v. Falcon,* 457 U.S. 147, 156, 102 S.Ct. 2364, 72 L.Ed.2d 740 (1982) (quoted in *Prado-Steiman v. Bush,* 221 F.3d 1266, 1278 (11th Cir.2000)). One of the "core purposes" of this "typicality" requirement is to "ensure that 'the named plaintiffs have incentives that align with those of absent class members so as to assure that the absentees' interests will be fairly represented." ' *Prado-Steiman,* 221 F.3d at 1279 (quoting *Baby Neal v. Casey,* 43 F.3d 48, 57 (3rd Cir.1994)).

Courts have held that in many ways, the commonality and typicality requirements overlap. *See Prado-*

Steiman, 221 F.3d at 1278. "Traditionally, commonality refers to the group characteristics of the class as a whole and typicality refers to the individual characteristics of the named plaintiff in relation to the class." *Id.* As the Supreme Court noted in *Falcon,* 457 U.S. at 157, in practice, the commonality and typicality requirements of Rule 23(a) tend to merge: "Both serve as guideposts for determining whether under the particular circumstances maintenance of a class action is economical and whether the named plaintiff's claim and the class claims are so interrelated that the interests of the class members will be fairly and adequately protected in their absence." *Falcon,* 457 U.S. at 157 n. 13 (quoted in *Griffin v. Dugger,* 823 F.2d 1476, 1489 n. 31 (11th Cir.1987)); *see also Prado-Steiman,* 221 F.3d at 1279; *Buford,* 168 F.R.D. at 350.

***10** Thus, in order for the plaintiff to establish that her claim against defendant is typical of the claims of other class members, she must establish that her claim shares the same "essential characteristics as the claims of the class at large." *Prado-Steiman,* 221 F.3d at 1279 (quoting *Appleyard v. Wallace,* 754 F.2d 955, 958 (11th Cir.1985) (citation omitted)). If the claims are substantially similar, a plaintiff can usually meet this burden because "a strong similarity of legal theories will satisfy the typicality requirement despite substantial factual differences." *Prado-Steiman,* 221 F.3d at 1279 (quoting *Appleyard,* 754 F.2d at 958); *see also Kornberg v. Carnival Cruise Lines, Inc.,* 741 F.2d 1332, 1337 (11th Cir.1984) ("A factual variation will not render a class representative's claim atypical unless the factual position of the representative markedly differs from that of other members of the class.").

Plaintiff argues that her claims are typical of those of the other members of the class because the legal theory of all the class members' claims is identical: that Wal-Mart's policy of excluding health insurance coverage for prescription contraceptives in its employee benefits plan violates Title VII because it discriminates against women by providing less comprehensive coverage of health care services for women. She alleges that she is female, she is a Wal-Mart employee, she is covered by the Plan, she uses and has used prescription contraceptives while covered by the Plan, and Wal-Mart failed to reimburse her for any costs for those prescription contraceptives because such coverage is specifically excluded by the Plan. She seeks to represent other women who are also covered by the Plan and who also use prescription contraceptives and, thus, argues that her claim is not only typical of all the claims of other members of the class, but virtually identical to those claims.

Defendant contends that the plaintiff has failed to meet the typicality requirement because she seeks to represent the interests of other women who only "wish to use" prescription contraceptives and thus her claim, which is based on the actual use of contraceptives, would not be typical of the claims of those women who were never actually prescribed contraceptives and never used them. The Court has already concluded that women who "wish to use" contraceptives should not be included within the definition of the class because such a definition is too vague and indefinite to meet the requirements of Rule 23. Therefore, defendant's objection on this point is moot.

Defendant further argues that plaintiff has failed to establish that the legal theories underlying her claim are typical of the theories presented by other potential class members. In her Complaint, plaintiff has alleged two counts under Title VII, both based solely on the defendant's policy of excluding health insurance coverage for prescription contraceptives. In Count I, she has asserted a claim for disparate treatment on the basis of sex, on the ground that Wal-Mart singles out female employees for disadvantageous treatment in its provision of employee benefits; in Count II, she has asserted a claim for disparate impact, on the ground that Wal-Mart's facially neutral policy of excluding coverage for prescription contraceptives in the Plan has an adverse disparate impact on women, because only women use prescription contraceptives. (Compl. [1] at ¶¶ 41-47.)

***11** Thus, the face of the plaintiff's Complaint reflects that her claims are based solely on defendant's class-wide treatment of women in providing health insurance coverage for its employees and their defendants. Defendant contends, however, that the plaintiff's "scanty" discussion of the legal theories underlying her claims precludes a finding that she has met the typicality requirement. The Court rejects defendant's argument, because the bare allegations of plaintiff's Complaint establish that the plaintiff's claim is based on a *uniform policy* that the defendant concedes was applied consistently to every person covered under the Plan. Thus, this case is inapposite to the cases cited by defendant that involved individualized issues of discriminatory treatment in employment involving hiring, promotions, and transfers that differed significantly from class member to class member. (*See* Def. Br.

[28] at 31-32.) In this case, if Wal-Mart is found liable for violating Title VII with respect to one class member, it will be found liable to all class members; the only individualized issues would arise in the context of computing damages and back pay.

Thus, defendant's argument that there are certain factual differences between the plaintiff's claim and the claims of other class members does not defeat the typicality requirement.[FN6] "The requirement is that Plaintiff and each member of the represented group have an interest in prevailing on similar legal claims. Assuming such interest, particular factual differences, differences in the amount of damages claimed, or even the availability of certain defenses against a class representative may not render his or her claims atypical." *Meyer v. Citizens & S. Nat'l Bank,* 106 F.R.D. 356, 361 (M.D.Ga.1985) (quoted in *Buford,* 168 F.R.D. at 350); *see also Kornberg,* 741 F.2d at 1337 ("Differences in the amount of damages between the class representative and other class members does not affect typicality."); *Davis v. Northside Realty Assocs., Inc.,* 95 F.R.D. 39, 43 (N.D.Ga.1982) ("Since all plaintiffs must establish the same basic elements to prevail and since there are no differences as to the type of relief sought or the theories of liabilities upon which plaintiffs are proceeding, the typicality requirement is met.").

> FN6. Defendant has also opposed the plaintiff's motion for class certification on the grounds that a) the plaintiff's claim is time-barred; b) certain members of the class also have claims that are time-barred; and c) plaintiff seeks to represent women who were covered by the Plan but who were not Wal-Mart employees. (*See* Def. Br. [28] at 24-27, 35-37.) It is not entirely clear whether these objections relate to the typicality requirement, or the adequacy of representation requirement of Rule 23(a)(4). The Court concludes that none of these objections precludes a finding that the plaintiff has met the typicality requirement, but the Court will further address these objections in connection with the adequacy of representation requirement, *infra.*

Accordingly, the Court concludes that the plaintiff has established that she has met the typicality requirement of Rule 23(a)(3).

4. *Adequacy of Representation*

The fourth and final prerequisite of Rule 23(a) is that the plaintiff must show that she will fairly and adequately protect the interests of the class. Fed.R.Civ.P. 23(a). Courts have traditionally held that, in order to satisfy this prerequisite, the plaintiff must show that: (1) the plaintiff's attorney is qualified, experienced, and will vigorously prosecute the action; and (2) the interest of the class representative is not antagonistic to or in conflict with the other members of the class. *Griffin v. Carlin,* 755 F.2d 1516, 1533 (11th Cir.1985); *Buford,* 168 F.R.D. at 351. Defendant contends that the plaintiff is not an adequate representative for the class because a) her claim is time-barred; b) she has not shown that she is willing to bear the costs of prosecuting this action; and c) she seeks to represent class members who are female dependents of male employees, but who are not Wal-Mart employees, and such putative class members do not have standing to bring claims against Wal-Mart under Title VII.

a. Timeliness Issues

***12** Title VII requires that an employee aggrieved by discriminatory acts file a charge of discrimination with the EEOC within 180 days "after the alleged unlawful employment practice occurred." 42 U.S.C. § 2000e-5(e). In the instant action, plaintiff has shown that she filed her charge of discrimination with the EEOC on September 4, 2001; therefore, she may only recover for discrete acts of discrimination that occurred on or after March 8, 2001. *See Beavers v. Am. Cast Iron Pipe Co.,* 975 F.2d 792, 796 (11th Cir.1992). In order to revive an otherwise time-barred claim based on events outside the 180-day period, a plaintiff must show that the conduct complained of is part of a pattern or continuing practice out of which the last incident arose. *Roberts v. Gadsden Mem'l Hosp.,* 835 F.2d 793, 799-800 (11th Cir.1988); *see also United Air Lines, Inc. v. Evans,* 431 U.S. 553, 97 S.Ct. 1885, 52 L.Ed.2d 571 (1977).

Plaintiff contends that defendant's own records establish that she never attempted to make any claim for reimbursement of her out-of-pocket costs for prescription contraceptives until August 21, 2001; thus, her EEOC claim that was filed a mere two weeks later, on September 4, 2001, was clearly timely. Furthermore, even if she had previously been denied reimbursement on some date outside the 180-day period, she argues that the continuing violation doctrine applies to her claims because defendant's policy of denying heath insurance coverage for

prescription contraceptives was an ongoing illegal practice. Thus, she argues that every time Wal-Mart refused to reimburse a claim for prescription contraceptives for a covered employee it was committing a discrete violation of Title VII.

In *Beavers v. American Cast Iron Pipe Co.*, 975 F.2d 792 (11th Cir.1992), the Eleventh Circuit Court of Appeals held that "[w]here an employee charges an employer with continuously maintaining any illegal employment practice, he may file a valid charge of discrimination based upon that illegal practice until 180 days after the last occurrence of an instance of that practice." *Id.* at 796 (quoting *Gonzalez v. Firestone Tire & Rubber Co.*, 610 F.2d 241, 249 (5th Cir.1980)). In contrast, "where the employer engaged in a discrete act of discrimination more than 180 days prior to the filing of a charge with the EEOC by the employee, allegations that the discriminatory act continues to adversely affect the employee or that the employer presently refuses to rectify its past violation" are not sufficient to constitute a continuing violation, and the charge must be filed within 180 days of the discrete act. *Id.* In determining whether the conduct constitutes a continuing violation, a court must distinguish between the "present consequences of a one-time violation," which does not extend the limitations period, and the "continuation of the violation into the present," which does. *Id.* (citation omitted); *see also Calloway v. Partners Nat'l Health Plans*, 986 F.2d 446, 448 (11th Cir.1993).

***13** Defendant argues that plaintiff's claim is untimely because she was aware of the Plan's policy excluding coverage of prescription contraceptives at some time in 2000. Thus, according to defendant, because the plaintiff believed that she was first discriminated against in 2000 and therefore became "aware" that she was being discriminated against at that time, she had until July 1, 2001, at the very latest, in which to file a timely charge of discrimination with the EEOC. (Def. Br. [28] at 24-25.) Under defendant's theory, once the plaintiff or any other class member became aware of the allegedly discriminatory policy, she had 180 days in which to file a claim with the EEOC, regardless of whether she actually filed a claim for reimbursement for insurance coverage and was denied coverage under the Plan. The Court rejects defendant's contention as being contrary to the law in this Circuit.

The Court concludes that, under law in the Eleventh Circuit, the defendant's ongoing policy of denying health insurance coverage for prescription contraceptives falls squarely within the definition of a continuing violation. It is undisputed that the defendant continues to maintain the policy alleged to be discriminatory and continues to deny health insurance coverage for prescription contraceptives. Thus, plaintiff is not arguing that she is continuing to be harmed by a one-time discrete act of discrimination that occurred at some time in the past; instead, she argues that she is harmed every time she purchases prescription contraceptives and is not reimbursed under the Plan, and that every other woman covered under the Plan is harmed every time they purchase prescription contraceptives that are not covered under the Plan.

Accordingly, under the plain holding of *Beavers,* the Court concludes that defendant's ongoing policy is a continuing violation, and every time it refuses to provide coverage or reimbursement for prescription contraceptives under the plan, the 180-day clock for filing charges of discrimination begins to run anew. The plaintiff has shown that she filed a claim for reimbursement of her out-of-pocket costs for prescription contraceptives on August 21, 2001, and that such claim was denied by Wal-Mart under the Plan. Thus, her EEOC charge filed on September 4, 2001, a mere two weeks later, was clearly timely filed under Title VII.

Furthermore, as a result of the Supreme Court's decision in *National Railroad Passenger Corp. v. Morgan,* 536 U.S. 101, 122 S.Ct. 2061, 153 L.Ed.2d 106 (2002) clarifying the period for back pay under Title VII, the plaintiff has sought to amend the definition of her proposed class to include "all persons who could have filed a timely EEOC charge on September 4, 2001," which she defines in her reply brief as "anyone who participated in the Plan from March 8, 2001." *See Freeman v. Motor Convoy, Inc.*, 409 F.Supp. 1100, 1115 (N.D.Ga.1976), *aff'd,* 700 F.2d 1339 (11th Cir.1983). (Pl. Reply Br. at 27-28.) The Court agrees with plaintiff that limiting the class to women covered by the Plan after March 8, 2001, excludes those women whose claims would be time-barred.

***14** Accordingly, the Court concludes that the plaintiff's charge of discrimination was timely filed and that she has shown that she will adequately represent the claims of other class members whose claims could have been timely filed by asserting charges of discrimination on September 4, 2001; *i.e.,* all female employees of Wal-Mart covered by the Plan after March 8, 2001, who used prescription contraceptives after that date and who were not reimbursed by defendant for the out-of-pocket costs

for those prescription contraceptives.

b. Plaintiff's Responsibility for Costs

Defendant argues further that the plaintiff has not established that she will be an adequate representative for the class because her deposition responses indicated her uncertainty over her ultimate responsibility for bearing the costs of the litigation. Plaintiff argues that the Georgia State Bar Rules permit her attorneys to advance the costs and expenses of the litigation, and that such Rules also permit the ultimate payment of those costs to be contingent upon the outcome of the case. Georgia State Bar Rule 1.8(e).

Indeed, defendant concedes that the Georgia State Bar Rules permit such advancement of the costs by the plaintiff's attorneys. (See Def. Br. [28] at 35.) Thus, the Court rejects the defendant's argument that the plaintiff's uncertainty about her ability and her ultimate responsibility for paying all the costs and expenses of this litigation renders her an inadequate class representative.

c. Standing of Non-Employee Class Members

Defendant's final objection to the plaintiff's status as an adequate class representative is that she is seeking to represent certain class members who have no standing to assert a claim under Title VII. Defendant does not contest the plaintiff's standing to assert a claim on her own behalf, but argues that certain putative class members would have no standing to assert claims under Title VII and, thus, those persons without standing should be excluded from the definition of the class. In particular, the defendant challenges the standing of females covered under the Plan who are *not* employees of Wal-Mart and are covered under the Plan as dependents of male employees. Because Title VII prohibits *employers* from discriminating against their *employees,* however, defendant argues that women who were not employees of Wal-Mart do not have standing to assert a claim against Wal-Mart for discrimination under Title VII. *See, e.g., Nicol v. Imagematrix, Inc.,* 773 F.Supp. 802, 806 (E.D.Va.1991) (third parties do not have standing to bring Title VII actions).

Defendant does concede, however, that male Wal-Mart employees would have standing to assert claims under Title VII based on Wal-Mart's policy of refusing to provide comprehensive health coverage to their wives or other female dependents. *See Newport News Shipbuilding & Dry Dock Co. v. EEOC,* 462 U.S. 669, 684-685, 103 S.Ct. 2622, 77 L.Ed.2d 89 (1983) (male employees have standing to sue their employer for discriminating against their female spouses in the provision of employee fringe benefits). Thus, the defendant argues that, should the court decide to certify the class, the class should be defined to include male employees whose female dependents were covered by the Plan and used prescription contraceptives that were not reimbursed under the Plan during the relevant time period.

***15** In her reply brief, the plaintiff declines to respond to the defendant's argument that women who were not employees of Wal-Mart do not have standing to assert claims under Title VII. She argues instead that Wal-Mart "concedes" that the class should include female employees and the covered spouses of male employees. (Pl. Reply Br. [33] at 34.) Plaintiff fails to explain where in its brief Wal-Mart so "concedes," however, because in the brief it filed with the Court, it argues vigorously that the spouses of male employees do not have standing to assert claims against Wal-Mart under Title VII because only *employees* have standing to bring claims against their employers under Title VII. Furthermore, although the plaintiff cites cases in support of defendant's contention that the male employees have standing to bring claims on behalf of their spouses, she has not provided any authority for her position that the female spouses have independent standing to assert claims on their own behalf under Title VII. (*See* Pl. Reply Br. [33] at 34-35.)

Thus, given plaintiff's failure to adequately respond to defendant's arguments, the Court concludes that women who were covered under the Plan during the relevant time period, but who were not employees of Wal-Mart, do not have standing to assert claims under Title VII and are not appropriate members of the class. As with defendant's argument regarding women who never actually used prescription contraceptives, however, the Court finds that the appropriate remedy is not to deny certification altogether, but to limit the definition of the class to exclude women who were not employees.

Accordingly, the Court concludes that the plaintiff has shown that she is an adequate representative for the class of female employees of Wal-Mart who were covered under the Plan, and thus has met the requirements of Rule 23(a)(4). Plaintiff has therefore shown that this action meets all the prerequisites for maintaining a class action under Rule 23(a). The

Court must now address whether the plaintiff has met the requirements under Rule 23(b).

B. *Requirements of Rule 23(b)*

In addition to satisfying the four factors of Rule 23(a), a plaintiff seeking class certification must show that the action is maintainable as a class action under either Rule 23(b)(1), (2), or (3). *Amchem Prods., Inc. v. Windsor,* 521 U.S. 591, 613, 117 S.Ct. 2231, 138 L.Ed.2d 689 (1997). In the instant action, the plaintiff contends that this action is maintainable under either Rule 23(b)(2), because the defendant has acted on grounds generally applicable to the class, making appropriate final injunctive or declaratory relief with respect to the class as a whole or, in the alternative, under Rule 23(b)(3), because questions of law or fact common to the members of the class predominate over any questions affecting only individual members and a class action is superior to other available methods for the fair and efficient adjudication of the controversy. Fed.R.Civ.P. 23(b); *see Amchem,* 521 U.S. at 614.

1. *Classwide Declaratory or Injunctive Relief*

***16** Rule 23(b)(2) permits class actions for declaratory or injunctive relief where "the party opposing the class has acted or refused to act on grounds generally applicable to the class." Fed.R.Civ.P. 23(b)(2); *Amchem,* 521 U.S. at 614. The Supreme Court has recognized that "[c]ivil rights cases against parties charged with unlawful, class-based discrimination are prime examples" of the types of class actions falling under Rule 23(b)(2). Thus, because the plaintiff alleges that the defendant has engaged in class-wide discrimination against all of its female employees by refusing to provide health insurance coverage for prescription contraceptives, the plaintiff argues that this case is suitable for class certification under Rule 23(b)(2).

The Court agrees with plaintiff that this action falls squarely within the requirements of Rule 23(b)(2). Plaintiff seeks declaratory and injunctive relief requiring the defendant to stop the practice of denying women health insurance coverage for prescription contraceptives, and any declaratory or injunctive relief would necessarily affect the class as a whole. Accordingly, this action is exactly the type of action contemplated by Rule 23(b)(2) and is therefore appropriately maintained as a class action pursuant to that rule.

As noted above, the plaintiff has withdrawn all claims for compensatory and punitive damages and is seeking only declaratory and injunctive relief, and other equitable relief, including back pay for the individual class members for the fringe benefits allegedly denied them by the defendant when it refused to reimburse their out-of-pocket expenses related to prescription contraceptives. (*See* Pl. Reply Br. [33] at 6-7.) Although the plaintiff thus seeks individual monetary relief for herself and the class members, this action may still be maintained as a "hybrid action" under Rule 23(b)(2): "A hybrid Rule 23(b)(2) class action is one in which class members seek individual monetary relief, typically back pay, in addition to class-wide injunctive or declaratory relief." *Cox v. Am. Cast Iron Pipe Co.,* 784 F.2d 1546, 1554 (11th Cir.1986).

Defendant argues that individualized issues related to the calculation of back pay and other damages for each individual class member will predominate over the common issues of law and the requested injunctive relief. Defendant maintains that it will be such a complicated and time-consuming procedure to ascertain the amount of damages and back pay for each class member that the individualized issues will thus outweigh the common issues. The cases cited by defendant in support of its argument, however, involved primarily claims for compensatory and punitive damages, however, and the plaintiff has specifically withdrawn those claims and seeks only equitable relief for the individual class members, including back pay: "Plaintiff only requests equitable relief in the form of reimbursement for costs which she and the class would not have had to pay but for defendant's discriminatory Plan." (Pl. Reply Br. [33] at 7.)

***17** Accordingly, the Court concludes that the plaintiff has established that this action should proceed as a class action under Rule 23(b)2).

2. *Common Questions of Law or Fact*

In addition to arguing that this action is appropriately brought as a class action under Rule 23(b)(2), plaintiff argues that, in the alternative, it is maintainable as a class action pursuant to Rule 23(b)(3). Under Rule 23(b)(3), an action may proceed as a class action if "the court finds that the questions of law or fact common to the members of the class predominate over any questions affecting only individual members, and that a class action is

superior to other available methods for the fair and efficient adjudication of the controversy." Fed. R. Civ. P. 23(b)(3).

Plaintiff argues that common questions of law or fact predominate over individual issues, and thus, this action is maintainable as a class action under Rule 23(b)(3). According to the plaintiff, common questions of law predominate in this action, because the primary legal question presented is whether Wal-Mart's policy of denying health insurance coverage for prescription contraceptives violates Title VII and it is undisputed that the policy is applied across the board to every person covered under the Plan without exception. Defendant argues that individual issues of fact would predominate over the common issues of law.

Because the Court has already concluded that this action may be certified as a class action under Rule 23(b)(2), it is not necessary to determine whether it would also qualify for class action status under Rule 23(b)(3). Thus, this action will proceed as a class action solely under Rule 23(b)2).

C. *Definition of the Class*

Although the Court concludes that this action is entitled to be maintained as a class action under Rule 23(b)(2), based on several of the considerations discussed above, the Court also concludes that the definition of the class, as proposed by the plaintiff, is too broad. The Court finds that the plaintiff has satisfied the requirements of Rule 23 to represent a sub-class of the class she has proposed to represent, but she has not satisfied the requirements with respect to the entire proposed class.

In her Motion for Class Certification, the plaintiff has moved the Court to certify a class defined as follows: All women nationwide who are covered, or have been covered, by Defendant's health insurance plan at any time after September 5, 1999 and who use or wish to use prescription contraceptives not covered by the plan.

(Pl. Mot. for Class Cert. [13] at 1.) Based on all the considerations discussed above, the Court concludes that the following persons should be *excluded* from the definition of the class members: 1) women who did not use prescription contraceptives during the relevant time period but merely "wished to use" them; 2) women who were not covered under the Plan after March 8, 2001; and 3) women who were not employees of Wal-Mart and were covered under the Plan as female dependents of male employees.

***18** As discussed above, Title VII prohibits discrimination in *employment;* thus, although all employees of Wal-Mart would have standing to assert claims against Wal-Mart, the plaintiff has not established that women who were covered by the Plan as dependents of male employees would also have standing to assert claims against Wal-Mart under Title VII. Moreover, she has not sought to include male employees with female dependants in her class. Accordingly, the Court finds that women who were not employees of Wal-Mart should not be included within the definition of the class.

The defendant argues that, if the plaintiff wishes to represent female dependents of male Wal-Mart employees, she *must* include within the definition of the class all male employees with female dependents who were covered by the Plan and who used or "wished to use" prescription contraceptives. Defendant argues that the male employees would have standing to assert claims on behalf of their female dependents and, thus, the class must include these male employees. The Court notes that defendant has not cited any authority that *requires* a plaintiff to include within the definition of the class all persons with potential claims similar to that of the plaintiff, and the Court concludes that the plaintiff is not required to do so. Although the Court is given wide discretion in certifying a class under Rule 23, it will not force the plaintiff to litigate claims on behalf of persons whose interests she has not sought to represent.

Thus, the Court concludes that the plaintiff has satisfied the requirements of Rule 23 to represent a class of female employees who actually purchased or used contraceptives during the relevant period, but at the present time, the Court is not satisfied that the plaintiff has satisfied the requirements for every member of the broad class she seeks to represent. Accordingly, plaintiff shall be permitted to proceed on behalf of herself and a class of persons that includes all female employees of Wal-Mart nationwide who are covered, or who have been covered, by Wal-Mart's health insurance plan at any time after March 8, 2001, and who used prescription contraceptives not covered by the plan during the relevant time period.

Although the Court has defined the class more narrowly than the plaintiff requested in her Motion for Class Certification, the Court notes that Rule

23(c)(1) specifically grants the Court the power to alter or amend the class certification order at *any* time prior to a final decision on the merits of the action. *Prado-Steiman v. Bush,* 221 F.3d 1266, 1273 (11th Cir.2000). The Eleventh Circuit has noted that the Court's power to amend the definition of the class "is critical, because the scope and contour of a class may change radically as discovery progresses and more information is gathered about the nature of the putative class members' claims." *Id.* Furthermore, if there are class members with substantially similar claims but significant factual differences, the Court may decide to separate the class into multiple sub-classes according to the types of injuries alleged by the separate sub-classes. *See, e.g., Prado-Steiman,* 221 F.3d at 1281 (separating large class into sub-classes may be useful when the type of proof for each claim differs).

***19** Accordingly, the plaintiff may file a motion requesting an amendment of this Order certifying the class at any stage of the litigation. If the plaintiff seeks to expand the definition of the class, she must present specific arguments why the class is defined too narrowly and she must establish that she is an adequate representative for other persons outside the class, as it is defined by the Court in this Order. If she seeks to enlarge the class to include women who were not employees of Wal-Mart, but who were nevertheless covered by the Plan during the relevant time period because they were dependents of male employees of Wal-Mart, she must explain why those women would have standing to assert any claim against Wal-Mart for employment discrimination under Title VII. Finally, if the plaintiff seeks to expand the definition of the class to include women who were covered by the Plan during the relevant time period, but who never used prescription contraceptives while they were covered by the Plan, she must explain why those women would be entitled to assert claims against Wal-Mart for monetary damages, including back pay, and also why she would be an adequate representative for that class of women who never used prescription contraceptives while they were covered by the Plan.

CONCLUSION

For the foregoing reasons, plaintiff's Motion for Class Certification [13] is GRANTED in part. The Court hereby CERTIFIES this action as a class action, but it has determined that the class should be defined more narrowly than the class proposed by the plaintiff in her motion. Plaintiff shall be permitted to bring this Title VII action on behalf of herself and a class of persons that includes all female employees of Wal-Mart nationwide who are covered, or who have been covered, by Wal-Mart's health insurance plan at any time after March 8, 2001, and who used prescription contraceptives during the relevant time period.

N.D.Ga.,2002.
Mauldin v. Wal-Mart Stores, Inc.
Not Reported in F.Supp.2d, 2002 WL 2022334 (N.D.Ga.), 89 Fair Empl.Prac.Cas. (BNA) 1600

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EXHIBIT D

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

JENNIFER ERICKSON,

Plaintiff,

v.

THE BARTELL DRUG COMPANY,

Defendant.

No. C00-1213L

ORDER CERTIFYING CLASS

This matter comes before the Court on "Plaintiffs' Motion for Class Certification." Plaintiff seeks to go forward with this litigation as the representative of a class, described as follows:

> All female employees of Bartell who at any time after December 29, 1997, were enrolled in Bartell's Prescription Benefit Plan for non-union employees while using prescription contraceptives.

Defendant agrees that this litigation involves issues of law and/or fact that are common to all potential class members and that plaintiff Erickson is typical of the class. It challenges plaintiff's assertions regarding numerosity and adequacy of representation, however, and raises some additional concerns regarding the description of the class.

Fed. R. Civ. P. 23(a)(1): Numerosity

Plaintiff asserts, based on general information regarding Bartell's employee population and unspecified utilization rates for prescription contraceptive drugs and devices, that the prospective class consists of at least one hundred women. Plaintiff's Memorandum at 5.

Defendant objects to the imprecision of plaintiff's calculations and argues that even if there are a hundred potential class members, plaintiff has failed to show that joinder would be impractical. While plaintiff's evidence regarding the size of the class is rather weak, the Court is persuaded that, in the absence of individual questioning, the estimate offered by plaintiff is reasonably sound and that identifying and joining all potential class members would be impractical. Although the Court agrees that self-identification would result in a more accurate count of the potential class members, where plaintiff's calculation is reasonable and the circumstances of the litigation suggest that self-identification may dissuade potential participants, the Court will not require self-identification simply to provide additional proof of numerosity. There are legitimate reasons why some potential plaintiffs might resist joinder efforts at the beginning of the case (when the benefits for participation are merely speculative and do not outweigh the risk of injury to her relationship with Bartell) even though they would be willing to come forward at the end of the case. Thus, the Court finds that plaintiff has met its burden of establishing numerosity.

Fed. R. Civ. P. 23(a)(4) : Adequacy of Representation

Having reviewed the documents submitted by the parties, the Court is satisfied that Ms. Erickson and her chosen counsel will adequately represent the interests of the class. The documents do suggest, however, that Ms. Erickson views this litigation as a vehicle for change in all employer-sponsored insurance plans, raising the concern that she may be unwilling to accept coverage for contraceptives in the absence of some public statement that could be used to assist non-Bartell employees. If, at any time in this litigation, it appears that the best interests of all potential class members are not Ms. Erickson's or her counsels' primary concern, the Court will reevaluate its certification decision.

Other Concerns

Defendant also argues that the class proposed by plaintiff is too vague and too narrow. Although members of the class are not readily identifiable by third parties, whether a person falls within or outside of the class is based on objective and clear standards. To the extent plaintiff's proposed class does not include male employees whose wives were using prescription contraceptives during the relevant time period, such choices belong to plaintiff. She asks to bring this litigation on behalf of a particular subgroup of Bartell employees of whom she is a typical representative. Even if plaintiff's proposed class is narrower than it could be, she is master of her complaint and may limit class membership to match her legal theories. The Court finds, therefore, that the class description is neither too vague nor too narrow.

For all of the foregoing reasons, plaintiff's motion for class certification is GRANTED. It is hereby ORDERED that the following class is certified pursuant to Fed. R. Civ. P. 23(a) and 23(b)(2):

> All female employees of Bartell who at any time after December 29, 1997, were enrolled in Bartell's Prescription Benefit Plan for non-union employees while using prescription contraceptives.

Ms. Erickson is appointed as representative of this class.

DATED this 14th day of December 2000.

Robert S. Lasnik
United States District Judge

EXHIBIT E

COHEN, MILSTEIN, HAUSFELD & TOLL, P.L.L.C. FIRM RESUME

For decades, Cohen, Milstein, Hausfeld & Toll, P.L.L.C. has represented individuals, small businesses, institutional investors, and employees in many of the major class action cases litigated in the United States for violations of the antitrust, securities, environmental, consumer protection, civil rights/discrimination, ERISA and human rights laws. The Firm is also at the forefront of numerous innovative legal actions that are expanding the quality and availability of legal recourse for aggrieved individuals and businesses both domestic and international. Over its history, Cohen Milstein has obtained many landmark judgments and settlements for individuals and businesses in the United States and abroad.

The firm's most significant past cases include:

- In re Vitamins Antitrust Litigation, MDL No. 1285 (D.D.C.). Cohen Milstein served as co-lead counsel for two certified classes of businesses that directly purchased bulk vitamins and were overcharged as a result of a ten year global price-fixing and market allocation conspiracy. Chief Judge Hogan approved four major settlements between certain vitamin defendants and Class Plaintiffs, including a landmark partial settlement of $1.1 billion. In a later trial before Chief Judge Hogan concerning four Class Plaintiffs' remaining unsettled Vitamin B4 (choline chloride) claims, a federal jury in Washington unanimously found Japan's second largest trading company, Mitsui & Co., Ltd., its wholly-owned U.S. subsidiary Mitsui & Co. (U.S.A.), Inc., DuCoa, LP, a choline chloride manufacturer based in Highland, Illinois, and DuCoa's general partner, DCV, Inc. liable for participating in the conspiracy and ordered them to pay $49,539,234, which is trebled to $148,617,702 under the federal antitrust laws. The case was subsequently settled against those defendants.

- Dukes v. Wal-Mart Stores, Inc., No. C-01-2252 (N.D. Cal.). Cohen Milstein is one of the co-lead counsel in this discrimination case. In June 2004, U.S. District Court Judge Martin Jenkins ruled that six current and former Wal-Mart employees from California may represent all female employees of Wal-Mart who worked at its U.S. stores anytime after December 26, 1998 in a nationwide sex discrimination class action lawsuit (appeal pending). As the largest civil rights class action ever certified against a private employer, the Judge described the case as "historic in nature, dwarfing other employment discrimination cases that came before it." The action charges that Wal-Mart discriminates against its female retail employees in pay and promotions. The class in this case includes more than 1.5 million current and former female employees of Wal-Mart retail stores in America, including Wal-Mart discount stores, super centers, neighborhood stores, and Sam's Clubs.

- In re Lucent Technologies Securities Litigation, Civ. Action No. 00-621 (JAP) (D.N.J.). A settlement in this massive securities fraud class action was reached in late March 2003. The class portion of the settlement amounts to over $500 million in cash, stock and warrants and ranks as the second largest securities class action settlement ever completed. Cohen Milstein represented one of the co-lead plaintiffs in this action, a private mutual fund.

- Nate Pease, et al. v. Jasper Wyman & Son, Inc., et al., Civil Action No. 00-015 (Knox County Superior Court, Me.). In 2004, a state court jury from Maine found three blueberry processing companies liable for participating in a four-year price-fixing and non-solicitation conspiracy that artificially lowered the prices defendants paid to approximately 800 growers for wild blueberries. The jury ordered defendants Cherryfield Foods, Inc., Jasper Wyman & Son, Inc., and Allen's Blueberry Freezer, Inc. to pay $18.68 million in damages, the amount which the growers would have been paid absent the defendants' conspiracy. After a mandatory trebling of this damage figure under Maine antitrust law, the total amount of the verdict for the plaintiffs is just over $56 million. The Firm served as co-lead counsel.

- In re StarLink Corn Products, Liability Litigation, MDL No. 1403. (N.D. Ill.). Cohen Milstein successfully represented U.S. corn farmers in a national class action against Aventis CropScience USA Holding and Garst Seed Company, the manufacturer and primary distributor of StarLink corn seeds. StarLink is a genetically modified corn variety that the United States government permitted for sale as animal feed and for industrial purposes, but never approved for human consumption. However, StarLink was found in corn products sold in grocery stores across the country and was traced to widespread contamination of the U.S. commodity corn supply. The Firm, as co-lead counsel, achieved a final settlement providing more than $110 million for U.S. corn farmers, which was approved by a federal district court in April 2003. This settlement was the first successful resolution of tort claims brought by farmers against the manufacturers of genetically modified seeds.

- In re Diet Drug Litigation (Fen-Phen), MDL No. 1203 (E.D. Pa.). As a member of the Plaintiffs' Management Committee and Sub-Class Counsel, Cohen Milstein played a major part in the success of the Fen-Phen diet drug litigation and settlement *(In re: Diet Drugs (Phentermine, Fenfluramine, Dexfenfluramine) Products Liability Litigation,* MDL 1203). CMHT and other plaintiffs' counsel achieved the largest settlement ever obtained in a mass tort case - $3.75 billion - on behalf of millions of U.S. consumers who used Pondimin (fenfluramine) or Redux (dexfenfluramine), either alone or in combination with phentermine, diet drugs that are associated with heart valve damage.

- Snyder v. Nationwide Mutual Insurance Company, No. 97/0633 (Sup. Ct. N.Y. Onondaga Cty.). Cohen Milstein served as one of plaintiffs' principal counsel in this case on behalf of persons who held life insurance policies issued by Nationwide through its captive agency force. The action alleged consumer fraud and misrepresentations. Plaintiffs obtained a settlement valued at more than $85 million. The judge praised the efforts of Cohen Milstein and its co-counsel for having done "a

very, very good job for all the people." He complimented "not only the manner" in which the result was arrived at, but also the "time … in which it was done."

- Oncology & Radiation Associates, P.A. v. Bristol Myers Squibb Co., et al., No. 1:01CV02313 (D.D.C.). Cohen Milstein has been co-lead counsel in this case since its inception in 2001. Plaintiffs alleged that Bristol-Myers Squibb unlawfully monopolized the United States market for paclitaxel, a cancer drug discovered and developed by the United States government, which Bristol sells under the brand name Taxol. Bristol's scheme included a conspiracy with American BioScience, Inc., a generic manufacturer, to block generic competition. Cohen, Milstein's investigation and prosecution of this litigation on behalf of direct purchasers of Taxol led to a settlement of $65,815,000 that was finally approved by U.S. District Judge Emmet G. Sullivan on August 14, 2003 and preceded numerous Taxol-related litigations brought by the Federal Trade Commission and State Attorneys General offices.

- Kruman v. Christie's International PLC, et al., Docket No. 01-7309. A $40 million settlement on behalf of all persons who bought or sold items through Christie's or Sotheby's auction houses in non-internet actions was approved in this action. Cohen Milstein served as one of three leading counsel on behalf of foreign plaintiffs. The Court noted that approval of the settlement was particularly appropriate, given the significant obstacles that faced plaintiffs and plaintiffs' counsel in the litigation. The settlement marked the first time that claims on behalf of foreign plaintiffs under U.S. antitrust laws have been resolved in a U.S. court, a milestone in U.S. antitrust jurisprudence.

- In re Infant Formula Consumer Antitrust Litigation (multiple state courts). Cohen Milstein instituted price-fixing cases on behalf of indirect-purchasers in 17 states under state antitrust laws against three companies who conspired to drive up the price of infant formula. The cases resulted in settlements of $64 million for purchasers of infant formula.

- Domestic Air Transportation Antitrust Litigation (N.D. Ga.) Plaintiffs alleged a conspiracy among major airlines to set prices. In one of the largest consumer class actions ever brought to a successful conclusion, Cohen Milstein was one of the lead counsel and obtained a settlement of travel discounts and cash totaling $458 million for the class of individuals and businesses.

- In re The Exxon Valdez Litigation, No. A89-095 Civ. (D. Ak.). The firm was selected from dozens of law firms around the country by federal and state judges in Alaska to serve as co-lead counsel for plaintiffs in the largest environmental case in United States history that resulted in a jury verdict of more than $5 billion (reversed and remanded for revised punitive damages award; further proceedings pending).

- Holocaust Litigation. In the historic Swiss Banks litigation, CMHT served, *pro bono,* as co-lead counsel for Holocaust survivors against the Swiss banks that collaborated with the Nazi regime during World War II by laundering stolen funds, jewelry and art treasures. Cohen Milstein obtained a $1.25 billion settlement, leading the

presiding judge to call the firm's work "indispensable." *See In re Holocaust Victim Assets Litig.*, Case No. CV 96-4849 (ERK) (MDG) (Memorandum of Chief Judge Korman dated July 26, 2002). The Firm was also a lead counsel in litigation by survivors of World War II-era forced and slave labor in litigation against the German companies that profited from using the labor of concentration camp inmates. This litigation, which resulted in an unprecedented settlement of $5.2 billion, was resolved by multinational negotiations involving the defendants, plaintiffs' counsel, and the governments of several countries for approximately two million claimants.

Cohen Milstein has contributed over 37,000 hours of time to human rights and *pro bono* cases since 1996. As an example, the Firm represented eight survivors and/or families of the victims of the September 11, 2001 attack on the Pentagon before the Federal compensation fund. Cohen Milstein has obtained a substantial recovery for each, including the highest recovery to date, $6.8 million, for an injured individual.

- Roberts v. Texaco, Inc., 94-Civ. 2015 (S.D.N.Y.). Cohen Milstein represented a class of African-American employees in this landmark litigation that resulted in the then-largest race discrimination settlement in history ($176 million in cash, salary increases and equitable relief). The Court hailed the work of class counsel for, *inter alia,* "framing an imaginative settlement, that may well have important ameliorative impact not only at Texaco but in the corporate context as a whole ...".

- Conanan v. Tanoue, No. 00-CV-3091 (ESH). Cohen Milstein represented African-American employees at the Federal Deposit Insurance Corporation (FDIC) in this race discrimination suit, which settled for $14 million. The settlement provides the largest payment made in an employment discrimination class action based on race against a federal agency.

- Trotter v. Perdue Farms, Inc., Case No. 99-893 (RRM) (JJF) (MPT), D. Del. This suit on behalf of hourly workers at Perdue's chicken processing facilities -- which employ approximately 15,000 people -- forced Perdue to pay employees for time spent "donning and doffing," that is, obtaining, putting on, sanitizing and removing protective equipment that they must use both for their own safety and to comply with USDA regulations for the safety of the food supply. The suit alleged that Perdue's practice of not counting donning and doffing time as hours worked violated the Fair Labor Standards Act and state law. In a separate settlement with the Department of Labor, Perdue agreed to change its pay practices. In addition, Perdue is required to issue retroactive credit under one of its retirement plans for "donning and doffing" work if the credit would improve employees' or former employees' eligibility for pension benefits. CMHT was co-lead counsel.

In addition, Cohen Milstein is an innovator in new areas of the law. The Firm was in the forefront of filing antitrust claims on behalf of indirect purchasers in 1993 and 1994, when it filed state-court actions in 18 states on behalf of indirect purchasers of infant formula. This was

the first effort to systematically and simultaneously pursue treble damages claims on behalf of indirect-purchasing consumers in all states where antitrust laws permitted such claims. This approach, and variations of it, have since become the accepted model for pursuing antitrust damages on behalf of indirect-purchasing consumers. The Firm also has been in the forefront of the development of international antitrust theory and litigation of claims. As the global economy has produced worldwide conglomerates, so, too, has the nature of antitrust violations changed. For example, in *Kruman v. Christie's International PLC, et al.* Docket No. 01-7309 and *In re Bulk Vitamins Antitrust Litigation*, MDL 1285 (D.D.C.), both the parties and the anticompetitive actions were played out on a world, rather than domestic, stage. The firm also represents and won Lead Plaintiff status for domestic and foreign investors in a foreign company's bonds, in a PSLRA litigation being pursued in the United States, *In re Parmalat Securities Litigation*, Master Docket 04 Civ 0030 (LAK) (S.D.N.Y.). The Firm has affiliated offices around the world, in the United Kingdom, Italy, South Africa, Panama and Australia.

Cohen, Milstein, Hausfeld & Toll, P.L.L.C. was established in March 1986 and is based in Washington, D.C. with offices in New York, Philadelphia and Chicago. From 1969 until 1986, the Firm was the Washington, D.C. office of the Philadelphia law firm currently known as Kohn, Swift & Graf, P.C..

The Firm has had one of the most varied and extensive plaintiffs' practices in the United States, and it has played a prominent role in major litigations since 1969. These cases include:

> In re North Atlantic Air Travel Antitrust Litigation, Civ. Action No. 84-1103 (D.D.C.); the Firm, as co-lead counsel, obtained a class settlement of $30 million in coupons for air travelers between the United States and England.
>
> In re Screws Antitrust Litigation, MDL No. 443 (D. Mass.); the Firm, as co-lead counsel, obtained a class settlement of approximately $50 million.
>
> Ocean Shipping Antitrust Litigation, MDL No. 395 (S.D.N.Y); the Firm, as co-lead counsel, obtained a class settlement of approximately $50 million.

In re Corrugated Container Antitrust Litigation, MDL No. 310 (S.D. Tex.); the Firm was one of a handful of firms involved in the successful trial of this massive antitrust case which was eventually settled for approximately $366 million.

Murphy, Derivatively On Behalf of Nominal Defendant National Health Laboratories Incorporated v. Perelman, Case No. 659511 (Cal. Sup. San Diego Cty.); as one of co-lead counsel in the derivative action, the firm and others obtained a global settlement of class and derivative litigation for $65 million.

In re Flat Glass Antitrust Litigation, MDL No.1200, (W.D. Pa.); the Firm as co-lead counsel obtained a total of $ 61.7 million in settlement funds on behalf of glass shops, window manufacturers, and others who directly purchased the affected products from the defendants.

Buspirone Antitrust Litigation, MDL No. 1413 (S.D.N.Y.); as one of four co-lead counsel, the Firm and others obtained a $90 million settlement for the class.

Masonite Hardboard Siding Litigation, Civ. Action No. 996787 (Cal. Super. Ct.); the Firm, as one of the lead counsel, obtained a settlement valued at hundreds of millions of dollars.

Polybutylene Pipe Litigation, Civ. Action No. W 2004-017770COA-R3-CV (W.D. Tenn.); the Firm helped obtain a settlement valued at $900 million.

Biben v. Card, No. 84-0844-CV-W-6 (W.D. Mo.); the Firm, as one of two co-lead counsel, negotiated settlements for $11.9 million, which was 93% of class members' damages.

In re Newbridge Networks Securities Litigation, Civ. Action No. 90-1061 (D.D.C.); the Firm, as co-counsel, obtained a cash and stock class settlement valued at approximately $20 million.

Jiffy Lube Securities Litigation, Civ. Action No. Y-89-1939 (D. Md.); the Firm, as co-lead counsel, obtained class settlements for a total of $12 million.

In re Saxon Securities Litigation, Civ. Action No. 82 Civ. 3103 (S.D.N.Y.); the Firm, as co-lead counsel, obtained a class settlement of approximately $20 million.

Grossman v. Waste Management, Civ. Action No. 83 Civ. 2167 (N.D. Ill.); the Firm, as co-lead counsel, obtained a class settlement of approximately $13 million.

In re Warner Communications Securities Litigation, 618 F. Supp. 735 (S.D.N.Y. 1986); the Firm was one of plaintiffs' counsel in this case where a class settlement of $18.4 million was obtained.

In re Tandon Securities Litigation, No. CV86-4566 (C.D. Cal.); the Firm played a major role in this class action where settlement was valued at approximately $16 million.

Immunex Securities Litigation, No. C92-548WD (W.D. Wash.); the firm was one of lead

counsel where the largest securities class action settlement in Seattle -- $14 million -- was recovered.

In re Caremark Securities Litigation, Case No. 94 C 4751 (N.D. Ill.); the Firm, as co-lead counsel, obtained a class settlement of $25 million.

In re Commercial Explosives Antitrust Litigation, Consolidated Case No. 2:96md 1093S (D. Utah); the Firm, as co-lead counsel, obtained a settlement of $77 million.

Cohen Milstein has also served as lead or co-lead counsel, or on Plaintiffs' Executive Committee(s), in many dozens of antitrust, securities, consumer protection or product liability, civil rights, and human rights class action cases.

Attorney Profiles - Partners

Michael D. Hausfeld

Michael Hausfeld, one of the country's top civil litigators, joined the Firm in 1971. He is a member of the Antitrust and International practice groups.

Mr. Hausfeld's career has included some of the largest and most successful class actions in the fields of human rights, discrimination and antitrust law. He long has had an abiding interest in social reform cases, and was among the first lawyers in the U.S. to assert that sexual harassment was a form of discrimination prohibited by Title VII; he successfully tried the first case establishing that principle. He represented Native Alaskans whose lives were affected by the 1989 Exxon Valdez oil spill; later, he negotiated a then-historic $176 million settlement from Texaco, Inc. in a racial-bias discrimination case.

In *Friedman v. Union Bank of Switzerland*, Mr. Hausfeld represented a class of victims of the Holocaust whose assets were wrongfully retained by private Swiss banks during and after World War II. The case raised novel issues of international banking law and international human rights law. He successfully represented the Republic of Poland, the Czech Republic, the Republic of Belarus, the Republic of Ukraine and the Russian Federation on issues of slave and forced labor for both Jewish and non-Jewish victims of Nazi persecution during World War II. He currently represents Jubilee 2000, Khulumani, and other NGOs in litigation involving abuses under apartheid law in South Africa, and is pursuing a RICO litigation against the tobacco industry with regard to the sale of and representations on "light" cigarettes.

Mr. Hausfeld has a long record of successful litigation in the antitrust field, on behalf of both individuals and classes, in cases involving monopolization, tie-ins, exclusive dealings and price fixing. He is or has been co-lead counsel in antitrust cases against manufacturers of genetically engineered foods, managed healthcare companies, bulk vitamin manufacturers, technology companies and international industrial cartels. He is actively involved in ongoing investigations into antitrust cases abroad, and was the only private lawyer permitted to attend and represent the interests of consumers worldwide in the 2003 closed hearings by the EU Commission in the Microsoft case.

Chief Judge Edward Korman (E.D.N.Y.), has noted that Mr. Hausfeld is one of the two "leading class action lawyers in the United States." He has been profiled in, and recognized by, many articles and surveys. Most recently, a *Forbes* magazine article reported on Mr. Hausfeld's work to establish an international alliance for the protection of consumers and investors worldwide. He was named one of thirty master negotiators in *Done Deal: Insights from Interviews with the World's Best Negotiators*, by Michael Benoliel, Ed.D. *The Wall Street Journal* profiled him and his practice, and he has been recognized by *The National Law Journal* as one of the "Top 100 Influential Lawyers in America." He has been described by one of the country's leading civil rights columnists as an "extremely penetrating lawyer", and by a colleague (in a *Washington Post* article) as a lawyer who "has a very inventive mind when it comes to litigation. He thinks of things most lawyers don't because they have originality pounded out of them in law school." *The New York Times* referred to Mr. Hausfeld as one of the nation's "most prominent antitrust lawyers," and *Washingtonian Magazine* has listed Mr. Hausfeld in several surveys as one of Washington's 75 best lawyers, saying he "consistently brings in the biggest judgments in the history of law" and that he is "a Washington lawyer determined to change the world -- and succeeding."

His most recent awards include the 2002 B'Nai Brith Humanitarian of the Year award; the Simon Wiesenthal Center Award for Distinguished Service; and the U.S. Department of Energy's Human Spirit Award, presented "in tribute to a person who understands the obligation to seek truth and act on it is not the burden of some, but of all; it is universal."

He is a frequent speaker on antitrust, human rights and international law, most recently participating in a panel discussion at the Spring Meeting of the ABA Section of Antitrust Law entitled "International Antitrust: Developments After Empagran and Intel" and at the School of Oriental and African Studies (SOAS) Annual Meeting in London entitled "Human Rights in An Integrated World: The Apartheid Reparations Litigation in the USA." He taught Masters Degree courses at Georgetown University Law Center from 1980 to 1987, and was an Adjunct Professor at the George Washington University Law School from 1996 to 1998 and now sits on its Board of Directors.

Mr. Hausfeld is a graduate of Brooklyn College, receiving a B.A. in Political Science with a minor in Russian History (*cum laud*e, 1966) and the National Law Center, George Washington University (J.D., *with honors*, 1969). He was a member of the Order of the Coif and the Board of Editors for the George Washington Law Review (1968-69).

He is admitted to practice in the District of Columbia.

Christine E. Webber

Christine Webber, a Partner at the Firm and a member of the Civil Rights & Employment Practice group, joined Cohen Milstein in 1997. She is the Partner in charge of the law clerk and summer associate program.

Ms. Webber represents plaintiffs in class action employment discrimination and Fair Labor Standards Act cases. Ms. Webber's current docket includes *Dukes v. Wal-Mart Stores, Inc.* (N.D. Cal.), a certified class action for 1.5 million current and former female employees of

Wal-Mart with complaints of discrimination in pay and promotion; *Hnot v. Willis* (S.D.N.Y.), representing a class of women at the vice-president level and above challenging sex discrimination in compensation and promotions; and *Jenkins v. BellSouth* (N.D. Ala.), representing a proposed class of African-American employees challenging race discrimination in promotions and compensation.

She represented plaintiffs in *Beck v. The Boeing Co.* (W.D. Wash.), a class action alleging sex discrimination in compensation and promotions which settled in 2004 for $72.5 million. She was counsel in *Trotter v. Perdue* (D. Del.), representing plaintiffs who were wrongly denied payment of overtime wages, and obtaining a $10 million settlement. She is also representing workers in a similar case against Tyson Foods, Inc.

In 2004, Ms. Webber was named one of the Top Lawyers in Washington, D.C. by *Washingtonian Magazine.*

Prior to joining Cohen Milstein, Ms. Webber received a Women's Law and Public Policy fellowship and worked for four years at the Washington Lawyers' Committee for Civil Rights and Urban Affairs in their Equal Employment Opportunity Project. She worked on a variety of employment discrimination cases, and focused in particular on the sexual harassment class action *Neal v. Director, D.C. Department of Corrections, et al.* Ms. Webber participated in the trial of this ground-breaking sexual harassment class action in 1995. Ms. Webber also tried the race discrimination case *Cooper v. Paychex* (E.D. Va.), and successfully defended the plaintiffs' verdict before the Fourth Circuit.

Ms. Webber is a member of the National Employment Lawyers' Association (NELA) and co-chair of their Class Action Committee, and is a member of the Board of Advisors for the Annual Review of Gender and Sexuality Law of the Georgetown Journal of Gender and Law.

She graduated from Harvard University with a B.A. in Government (*magna cum laude*, 1988) and the University of Michigan Law School (J.D., *magna cum laude*, 1991, Order of the Coif). Following law school, Ms. Webber clerked for the Honorable Hubert L. Will, United States District Judge for the Northern District of Illinois.

Ms. Webber is admitted to practice in Illinois and the District of Columbia.

Attorney Profiles – Of Counsel & Associates

Victoria S. Nugent

Victoria Nugent, an Associate, joined Cohen Milstein in 2000 and is a member of the Consumer Protection practice group.

Ms. Nugent has focused on consumer protection and public health litigation throughout her career, including *In re StarLink Product Liability Litigation* (N.D. Ill.), representing farmers whose corn crop was devalued as a result of StarLink's actions and recovering more than $100 million in a landmark settlement; *In re General Motors Dex-Cool Products Liability Litigation* (S.D.Ill.), representing car owners seeking to enforce product warranties for an extended life coolant; and *Howell v. State Farm* (D.Md.), representing flood policy holders who were denied

the full benefits of their government-backed insurance policies following Hurricane Isabel. Ms. Nugent has argued cases before the high courts of Georgia, Nebraska and the District of Columbia, and the federal D.C. Circuit Court of Appeals.

Before joining Cohen Milstein, she worked for seven years at Public Citizen, a national consumer advocacy organization. During that time, Ms. Nugent worked on many legislative and regulatory campaigns addressing issues that ranged from automobile safety to international trade policy. In 1998, Ms. Nugent received a two-year fellowship to undertake consumer rights litigation at Trial Lawyers for Public Justice (TLPJ), sponsored by the National Association for Public Interest Law (NAPIL). As a NAPIL Fellow, she helped develop and prosecute impact litigation in the areas of arbitration, banking, credit and insurance.

Ms. Nugent received her undergraduate degree in History from Wesleyan University in 1991 and graduated from Georgetown University Law Center in 1998.

Llezlie L. Green

Llezlie Green, an Associate at Cohen Milstein, joined the Firm in 2004 and is a member of the Civil Rights & Employment practice group.

Ms. Green currently is involved in *Keepseagle v. Veneman* (D.D.C.), where plaintiffs allege the USDA discriminated in granting access to and servicing of farm loans to Native American farmers and ranchers; *Chase v. AIMCO,* alleging that the U.S.'s largest apartment management company violates the Fair Labor Standards Act by failing to pay its maintenance employees for time spent responding to emergency tenant service requests; and *Arnold v. Cargill*, which alleges discrimination against African-American salaried employees in performance evaluations, promotions, compensation, and terminations.

Ms. Green is a member of the National Employment Lawyers Association and the Washington Council of Lawyers

Before joining Cohen Milstein, Ms. Green worked for Wilmer Cutler & Pickering, where she focused on complex litigation and securities investigations and worked on various civil rights and international human rights *pro bono* projects. Ms. Green then clerked for the Honorable Alexander Williams, Jr. on the United States District Court for the District of Maryland.

Ms. Green graduated from Dartmouth College with a B.A. in Government (*cum laude*, 1997) and Columbia Law School (J.D., 2002), where she was a Harlan Fiske Stone Scholar. At Columbia, Ms. Green was active in the Black Law Students Association, participated in the Human Rights Clinic, and served as an Articles Editor for the Columbia Human Rights Law Review. She authored a Note, *Gender Hate Propaganda and Sexual Violence in the Rwandan Genocide: An Argument for Intersectionality in International Law*, 33 Colum. Hum. Rts. L. Rev. 733 (2002). While in law school, Ms. Green interned at the Center for Constitutional Rights and the NAACP Legal Defense and Educational Fund.

Ms. Green is admitted to practice in New York and the District of Columbia.

Legal Resume of
Gordon Ball

Focusing on Consumer and Antitrust Class Actions

Suite 750, 550 Main Avenue
Knoxville, Tennessee 37902

Biography

Gordon Ball is a licensed Tennessee attorney whose practice focuses on consumer rights and antitrust class actions. Mr. Ball was born in Cocke County, Tennessee. He graduated from East Tennessee State University with a Bachelor of Science degree in 1970, and graduated from the Cecil C. Humphreys School of Law at Memphis State University in 1974. Mr. Ball entered the private practice of law the following year.

Mr. Ball has been admitted to or appeared before federal and state courts in Tennessee, Alabama, Arizona, California, Florida, Georgia, Indiana, Illinois, Kansas, Kentucky, Maryland, Michigan, New Mexico, New York, North Carolina, North Dakota, Oklahoma, South Dakota, West Virginia, and the District of Columbia.

In the late 1970's, Mr. Ball served as an Assistant United States District Attorney for the Eastern District of Tennessee. In 1977, he served as a delegate to the Tennessee Constitutional Convention. For several years after he returned to private practice, he specialized in the defense of "white-collar" federal prosecutions. In 1981, Mr. Ball was lead defense counsel in the case of *United States v. Sisk, et al* (aka, the "Pardons and Paroles" cases). His client was acquitted after a six-week trial. In 1986-87, Mr. Ball was lead defense counsel in the federal bank fraud prosecution of brothers Jake and C.H. Butcher, Jr., who had created a banking empire (United American Bank and C & C Bank) in East Tennessee. In *U.S. v. C.H. Butcher, et al.*, Mr. Ball was the only defense attorney to secure two not guilty jury verdicts during the *Butcher* trials.

Mr. Ball first became involved in major class action litigation in 1988, with *Shults v. Champion International Corporation.* Mr. Ball and his co-counsel represented approximately 2600 landowners against a paper company who had polluted the Pigeon River for nearly eighty years. Mr. Ball and his co-counsel litigated against one of the country's largest law firms and were successful in recovering $6.5 million for the landowners. Mr. Ball continues to litigate on behalf of landowners on the Pigeon River, filing a new lawsuit every three years. Recently, Mr. Ball obtained a jury verdict of $2 million against Blue Ridge Paper Co. for landowners.

For over fifteen years, Mr. Ball has been a pioneer in plaintiff's class action lawsuits on behalf of victims of abuse by powerful corporations. Mr. Ball has a long record of successful litigation on behalf of both individuals and classes, particularly in cases involving antitrust violations such as monopolization and price-fixing. Mr. Ball's aggregate multi-billion dollar recoveries have included cases against oil companies, telecommunications companies, health care companies, insurance companies, pharmaceutical companies, banks, auto manufacturers, record manufacturers, paper manufacturers, vitamin makers, boat manufacturers, stucco manufacturers, and supermarket chains. Mr. Ball and co-counsel are currently engaged in courtroom antitrust and consumer rights cases against credit card companies, electronics manufacturers, cigarette manufacturers, hospital bed manufacturers, and many others.

Mr. Ball has won a national reputation for fighting on behalf of American consumers by achieving recoveries in cases that other law firms did not want to handle. Several of the groundbreaking cases that Mr. Ball and his co-counsel have litigated have resulted in landmark decisions on previously untried or unsettled issues involving price-fixing and consumer rights.

An Experienced Class Action Litigation Firm

A lone consumer is often powerless against a powerful corporation. By creating a group or class, individuals can join together enhance their ability to assert their rights and challenge corporations who often have larger resources. As the premier class action law firm in Tennessee – and one of the premier class action firms in the South – Ball & Scott, and Mr. Ball in particular, specialize in cases concerning Antitrust Actions, Consumer Protection & Product Liability, and Healthcare Fraud. Mr. Ball has been involved as lead or co-counsel in dozens of class actions which have resulted in billions of dollars in recoveries for consumers. Although this list is not all-inclusive, Mr. Ball has represented (or is currently representing) consumers in the following class actions:

1. *Spartanburg Regional Health Services District, Inc. v. Hillenbrand Industries, Inc.*
($468,000,000 settlement in 2006; 6th largest antitrust settlement in U.S. history)

2. *Stinnett v. BellSouth Telecommunications*
($45,000,000.00 consumer settlement);

3. *Land v. United Tel. - Southeast*
($5,000,000.00 consumer settlement);

4. *In re Travel Agency Com'n Antitrust Litig.*
($70,000,000.00 settlement);

5. *Lowe v. Johnson City Medical Center Hospital*
($1,500,000.00 consumer settlement);

6. *Shelton v. Blue Cross and Blue Shield of Tennessee*
($4,000,000.00 consumer settlement);

7. *Nabors v. General Motors*
(nationwide settlement approved in Louisiana with settlement benefit to 6 million owners of GM vehicles);

8. *Cox, et al v. Shell Oil Co.*
($950,000,000.00 settlement) (product defect)
(One of the largest property damage settlement in U.S. history);

9. *Blake v. Abbott Laboratories, Inc.*
($62,000,000.00 settlement) (price-fixing of infant formula);

10. *Patrick v. Liberty Health Care Corp.*
($245,000.00 settlement) (unpaid sick leave);

11. *Hagy v. Sprint Cellular*
($4,000,000 settlement approved);

12. *Sandpiper Village Condominium Ass'n v. Louisiana-Pacific Corp.*,
($375,000,000.00 settlement) (defective hardboard siding;);

13. *Ottinger v. EMI Distribution, Inc.*
($65,000,000.00 nationwide settlement approved)
(price-fixing of compact discs);

14. *Sweet v. Ford Motor Co.*
($30,000,000 nationwide settlement approved as part of California settlement)
(multi-state class certified) (product defect);

15. *Fox v. American Cyanamid Co.*
($15,000,000.00 settlement) (vertical price-fixing conspiracy in pesticide market);

16. *Wilson v. Chesapeake Corp., et al.*
($600,000 Tennessee-only settlement) (horizontal price-fixing conspiracy in commercial tissue products market);

17. *Ferguson v. Columbia/HCA Healthcare Corp.*
($5,000,000 settlement) (overcharges in healthcare industry);

18. *Freeman v. Champion International Corporation*
($2,400,000 settlement) (nuisance action which alleged unlawful pollution of Pigeon River in Tennessee);

19. *McCampbell v. F. Hoffman - LaRoche Ltd., et al.*
($10,000,000 Tennessee settlement approved) (price-fixing conspiracy in vitamins market);

20. *Milligan v. Food Lion Corp.*
($3,000,000 nationwide settlement) (unfair or deceptive practices in sales tax charges);

21. *Hunter v. Bank One*
($25,000,000 nationwide settlement) (class certified) (deceptive bank financing practices);

22. *Carter v. First Tennessee Bank*
($7,000,000 nationwide settlement) (class certified) (deceptive bank financing practices);

23. *Posey v. Dryvit Corp.*
($50,000,000 nationwide settlement) (product defect in synthetic stucco);

24. *Couch v. Brunswick Corporation*
(Nationwide settlement for consumers valued at $125,000,000) (monopolization of inboard and stern drive marine engine market);

25. *Davis v. United States Tobacco Co., et al.*
($35,000,000 multi-state settlement) (unfair restraint in trade in smokeless tobacco market);

26. *Freeman v. Blue Ridge Paper Co.*
($2,000,000 jury verdict in 2005 in nuisance action against paper company for polluting Pigeon River in Tennessee; another suit pending);

Significant Settlements or Judgments

Mr. Ball has also served as one of the counsel in several major consumer and antitrust class actions, including:

Cox v. Shell Oil Company, et al. This lawsuit filed by Mr. Ball and a number of other counsel filed this case in 1995 charging Shell Oil Company, E.I. du Pont de Nemours, and Hoescht Celanese with manufacturing and marketing defective polybutylene pipes and plumbing systems. The settlement provided a minimum of $950 million settlement in relief and is the largest class action settlement of its kind in U. S. history.

Infant Formula Consumer Antitrust Litigation. Mr. Ball, along with co-counsel, instituted class actions in multiple state courts against three companies who conspired to drive up the price of infant formula. The cases resulted in an aggregate settlement of $64,000,000.00. Foremost among the cases was ***Blake v. Abbott Laboratories***, Civil Action Number L-8950 (Circuit Court, Blount Cty., Tennessee). ***Blake*** was the first opinion in the history of Tennessee jurisprudence granting indirect purchasers a private right of action under state antitrust and consumer protection laws.

Spartanburg Regional Health Services District, Inc. v. Hillenbrand Industries, Inc. Mr. Ball also represents Spartanburg Regional Health Services District in a direct purchaser class action against Hillenbrand Industries that was filed in 2003. *Spartanburg Regional Health Services District, Inc. v. Hillenbrand Industries, Inc.*, No. CA 7:03-2141-HFF (D.S.C.) After substantial discovery, a settlement was been reached between the parties in the *Spartanburg* case, providing for certification of a class of purchasers and a total of nearly $490 million in relief, including a cash payment to the class of $337.5 million (representing the sixth largest amount ever recovered in an antitrust class action). Research shows that *Spartanburg* was the first-ever direct purchaser class action successfully challenging the monopoly bundling of medical products.

Honors & Awards

In the late 1980's, Mr. Ball was selected to be included in the publication *The Best Lawyers in America* and has been included in every subsequent publication since 1989. In 1997, Mr. Ball was a recipient of a *Public Justice Achievement Award* by the *Trial Lawyers for Public Justice* for his work on behalf of consumers in the polybutylene pipe product liability litigation, which resulted in an unprecedented settlement providing a minimum of $950 million in relief and a potentially unlimited maximum recovery for property owners.

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BIOGRAPHY OF ROBERT POTTER AND MANN, COWAN & POTTER, P.C.

John "Robert" Potter began practice of law in the State of Alabama in 1994. For the past twelve years, he has exclusively practiced in the area of civil litigation. The entire twelve years of Mr. Potter's practice has involved representing plaintiffs in civil litigation. He began his practice with Pittman, Hooks, Marsh, Dutton & Hollis, P.C. for five and one-half years and since May 1999 has been associated with Mann, Cowan & Potter, P.C. The other partner with Mann, Cowan & Potter, P.C. is David M. Cowan formerly of Heninger, Burge & Vargo, P.C. Mann, Cowan & Potter, P.C. is a plaintiff's firm in Birmingham, Alabama representing plaintiffs in civil litigation.

Mr. Potter graduated in 1994 from Birmingham School of Law in Birmingham, Alabama. Mr. Potter has practiced before the state courts of Alabama, federal courts sitting in the Southern, Middle and Northern Districts of Alabama and the Eleventh Circuit Court of Appeals in Atlanta, Georgia.

Mr. Potter is an active member of the Alabama Bar Association, Alabama Trial Lawyers Association, American Trial Lawyers Association and the Birmingham Bar Association. Mr. Potter is a member of the Board of Governors of the Alabama Trial Lawyers Association.

Mr. Potter has tried numerous cases in state courts and federal courts within the State of Alabama. Mr. Potter is thirty-eight years of age and has been admitted to practice law since 1994 in the State of Alabama. He has been involved in a number of complex litigation cases, including *Bobby Davis v. State Farm Ins. Co.; Moseley v. Peoples Bank and Trust* (class action settlement); *Turner v. West AL Bank* (class action); *Woodson v. Troy Bank and Trust* (class action); *Baker v. Jacobs Bank* (class action); *Marcus Harris v. Honda Motor Co. Ltd.*, CV-05-5206, Circuit Court of Jefferson County, Alabama; *Nancy Tucker v. General Motors*, CV-06-342, Circuit Court of

Talladega County, Alabama; *V.C. Holt v. Precision Manufacturing*, CV-99-651, Circuit Court of Walker County, Alabama; *Ricky L. Wright v. Materials Marketing* CV-01-082 Circuit Court of Pickens County, Alabama; *Barnabas May v. Good Hope Contracting Co., Inc.*, CV-03-1391, Circuit Court of Jefferson County (Bessemer Division), Alabama; *Agathe Long v. Osborn Transportation, Inc.*, CV-04-1059, Circuit Court of Etowah County, Alabama; *Elzie Porter v. Druid City Hospital*, CV-04-043, Circuit Court of Tuscaloosa County, Alabama; *James Bowles v. Bobby Parks Truck & Equipment, Inc.*, CV-02-1510, Circuit Court of Tuscaloosa County, Alabama; *LaSandra Hurst v. R&O Transportation*, CV-04-314, Circuit Court of Forrest County, Mississippi; *Ruiz de Molina v. Merritt & Furma*, U.S.D.C., N.D. Ala.; and many other cases involving wrongful death, insurance fraud, insurance bad faith, consumer fraud, products liability and personal injuries.

EXHIBIT F

Not Reported in F.Supp.2d, 2005 WL 1027078 (D.Neb.)
(Cite as: Not Reported in F.Supp.2d)

H

Briefs and Other Related Documents

In re Union Pacific R.R. Employment Practices LitigationD.Neb.,2005.Only the Westlaw citation is currently available.

United States District Court,D. Nebraska.

In re: UNION PACIFIC RAILROAD EMPLOYMENT PRACTICES LITIGATION.

No. MDL 1597, 803CV437.

March 31, 2005.

Donald J. Munro, Jeffrey D. Fox, Thomas J. Mikula , Goodwin, Procter Law Firm, Washington, DC, Emi Murphy Donis, Bullard, Smith Law Firm, Jeffry S. Garrett, Paul B. George, Foster, Pepper Law Firm, Portland, OR, James A. Boevers, John S. Chindlund, Prince, Yeates Law Firm, J. Randall Call , Salt Lake City, UT, Brenda J. Council, Whitner Law Firm, Brian J. McGrath, Lamson, Dugan Law Firm, Omaha, NE, for Union Pacific R.R. Employment Practices Litigation.

Barbara C. Frankland, Rex A. Sharp, Gunderson, Sharp Law Firm, Prairie Village, KS, Claire Cordon , T. David Copley, Keller, Rohrback Law Firm, Kelly S. Reese, Roberta N. Riley, Planned Parenthood of Western Washington, Seattle, WA, Rick D. Holtsclaw, Holtsclaw, Kendall Law Firm, Sylvester James, Jr., Sly James Law Firm, Kansas City, MO, Stephen L. Brischetto, Portland, OR, Michael L. Schleich, Fraser, Stryker Law Firm, Omaha, NE, for Brandi Standridge, et al.

MEMORANDUM AND ORDER

SMITH CAMP, J.

***1** This matter is before the Court on the Report and Recommendation (Filing No. 166, ("R & R")) issued by Magistrate Judge F.A. Gossett, recommending the Plaintiffs' Motion for Class Certification (Filing No. 34) [FN1] be granted. The Defendants in these combined cases, the Union Pacific Railroad Company and the Board of Trustees of Union Pacific Employees Health Service collectively ("UPRR"), filed a Statement of Objection to the Report and Recommendation (Filing No. 171) and submitted a brief (Filing No. 173) as allowed by 28 U.S.C. § 636(b)(1)(C) and NECivR 72.3, and the scheduling order (Filing No. 167). The named plaintiffs, Brandi Standridge and Kenya Phillips, on behalf of themselves and all who are similarly situated ("proposed class members"), have submitted a brief in opposition to UPRR's Statement of Objections (Filing No. 175). For the reasons stated below, the Magistrate Judge's Report and Recommendation will be adopted as modified, and the Plaintiffs' Motion to Certify Class will be granted, as modified.

FN1. The recommendation misidentifies the Plaintiffs' Motion for Class Certification as Filing No. 35.

STANDARD OF REVIEW

The authority of federal magistrate judges is established in 28 U.S.C. § 636(b)(1)(A), which treats motions to "dismiss or permit the maintenance of a class action" as dispositive. Therefore, pursuant to NECivR 72.3, a magistrate judge's recommendation concerning class certification is reviewed *de novo* and the objecting party is required to file a statement of objection specifying the portions of the recommendation to which the party objects. The Court may accept, reject, or modify, in whole or in part, a magistrate judge's findings or recommendations.

STATEMENT OF FACTS

The Plaintiffs bring these actions, which have been transferred to this district by the Judicial Panel on Multidistrict Litigation, alleging sex discrimination in violation of Title VII of the Civil Rights Act of 1964, 42 U.S.C. § 2000e *et. seq.* as amended by the Pregnancy Discrimination Act, 42 U.S.C. §

2000e(k). Plaintiffs allege that the Defendants' decision to deny coverage for prescription contraceptives that are prescribed for the purpose of preventing pregnancy violates federal law. The named Plaintiffs and the proposed class members are all union members, referred to as "agreement employees" who receive or in the past have received health benefits under one or more plans referred to as "Agreement Plans." (*See* R & R at 2 for summary description of "Agreement Plans.") The Plaintiffs seek to certify a class defined as: "All females employed by Union Pacific Railroad Company at any time since February 9, 2001, enrolled in one of the Agreement Plans who used prescription contraception without insurance reimbursement from said plan, and those who will use such prescription contraception in the future." (Filing No. 150, Plaintiffs' Reply Brief at page 2.)

In support of Plaintiffs' Motion to Certify Class (Filing No. 34), Plaintiffs submitted an index (Filing No. 36) and a brief (Filing No. 35), and the UPRR filed a brief and evidence in opposition (Filing Nos. 135, 136). Judge Gossett issued a Report and Recommendation recommending that the class be certified pursuant to Fed.R.Civ.P. 23(b)(2), defined as:
***2** All females employed by Union Pacific Railroad Company at any time since after February 9, 2001, enrolled in one of the Agreement Plans who used prescription contraception without insurance reimbursement from said plan, and those who will use such prescription contraception in the future.

Filing No. 166.[FN2] Judge Gossett certified the class as requested, concluding that the four requirements of Rule 23(a) had been satisfied and that the case could be maintained as a class action pursuant to Rule 23(b)(2). In response, the Defendant filed a Statement of Objection to the Magistrate's Report and Recommendation (Filing No. 171), which the parties have fully briefed. (Filing Nos. 173 and 175).

FN2. The Report and Recommendation was filed under seal, but the parties now request that it be unsealed and that this Memorandum and Order not be sealed. I will direct the Clerk of the Court to unseal filing no. 166.

UPRR Objections

UPRR's first objection to the Magistrate Judge's report and recommendation is that the class definition is overbroad. UPRR argues that the class as defined includes female employees who are currently eligible to receive coverage for prescription contraception that is medically necessary for a reason other than to prevent pregnancy. Because these women have not been denied coverage, UPRR argues that they have suffered no injury.

The second objection is that the Magistrate Judge erred in concluding that the class should be certified under Rule 23(b)(2), because, according to UPRR, the monetary relief sought by the plaintiffs is more than "incidental" to the injunctive and declaratory relief that is also sought by the plaintiffs. UPRR argues that under the analysis set forth by the Fifth Circuit in *Allison v. Citgo Petroleum Corp.*, 151 F.3d 402, 411 (5th Cir.1998), and relied upon by this court in *Clayborne v. Omaha Pub. Power Dist.*, 211 F.R.D. 573, 579 (D.Neb.2002), monetary relief cannot be considered "incidental" if it is dependent upon subjective differences of each class member and would require additional hearings to resolve the disparate merits of an individual's claim.

ANALYSIS

To obtain certification of a class, a plaintiff must demonstrate compliance with the requirements of Rule 23(a), that: (1) the class is so numerous that joinder of all members is impracticable-numerosity, (2) there are questions of law or fact common to the class-commonality, (3) the claims or defenses of the representative parties are typical of the claims or defenses of the class-typicality, and (4) the representative parties will fairly and adequately protect the interests of the class-adequacy of representation. Additionally, a plaintiff must show that certification is appropriate under one of the subparagraphs of Rule 23(b). The Plaintiffs contend that the proposed class satisfies Rule 23(b)(2),

because the UPRR, as the party opposing the class, has acted or refused to act on grounds generally applicable to the class, thereby making the appropriate final injunctive relief or corresponding declaratory relief appropriate with respect to the class as a whole.

Numerosity

In considering UPRR's objections, I turn first to the requirements of Rule 23(a). With regard to the numerosity requirement, UPRR advances the objection that there are persons included in the recommended class definition to whom no injury has occurred, and therefore, the numerosity requirement has not been satisfied.

***3** After carefully considering the demographic information provided by UPRR regarding its female work force under 50 years of age (*see* R & R at 9, Tables 1 and 2), Judge Gossett determined that as of January 1, 2004, UPRR had between 490 and 581 female employees covered by one of the applicable health plans who were under the age of 50 and enrolled in a health plan offered by UPRR. Relying in part on the statements of Plaintiffs' expert witness, Leon Speroff, M.D., that a woman who wishes to have two children will require contraceptive protection for approximately 20 years of her life, Judge Gossett found that it was highly unlikely that fewer than 40 of those UPRR's female agreement employees fall within the class description, and he concluded that the numerosity requirement of Rule 23 had been satisfied. I agree.

Judge Gossett rejected UPRR's argument, (which it renews in the form of an objection to the Report and Recommendation), that more than half of the employees cannot be included in the proposed class because they would likely obtain coverage for prescription contraceptives if they filed a claim for coverage and provided the plan administrators with information showing that the prescription contraceptive was "medically necessary" for a purpose other than preventing pregnancy. While Judge Gossett noted that the UPRR's expert witness Suzanne Lowry, M.D., stated that, in her experience, 70 to 80 percent of prescriptions ordered for contraceptive purposes were simultaneously written for specific non-contraception health benefits, (Filing No. 136 at Ex. 10), he did not find that information to defeat the proposed class definition because the Complaint seeks health plan coverage for prescription contraceptives used "for the purpose of preventing pregnancy." Relying in part on the statements of Plaintiffs' expert witness, Leon Speroff, M.D., that there are significant health benefits related to preventing pregnancy, such as the ability to control the number and spacing of pregnancies and that the health risks to a woman of pregnancy are far greater than the health risks associated with the use of contraception, Judge Gossett determined that the UPRR's argument could not prevail because it did not address the claim advanced in the Complaint.

The UPRR asserts the same argument as an objection to the Report and Recommendation. The UPRR argues that the class is overbroad, lacks definition, and fails the numerosity requirement because it includes "female employees who are currently eligible to receive coverage for prescription contraceptives." UPRR argues that since these employees have made no claim for contraceptives that have been denied, they have not been injured. (Filing No. 172, Statement of Objections at ¶ 1). Like Judge Gossett, I too reject this argument because it sidesteps the primary claim asserted in the Complaint. Those persons who may be denied coverage for prescription contraceptives that are used for purposes *other than to prevent pregnancy* are not the persons whom the Plaintiffs seek to represent. Persons who take prescription contraceptives may be divided into three groups: those who take them for reasons not associated with preventing pregnancy, those who take them to prevent pregnancy, and those who take them for the dual or multiple purposes of preventing pregnancy and for some other health benefit. Plaintiffs seek certification for those female employees who have taken prescription contraceptives for the purpose of preventing pregnancy. Based on the evidence that there are approximately 500 female agreement-employees under the age of 50; that the average female who wishes to have two children will have to use contraception for approximately 20 years; and that there are preventive health benefits

associated with the prevention of unwanted pregnancies; I conclude that the numerosity requirement of Rule 23(a) has been satisfied. (Filing No. 150, Speroff Declaration).[FN3]

> FN3. Even if I were to assume as true that 70 to 80 percent of women who take prescription contraceptives would be able to satisfy the "medically-necessary" standard in UPRR's health plans, (*see* Filing No. 136, Lowry Dec.), then those female UPRR employees who wish to take contraceptives who cannot satisfy the medically-necessary standard would still number, conservatively-estimated, approximately 98. (20 percent of 490). Even if I were to remove from the group of 98 the 25 percent who, it has been stated, cannot use oral contraceptives, then there are approximately 75 of the 490 female agreement employees who would be subsumed in the class of those persons who want coverage for prescription contraceptives solely for the purpose of preventing pregnancy but who cannot get coverage under an Agreement Plan. Under any reasonable scenario, the numerosity requirement is satisfied.

Commonality

***4** Judge Gossett also considered commonality and concluded that the legality of UPRR's employment practice of not providing coverage for prescription contraceptives for the purpose of preventing pregnancy affects all members of the proposed class. The UPRR has not seriously challenged Plaintiffs' showing of commonality, and I agree that there is strong evidence that questions of law and fact common to all members of the proposed class exist. I conclude that the commonality component has been satisfied.

Typicality

In determining whether the "typicality" requirement is satisfied, Judge Gossett considered the UPRR's argument that Brandi Standridge's claims are not typical of the class members, because she would be able to demonstrate that her prescription contraceptive is "medically necessary" for a purpose other than preventing pregnancy, and she would likely obtain coverage for the prescription under the UPRR's health plans. Judge Gossett assumed, without deciding, that Standridge could make such a showing, but he rejected that such a showing defeated the typicality requirement because Standridge seeks coverage for the prescription for the purpose of birth control.

Judge Gossett found, and I believe the evidence demonstrates, that Brandi Standridge and Kenya Philips have been covered by the Agreement Plans, that they have used and continue to use prescription contraceptives for the purpose of preventing pregnancy, that they consider it a hardship to pay for the prescriptions, and that their attempts to obtain coverage under an Agreement Plan have been unsuccessful. (Filing No. 136, Ex. 8, Standridge Dep. at 38, 42, 91, 109-113, 124, 142 (also Filing No. 150 Ex. A9); and Filing No. 136, Ex. 15, Philips Dep. at 66-71, 77-79, 84 (also Filing No. 150 Ex. A10)). Based on this evidence, I agree with Judge Gossett's conclusion that Standridge and Philips have standing and possess the same interests as the proposed class members. The "typicality" requirement of Rule 23(a) has been satisfied.

Adequacy of Representation

There is no objection to the adequacy of representation. "Adequacy of representation" means that the class representative have common interests with the unnamed class members and the representatives have sufficient motive and ability to prosecute the interests of the class vigorously through qualified counsel. Judge Gossett determined that there was no genuine dispute that plaintiffs' counsel are experienced in this area of the law and that they have the means to litigate the matter as a class action. (*See also* Filing No. 36). I see no issue raised as to the adequacy of representation in the Statement of Objection, and I conclude that this requirement of Rule 23(a) is satisfied.

Rule 23(b)(2)

Judge Gossett concluded that the Plaintiffs had demonstrated that the action could be maintained as a class action under Rule 23(b)(2). Judge Gossett acknowledged that Rule 23(b)(2) permits class actions for declaratory relief and injunctive relief provided that the requirements of subdivision (a) are satisfied, and in cases where "the party opposing the class has acted or refused to act on grounds generally applicable to the class, thereby making appropriate final injunctive relief or corresponding declaratory relief with respect to the class as a whole." Fed.R.Civ.P. 23(b)(2). As the Advisory Committee Notes to Rule 23 state, Rule 23(b)(2) certification "does not extend to cases in which the appropriate final relief relates exclusively or predominately to money damages." Judge Gossett determined that the declaratory relief and injunctive relief [FN4] sought by the Plaintiffs predominate over any monetary damages sought by them. I agree.

> FN4. Plaintiffs seek a declaration that UPRR has violated Title VII, and an injunction prohibiting the UPRR from engaging in illegal and discriminatory conduct and requiring "Union Pacific to issue and disseminate to all eligible employees a revised benefit plan that covers all FDA-approved prescription contraceptive drugs and devices and all clinical services associated with each prescription contraceptive method"

***5** UPRR objects to that part of the Report that concludes that the monetary relief sought by the Plaintiffs is only "incidental" to the declaratory and injunctive relief. UPRR contends that Judge Gossett's failure to consider the factors set out by the Fifth Circuit in *Allison,* that were cited in *Clayborne,* led him to the erroneous conclusion that the requirements of Rule 23(b)(2) were satisfied. UPRR argues that because the monetary relief requested in this case is significantly dependent upon the subjective differences of each class member, and because, if they are successful, each individual plaintiff would require additional hearings to resolve the merits of each individual's case, monetary damages are not merely "incidental" to the declaratory and injunctive relief they seek. *See also Clayborne,* 211 F.R.D. at 599.

While it is true that Judge Gossett did not address the Fifth Circuit's *Allison* decision or the circuit courts' split that was created when, in 2001, the Second Circuit Court of Appeals adopted a different standard, *see, e.g., Robinson v. Metro-North Commuter R.R.,* 267 F.3d 147 (2nd Cir.2001), I find that under either analysis, Plaintiffs' proposed class should be certified under Rule 23(b)(2).[FN5] UPRR's objection must be overruled because the declaratory and injunctive relief that the Plaintiffs seek predominates over any "monetary equitable relief" to which the Plaintiffs may be entitled, such as lost fringe benefits, back pay, and out-of-pocket expenses incurred by the Plaintiffs.

> FN5. The Third, Sixth, Seventh and Eleventh Circuits have adopted the *Allison* predominance standard. The Ninth Circuit has adopted the *Robinson ad hoc* approach. Both *Allison* and *Robinson* have been have been relied upon by judges in this district. Compare *Barabin v. Aramark Corp.,* 2003 WL 355417 (3rd Cir.), *Coleman v. Gen. Motors Acceptance Corp.,* 296 F.3d 443, 446-7 (6th Cir.2002); *Murray v. Auslander,* 244 F.3d 807, 812 (11th Cir.2001), *Lemon v. Int'l Union of Operation Eng'rs,* 216 F.3d 577, 580-81 (7th Cir.2000) with *Molski v. Gleich,* 318 F.3d 937, 949-50 (9th Cir.2003). Compare *Clayborne v. OPPD,* 211 F.R.D. 573, 599 (D.Neb.2002) with *Evans v. American Credit Systems, Inc.,* 222 F.R.D. 388, 396 (D.Neb.2004).

The Fifth Circuit stated that "incidental damages" are those that "flow directly from liability to the class as a whole on the claims forming the basis of the injunctive relief." *Allison,* 151 F.3d at 415. It cautioned that liability for incidental damages should not require additional hearings to resolve the disparate merits of each individual's case, nor should it introduce new and substantial legal or factual issues, nor entail individualized

determinations. *Id.* It also stated that "because of the group nature of the harm alleged and the broad character of th relief sought, the (b)(2) class is, by its very nature, assumed to a homogenous and cohesive group with few conflicting interests among its members. The underlying premise of the (b)(2) class [is] that its members suffer from a common injury properly addressed by class-wide relief." *Id.* at 413. Under the Second Circuit's analysis, a court must focus on the subjective purpose of the class by "assess[ing] whether (b)(2) certification is appropriate in light of the relative importance of the remedies sought, given all the facts and circumstances of the case." *Robinson,* 267 F.3d at 164.

If the Plaintiffs prevail and demonstrate that they are entitled to back pay, then I surmise that proof relating to "equitable monetary damages" is most likely to be in the form lost fringe benefits in the amount approximating the expenses that the Plaintiff class members had to pay out-of-pocket during the relevant time period. This is not a case where individualized inquiry needs to be made to determine back pay or fringe benefits other than those related to the coverage of prescription contraceptives. The inquiry into equitable monetary damages would not be complex and almost certainly could be done on affidavit without a need for hearing. Finally, this is not a case involving compensatory and punitive damages that gives rise to due process concerns, which in turn would trigger mandatory class member notice and opt-out rights such as are required under Rule 23(b)(3).

Modifications

***6** I believe two modifications to the class definition are appropriate. First, to address the issue raised by UPRR that some persons who may use prescription contraceptives solely for a purpose other than to prevent pregnancy and who have not asked for coverage should not be within the class, the definition of the class will be modified by adding the phrase "at least in part for the purpose of preventing pregnancy." Second, I conclude that it is preferable to exclude from the definition "those who will use such prescription contraception in the future." Reference to "future" users is not necessary, given that the predominant remedies sought in this action are injunctive and declaratory relief. Thus, if the Plaintiffs prevail, they will obtain the declaratory and injunctive relief they seek which will protect the rights of future prescription contraceptive users.

Conclusion

The Eighth Circuit Court of Appeals has recognized that one of the purposes of class actions is eliminating "the possibility of repetitious litigation and providing small claimants with a means of obtaining redress for claims too small to justify individual litigation." *DeBoer v. Mellon Mortg. Co.,* 64 F.3d 1171, 1176 (8th Cir.1995)(quoting *Wetzel v. Liberty Mut. Ins. Co.,* 508 F.2d 239, 249 (3d Cir.) , *cert. denied,* 421 U.S. 1011 (1975)). I conclude that these purposes will be served in this case by certifying a class in this litigation.

I conclude that the class as defined by Judge Gossett, with the modifications noted herein, should be certified. The requirements of Rule 23 have been satisfied. The numerosity, commonality, and typicality requirements of Rule 23(a) have been demonstrated. I am persuaded that the representative parties can fairly and adequately protect the interests of the class. The proposed class members can be readily identified. The class members will seek declaratory and injunctive relief, which predominate over monetary relief. Therefore, the class action form serves a useful purpose. For all these reasons,

IT IS ORDERED:
1. Defendant's Statement of Objection (Filing No. 171) is overruled;
2. The Magistrate Judge's Report and Recommendation (Filing No. 166) is adopted in its entirety;
3. Plaintiffs' Motion for Class Certification (Filing No. 34) is granted;
4. Pursuant to Fed.R.Civ.P. 23(a) and (b)(2), the following is the certified class:
All females employed by Union Pacific Railroad Company after February 9, 2001, enrolled in one of

the Agreement Plans who used prescription contraception, at least in part for the purpose of preventing pregnancy, without insurance reimbursement from said Plan.
5. The Class Representatives are Brandi Standridge and Kenya Phillips;
6. Having considered the factors outlined in Fed.R.Civ.P. 23(g), Plaintiffs' counsel of record are appointed to serve as class counsel. Any person who objects to this appointment must file a written objection to the appointment within 10 days of the date of this order; and
*7 7. The Clerk of the Court is hereby directed to unseal the Report and Recommendation (Filing No. 166).

D.Neb.,2005.
In re Union Pacific R.R. Employment Practices Litigation
Not Reported in F.Supp.2d, 2005 WL 1027078 (D.Neb.)

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• 2003 WL 23791078 (Trial Motion, Memorandum and Affidavit) Plaintiffs' Memorndum in Support of Plaintiffs' Motion for Class Certification (Oct. 1, 2003) Original Image of this Document (PDF)
• 2003 WL 24251829 (Trial Motion, Memorandum and Affidavit) Response To Plaintiff's First Set of Requests for Admission by Defendant Union Pacific Railroad Company (Sep. 8, 2003) Original Image of this Document (PDF)

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EXHIBIT G

LEXSEE 1996 U.S. DIST. LEXIS 3381

MELODEE SHORES, etc. et al., Plaintiffs, v. PUBLIX SUPER MARKETS, INC., Defendant.

Case No. 95-1162-CIV-T-25(E)

UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF FLORIDA, TAMPA DIVISION

1996 U.S. Dist. LEXIS 3381; 69 Empl. Prac. Dec. (CCH) P44,477

March 12, 1996, DONE and ORDERED
March 12, 1996, FILED

CASE SUMMARY:

PROCEDURAL POSTURE: Plaintiff employees claimed that defendant employer engaged in an ongoing, company-wide practice of discriminating against its female employees. The matter was before the court on the employees' motion for class certification. The employer opposed class certification.

OVERVIEW: In their employment discrimination action, the employees sought to have a class certified pursuant to *Fed. R. Civ. P. 23(b)(2)* or *Fed. R. Civ. P. 23(b)(3)*. In granting the motion for class certification, the court found that the employees met their burden of establishing the existence of a sufficient number of women similarly situated and inclined to pursue the action against the employer, that the complaint raised questions of law and fact common to the entire class, that the employees' claims were typical of the class claims, and that each of the employees' counsel possessed the qualifications, experience, and abilities necessary for undertaking a class action. The court also found that the employees satisfactorily alleged that the employer acted on grounds generally applicable to the class and held that a hybrid class under *Fed. R. Civ. P. 23(b)(2)* class was the appropriate mechanism for the resolution of the case. The court determined, however, that the employees' proposed class was overbroad in that it had no time limitation. Thus, the court used the earlier-filed Equal Employment Opportunity Commission charge as a starting point.

OUTCOME: The court granted the motion for class certification.

LexisNexis(R) Headnotes

Civil Procedure > Class Actions > Prerequisites > General Overview
[HN1] The court must conduct a rigorous analysis before determining that class certification is appropriate, but the court may not conduct an inquiry on the merits at that early stage in the proceedings.

Civil Procedure > Class Actions > Prerequisites > Commonality
Civil Procedure > Class Actions > Prerequisites > Numerosity
Civil Procedure > Class Actions > Prerequisites > Typicality
[HN2] To obtain class certification, plaintiffs must demonstrate that they meet the general class certification requirements set forth in *Fed. R. Civ. P. 23(a)*. Those requirements are commonly referred to as (1) numerosity; (2) commonality; (3) typicality; and (4) adequacy of representation. After determining that those prerequisites have been met, the court must then determine which, if any, form of class action is appropriate pursuant to *Fed. R. Civ. P. 23(b)*.

Civil Procedure > Class Actions > Certification
Civil Procedure > Class Actions > Prerequisites > General Overview
Civil Procedure > Judgments > Relief From Judgment > General Overview
[HN3] Given the requirement of *Fed. R. Civ. P. 23(c)(1)* that a certification decision be made as soon as practicable after the commencement of the action, the standard of proof in support of certification is liberal. That liberality is tempered by the court's duty to modify or vacate a certification order as the case progresses.

Civil Procedure > Class Actions > Prerequisites > General Overview
[HN4] The fact that a large number of potential class members are satisfied with the status quo, or are unwilling to come forward, cannot defeat class certification.

Civil Procedure > Class Actions > Certification
Civil Procedure > Class Actions > Class Members > General Overview
Civil Procedure > Class Actions > Prerequisites > General Overview
[HN5] In an employment discrimination class, plaintiffs must specifically identify questions of law and fact common to the named plaintiffs and putative class members. At class certification, plaintiffs need only make a showing sufficient for the court to infer that class members suffered from a common policy of discrimination that pervaded the challenged employment decisions. However, *Fed. R. Civ. P. 23* does not require that all the questions of law and fact raised by the dispute be common.

Labor & Employment Law > Discrimination > Title VII of the Civil Rights Act of 1964 > General Overview
[HN6] The Eleventh Circuit holds that where an employer does not post openings or take applications for promotion, but uses an informal promotion system, the employer has a duty to consider all those who might reasonably be interested, as well as those who have learned of the job opening and expressed an interest.

Labor & Employment Law > Discrimination > Title VII of the Civil Rights Act of 1964 > General Overview
[HN7] the mere fact that an employer uses subjective criteria in its decision making process is not a per se violation of Title VII of the Civil Rights Act of 1964.

Civil Procedure > Class Actions > Prerequisites > Commonality
Civil Procedure > Class Actions > Prerequisites > Typicality
Labor & Employment Law > Discrimination > Actionable Discrimination
[HN8] Allegations of similar discriminatory employment practices, such as the use of entirely subjective personnel process that operate to discriminate, satisfy the commonality and typicality requirements of fed. R. Civ. P. 23(a).

Civil Procedure > Class Actions > Prerequisites > General Overview
Evidence > Testimony > Experts > Credibility > Impeachment
[HN9] Statistical dueling is very much a matter in dispute directed at the merits of the case. It is inappropriate for the court to determine the ultimate correctness of either parties' contentions in the context of class certification.

Civil Procedure > Class Actions > Class Members > General Overview
Civil Procedure > Class Actions > Prerequisites > General Overview
[HN10] The mere fact that questions peculiar to each individual member of the class remain after the common questions of the defendant's liability have been resolved does not dictate the conclusion that a class action is impermissible.

Civil Procedure > Class Actions > Prerequisites > General Overview
[HN11] Plaintiffs' claims are typical of the class where their claims arise from the same event or pattern or practice and are based on the same legal theory as the claims of the class. There is no requirement that the named plaintiffs each personally experience every difficulty outlined in the complaint. Rather, it is sufficient that the claims of the named plaintiffs are substantially similar to the claims of the class.

Civil Procedure > Class Actions > Prerequisites > General Overview
[HN12] Prior to certifying a class, the court must determine that plaintiffs' counsel are qualified, experienced, and generally able to conduct the litigation. The court must also determine that plaintiffs are adequate representatives of the class, and do not have interests antagonistic to the rest of the class.

Civil Procedure > Class Actions > Prerequisites > Commonality
[HN13] An action is maintainable under fed. R. Civ. P. 23(b)(2) when the plaintiff alleges that the defendant has acted or refused to act on grounds generally applicable to the class, thereby making appropriate final injunctive relief or corresponding declaratory relief with respect to the class as a whole. The requirement that the defendant

act on grounds generally applicable to the *Fed. R. Civ. P. 23(b)(2)* class is encompassed in the commonality requirement of *Fed. R. Civ. P. 23(a)*.

Civil Procedure > Class Actions > Opt-Out Provisions
Civil Procedure > Class Actions > Prerequisites > General Overview
[HN14] A hybrid class consists of two stages. In Stage I, the court resolves the issue of liability under the procedures of *Fed. R. Civ. P. 23(b)(2)*, and the issue of damages is resolved in Stage II using the "opt out" procedures established for *Fed. R. Civ. P. 23(b)(3)* actions.

Civil Procedure > Class Actions > Class Members > General Overview
Civil Procedure > Class Actions > Opt-Out Provisions
Civil Procedure > Class Actions > Prerequisites > General Overview
[HN15] Pursuant to *Fed. R. Civ. P. 23(b)(2)*, in Stage I, class members cannot "opt out" of the class action in order to pursue their own remedies.

Civil Rights Law > Civil Rights Acts > Civil Rights Act of 1964
Civil Rights Law > Practice & Procedure > Limitation Periods
Governments > Legislation > Statutes of Limitations > Time Limitations
[HN16] Statutory procedures for claims under Title VII of the Civil Rights Act of 1964, provide the same substantive protection as other limitations periods. They protect defendants from liability for their actions prior to a date certain. Title VII shields defendants from damages for any like conduct they may have engaged in prior to a certain number of days before the filing of an Equal Employment Opportunity Commission (EEOC) charge. In Florida and South Carolina which are deferral states, that liability is limited to actions occurring within 300 days prior to the filing of the charge. In Georgia, a non-deferral state, the limitation begins 180 days prior to the filing of the EEOC charge.

COUNSEL: [*1] For MELODEE SHORES, individually and on behalf of all other persons similarly situated, plaintiff: Thomas A. Warren, [COR LD NTC], Tallahassee, FL. Charles Gilbert Burr, III, [COR LD NTC], Charles G. Burr, P.A., Tampa, FL. Barry Goldstein, [COR LD NTC], Teresa Demchak, [COR LD], Jack W. Lee, [COR LD], Jollee Faber, [COR LD], Linda M. Dardarian, [COR LD], Saperstein, Goldstein, Demchak & Baller, Oakland, CA. Sam Jones Smith, [COR LD NTC], Law Offices of Thomas A. Warren, Tampa, FL. For DEBORAH CRUTCHER, individually and on behalf of all other persons similarly situated, plaintiff: Charles Gilbert Burr, III, [COR LD NTC], Charles G. Burr, P.A., Tampa, FL. Barry Goldstein, [COR LD NTC], Teresa Demchak, [COR LD], Jack W. Lee, [COR LD], Jollee Faber, [COR LD], Linda M. Dardarian, [COR LD], Saperstein, Goldstein, Demchak & Baller, Oakland, CA. For JANET MCCLUNG, individually and on behalf of all other persons similarly situated, DARLENE SARMIENTO, individually and on behalf of all other persons similarly situated, CARMEN PENA, individually and on behalf of all other persons similarly situated, VICKY GOODSON, individually and on behalf of all other persons similarly [*2] situated, MARGERY TERRY, individually and on behalf of all other persons similarly situated, SUSAN SHARP, individually and on behalf of all other persons similarly situated, plaintiffs: Charles Gilbert Burr, III, [COR LD NTC], Charles G. Burr, P.A., Tampa, FL. Teresa Demchak, [COR LD], Jack W. Lee, [COR LD], Jollee Faber, [COR LD], Linda M. Dardarian, [COR LD], Saperstein, Goldstein, Demchak & Baller, Oakland, CA.

For EQUAL EMPLOYMENT OPPORTUNITY COMMISSION, intervenor-plaintiff: Eve G. Lowe, [COR LD NTC], Equal Employment Opportunity Commission, Miami District Office, Miami, FL.

For PUBLIX SUPER MARKETS, defendant: Marvin E. Barkin, [COR], Dinita L. James, [COR LD NTC], Trenam, Kemker, Scharf, Barkin, Frye, O'Neill & Mullis, P.A., Tampa, FL. Robert David Hall, Jr., [COR], John-Edward Alley, [COR], James Morgan Craig, [COR], Alley & Alley, Chartered, Tampa, FL. C. Geoffrey Weirich, [COR], Leslie A. Dent, [COR], Paul, Hastings, Janofsky & Walker, Atlanta, GA. Charles A. Shanor, [COR], R. Lawrence Ashe, Jr., [COR LD NTC], William B. Hill, Jr., [COR], Paul, Hastings, Janofsky & Walker, Atlanta, GA. For PUBLIX SUPER MARKETS, intervenor-defendant: [*3] Marvin E. Barkin, [COR], Dinita L. James, [COR LD NTC], Trenam, Kemker, Scharf, Barkin, Frye, O'Neill & Mullis, P.A., Tampa, FL. Robert David Hall, Jr., [COR], John-Edward Alley, [COR], James Morgan Craig, [COR], Alley & Alley, Chartered, Tampa, FL. C. Geoffrey Weirich, [COR], Leslie A. Dent, [COR], Paul, Hastings, Janofsky & Walker, Atlanta, GA. Charles A. Shanor, [COR], R. Lawrence Ashe, Jr., [COR LD NTC], William B. Hill, Jr., [COR], Paul, Hastings, Janofsky & Walker, Atlanta, GA.

JUDGES: HENRY LEE ADAMS, JR., UNITED

STATES DISTRICT JUDGE

OPINION BY: HENRY LEE ADAMS, JR.

OPINION:

ORDER

This cause is before the Court on Plaintiffs' Motion for Class Certification (Dkt. 78) to which Publix has voiced its strong opposition (Dkt. 116). The Court heard the oral argument of counsel on January 26, 1996 and having reviewed the pleadings and the attachments thereto, the Court concludes that class certification is appropriate for the reasons set forth below.

I. INTRODUCTION

The twelve named Plaintiffs are current and former employees of Publix Super Markets. They each worked or work in various retail positions within Publix stores. Plaintiffs claim that Publix has [*4] "engaged in an ongoing, company-wide policy or pattern or practice of discriminating against its female employees." (Dkt. 78). The parties have engaged in extensive discovery on class certification issues and have presented numerous affidavits, expert opinions, and statistical analysis in support of their positions.

At this stage the Court is faced with a formidable task. On one hand [HN1] it must conduct a rigorous analysis before determining that class certification is appropriate. *General Tel Co. of the Southwest v. Falcon, 457 U.S. 147, 160-61, 72 L. Ed. 2d 740, 102 S. Ct. 2364 (1982).* On the other hand, the Court may not conduct an inquiry on the merits at this early stage in the proceedings. *Washington v. Brown & Williamson Tobacco Corp., 959 F.2d 1566, 1569 n.11 (11th Cir. 1992)* citing *Nelson v. United States Steel Corp., 709 F.2d 675, 679-80 (11th Cir. 1983); Krueger v. New York Tel. Co., 163 F.R.D. 433, 438 (S.D.N.Y. 1995)* (stating "court should not resolve any material factual disputes in the process of determining whether plaintiffs have provided a reasonable basis for their assertions") (citation omitted)).

This Court is mindful of the Supreme Court's warning [*5] in *Eisen v. Carlisle & Jacquelin, 417 U.S. 156, 40 L. Ed. 2d 732, 94 S. Ct. 2140 (1974)* that "tentative findings made in the absence of established safeguards, may color the subsequent proceedings and place an unfair burden on the defendant." *Id. at 179.* Accordingly, the Court's decision to certify a class in this cause should not be viewed as a prediction that Plaintiffs will ultimately prevail on the merits of their action, but simply that they have met their burden of establishing the requirements for class certification pursuant to *Fed.R.Civ.P. 23.*

II. THE PUBLIX ORGANIZATION

Publix operates approximately 500 retail grocery stores located in Florida, Georgia and South Carolina. The company's headquarters is located in Lakeland, Florida. Three of its four divisions cover the state of Florida, and are named for cities within their geographic region: Jacksonville, Lakeland, and Miami. The fourth, the Atlanta Division, covers both Georgia and South Carolina.

Divisions are managed by a Division Vice President who reports to the President of the corporation. Division Vice Presidents make the decisions about promotion above the level of Store Manager. Divisions are [*6] divided into two to four regions, each of which are headed by a Regional Director. Regional Directors report to the Division Vice President and make decisions about promotions to the level of store management.

Regions are divided into districts, each of which contains eight to ten stores and is managed by a District Manager. District Managers report to the Regional Director and review Store Managers recommendations concerning store level management promotions. They also recommend candidates to the Regional Managers for promotion.

Each District has Meat Merchandisers, Deli Merchandisers, Produce Merchandisers, and Bakery Improvement Analysts each of whom reports to the District Manager. Merchandisers are responsible for advising each store's Department Managers with regard to employee promotion and product merchandising. Merchandisers also insure that Department Managers follow company policies and procedures. However, Department Managers report directly to Store Managers.

Store Managers are responsible for entry level hiring, job assignment and starting pay. They also recommend candidates for promotion to the District Manager. Immediately under the Store Manager are a Store Assistant [*7] Manager, and one or two Store Second Assistant Managers. These managers supervise the Grocery Department which encompasses the check-out lanes and grocery shelves. Grocery Department personnel include Cashiers, front service personnel (Baggers), and stocking personnel.

Each store has a Grocery, Meat and Produce Department. Most also have Deli and Bakery Departments. Over 98% of the retail employees work in these five departments. Larger stores also have Floral, Photo and Pharmacy Departments.

The managers of the Meat, Produce, Bakery, and

Deli Departments report directly to the Store Manager. However, until 1994, Deli Managers reported to the Assistant Meat Department Manager. Each of these Departments generally have an assistant manager and various other clerk and craft positions. n1 Eighty percent of retail employees work in one of seven positions: Front Service, Grocery Clerk, Produce Clerk, Meat Cutter, Cashier, Deli Clerk, and Bakery Clerk.

> n1 In the Meat Department there are: Meat Clerks, Meat Utility Clerks, Meat Wrappers, Meat Cutters, Seafood Clerks, and Seafood Specialists. The Bakery Department employs: Cake Decators, Bakers, and Bakery Clerks. The Deli Department employs Deli Clerks. In stores with Floral Departments the Floral Specialist reports to the Produce Manager.

[*8]

III. CLASS CERTIFICATION

Plaintiffs seek to have a class certified pursuant to *Fed. R. Civ. P. 23(b)(2)* or *23(b)(3)*, on behalf of themselves and:

> All female management and non-management employees of Publix Super Markets, Inc. who have worked, are working, or will work in Publix's retail operations in Florida, Georgia, or South Carolina, except for those females who have worked only in Publix's pharmacy operations.

(Dkt. 78).

[HN2] To obtain class certification, Plaintiffs must demonstrate that they meet the general class certification requirements set forth in *Fed. R. Civ. P. 23(a)*. *Washington v. Brown & Williamson Tobacco Corp., 959 F.2d 1566, 1569 (11th Cir. 1992)*. Those requirements are commonly referred to as (1) numerosity; (2) commonality; (3) typicality; and (4) adequacy of representation. After determining that these prerequisites have been met, the Court must then determine which, if any, form of class action is appropriate pursuant to Rule 23(b).

[HN3] Given Rule 23(c)(1)'s requirement that a certification decision be made as soon as practicable after the commencement of the action, the standard of proof in support of certification is liberal. *See* [*9] *Binion v. Metropolitan Pier & Expo. Auth., 163 F.R.D. 517, 520 (N.D. Ill. 1995); Armstead v. Pingree, 629 F. Supp. 273, 279 (M.D.Fla. 1986)*. This liberality is tempered by the Court's duty to modify or vacate a certification order as the case progresses. *Binion, 163 F.R.D. at 520* (citing *General Telephone of Southwest v. Falcon, 457 U.S. 147, 160, 72 L. Ed. 2d 740, 102 S. Ct. 2364 (1982))*.

A. Rule 23(a) Prerequisites to a Class Action

1. Numerosity;

The proposed class is sufficiently numerous to make joinder of all members impracticable. Depending on the time period of the class, the number of potential class members could exceed one hundred thousand women.

Although Defendant did not directly address the issue of numerosity, it did submit hundreds of affidavits from women who believe that they have not been discriminated against. At the hearing, Defendant also argued that many of the purported class members are shareholders of Publix and would therefore be suing themselves.

[HN4] The fact that a large number of potential class members are satisfied with the status quo, or are unwilling to come forward, cannot defeat class certification. *Bremiller v.* [*10] *Cleveland Psychiatric Inst., 898 F. Supp. 572, 577 (N.D.Ohio 1995)* citing *Dawes v. Philadelphia Gas Comm., 421 F. Supp. 806 (E.D. Pa. 1976))*. As the *Bremiller* court noted, plaintiffs cannot be precluded from asserting their right to be free from discrimination merely because other employees chose not to assert those rights. *Id.*

Nor is the Court concerned that it might force women to "sue themselves." Such "involuntary" class members may actively support Defendant's position, and even testify on behalf of Defendant on the issue of liability. *Cox v. American Cast Iron Pipe Co., 784 F.2d 1546, 1554 (11th Cir. 1986), cert. denied, 479 U.S. 883, 93 L. Ed. 2d 250, 107 S. Ct. 274.* Furthermore, any class member may refrain from accepting an award of damages should one be made.

The Court concludes that Plaintiffs have met their burden of establishing that there are a sufficient number of women similarly situated and inclined to pursue this action against Publix to comport with the numerousity requirement for class certification.

2. Commonality;

Plaintiffs' meet the commonality requirement in that their complaint raises questions of law and fact common to the entire [*11] class.

[HN5] In an employment discrimination class, Plaintiffs must specifically identify questions of law and fact common to the named Plaintiffs and putative class members. *Hartman v. Duffey, 305 U.S. App. D.C. 256, 19 F.3d 1459, 1472 (D.C. Cir. 1994)* citing *Wagner v. Taylor, 266 U.S. App. D.C. 414, 836 F.2d 578, 589 (D.C. Cir. 1987))*. At class certification, Plaintiffs need only make a showing sufficient for the Court to infer that class members suffered from a common policy of discrimination that "pervaded the challenged employment decisions." *Hartman, 19 F.3d at 1472.* However, "Rule 23 does not require that *all* the questions of law and fact raised by the dispute be common." *Cox v. American Cast Iron Pipe Co., 784 F.2d at 1557* (emphasis added).

Plaintiffs assert a number of legal and factual commonalities in support of their overall position that Publix "administers its personnel decisions within a framework of gender stereotypes that excludes women from traditionally male-dominated positions." (Dkt. 79 p.32).

a. Employment Practices and Policy:

Publix uses a centralized policy of decentralized decision making. Centralized components of Publix's employment [*12] policies and practices include:

> 1. manuals and handbooks regarding the conduct of personnel and promotional opportunities;
>
> 2. rules regarding responsibilities of managers and local organizational structure;
>
> 3. similar methods of filling vacancies in all departments and divisions;
>
> 4. uniform criteria and evaluation forms to assess job performance;
>
> 5. supervisory group that oversees a uniform promotion system and evaluation process;
>
> 6. rotation of employees among job sites throughout the company.

Publix concedes that it has centralized employment policies and guidelines, but contends class certification is appropriate only where such centralized policies are the cause of the alleged discrimination. (Dkt. 116). The Court concurs, and finds that Plaintiffs have produced sufficient allegations for the Court to infer, for class certification purposes, that these common practices are the cause of the alleged discrimination.

For example, under Publix's uniform promotion practice, any individual desiring to attain the position of store manager must first work as a stock person. n2 As a general principle stock work involves heavy lifting. The named Plaintiffs [*13] allege that women were either discouraged from seeking stock positions because of the physical labor, or that they were denied such positions outright. Plaintiffs' allegation that women were denied access to the lowest rung of the promotional ladder because of real or perceived limitations of their gender, creates a common issue of fact.

> n2 Publix's promotion progression is set forth more fully in Plaintiffs' Memorandum in Support of their Motion for Class certification.

Likewise, to obtain the position of Bakery Department Manager or Meat Department Manager, employees must work in the craft positions of Baker or Meat Cutter. Plaintiffs allege that they and other women working in those departments were denied access to those craft positions, and instead were directed to "dead end" positions such as cake decorator and meat wrapper.

The only department in which women are significantly represented in store management is the Deli Department. However, Deli Managers do not maintain a position comparable to other [*14] department managers. Until 1994, the Deli Managers do not maintain a position comparable to other department managers. Until 1994, the Deli Manager was the only department manager who did not report directly to the Store Manager. Instead, Deli Managers reported to the Assistant Meat Managers. Since Deli Managers were responsible for training the Assistant Meat Managers, Plaintiffs allege that the women Deli Managers were required to train the men who became their supervisors. Furthermore, Plaintiffs allege that Deli Managers do not have the same managerial responsibilities of other managers, nor are their pay, benefits or bonuses comparable to other department managers.

Under Publix's policies of promoting from within and maintaining strict lines of promotion, only those individuals who have reached the level of Store Manager or Department Manager are eligible for upward promotion within the company. Therefore, Plaintiffs allege, they were denied access to higher management positions by virtue of the fact that they were initially excluded from craft worker and stock positions due to

their gender. In sum, Plaintiffs have adequately alleged that Publix's policies and practices had a [*15] classwide discriminatory effect so as to create common issues of fact.

b. Subjective Personnel Decision Making Process:

Publix's subjective personnel decision making process is the second factor which Plaintiffs proffer in support of commonality. Publix gives its Store Managers the responsibility for entry level hiring, job assignment and starting pay. Store Managers make recommendations about store level management promotions, but the decision to promote is made by the District Manager. Plaintiffs' allege that the decision making process is largely subjective.

For example, Plaintiffs allege that managers are not given written guidelines or training with regard to the decision making process to use when assigning employees entry level jobs, or deciding which employees will receive training. Plaintiffs also allege that in the absence of guidance, and given total discretion, managers choose to steer women into traditional female jobs and men into traditional male jobs. Plaintiffs also claim that managers exercise their discretion with regard to training in a discriminatory manner. Specifically, a number of the named Plaintiffs allege that their requests for training were denied [*16] while at the same time less experienced men were given training and eventually promoted.

Publix counters that women are not steered into traditional female jobs, but that the gender segregation is the result of self selection. At this preliminary stage Publix's own practices cause the Court to discount the "self selection" argument. Publix does not post job openings. Instead, it relies on the "tap on the shoulder" system in which managers subjectively determine which of their employees should be chosen for the position. Plaintiffs allege that male managers use this system to select men for promotion and to overlook qualified women. If, as Plaintiffs allege, women are unaware that the positions are available, they cannot be deemed to have chosen not to seek such positions.

[HN6] The Eleventh Circuit has held that where an employer does not post openings or take applications for promotion, but uses an informal promotion system, the employer has a "duty to consider all those who might reasonably be interested, as well as those who have learned of the job opening and expressed an interest." *Jones v. Firestone Tire and Rubber Co., Inc., 977 F.2d 527, 533 (11th Cir. 1992)* (citing *Carmichael* [*17] *v. Birmingham Saw Works, 738 F.2d 1126, 1133-34 (11th Cir. 1984)) cert. denied, 113 S. Ct. 2932.* The *Jones* court held that when the plaintiff had no notice or opportunity to apply for the job, the employer could not avoid a Title VII violation when it incorrectly assumed that plaintiff was uninterested in the job. *Id.* In light of Publix's informal promotion policy, the Court concludes that Plaintiffs failure to promote claims present common issues of fact and law.

Publix claims that this decentralized system, which relies on the subjective decision making of its managers, is not discriminatory. Publix is correct in claiming that [HN7] the mere fact that an employer uses subjective criteria in its decision making process is not a per se violation of Title VII. *Sengupta v. Morrison-Knudsen Co., 804 F.2d 1072, 1075 (9th Cir. 1986)* (citing *Gay v. Waiters' and Dairy Lunchmen's Union, Local No. 30, 694 F.2d 531, 554 (9th Cir. 1982)); Casillas v. United States Navy, 735 F.2d 338, 345 (9th Cir. 1984)* (citing *Ward v Westland Plastics, Inc., 651 F.2d 1266, 1270 (9th Cir. 1987)).* Ultimately at a trial on the merits, n3 subjectivity alone may be insufficient to establish [*18] liability.

> n3 The *Casillas* and the *Sengupta* courts addressed the issue of subjective decision making in their review of the merits. Neither case addresses the issue in the context of class certification.

However, at the preliminary class certification stage, subjectivity is one common factor the Court may consider in support of Plaintiffs' allegations. Indeed, several courts have held that "[HN8] Allegations of similar discriminatory employment practices, such as the use of entirely subjective personnel process that operate to discriminate, satisfy the commonality and typicality requirements of Rule 23(a)." *Shipes v. Trinity Industries, 987 F.2d 311, 316 (5th Cir. 1993), (citing Carpenter v. Stephen F. Austin State Univ., 706 F.2d 608, 617 (5th Cir. 1983)), cert. denied, 114 S. Ct. 548; See also, Falcon, 457 U.S. at 159 n.15; Cox, 784 F.2d at 1557.*

Publix's policy of delegating hiring and promotion decisions to managers, who make those decisions on the basis of subjective criteria, is [*19] a common course of conduct. Plaintiffs allegation that this course of conduct results in a discriminatory practice is adequate to meet the commonality requirement of Rule 23.

c. Gender Segregated Job Force

Plaintiffs next claim that the job force statistics create common issues of fact. Plaintiffs' statistical proffer, made by Dr. Richard Drogin, is based on data

from the years 1990-1994. Plaintiffs statistical proffer is lengthy and detailed, however a brief overview is adequate for the Court's immediate purpose.

At the end of 1994 women comprised fifty percent (50%) of Publix's retail job force. At that same time women comprised 20% of 5,453 Publix managers. However, 62% of the female managers were in the Deli Department, which as noted above, is a uniquely inferior managerial position.

Plaintiffs' expert calculates that 88% of Publix's female employees work in gender segregated jobs that are over 76% female and that 85% of the men work in highly segregated jobs that are over 79% male. Furthermore, an analysis of the new hires for 1994 shows an extreme amount of gender segregation in initial placement. n4 In 1994 over 90% of new employees were hired into six entry level [*20] jobs, for which no prior experience is necessary. The large majority of men worked in front service, to which less than 12% of the newly hired women were assigned. The majority of women worked as Cashiers, then Deli and Bakery Clerks. Almost no women worked as Grocery Clerks or Produce Clerks. Plaintiffs point to these statistics in support of their contention that Publix channeled new employees into gender segregated roles.

n4 Dr. Drogan did not have the data for initial assignment, so these numbers are based on the positions held by new hires at the end of 1994.

Publix does not quarrel with the actual numbers proffered by Plaintiffs. Instead, Publix contends that if the statistical expert controlled for women's job interests and qualifications the inference of discrimination would be dispelled. Publix argues at length that the failure to consider or incorporate employee choice, interest and qualification for advancement renders Plaintiffs statistical analyses misleading and worthless.

Publix relies in large [*21] part on a work force analysis from Dr. Deborah Jay who surveyed Publix employees. Dr. Jay concludes that there are substantial differences in prior experience of male and female job applicants at Publix and substantial differences in job preferences stated by men and women in their applications for employment. Publix also asserts that women are promoted to store management positions (Second Assistant Store Manager, Assistant Store Manager and Store Manager) at rates faster than similarly situated men.

In sum, the parties present a battle of experts in which Publix attacks several aspects of Plaintiffs statistical analysis and Plaintiffs attack Publix's survey research. As Judge Koeltl of the Southern District of New York recently noted, this "[HN9] statistical dueling is very much a matter in dispute directed at the merits of the case. It is inappropriate for the Court to determine the ultimate correctness of either parties' contentions in the context of class certification." *Krueger v. New York Tel. Co., 163 F.R.D. 433, 440 (S.D.N.Y. 1995)* (citation omitted)

The Court concludes that the raw statistics presented by Plaintiffs support their claim of commonality for purposes of class [*22] certification.

d. Common Issues of Law

Plaintiffs claim both disparate impact and disparate treatment theories of liability. Under disparate treatment Plaintiffs must show that their employer treats them less favorable then men, and that it does so with discriminatory intent. Intent may be shown by direct or circumstantial evidence, or it may be inferred from statistical evidence. Plaintiffs propose to proffer statistical and other evidence in support of their disparate treatment claim.

Having previously determined that Plaintiffs' statistical evidence raises common issues of fact, the Court now finds that the information of direct discriminatory treatment proffered by Plaintiffs is sufficient to raise common issues of law. Likewise, Plaintiffs' claim of disparate impact is, by its very nature, a class claim presenting a common issue of law.

e. Individual Damage Claims Do Not Defeat Commonality

Clearly not all aspects of this case present common issues. To the extent that Plaintiffs seek damages, they present unique issues. However, "[HN10] the mere fact that questions peculiar to each individual member of the class remain after the common questions of the defendant's liability [*23] have been resolved does not dictate the conclusion that a class action is impermissible." *Bremiller v. Cleveland Psychiatric Institute, 898 F. Supp. 572, 578 (N.D. Ohio 1995)* (citing *Sterling v. Velsicol, 855 F.2d 1188, 1197 (6th Cir. 1988)).*

The Court therefore concludes that Plaintiffs have met the commonality requirement of Rule 23.

3. Typicality;

[HN11] Plaintiffs' claims are typical of the class where, as here, their claims "arise from the same event or

pattern or practice and are based on the same legal theory" as the claims of the class. *Kornberg v. Carnival Cruise Lines, Inc., 741 F.2d 1332, 1337 (11th Cir. 1984), cert. denied, 470 U.S. 1004, 105 S. Ct. 1357, 84 L. Ed. 2d 379 (1985).* There is no requirement that the named plaintiffs each personally experience every difficulty outlined in the complaint. Rather, it is sufficient that the claims of the named Plaintiffs are substantially similar to the claims of the class. *Appleyard v. Wallace, 754 F.2d 955, 958 (11th Cir. 1985); Binion, 163 F.R.D. at 525.*

Upon reviewing Plaintiffs complaint, first amended complaint and the declarations filed in support of the motion for class certification, the Court concludes [*24] that the Plaintiffs claims are typical of the class claims.

4. Adequacy of Representation;

The final prerequisite to class certification is adequacy of representation. [HN12] Prior to certifying a class, the Court must determine that Plaintiffs' counsel are qualified, experience, and generally able to conduct the litigation. The Court must also determine that Plaintiffs are adequate representatives of the class, and do not have interests antagonistic to the rest of the class. *Griffin v. Carlin, 755 F.2d 1516, 1533 (11th Cir. 1985)* (citing *Johnson v. Georgia Highway Express, Inc., 417 F.2d 1122, 1125 (5th Cir. 1969)).*

The Court is satisfied that each of Plaintiffs' counsel possess the qualifications, experience and abilities necessary for an undertaking of this magnitude. Although Publix does not question the abilities of counsel, it does allege that counsel and the named Plaintiffs have a conflict of interest which makes them inadequate representatives. This purported conflict stems from the relationship between named Plaintiffs and the United Food and Commercial Workers International Union ("UFCW"). The Court has not been presented with evidence demonstrating that the UFCW [*25] has any agreement with Plaintiffs or their counsel concerning the funding, or conduct of this litigation. Publix's vague allegations are insufficient to support its position, and this Court remains firm in its opinion that the UFCW is irrelevant to this action.

Publix also contends that an inherent conflict will exist if the proposed class was permitted to represent both supervisory and non supervisory employees. The cases cited by Publix in support of their position are distinguishable n5 and the Court finds no such inherent conflict. As Plaintiffs assert in their Reply (Dkt. 119) there is nothing to suggest that the elimination of sex discrimination for non-managerial employees would adversely affect managerial employees and vice versa. Without assessment as to the likelihood of Plaintiff's success on the merits, the Court finds that Plaintiff has met the prerequisites for class certification pursuant to Rule 23(a).

n5 See Plaintiffs' Reply brief (Dkt. 119) p. 13-14 n.17.

B. Rule 23(b)(2) and (3); [*26] Form of Class Action Maintainable

Having met the prerequisite showing for the maintenance of a class action, Plaintiffs are required to establish that this action falls within the categories identified in *Fed.R.Civ.P. Rule 23(b).* Plaintiffs seek certification under 23(b)(2) or in the alternative (b)(3).

[HN13] An action is maintainable under 23(b)(2) when the plaintiff alleges that the defendant has "acted or refused to act on grounds generally applicable to the class, thereby making appropriate final injunctive relief or corresponding declaratory relief with respect to the class as a whole . . . ." *Fed.R.Civ.P. Rule 23(b)(2).* The requirement that the defendant act on grounds generally applicable to the 23(b)(2) class is encompassed in the commonality requirement of Rule 23(a). *Harriss v. Pan American World Airways, Inc., 74 F.R.D. 24, 45-46 (N.D. Cal. 1977).* Having previously found that the commonality requirement was met, the Court now finds that Plaintiffs have satisfactorily alleged that Publix has acted on grounds generally applicable to the class.

Publix opposes certification of a (b)(2) class on the grounds that the individual claims for damages predominate over the common [*27] claims for injunctive and declaratory relief. Publix relies on *Celestine v. Citgo Petroleum Corp.,* No. 93-864 (W.D.La. Aug. 7, 1995) to support its assertion that class relief is not appropriate. As the *Celestine* court recognized, the determination of which type of relief is predominant is a matter within the discretion of the court. *Id.* at p. 6-7.

Prevailing Title VII plaintiffs are entitled to a "make whole" remedy which includes backpay, front pay, injunctive relief, compensatory and punitive damages. The Court concurs with Plaintiffs position that injunctive relief and damage claims are intertwined. *See Albemarle Paper Co. v. Moody, 422 U.S. 405, 417-18, 45 L. Ed. 2d 280, 95 S. Ct. 2362 (1975)* ("If employers faced only the prospect of an injunctive order, they would have little incentive to shun practices of dubious legality."). The

instant Plaintiffs seek comprehensive injunctive relief, including:

> Comprehensive affirmative action goals and time tables, Rightful place relief for victims of gender discrimination, Wage rate adjustment, Requirement of posting job openings, Requirement of assigning, training, transferring, compensating, and promotions women [*28] in non-discriminatory manner, and monitoring, reporting, and retention of jurisdiction for further relief.

If Plaintiffs are able to prove their allegations that Publix engaged in a policy and practice of gender discrimination, all female employees are entitled to the benefits of such injunctive relief as the Court deems appropriate. Likewise, those women who can prove that they suffered damages pursuant to discriminatory conduct during the class period are entitled to recover damages for such conduct. The fact that allegedly discriminatory practices have a wide ranging effect resulting in numerous damage claims supports the desirability of the class mechanism to resolve such claims.

The Court finds that a hybrid Rule 23(b)(2) class is the appropriate mechanism for the resolution of this case. This procedure was approved by the Eleventh Circuit for Title VII litigation in *Cox v. American Cast Iron Pipe Co., 784 F.2d 1546 (11th Cir. 1986)*. [HN14] A hybrid class consists of two stages. In Stage I, the Court resolves the issue of liability under the procedures of Rule 23(b)(2), and the issue of damages is resolved in Stage II using the "opt out" procedures established for Rule 23(b)(3) [*29] actions. *Id.*

[HN15] In Stage I, class members cannot "opt out" of the class action in order to pursue their own remedies, hence Publix will not be subject to multiple trials and inconsistent adjudications. n6 If liability is established in Stage I, the case will progress to a Stage II proceeding to determine the damages, if any, that individual class members are entitled to recover. Such an individualized determination will protect the interest of all class members. At this time the Court has not determined what means it will employ to efficiently resolve Stage II claims. Nor has it determined how claims for punitive damages will be handled.

> n6 Once again, the Court notes that "involuntary plaintiffs," those female employees who oppose the present litigation may actively participate in Publix's defense.

C. Parameters of the Class

The final issue that remains to be resolved is the exact definition of the class. The Court finds that Plaintiffs proposed class is overbroad in that it has no time limitation. [*30] At the time they filed their motion, Plaintiffs were still attempting to locate earlier "like or related" class members charges in an effort to push the beginning date back as far as possible. Plaintiffs therefore suggest that the Court need not set a time limit for the portion of the class entitled to monetary relief. Although such charges can properly be considered in determining the proper start date, n7 the Court will not postpone its determination for some unspecified time while Plaintiffs keep searching for earlier charges.

> n7 An earlier filed charge of discrimination can serve to toll the limitations period even though it did not result in a federal action if it contained class claims. *Binion, 163 F.R.D. at 529.*

[HN16]

Statutory procedures for Title VII claims provide the same substantive protection as other limitations periods. They protect defendants from liability for their actions prior to a date certain. Title VII shields defendants from damages for any like conduct they may have engaged in prior to [*31] a certain number of days before the filing of an EEOC charge. *Larkin v. Pullman-Standard Div., Pullman, Inc., 854 F.2d 1549, 1561-62 (11th Cir. 1988).* In Florida and South Carolina which are deferral states, that liability is limited to actions occurring within 300 days prior to the filing of the charge. In Georgia, a non-deferral state, the limitation begins 180 days prior to the filing of the EEOC charge.

Although the first named Plaintiff filed her charge on November 25, 1992, the EEOC had previously entered a Commissioner Charge against Publix on March 17, 1992 alleging gender discrimination. If the employer is put on notice of the class wide nature of its alleged infractions by the earlier filed EEOC charge, the Court may properly use such charge as a starting point. *Id.*

It is therefore **ORDERED:**

1. Plaintiffs motion for class certification (Dkt. 78) is

GRANTED and the Court certifies a class comprised of:

a. All female management and non-management employees of Publix Super Markets, Inc. who from May 22, 1991 to the date of trial have worked, are working, or will work in Publix's retail operations in Florida, and South Carolina.

b. All female [*32] management and non-management employees of Publix Super Markets, Inc. who from October 19, 1991 to the date of trial have worked, are working, or will work in Publix's retail operations in Georgia. n8

c. No females who have worked only in Publix's pharmacy operations shall be included in this class.

n8 Naturally, women employed after the date of trial will benefit from any injunctive relief granted, yet the class need not be defined to incorporate them. *Bremiller, 898 F. Supp. at 580.*

2. Melodee Shores, Deborah Crutcher, Janet McClung, Darlene Sarmiento, Carmen Pena, Vicky Goodson, Margery Terry, Susan Sharp, Carol Atkins, Patricia Johnson, Lily Light, and Donna Gallagher are appointed as Plaintiff Class Representatives.

3. The law firm of Sapperstein, Goldstein, Demchak & Baller, the Law Office of Thomas A. Warren, and the Law Office of Charles G. Burr, P.A. are appointed as Plaintiff Class Counsel.

DONE and **ORDERED** at Tampa, Florida, this 12th day of March, 1996.

HENRY LEE [*33] **ADAMS, JR.**

UNITED STATES DISTRICT JUDGE

EXHIBIT H

VICKI BUTLER, et al., Plaintiffs
v.
HOME DEPOT, INC., Defendant, No.
C-94-4335 SI
U.S. District Court, Northern District of California
January 25, 1996

BNA Labor Relations Reporter Headnote - FEP Cases

CIVIL RIGHTS ACT OF 1964

1.Class action -- Commonality
C108.7504
N.D.Cal., 1996.

Female claimants have satisfied commonality requirement for bringing class action challenging employer's subjective employment practices, where common issues include whether they can sustain burden of proof under either disparate treatment or disparate impact theory, statistical evidence on which they propose to rely is common to class as whole, and inferences drawn from this evidence will be common to all class members and will raise common questions of law.

BUTLER v. HOME DEPOT
70 FEP Cases 51

BNA Labor Relations Reporter Headnote - FEP Cases

CIVIL RIGHTS ACT OF 1964

2.Class action -- Typicality
C108.7505
N.D.Cal., 1996.

Claims of women who seek to maintain class action against employer are typical of claims of class, where they contend that employer maintains personnel system characterized by use of subjective criteria by male management with hostile and stereotypical attitudes toward women and that they were discriminated against with respect to initial job placement, equal pay, and denial of training and promotional opportunities, and their claims depend on proof of same employment practices complained of by and on behalf of class members.

BUTLER v. HOME DEPOT
70 FEP Cases 51

BNA Labor Relations Reporter Headnote - FEP Cases

CIVIL RIGHTS ACT OF 1964

3.Class action -- Definition
C108.7351 C108.7511 C108.7518
N.D.Cal., 1996.

Any potential problems inherent in inclusion of applicants and employees, as well as supervisors and non-supervisors, in same class can be remedied by bifurcation of case into separate liability and remedy phases; during liability phase diversity of class membership will not present material conflcits.

BUTLER v. HOME DEPOT
70 FEP Cases 51

BNA Labor Relations Reporter Headnote - FEP Cases

CIVIL RIGHTS ACT OF 1964

4.Class action -- Rule 23(b)(2)
C108.7552
N.D.Cal., 1996.

Class action challenging employer's employment practices that allegedly deny women equal employment opportunities will be certified under Rule 23(b)(2) of Federal Rules of Civil Procedure with respect to liability phase of action, despite contention that damages issues will overwhelm requests for injunctive and declaratory relief, since damages claims are secondary to primary claim for injunctive relief to prohibit gender-based employment practices.

BUTLER v. HOME DEPOT
70 FEP Cases 51

BNA Labor Relations Reporter Headnote - FEP Cases

CIVIL RIGHTS ACT OF 1964

5.Bifurcation
C108.7353 C108.831
N.D.Cal., 1996.

Title VII claim action against employer will be bifurcated into separate liability and remedy phases, despite contention that bifurcation of liability and damages violates its right under Seventh Amendment to U.S. Constitution to fair trial because different juries would be deciding essentially same issues; Seventh Amendment does not mandate that all phases of litigation be heard by same jury.

BUTLER v. HOME DEPOT
70 FEP Cases 51

BNA Labor Relations Reporter Headnote - FEP Cases

CIVIL RIGHTS ACT OF 1964

6.Class action -- Definition
C108.7513
N.D.Cal., 1996.

Definition of class to include persons whose claims arise between class opening date and date of entry of judgment is not too broad.

BUTLER v. HOME DEPOT
70 FEP Cases 51

BNA Labor Relations Reporter Headnote - FEP Cases

STATE FEP ACTS

7.Class action -- Definition
C108.7513
N.D.Cal., 1996.

Class opening date for claim under California Fair Employment and Housing Act will be one year before first charge was filed with California Department of Fair Employment and Housing, despite contention that that charge was ineffective because person who filed it did not file action within one year after filing, where filing period was equitably tolled because EEOC was investigating her claim until it issued her notice of right to sue.

BUTLER v. HOME DEPOT
70 FEP Cases 51

Elizabeth Cabraser, James M. Finberg, Jacqueline Mottek, and Kelly Dermody (Lieff, Cabraser, Heimann & Bernstein), San Francisco, Calif., and Morris J. Baller, David Borgen, Jack W. Lee, and Susan Guberman-Garica (Saperstein Goldstein Demchak & Baller), Oakland, Calif., for plaintiffs.

Cynthia E. Gitt and Thomas P. Brown, IV (Epstein, Becker & Green), Los Angeles, Calif., and Janet Morgan (Epstein, Becker & Green), San Francisco, Calif., for defendant.

Full Text of Opinion

SUSAN ILLSTON, District Judge

On August 30, 1995, the Court heard argument on the plaintiffs' motion for class certification. On September 8, 1995; September 11, 1995; September 18, 1995; October 11, 1995; December 5, 1995; and December 6, 1995, the parties filed supplemental briefing and authorities. Having considered the arguments of counsel and the papers submitted, the Court hereby GRANTS the plaintiffs' motion for class certification and adopts the following class definition:

A. All female employees of Home Depot within the geographical area of Home Depot's West Coast Division who are or were employed on or after November 5, 1992, or who are or will be employed between this date and the date of entry of judgment

in this class action; and B. All female applicants who applied for employment in Home Depot stores within the geographical area of Home Depot's West Coast Division on or after November 5, 1992 and were qualified for employment in the positions of salespersons or assistant managers and who were not hired or were hired for cashier or other operations positions.

The Court further orders that this litigation be bifurcated into separate phases. The first phase will address liability and relief applicable to the class as a whole, including declaratory and injunctive relief, and whether defendant is liable for punitive damages. This phase of the action is certified under FRCP 23(b)(2). If liability is established, the second phase of this case will address appropriate individual compensatory and equitable relief, including individual entitlement to back and front pay. The precise procedures to be used during the second phase, if any, will be determined later in this litigation.

BACKGROUND

This action arises under Title VII of the Civil Rights Act of 1964, as amended, 42 U.S.C. Section 2000e et seq., and the California Fair Employment and Housing Act, Government Code Sections 12940 et seq. (FEHA). The complaint in this action was filed on December 12, 1994. Plaintiffs Vicki Butler, Susan Ellis, Felicia Funderburk, Jacqueline Genero, Sheryle Jones, Kimberly Stoddard, and Cheryl Williams allege violations of Title VII of the Civil Rights Act of 1964, as amended, 42 U.S.C. Section 2000e et seq., and allege gender discrimination practices against female employees and applicants throughout Home Depot's West Coast Division (hereafter "WCD").

A. Factual Background

Plaintiffs allege that Home Depot discriminates based upon gender in nearly all aspects of its personnel decision- making, including: (1) hiring and patterns of gender-based segregation of segregation of jobs and departments in initial job placement; (2) training; (3) transfer opportunities to merchandizing positions; (4) promotional opportunities to supervisorial and management positions; and (5) compensation.

First, plaintiffs allege that the defendant's system of hiring, job assignment, training, promotions, and compensation is entirely subjective. They allege that there are no specific, objective hiring criteria, nor are there objective criteria used to set pay levels, and that local gender biased male managers are therefore left broad discretion to make decisions that have an adverse effect upon women. Second, plaintiffs present statistical evidence of the low number of women in sales, merchandising, managerial and supervisorial positions, and the high number of men in these positions; and of the high number of women in cashier and other operations positions, and the corresponding low number of men in these same positions. This statistical evidence, upon which plaintiffs rely heavily, suggests a high level of segregation by gender. Plaintiffs contend that this is particularly significant, given that Home Depot is a store that promotes from within, provides on the job training, and has no minimum qualifications for entry level jobs.

In support of their motion, plaintiffs have submitted the following materials: (1)

the declarations of 55 members of the proposed class and of 8 other witnesses detailing incidents of gender discrimination in connection with hiring, job assignments, training, promotions and compensation; (2) the EEOC charges of 10 members of the proposed class; (3) Home Depot's standardized personnel forms, procedures and training materials; (4) excerpts from the depositions of 10 Home Depot managers; and (5) the declaration of plaintiffs' expert, Professor William T. Bielby.

In opposition to the motion, defendant filed: (1) declarations of 30 witnesses who are or were employees of Home Depot; (2) various charts and compilations concerning plaintiffs' employment history; (3) declarations of two experts; and (4) excerpts from the depositions of class representatives.

B. Legal Standard for Class Certification

As a threshold to class certification, Rule 23(a) of the Federal Rules of Civil Procedure requires a showing of the following: (1) that the class is so numerous that joinder of all members is impracticable; (2) that there are common questions of law or fact; (3) that the representative parties' claims or defenses are typical of the class claims or defenses; and (4) that the representative parties will fairly and adequately protect the class interests. The party moving for class certification bears the burden of showing that the 23(a) requirements are satisfied. General Tel. Co. of Southwest v. Falcon, 457 U.S. 147, 156, 102 S.Ct. 2364, 2370 [28 FEP Cases 1745] (1982).

In addition to demonstrating that the Rule 23(a) requirements are met, the plaintiffs must establish one or more of the following grounds for maintaining the suit as a class action pursuant to F.R.Civ.P. 23(b): (1) that there is a risk of substantial prejudice from separate actions; (2) that declaratory or injunctive relief benefitting the class as a whole would be appropriate; or (3) that common questions of law or fact predominate and the class action is superior to other available methods of adjudication.

DISCUSSION

A. Rule 23(a) Requirements

1. Rule 23(a)(1)--Numerosity

Rule 23(a)(1) requires that the class be so numerous that the number of potential plaintiffs cannot be practicably joined. Whether joinder would be impracticable depends on the facts and circumstances of each case, and does not require any specific minimum number of class members. In the present case, it is undisputed that the proposed class numbers in the thousands. The numerosity requirement is easily met.

2. Rule 23(a)(2)--Common Questions of Law or Fact

The requirement in Rule 23(a)(2) that there be questions of law or fact common to the class is satisfied by "the alleged existence of common discriminatory practices." The defendant's actions need not affect each class member in the same manner. Arnold v. United Artists Theatre Circuit, Inc., 158 F.R.D. 439, 448 [5 AD

Cases 685] (N.D.Cal. 1994) (citation omitted).

The Court finds that plaintiffs have satisfied the commonality requirement by their challenge to defendant's uniform personnel policies under Title VII. Common issues include whether the plaintiffs can sustain their burden of proof under either the disparate treatment (intentional acts of discrimination), or the disparate impact (not necessarily intentional) theories as to Home Depot's subjective employment practices. See Jaurequi v. Glendale, 852 F.2d 1128, 1135-36 [47 FEP Cases 1860] (9th Cir. 1988); Gay v. Waiters' and Dairy Lunchmen's Union, 694 F.2d 531, 554 [30 FEP Cases 605] (9th Cir. 1982). In addition, the evidence upon which plaintiffs propose to rely--statistical evidence of widespread discrimination--is common to the class as a whole. See Int'l Broth. of Teamsters v. United States, 431 U.S. 324, 339-40 [14 FEP Cases 1514] (1977); EEOC v. General Tel. Co., 885 F.2d 575, 579-82 [50 FEP Cases 1316] (9th Cir. 1989), cert. denied [498 U.S. 950], 111 S.Ct. 370 [54 FEP Cases 80] (1990). The inferences drawn from this evidence will be common to all class members and will raise common questions of law.

3. Rule 23(a)(3)--Typicality

In addition, the Court finds that the representative plaintiffs' claims are typical of the claims of the class. Plaintiffs contend that defendant maintains a personnel system characterized by the use of subjective criteria by male management with hostile and stereotypical attitudes toward women. Plaintiffs further allege that they were discriminated against with respect to initial job placement, equal pay, and denial of training and promotional opportunities. These class claims are the same claims raised by the class representatives, and the declarations filed in support of this motion demonstrate their typicality. The individual plaintiffs' claims depend upon proof of the same discriminatory employment practices complained of by and on behalf of the class members. Defendant's argument that these plaintiffs' claims are not typical is unpersuasive.

4. Rule 23(a)(4)--Adequacy of Representation

Adequacy of representation under Rule 23(a)(4) involves the satisfaction of two elements: 1) that the representative party's attorney be qualified, experienced and generally able to conduct the litigation; and 2) that the suit not be collusive and that the representative plaintiffs' interests not be antagonistic to those of the remainder of the class. Harriss v. Pan American World Airways, 15 FEP Cases at 1649.

The first element of the adequacy requirement is easily satisfied by the competence and experience in handling complex class action lawsuits of the firms representing plaintiffs.

With respect to the second element, defendant objects to the inclusion of applicants in the class, contending that applicants have different and "antagonistic" interests from employed class members since they are all competing "to get into the same sales and management positions." (Def. Br. at 5-6). Defendant also argues that no named representative is an applicant, because plaintiffs' former applicant representative, Wilson, is time-barred. Defendant further argues

that the presence of both supervisory and non-supervisory personnel in the proposed class precludes certification.

Plaintiffs concede that Wilson has been removed as a class representative, but argue that the absence of an applicant representative does not preclude class certification. Plaintiff cites several cases in which courts reversed decertification of classes comprised of both employees and applicants. See Watson v. Fort Worth Bank & Trust, 798 F.2d 791, 795-6 [41 FEP Cases 1179] (5th Cir. 1986), vac'd and remanded on other grounds, 487 U.S. 977 [47 FEP Cases 102] (1988) (reversing decertification of a class combining applicants and employees, stating that proof that an employer acted under a policy of discrimination could support certification of a class comprised of both applicants and employees if the discrimination manifested itself in hiring and promotion practices in the same general way, such as through subjective decisionmaking). Furthermore, plaintiffs argue that the Court may permit counsel to designate an appropriate employee member of the class to serve as an applicant representative.

Plaintiffs are correct that classes comprising both employees and applicants can be certified together. General Telephone v. Falcon, 457 U.S. at 159 n.15 (1982). Courts have routinely found that allegations that an employer operated under a general policy of discrimination can justify a class comprised of a diverse set of individuals. Neal v. Moore (D.D.C. No. 93-2420 (1994), Mem. Op. at 22), citing Richardson v. Byrd, 709 F.2d 1016, 1020 [32 FEP Cases 603] (5th Cir. 1983) (job assignment policy affected both employees and applicants). Some courts have concluded that "subjective decision-making" infected a company's employment practices as a whole, such that a broadly defined class is warranted. Neal v. Moore at 22, citing, Brown v. Eckerd Drugs, Inc., 564 F.Supp. 1440, 1446 [36 FEP Cases 1543] (W.D.N.C. 1983).

Moreover, as will be discussed in further detail below, any potential problems inherent in the fact that the proposed class in the present case is comprised of a diverse group of plaintiffs can be remedied by bifurcation of the case into a liability phase (addressing issues common to the class such as injunctive relief) and a remedial phase (addressing the individual compensatory damage claims). See e.g., Int'l Brotherhood of Teamsters v. United States, 431 U.S. 324 [14 FEP Cases 1514] (1977). If there is a second, remedial phase of this case, supervisors and non-supervisors will all be able to come forward with evidence of their own specific claims for relief. During the first, liability phase, by contrast, the diversity of class membership will not present material conflicts. [FN1]

Accordingly, this Court finds that the interests of the representative plaintiffs are not antagonistic to the remainder of the class; and that plaintiffs have met their burden of proving adequacy of representation, both of counsel and of the class representatives.

B. Rule 23(b) Requirements

Once the four requirements of 23(a) have been met, the Court must determine whether the case meets any of the three requirements of Rule 23(b). Plaintiffs argue that this class should be certified under 23(b)(2), which provides in pertinent part:

(b) Class Actions Maintainable. An action may be maintained as a class action if the prerequisites of subdivision (a) are satisfied, and in addition:

* * *
(2) the party opposing the class has acted or refused to act on grounds generally applicable to the class, thereby making appropriate final injunctive relief or corresponding declaratory relief with respect to the class as a whole . . .

Defendants argue that class certification under this subdivision is improper because the damages issues in this case predominate and "overwhelm" the requests for injunctive and declaratory relief.

In making this argument, defendant relies upon McDonnell Douglas Corp. v. U.S. Dist. Ct., C.D. of Cal., 523 F.2d 1083, 1087 (9th Cir. 1975). The facts of the cases cited by defendant are completely inapposite. In McDonnell Douglas, a wrongful death action for damages resulting from an airplane crash, the Ninth Circuit found that the plaintiffs' claims for declaratory relief "added nothing to [plaintiffs'] claim for damages." In the present case, plaintiffs' claims for damages are secondary to their primary claim for injunctive relief to prohibit gender biased employment practices. The fact that plaintiffs seek damages in addition to declaratory and injunctive relief does not preclude certification under Rule 23(b)(2). Probe v. State Teachers' Retirement System, 780 F.2d 776, 780 [40 FEP Cases 102] (9th Cir. 1986). It is "well established . . . that employment discrimination suits involving such individual-specific awards of lost back pay may be maintained as (b)(2) class actions . . . ." Arnold v. United Artists Theatre Circuit, Inc., 158 F.R.D. 439, 453 [5 AD Cases 685], citing, Probe, 780 F.2d at 780. [FN2]

Plaintiffs' allegations that the defendant maintains a policy and practice of denying women equal employment opportunities is sufficient to satisfy the Rule 23(b)(2) requirement. Defendant's arguments that the damage claims "overwhelm" the claims for injunctive relief are conclusory and, at this early stage, speculative. Accordingly, the Court finds that the first, liability phase of this case is appropriate for certification under Rule 23(b)(2).

C. Bifurcation

At oral argument, the Court requested supplemental briefing on whether this case could proceed in phases, and what, if any, constitutional limitations might affect such a process. [FN3]

In response to this request, plaintiffs have pointed to numerous cases, many of which are from the Northern District of California, indicating that the courts have routinely certified classes in similar employment discrimination cases by separating the trials into two phases. In Phase I, class wide damages and injunctive relief are determined. In Phase II--which the Court could certify now, or postpone until a later date--the individual compensatory damages issues would be resolved. In Arnold v. United Artists Theatre Circuit, Inc., 158 F.R.D. 439 [5 AD Cases 685] (N.D.Cal. 1994), Chief Judge Henderson addressed bifurcation of employment discrimination cases, and made the following general observations:

According to the authors of the leading treatise on class actions, most courts adjudicating civil rights class actions in the employment discrimination context opt to bifurcate the liability and damages phases of the trial. 5 H. Newberg, Class Actions Section 24.123, at 24-414-416 (3d ed. 1992). See, e.g., Teamsters v. United States, 431 U.S. 324, 360-362, 97 S.Ct. 1843, 1867-68, 52 L.Ed.2d 396 [14 FEP Cases 1514] (1977); Harriss v. Pan American World Airways, Inc., 74 F.R.D. 24 [15 FEP Cases 1640] (N.D.Cal. 1977); Barefield v. Chevron, 1988 WL 188433, 1988 U.S. Dist. LEXIS 15816, 48 Fair Empl. Cas. (BNA) 907 (N.D.Cal. 2988).

158 F.R.D. at 458-459. See also Barefield v. Chevron, 48 Fair Empl. Prac. Cas. (BNA) 907 (N.D. Cal. 1988).

Similarly, in Stender v. Lucky Stores, Inc., N.D. Cal. No. C-88-1467 (MHP), Judge Patel bifurcated a class action employment discrimination case into two separate phases. The first phase of the trial addressed class liability and liability for punitive damages. The claims of the individual plaintiffs for damages were deferred to later proceedings. [FN4]

Defendant argues that bifurcation of liability and damages would violate its Seventh Amendment right to a fair trial, because different juries would be deciding essentially the same issues. In re Innotron Diagnostics, 800 F.2d 1077, 1086 (Fed. Cir. 1986). Defendant argues that whether each individual plaintiff "can establish liability and the measure of compensatory and punitive damages" would have to be considered again in the second phase of the trial.

This Court is not persuaded by these arguments. Courts have routinely adopted the approach advocated by plaintiffs in which the first phase of the proceedings focuses exclusively on classwide claims, e.g., whether a defendant has in fact engaged in discriminatory employment practices. A jury verdict in favor of plaintiffs at this phase would result in injunctive and declaratory relief, and possibly, punitive damages. Individual compensatory damages would be resolved in the second phase of the proceedings which, since they would adjudicate individual claims, would not involve the "same issues" as did the first phase. As evidenced by the numerous cases across the country that have addressed this issue, the Seventh Amendment does not mandate that all phases of the litigation be heard by the same jury.

This Court will defer ruling on class certification with respect to the second phase of this trial. At such a time as it becomes necessary, the Court will adopt an approach that the Court and the parties can agree will best protect the rights of absent class members and defendant, in adjudicating the remaining issues.

D. Other Issues

The scope and starting and ending dates of the class are disputed by the parties. Defendant argues that the class is too broad, in that it encompasses those who might suffer some injury in the future. Plaintiffs have framed the class to include claims which arise between the class opening date, and the date of the entry of judgment in this action. In this respect, the Court does not find the class definition to be overly broad.

Defendants also argue that the named representatives are time-barred under Title VII and FEHA. With respect to the Title VII plaintiffs, the earliest filed charge is that of Kim Stoddard, who filed an EEOC and DFEH charge on November 5, 1993. Thus any claims that arose prior to January 9, 1993 (300 days prior to the November 5 date) must be excluded from the action.

With respect to the FEHA claims, defendant argues that the earliest proper DFEH claim was made on August 25, 1994 (by Funderburk) and thus any claims arising out of actions which occurred prior to August 25, 1993 (one year prior to the August 25 date) must be excluded. Defendant argues that plaintiff Stoddard's November 5, 1993 DFEH charge should be treated as ineffective, because Stoddard's lawsuit was not filed within one year after the DFEH issued her right to sue letter. Plaintiffs disagree, claiming that the class opening date for FEHA claims should be November 5, 1992 (one year prior to the date of Kim Stoddard's DFEH filing), and that Stoddard's claim is not time-barred because the statute of limitations for filing a complaint under FEHA may be equitably tolled during the pendency of an EEOC investigation. EEOC v. Farmers Bros. Co., 31 F.3d 891 [65 FEP Cases 857] (9th Cir. 1994); See also, Salgado v. Atlantic Richfield Co., 823 F.2d 1322, 1326 [48 FEP Cases 546] (9th Cir. 1987). Plaintiffs argue that since the EEOC was investigating Stoddard's claim until it issued her right-to-sue letter on September 22, 1994, Kim Stoddard's FEHA claim filed three months later was timely. This Court agrees. Accordingly, the class opening date for the Title VII issues as to all ten states in the WCD will be January 9, 1993. The class opening date for the FEHA claims in California will be November 5, 1992.

Finally, a related case--Frank v. Home Depot, Inc., No. C-95-2182 SI--has been filed against the same defendant with allegations that are almost identical to those in Butler. Plaintiffs have requested consolidation of these cases. Defendant points out that this motion was previously denied. [FN5] However, consolidation was denied before because adding new plaintiffs at that time would have necessitated modification of the briefing and discovery schedules with respect to the pending motion for class certification. In light of this Court's decision to grant plaintiffs' motion for class certification, these concerns are moot. Accordingly, the plaintiffs' motion to consolidate is GRANTED.

CONCLUSION

For the forgoing reasons and for good cause shown, the Court finds that the requirements of Rule 23(a) and (b)(2) have been satisfied, and determines that, subject to the terms and limitations discussed above, the actions may be maintained as a class action pursuant to the Federal Rules of Civil Procedure.

IT IS SO ORDERED.

FN1 One Court has commented that "an injunction against a few supervisory members of the class--who most likely did not exert significant influence over departmental policy-making--is fairly characterized as de minimus relative to the value of such an injunction in protecting these same supervisors from epidemic discrimination." Neal v. Moore (D.D.C. No. 93- 2420 (1994) Mem. Op. at 27)).

FN2 Defendant also points to Celestine v. Citgo Petroleum Corp., et al., Case No. 93-0864 [70 FEP Cases 80] (W.D. La.), in which Magistrate Judge Wilson's recommendation (filed 8/7/95) against class certification was adopted by the district court (9/11/95). This Court finds the analysis in that case inconsistent with controlling Ninth Circuit precedent and with other class action employment cases decided in this district. See, e.g., Probe, supra; Barefield v. Chevron, supra; Arnold v. United Artists, supra.

FN3 Specifically, the Court requested briefing on the effect, if any, of the enactment of the Civil Rights Act of 1991 (amending Title VII to add claims for compensatory and punitive damages for intentional discrimination, and a right to jury trial), and the Seventh Amendment implications if this case were to be tried in separate phases before separate juries.

FN4 The case settled after Judge Patel issued Findings of Fact and Conclusions of Law; the court never held the second phase of the trial.

FN5 This case was then pending before the Hon. Vaughn Walker.

END OF DOCUMENT

EXHIBIT I

LEXSEE 1990 U.S. DIST. LEXIS 19038

CLIFFORD A. O'NEAL, Plaintiff, v. CLARENCE THOMAS, Chairperson, EQUAL OPPORTUNITY COMMISSION, Defendant

Civil Action No. 1:89-CV-218-RHH

UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF GEORGIA, ATLANTA DIVISION

1990 U.S. Dist. LEXIS 19038; 56 Empl. Prac. Dec. (CCH) P40,815

October 15, 1990, Decided
October 15, 1990, Filed

CASE SUMMARY:

PROCEDURAL POSTURE: Plaintiff employee prevailed in his Title VII discrimination action against defendant Equal Opportunity Commission. The issue of damages and mitigation of damages then came before the magistrate.

OVERVIEW: The employee prevailed in his Title VII discrimination action against the Equal Opportunity Commission (commission). It was found that the employee had been discriminatorily denied a position for which he had applied. The magistrate then considered the issue of damages and mitigation of damages. The magistrate found that the facts in the case militated against bumping the current employee from the position sought by the employee. The magistrate did find, however, that the employee should be instated to a position in Atlanta of the same or equivalent title with the same or equivalent job responsibilities. The employee was to be given the same seniority and to be placed at the same grade and step that he would have reached had he been hired. The magistrate also ruled that the employee was entitled to backpay, but that it should be reduced by any bonuses or earnings the employee received by other employment. The magistrate ruled that in awarding back pay, a court was to place the injured party in the position he or she would have enjoyed absent discrimination. The magistrate ruled that the employee was not entitled to prejudgment interest due to sovereign immunity.

OUTCOME: The magistrate recommended that the employee be instated into a position of the same or equivalent title with the same or equivalent responsibilities as the position he was discriminatorily denied, that he be placed in the same position as to retirement and seniority, that he receive backpay and attorney fees, but that he not receive prejudgment interest. Backpay was to be decreased by any bonuses or earnings he received elsewhere.

LexisNexis(R) Headnotes

Labor & Employment Law > Discrimination > Racial Discrimination > Remedies > General Overview
Labor & Employment Law > Discrimination > Title VII of the Civil Rights Act of 1964 > Remedies > Equitable Relief
[HN1] A prevailing plaintiff in a Title VII action is presumptively entitled to promotion, reinstatement and back pay.

Labor & Employment Law > Discrimination > Racial Discrimination > Remedies > General Overview
[HN2] "Bumping" is an extraordinary remedy to be used sparingly and only when a careful balancing of the equities indicates that absent "bumping," plaintiff's relief will be unjustly inadequate. A defendant's recalcitrance, as evidenced by repeated discriminatory actions after it is on notice of past illegal discrimination against a plaintiff, militates in favor of granting this extraordinary relief.

Labor & Employment Law > Discrimination > Racial Discrimination > Remedies > General Overview
[HN3] In awarding back pay, the court is to place the injured party in the position he or she would have enjoyed absent discrimination. This generally includes

back pay. However, a person is required to mitigate damages by being reasonably diligent in seeking employment substantially equivalent to the position he was denied.

Labor & Employment Law > Discrimination > Racial Discrimination > Remedies > General Overview
Labor & Employment Law > Discrimination > Title VII of the Civil Rights Act of 1964 > Remedies > Mitigation of Damages
[HN4] Title VII requires reasonable diligence in locating employment and mitigating damages; it does not require that a person remain employed despite dissatisfaction.

Labor & Employment Law > Discrimination > Racial Discrimination > Remedies > General Overview
Labor & Employment Law > Discrimination > Title VII of the Civil Rights Act of 1964 > Remedies > Equitable Relief
[HN5] The object of relief under Title VII is to restore the victim of discrimination to the fruits and status of employment as if there had been no discrimination. Benefits may include back pay and fringe benefits. Fringe benefits may include sick and vacation pay and mileage expenses which the employer would have paid the employee in the normal course of business. The issue is whether the plaintiff was receiving the benefit from the defendant or was entitled to the benefit from the employer as a part of his employment.

Labor & Employment Law > Discrimination > Racial Discrimination > Remedies > General Overview
Labor & Employment Law > Discrimination > Title VII of the Civil Rights Act of 1964 > Remedies > Equitable Relief
Labor & Employment Law > Discrimination > Title VII of the Civil Rights Act of 1964 > Remedies > Mitigation of Damages
[HN6] *42 U.S.C.S. § 2000e-5*(g) states: Interim earnings or amounts earnable with reasonable diligence by the person or person discriminated against shall operate to reduce the back pay otherwise allowable.

Labor & Employment Law > Discrimination > Racial Discrimination > Remedies > General Overview
Labor & Employment Law > Discrimination > Title VII of the Civil Rights Act of 1964 > Remedies > Equitable Relief
[HN7] There is no distinction made between various types of interim earnings. This court will not create such a distinction. Under *42 U.S.C.S. § 2000e-5*(g), the amount which an employee would otherwise have been entitled in the absence of the discrimination will be reduced by any earnings acquired during the interim period regardless of the type of work involved.

Civil Procedure > Federal & State Interrelationships > Sovereign Immunity > State Immunity
Labor & Employment Law > Discrimination > Title VII of the Civil Rights Act of 1964 > Remedies > Costs & Attorney Fees
Labor & Employment Law > Discrimination > Title VII of the Civil Rights Act of 1964 > Remedies > Equitable Relief
[HN8] The sovereign immunity of the United States prevents it from paying any interest absent plain consent and the provision for "any other equitable relief" in *42 U.S.C.S. § 2000e-5*(g), as incorporated by § 2000e-16(d), is not such a waiver.

JUDGES: [*1]

John R. Strother, Jr., United States Magistrate.

OPINION BY:

STROTHER

OPINION:

SPECIAL MASTER'S REPORT AND RECOMMENDATION

The district court adopted the magistrates finding of discrimination in this Title VII action. The action has been referred to the magistrate on the issue of damages, including instatement. A hearing was held in this action on September 14, 1990. At the hearing testimony was heard concerning the plaintiff's damages and mitigation of damages as required by Title VII. The action is now ready for review.

INSTATEMENT

The plaintiff seeks instatement to the position for which he should have been hired on November 25, 1984. He argues that he should be given the position now held by Ms. Gonzales. The government argues that the plaintiff should be placed in a position equivalent to the one the plaintiff should have received in November, 1984, but asserts that "bumping" is not the correct remedy in this case.

[HN1] A prevailing plaintiff is presumptively entitled to promotion, reinstatement and back pay. *Crabtree v. Baptist Hosp. of Gadsden, Inc., 749 F.2d 150 (11th Cir. 1985)*. The central case concerning instatement

in this Circuit is *Walters v. City of Atlanta, 803 F.2d 1135 (11th Cir. 1986).* [*2] In Walters, the plaintiff had been repeatedly rejected for the position of Director of the Cyclorama, a unique position. The court stated:

[HN2] "Bumping" is an extraordinary remedy to be used sparingly and only when a careful balancing of the equities indicates that absent "bumping," plaintiff's relief will be unjustly inadequate. A defendant's recalcitrance, as evidenced by repeated discriminatory actions after it is on notice of past illegal discrimination against a plaintiff, militates in favor of granting this extraordinary relief. The City, through its illegal conduct in filling the position long after it was aware of Walters' claim, could not prevent the district court from ordering relief in vindication of the laws and the Constitution. [cite omitted] The district court's order is further supported by the uniqueness of the Cyclorama directorship and Walters' singular qualifications for it.

Id. at 1149. The facts in this case militate against bumping Gonzales from the position sought by the plaintiff. It does appear that the defendant aided Gonzales in gaining the position despite questions concerning the truthfulness of her application. However, there [*3] has been no ongoing discrimination as in Walters, this position is not unique as was the position in Walters, and the plaintiff, despite his better qualifications, did not have gaining this position as his life-long goal as did the plaintiff in Walters. Though bumping is not recommended in this case, the court does find that the plaintiff should be instated to a position in Atlanta of the same or equivalent title with the same or equivalent job responsibilities. The plaintiff is to be given the same seniority and to be placed at the same grade and step that he now would have reached had he been hired in November, 1984. He is also to be placed in the same position as to retirement under the CSR system that he would be at this time had he been hired in November, 1984.

BACK PAY

The plaintiff also seeks back pay from the time that he should have been hired, November 25, 1984, through the date of judgment. The government maintains that the plaintiff's back pay remedy should be discontinued at the time he left his job in Boston to move to Atlanta to search for work. The parties have agreed that dependant on the court's ruling as to the legal issues concerning back pay, they [*4] can reach an agreement as to the amount of back pay due the plaintiff.

A. Facts

At the time the plaintiff applied for the position in issue in this action, he was employed as an Equal Employment Officer in Boston, Mass. at a GM-13 level because his previous position as an Equal Opportunity Specialist in the Atlanta Department of the Interior had been phased out. (Exh. 4). The plaintiff applied for the position of EEO Specialist at the Atlanta District Office of the Equal Employment Opportunity Commission and was rejected for the position on November 25, 1984. He wanted the position because he wanted to return to Atlanta, did not like living in Boston, and was homesick. The plaintiff remained in the Boston office until September 12, 1987, at which time he voluntarily left the position to move back to Atlanta. While employed in Boston he continually attempted to obtain a position in Atlanta and continually, contacted persons he knew in the federal government in Atlanta concerning any job openings or announcements. In the summer of 1987, the plaintiff spoke to his supervisor in Boston and told him that he was unhappy and anticipated leaving his job in Boston to return to Atlanta. [*5] He was given a three week leave of absence without pay from August 2, 1987 through September 12, 1987, to return to Atlanta and think about his desire to leave his job in Boston. At the end of the three week period he resigned from his job in Boston. (Pl. Exhs. 9, 10). He left Boston and returned to the Atlanta area. Once in Atlanta, he continued to search for a job in the federal government and contacted persons concerning job openings and announcements. (See, Pl. Exhs. 4, 6, 7, 8). The plaintiff was unemployed from September 12, 1987 through April 11, 1988. He applied for a position with the Bureau of Census on January 25, 1988, and received an appointment with the Bureau on April 11, 1988. (Pl. Exh. 11). His job was temporary and ended as of September 30, 1990. His position at the Census Bureau was not subject to a retirement system. After a certain point, he was eligible for health benefits, but the government paid no portion of his health benefit premiums. During the period of time in which he was unemployed the plaintiff found health insurance coverage and paid his own health insurance premiums. His previous position with the Department of Interior and the position with the [*6] EEOC would have involved eligibility for retirement and the government would have paid a portion of his health insurance premiums.

B. Back Pay Period

The defendant maintains that the plaintiff's back pay award should be cut off at the time he voluntarily left his position in Boston and moved to Atlanta. The court disagrees. [HN3] In awarding back pay, the court is to place the injured party in the position he or she would have enjoyed absent discrimination. *EEOC v. Guardian*

Pools Inc., 828 F.2d 1507 (11th Cir. 1987), citing, *Albemarle Paper Co. v. Moody, 422 U.S. 405 (1975); Walters v. City of Atlanta, 803 F.2d 1135 (11th Cir. 1986).* This generally includes back pay. However, a person is required to mitigate damages by being reasonably diligent in seeking employment substantially equivalent to the position he was denied. *Smith v. American Service Co. of Atlanta, Inc., 796 F.2d 1430, 1431 (11th Cir. 1986).* The issue here is whether the plaintiff per se failed to mitigate his damages by leaving his job in Boston, which was in effect substantially equivalent to the one he had applied for in Atlanta. The court [*7] finds that this case is much like the Eleventh Circuit case of Guardian Pools. In Guardian Pools, the plaintiff was not hired as a pool attendant and found employment as a typesetter. She quit the job as a typesetter soon thereafter and went. to New Jersey for six weeks. She then enrolled full time in college and worked part time. After graduation she worked at various jobs. The district court cut off back pay at the time she graduated from college. The defendant argued that the back pay should have ceased when she left the typesetting company after a short time. The Eleventh Circuit disagreed, stating:

[HN4] Title VII requires reasonable diligence in locating employment and mitigating damages; it does not require that a person remain employed despite dissatisfaction.

Id. at 1511; see, *Stone v. D.A. & S. Oil Well Servicing Inc., 624 F.2d 142, 144 (10th Cir. 1980)* (a job seeker who leaves a noncomparable part time job and moves to another location to seek comparable work does not display a lack of reasonable diligence). The court finds that the plaintiff did undertake reasonable diligence by staying in the job in Boston for three years after [*8] he was wrongfully denied the position in Atlanta. He did not merely quit the job a short time after being turned down for the Atlanta position, but stayed in the position in Boston for what can only be considered a reasonable time. He continually looked for jobs in Atlanta while in Boston and also searched diligently for a position in Atlanta once he moved here in 1987. Thus, the fact that he voluntarily left the position in Boston does not convince the court that the back pay period should end at that time.

The second question is whether his back pay should be cut off at the time he took the position with the Census Bureau in 1988. The defendant has not argued that this was a comparable position to that he held in Boston or would have held in Atlanta but for the discrimination. His position was of a regional technician. The position was a temporary one which offered few of the benefits that permanent employment with the EEOC would have offered. Thus, the court finds that this employment would not serve to cut off his back pay.

Therefore, the magistrate RECOMMENDS that the plaintiff be awarded back pay for a period from November 25, 1984 through the date of judgment in this action, [*9] less any amount earned as will be discussed in this Report and Recommendation.

C. Health Insurance and Benefits

[HN5] The object of relief under Title VII is to restore the victim of discrimination to "the fruits and status of employment as if there had been no discrimination." *Bennett v. Carroon & Black Corp., 845 F.2d 104, 106 (5th Cir. 1988),* cert. denied, *U.S. , 109 S.Ct. 1140, 103 L.Ed.2d 201 (1989).* Benefits may include back pay and fringe benefits. *Mitchell v. Seaboard System R.R., 883 F.2d 451, 452 (6th Cir. 1989); Walker v. Ford Motor Co., 684 F.2d 1355, 1364-65 n. 16,* (11th Cir. 1982). Fringe benefits may include sick and vacation pay and mileage expenses which the employer would have paid the employee in the normal course of business. *Walker, supra.;* See, *Cox v. American Cast Iron Pipe Co., 784 F.2d 1546* (11th Cir.) cert. denied, *479 U.S. 883 (1986).* The issue is whether the plaintiff was receiving the benefit from the defendant or was entitled to the benefit from the employer as a part of his employment. The plaintiff has [*10] put in evidence that he had to pay full insurance premiums, instead of partial premiums, because he was denied the position. The plaintiff, as a federal employee in Boston, was entitled to health benefits for which the government paid a portion of the premiums. If he had received the position in 1984 in Atlanta, he would have transferred to that office and would have continued to receive health benefits for which the government paid a portion of the premiums. He did not receive the position, and as found above, did mitigate his damages. Thus, the court finds that the defendant is also to reimburse the plaintiff for the portion of his health insurance premiums which it would have paid if the plaintiff had transferred to the Atlanta office in 1984.

The plaintiff would also have received step increases while an employee with the defendant. Thus, the amount of back pay is to include any step increases or raises he would have received had he been working for the defendant in the EEO Specialist position from November 25, 1984.

D. Bonus

During the hearing the plaintiff also testified that he received a merit bonus while working in the Boston

office. He argues that the bonus amount should [*11] not be deducted from his back pay award. (Pl. Exh. 5). The court must disagree.

[HN6] *42 U.S.C. § 2000e-5*(g) states:

Interim earnings or amounts earnable with reasonable diligence by the person or person discriminated against shall operate to reduce the back pay otherwise allowable.

The Former Fifth Circuit has held:

[HN7] There is no distinction made between various types of interim earnings. This court will not create such a distinction. Under the statute, the amount which an employee would otherwise have been entitled in the absence of the discrimination will be reduced by any earnings acquired during the interim period regardless of the type of work involved.

Merriweather v. Hercules, Inc., 631 F.2d 1161, 1168 (5th Cir. 1980), overruled on other grounds, *Brown v. A.J.Gerrard Mfg. Co., 715 F.2d 783, 785-86 (7th Cir. 1979).* The plaintiff earned his bonus while working in the Boston office. Thus, the court finds that any back pay awarded to the plaintiff must be offset by all earnings while at the Boston office, including the bonus, as well as all earnings while employed by the Census Bureau.

E. Prejudgment Interest

The plaintiff requests prejudgment [*12] interest on the back pay in this action. This circuit has not specifically decided whether interest is available against a federal defendant, other than the postal service. See, *Nagy v. United States Postal Service, 773 F.2d 1190, 1192-93* and note 1 (11th Cir. 1985). The court specifically held in Nagy, however, that interest could be obtained on back pay in a Title VII suit against the Postal Service because of its somewhat hybrid nature as a federal defendant and private employer and that it had generally waived its sovereign immunity. Id. However, other courts have held, in cases not involving the Postal Service, that [HN8] the sovereign immunity of the United States prevents it from paying any interest absent plain consent and that the provision for "any other equitable relief" in *42 U.S.C. § 2000e-5*(g) as incorporated by *42 U.S.C. § 2000e-16*(d), is not such a waiver. *Id. at 1192* and cases cited therein; see, *Saunders v. Claytor, 629 F.2d 596 (9th Cir. 1980);* See, also, *Library of Congress v. Shaw, 478 U.S. 310 (1986)* (§ 706(k) of Title VII concerning awards of attorneys fees does not waive immunity [*13] from interest as to federal defendants). Thus, the court finds that the plaintiff is not entitled to prejudgment interest on the back pay award.

F. Attorney's Fees and Costs

The plaintiff is clearly the prevailing party in this case. Thus, he is entitled to attorneys' fees and costs. *42 U.S.C. 2000e-5*(k). No evidence has been received as of this date concerning the amount of attorneys' fees or costs in this action. Thus, the magistrate will defer any ruling on the amount of fees until after this Report and Recommendation is considered by the district court.

SUMMARY

The magistrate RECOMMENDS that the plaintiff be instated by the defendant into a position in Atlanta of the same or equivalent title with the same or equivalent responsibilities as the position he was discriminatorially denied in November, 1984.

The magistrate further RECOMMENDS that the plaintiff be placed in the same position as to retirement and seniority as he would have been if he had been given the position in 1984.

The magistrate further RECOMMENDS that the plaintiff be paid back pay from November 27, 1984, through the date of judgment, including any step increases or raises and less any bonuses or earnings [*14] from his job in Boston and with the Census Bureau.

The magistrate further RECOMMENDS that the plaintiff's request for prejudgment interest be DENIED.

The magistrate further RECOMMENDS that the plaintiff's request for attorneys' fees and costs be GRANTED and that any ruling on the amount of fees be deferred until after the district court rules on this Report and Recommendation.

IT IS SO RECOMMENDED this 15th day of October, 1990.

ORDER FOR SERVICE OF SPECIAL MASTER'S REPORT AND RECOMMENDATION - October 15, 1990, Filed

Attached is the report and recommendation of the United States Magistrate made in this action in accordance with *28 U.S.C. § 636*(b)(1) and this Court's Local Rules 260 and 500. Let the same be filed and a copy, together with a copy of this Order, be served upon counsel for the parties.

Pursuant to *28 U.S.C. § 636*(b)(1), each party may file written objections, if any, to the report and recommendation within ten (10) days of the receipt of this order. Should objections be filed, they shall specify with particularity the alleged error or errors made (including reference by page number to the transcript if

applicable) and shall be served upon the opposing party. The party [*15] filing objections will be responsible for obtaining and filing the transcript of any evidentiary hearing for review by the district court. If no objections are filed, the report and recommendation may be adopted as the opinion and order of the district court and any appellate review of factual findings will be limited to a plain error review. *United States v. Slay, 714 F.2d 1093 (11th Cir. 1983),* cert. denied, *464 U.S. 1050, 104 S.Ct. 729 (1984).*

The Clerk is directed to submit the report and recommendation with objections, if any, to the district court after expiration of the above time period.

SO ORDERED, this 15th day of Oct., 1990.

EXHIBIT J

1986 U.S. Dist. LEXIS 30537, *; 39 Fair Empl. Prac. Cas. (BNA) 1569;
39 Empl. Prac. Dec. (CCH) P35,936

LEXSEE 1986 U.S. DIST. LEXIS 30537

EQUAL EMPLOYMENT OPPORTUNITY COMMISSION, INTERNATIONAL UNION OF ELECTRICAL, RADIO AND MACHINE WORKERS, AFL-CIO and IUE LOCAL 1102, Plaintiffs, v. EMERSON ELECTRIC COMPANY, Defendant

No. 81-862 C (2)

UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF MISSOURI, EASTERN DIVISION

1986 U.S. Dist. LEXIS 30537; 39 Fair Empl. Prac. Cas. (BNA) 1569; 39 Empl. Prac. Dec. (CCH) P35,936

January 13, 1986, Decided and Filed

OPINION BY:

FILIPPINE

OPINION:

MEMORANDUM AND ORDER

This matter is before the Court on plaintiffs' motion for summary judgment. The litigation arises out of differences in defendant's employee health insurance plan coverage for pregnancy-related expenses as opposed to other medical expenses. The Court, in its November 29, 1983, order, decided the liability issue in favor of plaintiffs. The parties have stipulated to the amounts due to defendant's employees injured by the discriminatory plan except that the parties disagree on the propriety of prejudgment interest and the amount of recovery due to employees who purchased supplemental insurance to cover the deficiency in defendant's insurance plan.

The award of insurance benefits is in the nature of an award of back pay and prejudgment interest such is appropriate [*2] to make plaintiffs whole. *Greer v. University of Arkansas Board of Trustees, 719 F.2d 950 (8th Cir. 1983); Easley v. Anheuser-Busch, Inc., 572 F.Supp. 402, 415 (E.D. Mo. 1983),* rev'd on other grounds, *758 F.2d 251 (8th Cir. 1985); Hawkins v. Anheuser-Busch, Inc., 522 F.Supp. 159, 161 (E.D. Mo. 1981),* rev'd on other grounds, *697 F.2d 810 (8th Cir. 1983).* The parties have suggested different rates for any prejudgment interest award. The plaintiffs have suggested those set out in *26 U.S.C. § 6621,* calculated in accordance with the adjusted prime interest rate as utilized by the Internal Revenue Service. Defendant argues any interest should be at a rate established under state law. *Dependahl v. Falstaff Brewing Corp., 653 F.2d 1208, 1219 (8th Cir. 1981),* cert. denied *454 U.S. 968 (1981).* The rate established under Missouri law for interest on judgments is nine percent simple interest and the Court finds that under the circumstances in this case that rate constitutes full compensation due plaintiffs.

The Court is also of the opinion that employees who purchased supplemental insurance to cover the deficiency in the Emerson plan should be compensated by an award [*3] equal to the amount of premiums paid which were necessary to secure pregnancy-related coverage at the same level as coverage for nonpregnancy-related expenses under the Emerson plan. In addition, those employees are entitled to recover any pregnancy-related expenses not covered by supplemental insurance which would have been within amounts covered by Emerson's coverage for nonpregnancy-related expenses.

Summary judgment is a useful tool whereby needless trials may be avoided, and it should not be withheld in an appropriate case. *United States v. Porter, 581 F.2d 698, 703 (8th Cir. 1978).* Summary judgment is appropriate when there is no genuine issue of material fact and the moving party is entitled to judgment as a matter of law. *Fed.R.Civ.P. 56(c).* In the instant case, material issues exist regarding the amount of premiums attributable to supplemental insurance necessary to bring coverage for pregnancy-related expenses in line with coverage for other expenses. Further, there is a material issue of fact regarding the cause of employee Ruff's damage since his supplemental insurance was not purchased until after Emerson had corrected the deficiencies in its plan.

Accordingly, [*4]

IT IS HEREBY ORDERED that plaintiffs' motion for summary judgment be and is GRANTED in part as set out in the aforesaid memorandum, and otherwise DENIED.

Dated this 13th day of January, 1986.

Edward L. Filippine, UNITED STATES DISTRICT JUDGE