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9 UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF CALIFORNIA

10 CORLYN DUNCAN and BRUCE DUNCAN,
 11 individually and on behalf of all others similarly
 12 situated,

Civil Case No.

13 Plaintiffs,

14 v.

15 THE ALIERA COMPANIES, INC., f/k/a ALIERA
 16 HEALTHCARE, INC., a Delaware corporation; and
 17 TRINITY HEALTHSHARE, INC., a Delaware
 corporation,

18 Defendants.

19 **CLASS ACTION COMPLAINT**

20 **I. PARTIES**

21 1. Plaintiffs CORLYN DUNCAN and BRUCE DUNCAN, husband and wife, are
 22 citizens of California who reside in Benicia, Solano County. Mr. and Ms. Duncan were enrolled
 23 in a health care plan from Defendants Alieria Healthcare and/or Trinity Healthshare from
 24 January 1, 2018 through December 31, 2019.

25 2. Defendant THE ALIERA COMPANIES, INC. (“Alieria”) is a Delaware
 26 corporation headquartered in Atlanta, Georgia. It is incorporated as a for-profit business, without

1 any express religious affiliation. It changed its name in 2019 from ALIERA HEALTHCARE,
2 INC.

3 3. Defendant TRINITY HEALTHSHARE, INC. (“Trinity”) is a Delaware
4 corporation headquartered in Atlanta, Georgia and purports to be a nonprofit entity. Trinity was
5 incorporated on or about June 27, 2018. Alieria and Trinity are collectively referred to as
6 “Defendants.”

7 4. Alieria markets, sells, and administers insurance plans for Trinity and is solely
8 responsible for the development of plan designs, pricing, marketing materials, vendor
9 management, recruitment and maintenance of a sales force on behalf of Trinity.

10 5. Neither Alieria nor Trinity holds a certificate of authority from the California
11 Department of Insurance as required by Cal. Ins. Code § 700, and neither is authorized or licensed
12 to provide any type of insurance plan in California.

13 **II. JURISDICTION AND VENUE**

14 6. This Court has subject matter jurisdiction pursuant to 28 U.S.C. § 1332(a) and
15 § 1367 because there is diversity of citizenship and the amount in controversy related to the
16 proposed class claims exceeds \$75,000.

17 7. Venue is proper because some of the acts or omissions occurred in the Eastern
18 District of California, and the named Plaintiffs and many of the proposed class members reside in
19 that District.

20 **III. NATURE OF THE CARE**

21 8. Defendants sold inherently unfair and deceptive health care plans to California
22 residents, and failed to provide them with the coverage the purchasers believed they would
23 receive. Defendants claimed the health care plans were not “insurance” in order to avoid both
24 oversight by the state insurance commissioner and minimum requirements mandated by the
25 Patient Protection and Affordable Care Act (“ACA”). At the same time, Defendants created the
26

1 health care plans to look and feel like health insurance that would provide meaningful coverage
2 for the purchasers' health care needs.

3 9. When Congress passed the ACA in 2010, it required all individuals to be covered
4 by health insurance or pay a penalty. Congress allowed for a handful of exceptions to that
5 requirement, set out in 26 U.S.C. § 5000A. One of those exceptions was for members of existing
6 Health Care Sharing Ministries ("HCSMs"). In order to qualify as an HCSM under the ACA, an
7 entity must meet rigid requirements, including: (1) it must be recognized as a 501(c)(3) tax exempt
8 organization; (2) its members must "share a common set of ethical or religious beliefs and share
9 medical expenses among members according to those beliefs;" and (3) it must have "been in
10 existence at all times since December 31, 1999, and medical expenses of its members [must] have
11 been shared continuously and without interruption since at least December 31, 1999." 26 U.S.C.
12 § 5000A(d)(2)(B)(ii). At no time has for-profit Alera ever met the definition of an HCSM.

13 10. Alera, in an attempt to exploit this exception, falsely represented that the health
14 care products it designed and sold were from a legitimate HCSM. It initially sold its own products
15 in connection with an HCSM, Unity Healthshare LLC ("Unity"). It falsely represented to its
16 customers that they were purchasing a Unity HCSM product, even though Alera alone designed,
17 marketed, and sold the plans, administered all claims, directly received all payments from
18 members, and controlled the membership roster, without any meaningful input from Unity.

19 11. When Alera's relationship with Unity soured, it created defendant Trinity in July
20 2018, and claimed that Trinity had been "recognized" as an HCSM. Trinity did not meet the
21 requirements of 26 U.S.C. § 5000A(d)(2)(B)(ii) because it was not in existence continuously since
22 1999, and because it did not require its members to adhere to its stated ethical or religious beliefs.
23 It was never, and could not have been, "recognized" as an HCSM because the federal agency that
24 had at one time provided letters of recognition stopped doing so in 2016, before Trinity was
25 created. Trinity filled the role that Unity had played with Alera and its members, and assumed
26

1 the responsibilities and duties to existing members who had purchased the Alera product
2 marketed with the Unity name.

3 12. While falsely representing that members were purchasing an HCSM plan through
4 Unity, and then by representing that Trinity is a recognized HCSM, Defendants sought to avoid
5 state insurance protection statues by claiming the products they sell are not “insurance.” In fact,
6 Alera created, marketed, sold, and administered illegal and unauthorized insurance plans to
7 California residents. These plans do not comply with the minimum basic requirements for
8 authorized health care plans under state or federal law.

9 13. On information and belief, Defendants sold the illegal health insurance plans to
10 thousands of California residents. As a result, California residents (1) paid for an illegal contract,
11 and (2) were denied coverage for medical care required by law to be provided.

12 14. Alera and its owners, however, have realized exorbitant profits. On information
13 and belief, Alera takes over 83% of all payments made by individuals, while refusing to pay
14 claims.

15 15. Defendants’ representations that the insurance plans were HCSM plans and would
16 provide members with meaningful coverage were fraudulent, misleading, unfair and/or deceptive
17 in violation of California’s Unfair Competition Law, False Advertising Law, and Unfair Insurance
18 Practices Act. At no relevant time did the Defendants’ plans meet the requirements for HCSMs
19 under federal law as represented, meet the requirements of health insurance plans under federal
20 or California law, or provide the coverage that was represented.

21 16. Plaintiffs, on behalf of the class they seek to represent, filed this lawsuit to obtain
22 declaratory and injunctive relief to prevent Defendants from continuing to arbitrarily and in bad
23 faith deny or delay payment of claims that should be covered under legitimate health insurance
24 plans. On behalf of the proposed class and on their own behalf, Plaintiffs also seek either
25 rescission of their plans and return of premiums paid, or reformation of the plans to provide
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1 coverage for uncovered health care expenses that should have been paid had the plans sold been
2 authorized and legal rather than sham health insurance plans.

3 17. Plaintiffs, on behalf of the class they seek to represent, also seek disgorgement,
4 imposition of a constructive trust, and/or restitution of Defendants' unlawful profits. Defendants
5 have breached their fiduciary duties to class members and have been unjustly enriched by taking
6 unreasonable fees and commissions, while arbitrarily and unreasonably refusing to pay claims.
7 They have profited from payments class members made believing, based on Defendants'
8 representations, that they would be covered for medical expenses.

9 **IV. CLASS ALLEGATIONS**

10 18. **Definition of Class:** Pursuant to Fed. R. Civ. P. 23, Plaintiff brings this action on
11 behalf of herself and all persons similarly situated. The proposed Class is defined as follows:

12 All California residents who purchased a plan administered by Alera
13 from any of Defendants or their subsidiaries that purported to be a
14 "health care sharing ministry" plan at any time since September 11,
2017.

15 19. **Size of the Class:** The Plaintiffs' proposed class is so numerous that joinder of all
16 members is impracticable. On information and belief, at least 11,000 individuals in California
17 are or have been covered by Defendants' plans.

18 20. **Common Questions of Fact and Law:** There are questions of law and fact that
19 are common to all class members including: (1) whether the healthcare products that the
20 Defendants created, marketed, sold, and administered to class members met the legal
21 requirements of an HCSM under 26 U.S.C. § 5000A; (2) whether plans sold were "insurance"
22 under California insurance law; (3) whether California insurance law and regulations forbid the
23 creation, marketing, sale, and administration of health care products in the "business of insurance"
24 without authorization or other legal exception; (4) whether Defendants failed to obtain proper
25 authorization for the creation, marketing, sale, and administration of an insurance product in
26 California; (5) whether class members are entitled to (a) rescission of the plan(s) and refunds of

1 all premiums paid and/or (b) reformation of the plans to comply with the minimum insurance
2 coverage requirements of California and federal law, and re-processing of all claims for expenses
3 and costs incurred that would have been covered had the plan(s) properly complied with those
4 laws; (6) whether Defendants' actions were unfair, deceptive, untrue or misleading, and likely to
5 deceive consumers, in violation of California's Unfair Competition Law, False Advertising Law,
6 and/or Unfair Insurance Practices Act; (7) whether Defendants owed a fiduciary duty to their
7 members, and whether they breached that fiduciary duty; (8) whether Defendants have been
8 unjustly enriched by collecting members' payments while failing to pay claims, and by paying
9 themselves unreasonable fees and commissions; (9) whether a constructive trust should be
10 imposed; and (10) whether class members are entitled to other relief resulting from Defendants'
11 unfair and/or deceptive acts.

12 21. ***Class Representative:*** The claims of the named Plaintiffs are typical of the claims
13 of the proposed class as a whole resulting from Defendants' sale of unauthorized and illegal
14 insurance plans. The named Plaintiffs will fairly represent and adequately protect the interests of
15 the class members because they have been subjected to the same practices as other class members
16 and suffered similar injuries. The named Plaintiffs do not have interests antagonistic to those of
17 other class members as to the issues in this lawsuit.

18 22. ***Separate Suits Would Create Risk of Varying Conduct Requirements.*** The
19 prosecution of separate actions by class members against Defendants would create a risk of
20 inconsistent or varying adjudications with respect to individual class members that would
21 establish incompatible standards of conduct. Certification is therefore proper under Fed. R. Civ.
22 P. 23(b)(1).

23 23. ***Defendants Have Acted on Grounds Generally Applicable to the Class.***
24 Defendants have uniformly created, marketed, approved, sold and/or administered unauthorized
25 health insurance plans in California. They have misrepresented the plans as HCSM plans under
26 federal and state law. Defendants have acted on grounds generally applicable to the proposed

1 class, rendering declaratory and injunctive relief appropriate respecting the whole class.
2 Certification is therefore proper under Fed. R. Civ. P. 23(b)(2).

3 24. ***Questions of Law and Fact Common to the Class Predominate Over Individual***
4 ***Issues.*** The claims of the individual class members are more efficiently adjudicated on a class-
5 wide basis. Any interest that individual members of the class may have in individually controlling
6 the prosecution of separate actions is outweighed by the efficiency of the class action mechanism.
7 Upon information and belief, no class action suit is presently filed or pending against Defendants
8 for the relief requested in this action. Issues as to Defendants' conduct in applying standard
9 marketing, sales and administration practices towards all members of the class predominate over
10 questions, if any, unique to members of the class. Certification is therefore additionally proper
11 under Fed. R. Civ. P. 23(b)(3).

12 25. ***Venue.*** This action can be most efficiently prosecuted as a class action in this
13 jurisdiction, where Defendants do business and where Plaintiffs reside.

14 26. ***Class Counsel.*** Named Plaintiffs have retained experienced and competent class
15 counsel.

16 V. FACTUAL BACKGROUND

17 A. **Aliera Seeks Out an HCSM to Avoid Insurance Requirements,** 18 **and Sells Sham HCSM Products through Unity**

19 27. Defendant Aliera was incorporated in the State of Delaware by Timothy Moses, a
20 convicted felon, his wife Shelley Steele, and their son Chase Moses, in December 2015. Before
21 forming Aliera, Timothy Moses was the president and CEO of International BioChemical
22 Industries, Inc., a company that declared bankruptcy in 2004 after he was charged with felony
23 securities fraud and perjury. As a result of the case, titled *United States v. Moses*, 1:04-cr-00508-
24 CAP-JMF (N.D. Ga.), Moses was sentenced to over 6 years in prison, and ordered to pay \$1.65
25 million in restitution.
26

1 28. Alieria is a for-profit entity. Its stated scope of business is “to engage in the
2 business of providing all models of Health Care to the general public” and “to cultivate, generate
3 or otherwise engage in the development of ideas or other businesses, to buy, own or acquire other
4 businesses, to market and in any way improve the commercial application to the betterment and
5 pecuniary gain of the corporation and its stockholders ...” The formation documents of Alieria
6 Healthcare, Inc. do not include any discussion of religious or ethical purposes or missions.

7 29. Alieria began selling its healthcare products in late 2015. At the time it was formed,
8 it only sold “direct primary care medical home (DPCMH)” plans. DCPMH plans generally cover
9 limited services such as some doctors’ visits and basic lab services. These plans provide no
10 hospitalization or emergency room coverage and are not ACA-complaint.

11 30. Alieria realized that it could greatly increase the sales of its healthcare products if
12 it could take advantage of the federal statute that exempted taxpayers who purchased HCSMs
13 from the ACA’s individual mandate.

14 31. Non-party Anabaptist Healthshare (“Anabaptist”) was a small Mennonite entity
15 located in Virginia with about 200 members. Anabaptist had been recognized by the federal
16 Department of Health & Human Services’ Centers for Medicare & Medicaid Services (“CMS”) as an HCSM. CMS had provided a letter to Anabaptist that it met the requirements under 26
17 U.S.C. § 5000A to operate an HCSM. Specifically, CMS found that Anabaptist had been “in
18 existence at all times since December 31, 1999 and medical expenses of its members have been
19 shared continuously and without interruption since December 31, 1999.”

20 32. In 2016, Timothy Moses convinced Anabaptist to permit Alieria to market its own
21 DCPMH plan “side by side” with Anabaptist’s sharing program using Anabaptist’s HCSM
22 designation. Anabaptist created a wholly-owned subsidiary, called Unity Healthshare (“Unity”),
23 for that purpose. Under the proposal, Alieria would market both its own plan and the Unity HCSM
24 together as a healthcare product it claimed would be exempt from the ACA’s mandates.
25
26

1 33. Alieria entered into a contract with Unity on or about February 1, 2017. Under that
2 contract, Alieria would offer its own health products to the public that did not meet coverage
3 requirements under the ACA and did not independently qualify for the HCSM exemption under
4 26 U.S.C. § 5000A. In return, Alieria’s customers would join the Unity HCSM, increasing
5 members to Anabaptist’s HCSM.

6 34. Although Alieria marketed the plans to consumers throughout the country as
7 HCSM plans through Unity, in reality, Unity was merely a shell with an HCSM designation,
8 through which Alieria, a for-profit entity that was never an HCSM, could push its own DCPMH
9 plans, while also designing, marketing, selling, administering, and controlling the Unity HCSM
10 plans. For example:

- 11 (a) All member payments were paid directly to Alieria.
- 12 (b) The purported “sharing” component of the HCSM was delegated to Alieria.
- 13 (c) Alieria handled all member claims for health care coverage.
- 14 (d) Alieria served as the program administrator for the Unity HCSM plans.
- 15 (e) Members interfaced only with Alieria, not Unity.
- 16 (f) Alieria personnel made the final decision whether a claim would be paid.
- 17 (g) Alieria controlled the Unity member list.
- 18 (h) Alieria developed all plans and programs for the HCSM component of the
19 Alieria products.
- 20 (i) Alieria controlled the Unity website.

21 35. In selling the Unity-branded products, Alieria did not require members to attest to
22 any common religious belief. It required only an agreement to adhere to generic spiritual and
23 ethical beliefs that “personal rights and liberties originate from God,” “every individual has a
24 fundamental right to worship God in his or her own way,” there is a moral obligation “to assist
25 our fellow man when they are in need,” there is a duty to “maintain a healthy lifestyle,” and a
26 fundamental right of conscience to direct one’s own healthcare exists. *See Appendix E*, at 13-14.

1 36. On September 11, 2017, Alera registered to do business in the state of California.
2 On information and belief, Alera began selling its health plans to California residents on or
3 around that date, claiming they were plans exempt from the ACA because of the Unity affiliation.

4 37. The healthcare plans marketed under Unity’s name that Alera designed, marketed,
5 administered and controlled, and sold to California residents were sham HCSM products that did
6 not exempt them from California insurance regulation or the ACA.

7 **B. After Alera’s Relationship with Unity Soured, It Created Trinity, a Sham**
8 **HCSM, Converted the Unity Products to Trinity Products, and Continued to**
9 **Sell to California Consumers through Trinity**

10 38. In 2018, after thousands of Alera/Unity plans had been sold nationwide,
11 Anabaptist/Unity discovered that Mr. Moses had written himself approximately \$150,000 worth
12 of checks from Unity funds without board approval, and had not properly maintained assets for
13 payment of benefits to members. Unity terminated the relationship with Alera in summer 2018.
14 A lawsuit between Alera and Anabaptist Health Share/Unity was filed in Superior Court of Fulton
15 County Georgia in late 2018. *See Alera Healthcare v. Anabaptist Health Share et al.*, No. 2018-
16 cv-308981 (Hon. Alice D. Bonner, Ga. Sup. Ct.). The court found that administrative fees paid
17 to Alera under its agreement with Unity amounted to millions of dollars. *See Appendix A*, Order
18 Entering Interlocutory Injunction and Appointing Receiver dated April 25, 2019, at 8, ¶¶ 45-46.

19 39. With its relationship with Unity terminating, Alera would have no affiliation with
20 any HCSM. Therefore, Alera and its principals created Defendant Trinity on June 27, 2018 as a
21 purported nonprofit entity. William Rip Theede, III became the CEO of Trinity. Mr. Theede is
22 a former Alera employee. He is also a close family friend of the Moses family and officiated at
23 Chase Moses’ wedding.

24 40. Trinity could not qualify as an HCSM because it was created after December 31,
25 1999, and had no members when it was created. In order to qualify as an HCSM under federal
26 law, the entity or a predecessor of the entity must, among other requirements, have “been in
existence at all times since December 31, 1999, and medical expenses of its members [must] have

1 been shared continuously and without interruption since at least December 31, 1999.” 26 U.S.C.
2 § 5000A(d)(2)(B)(IV). Trinity has not had members who have shared medical expenses
3 “continuously and without interruptions since at least December 31, 1999,” and it had no
4 predecessor entity.

5 41. In addition, in order to qualify as an HCSM under federal law, the members of the
6 entity must “share a common set of ethical or religious beliefs and share medical expenses among
7 members in accordance with those beliefs....” 26 U.S.C. § 5000A(d)(2)(B)(III). Although
8 Trinity’s bylaws set forth a specific set of religious beliefs, it has never restricted its membership
9 to those individuals who affirm the specific common religious beliefs. Instead, it has continued to
10 use the identical set of generic spiritual and ethical “beliefs” that Alera had devised for the Unity
11 plans. *Appendix D*, at 18.

12 42. While prospective agents must take a training assessment before selling the Trinity
13 plans, the questions asked in the assessment do not address any religious or ethical motivation.
14 Defendants’ advertisements for prospective agents, and the training materials for agents do not
15 mention a religious or ethical component for purchasers of these plans. In a training video posted
16 on YouTube on November 1, 2018, an Alera trainer explains that the “statement of faith”

17 basically is saying that you believe in a higher power. It doesn't
18 necessarily have to be a Christian God, or a Buddhist God, or a
19 Jewish God. It doesn't ... matter as long as we all believe that there
20 is a higher power and we're all living our life that the best way that
21 we possibly can. We're maintaining a healthy lifestyle. We're trying
to avoid those types of foods, behaviors, habits – things that, you
know, cause us illness that are in our control.

22 As long as we're doing those types of things, we're all like-minded
23 individuals. So if you feel that way, and you are a like-minded
24 individual, that's all we're trying to find out. And, if you are, you're
gonna say, “Yes,” you believe in the five same statement of beliefs
that we all do.

25 43. Agents in California have represented Trinity as being the most flexible in terms
26 of belief statement and as having the “most relaxed statement of beliefs and qualifications” of

1 purported HCSMs. *Appendix B*, at 24. It represents that it “welcomes members of all faiths.”
2 *Appendix C*, at 11.

3 44. Defendants represent that Trinity is “recognized” as a qualified HCSM. *See*
4 *Appendix C*, at 3. It was, in fact, impossible for Trinity to be “recognized” as such because the
5 rule that provided such recognition was eliminated years before Trinity was even created. In
6 2013, the United States Department of Health and Human Services (“HHS”) promulgated a rule
7 under which it certified HCSMs by issuing a certificate of exemption to the entity. However, the
8 rule was eliminated in 2016. *See* 81 Fed. Reg. 12281 (final rule eliminates the issuance of
9 exemptions for HCSMs). Trinity has never appeared on any list of recognized HCSMs developed
10 by HHS.

11 45. Likewise, the Internal Revenue Service (“IRS”) does not and has never recognized
12 any entities as HCSMs. Its role is limited to accepting tax returns from individuals who may
13 claim that they are entitled to an HCSM exemption on their individual tax returns. Individual
14 members, in turn, rely on the plan provider to notify them whether the plan is from a legitimate
15 HCSM. The IRS has never recognized Defendants as a qualified HCSM under 26 U.S.C.
16 § 5000A(d)(2)(B). Defendants’ representations to the contrary are false and misleading.

17 46. On or about August 13, 2018, Alieria signed an agreement with Trinity to provide
18 the marketing, sale and administration of purported HCSM plans. The contract allowed Alieria to
19 use Trinity’s non-profit status to sell health care plans purporting to be HCSM plans, while
20 keeping complete control over the money, the administration of the plans and benefits paid, and
21 the membership roster. The agreement provides that all member “contribution” payments are
22 made directly to Alieria, which then allocates 30-40% (depending on the plan) of every payment
23 as commissions, and that Alieria will be paid substantial additional administrative fees. The
24 agreement provides that, for the AlieriaCare plan class Plaintiffs purchased here, only about 15.5%
25 of the members’ contributions are actually placed into a Trinity “Sharebox” account for payment
26 of claims.

1 47. Many of the plans Alera had sold through the Unity brand, including those sold
2 to the Plaintiffs, were then transferred to the Trinity brand, and pending claims were transferred
3 to Trinity who assumed responsibility for “sharing” them

4 **C. The Products Alera Creates, Markets, Sells, and Administers Are Health**
5 **Insurance**

6 48. Plaintiffs and members of the class have been, are, or will be enrolled in healthcare
7 insurance products created, marketed, sold, and administered by Defendant and Alera through
8 Unity and, after Defendant Trinity was created, through Trinity, that Defendants claimed were
9 HCSM plans.

10 49. The terminology Defendants use in connection with their plans is directly
11 analogous to terminology health insurers use, and the plans are designed to look and feel like a
12 health insurance policy. For example:

13 (a) The healthcare plans marketed, sold, and administered charge “members”
14 a “monthly contribution” to participate. Defendants described the “contributions” members pay
15 as “premiums.” *See, e.g., Appendix C*, at 3-4. The amount of the premium or “contribution”
16 charged is based on the plan selected by the insured. *Id.*, at 1.

17 (b) The plans require a member to pay a deductible, which Defendants call a
18 “Member Shared Responsibility Amount,” or “MSRA.” *Id.*, at 4. The higher a member’s MSRA,
19 the lower the member’s “contribution.”

20 (c) Once the MSRA has been paid, medical bills are paid in accordance with a
21 benefits booklet or “Member Guide” for the selected program. These benefit booklets contain the
22 “membership instructions” which detail the “eligible medical expenses,” “limits of sharing,” and
23 exclusions. *See Appendix D*.

24 (d) The plans require pre-authorization for certain non-emergency surgeries,
25 procedures or tests, as well as for certain types of cancer treatments. *See, e.g., Appendix D*, at 30.
26

1 (e) Defendants offer different health plans, with different levels of coverage,
2 including “Basic,” “Catastrophic,” “Standard,” and “Comprehensive.” *See Appendix C*, at 3-4.
3 The amount members are expected to pay depends on the plan chosen.

4 (f) The standard and comprehensive plans are offered at different benefit
5 levels. “Standard” is offered at “Value,” “Plus” and “Premium” levels. “Comprehensive” is
6 offered at “Bronze,” “Silver,” and “Gold” levels. The plans at the higher levels charge more and
7 therefore claim to provide more robust benefits for covered medical conditions. *Id.*, at 27.

8 (g) The plans may require members to pay a “co-expense,” analogous to a
9 “copay.” *Id.*, at 4.

10 (h) The plans provide for “maximum out of pocket” expenses. *Id.*

11 50. The plans provide coverage for medical expenses. Among other things, the plans
12 claim to provide coverage for preventive care, primary care, urgent care, labs and diagnostics, x-
13 rays, prescription benefits, specialty care, surgery, and emergency room services. *Appendix D*, at
14 33-35.

15 51. The plans have established preferred provider networks (“PPOs”).

16 52. The plans contain exclusions and lifetime limits, including a lower lifetime limit
17 for cancer treatment.

18 53. Payments are made directly to health care providers on behalf of members who are
19 current on their monthly premiums in the event they experience a covered loss, have met their
20 deductible or MSRA, and otherwise meet the coverage requirements set forth in the Member
21 Guides. These payments are expressly contingent upon the occurrence of a covered medical need
22 by the participating member.

23 54. Like insureds in traditional health plans, members receive an “Explanation of
24 Benefits (EOB)” when a claim is submitted. The EOBs are substantially similar in look and form
25 to EOBs received from traditional health plans. *See Appendix L*.

1 55. Although Defendants claim Trinity administers “voluntary sharing of healthcare
2 needs for qualifying members,” *Appendix D*, at 14, there is nothing voluntary about the insurance
3 plans Defendants market, sell, and administer. Payment from the program upon the occurrence
4 of a covered loss is determined exclusively by Defendants, purportedly according to the terms in
5 the Member Guide. Members do not decide who gets paid benefits. Instead, according to the
6 Member Guide, the members must accept Trinity’s adjudication of benefits: “The contributors
7 instruct [Trinity] to share clearinghouse funds in accordance with the membership
8 instructions ...” “By participation in the membership, the member accepts these conditions.” *Id.*,
9 at 21. The members, however, have no input into the “membership instructions.” According to
10 the Member Guide, Trinity, and not the members, is the “final authority for the interpretation” of
11 the membership instructions, and Trinity directs payment to providers on behalf of members who
12 have submitted medical claims that are covered under the benefits booklet. *Id.* The Member
13 Guide Alera created for Unity contains largely identical language. See *Appendix E*, at 15.

14 56. Members’ “contributions” (i.e. premiums) are not refundable. Although the
15 member “contributions” are called “voluntary,” if members fail to make the premium payment,
16 they are not entitled to coverage for medical expenses. *Appendix D*, at 16.

17 57. Defendants represent that the health programs “provide members with options that
18 look and feel like more traditional health care plans but at a fraction of the price.” *Appendix C*,
19 at 26. They explain that the reason the plans are cheaper is that they are “based on cost sharing ...
20 The trade-off is the member shared responsibility (MSRA) [i.e., the deductible] is high.” *Id.*

21 58. The plans Defendants sell or have sold are contracts whereby Defendants Alera
22 and Trinity undertook to indemnify its members against loss, damage, or liability arising from a
23 contingent or unknown event, and are insurance under Cal. Ins. Code § 22. Defendants are
24 required to comply with California and federal law governing health insurers and producers.
25
26

1 **D. The Health Insurance Plans Defendants Create, Market, Sell, and**
2 **Administer Are Illegal**

3 59. Defendants Alera and Trinity do not have a certificate of authority as required by
4 Cal. Insurance Code § 700 to issue insurance within this state and are not authorized insurers
5 under California law. Defendants have issued illegal and unauthorized insurance products to
6 Plaintiff and other members of the class.

7 60. Defendants' plans are not ACA-compliant because they do not meet the minimum
8 coverage requirements or Essential Health Benefits required under the ACA and Cal. Insurance
9 Code § 10112.27. For example:

10 (a) The plans impose a 24-month waiting period on coverage, or significantly
11 limit benefits for, preexisting conditions, which is illegal under the ACA. *See* 42 U.S.C.
12 § 300gg-3.

13 (b) The plans exclude coverage for abortion and/or contraception.

14 (c) The plans do not comply with the Mental Health Parity Act,

15 (d) The plans impose lifetime caps.

16 61. Defendants' plans purport to require binding arbitration, even though Defendants
17 fail to disclose the arbitration as a separate article prominently displayed in the enrollment form,
18 as required by Cal. Insurance Code § 10123.19(a).

19 62. The Member Guide, which has never been reviewed or approved, contains
20 inconsistent and contradictory coverage terms and conditions. For example:

21 (a) The Member Guide provides the amounts and types of benefits that are
22 covered, but then suggest Defendants are not required to pay any benefits whatsoever, and
23 provides members with no basis to enforce Defendants' promises, even after the members have
24 paid all required "contributions."

25 (b) The Member Guide states the plan is an "opportunity for members to care
26 for one another in a time of need, [and] to present their medical needs to other members," but in

1 fact Defendants—like an insurance carrier—make all coverage decisions without ever presenting
2 one member’s needs to other members.

3 (c) Defendants assert that over 1,000,000 providers are in their Preferred
4 Provider Network, and provide lists of in-network preferred providers whose claims they will pay,
5 but then assert providers are not on the list provided.

6 63. Alieria and Trinity have never maintained the 80% medical loss ratio of medical
7 expenses paid to premiums received required by the ACA. 42 U.S.C. § 300gg-18.

8 **E. California and Multiple Other States Have Found that Alieria and Trinity**
9 **Are Illegally Marketing, Selling and Administering Insurance Products That**
10 **Do Not Qualify as HCSMs**

11 64. On March 8, 2020, the Insurance Commissioner of the State of California issued a
12 Cease and Desist Order against Alieria and Trinity, ordering that they cease transacting insurance
13 business or receiving any payment in connection with any insurance transaction in the state.
14 *Appendix F.* The Order was based on the Commissioner’s findings that Alieria and Trinity are
15 acting as insurers in California without a certificate of authority and “make, issue and circulate
16 misleading advertisements and other materials to California consumers,” in violation of Insurance
17 Code § 790.03(a) and (b). *Id.*, at 5, ¶ 24. The Commissioner also found that they did not meet the
18 definition of an HCSM. *Id.*, ¶ 27.

19 65. Multiple other states have taken similar action against Alieria and Trinity. *Appendix*
20 *G.* Those states include:

21 (a) **Texas.** The Texas Attorney General filed suit against Alieria, claiming it
22 engaged in the business of insurance without a license, and the court entered a TRO on July 12,
23 2019, prohibiting it from accepting new customers in Texas. Alieria later agreed to accept no new
24 customers during the pendency of the lawsuit.

25 (b) **Washington.** The Insurance Commissioner entered cease and desist orders
26 against Alieria and Trinity on May 3, 2019, finding Alieria acted as an unlicensed healthcare
service contractor and Trinity was not an HCSM. Trinity entered into a consent order on

1 December 30, 2019, agreeing not to enroll any new Washington residents, and to pay a \$150,000
2 fine.

3 (c) **Colorado.** Colorado Division of Insurance found Defendants sold
4 insurance products and issued cease and desist orders on August 12, 2019. Final Agency Orders
5 dated January 17, 2020, prohibit Alera from selling the plans in Colorado, and prohibit Trinity
6 from doing business in Colorado.

7 (d) **New Hampshire.** The Insurance Commissioner entered a Cease and Desist
8 Order on October 30, 2019 against Alera and Trinity, prohibiting the sale or renewal of illegal
9 health insurance in New Hampshire.

10 (e) **Connecticut.** The Insurance Commissioner issued a Cease and Desist
11 Order on December 2, 2019, against Alera and Trinity, finding they were acting as insurers in
12 Connecticut without a certificate of authority

13 (f) **Maryland.** On February 27, 2020, the Insurance Commissioner entered an
14 Order revoking Alera's insurance producer license because it violated a 2018 consent order not
15 to solicit membership in unauthorized insurance plans.

16 **F. Plaintiff Was Sold Sham Products by Alera/Trinity That Did Not Provide**
17 **the Benefits Promised**

18 66. Plaintiffs Corlyn and Bruce Duncan enrolled in an AleraCare Comprehensive
19 Gold plan on or about November 28, 2017, while Alera was selling Unity-branded plans. The
20 plan was represented to them by their insurance agent to be like a Blue Cross insurance plan, but
21 cheaper. Their membership effective date was January 1, 2018, and they received what they
22 believed was an insurance card showing they had hospital, in-patient, out-patient, emergency
23 room, specialty visit, preventive, and X-ray and imaging, with certain co-pays and a \$1,000
24 MSRA. *Appendix H.*

25 67. They received a Member Guide from Alera/Unity after they filled out the
26 enrollment form and made their initial payment. *Appendix E.*

1 68. Their membership enrollment form did not disclose that they would be obligated
2 to arbitrate disputes.

3 69. In 2019, the Duncans were advised that their plan through Alieria/Unity was being
4 transferred to Alieria/Trinity, with the same benefits and the same monthly contribution amount
5 as the Alieria/Unity plan. *Appendix I.* They filled out a new enrollment form. That enrollment
6 form did not disclose that they would be obligated to arbitrate any disputes. *Appendix J.*

7 70. The Duncans received a new Member Guide that purported to be from Alieria and
8 Trinity. *Appendix D.* Trinity assumed responsibility for claims made under the Unity brand.

9 71. After they filled out the new enrollment form, they received new insurance cards
10 for AlieriaCare TrinityGold, reflecting an effective date of January 2018. The card falsely states
11 that they were members of an HCSM “*recognized pursuant to 26 U.S.C. § 5000A(d)(2)(B)*” even
12 though neither Trinity nor Alieria was ever certified or “recognized” by any government agency
13 as an HCSM. *Appendix K.*

14 72. The Duncans paid \$1,287.56 per month for their AlieriaCare Comprehensive Gold
15 plan while Alieria partnered with Unity, and \$1,612.91 per month for their AlieriaCare
16 Comprehensive Gold plan while it partnered with Trinity. They also paid \$125 in application fees.

17 73. The AlieriaCare Comprehensive Gold plan sold to the Duncans was insurance
18 under California law. However, the plan failed to comply with California and federal law in its
19 provisions of benefits.

20 74. On March 16, 2018, Ms. Duncan required surgery. Before the surgery, she
21 contacted Alieria for approval, and Alieria approved both the surgery and the facility where the
22 surgery was performed.

23 75. Nevertheless, Alieria/Trinity has paid only a fraction of the cost of the surgery,
24 leaving her with a hospital bill of over \$70,000. *Appendix L.*

25 76. The Duncans made repeated attempts to appeal Alieria/Trinity’s decision, but each
26 time they called, they were either left on hold, and/or given inconsistent answers about whether,

1 how much, and which charges would be covered. After authorizing the surgery, and despite
2 written verification from the surgeon to the contrary, Alera then insisted the surgery was for a
3 “pre-existing condition” and refused to pay it. *See Appendix L, M.* The Duncans have submitted
4 additional information in support of their appeal, but Alera/Trinity has failed to pay.

5 77. The Duncans continue to be pursued for this hospital debt, which has adversely
6 affected their credit.

7 VI. CLAIMS FOR RELIEF

8 A. First Claim: Illegal Contract

9 78. Plaintiffs reallege all prior allegations as though fully stated herein.

10 79. Defendants sold Plaintiff and all members of the proposed class unauthorized and
11 illegal health insurance plans in violation of California law:

12 (a) The plans were insurance, *see* ¶¶ 49-58 above, but were sold without
13 authorization in California.

14 (b) The plans failed to provide the Essential Health Benefits and imposed
15 waiting periods, excluded coverage for pre-existing conditions, and imposed caps in violation of
16 the ACA and California law. *See* ¶ 60, above.

17 (c) The Member Guide contains inconsistent and contradictory coverage terms
18 and conditions that allow Defendants to arbitrarily deny coverage.

19 (d) The plans included a binding arbitration provision that was not disclosed
20 and is illegal under California Ins. Code § 10123.19(a).

21 (e) Defendants fail to maintain the medical loss ratio required under the ACA.

22 80. Plaintiff and all members of the proposed class are entitled to either (a) rescission
23 of the illegal contract(s) and return of the insurance premiums paid; or (b) reformation of the
24 illegal contract(s) to comply with the mandatory minimum benefits and coverage required under
25 California and federal law.
26

1 **B. Second Claim: Violation of California’s Unfair Competition Law**

2 81. Plaintiffs reallege all prior allegations as though fully stated herein.

3 82. Defendants’ creation, marketing, sale and administration of unauthorized health
4 insurance plan(s) to class members are illegal under California’s Unfair Insurance Practices Act,
5 Ins. Code § 790 *et seq.*, and constitute unfair, unlawful, and/or fraudulent acts under California’s
6 Unfair Competition Law (UCL), Cal. Bus. and Prof. Code § 17200 *et seq.*

7 83. Defendants have committed unfair acts or practices that are deceptive or
8 misleading or have the capacity to be deceptive or misleading. These acts or practices include,
9 but are not limited to, the following:

10 (a) Defendants have consistently represented that their healthcare products are
11 “not insurance.” This representation appears in the Member Guides, in advertising material, in
12 training material and on its webpages. This representation, however, is false. Under California
13 law, Defendants are offering unregulated insurance to members of the public. *See* ¶¶ 49-58, above.
14 The California Insurance Commissioner has so found. *Appendix F.*

15 (b) While claiming their products are “not insurance,” Defendants’ deceptively
16 advertise and market their products as a viable substitute for insurance. Specifically, the
17 advertisements and solicitations deceive or mislead, or have the capacity to deceive or mislead,
18 members of the class that they were purchasing a legitimate health insurance product. The look
19 and feel of the advertising material suggest that the plans are the same as health insurance
20 products, and their agents represent the products to be comparable to health insurance. They claim
21 their products are “not insurance,” however, so that they can avoid state consumer protection and
22 solvency regulation. By claiming their products are “not insurance,” they also avoid providing the
23 minimal Essential Health Benefits required under the ACA. *See* ¶¶ 60-63, above.

24 (c) Defendants have advertised and represented that Trinity is a “Health Care
25 Sharing Ministry recognized pursuant to 26 U.S.C. § 5000A(d)(2)(B).” This is false. *See* ¶¶ 40-
26 45, above. They have falsely represented, either directly or through sales agents in California, that
Trinity is an “administrator for one of the HCSMs that has been around since before 1999,” and

1 that “Trinity has been helping people cover health care costs for years.” *Appendix B*. These
2 misrepresentations deceived consumers into believing that their healthcare plans were faith-based
3 and would be administered in an ethical manner for the benefit of members, rather than for the
4 benefit of for-profit Alieria.

5 (d) While representing that Trinity serves as a “neutral clearinghouse” for the
6 payment of claims, Defendants fail to disclose that only a fraction of the funds they receive as
7 member contributions are paid out in claims, that the ACA requires that an insurer pay 80% of
8 the premiums collected as benefits, or that for-profit Alieria takes most of the member
9 contributions as fees, while arbitrarily deciding whether benefits should be paid. Consumers were
10 led to believe that their premiums would primarily be used to pay claims of its members. In fact,
11 most of the contributions were used to pay Alieria and its owners.

12 (e) Defendants misrepresent that members’ monthly contributions are put into
13 a cost-sharing account with Trinity, which “acts as an independent and neutral clearing house,
14 dispersing [sic] monthly contributions as described in the membership instructions and
15 guidelines.” *Appendix D*, at 14. Defendants misrepresent that Trinity, because it is a nonprofit
16 with “nothing to gain or lose financially by determining if a need is eligible or not” is the entity
17 to whom members delegated coverage decision authority. *Id.*, at 21. In fact, contributions are not
18 placed into a cost-sharing account with Trinity, but are paid directly to for-profit Alieria which
19 maintains complete control over payments for medical expenses and maintains exclusive access
20 to and control over the Trinity membership list.

21 (f) Defendants misrepresent that the reason the plans are cheaper than ACA-
22 compliant plans is merely that they have higher deductibles, or “MSRAs.” *Appendix C*, at 26. In
23 fact, the reason the plans are cheaper is that Defendant Alieria asserts the unilateral discretion to,
24 and does, arbitrarily deny claims.

25 (g) Defendants claim they have a “growing nationwide PPO network of more
26 than 1,000,000 healthcare professionals and more than 6,000 facilities,” *Appendix D*, at 13, and

1 provide lists of those professionals and facilities, but then deny claims on the basis that those
2 professionals and facilities are not in-network, or that the providers are charging too much.

3 (h) Defendants systematically engage in unfair claims handling practices by
4 arbitrarily denying claims. Even though Defendants represent that the coverage provisions are not
5 legally binding upon them and that they are not legally obligated to pay claims, they then insist
6 members are legally obligated to follow the multilevel Dispute Resolution Procedure outlined in
7 the Member Guides. *Appendix D*, at 31-32. This burdensome Procedure is not disclosed to
8 consumers in the marketing materials before they commit to enrolling in the plans, and ultimately
9 requires binding arbitration, in violation of California law. Defendants deceptively use the
10 multilevel Procedure to subject members to Kafkaesque delays and false and inconsistent
11 promises, to delay payment of legitimate claims, and to shield Defendants from legal action.

12 84. Members of the public are likely to be, and have been, deceived by these unfair
13 and unlawful practices.

14 85. Alieria, who created, marketed, sold, and administered virtually identical plans
15 under both the Unity and Trinity brands, committed the above unfair and deceptive acts while
16 acting for both entities.

17 86. Plaintiffs and the class have been injured as a direct result of Defendants' conduct.
18 They were sold unregulated insurance products that are illegal under California law. The products
19 provide less coverage than permitted under law, thereby rendering the policies less valuable than
20 products that do comply with the law. Plaintiff and the class have been denied care, or limited in
21 care, due to illegal caps, exclusions and limitations. Plaintiff and the class have foregone coverage
22 under the ACA, including subsidized benefit packages that would provide legal, comprehensive,
23 and secure health insurance coverage. Defendants' policies were overpriced for the coverage they
24 purported to provide given that over 80% of the contributions were paid in fees and commissions,
25 rather than to benefits, causing Plaintiff and the class to overpay for the illegal and unregulated
26 policies. They purchased the products with the reasonable belief that their medical bills would be

1 paid, but Defendants have devised excuses not to pay those claims, or to unreasonably delay in
2 payment of the claims.

3 **C. Third Claim: Violation of California’s False Advertising Law**

4 87. Plaintiffs reallege all prior allegations as though fully stated herein.

5 88. Defendants have made untrue and/or misleading statements to residents of
6 California with an intent to induce them to forego legitimate health insurance coverage and to
7 purchase Defendants’ sham insurance coverage instead, in violation of California’s False
8 Advertising Law (FAL), Bus. & Prof. Code § 17500, *et seq.*

9 89. These untrue and/or misleading statements include:

10 (a) Advertising and representing Trinity as a “Health Care Sharing Ministry
11 recognized pursuant to 26 U.S.C. § 5000A(d)(2)(B).”

12 (b) Consistently and repeatedly misrepresenting that AlierCare/Trinity and
13 AlierCare/Unity and their related products are “not insurance.”

14 (c) Misrepresenting that the health care plans they sold were like insurance but
15 cheaper, or were a form of legitimate health insurance.

16 (d) Misrepresenting the plans as a “sharing” program that provides members
17 with a role in determining whether claims should be paid, when in fact all coverage decisions
18 were made arbitrarily by Alier, and in Alier’s best interest.

19 (e) Misrepresenting that Trinity, because it is a nonprofit with “nothing to gain
20 or lose financially by determining if a need is eligible or not” is the entity to whom members
21 delegated coverage decision authority.

22 (f) Misrepresenting that it provided coverage for medical expenses.

23 (g) Misrepresenting that there are over 1,000,000 providers and 6,000 facilities
24 within its PPO, and then denying claims from those providers and facilities listed as within the
25 PPO.
26

1 90. Members of the public are likely to, and have been, deceived by these unfair and
2 unlawful practices.

3 91. Plaintiffs and the class have been injured as a direct result of Defendants' conduct
4 by purchasing sham insurance products that did not provide either the benefits offered or that
5 should have offered under a legitimate healthcare plan.

6 **D. Fourth Claim: Breach of Fiduciary Duty**

7 92. Plaintiffs reallege all prior allegations as though fully stated herein.

8 93. Defendants represent that members "voluntarily submit monthly contributions into
9 a cost-sharing account," and that Trinity "act[s] as a neutral clearing house between members."
10 *Appendix D*, at 3. While disclaiming that there is any legally binding agreement to reimburse
11 members for medical needs, Defendants claim they will serve as the "neutral" intermediary to
12 allow members to share "voluntary" contributions with one another in accordance with "the
13 membership instructions." *Appendix D*, at 14.

14 94. Defendants further represent their trustworthiness by claiming Trinity is a "faith
15 based" or religious organization.

16 95. Defendants represent that "since Trinity HealthShare has nothing to gain or lose
17 financially by determining if a need is eligible or not, the contributor designates Trinity
18 HealthShare as the final authority for the interpretation of these guidelines." *Appendix D*, at 21.

19 96. Defendants have complete control over the financial "contributions" members pay,
20 and complete control over the coverage decisions.

21 97. As a result of these representations and their control over members'
22 "contributions," Defendants owe a fiduciary duty to the members.

23 98. Defendant Alieria has admitted in court filings and testimony in connection with
24 the Georgia Case that it has a fiduciary duty to the members.

25 99. Defendants have breached their fiduciary duty. Trinity has delegated all coverage
26 decisions to for-profit Alieria. Coverage decisions are made solely by the for-profit Alieria, and in

1 order to secure its profits, not to provide coverage for members' medical needs. Plaintiffs and
2 the class members have been arbitrarily denied claims for medical expenses in order to enrich
3 Defendants.

4 100. On information and belief, approximately 84% of the member contributions are
5 paid to Alera in fees and administrative expenses, and not to cover the medical needs of the
6 members.

7 101. Plaintiffs and the member class have been injured by Defendants' breaches of
8 fiduciary duty. The funds that should have been used to pay their claims have instead been used
9 to enrich Defendants. The excess payments should be disgorged, and held in constructive trust
10 for the benefit of the Plaintiffs and the class to pay their claims or reimburse their premiums.

11 **E. Fifth Claim: Unjust Enrichment**

12 102. Plaintiffs reallege all prior allegations as though fully stated herein.

13 103. Plaintiffs and the class paid substantial monthly contributions. On information and
14 belief, approximately 84% of the monthly contributions were siphoned off as fees and expenses,
15 largely to benefit Alera.

16 104. Plaintiffs and the class made their payments with the understanding that the funds
17 would be shared among the members to pay medical claims. They were never advised that a
18 majority of their payments would actually go to Alera's fees, administrative expenses, and
19 commissions.

20 105. Defendants have retained the members' contributions while arbitrarily denying
21 medical claims, and have been unjustly enriched at the expense of Plaintiffs and the class.

22 106. Plaintiffs and the class are entitled to restitution of the amount Defendants unjustly
23 retained.

VII. PRAYER FOR RELIEF

1 WHEREFORE, Plaintiffs request that this Court:

2 (a) Certify that this action may proceed as a class action as defined in ¶ 18
3 above;

4 (b) Designate Corlyn and Bruce Duncan as class representatives, and designate
5 Eleanor Hamburger and Richard E. Spoonemore, Sirianni Youtz Spoonemore Hamburger PLLC,
6 Michael David Myers, Myers & Company, PLLC, and Nina Wasow and Catha Worthman,
7 Feinberg, Jackson, Worthman & Wasow, as class counsel;

8 (c) Declare that Defendants' unauthorized health insurance plans were and are
9 illegal contracts;

10 (d) Declare that Defendants' actions as alleged herein towards the members of
11 the class violate California's Unfair Competition Law, False Advertising Law, and Unfair
12 Insurance Practices Act;

13 (e) Enjoin Defendants from denying and delaying payment of legitimate health
14 care claims;

15 (f) Order (i) rescission of the unauthorized health insurance plans and
16 restitution of all premiums received from members of the proposed class, including interest; or,
17 at the option of any class member (ii) reform the unauthorized health insurance plans to comply
18 with the minimum mandatory benefits required under the relevant state insurance code and federal
19 law, and permit class members to resubmit claims for medical services, costs and other expenses
20 that would have been covered;

21 (g) Enter judgment in favor of Plaintiffs and the class on their breach of
22 fiduciary duty claim, and impose a constructive trust for the benefit of the class on all amounts
23 wrongfully retained;

24 (h) Order disgorgement and restitution of all contributions Alera unjustly
25 retained;
26

1 (i) Order payment of reasonable attorneys' fees pursuant to Cal. Code Civ.
2 Proc. § 1021.5; and

3 (j) Grant such other relief as this Court may deem just, equitable and proper.

4 DATED: April 28, 2020.

5
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