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8 UNITED STATES DISTRICT COURT
9 EASTERN DISTRICT OF CALIFORNIA

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

12 Plaintiffs,

13 v.

14 THE ALIERA COMPANIES, INC., f/k/a ALIERA
15 HEALTHCARE, INC., a Delaware corporation;
16 TRINITY HEALTHSHARE, INC., a Delaware
17 corporation; and ONESHARE HEALTH, LLC,
18 formerly known as UNITY HEALTHSHARE, LLC
and as KINGDOM HEALTHSHARE MINISTRIES,
LLC, a Virginia limited liability corporation,

19 Defendants.

Case No.: 2:20-cv-867-TLN-KJN

[Assigned to the Hon. Troy L. Nunley]

**PLAINTIFFS' CONSOLIDATED
OPPOSITION TO MOTIONS TO
COMPEL OR DISMISS**

Hearing

Date: October 29, 2020

Time: 2:00 p.m.

Ctrm: 2

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I. INTRODUCTION

1 To be valid, an agreement to arbitrate must be the product of a conscious decision – a
2 meeting of the minds – where both parties to a contract agree to use a specific set of rules to
3 resolve disputes. In addition, any such agreement must be fair to both parties – a purported
4 agreement that is substantively and procedurally unconscionable will not be enforced. Finally,
5 the agreement cannot otherwise be prohibited by law. Defendants here seek to enforce arbitration
6 clauses that do not meet any of these requirements:

- 7 • No agreement to arbitrate was ever formed because the contract was created *before*
8 Defendants ever disclosed the existence of any purported arbitration clause to
9 plaintiffs.
- 10 • The purported agreement is procedurally unconscionable under California law because
11 it is adhesive, hidden, and hopelessly ambiguous with respect to the operative set of
12 arbitration rules that would supposedly apply to a dispute.
- 13 • Likewise, the clause the Defendants seek to enforce is, as alleged in the complaint,
14 part of a byzantine multi-step process that is designed for one purpose: to avoid paying
15 valid claims. It ultimately requires California residents who purchase Defendants’
16 products from California brokers in Californian to arbitrate disputes in either
17 Fredericksburg, Virginia or Atlanta, Georgia. Plaintiffs, in fact, would be required to
18 institute two separate proceeding under two sets of different rules in two different
19 locations. This is substantively unconscionable.
- 20 • As alleged in the Complaint and determined by the California Office of the Insurance
21 Commissioner, the contracts at issue here are forms of insurance that must comply
22 with California insurance law. Defendants’ clauses do not. Specifically, Cal. Ins.
23 Code § 10123.19 requires that if a policy requires binding arbitration, the requirement
24 must be disclosed in “clear and understandable” language ... prominently displayed
25 on the enrollment form signed by each ... enrollee ... immediately before the signature
26 line” on the enrollment form. No such disclosure was made here.

21 In addition to seeking to compel arbitration, Defendants make a host of other disparate
22 arguments concerning standing and the validity of specific claims. None of these arguments has
23 merit, and all are addressed below. Defendants’ motions should be denied.

II. BACKGROUND

25 When Congress passed the Affordable Care Act in 2010, it required, with a few limited
26 exceptions, all individuals to be covered by health insurance or pay a penalty. One of the

1 exceptions was for members of *existing* Health Care Sharing Ministries (“HCSMs”). To qualify
2 as an HCSM, an entity needed to meet the strict requirements in 26 U.S.C. § 5000A(d)(2)(b)(ii).
3 That statute required, among other things, that the entity had existed continuously since
4 December 31, 1999. The 1999 cutoff date serves two important legislative purposes: (1) it
5 ensures reliability of care that come with historical practice, and (2) it prevents “opening the flood
6 gate” to groups seeking to circumvent the requirements of the ACA. *Liberty Univ. v. Lew*, 733
7 F.3d 72, 102 (4th Cir. 2013). The founders of Defendant Alieria, however, exploited the exception
8 by duping people into purchasing what looked like insurance, while avoiding insurance
9 regulations.

10 After his release from a six-year prison sentence for securities fraud and perjury, Timothy
11 Moses, along with his wife Shelley Steele and son, Chase Moses, established Alieria as a for-profit
12 Delaware corporation in 2015. Dkt. 19, ¶¶ 29, 30 (Amended Complaint). It began selling its own
13 healthcare products, but soon realized it could make more money by selling products claiming to
14 be from an HCSM. It discovered that Anabaptist Healthshare, an entity that had shared healthcare
15 costs among a small group of Mennonites in Virginia, had been recognized as an HCSM. *Id.*,
16 ¶¶ 33, 34. Anabaptist agreed with Alieria to create a new entity, defendant Unity Healthshare, LLC
17 (“Unity,” now known as OneShare Health LLC), in late 2016, and by February 2017, they had
18 entered into an agreement under which Alieria would combine its own healthcare products with
19 products that Unity would offer, and market the products as from an HCSM.¹ *Id.*, ¶ 35. Unity
20 delegated all authority for designing, creating, marketing, and administering the healthcare plans
21 to Alieria. Alieria received all payments and controlled the membership list. *Id.*, ¶ 36.

22 The relationship between Alieria and Anabaptist began to sour by May 2018 when
23 Anabaptist discovered that Mr. Moses had misappropriated \$150,000 of Unity funds. *Id.*, ¶ 40;
24 Dkt. 19-1, ¶ 71. Anabaptist terminated the agreement on August 10, 2018 and demanded Alieria
25 turn over all member funds and member lists. Alieria refused. Alieria and Anabaptist sued each
26

¹ Unity could not qualify as an HCSM under 26 U.S.C. § 5000A(d)(2)(b)(ii) because, among other reasons, it had not been in existence continuously since December 1999.

1 other in state court in Georgia, *Aliera Healthcare v. Anabaptist Health Share et al.*, No. 2018-cv-
2 308981 (“Georgia Litigation”).

3 Since Aliera could no longer sell healthcare plans claiming to be HCSMs through Unity,
4 it created a new entity, defendant Trinity Healthshare, also as a purported nonprofit HCSM.
5 Dkt. 19, ¶ 41.² Trinity agreed, in August 2018, to delegate to Aliera all responsibility for
6 designing, marketing, and administering healthcare plans sold under the Trinity name, and
7 delegated to Aliera all control over the members’ payments and over the membership roster. *Id.*,
8 ¶ 48.

9 Aliera began selling Trinity-branded products by fall 2018 and notified Unity members
10 that it would transition all members in Unity plans to Trinity plans on January 1, 2019. Dkt. 19-1,
11 ¶¶ 91-93, 95. Unity, displeased with Aliera’s unilateral attempt to transition the members from
12 Unity to Trinity, obtained a temporary restraining order in the Georgia Litigation preventing
13 Aliera from moving its member to the new Trinity entity. Dkt. 38-2. Nevertheless, Aliera
14 represented itself as administering claims on behalf of Trinity to the members, including plaintiffs
15 here, after the TRO was entered. Dkt. 19-12. The court in the Georgia Litigation allowed Aliera
16 to solicit Unity members after April 28, 2019 and appointed a receiver to oversee Aliera’s
17 administration of Unity claims. Dkt. 19-1, p. 29 of 32.

18 Plaintiffs Bruce and Corlyn Duncan signed up for the AlieraCare Gold healthcare plan
19 during the ACA’s open enrollment period on or about November 28, 2017, while Aliera was
20 selling Unity plans. They signed up for the plan at the office of an insurance agent who advised
21 them that the plan was like a Blue Cross plan. Dkt. 19, ¶ 69. The Gold Plan that they purchased
22 was to pay for 80% of hospitalization charges for a medically diagnosed condition after payment
23 of the deductible (MSRA), Dkt. 19-5, pp. 13, 17 of 21.

24 Ms. Duncan needed surgery in March 2018. Her healthcare provider contacted Aliera and
25 obtained preauthorization of both the surgery and the facility where it was to be performed.

26 ² Trinity could not qualify as an HCSM because, among other reasons, it had not been in continuous existence since December 1999.

1 Duncan Decl., ¶ 5. Nevertheless, after the surgery was completed, Alieria refused to pay, claiming
2 the surgery was for a pre-existing condition. *Id.*, ¶ 6. The Duncans attempted to appeal. They
3 called Alieria at least thirty times beginning in December 2018. *Id.*, ¶ 8. Their provider also
4 appealed. *Id.* One of the surgery-related bills went to collections, and the Duncans were forced
5 to pay it. *Id.*, ¶ 7. They received an Explanation of Benefits with the Trinity logo dated April 26,
6 2019, denying their claims for over \$79,000 of the charges. Dkt. 19-12.

7 On May 3, 2019 – shortly after the court’s April 28 order in the Georgia Litigation – Alieria
8 sent the Duncans an email requesting that they authorize the transfer of their account to Trinity.
9 The email promised that their plan services “will remain the same” and that “medical history and
10 historical claims” as well as amounts spent toward the MSRA (deductible) would “continue to
11 track.” Dkt 19-9. At no time were the Duncans told that any prior claims would be the sole
12 responsibility of Unity, that any claim they had might be subject to the receiver oversight, or that
13 Trinity would later deny these claims that they represented “would continue to track.”

14 III. ARGUMENT

15 A. Defendants Fail to Demonstrate the Existence of a Valid, Enforceable 16 Arbitration Agreement.

17 1. No Agreement to Arbitrate Was Formed.

18 As the parties seeking to compel arbitration, Defendants have the burden of demonstrating
19 by a preponderance of the evidence that a valid agreement exists to arbitrate the claims at issue.
20 *Norcia v. Samsung Telecommunications Am., LLC*, 845 F.3d 1279, 1283 (9th Cir. 2017).
21 California contract law controls the question of whether the parties agreed to arbitrate. *Knutson*
22 *v. Sirius XM Radio*, 771 F.3d 559, 565 (9th Cir. 2014) (although FAA preempts state laws
23 applicable only to arbitration agreements, general contract principles and defenses grounded in
24 state contract law may invalidate arbitration agreements). If the parties contest the existence of
25 an arbitration agreement, any presumption favoring arbitrability falls away. *Goldman, Sachs &*
26 *Co. v. City of Reno*, 747 F.3d 733, 742 (9th Cir. 2014). Contract formation requires mutual assent
under California law. *Knutson*, 771 F.3d at 565. It is “axiomatic that ‘[a]rbitration is a matter of

1 contract and a party cannot be required to submit any dispute which he has not agreed so to
2 submit.” *Sanford v. Member Works, Inc.*, 483 F. 3d 956, 962 (9th Cir. 2007), *quoting AT&T*
3 *Tech. Inc. v. Comm’n Workers of Am*, 457 U.S. 643, 648 (1986).

4 Defendants fail to meet their burden of demonstrating that the Duncans ever entered into
5 a valid arbitration agreement. Defendants provide no evidence that they disclosed even the
6 existence of an arbitration agreement before the Duncans enrolled and made a significant
7 payment. They do not claim that the Duncans were asked to affirmatively assent to arbitration.

8 Alier’s own evidence shows that the first disclosure of any arbitration provision was a
9 link to a Quick Guide on a welcome email sent *after* the Duncans’ credit card was charged
10 \$1,412.56. Dkt. 36-2, p. 5 of 6.³ Defendants do not dispute that the Duncans did not receive the
11 Guide with the arbitration agreement until *after* they enrolled and paid. Dkt. 19, ¶70, 71.

12 Defendants suggest instead that the Duncans “manifested their assent” to arbitration
13 because they did not cancel their enrollment once the link was provided. Under the circumstances
14 here, it was unreasonable for Defendants to believe that the Duncans’ failure to cancel was a
15 manifestation of assent. *Knutson*, 771 F.3d at 566 (courts must determine whether the outward
16 manifestations of consent would lead a reasonable person to believe the offeree has assented to
17 the agreement). An offeree, regardless of apparent manifestation of consent, is not bound by
18 inconspicuous contractual provisions of which he was unaware, contained in a document whose
19 contractual nature is not obvious. *Windsor Mills, Inc. v. Collins & Aikman Corp.*, 25 Cal. App. 3d
20 987, 993 (1972). Even where a hyperlink is conspicuous, if the provider “otherwise provides no
21 notice to user nor prompts them to take any affirmative action to demonstrate assent,” the
22 placement of the hyperlink button is insufficient to give rise to notice of an arbitration agreement.
23 *Nguyen v. Barnes & Noble Inc.*, 763 F.3d 1171, 1179 (9th Cir. 2014).

24
25
26 ³ The Welcome Email advises that the Guide would arrive in the mail “within 14 business days *after your plan’s effective date.*” Dkt. 36-2, p. 3 of 6 (emphasis in original). Since the Duncan’s plan did not go into effect until January 1, 2018, they would not have received a copy in the mail until as late as mid-January.

1 Nothing about the link to the Guide suggests to the member who had already enrolled in
2 the healthcare plan that the Guide would contain any agreement to arbitrate. Instead, the link
3 appears below the caption, “become familiar *with your benefits*.” Dkt. 36-2, p. 3 of 6 (emphasis
4 added). After instructing the new member to consult the Guide for “everything you need to know
5 regarding your healthcare plan,” the email then provides instructions on how to take advantage of
6 *the benefits* by registering for telemedicine, and how to activate the card and access an online
7 member portal. *Id.*, p. 3-4 of 6. A reasonably prudent purchaser who reads these email instructions
8 would assume that the Guide would provide details about *the benefits* of the healthcare plan, and
9 not that the member had somehow agreed to arbitrate or to waive significant legal rights. *See*
10 *Savetsky v. Pre-Paid Legal Servs.*, No. 14-03514, 2015 U.S. Dist. LEXIS 17591, *13 (N.D. Cal.
11 Feb. 12, 2015) (a reasonable person could conclude that a link, in context that it appeared, would
12 simply provide fuller list of plan features and not an arbitration agreement).

13 Alieria also points to an enrollment form (Dkt. 19-10) the Duncans signed *after* their plan
14 transferred to Trinity as evidence that they affirmed “that any expenses they submitted were
15 subject to the sharing guideline” contained in the Trinity Member Guide. Dkt. 36, p. 8. It points
16 to no language in that form, signed at a time when the Duncans had already incurred substantial
17 unpaid medical expenses, that they agreed to any arbitration clause. *See Norcia v. Samsung*
18 *Telcoms. Am., LLC*, 845 F. 3d 1279, 1290 (9th Cir. 2017) (rejecting arguments that silence alone
19 constitutes assent when the purchaser failed to opt out of an arbitration agreement contained inside
20 a product box received after purchase).

21 Because these are healthcare plans, it was particularly and objectively unreasonable for
22 Defendants to interpret the Duncans’ continued payment of monthly premiums as “assent” to the
23 arbitration provision. The Duncans enrolled in the Unity plan in late November 2017. Dkt. 19,
24 ¶ 69. Open enrollment for alternate insurance plans ended December 15, 2017. Had the Duncans
25 terminated their plan, they would have been left without healthcare coverage at a time when
26 alternate plans would have been difficult to obtain. Moreover, by March 2018, Ms. Duncan had

1 a substantial medical bill, to which her MSRA (deductible) should already have been applied, and
2 she would have lost credit for that deductible even if she could have found an alternate plan.

3 As a result, as admitted by Chase Moses, Alieria’s Executive Vice President in sworn
4 testimony in the Georgia Litigation, the plans cannot simply be “terminated:”

5 Alieria could not just “terminate” its members’ plans with a Unity component two-
6 thirds of the way through the year. ***In addition to the problem of the MSRAs,***
7 ***individual members would face additional problems obtaining coverage based***
8 ***on pre-existing conditions and other potential roadblocks.*** They would have to
9 meet and pay a new deductible, even though their deductible had already been met
10 and paid under a plan with a Unity component. It would have been a violation of
11 Alieria’s fiduciary duties to members to unilaterally terminate every plan with a
12 Unity component, thereby ***leaving many of them uncovered and unable to obtain***
13 ***coverage for medical expenses for the remainder of the year.***

14 Declaration of Eleanor Hamburger, *Exh. 1*, ¶ 11 (emphasis added).

15 Moreover, Defendants could not reasonably believe that the Duncans’ continued payment
16 of monthly premiums was assent to the arbitration clause when Defendants themselves did not
17 provide any acknowledgment of the existence of the Dispute Resolution Procedures when the
18 Duncans attempted to resolve their claim. At no time during the many phone calls the Duncans
19 made to Alieria did it inform or remind them of those Procedures. Duncan Decl., ¶¶ 8-10. The
20 EOBs Ms. Duncan received denied claims as “pre-existing,” without mentioning appeals rights
21 or arbitration. *Id.*, *Exh. 1*.

22 Defendants’ cases are inapposite. In *Hoekman v. Tamko Bldg. Prods., Inc.*, No. 2:14-cv-
23 01581-TLN-KJN, 2015 U.S. Dist. LEXIS 113414 (E.D. Cal. Aug. 26, 2015), marketing materials
24 that the plaintiffs reviewed ***before*** purchase directed the reader to the website where the full terms
25 were available. *Id.*, at *9. Defendants here do not claim they ever made the arbitration provision
26 available for review before members purchased the healthcare plans. In *Mangahas v. Barclays*
Bank Delaware, SACV 16-00093 JVS, 2016 U.S. Dist. LEXIS 195268 (C.D. Cal. May 9, 2016),
plaintiff received the arbitration agreement before she activated her credit card. Here, the Duncans
had already paid for their plan and forewent the opportunity to enroll in other plans before
receiving the Member Guide. In *Gonzales v. Credit One Bank, N.A.*, No. 19-cv-00733-DAD-

1 BAM, 2020 U.S. Dist. LEXIS 46236, *11-12 (E.D. Cal. March 17, 2020), defendant credit card
2 company disclosed to plaintiff in its initial solicitation that the card would include an arbitration
3 agreement, every subsequent amendment of the arbitration agreement provided notice on how
4 plaintiff could opt out of the agreement, and plaintiff did not dispute that there was a valid
5 arbitration agreement. *Id.*, at * 11-12. None of these facts is present here.

6 **2. The Arbitration Agreement Is Unconscionable.**

7 In order to decide whether an arbitration provision is unconscionable under California law,
8 a court considers both procedural and substantive unconscionability. *Chavarria v. Ralphs*
9 *Grocery Store*, 733 F. 3d 916, 922 (9th Cir. 2013). A sliding scale is applied so that the more
10 substantively oppressive the contract term, the less evidence of procedural unconscionability is
11 required to conclude the term is unenforceable, and vice versa. *Id.*; *Nagrampa v. MailCoups, Inc.*,
12 469 F.3d 1257, 1280 (9th Cir. 2006). The arbitration agreements here are both procedurally and
13 substantively unconscionable.

14 **a. The Arbitration Agreement Is Procedurally Unconscionable.**

15 For starters, the arbitration clauses here are found in non-negotiable forms drafted by a
16 party of superior bargaining strength and are adhesive and procedurally unconscionable. *Ting v.*
17 *AT&T*, 319 F.3d 1126, 1148-49 (9th Cir. 2003). The level is heightened here because its terms
18 were not provided until after the members enrolled. *Laster v. T-Mobile United States*, 407 F.
19 Supp. 2d 1181, 1189 (S.D. Cal 2005) (notification of an arbitration clause in a 52-page “Welcome
20 Guide” available after purchase amounted to procedural unconscionability at a heightened level).

21 On top of that, the failure to provide copies of the particular arbitration rules to the
22 Duncans substantially increases the level of procedural unconscionability. *Raymundo v. ACS*
23 *State & Local Solutions, Inc.*, No. C 13-00442 WHA, 2013 U.S. Dist. LEXIS 70141, * 10 (N.D.
24 Cal. May 16, 2013). *See also, Carbajal v. CWPSC, Inc*, 245 Cal. App. 4th 227, 244 (2016)
25 (collecting cases that hold failure to provide a copy of the arbitration rules supports finding of
26 procedural unconscionability). The Unity Guide identifies the Rules of Procedure for Christian

1 Conciliation as the operative Rules, Dkt. 36-1, p. 5, while the Trinity Guide identifies the “Rules
2 and Procedure of the American Arbitration Association.” *Id.*, p. 10. Neither Guide included a
3 copy of, or even a link to, the applicable rules.

4 As for the AAA Rules referenced in the Trinity Guide, it is never specified which of the
5 many sets of AAA rules would be used. *See* <https://adr.org/Rules> (seven sets of different rules).
6 Even Alera apparently does not know whether the AAA’s commercial or consumer rules would
7 apply. *See* Dkt. 36, p. 11. “The level of oppression is increased when, as here, the employer not
8 only fails to provide a copy of the governing rules, but also fails to clearly identify which rules
9 will govern so the employee could locate and review them.” *Carbajal*, 245 Cal. App. 4th at 245
10 (holding as “patently unreasonable” the claim the plaintiff could have obtained the applicable
11 rules from the AAA, when defendant could not identify which set of AAA rules applied).

12 *a. The Arbitration Agreement Is Substantively Unconscionable.*

13 In order to appreciate the extent to which the arbitration agreements are substantively
14 unconscionable, it is necessary to put them into context. As specifically alleged in the Complaint,
15 the multi-step Dispute Resolution Procedures (“DRP”) in both the Trinity and Unity Member
16 Guides are intended to delay payment of legitimate claims and to shield Defendants from legal
17 action, rather than to resolve disputes. Dkt. 19, ¶¶ 79, 66, 86(h). This process gives Defendants
18 control over whether disputes are addressed, and ultimately whether a member has any
19 meaningful ability to access an unbiased forum. The DRP includes multiple levels of appeal:

- 20
 - **First level of appeal.** “Most differences of opinion can be resolved simply by
21 calling [Trinity or Unity] ⁴ ... who will try to resolve the matter ...”

22 Dkt. 19-4 p. 18 of 27 (Trinity), 19-5, p. 12 of 21 (Unity). This first level is designed as a wall.
23 Members go no further if they are put on hold, given false promises or conflicting responses, or
24 advised someone will get back to them. *See* Dkt. 19, ¶79; Duncan Decl. ¶ 8. If members can
25 mount this first obstacle, the Procedure imposes additional obligations that take months:

26 _____
⁴ Regardless of whether the Unity or Trinity plan was in place, the call would be to Alera, who handled claims
administration for both entities. Dkt. 19, ¶¶ 36, 48; Duncan Decl., ¶8.

- 1 • **Second level of appeal.** The member “may request a review by the Internal
2 Resolution Committee, made up of three [Unity or Trinity] officials. The
3 appeal must be in writing ...” This Committee is to render a written decision
4 within thirty days, without a means of expediting the review.
- 5 • **Third level of appeal.** The member “may ask that the dispute be submitted to
6 three sharing members” chosen by Unity/Trinity “who shall constitute an
7 External Resolution Committee.” This Committee is to render its opinion
8 within *another 30 days*.
- 9 • **Final Appeal.** The member “may ask that the dispute be submitted to a medical
10 expense auditor, who shall have the matter reviewed by a panel consisting of
11 personnel who were not involved in the original determination ...” This panel
12 has *another 30 days* to render an opinion.

13 Dkt. 19-4, pp. 18-19 of 27; 19-5 p. 12 of 21.

14 If a member can make her way through these four appeals, she is expected to mediate and
15 then arbitrate. Meanwhile, the claims Defendants advertised would be covered under the
16 AlierCare plan go unpaid, and accounts are sent to collection. Duncan Decl., ¶ 7. In reality,
17 AlierCare, as the administrator for both plans, never operated under this appeal process, but strung
18 people along for months. *Id.*, ¶¶ 8-10, 12. This multi-step DRP – a process that is designed to
19 avoid paying claims – is itself unconscionable. *Pokorny v. Quixtar, Inc.*, 601 F.3d 987, 1000 (9th
20 Cir. 2010) (unfair and one-sided limitations to pre-arbitration dispute resolution process rendered
21 it unconscionable and unenforceable). *See also, Greer v. Sterling Jewelers, Inc.*, 2018 U.S. Dist.
22 LEXIS 114640 (E.D. Cal. July 10, 2018) (finding multi-step pre-arbitration procedure
23 substantively unconscionable). Indeed, under California law, health plans can only have 1-2 levels
24 of internal dispute resolution procedures. *See* 10 CCR § 2509.44 (describing one internal appeal
25 before an insured may appeal to the Insurance Commissioner directly).

26 Setting aside the impossibility of working through the cumbersome pre-arbitration
process, the arbitration clause itself is substantively unconscionable. The Unity Guide provides
that “arbitration shall be held in Fredericksburg, Virginia,” while the Trinity Guide provides “any
arbitration shall be held in Atlanta, Georgia.” Regardless of whether arbitration were to take place
in Virginia or Georgia, it is unconscionable to require the Duncans, who are California residents,

1 purchased healthcare plans in California, and incurred medical expenses from California
2 healthcare providers, to travel across the country in order to resolve unpaid claims that Defendants
3 should have paid. The venue clauses benefit only Defendants. *Nagrampa v. MailCoups, Inc.*,
4 469 F.3d 1257, 1290 (9th Cir 2006) (forum selection clause that required plaintiff to travel from
5 California to Massachusetts had “no justification other than as a means of maximizing an
6 advantage over plaintiffs” and was unconscionable); *Magno v. The College Network, Inc.*, 1 Cal
7 App. 5th 277, 289 (2016) (arbitration clause requiring travel to another state when the contract
8 was entered into in California and involved only California interests was unconscionable).

9 It is particularly unconscionable that the Duncans face the daunting prospect of filing two
10 separate arbitrations in two separate states. Not only does that double their burden of seeking
11 relief, it also puts them at risk of inconsistent findings. After their medical expenses were incurred
12 while covered under the Unity plan, their plan was transferred to Trinity with the promise that
13 “historical claims” would track to the Trinity plan. Duncan Decl., ¶ 11, and *Exh. 2*. Alieria, acting
14 as an agent for Unity, denied payment for the Duncans’ claims, and then continued to deny
15 payment for the same claims as an agent of Trinity, and recovering against Alieria would
16 potentially mean filing two separate arbitrations. Moreover, Trinity points to Unity as
17 responsible, Dkt 38, p. 11 of 27; Unity points to Alieria, Dkt. 37, p. 21 of 25; and Alieria appears
18 to disclaim responsibility altogether because the healthcare plans were offered by Unity or Trinity,
19 but not Alieria. Dkt. 36, p. 2. Unless the Duncans can bring all three defendants into one unified
20 action, they risk being whipsawed between them.

21 Adding to the substantive unconscionability of the Unity plan is its incorporation of the
22 rules of the Institute for Christian Conciliation. Those rules provide:

23 **Application of Law.** Conciliators shall take into consideration any state, federal,
24 or local laws that the parties bring to their attention, but *the Holy Scriptures (the*
25 *Bible) shall be the supreme authority governing every aspect of the conciliation*
process.

26 ICC Rule 4, see <https://www.instituteforchristianconciliation.com/rules-2019/> (emphasis added).

Although the Duncans agreed to the Statement of Beliefs required of members, Defendants

1 purposely adopted a very generic ethical statement so that they could market their products to the
2 widest possible population, including those outside the Christian religion. Dkt. 19, ¶ 37, 19-5,
3 pp. 9-10 of 21. Absent from the Statement of Beliefs signed by members is any reference to the
4 Holy Scriptures or Bible. At least one federal district court was “troubled” by this provision that
5 required “a now-unwilling participant to engage in an arbitration process which may deprive them
6 of due process and access to secular law.” *Higher Ground Worship Ctr. v. Arks, Inc.*, No. 1:11-
7 cv-00077-BLW, 2011 U.S. Dist. LEXIS 116138, *11, n. 4 (D. Idaho Oct. 6, 2011).

8 Finally, it is substantively unconscionable for Alieria to claim entitlement to the benefit of
9 the arbitration clause. Alieria drafted both the Unity and Trinity Member Guides, and left the
10 clause purposely ambiguous as to whether a member could demand that Alieria arbitrate. Where
11 an arbitration agreement is one of adhesion and drafted entirely by one side, it should be
12 interpreted against the drafter. *Juarez v. Wash Depot Holdings, Inc.*, 24 Cal. App. 5th 1197, 1203
13 (Cal Ct. App. 2018).

14 **3. The Court Should Decide Whether a Valid Arbitration Agreement**
15 **Was Formed.**

16 Defendants claim that because they referenced the rules of two different arbitral entities
17 in the DRPs, plaintiffs have necessarily agreed to delegate to an arbitrator whether the arbitration
18 agreement is enforceable. They are wrong. A *court* must decide whether a valid agreement to
19 arbitrate exists in the first place. *Wilson v. Huuuge, Inc.*, 944 F.3d 1212, 1219 (9th Cir. 2019).

20 An agreement to delegate arbitrability is a severable agreement to arbitrate. When the
21 challenge is to both the delegation clause and the arbitration clause, *the court* decides whether the
22 parties formed a valid, enforceable agreement to arbitrate. *Rent-A-Center, West, Inc. v. Jackson*,
23 561 U.S. 63, 71 (2010). There is no requirement that the challenge to the delegation clause be
24 substantially different than the challenge to the arbitration agreement as a whole, so long as the
25 challenge is directed specifically to the delegation clause. *Id.*, at 74. *See also, Henry Schein, Inc.*
26 *v. Archer & White Sales, Inc.*, 139 S. Ct. 524, 530 (2019) (“to be sure, before referring a dispute
to an arbitrator, the court determines whether a valid arbitration agreement exists”); *Nagrampa v.*

1 *MailCoups, Inc.*, 469 F.3d 1257, 1270 (9th Cir. 2006) (where plaintiff specifically challenged the
2 arbitration agreement as unconscionable, the court decides its validity).

3 The Duncans specifically challenge both the validity of the delegation clause
4 independently and the arbitration agreement as a whole. *See Bridge Fund Capital Corp. v.*
5 *Fastbucks Franchise Corp.*, 622 F.3d 996, 1001 (9th Cir. 2010) (party may effectively challenge
6 a delegation provision in its opposition to a motion to compel arbitration). The Duncans never
7 objectively manifested their assent to either arbitrate or delegate questions of arbitrability, and
8 both the delegation clause and the arbitration provision as a whole are unconscionable. *See* Section
9 III.A.1, *above*.

10 Defendants rely on cases that do not apply to consumers, and do not support their argument
11 that mere reference to those arbitration rules alone constitutes a “clear and unmistakable”
12 agreement to delegate arbitrability. *See Oracle Am., Inc. v. Myriad Group A.G.*, 724 F.3d 1069,
13 1075 (9th Cir. 2013) (as long as an arbitration agreement is “between sophisticated parties to
14 commercial contracts,” incorporation of arbitral rules can be evidence of an agreement to
15 arbitrate); *Brennan v. Opus Bank*, 796 F.3d 1125, 1130 (9th Cir. 2013) (leaving open the question
16 of whether reference to arbitral rules binds an unsophisticated consumer). In fact, the majority of
17 district courts in the Ninth Circuit hold that incorporation of the AAA rules is *insufficient* for
18 delegation in consumer contracts involving at least one unsophisticated party. *Eiess v. USAA Fed.*
19 *Sav. Bank*, 404 F. Supp. 3d 1240, 1253 (N.D. Cal. 2019) (collecting cases).

20 The Duncans, *after* they had paid over \$1,400 to join AlierCare, were apparently
21 supposed (1) to click on a link under a heading referring to “benefits” in a welcome email, (2) find
22 the arbitration clause buried at the end of the DRP, (3) go online and independently find the ICC
23 rules, (4) scroll down to ICC Rule 34(B), and then (5) determine that because that Rule provides
24 the arbitrator “shall have the power to rule on his or her own jurisdiction,” they agree to forego
25 the right to have a court determine whether the arbitration agreement is valid. This is ridiculous.
26 In *Tompkins v. 23andMe, Inc.*, 2014 U.S. Dist. LEXIS 88968 (N.D. Cal. June 25, 2014), the court
found that “bare reference to the AAA rules” did not show that the parties “clearly and

1 unmistakably intended to delegate arbitrability,” and that a “heightened standard” of intent applies
2 to consumer contracts. *Id.*, at *41, 43. There was no agreement to delegate when the reference to
3 nonspecific AAA rules “forces a customer to comprehend the import” of the reference, determine
4 which rules ultimately apply, locate those rules independently, then locate the specific rule to
5 learn of the delegation provision. *Id.* at *47. *See also, Yan Guo v. Kyani, Inc.*, 311 F. Supp. 3d
6 1130, 1156 (C.D. Cal. 2018) (no “clear and unmistakable” intent to delegate questions of
7 arbitrability where defendants provided neither a paper copy nor a link to the AAA rules); *Belyea*
8 *v. GreenSky, Inc.*, No. 20-cv-01693-JSC, 2020 U.S. Dist. LEXIS 116809, *19 (N.D. Cal. July 2,
9 2020) (when plaintiff challenged the existence of an enforceable arbitration agreement, the issue
10 of arbitrability was not delegated, notwithstanding incorporation of AAA rules in the arbitration
11 agreement).

12 **4. The Dispute Resolution Procedure and its Arbitration Clause Are**
13 **Illegal Under California Insurance Code § 10123.19.**

14 *a. The Unity and Trinity Plans Are “Insurance” Under California*
15 *Law.*

16 Under California law, “insurance” is defined as “a contract whereby one undertakes to
17 indemnify another against loss, damage, or liability arising from a contingent or unknown event.”
18 Cal. Ins. Code § 22. It is “nothing more nor less than an aggregation of persons who have
19 voluntarily pooled their resources to protect each other from the hazards to themselves as
20 individuals of casualties incident to the vicissitudes of human life.” *Garrison v. State*, 64 Cal.
21 App. 2d 820, 828 (1944). Insurance has been interpreted as requiring two elements: (1) shifting
22 one party’s risk of loss to another party; and (2) distribution of that risk among similarly situated
23 persons. *Williby v. Aetna Life Ins. Co.*, 867 F.3d 1129, 1134 (9th Cir. 2017).

24 The Unity and Trinity plans that Alera marketed and administered meet this definition.
25 The Duncans and the other members pooled their resources by paying monthly “contributions”
26 so that they could “share” or protect each other from unexpected health care expenses. By paying
Defendants to create a pool, each member shifted her own risk to that pool, and distributed that

1 risk among the other members who also paid into the pool. Courts in other jurisdictions have held
2 that entities claiming to be health care sharing ministries with functionally identical programs
3 constitute “contracts of insurance.” *Commonwealth v. Reinhold*, 325 S.W.3d 272, 276-77 (Ky.
4 2010) (despite disclaimers that it is not insurance, when members paid each month into a pool to
5 remain eligible to receive payment for their medical needs, this is a shifting of risk that qualifies
6 as insurance). *See also, Rowden v. Am. Evangelical Assoc.*, 2007 Mont. Dist. LEXIS 7, *11
7 (2007).

8 Plaintiffs have sufficiently pled that the Unity and Trinity plans the Duncans purchased
9 were designed to look and feel just like health insurance. Dkt. 19, ¶¶ 51-59. Members pay a
10 monthly premium, or “contribution.” The amount they pay is based on the level of coverage they
11 receive. *Id.*, ¶¶ 51(a), (e), (f). The plans claim to provide coverage for services typically covered
12 by health insurers, including preventive care, primary care, urgent care, labs and x-rays, surgery,
13 prescription drugs, and emergency room services. *Id.*, ¶ 52. Just like ACA plans, the AlierCare
14 plans are offered at “Bronze,” “Silver,” and “Gold” levels, with enhanced benefits with each
15 higher level. *Id.*, ¶ 51(f). Members pay a “co-expense,” analogous to a co-pay, for certain medical
16 expenses. *Id.*, ¶ 51(g). The plan provides coverage once the members have met an annual
17 deductible, or “MSRA.” *Id.*, ¶ 51(b), (c). The plans claim to have arrangements with Preferred
18 Provider Organizations, and benefits will be limited to, or provided at a higher level for, services
19 provided by “in network” providers. *Id.*, ¶ 53; Dkt. 19-4, pp. 19-20 of 27; 19-5, pp. 15-18 of 21.
20 The plans contain certain exclusions and lifetime limits. *Id.*, ¶ 54. The plans are sold by insurance
21 brokers or agents. Dkt. 19, ¶ 69.

22 Members are given a card that looks like an insurance card to show to their health care
23 providers who will then bill AlierCare directly, and are instructed to “verify eligibility before
24 treatment or service.” *Id.*, ¶¶ 69, 74; Dkt. 19-8 and 19-11. An Explanation of Benefits (EOB) is
25 sent to the provider and member that looks exactly like an EOB from a health insurer. Duncan
26 Decl., *Exh. 1*. Defendants pay providers directly. Dkt. 19, ¶ 55.

1 In March of 2020, California’s Insurance Commissioner found the Trinity products that
2 Alieria designed, sold, and administered to meet the definition of insurance, and issued a cease
3 and desist order against both entities. Dkt. 19-6. Specifically, it found that “in exchange for the
4 fixed monthly payments ... [Alieria and Trinity] under[took] to indemnify its members for loss,
5 damage, or liability arising from costs incurred in connection with health events.” *Id.*, ¶ 22.⁵
6 Regulators in other states have also found the products to be unauthorized insurance, including
7 Texas, Dkt. 17-8, p.2-53 of 172 (Alieria and Trinity), Washington, Dkt 17-8, p.54-113, Dkt. 17-
8 15, 17-16 (Alieria, Trinity, and Unity), Colorado (Alieria and Trinity), Dkt. 17-8, p. 114-139, New
9 Hampshire (Alieria and Trinity), *id.*, p. 141-146, Connecticut (Alieria and Trinity), *id.*, p. 147-156,
10 and Maryland (Alieria and Unity), *id.*, p. 164-172. Recently, the Iowa Insurance Commissioner
11 also filed an action against Alieria, Trinity, and others, charging that Trinity and Alieria were
12 selling insurance contracts. [https://iid.iowa.gov/documents/statement-of-charges-trinity-and-](https://iid.iowa.gov/documents/statement-of-charges-trinity-and-aliera-companies)
13 [aliera-companies](https://iid.iowa.gov/documents/statement-of-charges-trinity-and-aliera-companies) (last visited October 11, 2020).

14 The fact that Unity⁶ claims to be a Health Care Sharing Ministries does not exempt it from
15 California insurance law if what Alieria sold through Unity was, in fact, insurance. To be a
16 federally-recognized HCSM, Unity must have been recognized as a 501(c)(3) organization and in
17 existence continually since 1999. 26 U.S.C. § 5000A(d)(2)(B)(ii). Unity admits it was not created
18 until November 2016. Dkt. 37-1, ¶ 6. It cannot claim HCSM status through Anabaptist, because
19 that entity was never its “predecessor” as required to extend the existence date back under the
20 statute. Even if it could claim that status through Anabaptist, it did not operate as a true HCSM
21 while it was affiliated with Alieria and at the time the Duncans purchased their plan. Unity
22 delegated all authority to Alieria, a for-profit entity, who designed and operated the Unity plans
23 for its own benefit, not for the benefit of Unity’s members. Unity allowed Alieria to combine its
24

25 ⁵ Although when the California Insurance Commissioner took action against Alieria and Trinity, Alieria was no
26 longer selling the Unity plans, the Unity plans had the identical earmarks of insurance as the Trinity plans.

⁶ For purposes of this motion, Trinity does not claim to be exempt from insurance law as an HCSM. Dkt. 38,
p. 9 of 27, n. 3. It cannot qualify as an HCSM because, *inter alia*, it was created in 2018.

1 own plans to sell “side by side” with the Unity plans, even though Alier’s plans could never
2 qualify as HCSM plans. Dkt. 19, ¶¶ 34-37. Moreover, the Duncans were never asked to “share”
3 their monthly contributions with other members, and they were never informed that other
4 members were asked to “share” their contributions with the Duncans. Duncan Decl., ¶ 13. The
5 lack of sharing further prevents Unity from qualifying as an HCSM.

6 ***b. The Arbitration Agreements Were Not Disclosed as Required in***
7 ***California Health Plans and Are Invalid.***

8 Cal. Ins. Code § 10123.19 requires that if a disability policy⁷ requires binding arbitration,
9 the requirement must be disclosed in “clear and understandable” language ... prominently
10 displayed on the enrollment form signed by each ... enrollee ... immediately before the signature
11 line” on the enrollment form. The section is strictly construed. In *Malek v. Blue Cross of*
12 *California*, 121 Cal. App. 4th 44 (2004), the court considered whether the disclosure of an
13 arbitration clause in a health care service contract met the statutory disclosure requirements.⁸
14 Although the arbitration clause there appeared on the enrollment form, it failed to meet the
15 prominence requirement because it was in the same type size and font as other provisions on the
16 form, and was not displayed immediately above the signature line. The noncompliance rendered
17 the contractual arbitration provision unenforceable. The court held that the disclosure
18 requirements were mandatory, and if the requirements were not met, “there is no indicia that the
19 health care service plan enrollee knowingly assented to arbitration.” *Id.*, at 67. *Accord, Imbler v.*
20 *PacifCare of Cal., Inc.*, 103 Cal. App. 4th 567, 579 (Cal. Ct. App. 2002) (arbitration disclosure
21 did not stand out from other disclosures that immediately preceded the signature line, was not
22 “readily noticeable,” and failed to meet the prominence requirement).

24 ⁷ Under California law, health insurance is a form of disability insurance. Cal. Ins. Code § 106; *Blue Shield of*
25 *California Life & Health Ins. Co. v. Superior Court*, 192 Cal. App. 4th 727, 733 (2011) (“health insurance policies
are considered a form of disability insurance”).

26 ⁸ The arbitration disclosure statute applicable to health care service contracts in Cal. Health & Safety Code
§ 1363.1 considered in *Malek* is identical to the arbitration disclosure statute applicable to disability and health
insurance contracts in Cal. Ins. Code § 10123.19.

1 The case for invalidating the arbitration clause here is much greater than in *Malek* or
2 *Imbler*. Defendants fail to provide any evidence that their enrollment forms disclosed an
3 arbitration requirement *at all*, much less that they disclosed an arbitration requirement
4 prominently or directly above the signature line. The “Plan Update Authorization Form” that
5 Trinity submits merely alludes vaguely, and without any link, to “fees, regulations, and limitations
6 of the above said plan.” Dkt. 38-3, p. 2. This is hardly the “clear and understandable language”
7 that the statute requires. The arbitration clause is unenforceable.

8 Defendants argue that the Federal Arbitration Act preempts any state law that limits
9 enforcement of arbitration agreements. They fail to recognize the exception to that rule, embodied
10 in the McCarron-Ferguson Act (the “MFA”), 15 U.S.C. § 1101, *et seq.* The MFA provides that
11 an Act of Congress may not be construed to “invalidate, impair, or supersede” a state law enacted
12 “for the purpose of regulating the business of insurance ... unless such Act specifically relates to
13 the business of insurance.” 15 U.S.C. § 1012(b). It overrides, or “reverse preempts,” the FAA
14 when a particular statute regulates insurance. The “clear purpose” of the MFA was to ensure that
15 states “would continue to enjoy broad authority in regulating the dealings between insurers and
16 their policyholders.” *Smith v. Pacificare Behavioral Health of California*, 93 Cal. App. 4th 139,
17 150 (2001) (statute identical to Cal. Ins. Code § 10123.19 that requires prominent disclosure of
18 binding arbitration is intended to protect insureds, regulates the business of insurance, and is
19 exempted from the FAA). The MFA overrides, or “reverse-preempts,” the FAA when the
20 particular state statute regulates insurance.

21 Defendants inaccurately argue that this Court cannot decide whether their arbitration
22 clause – disclosed only in the back of the Member Guides received after enrolling – is illegal
23 because that would require determination of the merits of the underlying case. The question
24 relevant to the enforceability of the arbitration agreement is whether arbitration was prominently
25 disclosed above the signature line. The question in the underlying lawsuit is whether Defendants
26 provided the benefits required by law in their healthcare plans, maintained adequate resources, or
breached their fiduciary duties. Those are different questions. A common issue – whether the

1 plan are insurance – may be relevant to answer both questions, but the questions themselves are
2 different.⁹

3 *Buckeye Check Cashing, Inc. v. Cardegna*, 546 U.S. 440 (2006), does not support
4 Defendants. The plaintiff there did not challenge the arbitration clause itself but claimed that
5 **because** the underlying contract violated state usury law, the arbitration clause within it was
6 therefore unenforceable. The Duncans challenge the underlying contract because it fails to
7 provide benefits required of health insurance contracts, and because Defendants failed to cover
8 the medical expenses they had committed to pay. The statutory challenge to the arbitration clause
9 is different. That challenge is that the arbitration clauses are statutorily illegal because there was
10 no notice of binding arbitration not prominently disclosed above the signature line in the
11 enrollment form. That challenge is directed **only** at the arbitration agreement, not to the
12 underlying contract. The “material question” in determining whether a court can consider
13 arbitrability is “whether the challenge to the arbitration clause is severable from the contract as a
14 whole.” *Bridge Fund Capital Corp. v. Fastbucks Franchise Corp.*, 622 F.3d 996, 1001 (9th Cir.
15 2010). The statutory challenge to the arbitration clause here is severable and distinct from the
16 ultimate merits of the case.

17 Well-reasoned decisions in other jurisdictions have concluded that it is for the court to
18 decide whether a statute invalidating arbitration in insurance contracts is arbitrable, even when
19 the parties dispute whether the underlying contract is one for insurance. In *Minnieland Private*
20 *Day Sch. v. Applied Underwriters Captive Risk Assur. Co.*, 867 F.3d 449 (4th Cir. 2017), *cert.*
21 *denied*, 138 S. Ct. 925 (2018), at issue was whether an underlying agreement with an arbitration
22 clause was “insurance.” A Virginia statute rendered void arbitration agreements in insurance
23 contracts. The court held that the court must determine the nature of the underlying agreement
24 because delegating the issue to an arbitrator would undermine the protective purpose of the law.

25
26 ⁹ In a similar case, the district court came to the opposite conclusion. *Jackson v. Alieria Companies*, No. 19-cv-
01281-BJR, 2020 U.S. Dist. LEXIS 149772 (W.D. Wash. Aug. 18, 2020). For the reasons set forth above, the court
erred in its conclusion there. In addition, the court there did not consider the assent and unconscionability issues
presented here.

1 *Id.*, at 457. Several California courts have come to the same conclusion. *Luxor Cabs, Inc. v.*
2 *Applied Underwriters Captive Risk Assur. Co.*, 30 Cal. App. 5th 970, 981 (Cal. Ct. App. 2018),
3 *review denied*, 2019 Cal. LEXIS 1822 (Cal. May 13, 2019) (rejecting the argument that the
4 challenge to the delegation clause was not specifically targeted because it was the same challenge
5 to the enforceability of the arbitration agreement and the underlying agreement as a whole);
6 *Nielsen Contracting, Inc. v. Applied Underwriters, Inc.*, 22 Cal. App. 5th 1096, 1113 (Cal. Ct.
7 App. 2018), *review denied*, 2018 Cal. LEXIS 5991 (Cal. Aug. 15, 2018) (rejecting argument that
8 “any time there is a similar challenge to the delegation clause and to other contractual provisions,
9 a court must ignore its statutory obligation to rule on state law contract defenses specifically
10 asserted against the enforceability of the delegation clause”); *Jackpot v. Applied Underwriters*
11 *Captive Risk Assur. Co.*, 33 Cal. App. 5th 719, 732 (Cal. App. 2019), *review denied*, 2019 Cal.
12 LEXIS 5020 (Cal. July 10, 2019) (legal challenge to arbitration need not relate solely to the
13 arbitration agreement).¹⁰

14 **B. Defendants’ Mandatory Mediation Clause Is Part of its Unconscionable**
15 **Dispute Resolution Process.**

16 Defendants Alera and Trinity argue that the Duncans are precluded from filing suit
17 because they have not mediated, which they contend is a “condition precedent.” For the reasons
18 set forth above, the mediation clause is part of the unfair, unconscionable and illegal Dispute
19 Resolution Process to which the Duncans never agreed. The fact that they have not mediated does
20 not preclude this lawsuit. *Pokorny v. Quixtar, Inc.*, No. 07-00201 SC, 2008 U.S. Dist. LEXIS
21 28439, *42 (N.D. Cal. March 31, 2008), *aff’d* 601 F.3d 987 (2010) (pre-arbitration dispute
22 resolution provisions were unconscionable and unenforceable).
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25 ¹⁰ Defendants cite *S. Jersey Sanitation Co. v. Applied Underwriters Captive Risk Assur. Co.*, 840 F.3d 138 (3d
26 Cir. 2016) and *Milan Express Co. v. Applied Underwriters Captive Risk Assur. Co.*, 590 F. Appx. 482 (6th Cir. 2014),
which considered a similar contract as the ones cited above, but ultimately ruled the arbitrator must decide
arbitrability. Unlike the plaintiff in *Minnieland* or the Duncans here, the plaintiffs in those cases alleged the entire
agreement was fraudulent but alleged no arbitration-specific fraud, and did not specifically challenge the delegation
provision. *S. Jersey*, 840 F.3d at 144, *Milan Express*, 590 F. Appx. at 486.

1 **C. The Duncans Have Standing to Sue Trinity.**

2 Trinity claims no responsibility for the Duncans’ loss because the Duncans received
3 medical care and incurred medical expenses at the time they were covered by the Unity plan.
4 Dkt. 38, p. 14 of 27. But Trinity ignores the fact that it delegated authority to Alieria to administer
5 claims under the Trinity name, and Alieria denied the Duncans’ claims as an apparent or express
6 agent for Trinity. Dkt. 19-12.

7 By summer 2018, Alieria knew that its relationship with Unity was ending so it created
8 Trinity, and then led members to believe the plans had transferred to Trinity. With control over
9 the Unity website, Alieria automatically redirected Unity’s website to the new Trinity site that it
10 had created. Dkt. 19-1, ¶ 89. In November 2018, Alieria sent a notice to Unity members that if
11 they took no action, their Unity plans would automatically transfer to Trinity plans, and that
12 “*[n]othing changes on your plan except for the HCSM name. You don’t have to do anything*
13 *to maintain your current plan.*” *Id.*, ¶ 95. The notice made no mention of Unity. *Id.*, ¶ 99.
14 Although Alieria was ordered by the court in the Georgia Litigation to walk back that notice, *id.*,
15 ¶¶ 100-102, that did not prevent Alieria from holding itself out as the representative of Trinity, or
16 prevent Trinity from leading its members into believing that their plan had become a Trinity one.

17 The Duncans received a Trinity insurance card showing that they had been a member in a
18 Trinity plan since January 1, 2018, months before they incurred any medical expenses. Dkt. 19,
19 ¶ 74, 19-11. On April 26, 2019, before Trinity claims the plan was transferred, the Duncans
20 received an Explanation of Benefits under the Trinity logo, denying payment of \$79,312 of the
21 Duncans’ medical claim. Dkt. 19-12. On May 3, 2019, Alieria solicited the Duncans in an email.
22 Dkt. 19-9. The email represented that although Alieria was no longer selling the Unity plan, the
23 plan through its “trusted alliance” with Trinity would offer the “same benefits and services,” that
24 “all your plan services will remain the same,” and that “medical history *and historical claims*,”
25 payments toward the MSRA (deductible), and time spent in the plan “*will continue to track* with
26 each member.” *Id. See also*, Dkt. 38-3 (emphasis added). Nowhere in that email does Alieria
 suggest that Unity would remain liable for any pending unpaid claims, that a receiver appointed

1 in a lawsuit would oversee the administration of any unpaid claims, or that they needed to file a
2 claim or appeal with the receiver or with Unity in order to be paid.

3 Trinity suggests that it is unreasonable to conclude that it would have “assumed” a Unity
4 liability, when it was in competition with Unity. Dkt. 38, p. 15 of 27. In fact, it is very reasonable
5 that in order to compete with Unity, Trinity would aggressively court Unity members by offering
6 benefits it later denied. Trinity and Alieria had every incentive to make an attractive offer to
7 former Unity members in order to induce them to switch their plans. They had every reason to
8 persuade the members that the transition would be “seamless.” Dkt. 19-9. Had Trinity/Alieria
9 notified members that their historical claims would have to be resolved through a separate entity
10 rather than through the Trinity plan, the members would have been less likely to agree to the
11 transition. The Duncans have alleged sufficient facts to demonstrate standing to sue Trinity.

12 **D. The Duncans Have Stated a Cause of Action Under the UCL and the FAL.**

13 California’s Unfair Competition Law (“UCL”), Cal. Bus. & Prof. Code § 17200, *et seq.*,
14 broadly prohibits “any unlawful, unfair *or* fraudulent business act or practice.” (Emphasis added).
15 Because the statute is written in the disjunctive, it is violated if any one of these three prongs is
16 present. *Friedman v. AARP, Inc.*, 855 F.3d 1047, 1051 (9th Cir. 2017). The Duncans have alleged
17 the presence of all three of these prongs.

18 *First*, virtually any state, federal or local law can serve as a predicate under the “unlawful”
19 prong of the UCL. *Friedman*, 855 F.3d at 1052. In that case, plaintiff alleged that defendant sold
20 insurance without a license in violation of California law, and that plaintiff purchased that product.
21 The allegations were sufficient to state a claim for “unlawful” acts under the UCL. The Duncans
22 allege unlawful conduct because Defendants sold health insurance without a certificate of
23 authority required by Cal. Ins. Code § 700. Dkt. 19, ¶¶ 61, 82(a), 86(a). The health insurance
24 Defendants sold did not meet the minimum requirements of California health insurance law, and
25 in particular limited benefits for preexisting conditions. *Id.*, ¶¶ 62, 82(b). Because a claim under
26 the “unlawful” prong does not involve fraudulent conduct, it is not necessary to prove the elements
of fraud. All that is necessary is that there is a causal connection between the unlawful act and

1 the alleged loss of money or property. *See Rubio v. Capital One Bank*, 613 F.3d 1195, 1204 (9th
2 Cir. 2010) (by alleging violation of Truth In Lending Act and a causal connection to her loss,
3 plaintiff stated a claim for a violation of the UCL under the “unlawful” prong).

4 The Duncans paid over \$30,000 for unlicensed insurance products Alieria sold, first for the
5 Alieria/Unity plan (\$1,287,56 per month) and then for the Alieria/Trinity plan (\$1,612.91 per
6 month). *Id.*, ¶ 75. They lost money directly as a result of the sale of illegal products that should
7 never have been sold to California residents. More particularly, the health insurance limited
8 coverage for preexisting conditions, a violation of Cal. Ins. Code § 10112.27 and 42 U.S.C.
9 § 300gg-3. *Id.*, ¶ 62. As a result, Alieria (first on behalf of Unity and then on behalf of Trinity)
10 denied coverage for Ms. Duncan’s surgery, leaving the Duncans with a bill of over \$70,000. *Id.*,
11 ¶¶ 78, 80. The Duncans have alleged a violation of the UCL under the “unlawful” prong.

12 **Second**, unfair claims practices are a violation of the UCL. *Zhang v. Superior Court*, 57
13 Cal. 4th 364, 383 (2013) (allegations that defendant engaged in bad faith claims practice,
14 including unreasonable delays and withholding policy benefits, stated claim as an unfair practice
15 under UCL); *State Farm Fire & Casualty v. Superior Court*, 45 Cal. App. 4th 1093, 1105 (1996)
16 (failure to act fairly and in good faith with respect to claims constitutes an “unfair” practice under
17 the UCL). The Duncans allege that, although Alieria approved Ms. Duncan’s surgery, it later
18 unfairly and arbitrarily refused to pay, falsely claiming that the surgery was for a “pre-existing
19 condition,” even though her surgeon verified that it was not. Dkt. 19, ¶¶ 77-79, 19-12, 19-13. The
20 Duncans made repeated attempts to appeal and resolve Alieria’s decision not to pay, but were met
21 with inconsistent answers, left on hold for unreasonable amounts of time, and were strung along
22 for months. Dkt. 19, ¶ 79.

23 The Duncans allege that this is a symptom of a concerted unfair claims handling practice
24 that requires multiple levels of appeal and that is designed to unfairly deny legitimate claims. *Id.*,
25 ¶ 86(h). Defendants claim a member is obligated to follow this unfair claims process while at the
26 same time claiming that they have no legal obligation whatsoever to the members. *Id.* As a result
of Defendants’ unfair claims practices, the Duncans have been forced to pay for medical expenses

1 that should have been covered under their AlierCare Gold plan, and they continue to be pursued
2 for their hospital debt which has adversely affected their credit. *Id.*, ¶ 80. *See Ghazarian v.*
3 *Magellan Health, Inc.*, 53 Cal App. 5th 171, 192-93 (2020) (insurer’s bad faith in unfairly
4 evaluating and denying a claim caused plaintiff to expend money appealing the denial, and was a
5 violation of the UCL).

6 **Third**, under the “fraudulent” prong of the UCL, a plaintiff need only show “that members
7 of the public are likely to be deceived by the practice.” *Friedman*, 855 F. 3d at 1055. The reliance
8 necessary to prove a fraud claim under the UCL may be inferred from the misrepresentation of a
9 material fact, and whether a fact is “material” is generally a question of fact. *Id.* When the claim
10 is based on a material omission, a plaintiff need not plead that she actually saw the allegedly
11 deceptive statements. *Stevenson v. Allstate Ins. Co.*, No. 15-cv-04788-YGR, 2016 U.S. Dist.
12 LEXIS 34923, *12 (N.D. Cal. March 17, 2016). Plaintiffs allege here that they purchased the
13 Unity/AlierCare Gold plan based on representations that it provided coverage equivalent to a
14 Blue Cross health insurance plan, and they reasonably believed that they would be covered for
15 major medical expenses. Dkt. 19, ¶¶ 69, 86(b). The complaint extensively details why the plans
16 appear to the average reasonable consumer to be insurance plans. *Id.*, ¶¶ 51-58. The Duncans were
17 never advised that a majority of the premiums collected went to Alier rather than to pay claims,
18 or that none of the Defendants qualified as legitimate HCSMs that would exempt them from
19 insurance oversight, or that their claims could be arbitrarily denied. *Id.*, ¶¶ 86(c), (d), (h). These
20 facts, had they been disclosed, would have led a reasonable consumer, including Plaintiffs, who
21 were searching for a health plan to look elsewhere.¹¹

24 ¹¹ OneShare claims “no reasonable consumer could confuse this with buying insurance.” Dkt 37, p. 9 of 25. Yet,
25 the insurance commissioners of at least eight states, including California, believe the AlierCare products to be
26 insurance, and the confusion is cited as the reason for preventing Alier to continue to sell these products. *See*
[https://www.insurance.wa.gov/news/kreidler-orders-oneshare-health-llc-stop-selling-illegal-insurance-washington-](https://www.insurance.wa.gov/news/kreidler-orders-oneshare-health-llc-stop-selling-illegal-insurance-washington-state)
[state](https://iid.iowa.gov/documents/statement-of-charges-trinity-and-aliera-companies); Dkt. 19-6, 7, 8, 14, 15. *See also*, [https://iid.iowa.gov/documents/statement-of-charges-trinity-and-aliera-](https://iid.iowa.gov/documents/statement-of-charges-trinity-and-aliera-companies)
[companies](https://iid.iowa.gov/documents/statement-of-charges-trinity-and-aliera-companies) (noting that 40% of members surveyed believed they were joining a health insurance company when they
purchased products through Alier/Trinity). The Unity products Alier sold were no different and equally confusing.

1 Moreover, the Duncans allege that they authorized the transfer of their plan to Trinity
2 based on representations that their medical history and existing claims would “continue to track”
3 with the Trinity plan. *Id.*, ¶ 72, Dkt. 19-9. The representation was false, as Trinity now claims it
4 has no responsibility for the Duncans’ historical claim, and it has not paid any of the costs it led
5 the Duncans to believe would be covered. They have made payments of \$1,612 per month for six
6 months for a Trinity plan that did not provide the benefits represented. They have stated a claim
7 under the UCL against Trinity for fraudulent conduct. They have suffered economic injury as a
8 result of Trinity’s misrepresentation.

9 California’s False Advertising Law (FAL), Bus. & Prof. Code § 17500, prohibits untrue
10 or misleading statements to the public “with intent to perform services ... or to induce the public
11 to enter into any obligation relating thereto ...” The statute applies to omissions of material fact
12 in the sale of insurance. *Quelimane Co. v. Stewart Title Guaranty Co.*, 19 Cal. 4th 26, 52 (1998)
13 (failure to disclose limitations to representations regarding insurance is a violation of FAL)
14 Where advertising does not target a particular group, it is judged by the effect it would have on a
15 reasonable consumer. *Stevenson v. Allstate Ins. Co.*, No. 15-cv-04788-YGR, 2016 U.S. Dist.
16 LEXIS 34923, *12 (N.D. Cal. March 17, 2016). A literally true statement may be actionable under
17 the FAL if “couched in such a manner that it is likely to mislead or deceive the consumer, such
18 as by failure to disclose other relevant information.” *Id.*, quoting *Day v. AT&T Corp.*, 63 Cal.
19 App. 4th 325, 332-33 (1998). If there is any doubt whether Defendants’ materials were deceptive
20 and misleading to a reasonable purchaser of health coverage, that is answered by the Insurance
21 Commissioner, who found that Alera and Trinity’s “advertisements, solicitations, and other
22 materials are deceptive and have the capacity and tendency to mislead or deceive consumers to
23 believe they are purchasing traditional health coverage...” Dkt. 17-7, ¶ 24. Although the
24 Insurance Commissioner’s findings applied only to the Trinity plans Alera was selling at the time
25 of the Commissioner’s action, there is no material difference between the Unity and Trinity plans.

26 A plaintiff meets the Rule 9(b) standard by alleging “the basic premise of what is false or
misleading about a statement, and why it is false.” *Moore v. Mars Petcare US, Inc.*, 966 F.3d

1 1007, 1019 (2020) (internal quote omitted). In that case, the plaintiffs described how the
2 ingredients of prescription pet food they purchased was similar to the ingredients of non-
3 prescription pet food, and that the non-overlapping ingredients were not drugs and did not justify
4 defendants' products to be sold by prescription at a higher price. These allegations were sufficient
5 to meet the Rule 9(b) particularity requirements. *Id.* The plaintiffs alleged that as a result of a
6 false and fraudulent requirement to obtain a prescription to purchase pet food, they paid more for
7 defendants' pet food than they would have paid in the absence of the requirement, or would never
8 have purchased the defendants' pet food. The court held that this allegation was sufficient to
9 survive a motion to dismiss. The fact that plaintiffs were directed to the pet food by a veterinarian
10 rather than discovering the pet food on their own did not negate actual reliance. *Id.* at 1020.

11 Like the plaintiffs in *Moore*, the Duncans explain in detail how Defendants' healthcare
12 plans are designed and marketed to look and feel like insurance, and deceived purchasers into
13 believing that health care expenses would be paid, when in reality, the majority of the payments
14 made went to for-profit Alera rather than to cover healthcare claims, and that members are left
15 effectively uninsured because Defendants claim to have no obligation to pay claims. Dkt. 19,
16 ¶¶ 40, 48, 51-59, 86. They purchased their AleraCare Gold plan based in part on representations
17 of an agent Defendants authorized to sell their healthcare plans that the plans were like traditional
18 insurance. *Id.*, ¶ 69. *See Loehr v. Great Republic Ins. Co.*, 226 Cal. App. 3d 727, 734 (1990)
19 (insurance company liable for the acts and omissions of independent insurance agent). They
20 authorized the transfer of the plan to Trinity based on representations that their claims would
21 "continue to track." *Id.*, ¶ 72. They allege that they suffered economic injury by paying for
22 unregulated insurance products that are illegal, that provided less coverage than permitted by law,
23 and that were overpriced. *Id.*, ¶ 89. They have alleged sufficient facts to state a plausible claim
24 for violations of the UCL and FAL against Defendants.¹²

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¹² If the Court finds the pleadings deficient, Plaintiffs request leave to amend.

1 **E. Plaintiffs Have Stated a Claim for Breach of Fiduciary Duty Against Trinity.**

2 Plaintiffs allege Trinity has a fiduciary duty to them. Dkt. 19, ¶¶ 96-101. They allege that
3 Trinity delegated sole control over the members’ funds, and all coverage decisions to Alera, in
4 breach of their fiduciary duty. *Id.*, ¶ 102. Coverage decisions over which Trinity has fiduciary
5 duty include those decisions on “historic claims” that they represented “would track” if Plaintiffs
6 agreed to transfer their plan to Trinity. They have sufficiently alleged damage as a result of
7 Trinity’s breach of fiduciary duty.

8 **F. Plaintiffs State a Claim for Illegal Contract or Alternatively, Breach of Contract.**

9 The Duncans have plausibly alleged that the health plans sold by Unity and Trinity, as
10 marketed and administered by Alera, are “insurance” under California law. *See* Dkt. 19, ¶¶ 51-
11 60. If Defendants’ plans are insurance, then the products they sold to the Duncans and others
12 were unauthorized since they were never approved by the California Department of Insurance (or
13 any other regulator). *Id.*, ¶ 61. They are also illegal because the policies do not comply with the
14 mandatory minimum consumer protections required under California law. *Id.*, ¶¶ 62-66. The
15 health plans were, as alleged by the Duncans, illegal, unauthorized, insurance contracts.¹³ *Id.*

16 Under California law, a contract must be construed as to give it a legal effect if possible
17 under the circumstances. *Kashani v. Tsann Kuen China Enter. Co.*, 118 Cal. App. 4th 531, 548
18 (2004), *citing to* Cal. Civ. Code § 1643 (“A contract must receive such an interpretation as will
19 make it lawful, operative, definite, reasonable and capable of being carried into effect, if it can be
20 done without violating the intention of the parties”). “As a general rule, if a contract can be
21 performed legally, a court will presume that the parties intended a lawful mode of performance.”
22 *Id.* at 549. That is because in “securing justice” between the contracting parties, the courts must
23 consider “a higher interest – that of the public whose welfare demands that certain transactions
24 be discouraged.” *Id.* at 542. An illegal contract may be enforced when “the party seeking its

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¹³ To the extent the Court concludes that there is no common law claim in California for illegal contract, it should permit Plaintiffs to amend the Complaint to plead “breach of contract.” As described above, these claims are largely one and the same.

1 enforcement is less morally blameworthy than the party against whom the contract is being
2 asserted, and there is no overriding public interest to be served by voiding the agreement.”
3 *McIntosh v. Mills*, 121 Cal. App. 4th 333, 347 (2004).

4 This is also true with insurance contracts. “[T]he fact that an insurance contract is illegal
5 because it provides for an unlawful rebate or constitutes an unlawful discrimination in rates is not
6 held to void the insurance contract.” *Homestead Supplies, Inc. v. Exec. Life Ins. Co.*, 81 Cal. App.
7 3d 978, 989 (1978). Instead, the insurance contract is reformed and enforced as if the non-
8 conforming statutory provisions were in place. *See id.* (“In some cases, on the other hand, ...
9 effective deterrence is best realized by enforcing the plaintiff’s claim rather than leaving the
10 defendant in possession of the benefit”). Based upon discovery and after liability is determined,
11 the Court will be asked to determine the proper remedy – whether reformation or rescission. *Id.*
12 at 990-91.

13 Reformation or rescission of the Defendants’ contracts are proper remedies under
14 California law. As a matter of law, Defendants’ insurance contracts include not only the literal
15 terms of the policy but also the mandatory minimum requirements for health insurance in
16 California. *Samson v. Transamerica Ins. Co.*, 30 Cal. 3d 220, 231 (1981) (“Any provisions of
17 such a policy which are in conflict with the pertinent statutes are nullified and superseded to that
18 extent, particularly where the policy itself, expressly so provides.”). “The interpretation of the
19 insurance policy must be by reference both to its express terms, *and* to the relevant statutory and
20 [regulatory] provisions.” *Transamerica Ins. Co. v. Tab Transp.*, 12 Cal. 4th 389, 399 (1995)
21 (emphasis added).¹⁴ Thus, if the Defendants’ health plans are insurance, then they must be
22 interpreted and applied so as to be consistent with all relevant statutory and regulatory
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¹⁴ Defendants ignore this caselaw entirely when arguing that the Court may not apply insurance code requirements that do not appear in the “face of the enrollment form and member guide.” *See* Dkt. 38, p. 18.

1 provisions.¹⁵ Under the reformed insurance contracts, Plaintiffs are entitled to coverage of all
2 unpaid benefits, consistent with the mandatory minimums under California law.

3 Alternatively, and at the very least, Plaintiffs are entitled to rescission of the contracts and
4 return of the premiums that they paid. *See S. Ins. Co. v. Workers' Comp. Appeals Bd.*, 11 Cal.
5 App. 5th 961, 971 (2017) (rescission is an available remedy for misrepresentation in workers'
6 compensation insurance policies). Nonetheless, Defendants claim that there is no cause of action
7 in California for the claim of "illegal contract" because it is essentially a claim for rescission. Dkt.
8 No. 38, p. 25, Dkt. 37, p. 13. Defendants mischaracterize Plaintiffs' claim and are wrong on the
9 law.

10 California law recognizes a cause of action brought by an insured against the company
11 that sold the insured an illegal policy. Specifically, the California Supreme Court has concluded
12 that unauthorized health plans sold illegally in the state "may be enforced by the insured." *People*
13 *v. United Nat'l Life Ins. Co.*, 427 P.2d 199, 214 (1967); *see also Royal Globe Ins. Co. v. Superior*
14 *Court*, 592 P.2d 329, 333 (1979) ("[P]rivate litigants may rely upon the prescriptions set forth in
15 the [Insurance] act as a basis for the imposition of civil liability upon an insurer").¹⁶ *See e.g.*,
16 *Nathanson v. Hertz Corp.*, 183 Cal. App. 3d 78, 80 (1986) (Plaintiff properly alleged that a
17 contract with rental care company was illegal insurance). Such civil claims may proceed, despite
18 any administrative actions by the Department of Insurance for violations of the California
19 Insurance Code. *See Cal. Ins. Code* § 790.09; *Shernoff v. Superior Court*, 44 Cal. App. 3d 406,

21 ¹⁵ Defendants' cases are unavailing as none involve allegations that defendants operated unauthorized insurance
22 plans. *See* Dkt. 38, p. 19, *citing to Bailard v. Marden*, 36 Cal. 2d 703, 709, 227 P.2d 10, 13 (1951) (real property
23 dispute); *Spiegler v. Home Dept U.S.A., Inc.*, 2008 U.S. Dist. LEXIS 120397, at *46 (C.D. Cal. June 30, 2008)
24 (property dispute); Dkt. 37, p. 13, *citing to Agam v. Gavra*, 236 Cal. App. 4th 91, 112, 186 Cal. Rptr. 3d 295, 312
(2015) (partnership dispute); *Dijamco v. Wells Fargo Bank, N.A.*, 2012 Cal. Super. LEXIS 9369, *2 (Cal. Super. Ct.
December 2012) (banking dispute); *Microsoft Corp. v. Hon Hai Precision Indus. Co.*, 2020 U.S. Dist. LEXIS 31402,
at *15-16 (N.D. Cal. Feb. 20, 2020) (dispute over patent license agreement).

25 ¹⁶ *Royal Globe's* holding was limited to only claims of illegal insurance or violations of the Insurance code
26 between an insured and an insurer, excluding litigation involving third parties. *See Royal Surplus Lines Ins. Co. v.*
Ranger Ins. Co., 100 Cal. App. 4th 193, 198, 122 Cal. Rptr. 2d 459, 462 (2002) describing the disapproval of *Royal*
Globe in *Moradi-Shalal v. Fireman's Fund Ins. Companies*, (1988) 46 Cal. 3d 287, 292, [250 Cal. Rptr. 116, 758
P.2d 58] and 304-305, and its progeny. This case, however, only involves claims by insureds directly against the
insurer (Trinity and Unity) and their agent, Alieria.

1 410, 118 Cal. Rptr. 680, 682 (1975); *Homestead Supplies, Inc.*, 81 Cal. App. 3d at 992
2 (Recognizing the right of enrollees to pursue a claim of illegal insurance: “When the Legislature
3 enacts a statute forbidding certain conduct for the purpose of protecting one class of persons from
4 the activities of another, a member of the protected class may maintain an action” even though
5 they entered into the illegal contract). Ultimately, Defendants’ arguments about the proper
6 remedy to redress their marketing, sale and administration of illegal health insurance (*i.e.*, whether
7 reformation and reprocessing of benefits or rescission) are premature. Once Plaintiffs have
8 demonstrated Defendants’ liability on the merits of their illegal contract claim, then the Court
9 may determine the proper measure of damages to be applied.

10 IV. CONCLUSION

11 The Duncans are the victims of a scam perpetrated by Defendants – a scheme to market
12 sham health insurance products to consumers in the State of California. They, and others just like
13 them, are entitled to their day in court to remedy the harm they caused, and they should not be
14 subject to an arbitration clause that is illegal, undisclosed and unconscionable. Defendants’
15 motion should be denied.

16 Respectfully submitted this 15th day of October, 2020.

17 s/ Eleanor Hamburger

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6 Email: ehamburger@sylaw.com
7 *Attorneys for Plaintiffs*

8 UNITED STATES DISTRICT COURT
9 EASTERN DISTRICT OF CALIFORNIA

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

13 Plaintiffs,

14 v.

15 THE ALIERA COMPANIES, INC., f/k/a ALIERA
HEALTHCARE, INC., a Delaware corporation;
16 TRINITY HEALTHSHARE, INC., a Delaware
corporation; and ONESHARE HEALTH, LLC,
17 formerly known as UNITY HEALTHSHARE, LLC
and as KINGDOM HEALTHSHARE MINISTRIES,
18 LLC, a Virginia limited liability corporation,

19 Defendants.

Case No.: 2:20-cv-867-TLN-KJN

[Assigned to the Hon. Troy L. Nunley]

**DECLARATION OF ELEANOR
HAMBURGER IN SUPPORT OF
PLAINTIFFS' CONSOLIDATED
OPPOSITION TO MOTIONS TO
COMPEL OR DISMISS**

Hearing

Date: October 29, 2020

Time: 2:00 p.m.

Ctrm: 2

[Action Filed: April 28, 2020]

20 I, Eleanor Hamburger, declare under penalty of perjury and in accordance with the laws
21 of the United States of America that:

22 1. I am a partner at Sirianni Youtz Spoonemore Hamburger PLLC and am one of
23 Plaintiffs' Counsel and Proposed Class Counsel in this action.

24 2. Attached as *Exhibit 1* is a true copy of the Affidavit of Chase Moses dated
25 December 23, 2018, and filed in Opposition to Defendants' Motion for Interlocutory Relief in the
26 case, *Aliera Healthcare, Inc. v. Anabaptist Healthshare, et al.*, case No. 2018-CV-308981, in the

1 Superior Court of Fulton County, Georgia. We obtained that Affidavit from the Fulton County,
2 Georgia Superior Court.

3 DATED: October 15, 2020, at Seattle, Washington.

4
5 s/ Eleanor Hamburger

Eleanor Hamburger, *Pro Hac Vice*
6 SIRIANNI YOUTZ SPOONEMORE HAMBURGER PLLC
7 3101 Western Avenue, Suite 350
Seattle, WA 98121
8 Tel. (206) 223-0303
Email: ehamburger@sylaw.com
9 Attorneys for Plaintiffs

Exhibit 1

IN THE SUPERIOR COURT OF FULTON COUNTY
STATE OF GEORGIA

ALIERA HEALTHCARE, INC.,)
)
 Plaintiff,)

v.)

ANABAPTIST HEALTHSHARE, n/k/a)
 KINGDOM HEALTHSHARE)
 INTERNATIONAL, UNITY HEALTHSHARE,)
 LLC, n/k/a KINGDOM HEALTHSHARE)
 MINISTRIES, LLC, ALEXANDER CARDONA,)
 TYLER HOCHSTETLER, VICTOR)
 MENSAVAGE, and JEREMY HULKENBERG,)

CIVIL ACTION
FILE NO. 2018-CV-308981

Defendants.

AFFIDAVIT OF CHASE MOSES

Personally appeared before the undersigned officer, duly authorized to administer oaths, Chase Moses, who, first being duly sworn, deposes and states as follows:

1. My name is Chase Moses. I am over the age of 18 years, and I am competent to testify regarding the matters contained herein. I am personally familiar with and have knowledge of the matters set out in this Affidavit.

2. I am the Executive Vice President of Alieria Healthcare, Inc. ("Alieria"). As Executive Vice President, I am responsible for and my job duties include creating and managing Alieria's healthcare offerings, as well as communicating with and serving its members.

3. I was present at the July 16, 2018 meeting between representatives of Alieria and Unity Healthshare, LLC ("Unity").

4. After the meeting concluded and I was walking out, I was handed a notice of Board meeting of Anabaptist Healthshare (“AHS”), of which I was a Board member. Thus, I had approximately 30 seconds of notice before the meeting started.

5. At the meeting, I was promptly kicked off the Board. I did, however, hear Tyler Hochstetler thanking Alex Cardona (Alieria’s former VP of National Sales, who left Alieria for Unity) for bringing to Unity the information that he learned at Alieria and expressing appreciation for Unity being able to use Alex’s extensive knowledge of Alieria’s business for Unity’s benefit.

6. Alex had vast amounts of confidential and proprietary information of Alieria, and he also had an NDA with Alieria. Alieria takes steps to maintain the confidentiality of its information, including requiring its employees to sign NDAs as a condition of employment.

7. After an unsuccessful mediation between the parties, AHS and Unity sent a notice of termination letter, dated August 10, 2018, of the parties’ Agreement.

8. After receiving this letter, Alieria immediately took steps to cease all sales of Alieria’s alternative healthcare programs containing a Unity HCSM component.

9. Alieria did, however, continue to administer Unity plans currently in existence, in accordance with the terms of the parties’ Agreement.

10. Plans with an HCSM component include a Membership Shared Responsibility Amount (“MSRA”) that functions similarly to a traditional deductible. Each individual member must meet his or her MSRA each calendar year before the HCSM will provide coverage.

11. Alieria could not just “terminate” its members’ plans with a Unity component two-thirds of the way through the year. In addition to the problem of the MSRAs, individual members would face additional problems obtaining coverage based on pre-existing conditions and other potential roadblocks. They would have to meet and pay a new deductible, even though their

deductible had already been met and paid under a plan with a Unity component. It would have been a violation of Alier's fiduciary duties to members to unilaterally terminate every plan with a Unity component, thereby leaving many of them uncovered and unable to obtain coverage for medical expenses for the remainder of the year.

12. With the August 10, 2018 notice of termination letter from AHS/Unity, Alier was forced to immediately obtain a replacement HCSM, which it did with Trinity Healthcare ("Trinity").

13. Trinity is a registered 501(c)(3) healthcare sharing ministry that aligns with Alier's company mission.

14. Alier spent several months building additional provider network options that create unique one-of-a-kind offerings for Alier members. These network options would service Alier members with a Trinity HCSM component in 2019. Alier has not made any efforts to build a similar network for Unity in 2019 because it no longer offers, and cannot offer, plans containing a Unity component.

15. Alier has entered into contracts with brokers, agents, and other third parties to broker and sell Alier plans with a Trinity component. This process took several months and countless hours to complete and cannot be reversed in a few days. It would take months of hard work and expense.

16. As the new Trinity HCSM program component has no relation to its predecessor (the Unity HCSM component), Alier had to build new system builds, engage in account set up, and procedures had to be created for the new vendor component that had no effect on its predecessor (Unity).

17. I was responsible for creating a new operational procedure. I created a separate claims account so that there would be two claims accounts functioning simultaneously, but from an accounting standpoint completely separate.

18. Previous Alera membership would function out of the previous membership claims pool that neither belongs to Alera nor Unity, as it is members' money. The members' claim contributions would continue to flow into this account as they always had, to pay for the group sharing of claims funds that is designated member funds. A separate member claims fund was created, however, for member payments post-termination. All new members created on and after this date would have their claims contributions facilitate to this account. New products were immediately built in the claims system to facilitate these members, the new vendor (Trinity), and appropriately direct member contributions to the appropriate areas.

19. I had new marketing material, consisting of membership guides, letters, membership cards, notifications, fulfillment materials, ad campaigns, logos, website landing pages, and other miscellaneous material created.

20. With the ability to onboard new membership in a completely separate vendor and process complete, I began creating the procedure to protect the past members to have uninterrupted healthcare services beginning 1/1/2019, as outlined in the post-termination clause of the Agreement, once AHS/Unity sent the notice of termination dated 8/10/2018.

21. American consumers who do not have employer-provided coverage sign up for coverage during what is known as the open enrollment period. For plan year 2019, the open enrollment period lasted from November 1st to December 15th, 2018.

22. The AHS/Unity notice of termination stated actions to be taken to terminate all members containing a Unity HCSM component of an Alera alternative healthcare program.

23. Year-end renewal would commence on 1/1/2019, as that is the first day of the new year and the first day of the new year for all health plans. Therefore, I began creating the process for the voluntary membership transition into the HCSM component with Trinity to take effect 1/1/2019, as the members' HCSM portion with Unity would be terminated effective 12/31/2018, and a new vendor would need to be in place to take care of the members so there would be no interruption in their healthcare offering.

24. The process I created for this conversion was based on a completely voluntary system where Alieria members decided if they wanted to continue with Alieria programs containing a new HCSM component on 1/1/2019 so they would not have interrupted healthcare services. The process was an opt-out process created so that members were notified of the change, and if they decided not to proceed with Trinity, they would click on a link in the email they received or call a toll-free number, where they could also ask any questions they may have had.

25. Internal staff was trained regarding properly handling members' expressed choices on 10/26/2018. The exact process is as follows: 1. A member letter was sent to all Alieria members containing a Unity HCSM component, notifying them of an HCSM component replacement effective 1/1/2019 so they would not have interrupted healthcare services; 2. The letter was sent out through a campaign monitor system so the appropriate KPI's (key performance indicator) could be tracked; 3. If the member decided to opt out and clicked the opt-out link, it would take him/her to a form fill landing page where their membership details would be collected. The information collected was their membership ID, first name, last name, and reason for cancellation. All of this information was needed to finalize the cancellation process; 4. This form fill when submitted automatically populated the email membershipoptout@alierahealthcare.com. The notification in this inbox prompted the workflow for our cancellation department known as

Member Relations to finalize the cancellation process with Alieria members that had voluntarily decided to opt-out of the upcoming renewal plan offering. There were approximately 800 members that decided to immediately cancel or cancel upon renewal 12/31/2018. The loss of these 800 members consists of roughly \$324,000 of premium lost per month and roughly \$3,888,000 for the upcoming year. The remaining Alieria members did not opt out and chose to enter into coverage through Trinity.

26. Thus, the vast majority of Alieria members have already made the decision over a month ago to continue with an Alieria plan containing a Trinity HCSM component.

27. Alieria informed its members, accurately, that the Trinity HCSM component would offer them the same benefits they had previously received from the Unity HCSM component. Alieria members will receive the same benefits from Trinity and pay the same amount.

28. In addition to sending Alieria members the choice of coverage through Trinity, I was also responsible for sending Alieria members new materials, such as new cards, membership guides, and instructions for the membership plan year renewal for 1/1/2019. This has to be done in a very structured, timely format to ensure that Alieria's membership wishing to continue with coverage would receive adequate materials for their renewal on 1/1/2019. All of the new materials were created in October of 2018, while the process for the transition was being finalized.

29. On 11/1/2018, updated custom cards and materials were created. Some of the customizations include unique printing for each member based on plan type, name, MSRA, eligible services, and address. This process takes approximately one (1) month to complete, beginning 11/1/2018, and to be completed and sent out on 12/1/2018. This had to be sent on 12/1/2018 to meet with bulk shipping time frames to arrive on time with the holiday postal hours

and increased volume of mass mailings that occur in December to arrive for a January 1, 2019 renewal date.

30. The cost associated with this mass reprint consisted of approximately \$150,000 in additional costs. All printing was completed on 11/28/2018, and Alera members who decided to opt out of the transition were sent to the fulfillment center to be removed from the preprinted materials to be sent out on 12/1/2018. The final membership kits for renewal were sent out on the original planned date of 12/1/2018, in order for them to arrive on or before the membership renewal date of 1/1/2019, so members would have proper renewals, uninterrupted healthcare services and could utilize the plan the day of renewal on January 1, 2019.

31. The most intricate part of the transition that has been worked on for months is the tracking of the accumulators in the claims system (amount of money members spend out of pocket on their respective health plans, often referred to as a deductible in insurance terms). The accumulators have to be transferred over to the new plan builds in the claims system for Alera members that elected to renew with the new HCSM component. Testing has been done over the course of months to ensure the numbers matchup between old claims system builds and new claims system builds. This transition in the system is what will lead to a seamless transference of health expenses so there is not a gap in health services for the member beginning day one.

32. This process is now complete and had large overhead expenses, distracting from the day-to-day operational duties performed by Alera full-time employees.

33. The final step in the transition procedure is the members' claims contributions: Contributions neither belonging to Alera nor Unity follow the member upon the transition/renewal. Already set up in the automated claims system, members' claim contributions (members' money) for the past members will roll into the new members' claims funds for any

claim received on their behalf after 12/31/2018. This is the same account set up for membership post Unity contract termination on 8/10/2018.

34. This account is not Alier's nor Unity's nor Trinity's; it is the members' claims account for sharing payments to providers. It will now house all membership claims funds (members' money) post membership transition, not just new member claims funds. Members with a Unity HCSM component are set to be automatically terminated in Alier's administration system on 12/31/2018, and Alier members' voluntary decision to renew their plan containing a Trinity HCSM component will take effect on 1/1/2019.

35. This follows the wishes of AHS/Unity's notice of termination letter, which stated to terminate all members who have a Unity HCSM component in an Alier healthcare alternative program and follows the provisions outlined in the parties' Agreement.

36. Additionally, providers that have signed up with Trinity will base the amount of co-pays that the members pay, the way that they bill members for services, and the services they are willing to provide, on Alier members' status as Trinity HCSM participants.

37. There is no "switch" Alier can flip in the week before the New Year that will reverse members' decisions to continue their Alier plans with Trinity providing the HCSM service. The actions set out above involved extensive time, efforts, and expense and would take months to undo.

38. Furthermore, it would be a violation of Alier members' expressed choice to refuse to honor their decision to proceed with Trinity.

39. Alier cannot renegotiate contracts with unique provider networks in this time frame. It cannot cancel thousands of member contracts and start back administering the Unity HCSM in this time frame. It cannot retrain hundreds of new employees who are now prepared to

administer Trinity's services to manage new Unity claims. And it cannot replace the Trinity infrastructure it has spent months building with a non-existent Unity infrastructure.

40. Alieria would suffer irreparable harm if it were required to continue to administer the Unity HCSM component to its members because it would not be able to do so and, therefore, could not comply with such an order.

41. Alieria would suffer irreparable harm if it were forced to provide Alieria membership information to Unity, for Unity to appropriate Alieria's members. Alieria's members are one of the most valuable assets (or the most valuable asset) of Alieria's. To strip Alieria of its valuable members would destroy Alieria's business and cause irreparable harm.

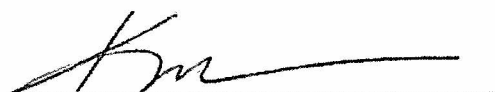
42. Alieria is not retaining operational control of AHS/Unity's Mennonite members in rural Virginia. Defendants will retain those members and may continue to operate their HCSM program for the benefit of those members as a non-profit organization.

43. In late August of 2018, Alieria was informed that Unity was contacting Alieria's members and encouraging them to cancel their membership with Alieria, and switch to Unity.

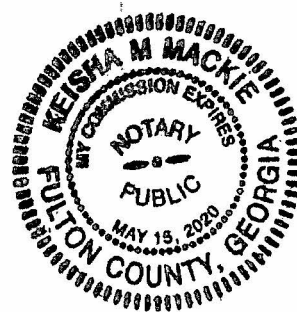
FURTHER AFFIANT SAYETH NAUGHT.


Chase Moses

Sworn to and subscribed before me
this 23 day of December, 2018.


Notary Public

My Commission Expires: 5-15-20



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UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF CALIFORNIA

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

Plaintiffs,

v.

THE ALIERA COMPANIES, INC., f/k/a
ALIERA HEALTHCARE, INC., a Delaware
corporation; TRINITY HEALTHSHARE, INC.,
a Delaware corporation; and ONESHARE
HEALTH, LLC, formerly known as UNITY
HEALTHSHARE, LLC and as KINGDOM
HEALTHSHARE MINISTRIES, LLC, a Virginia
limited liability corporation,

Defendants.

Case No.: 2:20-cv-867-TLN-KJN

**DECLARATION OF CORLYN
DUNCAN**

I, Corlyn Duncan, declare under penalty of perjury and in accordance with the
laws of the United States and the State of California that:

1. I am over the age of 18 and competent to testify to all matters stated herein.

All statements are made upon my personal knowledge.

2. I am one of the named plaintiffs in this litigation.

1 3. I was never asked to sign anything agreeing to arbitrate at the time I
2 enrolled. I was never asked to sign anything that informed me that there was an
3 arbitration agreement included in our AlieriaCare Gold plan.

4 4. My husband, Bruce, and I signed up for our AlieriaCare Gold plan at our
5 insurance agent's office. His name is Marc Protenic. His office is located at 1200 Contra
6 Costa Boulevard, Suite A, Concord, California 94523.

7 5. In March 2018 I needed surgery. My healthcare provider contacted Alieria
8 for preauthorization. Alieria approved both the surgery and the facility where it was to
9 be performed.

10 6. By July 2018 my health care providers advised me that Alieria had not paid
11 my surgery-related bills and that I had an outstanding balance. My providers informed
12 me they received notice from Alieria that it would not pay for the surgery-related bills
13 because they were related to a pre-existing condition.

14 7. I received a letter dated May 22, 2019 from Alieria indicating that the \$5,229
15 anesthesia charge in connection with my surgery was denied. Alieria indicated it was
16 denied because my surgery was related to a pre-existing condition. The \$5,229 bill went
17 to collections and I ultimately paid it. The surgery bill and facility bill were never paid.

18 8. My provider sent Alieria a letter appealing its denial. My husband, Bruce,
19 and I contacted Alieria at (844) 834-3456 at least 30 times beginning in December 2018 to
20 find out why Alieria had not paid for my surgery when it was preauthorized. Bruce and
21 I were given different reasons each time we called. We were told Alieria would research
22 the denial and get back to us, we were told Alieria was still processing the charges and
23 we were told Alieria would elevate our appeal to management. On at least 20 occasions
24 Bruce and I were left on hold for over an hour. We asked to speak with a supervisor at
25 least 20 times but were never allowed to speak with anyone in management. We also
26

1 asked for a phone number to call in order to appeal the denial of my surgery bill. We
2 were just given the same (844) 834-3456 number we had been calling.

3 9. Mr. Protenic also tried to investigate Alieria's denial and our appeal. He
4 was unsuccessful.

5 10. At no time during any of our calls to Alieria were we advised to follow any
6 dispute resolution procedure in our Member Guide. We were never advised to arbitrate
7 any dispute. The explanations of benefits we received are attached as *Exhibit 1*. They
8 did not advise us of any right to appeal Alieria's decision or any procedure by which we
9 could appeal.

10 11. On May 3, 2019 we received the email attached as *Exhibit 2*. We
11 understood that our pending claims would continue to be processed through Alieria
12 under the Trinity name. Mr. Protenic advised us that our AlieriaCare Gold plan was
13 switching to a Trinity plan. We did not believe it was a viable option to terminate our
14 plan for three reasons:

15 a. I had a pending claim. Because I had a large outstanding hospital
16 bill that I believed Alieria was in the process of resolving, I did not want to terminate my
17 plan.

18 b. At the time Mr. Protenic told us we would need to sign online with
19 Trinity in May 2019 we could not have obtained insurance on the market because it was
20 not during the open enrollment period. When our AlieriaCare Gold plan switched to a
21 Trinity plan, our credit card continued to be charged. The payment appeared to be going
22 directly to Alieria.

23 c. We would lose the money we spent towards meeting our deductible
24 if we terminated our plan.

25 12. All of our contact was with Alieria. We called it at (844) 834-3456. We were
26 told that our plan stayed the same even after it switched to Trinity. We did not know

1 there was a difference between the plans. There was no difference in our communication
2 with Alieria before or after the plan was transferred to Trinity.

3 13. At no time were we ever asked to share our monthly contributions with
4 other members. At no time were we ever informed that other members would be asked
5 to share their contributions in order to pay our medical bills. Our understanding was
6 that Alieria would decide what bills would be paid and then would make they payment.

7 DATED: October 8, 2020, at Benica, California.

8 
9 _____
CORLYN DUNCAN

Exhibit 1

Alera HealthCare
5901 PEACHTREE DUNWOODY RD
STE B200
ATLANTA GA 30328-7149



AR[-]

Explanation of Benefits

THIS IS NOT A BILL

Forwarding Service Requested

|||||
*****MIXED AADC 945
PB-DSM-407-ENV 778
CORLYN DUNCAN
BENICIA CA 94510

Your Member Information

Name: CORLYN DUNCAN
EOB Date: 04/26/2019
ID No: ██████████ 5982
Group ID: AHUNC
Group Name: ALIERA HEALTHCARE

Contact Us

Phone: 1-844-834-3456
Web Address: www.alierahealthcare.com
Hours: 9AM - 6PM EST

The information below is a summary of your health care claims, including any MSRA or non-covered amounts that you may owe the provider(s). Please review the detailed claim breakdown carefully. Some claims may require more information from you or your provider before they can be processed. You also should compare this summary to any health care bills you may receive.

Total Charge	\$115,193.81	This is the amount billed by the provider for health care services.
Reduction Amount	\$31,217.50	This is the amount saved using available pricing programs and network arrangements. These dollars are not your responsibility.
Plan Pay Amount	\$4,663.71	This is the amount the Plan paid for billed services.
Member Shared Responsibility	\$79,312.60	This is the amount you may be billed by the provider after reductions or discounts, and after Plan benefits have been applied.

Your next statement, if any claims are processed, may arrive no later than the week of: May 19, 2019

Patient: CORLYN DUNCAN

Claim #: AHL540330

Dates of Service	Service Description	Rmk Code*	Total Charge	Reduction Amount	Amount Excluded	Consult Fee	MSRA	Co-Expense	Paid At %	Plan Pay Amount		
03/16-03/17/2018	Professional Service	13, 2712, P1450	\$8,432.00	\$6,346.93	\$0.00	\$0.00	\$2,000.00	\$85.07		\$0.00		
03/16-03/17/2018	Professional Service	13, 2712, P1450	\$8,588.00	\$8,216.17	\$0.00	\$0.00	\$0.00	\$371.83		\$0.00		
03/16-03/17/2018	Professional Service	2711, P1450, 13	\$86,524.40	\$13,167.24	\$69,289.95	\$0.00	\$0.00	\$746.17	86%	\$3,321.04		
03/16-03/17/2018	Professional Service	13, P1450, 2712	\$548.00	\$378.53	\$0.00	\$0.00	\$0.00	\$23.73	86%	\$145.74		
03/16-03/17/2018	Professional Service	13, P1450, 2712	\$4,070.66	\$2,811.78	\$0.00	\$0.00	\$0.00	\$176.24	86%	\$1,082.64		
03/16-03/17/2018	Professional Service	13, 2712, P1450	\$429.75	\$296.85	\$0.00	\$0.00	\$0.00	\$18.61	86%	\$114.29		
Member Shared Responsibility:			\$72,711.60	Totals:		\$108,592.81	\$31,217.50	\$69,289.95	\$0.00	\$2,000.00	\$1,421.65	\$4,663.71

The Reduction Amount reflects a previously paid payment of \$4069.36

Patient: CORLYN DUNCAN

Claim #: AHL586909

Dates of Service	Service Description	Rmk Code*	Total Charge	Reduction Amount	Amount Excluded	Consult Fee	MSRA	Co-Expense	Paid At %	Plan Pay Amount	
03/16-03/16/2018	Professional Service	2460, 2487	\$6,601.00	\$0.00	\$6,601.00	\$0.00	\$0.00	\$0.00		\$0.00	
Member Shared Responsibility:			\$6,601.00	Totals:		\$6,601.00	\$0.00	\$6,601.00	\$0.00	\$0.00	\$0.00

Code	Description
13	TO MEMBER AND PROVIDER: This statement represents an adjustment of a previously processed charge.
2460	TO MEMBER AND PROVIDER: Your Plan does not provide shared amounts for this service, supply, or equipment.
2487	TO PROVIDER: This claim was received beyond the Plan's timely filing provision. If this claim was filed within the Plan's timely filing requirement or it was not reasonably possible to submit the claim any earlier, supporting documentation may be submitted for review.
2711	TO MEMBER AND PROVIDER: Your shared amount has been increased due to a pre-existing condition.
2712	TO MEMBER AND PROVIDER: The plan year maximum has been met for this pre-existing condition.

Aliera Healthcare
5901 PEACHTREE DUNWOODY RD
STE B200
ATLANTA GA 30328-7149

UNIFY HEALTHSHARE
Explanation of Benefits



Forwarding Service Requested

THIS IS NOT A BILL

*****ALL FOR AADC 945
PB-DSM-407-ENV 16772 51
CORLYN DUNCAN
BENICIA CA 94510-

1/23/19 - TALKed with Jeffrey @ Aliera Healthcare - Claims dept. taking it to escalations claims to evaluate. Paying it - Jay!

Your Member Information

Name: CORLYN DUNCAN
EOB Date: 12/21/2018
ID No: 5982
Group ID: AHUNC
Group Name: ALIERA HEALTHCARE

Contact Us

Phone: 1-844-834-3456
Web Address: www.alierahealthcare.com
Hours: 9AM - 6PM EST

Recent Claim Activity

The information below is a summary of your health care claims, including any MSRA or non-covered amounts that you may owe the provider(s). Please review the detailed claim breakdown carefully. Some claims may require more information from you or your provider before they can be processed. You also should compare this summary to any health care bills you may receive.

Total Charge	\$113,821.81	This is the amount billed by the provider for health care services.
Reduction Amount	\$83,899.43	This is the amount saved using available pricing programs and network arrangements. These dollars are not your responsibility.
Plan Pay Amount	\$8,277.36	This is the amount the Plan paid for billed services.
Member Shared Responsibility	\$21,645.02	This is the amount you may be billed by the provider after reductions or discounts, and after Plan benefits have been applied.

Your next statement, if any claims are processed, may arrive no later than the week of: January 13, 2019

Patient: CORLYN DUNCAN
Claim #: AHL329878

Provider: MEDICAL ANESTHESIA CONSULTANTS MEDICAL GROUP INC
IDOHMEIER, KEELEY

Dates of Service	Service Description	Rmk Code*	Total Charge	Reduction Amount	Amount Excluded	Consult Fee	MSRA	Co-Expense	Paid At %	Plan Pay Amount
03/16-03/16/2018	Professional Service	2712	\$5,229.00	\$0.00	\$5,229.00	\$0.00	\$0.00	\$0.00		\$0.00
Member Shared Responsibility:			\$5,229.00							
Totals:			\$5,229.00	\$0.00	\$5,229.00	\$0.00	\$0.00	\$0.00		\$0.00

Patient: CORLYN DUNCAN
Claim #: AHL329879

Provider: JOHN MUIR MEDICAL CENTER

Dates of Service	Service Description	Rmk Code*	Total Charge	Reduction Amount	Amount Excluded	Consult Fee	MSRA	Co-Expense	Paid At %	Plan Pay Amount
03/16-03/17/2018	Professional Service	2711, 2712, 13	\$8,432.00	\$7,350.32	\$0.00	\$0.00	\$0.00	\$216.34	80%	\$865.34
03/16-03/17/2018	Professional Service	P1450, 13, 2711	\$8,588.00	\$7,486.31	\$0.00	\$0.00	\$1,101.60	\$0.02	60%	\$0.07
03/16-03/17/2018	Professional Service	2711, 2712, P1450	\$87,072.40	\$65,139.71	\$12,346.69	\$0.00	\$898.40	\$1,737.50	80%	\$6,950.10
03/16-03/17/2018	Professional Service	P1450, 13, 2712	\$4,070.66	\$3,548.47	\$0.00	\$0.00	\$0.00	\$104.44	80%	\$417.75
03/16-03/17/2018	Professional Service	2711, 2712, 13	\$429.75	\$374.62	\$0.00	\$0.00	\$0.00	\$11.03	80%	\$44.10
Member Shared Responsibility:			\$16,416.02							
Totals:			\$108,592.81	\$83,899.43	\$12,346.69	\$0.00	\$2,000.00	\$2,069.33		\$8,277.36

Reason Code Description

Code	Description
13	TO MEMBER AND PROVIDER: This statement represents an adjustment of a previously processed charge.
2711	TO MEMBER AND PROVIDER: Your shared amount has been increased due to a pre-existing condition.
2712	TO MEMBER AND PROVIDER: The plan year maximum has been met for this pre-existing condition.
P1450	Paid in accordance with the PHCS discount rate agreement.

Medical Year to Date Totals

Individual In Network COEXPENSE	Member: Corlyn	Used: \$1,505.56
Individual In Network MSRA	Member: Corlyn	Used: \$1,000.00

Exhibit 2

Find messages, documents, photos or people

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- Unread
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- Custom...
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- delux.com ... 2
- Design I... 431
- Drafts
- Duncan T...
- EnerBank In... 2
- Eric Swa...
- Exotic Tr...
- Insurance I... 2

Aliera Healthcare Member Update: Get Your Next Month Free Yahoo/Inbox

P planupdate@alierahealthcare.com May 3 at 4:20 PM
To: bkduncan [redacted]



Dear Corlyn,

We have an important update regarding your healthcare plan. Aliera is no longer selling your current health plan with the Aliera Healthcare/Unity HealthShare, LLC component. However, an affordable, seamless option – with the same benefits and services – exists through our trusted alliance with Aliera Healthcare/Trinity HealthShare. With this simple move, you will continue to enjoy access to more than 1,000,000 healthcare professionals in over 6,000 facilities across the United States through our nationwide preferred provider organization (PPO) and to show our appreciation for your continued membership, we will waive your next month's contribution!

All your plan services will remain the same and the following will continue to track with each member:

- Medical history and historical claims
- Payments toward member shared responsibility amount (MSRA)
- Time spent in the plan

We are also excited to announce the launch of several value-added services we've been building into our member-focused model of care:

- Aliera's industry-leading white glove member service helps members navigate the complexities of healthcare while reaping the rewards of community-based cost sharing
- As of June 15th, affiliation with CVS MinuteClinic provides both individual and group health plan members access to MinuteClinic services with no consult fee, MSRA or deductible

As one of the country's most established and valued healthcare solution companies, Aliera Healthcare is a trusted name in over 40 states with more than 400 member-focused employees to serve our loyal and growing membership. We are committed to consistently achieving the highest standards of excellence in member satisfaction and look forward to meeting your needs with high quality, customizable plans for any need or budget.

(Please note: In our prior communication, there was an error regarding the new monthly rate. We apologize for any confusion. The corrected rate is below.)

Your monthly rate: **\$1,612.91**

Simply follow the link below (or [here](#)) to complete a DocuSign form and skip one month's contribution!



If you have any questions, please give us a call at the number below and thank you for your time and continued membership.

In the event, you've already received notification and taken action, please disregard this email.

Aliera Healthcare
Toll Free 844-326-2980

5/13/19
Approved