UNITED STATES DISTRICT COURT
DISTRICT OF COLORADO

Civil Action No.

ELLEN LARSON, individually and on behalf of all others similarly situated,

Plaintiff,

v.

THE ALIERA COMPANIES, INC., a Delaware corporation;
ALIERA HEALTHCARE, INC., a Delaware corporation; and
TRINITY HEALTHSHARE, INC., a Delaware corporation,

Defendants.

CLASS ACTION COMPLAINT

I. PARTIES

1. Plaintiff ELLEN LARSON is a citizen of Colorado who resides in Colorado Springs. Ms. Larson was enrolled in a health care plan from Defendants Aliera Healthcare and/or Trinity Healthshare from July through December, 2018.

2. Defendant ALIERA HEALTHCARE, INC. is a Delaware corporation headquartered in Atlanta, Georgia. It is incorporated as a for-profit business, without any express religious affiliation.

3. Defendant THE ALIERA COMPANIES, INC. is a Delaware corporation headquartered in Atlanta, Georgia. It is incorporated as a for-profit entity without any express religious affiliation. Based on information and belief, it either changed its name from ALIERA HEALTHCARE, INC., or is the parent corporation of Aliera Healthcare, Inc. Collectively, defendants The Aliera Companies, Inc. and Aliera Healthcare, Inc. are referred to as "Aliera."

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

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

6. Neither Aliera nor Trinity hold a certificate of authority from the Colorado Division of Insurance as required by § 10-3-105 C.R.S., and neither are authorized or licensed to provide any type of insurance plan in Colorado.

II. JURISDICTION AND VENUE

7. Jurisdiction of this Court arises pursuant to 28 U.S.C. § 1332(a) and § 1367 because there is diversity of citizenship and the amount in controversy related to the proposed class claims exceeds $75,000.

8. Venue is proper because some of the acts or omissions occurred in the District of Colorado, and the named Plaintiff and many of the proposed class members reside in Colorado.

III. NATURE OF THE CARE

9. When Congress passed the Patient Protection and Affordable Care Act ("ACA") in 2010, it required all individuals to be covered by health insurance or pay a penalty. Congress allowed for a handful of exceptions to that requirement, set out in 26 U.S.C. § 5000A. One of those exceptions was for members of existing Health Care Sharing Ministries ("HSCMs"). In order to qualify as an HSCM under the ACA, an entity must meet rigid requirements, including: (1) it must be recognized as a 501(c)(3) tax exempt organization; (2) its members must "share a common set of ethical or

religious beliefs and share medical expenses among members according to those beliefs;" and (3) it must have "been in existence at all times since December 31, 1999, and medical expenses of its members [must] have been shared continuously and without interruption since at least December 31, 1999." 26 U.S.C. § 5000A(d)(2)(B)(ii).

10. Defendants, in an attempt to exploit this exception, falsely represented that Trinity has been "recognized" as an HCSM. Trinity did not meet the requirements of 26 U.S.C. § 5000A(d)(2)(B)(ii) because it was not in existence until 2018, and because it did not require its members to adhere to its stated ethical or religious beliefs. It was never, and could not have been, "recognized" as an HCSM because the federal agency that had at one time provided letters of recognition stopped doing so in 2016, before Trinity was created.

11. While falsely representing that Trinity is a recognized HCSM, Defendants issued illegal and unauthorized health insurance products to citizens of the State of Colorado. They sold illegal insurance plans to hundreds, if not thousands, of Colorado residents. These plans did not comply with the minimum basic requirements for authorized health care plans under state or federal law, and have resulted in Colorado residents (1) paying for an illegal contract, and (2) being denied coverage for medical care required by law to be provided. Aliera and its owners, however, have realized exorbitant profits, by taking over 83% of all payments made by individuals, while refusing to pay claims.

12. Aliera, using Trinity as a purported HCSM, created, marketed, sold, and administered plans in Colorado. These plans qualify as health insurance under Colorado law, §10-1-102(6)(a) C.R.S. and are unauthorized under §10-3-105 C.R.S. The unauthorized insurance plans created, marketed, sold, and administered by Defendants

did not meet the minimum benefits, coverage and other requirements for health insurance in Colorado. They are illegal contracts.

13. Defendants' representations that the insurance plans were HCSM plans were misleading, unfair and/or deceptive in violation of the Colorado Consumer Protection Act. At no relevant time did the Defendants' plans meet the requirements for HCSMs under federal law as represented.

14. Plaintiff, on behalf of the class she seeks to represent, filed this lawsuit to obtain declaratory and injunctive relief to prevent Defendants from continuing to create, market, sell, and administer unauthorized and illegal health insurance plans in Colorado. On behalf of the proposed class and on her own behalf, Plaintiff also seeks damages related to uncovered health care expenses, premiums paid and other losses due to Defendants' creation, marketing, sale, and administration of unauthorized and illegal health insurance plans.

15. Specifically, Defendants created, marketed, sold, and administered plans that provided certain payment benefits in the event of specified health-related contingencies in exchange for a monthly payment. The amount of benefits was tied to the amount of the monthly premium payment and the cost incurred by the customer for health-related medical treatments. Under Colorado law, the arrangement fits squarely within the definition of "insurance" and may not be marketed, sold or administered without meeting minimum requirements and obtaining authorization from the Colorado Department of Insurance.

IV. CLASS ALLEGATIONS

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

> All Colorado residents who purchased a plan from any of Defendants or their subsidiaries that purported to be "health care sharing ministry" plan at any time since June 29, 2018.

17. ***Size of the Class:*** The Plaintiffs' proposed class is so numerous that joinder of all members is impracticable. Hundreds, if not thousands, of individuals in Colorado are covered by Defendants' plans.

18. ***Common Questions of Fact and Law:*** There are questions of law and fact that are common to all class members including: (1) whether the healthcare products that the Defendants created, marketed, sold, and administered to class members met the legal requirements of an HCSM under 26 U.S.C. § 5000A; (2) whether plans sold were "insurance" under Colorado insurance law; (3) whether Colorado insurance law and regulations forbid the creation, marketing, sale, and administration of health care products in the "business of insurance" without authorization or other legal exception; (4) whether Defendants failed to obtain proper authorization for the creation, marketing, sale, and administration of an insurance product in Colorado; (5) whether class members are entitled to (a) rescission of the plan(s) and refunds of all premiums paid and/or (b) reformation of the plans to comply with the minimum insurance coverage requirements of Colorado and federal law, and re-processing of all claims for expenses and costs incurred that would have been covered had the plan(s) properly complied with those laws; (6) whether Defendants' actions were "unfair" and/or "deceptive" under the Colorado Consumer Protection Act ("CCPA"); and (7) whether class members are entitled to other damages, including statutory treble damages, resulting from Defendants' unfair and/or deceptive acts.

19. ***Class Representative:*** The claims of the named Plaintiff are typical of the claims of the proposed class as a whole resulting from Defendants' sale of unauthorized and illegal insurance plans. The named Plaintiff will fairly represent and adequately

protect the interests of the class members because she has been subjected to the same practices as other class members and suffered similar injuries. The named Plaintiff does not have interests antagonistic to those of other class members as to the issues in this lawsuit.

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

21. ***Defendants Have Acted on Grounds Generally Applicable to the Class.*** Defendants Aliera and Trinity have uniformly created, marketed, sold and administered unauthorized health insurance plans in Colorado. They have misrepresented the plans as HCSM plans under federal law. Defendants have acted on grounds generally applicable to the proposed class, rendering declaratory and injunctive relief appropriate respecting the whole class. Certification is therefore proper under Fed. R. Civ. P. 23(b)(2).

22. ***Questions of Law and Fact Common to the Class Predominate Over Individual Issues.*** The claims of the individual class members are more efficiently adjudicated on a class-wide basis. Any interest that individual members of the class may have in individually controlling the prosecution of separate actions is outweighed by the efficiency of the class action mechanism. Upon information and belief, no class action suit is presently filed or pending against Aliera and/or Trinity for the relief requested in this action. Issues as to Aliera's and/or Trinity's conduct in applying standard marketing, sales and administration practices towards all members of the class

predominate over questions, if any, unique to members of the class. Certification is therefore additionally proper under Fed. R. Civ. P. 23(b)(3).

23. ***Venue***. This action can be most efficiently prosecuted as a class action in this jurisdiction, where Defendants do business and where Plaintiff resides.

24. ***Class Counsel***. Named Plaintiff has retained experienced and competent class counsel.

V. FACTUAL BACKGROUND

Aliera Seeks Out an HCSM to Avoid Insurance Requirements, But Its First Relationship Ends in Litigation

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

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

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

28. Upon his release from prison, and after forming Aliera, Timothy Moses convinced Anabaptist to permit Aliera to market HCSMs using Anabaptist's designation. Anabaptist created a wholly-owned subsidiary, called Unity Healthshare ("Unity"), for that purpose. Under the proposal, Aliera would market the plans in exchange for a $25 per member per month fee for its administrative services.

29. Aliera entered into a contract with Unity on or about February 1, 2017. Under that contract, Aliera would offer health products to the public that did not meet the insurance benefits and coverages required by the Affordable Care Act through its HCSM exemption in 26 U.S.C. § 5000A. In return, Aliera's customers would join the Unity HCSM, increasing members to Anabaptist's HCSM.

30. Under the contract with Unity, Aliera was responsible for maintaining and segregating the assets received that were reserved for payment of benefits to Unity members.

31. In 2018, after thousands of Aliera/Unity plans had been sold nationwide, Anabaptist/Unity discovered that Mr. Moses had written himself approximately $150,000 worth of checks from Unity funds without board approval and had not properly maintained assets reserved for payment of benefits. It requested an accounting and, in July 2018, demanded Aliera turn over control of all Unity funds.

32. Unity terminated the relationship with Aliera in summer, 2018. A lawsuit between Aliera and Anabaptist Health Share/Unity was filed in Superior Court of Fulton County Georgia in late 2018. *See Aliera Healthcare v. Anabaptist Health Share et al.*, No. 2018-cv-308981 (Hon. Alice D. Bonner, Ga. Sup. Ct.). As a result of the lawsuit, a court-ordered receiver now monitors Aliera's administration of HCSM assets and benefits for Unity members. *See* ***Appendix A***, Order Entering Interlocutory Injunction and Appointing Receiver dated April 25, 2019.

Aliera Created Trinity as a Sham Health Care Sharing Ministry to Avoid ACA Requirements

33. With its relationship with Unity terminating, Aliera would have no affiliation with any HCSM. Trinity was therefore created by Aliera and its principals on June 27, 2018 as a purported nonprofit entity. William Rip Theede, III was the CEO of Trinity. Mr. Theede is a former Aliera employee. He is also a close family friend of the Moses family and officiated at Chase Moses' wedding.

34. Trinity had no predecessor entity.

35. Trinity had no members when it was formed.

36. Trinity could not qualify as an HCSM because it was created after December 31, 1999, and at the time of its creation, had no members. In order to qualify as an HCSM under federal law, the entity or a predecessor of the entity must, among other requirements, have "been in existence at all times since December 31, 1999, and medical expenses of its members [must] have been shared continuously and without interruption since at least December 31, 1999." 26 U.S.C. § 5000A(d)(2)(B)(IV). Trinity has not had members who have shared medical expenses "continuously and without interruptions since at least December 31, 1999."

37. In addition, in order to qualify as an HCSM under federal law, the members of the entity must "share a common set of ethical or religious beliefs and share medical expenses among members in accordance with those beliefs. . . ." 26 U.S.C. § 5000A(d)(2)(B)(III). Although Trinity's bylaws set forth a specific set of religious beliefs, it has never restricted its membership to those individuals who affirm the specific common beliefs.

38. Trinity's bylaws (1) set forth a Protestant understanding of the Bible as the "final and only source of absolute spiritual authority," (2) affirm God is "triune," or a trinity, (3) set forth an orthodox view of Jesus Christ as fully God and fully man, (4) affirm Jesus Christ as sinless, and the result of a virgin birth, (5) affirm that people can only be saved "by grace alone, through faith alone," and (6) affirm the literal resurrection of Jesus Christ.

39. Nevertheless, Trinity does not require members to affirm agreement to any of these sectarian principles, and does not exclude members from faiths that do not adhere to these beliefs. Members are only asked to generically affirm a "Statement of Beliefs" that "personal rights and liberties originate from God," "every individual has a fundamental right to worship God in his or her own way," there is a moral obligation "to assist our fellow man when they are in need," there is a duty to "maintain a healthy lifestyle," and a fundamental right of conscience to direct one's own healthcare exists. See ***Appendix B,*** p. 21. As stated in "frequently asked questions" on Defendants'' website, "Trinity HealthShare welcomes members of all faiths who can honor the Statement of Beliefs, by which the Trinity HealthShare program operates." ***Appendix C, p. 11.***

40. While prospective agents must take a training assessment, the questions asked in the assessment do not address any religious or ethical motivation. Defendants'

advertisements for prospective agents, and the training materials for agents do not mention a religious or ethical component for purchasers of these plans.

41. In a video posted to YouTube dated November 1, 2018, an unidentified Aliera trainer for new or prospective agents discussed the Aliera Healthcare Enrollment Process. According to the video, in order to enroll in Aliera, the consumer must positively respond to a number of questions. The first question asks if the consumer agrees with Trinity's "statement of faith:"

> **At the core of what the Healthcare Sharing Ministry does, and how they relate to and engage with one another as a community of people is a set of common beliefs**.
>
> 1. We believe that our personal rights and liberties originate from God and are bestowed on us by God. 2. We believe that every individual has a fundamental religious right to workshop God in his or her own way. 3. We believe it is our moral and ethical obligation to assist our fellow man when they are in need according to our available resources and opportunity. 4. We believe it is out spiritual duty to God and our ethical duty to others to maintain a healthy lifestyle and avoid foods, behaviors or habits that produce sickness or disease to ourselves or others. 5. We believe it is our fundamental right of conscience to direct our own healthcare, in consultation with physicians, family or other valued advisors.
>
> - Yes
> - No

42. The training explains what the "statement of faith" means:

> Just to give you a general overall synopsis of what it's saying … It basically is saying that you believe in a higher power. It doesn't necessarily have to be a Christian God, or a Buddhist God, or a Jewish God. It doesn't … matter as long as we all believe that there is a higher power and we're all living our life that the best way that we possibly can. We're maintaining

> a healthy lifestyle. We're trying to avoid those types of foods, behaviors, habits - things that, you know, cause us illness that are in our control.
>
> As long as we're doing those types of things, we're all like-minded individuals. So if you feel that way, and you are a like-minded individual, that's all we're trying to find out. And, if you are, you're gonna say, "Yes," you believe in the five same statement of beliefs that we all do.

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

44. Likewise, the Internal Revenue Service ("IRS") does not and has never recognized any entities as HCSMs. Its role is limited to accepting tax returns from individuals who may claim that they are entitled to an HCSM exemption on their individual tax returns. The IRS has never recognized Defendants as a qualified HCSM under 26 U.S.C. § 5000A(d)(2)(B). Defendants' representations to the contrary are false and misleading.

45. On or about August 13, 2018, Aliera signed an agreement with Trinity to provide the marketing, sale and administration of the purported HCSM plans. The contract allowed Aliera to use Trinity's non-profit status to sell health care plans purporting to be HCSM plans, while keeping complete control of the money, the administration of the plans, and the membership roster.

The Products Defendants Create, Market, Sell, and Administer are Health Insurance

46. During certain times on and after June 27, 2018, when Defendant Trinity was incorporated, Plaintiff and members of the class have been, are, or will be enrolled in healthcare insurance products created, marketed, sold, and administered by Defendants that Defendants claimed were HCSM plans.

47. The healthcare products marketed, sold, and administered charge "members" a "monthly contribution" to participate. Defendants described the "contributions" members pay as "premiums." *See e.g.,* ***Appendix C***, pp. 3-4**.**

48. The amount of the premium charged is based on the medical program selected by the insured. The programs include "interim medical," "comprehensive," "standard," "basic care," and "catastrophic." *Id.,* p. 1. The programs require a member to pay a deductible, which Defendants call a "Member Shared Responsibility Amount." *Id.,* p. 4. Once this amount has been paid, then medical bills are paid in accordance with a benefits booklet or member guide for the selected program. These benefit booklets contain the "membership instructions" which detail the "eligible medical expenses," "limits of sharing," limitations on pre-existing conditions, and exclusions. The programs require pre-authorization of certain non-emergency surgeries, procedures or tests, as well as for certain types of cancer treatments. *See e.g.,* ***Appendix B***, p. 29.

49. The programs are offered at least three benefit levels. The programs at the higher levels charge more and therefore provide more robust benefits for covered medical conditions. ***Appendix C***, p.1

50. The programs provide coverage for medical expenses. Among other things, the programs provide coverage for preventive care, primary care, urgent care, labs and diagnostics, x-rays, prescription benefits, specialty care, surgery, and

emergency room services. ***Appendix B***, pp. 22-25**.** The programs, for an additional premium, will also provide maternity care. ***Appendix C, p. 7.***

51. The programs have established preferred provider networks ("PPOs") through which members can seek care. Payments are made by Defendants directly to providers.

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

53. Payments are made to health care providers on behalf of members who are current on their monthly premiums in the event they experience a covered loss, have met their deductible or "Member Shared Responsibility Amount," and otherwise meet the coverage requirements set forth in the coverage booklet. These payments are expressly contingent upon the occurrence of a covered medical need by the participating member.

54. Payment from the program upon the occurrence of a covered loss is not voluntary. Under the terms of the program, as set forth in the Member Guide, Trinity is instructed and required to "share clearing house funds in accordance with the membership instructions." ***Appendix B***, p. 21 (Contributors' Instructions and Conditions). The "membership instructions" is nothing more than a booklet of benefits created by Defendants. The members have no role in the creation of the benefits booklet. Members do not decide who gets paid benefits. Instead, according to the Member Guide, the members must accept Trinity's adjudication of benefits: "By participation in the membership, the member accepts these conditions." According to the benefits booklet, Trinity, and not the members, is the "final authority for the interpretation" of the membership instructions, and Trinity directs payment to

providers on behalf of members who have submitted medical claims that are covered under the benefits booklet. *Id.*

55. Members' "contributions" (i.e. premiums) are not refundable. Although the member "contributions" are called "voluntary," if members fail to make the premium payment, they are not entitled to coverage for medical expenses. *Id.*, p. 18.

56. Defendants' programs are contracts whereby Defendants undertake to indemnify a member upon the occurrence of determinable contingencies and therefore constitute "insurance" as defined by Colorado law. *See* §10-1-102(12) C.R.S. The Colorado Division of Insurance has so concluded. ***Appendices E and F.*** Defendants are required to comply with Colorado and federal law governing insurers.

The Health Insurance Plans Defendants Create, Market, Sell, and Administer Are Illegal

57. Defendants do not have a certificate of authority as required by § 10-3-105 C.R.S. from the State of Colorado to issue insurance within this state and are not authorized insurers under Colorado law. Defendants have issued illegal and unauthorized insurance products to Plaintiff and other members of the class.

58. Defendants' plans are not ACA-compliant because they do not meet the minimum coverage requirements under the ACA's Essential Health Benefits. For example, the policies impose a 24-month waiting period on coverage, which is illegal under the ACA. *See* 42 U.S.C. §300gg-3. *See also,* § 10-16-118 C.R.S.

59. The plans purport to require binding arbitration, which is illegal in Colorado. § 10-3-1116(3) C.R.S.

60. The benefits booklet, which has never been reviewed or approved, contains inconsistent and contradictory coverage terms and conditions. For example, on one hand it suggests that Defendants are required to administer benefits in

accordance with the terms of the benefits booklet, while other provisions suggest that Defendants are not required to pay any benefits whatsoever. The benefits booklet also states the plan is an "opportunity for members to care for one another in a time of need, [and] to present their medical needs to other members," but in fact Defendants – like an insurance carrier - make all coverage decisions without ever presenting one member's needs to other members.

Multiple States Have Found that Aliera and Trinity Are Illegally Marketing, Selling and Administering Insurance Products That Do Not Qualify as HCSMs

61. On August 12, 2019, the State of Colorado Division of Insurance found Defendants were selling insurance products, and issued cease and desist orders ordering them to immediately stop selling the unauthorized insurance in the State of Colorado. ***Appendices E and F***.

62. The State of Texas has successfully enjoined Aliera from enrolling any new members in Texas. As the Texas Attorney General argued on July 11, 2019 in *State of Texas v. Aliera Healthcare, Inc.,* Travis County Cause No. D-1-GN-19-003388:

> The Defendant Aliera Healthcare, Inc., is engaged in the business of insurance in this State without a license, in violation of Tex. Ins. Code § 101.101. … In meetings with State regulators, Aliera representatives have asserted that Aliera is exempt from state regulation because it merely administers a "health care sharing ministry." ***Aliera is no ministry, however; it is a multi-million dollar for profit business that admittedly siphons off over 70% of every dollar collected from its members to "administrative costs."***

Appendix G, pp. 1-2 (emphasis added).

63. The Washington Insurance Commissioner, Mike Kriedler, conducted a formal investigation in response to consumer complaints and concluded that Trinity did not meet the statutory definition of an HCSM under Washington and federal law. *See* ***Appendix H***. Commissioner Kriedler further concluded that Aliera acted as an

unauthorized health care service contractor without being registered and was doing business as an unlicensed discount plan organization, and that Aliera's advertisements on behalf of Trinity were deceptive and had the capacity to mislead or deceive consumers into believing that they purchased insurance. On May 13, 2019, Commissioner Kriedler issued "Orders to Cease and Desist" to Aliera and Trinity. *See* ***id.*** and ***Appendix I.*** On December 30, 2019, Trinity entered into a consent order that prohibited it from enrolling any new Washington residents, and was fined $150,000. ***Appendix J***.

64. The New Hampshire Insurance Department entered a Cease and Desist Order against Aliera and Trinity on October 30, 2019, ordering them to stop selling or renewing illegal health insurance in New Hampshire. ***Appendix K.***

65. Regulators in Georgia have also issued warnings. *See e.g*. ***Appendix L.***

Plaintiff Was Sold Sham Products by Aliera/Trinity
That Did Not Provide the Benefits Promised

66. Plaintiff Larson enrolled in AlieraCare in July of 2018, while Aliera partnered with Unity.

67. Her plan through Aliera/Unity was subsequently transferred to Aliera/Trinity.

68. She made a payment to Aliera for $452.44 and to Unity for $25 in July 2018, and made monthly premium payments of $352.44 per month each month from August through December 2018.

69. Ms. Larson received what she believed was an insurance card from Aliera/Trinity. *See* ***Appendix D***. The insurance card falsely stated that she was a member "of a Health Care Sharing Ministry ***recognized pursuant to 26 U.S.C.***

§ 5000A(d)(2)(B)" even though neither Trinity nor Aliera was ever certified or "recognized" by any government agency as an HCSM.

70. The AlieraCare Trinity plan sold to Ms. Larson was insurance under Colorado law. However, it failed to comply with Colorado and federal law in its provisions of benefits.

71. Ms. Larson was assaulted on August 3, 2018, while covered by Defendants' Plan. She was attacked and knocked unconscious. She was taken to the hospital with serious injuries, including a skull fracture, cervical spine fracture, and intercranial bleeding. When she submitted her bill for payment by Defendants, her claim was denied. When she appealed, Defendants decided to cover a different denied claim as a result of the appeal. ***Appendix M.***

72. Ms. Larson appealed a second time. Defendants then took the position that Ms. Larson's injuries were "self-inflicted" and excluded under her policy. ***Appendix N.***

73. Ms. Larson continues to be pursued for these debts.

VI. CLAIMS FOR RELIEF

A. Illegal Contract

74. Plaintiffs reallege all prior allegations as though fully stated herein.

75. Defendants sold Plaintiff and all members of the proposed class unauthorized and illegal health insurance plans in violation of Colorado law:

a. The plans were insurance, but were sold without authorization in Colorado.

b. The plans failed to provide the essential health benefits required under the ACA, and Colorado law.

c. The plans exclude coverage for pre-existing conditions and impose waiting periods.

d. The Member Guide contains inconsistent and contradictory coverage terms and conditions that allow Defendants to arbitrarily deny coverage.

e. The plans included a binding arbitration provision illegal under Colorado law. §10-3-1116 C.R.S.

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

B. Violation of the Colorado Consumer Protection Act

77. Plaintiffs reallege all prior allegations as though fully stated herein.

78. Defendants' creation, marketing, sale and administration of unauthorized health insurance plan(s) to class members constitutes unfair and/or deceptive acts under the Colorado Consumer Protection Act ("CCPA"). Under the CCPA, Plaintiffs and members of the proposed class are entitled to damages, injunctive relief, statutory treble damages (up to $25,000 for each violation) and attorneys' fees and costs.

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

(a) Defendants have advertised and represented that Trinity is a "Health Care Sharing Ministry recognized pursuant to 26 U.S.C. § 5000A(d)(2)(B)." This is false and/or misleading for at least the following reasons:

(i) Trinity has not "been in existence at all times since December 31, 1999, and medical expenses of its members have been shared

continuously and without interruption since at least December 31, 1999." 26 U.S.C. § 5000A(d)(2)(B)(IV). It therefore is not, as a matter of law, a HCSM.

(ii) Trinity was never "certified" or "recognized" by any governmental agency as an HCSM.

(iii) Trinity is not now, and was never on, the list of recognized HCSMs created by the Department of Health and Human Services.

(iv) The Department of the Treasury/IRS has never recognized, approved or disapproved entities as HCSMs under 26 U.S.C. § 5000A. It has no process for doing so.

(v) Trinity does not restrict membership to only those members that share its beliefs as set forth in its bylaws as required by 26 U.S.C. § 5000A. Rather, individuals who do not share Trinity's Protestant statement are allowed membership.

(b) Defendants have consistently and repeatedly represented that AleriaCare/Trinity and related products are "not insurance." This representation appears in the benefits book, in advertising material, in training material and on its webpages. This representation, however, is false and/or misleading. Under Colorado law, Defendants are offering insurance to members of the public.

(c) Defendants' insurance products include provisions, conditions, exclusions and restrictions that are illegal under Colorado law. These include, but are not limited to, the following:

(i) Defendants purport to require members to submit disputes to arbitration even though Colorado law prohibits binding arbitration agreements in insurance contracts.

(ii) Defendants purport to exclude certain pre-existing conditions even though such exclusions are illegal under Colorado and federal law.

(iii) Defendants purport to impose waiting periods even though such waiting periods are illegal under Colorado and federal law.

(iv) Defendants fail to provide coverage for treatments and conditions that are mandated benefits under Colorado and federal law.

(v) Defendants purport to exclude or limit treatments and conditions that are required to be covered under Colorado and federal law.

(vi) Defendants impose lifetime caps and limits on coverage that are illegal under Colorado and federal law.

(vii) The benefits booklet, which has never been reviewed or approved by the Colorado Department of Insurance, contains inconsistent and contradictory coverage terms and conditions. Defendants do not hold a Certificate of Authority to issue insurance in the State of Colorado as required by 10-2-105 C.R.S., yet they market and sell insurance plans to class members.

(d) Colorado law requires that an insurer maintain certain loss ratios. Defendants' loss ratios do not comply with these law and regulations. Defendants, in fact, do not maintain enough reserves to protect its members from insolvency. For-profit Aliera, in fact, takes most of the member premiums as fees.

(e) Given that the vast majority of the premiums paid are taken by Aliera as fees, the Defendants' program is not a true ministry, but a profit-making enterprise designed to enrich the owners of Aliera. Consumers were led to believe that their premiums would primarily be used to pay claims of other members. In fact, most of the contributions were used to pay Aliera and its owners.

(f) Defendants' advertisements and solicitations of customers for its products is misleading and/or deceptive. Specifically, the advertisements and solicitation deceive or mislead, or have the capacity to deceive or mislead, members of

the class that they were purchasing an authorized health insurance product. The look and feel of the advertising material suggest that the plan is a health insurance product. Defendants use such things as insurance cards, PPO networks, plan booklets, plan levels, health insurance lexicon (such as "healthcare") to create the impression that they are offering real health insurance benefits.

(g) Online training videos, available to the public and brokers, downplay the ministry aspects of the program and suggest that the program is a form of legitimate healthcare insurance when it is not.

(h) Defendants misrepresent the program as a "sharing" program that provides members with a role in determining whether claims should be paid, when in fact all coverage decisions were made arbitrarily by Aliera, and in Aliera's best interest.

(i) Defendants misrepresent that Trinity, because it is a nonprofit with "nothing to gain or lose financially by determining if a need is eligible or not" is the entity to whom members delegated coverage decision authority. In reality, all coverage decisions were made by Aliera, a for-profit that made substantial profits from not paying health care claims.

80. The deceptive or unfair acts or practices of Defendants occurred in trade or commerce; specifically, the marketing, sale and administration of insurance products to Colorado residents.

81. The public interest element of the CCPA exists here because the business of insurance is one affected by the public interest, requiring that all persons be actuated by good faith, abstain from deception, and practice honesty and equity in all insurance matters. The sale of healthcare plans to the public also directly affects the public interest.

82. Plaintiffs and the class have been injured as a direct result of Defendants' conduct. They were sold unregulated insurance products that are illegal under Colorado law. The products do not have enough loss ratios to provide protection. The products provide less coverage than permitted under law, thereby rendering the policies less valuable than products that do comply with the law. Plaintiff and the class have been denied care, or limited in care, due to illegal caps, exclusions and limitations. Plaintiff and the class have foregone coverage under the ACA, including subsidized benefit packages that would provide legal, comprehensive, and secure health insurance coverage. Defendants' polices were overpriced for the coverage they purported to provide given that over 80% of the contributions were paid in fees to Aliera, causing Plaintiff and the class to overpay for the illegal and unregulated policies.

VII. PRAYER FOR RELIEF

WHEREFORE, Plaintiffs request that this Court:

(a) Certify that this action may proceed as a class action as defined in ¶16 above;

(b) Designate Ms. Larson as class representative and designate Michael David Myers, Myers & Company, PLLC and Victoria Lovato, Michael Best & Friedrich, as class counsel;

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

(d) Declare that Defendants' actions as alleged herein towards the members of the class violate the Colorado Consumer Protection Act;

(e) Order Defendants to (i) rescind the unauthorized health insurance plans and refund all premiums improperly received from members of the proposed class, including interest; or, at the option of any class member (ii) reform the

unauthorized health insurance plans to comply with the minimum mandatory benefits required under the relevant state insurance code and federal law, permit class members to submit claims for medical services, costs and other expenses that would have been covered;

(f) Order payment of all other expenses causally related to Defendants' unfair and/or deceptive acts;

(g) Order an award of treble damages under the CCPA;

(h) Order payment of reasonable attorneys' fees; and

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

DATED: January 13, 2020.

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APPENDIX A

IN THE SUPERIOR COURT OF FULTON COUNTY
BUSINESS CASE DIVISION
STATE OF GEORGIA

ALIERA HEALTHCARE, INC., Plaintiff/Counterclaim Defendant, v. ANABAPTIST HEALTHSHARE; and UNITY HEALTHSHARE, LLC, Defendants/Counterclaimants, ALEXANDER CARDONA, and TYLER HOCHSTETLER, Defendants.	CIVIL ACTION FILE NO. 2018CV308981 Business Case Div. 1

ORDER ENTERING INTERLOCUTORY INJUNCTION AND APPOINTING RECEIVER

The Court has carefully considered the Application for an Interlocutory Injunction and for the Appointment of a Receiver submitted by Defendants-Counterclaimants Anabaptist Healthshare ("Anabaptist") and Unity Healthshare LLC ("Unity") (collectively, "AHS/Unity"), the exhibits and briefs submitted in support, the responses and exhibits submitted by Plaintiff-Counterclaim Defendant Aliera Healthcare, Inc. ("Aliera"), and the evidence and arguments presented at the evidentiary hearing held on January 22, 2019 and January 24, 2019. This Order reduces to writing the oral order and interlocutory injunction of the Court issued at the conclusion of the hearing on January 24, 2019.

Having allowed the parties several opportunities to confer on a proposed order following the January hearing and having considered the parties' respective submissions and the record, the Court finds and orders as follows:

I. FINDINGS OF FACT[1]

Background

1. Defendant/Counterclaimant AHS is a non-profit Section 501(c)(3) tax exempt organization. Affidavit of T. Hochstetler (Hochstetler Aff.) at ¶ 2; Transcript of Hearing on AHS/Unity's Application for Interlocutory Injunction and for Appointment of a Receiver ("Hr'g Tr.") 42:14-18.[2]

2. AHS has, for some years, managed a Health Care Sharing Ministry ("HCSM") for members of the Anabaptist communities in Virginia. Hochstetler Aff. ¶ 2; Hr'g Tr. 94:18-95:19.

3. Health care sharing ministries ("HCSM") facilitate the sharing of certain medical expenses among their members. Hochstetler Aff. at ¶ 3; Hr'g Tr. 43:16-44:13.

4. The Affordable Care Act (the "ACA") exempts members of a qualifying HCSM from the tax penalty levied on those who fail to purchase health insurance, commonly referred to as "the individual mandate." Hochstetler Aff. ¶ 3; Hr'g Tr. 43:16-24.

5. AHS received a letter from the Centers for Medicare and Medicaid Services ("CMS") stating that it met the ACA's requirements for its members to claim the tax exemption, which included the requirement that AHS has been "in existence at all times since December 31, 1999, and medical expenses of its members have been shared continuously and without interruption since December 31, 1999." Hochstetler Aff. ¶ 3; Hr'g Tr. 43:25-44:3.

6. The United States Department of Health and Human Services certified that AHS is an HCSM whose members qualified for the exemption from the individual mandate. Hochstetler Aff. ¶ 6; Hr'g Tr. 45:1-12; Joint Ex. 2.

7. AHS's wholly-owned subsidiary, Unity, is also an HCSM whose members qualified for the exemption from the individual mandate to the same extent as AHS. Hr'g Tr. 49:18-50:6.

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[1] As demonstrated by the parties' respective proposed findings of fact and other submissions, the evidence adduced to date in this matter is too vast to adequately summarize here. Included herein are the Court's preliminary findings that are most relevant to the Court's rulings and analysis.

[2] The exhibits cited herein were either received in evidence at the evidentiary hearing on AHS/Unity's motion for interlocutory injunction or are attached to the parties' pleadings and filings in connection with AHS/Unity's motion for a TRO/interlocutory injunction.

8. AHS was formed in 2015, and Unity was formed in late 2016. Hr'g Tr. 96:7-8; 300:3-5.

9. Congress eliminated the individual mandate's tax penalty beginning January 1, 2019. *See* Pub. L. No. 115-97, § 11081 (2017); Hr'g Tr. 98:23-99:9.

10. Georgia's Insurance Code defines a "health care sharing ministry" as "a faith-based, nonprofit organization that is tax exempt under the Internal Revenue Code" and that meets the six specific requirements set forth in the statute. O.C.G.A. § 33-1-20 (providing that HCSMs meeting such requirements are neither insurance nor subject to the jurisdiction of the Commissioner of Insurance).

11. Other states have similar statutes defining HCSMs. *See, e.g.*, Fla. Stat. § 624.1265(1) (defining a healthcare sharing ministry as "[a] nonprofit religious organization" that satisfies certain requirements); Tex. Ins. Code § 1681.001 ("A faith-based, nonprofit organization that is tax-exempt under the Internal Revenue Code of 1986 qualifies for treatment as a health care sharing ministry…"); Va. Code Ann. § 38.2-6300 ("As used in this chapter, 'health care sharing ministry' means a health care cost sharing arrangement…administered by a non-profit organization that has been granted an exemption from federal income taxation pursuant to § 501(c)(3) of the Internal Revenue Code of 1986…").

12. Additionally, the federal ACA provision that allowed HCSM members to claim an exemption from the tax penalty of the individual mandate makes clear that an HCSM must be a non-profit federally tax-exempt organization. *See* 26 U.S.C. § 5000A(d)(2)(B) (defining a "health care sharing ministry" as a non-profit tax exempt 501(c)(3) organization that meets certain criteria including having members who share a common set of ethical or religious beliefs and who share medical expenses, and that the HCSM must have been in existence and sharing continuously and without interruption since at least December 31, 1999).

13. Aliera is an Atlanta-based for-profit company that sells healthcare products. Hochstetler Aff. at ¶ 10; *see also* Hr'g Tr. 48:12-20; 89:1-2. Aliera offers alternative healthcare that is not insurance. Hr'g Tr. 251:1-23; Steele Aff. at ¶2.

14. As a for-profit company, Aliera does not qualify as an HCSM under state or federal law. *See* Hr'g Tr. 48:12-20; 50:10-17; 52:1-8; 55:17-23; 89:1-2.

15. Aliera began selling its healthcare products in 2015. Hr'g Tr. at 185:5-17. At that time, Aliera's products included services such a direct primary care medical home (DPCMH) service but did not include coverage for emergency room visits and hospitalization. Hr'g Tr. at 50:7-17, 185:5-17; Steele Aff. at ¶ 4.

16. Before Aliera established a relationship with an HCSM to offer an HCSM product, members who purchased Aliera's products did not qualify for exemption from the individual mandate's tax penalty. In other words, individuals who purchased Aliera's products did not satisfy the ACA's individual mandate unless they also purchased additional healthcare products from another source that satisfied the individual mandate. Hr'g Tr. 186:9-11.

17. At some point after it began selling its products, Aliera determined that if it could sell its plans side-by-side with an ACA-exempt HCSM plan, it would make the Aliera plan much more attractive to consumers and increase sales of Aliera's own products. Hr'g Tr. 186:12-189:4. Such concurrent offering of non-ACA exempt Aliera products with ACA-exempt AHS/Unity products would not, however, make Aliera's own products satisfy the individual mandate.

Aliera Approaches AHS and the Parties Negotiate and Execute an Amended MOU and a Written Agreement

18. To this end, in 2016, Aliera approached AHS to pitch a relationship between Aliera and AHS. Hochstetler Aff. at ¶ 7; Hr'g Tr. 46:4-9.

19. Timothy Moses, Alexander Cardona, and G. Michael Smith pitched the relationship and negotiated with AHS on behalf of Aliera. Hochstetler Aff. at ¶¶ 7-14; Hr'g Tr. 46:4-47:25; Smith Aff. at ¶¶3-5. Tyler Hochstetler led the negotiations for AHS. Hr'g Tr. 46:4-65:4.

20. Tyler Hochstetler testified that Aliera representatives proposed an arrangement under which Aliera would work with AHS to build AHS's HCSM network. Hochstetler Aff. at ¶ 8; Hr'g Tr. 46:10-50:3.

21. Timothy Moses explained to Tyler Hochstetler that Aliera sought to enter into a business relationship with AHS because Aliera could not offer hospitalization coverage through its direct primary

care medical home (DPCMH) products, nor could Aliera – as a for-profit company – offer HCSM products by itself. Hr'g Tr. 50:10-17.

22. Aliera valued AHS's exemption from the individual mandate, and entering into a relationship with AHS would allow Aliera to bundle HCSM plans with its products to offer participants the ability to qualify for the tax exemption from the ACA's individual mandate. Hochstetler Aff. at ¶¶ 11-13; Hr'g Tr. 48:12-20.

23. Timothy Moses stated that, if the parties were to enter into a business relationship, Aliera would market and administer AHS's HCSM plans. Hr'g Tr. 46:10-18; 49:21-24.

24. Timothy Moses proposed that AHS/Unity compensate Aliera $25 per member per month as Aliera's fee for the administrative services Aliera performed as part of its business relationship with AHS. Hr'g Tr. 51:14-25. Timothy Moses suggested that this fee was reasonable because it was similar to the fee other HCSMs paid for administrative services. Hr'g Tr. 51:11-25.

25. AHS asserts it was interested in partnering with Aliera because it desired to expand its ministry, and Aliera presented itself as an experienced and reputable company that could help AHS expand its HCSM nationwide. Hochstetler Aff. at ¶¶ 13-14; Hr'g Tr. at 50:21-50:1.

26. For example, Aliera represented to AHS that it had a strong compliance strategy and maintained strong relationships with insurance commissioners in every state. According to Tyler Hochstetler, this was extremely important to AHS. Hochstetler Aff. at ¶ 14; Hr'g Tr. 51:2-10.

27. Following their negotiations, Aliera and AHS executed a Memorandum of Understanding on October 31, 2016. Hochstetler Aff. at ¶ 15.

28. On November 10, 2016, AHS and Aliera executed an Amended Memorandum of Understanding. Hochstetler Aff. at ¶¶ 16; Hr'g Tr. 55:7-9.

29. Aliera primarily drafted the Amended Memorandum of Understanding with participation from AHS representatives. Hr'g Tr. 55:15-16; 164:7-20; Smith Aff. at ¶5.

30. The Amended Memorandum of Understanding contemplated that AHS would create a new nonprofit subsidiary, Unity, to offer HCSM plans. Hochstetler Aff. at ¶ 16.

31. The Amended Memorandum of Understanding further contemplated that Aliera and AHS, through its new subsidiary Unity, would partner to sell two-part healthcare products. It provided that "AHS and [Aliera] wish to cooperate as set forth in this MOU so that the [Aliera] products along with the AHS products are sold side by side and marketed to the public members who are or agree to become members of the faith-based ministry membership and health plan." Joint Ex. 3 at p. 1 (Amended Memorandum of Understanding); Hochstetler Aff. at ¶ 16; Hr'g Tr. 57:5-11.

32. The Amended Memorandum of Understanding described Aliera's role in Section 2.5(j) as follows: "AHS will contract with [Aliera] to market Unity Healthshare, service memberships, cover claims, handle bill reductions, and generally operate Unity Healthshare, subject to the direction of the board of AHS. [Aliera] will charge an anticipated $25 per member, per month for this service." Joint Ex. 3 at p.3.

33. The Amended Memorandum of Understanding at Section 1.2 provided in part: "[Aliera] is and shall remain the sole and exclusive owner or authorized licensee of and will retain all right, title, and interest, including all intellectual property rights, in and to the [Aliera] Products, and AHS is and shall remain the sole and exclusive owner or authorized licensor of and will retain all right, title, and interest, including all intellectual property rights, in and to the AHS product offerings, except for the specific licenses granted to [Aliera] or specific grants by [Aliera] to AHS…" Joint Ex. 3 at p.2.

34. The Amended Memorandum of Understanding also contemplated that the parties would "enter into a more formal understanding and written agreement as quickly as possible . . . to formalize their understanding and agreement." Joint Ex. 3 at p. 1.

35. On February 1, 2017, Aliera and AHS entered into a written contract ("the Agreement"). Hochstetler Aff. at ¶ 17; Hr'g Tr. 59:4-7; Joint Ex. 4 (Agreement).

36. Aliera drafted the Agreement although the parties negotiated the terms. Hr'g Tr. 58:23-24, 59:12-14; Smith Aff. at ¶5.

37. The fourth "Whereas" clause on the first page of the Agreement provides, in relevant part, that AHS and Aliera "have agreed to cooperate and partner together in accordance with the

Amended Memorandum of Understanding, whereby the two parties agree to enable ALIERA to market and sell the two part non-insurance products to AHS and ALIERA and/or [Unity] members." Joint Ex. 4 at p. 1.

38. The fifth "Whereas" clause goes on to state that "AHS and its subsidiary, UHS, wish to market products through ALIERA's DPCMH model of care, network, administration, call center, marketing, plan design, website administration, enrollment portal, concierge services, telemedicine, and other related services, and whereas, AHS and [Unity] do hereby contract with ALIERA to provide said services, in accordance with the terms and conditions contained herein." Joint Ex. 4 at p. 1.

39. The ninth "Whereas" clause provides: "AHS is granting ALIERA an exclusive **license to sell and distribute [Unity] products** to the public markets (*pubic markets means persons who will acknowledge the standard of beliefs and other requirements as deemed necessary by AHS*) via all distribution channels…" Joint Ex. 4 at p. 2 (capitalized and italicized emphasis in original; bold emphasis added). Section 1.2 further provides that AHS, on Unity's behalf, granted Aliera a "U.S. wide, royalty-free, non-transferable, exclusive[] **license**." Joint Ex. 4 at p. 2 (bold emphasis added).

40. Section 1.3 provides: "**During the term of this agreement** ALIERA shall remain the sole and exclusive authorized non-insurance health care company allowed to market and sell health care products to ALIERA and Unity HealthShare members. Aliera will retain all right, title, and interest including all intellectual property rights, in and **to the ALIERA products**, and AHS is and shall remain the sole and exclusive owner or authorized licensor of and will retain all right, title, and interest, including all intellectual property rights, in and to the membership roster, except for the specific licenses granted in Sections 1.2." Joint Ex. 4 at p. 2 (bold emphasis added).

41. Section 1.4 provides that the "HealthShare offerings [are] to be marketed and sold by Unity HealthShare, LLC." Joint Ex. 4 at p.2.

42. Section 7(g) states that "Aliera will design and implement all cost sharing plans, marketing materials, operational controls and general business banking for [Unity] subject to access and approval by the AHS Board of Directors." Joint Ex. 4 at p. 5.

43. Under Section 7(d), Unity was to escrow $2.00 per member per month from each new membership application into a "ministry fund" to be administered directly by AHS. Joint Ex. 4 at p. 5. Unity also agreed to deposit $25.00 from each one-time application fee per membership to be used by AHS as it deemed most appropriate to further the intent of the ministry and cover administration and related costs. *Id.*

44. Section 7(f) sets forth a "profit-sharing arrangement" whereby Eldon and Tyler Hochstetler each received $2.50 per enrolled member in Unity per month. Joint Ex. 4 at p. 5.

45. Section 4 of the Agreement is entitled "Administrative Fees" and states, in relevant part: "It is agreed that ALIERA shall be entitled to retain the initial enrollment fee, and the first monthly membership fee payment. The second monthly membership fee payment shall also be retained by ALIERA, to be used if necessary for ALIERA or [Unity] expenses. Thereafter, any succeeding month(s) which the membership is continued, ALIERA shall be entitled to retain $25.00 PMPM [*i.e.*, "per member per month"] as payment for its services." Joint Ex. 4 at pp. 3-4. Thus, the parties' Agreement provides Aliera with more compensation than what was contemplated in the Amended Memorandum of Understanding.

46. The Administrative Fees paid to Aliera under Section 4 of the parties' Agreement amounted to millions of dollars. Hr'g Tr. 307:17-308:5.

47. Section 7(l) of the Agreement states that the parties' contract is integrated: "This Agreement contains the entire understanding between the Parties with respect to the subject matter hereof and supersedes all and any prior understandings, undertakings and promises between AHS, [Unity], and ALIERA, whether oral or in writing." Joint Ex. 4 at p. 6.

48. Tyler Hochstetler testified that, during the parties' negotiations concerning the Agreement, Timothy Moses told Tyler that he had retired after building a billion-dollar company. Hr'g Tr. 54:8-55:1.

49. In 2005, a federal jury found Timothy Moses guilty of securities fraud and perjury. *See United States v. Moses*, No. 1:04-cr-508-CAP (N.D. Ga.), at ECF 86. Mr. Moses was sentenced on

February 17, 2006 to 78 months' imprisonment followed by a term of five years' supervised release. *Id.* at ECF 96. Soon after his release, Judge Pannell revoked Mr. Moses's supervised release because he had misled his supervising probation officer about his financial affairs and failed to disclose bank account information and new lines of credit. *Id.* at ECF 145 & 150. Mr. Moses's supervised release was terminated in April 2015 (*see id.* at ECF 167), approximately six months prior to Aliera's creation and approximately one and a half years prior to Aliera and Mr. Moses approaching AHS and Mr. Hochstetler about forming a relationship.

50. Tyler Hochstetler testified that he learned about Tim Moses' criminal conviction in the "first half" of 2017. Hr'g Tr. 151:21-24.

The Parties' Business Relationship

51. Aliera offered its products to the public in conjunction with the Unity HCSM plans. Hochstetler Aff. at ¶ 19; Hr'g Tr. 107:8-20.

52. Individuals and families who purchased a Unity HCSM plan could claim an exemption from the tax penalty of the ACA individual mandate. Hochstetler Aff. at ¶¶ 12, 19; Hr'g Tr. 50:4-6

53. The marketing materials for the side-by-side plan offerings emphasized the Unity HCSM exemption from the tax penalty of the ACA's individual mandate. Hr'g Tr. 188:22-189:18.

54. Members interfaced with Aliera with respect to both plans because Aliera served as the program administrator for the Unity HCSM plans under the Agreement. Hochstetler Aff. at ¶ 20.

55. Unity entrusted Aliera with Unity HCSM member information and the Unity HCSM plan assets. Hochstetler Aff. at ¶ 20; Hr'g Tr. 80:21-81:4.

56. Some individuals purchased plans that contained only an Aliera product and some individuals purchased plans that contained only a Unity HCSM product. The vast majority of individuals, however, purchased plans that contained two separate products: an Aliera DPCMH product and a Unity HCSM product. Hr'g Tr. 188:13-189:18. Though those plans were offered side by side, Aliera represented to third parties during the course of its relationship with AHS/Unity, consistently with the fact that only the Unity HCSM was ACA exempt, that the plans were legally separate and distinct. *See*

Corresp. to Fla. Office of Ins. Reg., Joint Ex. 6 at pp. 1-2; Corresp. to Maryland Ins. Comm'r, Joint Ex. 1 at p. 2.

57. The separate and distinct nature of the Unity HCSM plans is also reflected in the Member Guide admitted into evidence, which was drafted by Aliera. Joint Ex. 5; Hr'g Tr. 65:25-66:12.

58. The Member Guide delineates between the Aliera component and the Unity HCSM component of the combined plans. For example, the Member Guide distinguishes between "Aliera Healthcare services and Unity HealthShare cost sharing," which "combine to create a full range of services and benefits." Joint Ex. 5 at p. 4. Part I of the Member Guide relates to information about Aliera's products. Part II of the Member Guide relates to the Unity HCSM. *See generally* Joint Ex. 5.

59. Part II of the Member Guide makes clear that the HCSM is a Unity HealthShare plan and that the members of such plan are Unity HealthShare members. For example, Part II begins by describing Unity HealthShare as "a health care sharing ministry (HCSM) which acts as an organizational clearing house to administer sharing of health care needs for qualifying members." *Id.* It also outlines certain criteria that individuals must meet in order to "become and remain a member of Unity HealthShare." *Id.* at p. 11. The Member Guide also states that "[m]embers wishing to change to a membership type other than that in which they are currently participating may, at the discretion of Unity HealthShare, be required to submit a new signed and dated membership application for review." *Id.* at p. 12. And page 13 of the Member Guide defines the term "Membership" as "[a]ll members of Unity HealthShare." *Id.* at p. 13. Monthly contributions are defined as monetary contributions "voluntarily given to Unity HealthShare to hold as an escrow agent and to disburse according to the membership escrow instructions." *Id.* at p. 14. These are just a few examples of how Part II of Member Guide defines the HCSM plan as a Unity product, separate and distinct from the Aliera product.

60. Moreover, the Member Guide requires members to seek resolution of any disputes concerning their HCSM plan with Unity, ***not*** Aliera. *See id.* at p. 17. The Dispute Resolution and Appeal section of the Member Guide outlines the various steps that a member must take to challenge determinations made by the HCSM. The first level of appeal asks the member to "call[] Unity

Healthshare," which "will try to resolve the matter within ten (10) working days in writing." *Id.* The second level of appeal is to an "Internal Resolution Committee, made up of three Unity HealthShare officials." *Id.* The third level of appeal is to submit the dispute to "three sharing members in good standing and randomly chosen by Unity HealthShare." *Id.*

61. If the various levels of appeal do not result in a resolution that is satisfactory to the member, then the member must pursue the claims through a mediation and arbitration with Unity HealthShare. The Member Guide states that "Unity HealthShare shall pay the fees of the arbitrator in full and all other expenses of the arbitration." *Id.*

62. Aliera is not referenced in the dispute resolution provision in Part II for the HCSM plan.

63. The Member Guide also expressly accords Unity, not Aliera, with exclusive subrogation rights for amounts paid or found to be payable by an institutional source or a liable third party, which further evidences that the HCSM plans belonged to Unity, not Aliera. *Id.* at p. 19.

64. Consistent with the Member Guide, during the course of the parties' relationship, Aliera described itself to regulators as a third-party administrator of the Unity HCSM plans. For example, Aliera explained to the Maryland Insurance Commissioner that "as a program administrator for Unity plans, Aliera is exempt from Maryland licensing laws because Aliera does not market insurance in Maryland." Corresp. to Maryland Ins. Comm'r, Joint Ex. 1 at p. 2.

65. Tyler Hochstetler testified that AHS/Unity understood that, under the parties' Agreement, member funds collected for Unity products were to be segregated in a separate account that belonged to Unity. Hr'g Tr. at 70:14-17.

66. Tyler Hochstetler also testified that AHS/Unity trusted that Aliera would properly account for Unity HCSM plan assets and that Aliera would keep the Unity HCSM plan assets separate from Aliera's funds. Hr'g Tr. 80:21-81:4.

67. Aliera represented to third parties, such as the Florida Office of Insurance Regulation, that it was in fact segregating the Unity HCSM plan assets from other funds. Specifically, a law firm retained by Aliera to represent it in proceedings before the Florida Office of Insurance Regulation stated

in September 2017 that "Aliera provides and maintains the portal used by members to purchase products. Funds collected through the portal for Unity products are disbursed directly to Unity Healthshare. Likewise, funds collected through the portal for Aliera products are disbursed directly to Aliera." Corresp. to Fla. Ins. Comm'r, Joint Ex. 6 at 1. Aliera also stated in its Motion to Reconsider that "[a]ll of the [Unity HCSM plan members'] money – in the form of payments to Aliera, to Trinity, to Unity, and payments from those entities to providers – can be traced." Aliera's Motion to Reconsider at 8 (Jan. 2, 2019).

68. Tyler Hochstetler testified that in January 2018, he learned for the first time that Aliera was not properly segregating the Unity HCSM plan assets. According to Tyler Hochstetler, Timothy Moses stated at a January 2018 meeting of the AHS Board that Aliera had not segregated the Unity HCSM plan assets, but instead unilaterally allocated revenues in the manner in which Aliera saw fit, keeping as much of the incoming member funds for Aliera's own benefit as it desired. Hr'g Tr. 71:10-16; 79:20-80:10.

69. Tyler Hochstetler testified that Aliera did not have AHS/Unity's permission or authorization to treat member funds in this way, and that AHS/Unity never authorized Aliera to place Unity funds into Aliera accounts or to use Unity funds for Aliera's own purposes. Hr'g Tr. 70:21-24 & 80:14-20.

70. The evidence shows that, per Timothy Moses' admissions to AHS/Unity, the representations that Aliera made to the Florida Office of Insurance Regulation about the way it treated Unity HCSM plan funds were incorrect. Indeed, Aliera's Comptroller, James F. Butler, III, acknowledged at the interlocutory injunction hearing in this case that member contributions associated with the Unity HCSM plans were not sent directly to Unity Healthshare. Hr'g Tr. at 334:6-335:4. Rather, Mr. Butler testified that: payments were received by Aliera and deposited into an account; when transactions occurred Aliera transferred money to pay for the claims; and later there would be a monthly reconciliation whereby contribution payments were segregated into Aliera and Unity accounts. Hr'g Tr. 331:21-333:13.

71. On May 4, 2018, Unity also learned that Timothy Moses had written approximately $150,000 dollars in checks to himself out of the Unity operating account without AHS/Unity's knowledge or authorization. Hochstetler Aff. at ¶ 28; Hr'g Tr. 83:5-86:3.

72. Tyler Hochstetler testified that after learning that the Unity HCSM plan assets were not being properly segregated, AHS/Unity took immediate steps to secure the integrity of its funds. Hr'g Tr. 81:5-12.

73. AHS/Unity first demanded an accounting of Unity funds so that AHS/Unity could assess whether Aliera was handling Unity HCSM plan assets appropriately. Hr'g Tr. 81:5-12. Aliera did not provide Unity with an accounting. Hochstetler Aff. at ¶¶ 24-25.

74. On July 25, 2018, AHS/Unity instructed Aliera to turn over control of Unity funds to Unity immediately and directed Unity HCSM plan members to make future payments to Unity. Hr'g Tr. at 81:13-22. Aliera did not comply with either of these demands, and continued to collect funds associated with the Unity HCSM component of member plans. Hr'g Tr. at 83:2-4; 195:2-23.

75. AHS/Unity has presented evidence that it became increasingly concerned about Aliera's administration of its plans during the summer of 2018. It was particularly troubled by Aliera's repeated refusals to disclose information about the Unity HCSM plans that Aliera had assumed complete control over. Hochstetler Aff. at ¶¶ 24-26; Hr'g Tr. 79:20-86:17.

76. Tyler Hochstetler testified that given Timothy Moses's criminal history, Mr. Moses's taking funds from the Unity operating account, and Aliera's refusal to disclose complete financial information, he and other AHS Board members became seriously concerned that the Unity HCSM plan assets were at risk of misappropriation. Hochstetler Aff. at ¶ 24-29; Hr'g Tr. 79:20-86:17.

77. Tyler Hochstetler testified that AHS/Unity removed Timothy Moses and Shelley Steele from certain Unity bank accounts as signers and ultimately froze two accounts containing approximately $5 million in funds used to pay claims. Hr'g Tr. 82:21-83:4, 147:8-149:24.

AHS/Unity Terminates the Agreement

78. With respect to termination, Section 3 of the Agreement provides:

> This Agreement will commence on the Effective Date and will remain in effect perpetually after the execution date of this [A]greement, unless terminated or modified earlier by mutual agreement or substantial, material breach of this contract. However, upon termination, any existing member plans will remain active until the member's next renewal date.
>
> **Upon termination of this Agreement, all licenses granted hereunder shall immediately terminate, and the Parties will promptly destroy or return all materials in its possession which belong to the other Party, including any and all confidential information which may have come into its possession.** In the event of any termination of this Agreement, Sections 2, 3.2 and 4., 5. and 6. will survive in accordance with their terms.

Joint Ex. 4 at p. 3 (bold emphasis added).

79. On August 10, 2018, following a failed mediation with Aliera, AHS terminated the Agreement. Hochstetler Aff. at ¶ 30; Hr'g Tr. 86:18-19, 146:14-20.

80. AHS/Unity's termination included an express revocation of Aliera's right to hold the Unity HCSM plan funds and demanded that Aliera return control over those funds to AHS/Unity. Hr'g Tr. 89:12-21; 179:17-23. Aliera disagreed and did not turn over the Unity HCSM plan funds. Hr'g Tr. 89:19-21.

81. AHS/Unity sought to have Aliera provide it with the Unity HCSM membership roster. Hr'g Tr. 88:16-22. Aliera disagreed and did not provide the Unity HCSM membership roster to AHS/Unity. Hr'g Tr. 88:16-22.

82. Aliera retained possession of the Unity membership roster, all of the Unity HCSM plans, all of the Unity HCSM plan assets, Unity's intellectual property, including the Unity website, and Unity's employees. Hr'g Tr. 88:11-22.

83. Tyler Hochstetler testified that Aliera's retention of the financial information concerning the Unity HCSM plans has prevented AHS/Unity from completing its 2017 and 2018 audits, which are necessary to retain Unity's status as a HCSM. Hr'g Tr. 91:13-92:5; 92:12-19.

84. AHS/Unity's inability to complete its audit jeopardizes its status as a tax exempt and ACA-approved HCSM. Hr'g Tr. 91:13-92:16.

85. Tyler Hochstetler testified that if AHS/Unity's HCSM status as an ACA-approved HCSM is lost, it may become very difficult to recover, as HCSMs must share healthcare expenses of its members continuously and without interruption from 1999 to the present. Hr'g Tr. 92:6-11.

86. Tyler Hochstetler testified that Aliera has prevented AHS/Unity from doing business with a key vendor. Hr'g Tr. 90:6-20.

87. After termination of the Agreement, Aliera retained the entirety of the Unity HCSM plans' member base for itself. Hr'g Tr. 90:6-12.

88. After termination of the Agreement, Aliera continued to maintain control over Unity's website and refused Unity's claims to it. Hr'g Tr. 91:2-12.

89. The testimony at the hearing demonstrates that Aliera continues to controls the Unity website, www.unityhealthshare.org and www.unityhealthshare.com. Aliera has configured those website so that when a member visits them, the member is automatically redirected to the website of Trinity Healthshare ("Trinity"). Hr'g Tr. 91:2-12.

90. In 2018, Unity changed its name to Kingdom Healthshare. Mr. Cardona testified that Unity decided to change its name to Kingdom Healthshare in part because Aliera maintained control of the Unity HCSM plans and Unity's website. Hr'g Tr. 170:22-25; 195:24-198:6.

Change from Unity HSCM to Trinity HCSM

91. On November 15, 2018, Aliera sent a notice to all Unity HCSM members. Joint Ex. 9.

92. Aliera's November 15, 2018 notice stated "***No Action is Needed***" in bold italics font, near the top of the notice. Joint Ex. 9.

93. Aliera's November 15, 2018 notice announced that it would transition all Unity HCSM members to Trinity on January 1, 2019. Joint Ex. 9.

94. Trinity was created in 2018 by Aliera and its principals. Its Chief Executive Officer is William H. ("Rip") Thead, III, a former Aliera employee. Hr'g Tr. 300:8-16. Mr. Thead is a Moses

family friend who officiated Chase Moses's wedding. Hr'g Tr. 300:19-23. Chase Moses testified that Trinity is a 501(3)(c) and that it is "based on the Baptist faith." Hr'g Tr. 301:2-302:20.

95. The November 15, 2018 notice stated in part: "Beginning January 1st, 2019 Aliera is excited to announce Trinity HealthShare as its new Healthcare Sharing Ministry (HCSM) partner…All plan features, including eligible medical services, Member Shared Responsibility Amount ("MSRA"), and monthly member contribution amounts (how much you are billed each month) will remain the same. You also retain access to the same network providers and facilities with the same discounts. ***Nothing changes on your plan except for the HCSM name. You don't have to do anything to maintain your current plan.*** You will retain your Member ID number and continue to contact Aliera Member Services for any assistance you may need regarding your membership. You will receive an updated plan membership card. All contact and processing information remains the same. If for any reason, you wish not ***to continue*** with your AlieraCare 5000 – Premium Plan Plan, [sic] you may opt-out by clicking here to complete a member cancellation form. An Aliera representative will follow up with you promptly to process your request." Joint Ex. 9 (emphasis added).

96. Unity HCSM members had to take affirmative action to opt out of the transition of their plans from Unity plans to Trinity plans.

97. Trinity is a separate and distinct entity from Unity Healthshare. Trinity is in no way affiliated with Unity. Hochstetler Aff. at ¶ 34; Hr'g Tr. 91:10-12.

98. Trinity was created in Delaware on June 26, 2018, and authorized to conduct business in Georgia on October 26, 2018. Joint Ex. 10.

99. The November 15, 2018 notice made no mention of Unity, or the fact that Unity had terminated its Agreement with Aliera. Joint Ex. 9.

The Court's TRO

100. On December 28, 2018, the Court entered a Temporary Restraining Order, which – in part – enjoined Aliera from "transitioning any Unity HCSM members and plan assets to Trinity HealthShare LLC while this Temporary Restraining Order is in effect."

101. The Temporary Restraining Order also required Aliera to "use electronic means to notify as many Unity HSCM plan members as possible by January 1, 2019, that they will not automatically move to Trinity effective January 1, 2019, as previously stated in Aliera's November 15, 2018 electronic correspondence . . ."

102. Aliera, however, did not send this notice out to Unity HCSM members until two days after denial of its motion to reconsider the Court's TRO, on January 10, 2019. Hr'g Tr. 312:1-8.

II. CONCLUSIONS OF LAW

Under Georgia law, a court may enter an interlocutory injunction "to maintain the status quo, if, after balancing the relative equities of the parties, it appears the equities favor the party seeking an injunction." *Bernocchi v. Forcucci*, 279 Ga. 460, 461, 614 S.E.2d 775, 777 (2005).

In weighing the relevant equities, the Court considers the following factors:

(1) whether there is a substantial threat that the moving party will suffer irreparable injury if the injunction is not granted;

(2) whether the threatened injury to the moving party outweighs the threatened harm that the injunction may do to the party being enjoined;

(3) whether there is a substantial likelihood that the moving party will prevail on the merits of her claims at trial;

(4) whether granting the interlocutory injunction will not disserve the public interest.

Bishop v. Patton, 288 Ga. 600, 604, 706 S.E.2d 634, 638 (2011). These factors guide the Court's weighing of the equities, but "a party seeking interlocutory injunctive relief need not always 'prove all four of these factors.'" *SRB Inv. Servs., LLLP v. Branch Banking & Tr. Co.*, 289 Ga. 1, 5 n. 7, 709 S.E.2d 267, 271 (2011).

As an initial matter, in weighing the relevant equities on the facts presented here, the Court finds instructive the Georgia Supreme Court's decision in *Grossi Consulting, LLC v. Sterling Currency Grp., LLC*, 290 Ga. 386, 722 S.E.2d 44 (2012). In that case, the Supreme Court affirmed an interlocutory injunction where the moving party's former contractor – initially hired to create a website and technology infrastructure to aid the movant's business – held the movant's assets after termination of the parties'

business relationship. *Id.* The Supreme Court found that because the former contractor had gained control of the movant's assets by virtue of the parties' business relationship, the Court did not abuse its discretion in ordering the contractor to relinquish control of those assets. *Id.* The contractor's continued possession of the movant's assets threatened dissipation of the assets during litigation. *Id.*

In this case, and as more fully set forth below, the evidence shows that AHS/Unity is substantially likely to succeed on its claim that it held all rights to the Unity HCSM plans and that Aliera serviced those plans solely as a third-party administrator under the parties' Agreement. *See* Findings of Fact ("FOF") at ¶¶ 23-24, 54-56, 64. The evidence further shows that, as in *Grossi*, Aliera had substantial control over the Unity HCSM plan assets by virtue of the parties' Agreement and Aliera's role as an administrator of the Unity HCSM plans. FOF at ¶¶ 55, 65-66, 87-90. And, most importantly, the evidence shows that Aliera has taken actions to misappropriate those assets; namely, by unilaterally attempting to transition the Unity HCSM plans to Trinity. FOF at ¶¶ 91-99.

An interlocutory injunction is legally appropriate to prevent Aliera from transitioning all Unity plan members and plan funds to a new HCSM, and to protect those funds from misappropriation and waste pending a final resolution on the merits. Moreover, the terms of the interlocutory injunction – enjoining the transition of Unity HCSM members to Trinity coupled with a receivership – are less intrusive than in *Grossi* where the court ordered a transfer of all disputed assets to the movant. Accordingly, the Court finds that the Georgia Supreme Court's decision in *Grossi* governs the propriety of granting an interlocutory injunction under the circumstances presented here.

Moreover, upon consideration of the parties' briefing, the exhibits attached thereto, and the evidence adduced at the hearing, the Court finds that each equitable factor weighs in favor of an interlocutory injunction in this case.[3]

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[3] To the extent Defendants argue Section 2.4 of the Agreement forecloses injunctive relief, the Court disagrees. That section provides:

> EXCEPT FOR (i) A PARTY'S BREACH OF ITS CONFIDENTIALITY OBLIGATIONS SET FORTH IN SECTION 6. AND (ii) A PARTY'S INDEMNITY OBLIGATIONS SET FORTH IN SECTION 5. **NEITHER PARTY WILL BE**

Likelihood of Success on the Merits

The Court finds that AHS/Unity is likely to succeed on its claim for breach of the parties' Agreement. While the Court is not making a final determination regarding contract interpretation at this time nor deciding the parties' claims seeking declaratory relief, the Court preliminarily concludes for purposes of deciding this interlocutory injunction that a fair reading of the Agreement is that the Unity HCSM plans belonged to AHS/Unity with Aliera administering the Unity HCSM plans as consideration for the administrative fees provided for under the Agreement. FOF at ¶¶ 45-46. This interpretation is consistent with the statutory requirements for HCSMs like Unity. The Court finds that there is a substantial likelihood that AHS/Unity will succeed on the merits of its declaratory judgment claim and its claim that Aliera's treatment of the Unity HCSM plans and its retention of the Unity HCSM plans and plan assets after termination of the parties' contract was a material breach of the parties' Agreement. Unity is also likely to succeed on the merits of its breach of fiduciary duty claim.

First, AHS/Unity is likely to succeed on its declaratory judgment claim that the Agreement

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> **LIABLE TO THE OTHER PARTY FOR ANY INCIDENTAL, CONSEQUENTLY, SPECIAL, OR PUNITIVE DAMAGES** ARISING OUT OF THIS AGREEMENT, WHETHER LIABILITY IS ASSERTED IN CONTRACT OR TORT, AND REGARDLESS OF WHETHER EITHER PARTY HAS BEEN ADVISED OF THE POSSIBILITY OF ANY SUCH LOSS OR DAMAGE THIS SECTION DOES NOT LIMIT EITHER PARTY'S LIABILITY FOR BODILY INJURY (INCLUDING DEATH), OR PHYSICAL DAMAGE TO TANGIBLE PROPERTY. NOTWITHSTANDING ANYTHING TO THE CONTRARY IN THIS AGREEMENT, EXCEPT AS PROVIDED FOR A BREACH OF SECTION 4.1 (CONFIDENTIALITY OBLIGATIONS) OR EXCEPT AS PROVIDED UNDER SECTION 2.5 (INDEMNITY OBLIGATIONS), **IN NO EVENT SHALL EITHER PARTY'S TOTAL LIABILITY TO THE OTHER PARTY IN CONNECTION WITH, ARISING OUT OF OR RELATING TO THIS AGREEMENT EXCEED $5,000 (USD).** THE PARTIES AGREE THAT THE LIMITATION SPECIFIED IN THIS SECTION WILL APPLY EVEN IF ANY LIMITED REMEDY PROVIDED IN THIS AGREEMENT IS FOUND TO HAVE FAILED OF ITS ESSENTIAL PURPOSE.

Joint Ex. 4 at p. 3 (capitalized emphasis in original; bold emphasis added). The foregoing section plainly describes "liability" in terms of damages and limits the parties' entitlement to monetary relief. However, it does not address injunctive or other equitable relief, much less do so explicitly, prominently clearly and unambiguously. *See Imaging Sys. Int'l, Inc. v. Magnetic Resonance Plus, Inc.*, 227 Ga. App. 641, 644–45, 490 S.E.2d 124, 128 (1997) ("Provisions severely restricting remedies act as exculpatory clauses and therefore should be explicit, prominent, clear and unambiguous") (citation and punctuation omitted); *2010-1 SFG Venture LLC v. Lee Bank & Tr. Co.*, 332 Ga. App. 894, 898, 775 S.E.2d 243, 248 (2015) ("[B]ecause exculpatory clauses may amount to an accord and satisfaction of future claims and waive substantial rights, they require a meeting of the minds on the subject matter and must be explicit, prominent, clear and unambiguous") (citation and punctuation omitted).

provides that AHS/Unity holds the rights to the Unity HCSM plans, and that Aliera has breached the Agreement in how it has treated the Unity HCSM plans and plan assets as its own. As summarized in *Scrocca v. Ashwood Condo. Ass'n, Inc.*, 326 Ga. App. 226, 756 S.E.2d 308 (2014):

> [C]ontract construction proceeds in a series of steps, moving from one to the next only if necessary. The construction of contracts involves three steps. At least initially, construction is a matter of law for the court. First, the trial court must decide whether the language is clear and unambiguous. If it is, the court simply enforces the contract according to its clear terms; the contract alone is looked to for its meaning. Next, if the contract is ambiguous in some respect, the court must apply the rules of contract construction to resolve the ambiguity. Finally, if the ambiguity remains after applying the rules of construction, the issue of what the ambiguous language means and what the parties intended must be resolved by a jury....
>
> When courts construe contracts, the primary purpose is ascertaining the parties' intent: [C]ourts should ascertain the parties' intent after considering the whole agreement and interpret each of the provisions so as to harmonize with the others. That is, in construing contracts, it is important to look to the substantial purpose which must be supposed to have influenced the minds of the parties, rather than at the details of making such purpose effectual.

Id. at 228-29 (citations omitted).

Here, Section 1.3 of the Agreement states, in part, that "AHS is and shall remain the sole and exclusive owner or authorized licensor of and will retain all right, title, and interest, including all intellectual property rights, in and to the membership roster, except for the specific licenses granted in Sections 1.2." Agreement, Joint Ex. 4 at p. 2. Upon consideration of two days of testimony from six witnesses and the voluminous evidence and briefing submitted by the parties, the Court finds that AHS/Unity is likely to succeed on its claim that the parties' Agreement provides that Unity, and not Aliera, is the owner of the Unity HCSM plans and plan assets.[4] A fair reading of the Agreement is that

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[4] The Court rejects Aliera's argument that such a construction of the Agreement violates federal antitrust laws. Accepting AHS/Unity's construction of the Agreement does not allocate customers between horizontal competitors as Aliera suggests. Indeed, Aliera and Unity are not horizontal competitors because only Unity is a non-profit organization and therefore only Unity can qualify as an HCSM under Georgia law, federal law, and the laws of numerous other states. Because Aliera cannot compete with Unity for HCSM members, there is no basis for a claim of an antitrust violation. *See Ad-Vantage Tel. Directory Consultants v. GET Directories Corp.*, 849 F.2d 1336, 1346 (11th Cir. 1987) ("[T]here can be no antitrust violation without a competitor, and agents do not compete with those whom they represent"). Even if Aliera and AHS/Unity, through their affiliates, currently "compete" in the HCSM market, such does not change the Court's analysis. As noted above, a fair reading of the Agreement is that AHS/Unity granted Aliera a license to market and sell the Unity HCSM plans, not that AHS/Unity was "allocating" customers to a competitor.

AHS/Unity granted Aliera a license to market and sell the Unity HCSM plans. As the party with authority to grant a license to market and sell the plans, AHS/Unity is substantially likely to be able to demonstrate that it is the plan owner. Moreover, Section 1.4 of the Agreement confirms that the "Healthshare offerings" are "to be marketed and sold by Unity HealthShare, LLC." Aliera's role in the parties' relationship is delineated in Section 7(g) of the Agreement, which provides that "ALIERA will design and implement all cost sharing plans, marketing materials, operational controls and general business banking for [Unity] for its operation of Unity HealthShare, subject to access and approval by the AHS Board of Directors."

Aliera's compensation structure under the Agreement is further evidence that AHS/Unity's reading of the contract is substantially likely to be correct. Section 4 of the Agreement entitles Aliera to "Administrative Fees" on a per member per month basis. FOF at ¶45. Aliera has received millions of dollars in administrative fees. FOF at ¶ 46. Through Section 4, AHS/Unity and Aliera agreed that Aliera would be paid substantial administrative fees for administering the Unity HCSM plans. Such a provision is wholly consistent with administration, not ownership.

Moreover, AHS/Unity's reading of the contract is consistent with the nature of the parties' business relationship. The testimony reveals that only AHS/Unity, not Aliera, is a recognized HCSM. Indeed, Aliera, as a for-profit company, cannot qualify as an HCSM. *See, e.g.*, O.C.G.A. § 33-1-20 (defining an HCSM as "a faith-based, nonprofit organization that is tax exempt under the Internal Revenue Code" which meets the six specific requirements set forth in the statute).[5] FOF at ¶¶ 10-14. Thus, it makes sense that AHS/Unity, and not Aliera, would retain the right to the Unity HCSM plans and plan assets after termination of the Agreement. Further, Aliera represented to, *e.g.*, the Maryland Insurance Commissioner that it acted as an administrator for the Unity HCSM plans, nothing more. FOF

[5] *See also* Fla. Stat. § 624.1265(1) (defining a healthcare sharing ministry as "[a] nonprofit religious organization" that satisfies certain requirements); Tex. Ins. Code § 1681.001 ("A faith-based, nonprofit organization that is tax-exempt under the Internal Revenue Code of 1986 qualifies for treatment as a health care sharing ministry…"); Va. Code Ann. § 38.2-6300 ("As used in this chapter, 'health care sharing ministry' means a health care cost sharing arrangement…administered by a non-profit organization that has been granted an exemption from federal income taxation pursuant to § 501(c)(3) of the Internal Revenue Code of 1986…").

at ¶¶ 56, 64. In light of these facts, AHS/Unity is substantially likely to succeed on the merits of its claim that under a fair reading of the Agreement AHS/Unity holds the rights to the Unity HCSM plans.

Even if the Court were to ultimately conclude that the Agreement is ambiguous and consider parol evidence to determine which entity owns the Unity HCSM plans, the Court still finds that AHS/Unity is substantially likely to succeed on the merits. Tyler Hochstetler provided credible testimony that the parties intended that AHS/Unity, and not Aliera, would retain all rights to the Unity HCSM plans and plan assets. Furthermore, the law governing HCSMs, referenced above, strongly supports a conclusion that AHS/Unity's reading of the Agreement is not only correct, but the only reading permitted by law. Again, while the Court does not make that final determination at this point, there is a likelihood of success in favor of AHS/Unity on its claim that the Unity HCSM plans belong to it, not Aliera.

Finally, the Court finds that AHS/Unity is likely to succeed on the merits of its breach of fiduciary duty claim. "[A] claim for breach of fiduciary duty requires proof of three elements: (1) the existence of a fiduciary duty; (2) breach of that duty; and (3) damage proximately caused by the breach." *Engelman v. Kessler*, 340 Ga. App. 239, 246, 797 S.E.2d 160, 166 (2017) (quoting *Nash v. Studdard*, 294 Ga. App. 845, 849-850 (2), 670 S.E.2d 508 (2008)). Under Georgia law, "[a] fiduciary duty arises where one party is so situated as to exercise a controlling influence over the will, conduct, and interest of another." *Curry v. TD Ameritrade, Inc.*, No. 1:14-cv-1361, 2015 WL 11251449, at *10 (N.D. Ga. June 30, 2015) (quoting O.C.G.A. § 23-2-58). "The showing of a relationship in fact which justifies the reposing of confidence by one party in another is all the law requires." *Cochran v. Murrah*, 235 Ga. 304, 307, 219 S.E.2d 421, 424 (1975).

Here, the Court finds, for purposes of this interlocutory injunction, that AHS/Unity is likely to succeed in establishing that Aliera owed it a fiduciary duty given the testimony set forth above demonstrating that AHS/Unity delegated the administration of virtually all aspects of the Unity HCSM plans and plan assets to Aliera. *See Tom Brown Contracting, Inc. v. Fishman*, 289 Ga. App. 601, 603, 658 S.E.2d 140, 142 (2008) (finding fiduciary duties created under Georgia law when one party holds funds in escrow for another). AHS/Unity is also likely to succeed in establishing that Aliera breached this

fiduciary duty by refusing to provide AHS/Unity with complete information about the Unity HCSM plans and plan assets and in light of Tyler Hochstetler's testimony that Timothy Moses informed the AHS Board of Directors that Aliera was using funds that were supposed to be allocated to Unity for whatever purpose Aliera wished. *See Wright v. Apartment Inv. & Mgmt. Co.*, 315 Ga. App. 587, 594, 726 S.E.2d 779, 787 (2012) ("When a fiduciary relationship exists, the agent may not make a profit for himself out of the relationship to the injury of the principal.").

Irreparable Harm

The Court also finds that Aliera's actions, if not enjoined, will result in irreparable harm to AHS/Unity. The threat of irreparable harm "is the most important [factor], given that the main purpose of an interlocutory injunction is to preserve the status quo temporarily to allow the court and the parties time to try the case in an orderly manner." *Bishop*, 288 Ga. at 605. That said, "a demonstration of irreparable injury is not an absolute prerequisite to interlocutory relief." *Parker v. Clary Lakes Recreation Ass'n, Inc.*, 272 Ga. 44, 44, 526 S.E.2d 838, 839 (2000).

Aliera's plan to transition all Unity HCSM Members to Trinity threatens Unity with irreparable harm. The evidence shows that Trinity is not affiliated with Unity. FOF at ¶ 97. The evidence further shows that Aliera intended to unilaterally transition all Unity HCSM members to Trinity effective January 1, 2019. FOF at ¶¶ 91-99. Aliera made this intention clear in its November 15, 2018 notice to Unity HCSM members (*id.*) which, notably, was sent after this litigation was initiated and when the parties' rights with respect to the Unity HCSM plans were plainly in dispute.

The Court finds that Aliera's intent to transition all of Unity's members and plan assets to an entirely different entity – unaffiliated with Unity – amounts to irreparable harm. *See TMX Fin. Holdings, Inc. v. Drummond Fin. Servs.*, LLC, 300 Ga. 835, 839 n. 9, 797 S.E.2d 842, 846 (2017) (affirming interlocutory injunction where trial court balanced the equities and found "there was 'a substantial threat' that [the movant] would 'suffer irreparable injury in the form of lost customers"). The Court finds that the irreparable harm here – caused not by any external factors but by the very conduct that breached the parties' Agreement – weighs heavily in favor of equitable relief.

Further, the Court finds that Aliera's conduct during the parties' relationship and in light of AHS's termination of the Agreement threatens Unity's status as an HCSM. FOF at ¶¶ 83-85. Aliera's failure to provide AHS/Unity with important information about the Unity plan assets or to return control of the Unity plan assets to AHS/Unity upon termination threatens AHS/Unity's status as a 501(c)(3) non-profit organization and therefore its ability to function as an HCSM. Moreover, Aliera's refusal to provide AHS/Unity with information about its funds has impaired AHS/Unity's ability to complete its 2017 and 2018 annual audits, which are required to maintain its status as a 501(c)(3) organization. *Id.* AHS/Unity's 501(c)(3) status is integral to its status as an ACA-approved HCSM and its ability to operate as an HCSM under numerous state laws. *Id.* And once lost, an ACA-exemption cannot be recovered because the ACA requires continuous operation as an HCSM from December 1999 to the present. 26 U.S.C. § 5000A(d)(2)(B). As such, loss of AHS/Unity's status as a 501(c)(3) would amount to irreparable harm, and Aliera's conduct – unless enjoined – threatens such harm.

Finally, the Court finds that Aliera's conduct has harmed AHS/Unity's goodwill. *See Dunkin Donuts, Inc. v. Kashi Enters., Inc.*, 119 F. Supp. 2d 1363, 1364 (N.D. Ga. 2000) (harm to goodwill "constitutes an irreparable injury"). Aliera's unilateral decision to transition all of the Unity HCSM members to Trinity harms Unity's goodwill because the members have not been provided with any information about the reason that Aliera is attempting to transition the plans to Trinity and therefore conveys the impression that Unity was somehow unable to maintain their plans. This irreparable harm is especially acute given the unique nature of HCSMs, which require members to put a great deal of trust in the organizations that hold their member contributions, and the relatively small market of HCSMs. Moreover, Aliera's retaining the Unity website – and redirecting visitors to that website automatically to Trinity – also harms Unity's goodwill by suggesting that Unity has some sort of relationship with Trinity, which is not the case.

Public Interest

The Court is most concerned with the plan members' rights and welfare. The Court finds that an interlocutory injunction is in the members' interest, and thus the public interest.

Aliera has demonstrated a lack of transparency with respect to the Unity HCSM plans and funds. Aliera did not provide Unity with information about the Unity HCSM funds Aliera held and controlled — funds that members contributed with the understanding that they would be used to share in other members' healthcare expenses. After termination of the parties' Agreement, Aliera did not return control of the Unity funds to Unity as requested. Further, Aliera represented to state insurance regulators that it kept Unity funds separate from Aliera funds, but Aliera's Controller has now stated under oath that Aliera's prior representations to state regulators were not accurate. In light of the foregoing, and in consideration of all of the testimony, documentary evidence, and briefing in this case, the Court finds that Aliera's course of conduct evinces a threat of misappropriation of the plan assets. An interlocutory injunction – and appointment of a receiver, discussed more fully below – is necessary to protect the members' interests, and the public interests, during this litigation.

Moreover, the evidence shows that Timothy Moses, who exercises substantial control over Aliera, was convicted of felony securities fraud and perjury in federal court. Following his custodial sentence, the court revoked Moses's supervised release after finding that he lied to his probation officer about his financial situation. Moses did not inform AHS/Unity of any of this when proposing a relationship to AHS. Moreover, during the parties' relationship Moses wrote checks to himself out of the AHS/Unity operating account, without AHS/Unity's knowledge or authorization.

Balance of Harms

The Court finds that the threatened irreparable harm to AHS/Unity outweighs any harm to Aliera. As discussed more fully above, Aliera's conduct threatens irreparable harm to AHS/Unity. Importantly, the harm claimed by Aliera from the interlocutory injunction is largely self-inflicted. Had Aliera given control of the Unity HCSM plans back to Unity upon termination of the parties' Agreement – as requested by AHS/Unity – it would not have had to incur costs associated with maintaining those plans following termination. And if Aliera had not taken steps to unilaterally transition those Unity HCSM plans to Trinity – a separate and distinct entity from Unity – Aliera would not have had to incur costs of stopping that transition – a transition the Court has found is likely unlawful. Moreover, the interlocutory

injunction impacts only the Unity HCSM plans. It does not impact any of Aliera's other products, including the DPCMH products that Aliera sold. The interlocutory injunction also does not impact Aliera's ability to market and sell the Trinity HCSM. In consideration of all of the evidence and argument presented, the Court finds the balance of the harms favors AHS/Unity.

Appointment of Receiver

Under Georgia law, "[w]hen any fund or property is in litigation and the rights of either or both parties cannot otherwise be fully protected or when there is a fund or property having no one to manage it, a receiver of the same may be appointed by the judge of the superior court having jurisdiction thereof." O.C.G.A. § 9-8-1. The Georgia Supreme Court has recognized that Superior Courts have broad power to appoint a receiver to administer disputed assets. *Georgia Rehab. Ctr., Inc. v. Newnan Hosp.*, 283 Ga. 335, 336, 658 S.E.2d 737, 738 (2008). Appointment of a receiver is appropriate under the circumstances presented here.

The Unity HCSM and plan assets are disputed. As discussed more fully above, AHS/Unity is likely to succeed on its claim that it holds the rights to the Unity HCSM plans and the right to possess the Unity HCSM plan assets under the parties' Agreement. However, Aliera disputes AHS/Unity's right to the plans and plan assets; and instead argues that Aliera should have control over those Unity HCSM plans and be allowed to transition or otherwise transfer those plans to Trinity. The parties' diametrically opposed positions with respect to the ownership of and rights to the Unity HCSM plans is a dispute over assets during litigation for which appointment of a receiver is appropriate. *See Ga. Rebab Ctr. Inc.*, 283 Ga. at 336 (appointment of receiver appropriate where dissolution of joint venture leaves disputed assets).

The Court finds a receivership all the more appropriate here because the evidence shows that Aliera did not provide a full accounting of Unity funds when AHS/Unity made a demand for such an accounting prior to the termination of the parties' Agreement. The Georgia Supreme Court has recognized that appointment of a receiver is appropriate where the parties cannot meaningfully account for the disputed assets during litigation. *Id.* (receivership appropriate where "no meaningful accounting could be done" because of "conflicting, incomplete, and inconsistent information"). Aliera's lack of

transparency with respect to the Unity HCSM funds has prevented any accounting of those same disputed funds. Appointment of a receiver is appropriate to account for, administer, and oversee those Unity HCSM plan funds during the pendency of this litigation.

Finally, the evidence shows a risk of Aliera misappropriating those disputed assets in absence of a receiver. *Mirko Di Giacomantonio v. Romagnoli*, No. 2007CV133477, 2007 WL 7330441 (Ga. Super. Oct. 4, 2007) (receivership appropriate under circumstances showing "waste . . . mismanagement, or misappropriation of assets"). As set forth above, AHS/Unity is likely to succeed on its claim that it holds the rights to the Unity HCSM plans. Aliera has attempted, however, during the pendency of this litigation to move those same assets to an entirely different entity that is unaffiliated with Unity. FOF at ¶91-99. Aliera's attempt to move what are likely Unity assets to a different entity after the Agreement was terminated and while litigation with respect to those assets was ongoing amounts to an attempt to misappropriate those assets. Accordingly, appointment of a receiver is necessary to protect the integrity of the plan funds during the pendency of the litigation.

The Court has considered – and rejects – Aliera's argument that the appointment of a receiver is inappropriate because it allegedly permits the receiver to take over Aliera's business. The Court's Order merely permits the receiver to have oversight of the Unity HCSM plans and assets (i.e., the member funds that are properly allocated to the Unity HCSM component of member plans) in order to monitor their proper allocation, preserve them and to ensure that member claims are paid consistently with the plan documents. The Georgia Supreme Court has consistently held that the appointment of a receiver is warranted in circumstances akin to these. *See, e.g.*, *Richardson v. Roland*, 267 Ga. 34, 35, 472 S.E.2d 301, 302 (1996) (receiver appropriate where evidence presented to court showed that "the assets belonging to [movant] were in [non-movant's] control and were likely to be impaired or depleted should they remain under that control"); *Alstep, Inc. v. State Bank & Tr. Co.*, 293 Ga. 311, 745 S.E.2d 613 (2013) (same); *Ebon Found. v. Oatman*, 269 Ga. 340, 344, 498 S.E.2d 728, 732 (1998) (evidence of commingling of disputed assets with non-disputed assets necessitated interlocutory injunction and appointment of receiver); *Warner v. Warner*, 237 Ga. 462, 462, 228 S.E.2d 848, 849 (1976) ("A receiver

is also appropriate…where the person who is managing the property seems inimical to its best interests"). Thus, for all of the reasons set forth above, the Court finds that the appointment of a receiver is appropriate here.

CONCLUSION

After full and careful consideration of the parties' briefing, exhibits attached thereto, and evidence presented at the hearing on AHS/Unity's Application for Interlocutory Injunction and for Appointment of Receiver, the Court finds that an Interlocutory Injunction and appointment of a receiver are appropriate under the facts presented here and under Georgia law.

The Court finds that there is a likelihood of success on the merits for AHS/Unity in this case, that the actions of Aliera are causing irreparable harm to Anabaptist and Unity, and that this harm outweighs any harm that may occur to Aliera as a result of this Order. The Court concludes that converting the Temporary Restraining Order that is currently in place, with some modification, to an Interlocutory Injunction is proper. Accordingly, the Court **ORDERS** that:

Aliera Healthcare Inc. ("Aliera") remains **ENJOINED** from moving, converting, or in any way unilaterally transitioning Unity Healthcare Sharing Ministry ("HCSM") members and Unity HCSM plan assets relating to all Unity HCSM members whose Unity HCSM plans existed as of August 10, 2018 and prior to that time to Trinity HealthShare, LLC.

However, insofar as Aliera asserts that, through its affiliate Trinity, it is offering an HCSM product to members/prospective members similar to AHS/Unity (now known as Kingdom Healthshare) and the Agreement does not include a non-compete or non-solicitation provision post-termination, the Court finds it would be improper to prohibit Aliera from soliciting the "legacy" Unity HCSM plan members after the termination as that would grant greater rights to AHS/Unity then contemplated under the Agreement. Thus, the Court finds either side may solicit the Unity HCSM plan members under the traditional confines of fair competition and Unity HCSM plan members are free to make their own decision as to whether to terminate or change their plan and which HCSM they wish to associate with, if any. Indeed, such is most consistent with the fundamental premise of a "health care sharing ministry" as a

faith-based, nonprofit organization with participants who are of a similar faith and who voluntarily agree to share in each other's medical expenses. In line with the Court's findings and rulings above, Aliera is **ORDERED** to provide AHS/Unity with the names and all contact information available for all Unity HCSM members whose Unity HCSM plans existed as of August 10, 2018 and prior to that time **within twenty-four (24) hours of the entry of this order**. Aliera may not begin to market/solicit the Unity HCSM members until members' contact information has been provided to AHS/Unity. Additionally, particularly given the history of this case and the ongoing litigation, the Court **strongly cautions** the parties not to disparage each other in any such marketing/solicitation efforts or to engage in other improper conduct which may result in the Court ordering additional injunctive relief. The Court **DENIES** Aliera's request to stay the injunction ordered herein pending an appeal.

The Court **ORDERS** appointment of a receiver pursuant to O.C.G.A § 9-8-1 to oversee the legacy Unity HCSM plans and to oversee all Unity HCSM plan assets during the pendency of this litigation in accordance with the instructions set forth below. The receiver shall have complete access to the books and records of Aliera and Unity that the receiver determines, subject to the direction of the Court, are necessary to fulfill the duties set forth in this Order. The receiver's access to any confidential information shall be subject to an appropriate Protective Order that restricts the receiver's use or disclosure of the information to the receiver's duties in this action.

The receiver shall examine Aliera's and Unity's books and records as necessary to determine the total amount of funds in Aliera's possession, custody, or control corresponding to the Unity HCSM component of member plans. Aliera shall segregate those funds – *i.e.*, the Unity HCSM plan assets – to an account over which the receiver shall have access and oversight. The receiver shall have all financial access and audit rights necessary to confirm the proper allocation, as well as payment of claims and expenses.

Aliera shall continue to administer the Unity HCSM member plans as it has in accordance with the Temporary Restraining Order. While the Unity HCSM claims administration and payment of member claims shall continue through Aliera and its third-party administrator HealthScope Benefits, Inc. (or such

other qualified third-party administrator approved by the receiver and the Court), the receiver will have access to and oversight of the use of Unity HCSM member funds to pay for the claims administration services provided by Aliera, HealthScope, and any other entities providing approved administration or other necessary services for the Unity HCSM plans. The receiver also has review and audit rights with respect to Aliera's administration of Unity HCSM claims to ensure that Aliera is administering the members' plans and paying member claims consistently with the plan documents. If any issue arises with the manner in which Aliera is allocating funds or administering the Unity HCSM plans and claims, the receiver may bring the issue to the Court's attention as he deems appropriate. Aliera shall not make changes to its plan administration practices without prior written approval of the receiver and the Court.

The parties have each submitted the name of their preferred candidates to serve as the receiver. Aliera has proposed Marshall Glade of GlassRatner. AHS/Unity has proposed Tim Renjilian of FTI Consulting, Inc. After careful consideration, the Court hereby **ORDERS** that **Marshall Glade of GlassRatner** is appointed as the receiver in this action.

The Court will hold a status conference on **May 17, 2019 beginning at 10:00 AM** to further address the role and compensation of the receiver. The receiver shall be present along with counsel for the parties. The status conference will be held in Courtroom 9J of the Fulton County Courthouse, 136 Pryor Street, 9th Floor, Atlanta, Georgia 30303. A court reporter will not be provided. If the parties wish for the conference or any other court proceeding to be taken down, counsel must confer and make appropriate arrangements to have a court reporter present.

Until the receiver assumes its role, Aliera is required to maintain the status quo. The Court declines to order bond. The Court declines to enter a declaratory judgment at this point. The Court is most concerned with the plan members. The Court strongly cautions the parties that the members' rights need to be taken care of and handled, and this case needs to proceed in an expedited manner.

The parties are **ORDERED** to submit a Joint Case Management Order to the Court no later than ten (10) days from this Order. In doing so, the parties shall also prioritize the pending motions. The Court does not believe that a long discovery period will be necessary, as much of the work in this case has been

done.

Aliera is **ORDERED** to provide notice of this Order to its officers, agents, servants, employees, attorneys, and anyone acting in concert or participation with them with respect to the Unity HCSM plans, and this Order shall also be binding on such persons with respect to the Unity HCSM plans.

IT IS SO ORDERED, this 25th day of April, 2019.

Alice D. Bonner

JUDGE ALICE D. BONNER
Superior Court of Fulton County
Business Case Division
Atlanta Judicial Circuit

Served upon registered service contacts through eFileGA

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Summary for Legacy Unity HCSM Members: April 27, 2019

You enrolled in a Unity health care sharing ministry ("HCSM") plan through Aliera Healthcare, Inc. ("Aliera"). We at Unity have terminated our relationship with Aliera Healthcare, Inc., and have rebranded to OneShare Health, LLC. There is pending legal action in the Superior Court of Fulton County, Georgia between Aliera and Unity Healthshare, LLC ("Unity"), concerning the Unity HCSM plans and the central issue is whether Unity or Aliera has the legal right to the Unity HCSM plans. On December 28, 2019, the Court enjoined Aliera's plan to transition the plans over to Trinity Healthshare on January 1, 2019. The Court required Aliera to inform Unity HCSM members that the plans were not being transitioned to Trinity at that time, and you may recall receiving that notification.

On April 25, 2019, the Court entered an order granting Unity's motion for an interlocutory injunction and appointing a receiver to oversee Aliera's administration of the Unity HCSM plans and plan assets. You can read the Court's entire written decision and specific findings below.

The Court is allowing us to reach out to the Unity HCSM members about their options to choose to move to another plan and we are reaching out to you to offer you the opportunity to enroll in one of our OneShare HCSM plans. The OneShare HCSM plans are not affiliated with Aliera or Trinity in any way. You may be separately contacted by Aliera asking you to enroll in Trinity or another plan as the Court is permitting both parties to contact you in this regard.

If you choose to take no action, you will remain in your current Unity HCSM plan, which will be overseen by the court-appointed receiver and will continue to be administered by Aliera while the litigation is pending.

It is for you to decide if you prefer to remain in the legacy Unity HCSM plan during the litigation or to change your plan now. We invite you to take a look at OneShare's offerings, which are offered by leaders with extensive experience in the HCSM space.

If you choose to take no action, you will remain in your current Unity HCSM plan, which will be overseen by the court-appointed receiver and will continue to be administered by Aliera while the litigation is pending.

We invite you to take a look at OneShare's offerings, which are offered by leaders with extensive experience in the HCSM space.

A few of the benefits of joining OneShare Health are:

- No Application Fee, a savings of $125
- Your first month is FREE
- Member Shared Responsibility Amount (MSRA/ISA) accrued for current program year is honored

It is for you to decide if you prefer to remain in the legacy Unity HCSM plan during the litigation or to change to OneShare Health.

APPENDIX B

2018-2019 MEMBER GUIDE

ALIERACARE™

VALUE | PLUS | PREMIUM

INDIVIDUAL FAMILY

ALIERA™ HEALTHCARE

AlieraCare Plans are NOT Insurance

CONTENTS

MEMBER GUIDE

WELCOME

Welcome to Aliera Healthcare, Inc. | Trinity HealthShare. Thank you for becoming a member. We are committed to providing you and your family with unparalleled service and care at an affordable cost, and we pledge to keep our focus on what's most important – your overall health and wellness.

Please take a few minutes to review the information in this guide. The more informed you are, the easier it will be to get the care you need when you need it the most. Your membership card(s) and this booklet provide important information about your Plan, as well as the steps you need to take to access healthcare at one of the thousands of participating network provider locations. Your welcome information, Member Portal access and temporary member cards are contained in your Welcome Email: please print it and save a copy for reference.

If you have any questions about your Plan, activating your Membership Card, setting up your telemedicine account, Rx discount program, or accessing a healthcare provider, please contact a Member Care Specialist for assistance, **Monday through Friday, 8 a.m. to 8 p.m. ET at (844) 834-3456.**

Member Portal

Username and password credentials are needed to enter the Member's portal to update payment or personal information. Visit www.alierahealthcare.com and click the Member Login tab. Your user name and password are on the Welcome Email sent at the time of initial enrollment. Member Services can send you a copy of this email following confirmation of identity.

Contact Information

For general information, account management, monthly contribution, or medical needs, please contact us:

Phone: 844-834-3456

Fax: 404-937-6557

Email: memberservices@alierahealthcare.com or memberservices@trinityhealthshare.org

Online: www.alierahealthcare.com or www.trinityhealthshare.org

Mail: 990 Hammond Drive, Suite 700
Atlanta, GA 30328

[redacted]

Disclaimer

AlieraCare offering by Trinity HealthShare, through Aliera Healthcare, Inc., is a faith-based medical needs sharing membership. Medical needs are only shared by the members according to the membership guidelines. Our members agree to the Statement of Beliefs and voluntarily submit monthly contributions into a cost-sharing account with Trinity HealthShare, acting as a neutral clearing house between members. Organizations like ours have been operating successfully for years. We are including the following caveat for all to consider:

This publication or membership is not issued by an insurance company, nor is it offered through an insurance company. This publication or the membership does not guarantee or promise that your eligible medical needs will be shared by the membership. This publication or the membership should never be considered as a substitute for an insurance policy. If the publication or the membership is unable to share in all or part of your eligible medical needs, or whether or not this membership continues to operate, you will remain financially liable for any and all unpaid medical needs.

This is not a legally binding agreement to reimburse any member for medical needs a member may incur, but is instead, an opportunity for members to care for one another in a time of need, to present their medical needs to other members as outlined in the membership guidelines. The financial assistance members receive will come from other members' monthly contributions that are placed in a sharing account, not from Trinity HealthShare.

PLAN SERVICES & MEMBERSHIP AT A GLANCE

Aliera Healthcare services in conjunction with Trinity HealthShare cost-sharing creates a full range of services and offerings, each part summarized below:

Preventive Care

As part of our solution, the Plans cover medical services recommended by the USPSTF and outlined in the ACA for preventive care. There is zero out of pocket expense and zero obligation to reach the Member Shared Responsibility Amount (MSRA) for any scheduled preventive care service or routine in-network check-up, pap smear, flu shot and more. It's easier to stay healthy with regular preventive care.

Episodic Primary Care

Primary care is at the core of an Aliera plan, and we consider it a key step in living a healthier lifestyle. Our model is based on an innovative approach to care that is truly patient-centered, combining excellent service with a modern approach. This includes medical care needs such as primary care, office visits, sick care, and the general care of a member's day to day medical needs.

Chronic Maintenance

With AlieraCare Premium, members are eligible to receive chronic care management from their primary care physician for conditions such as diabetes, asthma, blood pressure, cardiac conditions, etc.

Labs & Diagnostics

Labs at in-network facilities are included.

Telemedicine

With full 24/7 365-day access to a board-certified physician, it has never been simpler to stay healthy. You can contact them easily by phone or via video chat. If it's something minor such as a sinus infection, poison ivy or pink eye they can even send a prescription right over to your pharmacist.

Urgent Care

For those medical situations that can't wait or are more complex than primary care services, AlieraCare plans offer access to Urgent Care facilities at hundreds of medical centers throughout the United States.

PLAN SERVICES & MEMBERSHIP AT A GLANCE

Membership

Trinity HealthShare is a health care sharing ministry (HCSM) which acts as an organizational clearing house to administer sharing contributions across qualifying members healthcare needs. The AlieraCare membership is NOT health insurance. The membership is based on a religious tradition of mutual aid, neighborly assistance, and burden sharing. The membership does not subsidize self-destructive behaviors and lifestyles, but is specifically tailored for individuals who maintain a healthy lifestyle, make responsible choices in regards to health and care, and believe in helping others. Because Trinity HealthShare is a religious organization, members are required to agree with the organizations Statement of Beliefs; see Part II of this guide for the full description and membership details.

Specialty Care

For most everyday medical conditions, your PCP is your one-stop medical shop. However, there are cases when it's time to see a specialist who's had additional education and been board certified for that specialty. For situations like these, the AlieraCare Premium plans provides specialty care offerings after the members shared responsibility has been met (MSRA). A member will need to receive a PCP referral to see a specialist for treatment or consultation outside of their scope of knowledge.

Hospitalization

Hospitalization is eligible, once the Member Shared Responsibility Amount has been met, under all the individual plans.

Surgery

Both in-patient and out-patient procedures are eligible, once the Member Shared Responsibility Amount has been met, under all individual plans.

Emergency Room

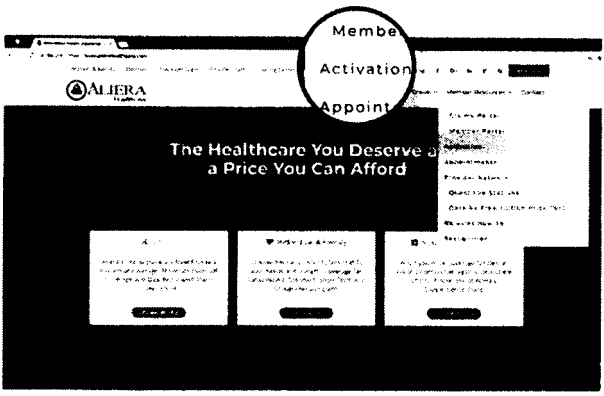
An emergency is defined as treatment that must be rendered to the patient immediately for the alleviation of the sudden onset of an unforeseen illness or injury that, if not treated, would lead to further disability or death. Examples of an emergency include, but are not limited to, severe pain, choking, major bleeding, heart attack, or a sudden, unexplained loss of consciousness.

GETTING STARTED

What does it mean?

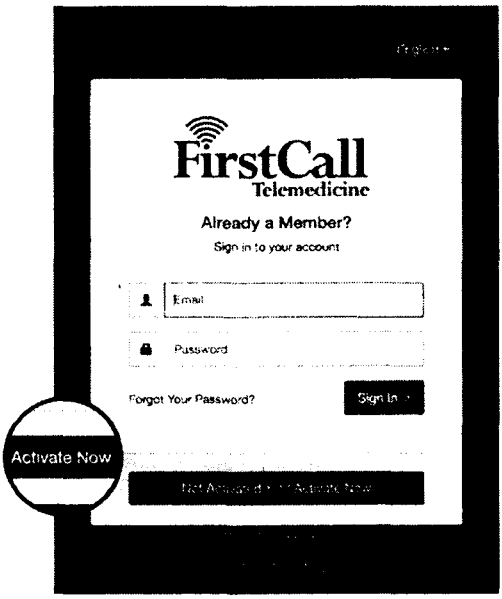
Many of the terms used in describing health cost-sharing may be unfamiliar to those new to the programs and plans provided by Aliera and Trinity. Please refer to the Definition of Terms section for a quick and easy understanding of terms used in this guide and other plan documents.

1. **Activate Your Membership**
   On or after your effective date, visit www.alierahealthcare.com to securely enter your information. Click the Activate tab on the navigation bar and follow the instructions.
   If you require assistance, contact a Member Care Specialist toll-free at (844) 834-3456 or email memberservices@alierahealthcare.com.



2. **Set Up Your Telemedicine Account**
   Follow the steps below to set up your telemedicine account. If you have not activated your Membership Card, or if your Membership fees are not paid up to date, you are not eligible to set up your telemedicine account.
   - Set up your account (Primary Member)
     Visit www.firstcalltelemed.com, Click "Set up account." Follow the online instructions and provide the required information, including your medical history.

GETTING STARTED



- Set up minor dependents (17 years or younger)
  Log in to your account and click "My Family" on the top menu. Follow the online instructions to provide the necessary information and complete your dependent's medical history.
- Set up adult dependents (18 – 26 years)
  Adult dependents must set up their own account. Visit the website and click "Set up account." Follow the online instructions to provide the required information and to complete your medical history.

3. **Set Up your Prescription Discount Account**
   Follow the steps below to set up your prescription discount account. If you have not activated your Membership Card, or if your Membership fees are not paid up to date, you are not eligible to set up your prescription discount account.

Please go to www.myrxvalet.com/memberlogin.php

1. Enter your Member ID that is located on your Aliera Healthcare ID card
2. For your Group ID type in Aliera
3. Complete your profile for yourself and any dependents

After registration is complete, you will receive an email with instructions and a video on how to use Rx Valet for home delivery and at your local pharmacy.

GETTING STARTED

Please download the Rx Valet APP on your smartphone at your convenience.

If you are experiencing an urgent situation and don't have time to set up your account, you can hand your Aliera card to the pharmacist to receive your medication. The discount will not be as great, so please set up your account when you have time.

Home Delivery Prescription Information:

- Home Delivery orders are fulfilled exclusively through Advanced Pharmacy, LLC. To save time, have your physician send your prescription directly to Advanced Pharmacy electronically.
- Alternatively, they can also transfer your existing prescriptions from another pharmacy to fulfill your order. Please call their live Customer Care Team at 1-855-798-2538 and provide the medication details, pharmacy name, and pharmacy telephone number.
- Electronic prescriptions should be sent to **Advanced Pharmacy, LLC located at 350-D Feaster Road Greenville, SC 29615.**

Phone: 855-240-9368 **Fax:** 888-415-7906
NPI: 1174830475 **NCPDP:** 4229971

4. **Review Your Offerings**
   This guide contains the information you need to understand each offering available with your Plan. Keep your Member Card with you at all times; the contact number for your telemedicine provider is printed on your card. It is highly encouraged to contact your telemedicine provider before seeking medical attention.

PART I

How to Use Your Membership

The Telemedicine Program

More than 80% of primary medical conditions can be resolved by your telemedicine provider. It is always encouraged that members contact their telemedicine provider first for quick, convenient medical assistance. The contact information for your telemedicine provider is found on your member card. Instructions are also found on the back of your Welcome Letter, as well as on our web site, under Member Resources.

Offerings of the Telemedicine Program

- At home, at work, or while traveling in the US, speak to a telemedicine doctor from anywhere, anytime, on the go.
- 24/7 access to a doctor via face-to-face internet consultation or by phone is available for you and dependents on your Plan.
- Speak with the next available doctor or schedule an appointment for a more convenient time.
- Telemedicine doctors typically respond within 15 minutes of your call.
- Save time and money by avoiding expensive emergency room visits, waiting for an appointment, or driving to a local facility.
- Telemedicine consultations are free for you and dependents on your Plan.
- Telemedicine providers can treat conditions such as:
  - Cold and flu symptoms
  - Bronchitis
  - Allergies
  - Poison ivy
  - Pink eye
  - Urinary tract infections
  - Respiratory infections
  - Sinus problems
  - Ear infections, and more

Antibiotics are not always the answer to treat a medical condition. Doctors may choose not to prescribe antibiotics for viral illnesses such as common colds, sore throats, coughs, sinus infections, and the flu.

If the telemedicine doctor recommends that you see your PCP or visit an urgent care facility, contact Aliera's Concierge Service, and a member care specialist will be happy to assist you with scheduling an appointment.

PREVENTIVE CARE

It's easier to stay healthy when you have regular preventive care. Members have no out-of-pocket expenses for preventive services, which include, but are not limited to, routine in-network checkups, pap smears, flu shots and more.

How to Use Preventive Care Services

1. Download the Preventive Healthcare Guidebook from the link found in your Welcome email or visit us online at www.alierahealthcare.com or www.trinityhealthshare.org
2. Members do not need to call their telemedicine provider to schedule preventive care.
3. Upon arrival at a PCP, please present your Membership Card and one photo ID. The front desk admin will check your eligibility status. If you have not activated your Membership Card, or if Membership fees are not current, your Plan will not share the costs of the provider.
4. Preventive health services must be appropriate for the eligible person and follow the guidelines below:
   A) In general – those of the U.S. Preventive Services Task Force that have an A or B rating.
   B) For immunizations – those of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
   C) For preventive care and screenings for children and adolescents – those of the Health Resources and Services Administration.
   D) For preventive care and screenings for women – those of the Health Resources and Services Administration that are not included in section (A) of the U.S. Preventive Services Task Force schedule.

Labs and Diagnostics

Aliera and Trinity Members have access to lab work in the convenience of their in-network provider's office or at any lab location nationwide.

URGENT CARE

Your membership raises the standard of healthcare available to you by putting individuals first, treating them with clinical excellence, and focusing on their well-being. Members can access services from hundreds of Urgent Care network facilities throughout the United States.

- Plans vary, and can provide up to two (2) visits, where consult fee may apply.
- See Appendix for your specific plan details.
- X-rays are included, and subject to $25 per read fee at an Urgent Care facility.

How to Use the Urgent Care Service

1. Call 911 if your emergency is life threatening; otherwise, please contact your telemedicine provider first via telephone or a scheduled face-to-face internet conference. Your provider will determine if your medical condition can be resolved without visiting a local Urgent Care facility.
2. If your medical issue cannot be resolved after your free consultation with a telemedicine doctor, visit the closest in-network Urgent Care facility.
3. Upon arrival at an Urgent Care facility, present your Membership Card and one photo ID. The front desk admin will check your eligibility status. If you have not activated your Membership Card, or if Membership fees are not current, your Plan will not cover the costs of the provider.
4. At time of service, payment of $20 (on average) is due for the consultation, and a $25 per read fee for X-rays if needed may be due. Costs may be higher depending on your state and provider.

If Urgent Care Services are Unavailable

If an in-network Urgent Care facility is unavailable to a Member requiring immediate Urgent Care, please adhere to the following procedure:

1. Visit www.alierahealthcare.com. Click "Network" to find the nearest Urgent Care facility under MultiPlan.
2. If the nearest in-network facility is more than 20 miles away from the Member, is closed (after 6:00 p.m.), or is no longer in business, the Member should seek out the nearest Urgent Care facility or hospital emergency room to receive urgent medical attention.
3. AlieraCare products are not health insurance plans and Aliera nor Trinity are responsible for payment to out-of-network Urgent Care or hospital emergency room facilities. The Member is solely responsible for such Urgent Care medical payments. Aliera and or Trinity maintain an allotment fund designed to provide a Member with supplemental payment assistance (ex gratia) in the amount of $105.00 to offset the cost incurred at an out-of-network Urgent Care or Hospital Emergency Room facility. This monetary assistance is limited to one visit per year, per Member. Payment is made directly to the Member after confirmation of submitted proof of Urgent Care necessity and unavailability of an in-network provider.

PRIMARY CARE

Primary Care For Sick Care

In addition to our Urgent Care services, many of our plans offer Members under the age of 65 episodic primary care or sick care.

- Plans with annual PCP visits include one (1), three (3), or five (5) visits, each with consult fee ranging from $20 to $40 in certain markets.
- For convenience, some clinics are open evenings and weekends.

How to Use Primary Care Service for Sick Care

1. Contact your telemedicine provider to speak with a U.S. board-certified doctor via telephone or a scheduled face-to-face internet conference.
2. The telemedicine doctor may be able to resolve your medical issue and prescribe medication if needed. More than 80% of primary medical conditions can be resolved by your telemedicine provider.
3. If your medical issue cannot be resolved after no fee consultation with the telemedicine doctor, visit the closest in-network Primary Care facility.
4. Upon arrival at a clinic, present your Membership Card and one photo ID. The front desk admin will check your eligibility status before you can see a provider. If you have not activated your Membership Card, or if Membership fees are not current, your Plan will not cover the costs of the provider.
5. At the time of service, a payment of $20 (on average) is due for the consultation, and a $25 per read fee for X-rays if needed. Costs may be higher depending on your state and provider.

SPECIALTY CARE

Specialty Care

AlieraCare Premium members are required to obtain referrals to visit a specialist, except for women in need of gynecological care for routine medical needs. Specialty visits have a consult fee of $75 and the member has full responsibility of the bill until their Member Shared Responsibility Amount (MSRA) has been met. After MSRA is met, Specialty visits only have the cost of the $75 consult fee.

Hospitalization

Your hospitalization cost-sharing is provided to you in an effort to alleviate the stress and strain during times of crisis or medical needs.

1. Members are required to pre-authorize all hospitalization services and visits unless it is an obvious medical emergency. Please see pre-authorization section for instructions.
2. The member will be responsible for first reaching their MSRA before any cost-sharing will be available. Once the MSRA has been reached in full, the sharing will then be reimbursed directly back to the providers and hospital facilities.
3. Several plans allow for fixed cost-sharing in the emergency room. Please see Appendix A for your exact plan details.

PPO Network

With a growing nationwide PPO network of more than 1,000,000 healthcare professionals and more than 6,000 facilities, Multiplan PHCS network offers Plan Members a range of quality choices to help them stay healthy.

- Search for providers by distance, cost efficiency, and specialty.

Find a Network Healthcare Professional

- Visit **www.alierahealthcare.com**
- Hover over the Member Resources tab
- Click Provider Network
- Click on the Medical Provider logo associated with your plan.
- Search for a provider by Zip Code, City, County, State, or other search criteria.

Call Aliera Healthcare at (844) 834-3456
OR
Trinity HealthShare at (844) 763-5338.

Select the Provider Coordination Department and a care coordinator will help you navigate the healthcare process effectively and efficiently.

PART II

How Your Healthcare Cost-Sharing Ministry (HCSM) Works

Membership Overview

Trinity HealthShare is a clearing house that administers voluntary sharing of healthcare needs for qualifying members. The membership is based on a tradition of mutual aid, neighborly assistance, and burden sharing. The membership does not subsidize self-destructive behaviors and lifestyles, but is specifically tailored for individuals who maintain a healthy lifestyle, make responsible choices in regards to health and care, and believe in helping others. The Trinity HealthShare membership is not health insurance.

Guidelines Purpose and Use

The HCSM guidelines are provided as an outline for eligible needs in which contributions are shared in accordance with the membership's clearing house instructions. They are not for the purpose of describing to potential contributors the amount that will be shared on their behalf and do not create a legally enforceable right on the part of any contributor. Neither these guidelines nor any other arrangement between contributors and Trinity HealthShare creates any rights for any contributor as a reciprocal beneficiary, as a third-party beneficiary, or otherwise.

The edition of the guidelines in effect, on the date of medical services, supersedes all previous editions of the guidelines and any other communication, written or verbal. With written notice to the general membership, the guidelines may change at any time based on the preferences of the membership and on the decisions, recommendations, and approval of the Board of Trustees.

An exception to a specific provision only modifies that provision and does not supersede or void any other provisions.

Individuals Helping Individuals

Contributors participating in the membership help individuals with their medical needs. Trinity HealthShare facilitates in this assistance and acts as an independent and neutral clearing house, dispersing monthly contributions as described in the membership instructions and guidelines.

MEMBERSHIP QUALIFICATIONS

To become and remain a member of Trinity HealthShare, a person must meet the following criteria:

Religious Beliefs and Standards. The person must have a belief of helping others and/or maintaining a healthy lifestyle as outlined in the Statement of Beliefs contained in the membership application. If at any time during participation in the membership, the individual is not honoring the Statement of Beliefs, they will be subject to removal from participating in the membership.

Medical History. The person must meet the criteria to be qualified for a membership on his/her application date, based on the criteria set forth in this guidebook and the membership application.

If, at any time, it is discovered that a member did not submit a complete and accurate medical history on the membership application, the criteria set forth in the Membership Eligibility Manual on his/her application date will be applied, and could result in either a retroactive membership limitation or a retroactive denial to his/her effective date of membership.

Members may apply to have a membership limitation removed by providing medical evidence that they qualify for such removal according to the criteria set forth in the Membership Eligibility Manual. Membership limitations and denials can be applied retroactively but cannot be removed retroactively.

Application, Acceptance, and Effective Date. A person must submit a membership application and be accepted into the membership by meeting the criteria of the Member Eligibility Manual. The membership begins on a date specified by Trinity HealthShare in writing to the member.

Dependent(s). A dependent may participate under a combined membership with the head of household.

A dependent wishes to continue participating in the membership but no longer qualifies under a combined membership must apply and qualify for a membership based on the criteria set forth in the Membership Eligibility Manual.

Under a combined membership, the head of household is responsible for ensuring that everyone participating under the combined membership meets and complies with the Statement of Beliefs and all guideline provisions.

Financial Participation. Monthly contributions are requested to be received by the 1st or 15th of each month depending on the member's effective date. If the monthly contribution is not received within 5 days of the due date, an administrative fee may be assessed to track, receive, and post the monthly contribution. If the monthly contribution is not received by the end of the month, a membership will become inactive as of the last day of the month in which a monthly contribution was received.

MEMBERSHIP QUALIFICATIONS

Any member who has a membership that has become inactive will be able to reapply for membership under the terms outlined to them in writing by Trinity HealthShare. A member will not be able to reapply for membership if their account has been made inactive a total of three times.

Needs occurring after a member's inactive date and before they reapply are not eligible for sharing.

When Available Shares are less than Eligible Needs. In any given month, the available suggested share amounts may or may not meet the eligible needs submitted for sharing. If a member's eligible bills exceed the available shares to meet those needs, the following actions may be taken:

1. A pro-rata sharing of eligible needs may be initiated, whereby the members share a percentage of eligible medical bills within that month and hold back the balance of those needs to be shared the following month.
2. If the suggested share amount is not adequate to meet the eligible needs submitted for sharing over a 60-day period, then the suggested share amount may be increased in sufficient proportion to satisfy the eligible needs. This action may be undertaken temporarily or on an ongoing basis.

Other Criteria. Children under the age of 18 may not qualify for their own membership. Non-U.S. citizens may qualify for membership as determined by Trinity HealthShare on a case-by-case basis.

Monthly Contributions

Monthly contributions are voluntary contributions or gifts that are non-refundable. As a non-insurance membership, neither Trinity HealthShare nor the membership are liable for any part of an individual's medical need. All contributors are responsible for their own medical needs. Although monthly contributions are voluntary contributions or gifts, there are administrative costs associated with monitoring the receipt and disbursement of such contributions or gifts. Therefore, declined credit cards, returned ACH payments, or any contribution received after the members reoccurring active date may incur an administrative fee.

MEMBERSHIP QUALIFICATIONS

Important Information About Plan Changes:

Members wishing to change to a membership type other than that which they are currently participating may, at the discretion of Trinity HealthShare, be required to submit a new signed and dated membership application for review. Membership type changes can only become effective on the first of the month after the new membership application has been approved.

1. When switching from one annual product category to another (i.e. AlieraCare to Trinity HealthShare's CarePlus Advantage) your plan will be reset as if it is a new enrollment. This rule does not apply when transitioning from an InterimCare plan.
2. You are allowed two plan changes per membership year. The first is free of cost, the second will incur the application fee of the desired product.

Contributors wishing to discontinue participation in the membership must submit the request in writing by the 20th day of the month before which the contributions will cease. The request should contain the reason why the contributor is discontinuing participation in the membership. Should the contributor fail to follow these guidelines as they pertain to discontinuing their participation in the membership and later wish to reinstate their membership, unsubmitted contributions from the prior participation must be submitted with a new application.

A member is not eligible for cost-sharing when a member:

A) Receives care within the first 60 days of the plan and cancels membership within 30 days of receiving medical care, except within the last 90 days of the membership term.

B) Receives or requires surgery within the first 60 days of becoming a member except in the case of an accident.

Early Voluntary Termination

Members of the Trinity HealthShare may terminate their membership at any time, with 30 days prior notice. Trinity HealthShare plans are not a substitute for "short term medical plans." Medical expenses incurred during the term of the membership and followed by early voluntary termination within 90 days of incurring medical expenses, will be reviewed and may not be eligible for cost-sharing, where the early termination was not as a direct result of affordability issues with the health sharing program.

MEMBERSHIP QUALIFICATIONS

Statement of Beliefs

At the core of what we do, and how we relate to and engage with one another as a community of people, is a set of common beliefs. Our Statement of Shared Beliefs is as follows:

1. We believe that our personal rights and liberties originate from God and are bestowed on us by God.
2. We believe every individual has a fundamental religious right to worship God in his or her own way.
3. We believe it is our moral and ethical obligation to assist our fellow man when they are in need per our available resources and opportunity.
4. We believe it is our spiritual duty to God and our ethical duty to others to maintain a healthy lifestyle and avoid foods, behaviors, or habits that produce sickness or disease to ourselves or others.
5. We believe it is our fundamental right of conscience to direct our own healthcare in consultation with physicians, family, or other valued advisors.

DEFINITION OF TERMS

Terms used throughout the Member Guide and other documents are defined as follows:

Affiliated Practitioner. Medical care professionals or facilities that are under contract with a network of providers with whom Trinity HealthShare works. Affiliated providers are those that participate in the PHCS network. A list of providers can be found at http://www.multiplan.com.

Application Date. The date Trinity HealthShare receives a complete membership application.

Combined Membership. Two or more family members residing in the same household.

Contributor. Person named as head of household under the membership.

Dependent. The head of household's spouse or unmarried child(ren), under the age of 20 or 26 if a full-time student, who are the head of household's dependent by birth, legal adoption, or marriage who is participating under the same combined membership.

Eligible. Medical needs that qualify for voluntary sharing of contributions from escrowed funds, subject to the sharing limits.

Escrow Instructions. Instructions contained on the membership application outlining the order in which voluntary monthly contributions may be shared by Trinity HealthShare

Guidelines. Provided as an outline for eligible medical needs in which contributions are shared in accordance with the membership's escrow instructions.

Head of Household. Contributor participating by himself for herself; or the husband or father that participates in the membership; or the wife or mother that participates in the membership. The Head of Household is the oldest member on the plan.

Licensed Medical Physician. An individual engaged in providing medical care and who has received state license approval as a practicing Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.).

Medically Necessary. A service, procedure, or medication necessary to restore or maintain physical function and is provided in the most cost-effective setting consistent with the member's condition. Services or care administered as a precaution against an illness or condition or for the convenience of any party are not medically necessary. The fact that a provider may prescribe, administer, or recommend services or care does not make it medically necessary, even if it is not listed as a membership limitation or an ineligible need in these guidelines. To help determine medical necessity, Trinity HealthShare may request the member's medical

DEFINITION OF TERMS

records and may require a second opinion from an affiliated provider.

Member(s). A person(s) who qualifies to receive voluntary sharing of contributions for eligible medical needs per the membership clearing house instructions, guidelines, and membership type.

Member Shared Responsibility Amounts (MSRA). The amounts of an eligible need that do not qualify for sharing because the member is responsible for those amounts.

Membership. All members of Trinity HealthShare.

Membership Eligibility Manual. The reference materials that contain the criteria used to determine if a potential member is eligible for participation in the membership and if any membership limitations apply.

Membership Type. HCSM sharing options are available with different member shared responsibility amounts (MSRA) and sharing limits as selected in writing on the membership application and approved by Trinity HealthShare.

Monthly Contributions. Monetary contributions, excluding the annual membership fee, voluntarily given to Trinity HealthShare to hold as an escrow agent and to disburse according to the membership escrow instructions.

Need(s). Charges or expenses for medical services from a licensed medical practitioner or facility arising from an illness or accident for a single member.

Non-affiliated Practitioner. Medical care professionals or facilities that are not participating within our current network.

Pre-existing Condition. Any illness or accident for which a person has been diagnosed, received medical treatment, been examined, taken medication, or had symptoms within 24 months prior to the effective date. Symptoms include but are not limited to the following: abnormal discharge or bleeding; abnormal growth/break; cut or tear; discoloration; deformity; full or partial body function loss; obvious damage, illness, or abnormality; impaired breathing; impaired motion; inflammation or swelling; itching; numbness; pain that interferes with normal use; unexplained or unplanned weight gain or loss exceeding 25% of the total body weight occurring within a six-month period; fainting, loss of consciousness, or seizure; abnormal results from a test administered by a medical practitioner.

Usual, Customary and Reasonable (UCR). The lesser of the actual charge or the charge most other providers would make for those or comparable services or supplies, as determined by Trinity HealthShare.

CONTRIBUTORS' INSTRUCTIONS AND CONDITIONS

By submitting monthly contributions, the contributors instruct Trinity HealthShare to share clearing house funds in accordance with the membership instructions. Since Trinity HealthShare has nothing to gain or lose financially by determining if a need is eligible or not, the contributor designates Trinity HealthShare as the final authority for the interpretation of these guidelines. By participation in the membership, the member accepts these conditions

PART III

Your Summary of Cost-Sharing, Eligible Needs, & Limits

Eligible Medical Expenses*

Medical Expenses Eligible for Sharing. Medical costs are shared on a per person per incident basis for illnesses or injuries incurring medical expenses after the membership effective date when medically necessary and provided by or under the direction of licensed physicians, osteopaths, urgent care facilities, clinics, emergency rooms, or hospitals (inpatient and outpatient), or other approved providers. Unless otherwise limited or excluded by these Guidelines, medical expenses eligible for sharing include, but are not limited to, physician and hospital services, emergency medical care, surgical procedures, medical testing, x-rays, ambulance transportation, and prescriptions.

**See the Appendix for other limits and conditions of sharing by plan*

1. **Allergy Office Visits and Testing**
2. **Anesthesiologist Services**
3. **Ambulance.** Emergency land or air ambulance transportation to the nearest medical facility capable of providing the medically necessary care to avoid seriously jeopardizing the sharing member's life or health. Air transportation is limited to $10,000.
4. **Cancer.** Cancer sharing eligibility is different based on plan option chosen. AlieraCare plans have a 12 month wait period for cancer. Sharing is available the 1st day of the 13 month of continuous membership. Any pre-existing or recurring cancer condition is not eligible for sharing. Cancer sharing will not be available for individuals who have cancer at the time of or five (5) years prior to application. If cancer existed outside of the 5-year time frame of a pre-existing look-back, the following must be met in the five (5) years prior to application, to be eligible for future, non-recurring cancer incidents.
    1. The condition had not been treated nor was future treatment prescribed/planned;
    2. The condition had not produced harmful symptoms (only benign symptoms); 3. The condition had not deteriorated. Cancer is limited to a maximum per term of $500,000 when applicable.
5. **Chemotherapy.** Subject to cancer limitations.
6. **Radiation Therapy.** Subject to cancer limitations.

YOUR SUMMARY OF COST-SHARING, ELIGIBLE NEEDS, & LIMITS

7. **Chronic Maintenance.** Chronic maintenance is eligible when a member has chosen a plan with chronic maintenance specifically included and a listing of the maximum number of allowable visits. See 'Appendix A' attached hereto.
8. **Cardiac Rehabilitation.** Eligible after MSRA
9. **Competitive Sports.** Plan holders who participate in organized and/or sanctioned competitive sports are eligible for $5,000 (max) of sharing per incident at an emergency room, subject to the member-shared responsibility amount.
10. **Emergency Room.** Emergency room services for stabilization or initiation of treatment of a medical emergency condition provided on an outpatient basis at a hospital, clinic, or Urgent Care facility, including when hospital admission occurs within twenty-three (23) hours of emergency room treatment.
11. **Eye Care.** Limited to medical necessity and accident only. Excludes cosmetic, frames, lenses, contacts, extensive eye exams and subject to pre-existing limitations.
12. **Hospitalization.** Hospital charges for inpatient or outpatient hospital treatment or surgery for a medically diagnosed condition.
13. **Labs & Diagnostics.** The membership includes over 180 different lab tests, at any lab facility, to ensure the member gets the medical care they need.
14. **Maternity.** Maternity medical expenses are only eligible for sharing in the Premium AlieraCare Plan, which offers sharing for medical expenses rendered for a natural delivery up to $5,000. Medical expenses for maternity ending in a delivery by emergency cesarean section that are medically necessary, are eligible for sharing up to $8,000 subject to the applicable Member Shared Responsibility Amount. Medical expenses for a newborn arising from complications at the time of delivery, including, but not limited to, premature birth, are treated as a separate incident and limited to $50,000 of eligible sharing, subject to the Member Shared Responsibility Amount. See the Appendix for specific sharing inclusions and limits for your plan choice.
15. **Mental Health.** Plan holders are eligible for $2,500 (max) for Psychotherapy office visits and $1,000 (max) at out-patient facilities. Excludes in-patient and residential settings.
16. **Occupational Therapy.** Up to six (6) visits per membership year for occupational therapy.

YOUR SUMMARY OF COST-SHARING, ELIGIBLE NEEDS, & LIMITS

17. **Organ Transplant Limit.** Eligible needs requiring organ transplant may be shared up to a maximum of $150,000 per member. This includes all costs in conjunction with the actual transplant procedure. Needs requiring multiple organ transplants will be considered on a case-by-case basis.
18. **Physical Therapy.** Up to six (6) visits per membership year for physical therapy by a licensed physical therapist.
19. **Prescription Drugs.** The AlieraCare plan includes a service by RX Valet, which includes discounts for prescription drugs. See Appendix for details.
20. **Preventive.** Most programs from either Trinity HealthShare or Aliera provide everyone with the necessities of the 63 Preventive Care services as outlined by the United States Preventive Task force. (Excludes CarePlus Advantage.) Preventive Care includes the PCP office visit and does not require a co-expense or consult fee.
21. **Primary Care.** Depending on your plan choice, primary care is at the core of preventing medical issues from escalating into a more catastrophic need. See Appendix for the specific plan details.
22. **Routine Hearing Exams.** At primary care (PCP) only.
23. **Sleep Disorders.** Overnight Sleep Testing Limit: All components of a polysomnogram must be completed in one session. A second overnight test will not be eligible for sharing under any circumstance. Overnight sleep testing must be medically necessary and will require pre-authorization. Allowed charges will not exceed the Usual, Customary, and Reasonable charges for the area.
24. **Smoking Cessation.** Members who have acknowledged they smoke and made an additional contribution are provided the opportunity to obtain free smoking cessation medication and counseling through the eligible preventive services.
25. **Specialty Care.** Specialty Care is included in the AlieraCare Premium plan. Specialty visits have a consult fee of $75 and the member has full responsibility of the bill until their Member Shared Responsibility Amount (MSRA) has been met. After MSRA is met, Specialty visits only have the cost of the $75 consult fee.
26. **Speech Therapy.** Up to six (6) visits per membership year. Only applicable after a stroke.
27. **Surgical Offerings.** Non-life-threatening surgical offerings are not available for the first 60 days of membership for Premium plans and all other plans require six (6) month wait period. Please verify eligibility by calling Members Services before receiving any surgical services.

YOUR SUMMARY OF COST-SHARING, ELIGIBLE NEEDS, & LIMITS

28. **Telemedicine.** Telemedicine is included in all AlieraCare programs offered by Trinity HealthShare and Aliera Healthcare as your first line of defense. Your membership provides you and your family 24/7/365 access to a U.S. Board certified medical doctor.
29. **Urgent Care.** If your plan provides cost-sharing for Urgent Care, you will have the added offering of enjoying the ability to choose an Urgent Care facility in lieu of an emergency room. See the Appendix for any Urgent Care options and any limitations to plan.
30. **X-rays.** X-rays listed on your plan details in the Appendix are for imaging services at PCP or Urgent Care facilities only and requires a $25 read fee per view at time of service. Your MSRA will apply to all other x-rays. MRI, CT Scans and other diagnostics must be paid with your MSRA before cost-sharing is provided.

**Medical Expense Incident is any medically diagnosed condition receiving medical treatment and incurring medical expenses of the same diagnosis. All related medical bills of the same diagnosis comprise the same incident. Such expenses must be submitted for sharing in the manner and form specified by Trinity HealthShare. This may include, but not be limited to, standard industry billing forms (HCFA1500 and/or UB 92) and medical records. Members share these kinds of costs.*

LIMITS OF SHARING (MAXIMUM PAYABLE)

Total eligible needs shared from member contributions are limited as defined in this section and as further limited in writing to the individual member.

1. **Lifetime Limits.** $1,000,000: the maximum amount shared for eligible needs over the course of an individual member's lifetime.
2. **Per Incident.** The occurrence of one particular sickness, illness, or accident.
3. **Cancer Limits when applicable.** Cancer is limited to a maximum per term of $500,000 when applicable
4. **Member Shared Responsibility Amounts (MSRA).** The eligible amount that does not qualify for sharing based on the membership type chosen by the member.
5. **Office Visit/Urgent Care.** Office visits, in particular, primary and urgent, have certain limits and inclusions. Please refer to the Appendix for your specific plan.
6. **Non-Affiliated Practitioner.** Services rendered by a non-affiliated practitioner will not be eligible for sharing nor will any amount be applied to your MRSA unless specified differently in the plan details contained herein.
7. **Cost-Sharing for Pre-Existing Conditions.** Hospitalization, In-Patient and Out-Patient Surgery, Specialty Care, and Emergency Room services for pre-existing conditions have a 24-month waiting period. All other healthcare services for pre-existing conditions are eligible upon effective date.

Other Resources. Offerings available to the member from other sources such as insurance, VA, Tricare, private gxrants, or by a liable third party (primary, auto, home insurance, educational, etc.), will be considered the member's primary benefit source, and the member will be required to file medical claims with those providers first. If there are medical expenses that those sources do not pay, the member is authorized to submit the excess medical expenses for sharing, and the MSRA will be waived, up to the maximum MSRA as defined in the member's plan. The MSRA will only be waived if a third party source pays on the member's behalf. Sharing of monthly contributions for a need that is later paid, or found to payable by another source will automatically allow Trinity HealthShare full rights to recover the amounts that were shared with the member.

MEDICAL EXPENSES NOT GENERALLY SHARED BY HCSM

Only needs incurred on or after the membership effective date are eligible for sharing under the membership instructions. The member (or the member's provider) must submit a request for sharing in the manner and format specified by Trinity HealthShare. This includes, but is not limited to, a Need Processing Form, standard industry billing forms (HCFA 1500 and/or most recent UB form), and may include medical records. All participating members have a responsibility to abide by the Members' Rights and Responsibilities published by Trinity HealthShare and are included at the end of these guidelines.

Needs arising from any one of the following are not eligible for sharing under the membership clearing house instructions:

1. Abortion Services
2. Acupuncture Services
3. Aqua Therapy
4. B12 Injections
5. Biofeedback
6. Birth Control (Female)
7. Birth Control (Male) Elective Sterilization
8. Birth Control (Male) Reversal of Sterilization
9. Cataract Contacts or Glasses
10. Chemical Face Peels
11. Chiropractic Services
12. Christian Science Practitioner
13. Cochlear Devices
14. Cosmetic Surgery
15. Cost-Sharing for Pre-existing Conditions. Hospitalization, In-Patient and Out-Patient Surgery, Specialty Care, and Emergency Room services for pre-existing conditions have a 24-month waiting period. All other healthcare services for pre-existing conditions are eligible upon effective date.
16. Custodial Care Services
17. Dental Services
18. Dermabrasion Services
19. Diabetic Insulin, Supplies, and Syringes
20. Doula
21. Durable Medical Equipment
22. Education Services
23. Exercise Equipment
24. Experimental Drugs
25. Experimental Procedures
26. Extreme sports: Sports that voluntarily put an individual in a life-threatening situation. Sports such as but not limited to "free climb" rock climbing, parachuting, fighting, martial arts, racing, cliff diving, powerboat racing, air racing, motorcycle racing, extreme skiing, wing-suit, and similar.
27. Gender Dysphoria Office Visit – PCP
28. Gender Dysphoria Office Visit – Specialist

MEDICAL EXPENSES NOT GENERALLY SHARED BY HCSM

29. Gender Dysphoria
30. Genetic Testing
31. Group Therapy Services
32. Hemodialysis
33. Home Health Care
34. Home Infusion Services
35. Hospice Services
36. Hypnotherapy Services
37. Infertility Diagnostic or treatment
38. Infertility Services
39. Investigational Drugs/Procedures
40. Lifestyles or activities engaged in after the application date that conflicts with the Statement of Beliefs (on the membership application).
41. Massage Therapy
42. Midwifery
43. MILIEU Situational Therapy Services
44. Morbid Obesity
45. Non-Routine Hearing Exams & Hearing Aids
46. Nurse Practitioner
47. Orthotics (back, neck, knee, wrist, etc.)
48. Orthopedic Shoes
49. Pain Management
50. Personal aircraft includes hang gliders, parasails, ultra-lights, hot air balloons, sky/diving, and any other aircraft not operated by a commercially licensed public carrier.
51. Personal Convenience Items
52. Post-Surgical Bras
53. Podiatry Services
54. Preadmission Testing
55. Private Duty Nursing Services
56. Professional Sports Injuries
57. Prosthetic Appliances
58. Pulmonary Rehab
59. Robotic Surgery
60. Routine Nursery Care of Newborn Infant
61. Self-Inflicted Injury
62. Sexual Dysfunction Services
63. Sexual Transformation Services
64. Skilled Nursing Facility
65. Substance Abuse
66. Surgical Stockings
67. Treatment or referrals received or obtained from any family member including, but not limited to, father, mother, aunt, uncle, grandparent, sibling, cousin, dependent, or any in-laws.

PRE-AUTHORIZATION REQUIRED

Non-Emergency Surgery, Procedure, or Test. The member must have the following procedures or services pre-authorized as medically necessary prior to receiving the service. Failure to comply with this requirement will render the service not eligible for sharing.

Hospitalizations. Non-emergency prior to admission; emergency visits notification to Trinity HealthShare within 48 hours.

- MRI studies/CT scans/Ultrasounds
- Sleep studies must be completed in one session
- Physical or occupational therapy
- Speech therapy under limited circumstances only
- Cardiac testing, procedures, and treatments
- In-patient cancer testing, procedures, and treatments
- Infusion therapy within facility
- Nuclide studies
- EMG/EEG
- Ophthalmic procedures
- ER visits, emergency surgery, procedure, or test: Non-emergency use of the emergency room is not eligible for sharing. Trinity HealthShare must be notified of all ER visits within 48 hours. Medical records will be reviewed for all ER visits to determine eligibility. An emergency is defined as treatment that must be rendered to the patient immediately for the alleviation of the sudden onset of an unforeseen illness or injury that, if not treated, would lead to further disability or death. Examples of an emergency include, but are not limited to, severe pain, choking, major bleeding, heart attack, or a sudden, unexplained loss of consciousness.

Eligibility for Cancer Needs. In order for needs related to cancer hospitalization of any type to be eligible (e.g. breast, colorectal, leukemia, lymphoma, prostate, skin, etc.), the member must meet the following requirements:

The member is required to contact Trinity HealthShare within 30 days of diagnosis. If the member fails to notify Trinity HealthShare within the 30-day time frame, the member will be responsible for 50% of the total allowed charges after the MRSA(s) has been assessed to the member for in-patient cancer hospitalization.

Early detection provides the best chance for successful treatment and in the most cost effective manner. Effective January 1, 2017, the membership requires that all members aged 40 and older receive appropriate screening tests every other year – mammogram or thermography and pap smear with pelvic exams for women and PSA testing for men. ***Failure to obtain biannual mammograms and gynecological tests listed above for women or PSA tests for men will render future needs for breast, cervical, endometrial, ovarian, or prostate cancer ineligible for sharing.***

DISPUTE RESOLUTION AND APPEAL

Trinity HealthShare is a voluntary association of like-minded people who come together to assist each other by sharing medical expenses. Such a sharing and caring association does not lend itself well to the mentality of legally enforceable rights. However, it is recognized that differences of opinion will occur, and that a methodology for resolving disputes must be available. Therefore, by becoming a Sharing Member of Trinity HealthShare you agree that any dispute you have with or against Trinity HealthShare its associates, or employees will be settled using the following steps of action, and only as a course of last resort.

If a determination is made with which the sharing member disagrees and believes there is a logically defensible reason why the initial determination is wrong, then the sharing member may file an appeal.

A. **1st Level Appeal.** Most differences of opinion can be resolved simply by calling Trinity HealthShare who will try to resolve the matter telephonically within a reasonable amount of time.

B. **2nd Level Appeal.** If the sharing member is unsatisfied with the determination of the member services representative, then the sharing member may request a review by the Internal Resolution Committee, made up of three Trinity HealthShare officials. The appeal must be in writing, stating the elements of the dispute and the relevant facts. Importantly, the appeal should address all of the following:

1. What information does Trinity HealthShare have that is either incomplete or incorrect?
2. How do you believe Trinity HealthShare has misinterpreted the information already on hand?
3. Which provision in the Trinity HealthShare Guidelines do you believe Trinity HealthShare applied incorrectly?

Within thirty (30) days, the Internal Resolution Committee will render a written decision, unless additional medical documentation is required to make an accurate decision.

C. **3rd Level Appeal.** Should the matter remain unresolved, then the aggrieved party may ask that the dispute be submitted to three sharing members in good standing and randomly chosen by Trinity HealthShare, who shall agree to review the matter and shall constitute an External Resolution Committee. Within thirty (30) days the External Resolution Committee shall render their opinion in writing, unless additional medical documentation is required to make an accurate decision.

D. **Final Appeal.** If the aggrieved sharing member disagrees with the conclusion of his/her fellow sharing

members, then the aggrieved party may ask that the dispute be submitted to a medical expense auditor, who shall have the matter reviewed by a panel consisting of personnel who were not involved in the original determination and who shall render their opinion in writing within thirty (30) days, unless additional medical documentation is required to make an accurate decision.

E. **Mediation and Arbitration.** If the aggrieved sharing member disagrees with the conclusion of the Final Appeal Panel, then the matter shall be resolved by first submitting the disputed matter to mediation. If the dispute is not resolved the matter will be submitted to legally binding arbitration in accordance with the Rules and Procedure of the American Arbitration Association. Sharing members agree and understand that these methods shall be the sole remedy to resolve any controversy or claim arising out of the Sharing Guidelines, and expressly waive their right to file a lawsuit in any civil court against one another for such disputes; except to enforce an arbitration decision. Any arbitration shall be held in Atlanta, Georgia, and conducted in the English language subject to the laws of the State of Georgia. Trinity HealthShare shall pay the filing fees for the arbitration and arbitrator in full at the time of filing. All other expenses of the arbitration shall be paid by each party including costs related to transportation, accommodations, experts, evidence gathering, and legal counsel. Further agreed that the aggrieved sharing member shall reimburse the full costs associated with the arbitration, should the arbitrator render a judgment in favor of Trinity HealthShare and not the aggrieved sharing member.

The aggrieved sharing member agrees to be legally bound by the arbitrator's final decision. The parties may alternatively elect to use other professional arbitration services available in the Atlanta metropolitan area, by mutual agreement.

APPENDIX A: PLAN DETAILS
VALUE PLAN

	Multiplan PHCS
Plan Services[1]	Network
Eligible prior to meeting Member Shared Responsibility Amount (MSRA)	
Wellness & Preventive Care	100%
Telemedicine*	100%
Primary Care	1 per year** $20 Consult Fee
Urgent Care	N/A
Labs & Diagnostics	Preventive Only
X-Rays***	Preventive Only
Chronic Maintenance	N/A
Pediatrics	Preventive Only
OB/GYN	Preventive Only
Prescription Discount	Included
Eligible after meeting Member Shared Responsibility Amount (MSRA)[2 3 4]	
MSRA Options / Per member	$5,000, $7,500, $10,000
Per Incident Maximum Limit	$150,000
Lifetime Maximum Limit	$1,000,000
Specialty Care[5]	N/A
Maternity[7]	N/A
Hospitalization	Included
In-Patient Surgery	Included
Out-Patient Surgery	Included
Emergency Room[6]	Full MSRA

See Plan Details Appendix on page 35

APPENDIX A: PLAN DETAILS
PLUS PLAN

	Multiplan PHCS
Plan Services[1]	Network
Eligible prior to meeting Member Shared Responsibility Amount (MSRA)	
Wellness & Preventive Care	100%
Telemedicine*	100%
Primary Care	3 per year** $20 Consult Fee
Urgent Care	1 per year** $20 Consult Fee
Labs & Diagnostics	PCP & Urgent Care
X-Rays***	100%***
Chronic Maintenance	N/A
Pediatrics	Preventive Only
OB/GYN	Preventive Only
Prescription Discount	Included
Eligible after meeting Member Shared Responsibility Amount (MSRA)[2,3,4]	
MSRA Options / Per member	$5,000, $7,500, $10,000
Per Incident Maximum Limit	$250,000
Lifetime Maximum Limit	$1,000,000
Specialty Care[5]	N/A
Maternity[7]	N/A
Hospitalization	Included
In-Patient Surgery	Included
Out-Patient Surgery	Included
Emergency Room[6]	$500 MSRA

See Plan Details Appendix on page 35

APPENDIX A: PLAN DETAILS
PREMIUM PLAN

	Multiplan PHCS
Plan Services[1]	Network
Eligible prior to meeting Member Shared Responsibility Amount (MSRA)	
Wellness & Preventive Care	100%
Telemedicine*	100%
Primary Care	5 per year** $20 Consult Fee
Urgent Care	2 per year** $20 Consult Fee
Labs & Diagnostics	PCP & Urgent Care
X-Rays***	100%***
Chronic Maintenance	Included with PCP
Pediatrics	As Primary Care
OB/GYN	As Primary Care
Prescription Discount	Included
Eligible after meeting Member Shared Responsibility Amount (MSRA)[2,3,4]	
MSRA Options / Per member	$5,000, $7,500, $10,000
Per Incident Maximum Limit	$500,000
Lifetime Maximum Limit	$1,000,000
Specialty Care[5]	$75 Consult Fee (100% after MSRA)
Maternity[7]	$5,000 Max
Hospitalization	Included
In-Patient Surgery	Included
Out-Patient Surgery	Included
Emergency Room[6]	$300 MSRA

See Plan Details Appendix on page 35

APPENDIX A: PLAN DETAILS VALUE, PLUS, AND PREMIUM PLANS

1. Non-emergency surgical services are unavailable for the first 6 months for Value and Plus, and 2 months for Premium. Surgical services do not include cosmetic surgery.
2. Hospitalization, In-Patient and Out-Patient Surgery, Specialty Care, and Emergency Room services for pre-existing conditions have a 24 month waiting period. All other healthcare services for pre-existing conditions are eligible upon effective date.
3. Eligibility for cancer conditions is provided after 12 months of continuous membership, if a pre-existing cancer condition did not exist prior to or at the time of application.
4. The consult fee is in addition to the cost of your specialty visit and does not apply toward your annual MSRA.
5. Maternity services are unavailable for the first 10 months of membership.
6. ER visits are subject to review, and are meant only for life threatening situations. Maximum out-of-pocket is $300 for the Premium plan, $500 for the Plus plan, and full MSRA for the Value plan.
7. Members under the age of 20 can qualify as dependents. Members ages 20–26 can qualify as a dependent if proven to be a full-time student.

Trinity HealthShare plans follow medical eligibility review protocols described in the plan but are not a promise to pay. Sharing is available for all eligible medical needs.

Administrative and Conditional Fees:
$125 one-time application fee per enrollment. Add $60 for persons who smoke. Add $130 per member for additional $500,000 per incident.

* Annual physicals are available immediately at the cost of a Primary Care (PCP) visit. An inclusive annual physical is only available after 9 months of continual membership; lifestyle lab testing not included
** $25 per x-ray read fee at Urgent Care, (may vary by city)
*** Add $50 per additional dependent for families of 6 or more

APPENDIX B: TERMS, CONDITIONS, & SPECIAL CONSIDERATIONS

1. The Welcome Kit you received electronically includes this Member Guide, your Membership Card(s), a Welcome Letter, and important information to activate your membership.
2. Keep your Membership Card with you at all times to present to a provider to confirm eligibility.
3. The ACA is subject to change at any time; Aliera reserves the right to adhere to those changes without notice to the Member.
4. Activate your Plan Membership by following the instructions in this Member Guide.
5. Set up your telemedicine account by following the instructions on the Welcome Letter. Within three weeks of enrollment in Aliera's telemedicine partnering company, Members receive ID Card(s) for the telemedicine service along with instructions on how to utilize the service.
6. Telemedicine phone consultations are available 24/7/365. with face-to-face internet consultations available between the hours of 7 a.m. and 9 p.m., Monday – Friday.
7. Telemedicine does not guarantee that a prescription will be written.
8. Telemedicine does not prescribe DEA-controlled substances, non-therapeutic drugs, and certain other drugs which may be harmful because of their potential for abuse. Telemedicine doctors reserve the right to deny care for potential misuse of services.
9. Durable Medical Equipment (DME) – i.e. crutches, etc. – is not included in your Plan. Members will be charged for DME at time of service.
10. Member Care Specialists are available to assist you, Monday through Friday, 8 a.m. to 8 p.m. ET at (844) 834-3456. If you call after hours, follow the prompts.
11. At the time of service, payment of $20 (on average) is due for the consultation, and a $25 per read fee for X-rays at PCP or Urgent Care if needed. Consult fees vary in different states and may be higher in some cities, including but not limited to, New York City, Chicago, Detroit, Miami, Sacramento, Los Angeles, and San Francisco.
12. Plans may vary from state to state Providers may be added or removed from Aliera's network at any time without notice.
13. Not all geographical areas are serviced by Aliera Healthcare. Should a Member visit an emergency room because urgent care facilities are unavailable in the Member's area, Aliera offers a one-time, once-a-year, $105 credit (ex gratia) to the Member to help offset the

APPENDIX B: TERMS, CONDITIONS, & SPECIAL CONSIDERATIONS

costs incurred.

14. Aliera telemedicine partners do not replace the Primary Care Provider.
15. Primary Care is defined as "episodic primary care" or "sick care." Members are responsible for paying a consult fee at the time of service; no consult fee is due for preventive service.
16. Most network facilities are able to accommodate both urgent care and primary care needs.
17. Not all PPO providers accept an AlieraCare plan. While Aliera offers one of the largest PPO networks in the country, some providers may not participate.

Disclosures

1. Aliera Healthcare, the Aliera Healthcare logo, and other plan or service logos are trademarks of Aliera Healthcare, Inc. and may not be used without written permission.
2. Aliera and Trinity programs are NOT insurance. Aliera Healthcare, Inc./Trinity HealthShare does not guarantee the quality of services or products offered by individual providers. Members may change providers upon 30 days' notice if not satisfied with the medical services provided.
3. Aliera's Healthcare Plans offer services only to Members and dependents on your Plan.
4. Aliera reserves the right to interpret the terms of this membership to determine the level of medical services received hereunder.
5. This membership is issued in consideration of the Member's application and the Member's payment of a monthly fee as provided under these Plans. Omissions and misstatements, or incorrect, incomplete, fraudulent, or intentional misrepresentation to the assumed risk in your application may void your membership, and services may be denied.

Abbreviations

ACA	Affordable Care Act (Obamacare)
CMS	Center for Medicare and Medicaid Services
DEA	Drug Enforcement Administration
DME	Durable Medical Equipment
DPCMH	Direct Primary Care Medical Home Plans
HCSM	Health Care Sharing Ministry
MEC	Minimum Essential Coverage
PCP	Primary Care Provider
PPO	Participating Provider Organization
UC	Urgent Care

APPENDIX C: LEGAL NOTICES

The following legal notices are the result of discussions by Trinity HealthShare or other healthcare sharing ministries with several state regulators and are part of an effort to ensure that Sharing Members understand that Trinity HealthShare is not an insurance company and that it does not guarantee payment of medical costs. Our role is to enable self-pay patients to help fellow Aliera members through voluntary financial gifts.

General Legal Notice

This program is not an insurance company nor is it offered through an insurance company. This program does not guarantee or promise that your medical bills will be paid or assigned to others for payment. Whether anyone chooses to pay your medical bills will be totally voluntary. As such, this program should never be considered as a substitute for an insurance policy. Whether you receive any payments for medical expenses and whether or not this program continues to operate, you are always liable for any unpaid bills.

State Specific Notices

Alabama Code Title 22-6A-2

Notice: The organization facilitating the sharing of medical expenses is not an insurance company, and neither its guidelines nor plan of operation is an insurance policy. Whether anyone chooses to assist you with your medical bills will be totally voluntary because no other participant will be compelled by law to contribute toward your medical bills. As such, participation in the organization or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive any payment for medical expenses or whether this organization continues to operate, you are always personally responsible for the payment of your own medical bills.

Arizona Statute 20-122

Notice: the organization facilitating the sharing of medical expenses is not an insurance company and the ministry's guidelines and plan of operation are not an insurance policy. Whether anyone chooses to assist you with your medical bills will be completely voluntary because participants are not compelled by law to contribute toward your medical bills. Therefore, participation in the ministry or a subscription to any of its documents should not be considered to be insurance. Regardless of whether you receive any payment for medical expenses or whether this ministry continues to operate, you are always personally responsible for the payment of your own medical bills.

Arkansas Code 23-60-104.2

APPENDIX C: LEGAL NOTICES

Notice: The organization facilitating the sharing of medical expenses is not an insurance company and neither its guidelines nor plan of operation is an insurance policy. If anyone chooses to assist you with your medical bills, it will be totally voluntary because participants are not compelled by law to contribute toward your medical bills. Participation in the organization or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive a payment for medical expenses or if this organization continues to operate, you are always personally responsible for the payment of your own medical bills.

Florida Statute 624.1265

Trinity HealthShare is not an insurance company, and membership is not offered through an insurance company. Trinity HealthShare is not subject to the regulatory requirements or consumer protections of the Florida Insurance Code.

Georgia Statute 33-1-20

Notice: The organization facilitating the sharing of medical expenses is not an insurance company, and neither its guidelines nor plan of operation is an insurance policy. Whether anyone chooses to assist you with your medical bills will be totally voluntary because no other participant will be compelled by law to contribute toward your medical bills. As such, participation in the organization or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive any payment for medical expenses or whether this organization continues to operate, you are always personally responsible for the payment of your own medical bills.

Idaho Statute 41-121

Notice: The organization facilitating the sharing of medical expenses is not an insurance company, and neither its guidelines nor plan of operation is an insurance policy. Whether anyone chooses to assist you with your medical bills will be totally voluntary because no other participant will be compelled by law to contribute toward your medical bills. As such, participation in the organization or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive any payment for medical expenses or whether this organization continues to operate, you are always personally responsible for the payment of your own medical bills.

Illinois Statute 215-5/4-Class 1-b

Notice: The organization facilitating the sharing of medical expenses is not an insurance company, and neither its guidelines nor plan of operation constitute or create an insurance policy. Any assistance you receive with your

APPENDIX C: LEGAL NOTICES

medical bills will be totally voluntary. As such, participation in the organization or a subscription to any of its documents should never be considered to be insurance. Whether or not you receive any payments for medical expenses and whether or not this organization continues to operate, you are always personally responsible for the payment of your own medical bills.

Indiana Code 27-1-2.1

Notice: The organization facilitating the sharing of medical expenses is not an insurance company, and neither its guidelines nor its plan of operation is an insurance policy. Any assistance you receive with your medical bills will be totally voluntary. Neither the organization nor any other participant can be compelled by law to contribute toward your medical bills. As such, participation in the organization or a subscription to any of its documents should never be considered to be insurance. Whether or not you receive any payments for medical expenses and whether or not this organization continues to operate, you are always personally responsible for the payment of your own medical bills.

Kentucky Revised Statute 304.1-120 (7)

Notice: Under Kentucky law, the religious organization facilitating the sharing of medical expenses is not an insurance company, and its guidelines, plan of operation, or any other document of the religious organization do not constitute or create an insurance policy. Participation in the religious organization or a subscription to any of its documents shall not be considered insurance. Any assistance you receive with your medical bills will be totally voluntary. Neither the organization nor any participant shall be compelled by law to contribute toward your medical bills. Whether or not you receive any payments for medical expenses, and whether or not this organization continues to operate, you shall be personally responsible for the payment of your medical bills.

Louisiana Revised Statute Title 22-318,319

Notice: The ministry facilitating the sharing of medical expenses is not an insurance company. Neither the guidelines nor the plan of operation of the ministry constitutes an insurance policy. Financial assistance for the payment of medical expenses is strictly voluntary. Participation in the ministry or a subscription to any publication issued by the ministry shall not be considered as enrollment in any health insurance plan or as a waiver of your responsibility to pay your medical expenses.

Maine Revised Statute Title 24-A, §704, sub-§3

Notice: The organization facilitating the sharing of medical expenses is not an insurance company and neither its guidelines nor plan of operation is an insurance policy.

APPENDIX C: LEGAL NOTICES

Whether anyone chooses to assist you with your medical bills will be totally voluntary because no other participant will be compelled by law to contribute toward your medical bills. Participation in the organization or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive payment for medical expenses or whether this organization continues to operate, you are always personally responsible for the payment of your own medical bills.

Maryland Article 48, Section 1-202(4)

Notice: This publication is not issued by an insurance company nor is it offered through an insurance company. It does not guarantee or promise that your medical bills will be published or assigned to others for payment. No other subscriber will be compelled to contribute toward the cost of your medical bills. Therefore, this publication should never be considered a substitute for an insurance policy. This activity is not regulated by the State Insurance Administration, and your liabilities are not covered by the Life and Health Guaranty Fund. Whether or not you receive any payments for medical expenses and whether or not this entity continues to operate, you are always liable for any unpaid bills.

Mississippi Title 83-77-1

Notice: The organization facilitating the sharing of medical expenses is not an insurance company, and neither its guidelines nor plan of operation is an insurance policy. Whether anyone chooses to assist you with your medical bills will be totally voluntary because no other participant will be compelled by law to contribute toward your medical bills. As such, participation in the organization or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive any payment of medical expenses or whether this organization continues to operate, you are always personally responsible for the payment of your own medical bills.

Missouri Section 376.1750

Notice: This publication is not an insurance company nor is it offered through an insurance company. Whether anyone chooses to assist you with your medical bills will be totally voluntary, as no other subscriber or member will be compelled to contribute toward your medical bills. As such, this publication should never be considered to be insurance. Whether you receive any payments for medical expenses and whether or not this publication continues to operate, you are always personally responsible for the payment of your own medical bills.

Nebraska Revised Statute Chapter 44-311

IMPORTANT NOTICE. This organization is not an insurance

APPENDIX C: LEGAL NOTICES

company, and its product should never be considered insurance. If you join this organization instead of purchasing health insurance, you will be considered uninsured. By the terms of this agreement, whether anyone chooses to assist you with your medical bills as a participant of this organization will be totally voluntary, and neither the organization nor any participant can be compelled by law to contribute toward your medical bills. Regardless of whether you receive payment for medical expenses or whether this organization continues to operate, you are always personally responsible for the payment of your own medical bills. This organization is not regulated by the Nebraska Department of Insurance. You should review this organization's guidelines carefully to be sure you understand any limitations that may affect your personal medical and financial needs.

New Hampshire Section 126-V:1

IMPORTANT NOTICE This organization is not an insurance company, and its product should never be considered insurance. If you join this organization instead of purchasing health insurance, you will be considered uninsured. By the terms of this agreement, whether anyone chooses to assist you with your medical bills as a participant of this organization will be totally voluntary, and neither the organization nor any participant can be compelled by law to contribute toward your medical bills. Regardless of whether you receive payment for medical expenses or whether this organization continues to operate, you are always personally responsible for the payment of your own medical bills. This organization is not regulated by the New Hampshire Insurance Department. You should review this organization's guidelines carefully to be sure you understand any limitations that may affect your personal medical and financial needs.

North Carolina Statute 58-49-12

Notice: The organization facilitating the sharing of medical expenses is not an insurance company and neither its guidelines nor its plan of operation is an insurance policy. Whether anyone chooses to assist you with your medical bills will be voluntary. No other participant will be compelled by law to contribute toward your medical bills. As such, participation in the organization or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive any payment for medical expenses or whether this organization continues to operate, you are always personally liable for the payment of your own medical bills.

Pennsylvania 40 Penn. Statute Section 23(b)

Notice: This publication is not an insurance company nor is it offered through an insurance company. This publication does not guarantee or promise that your medical bills will be

APPENDIX C: LEGAL NOTICES

published or assigned to others for payment. Whether anyone chooses to pay your medical bills will be totally voluntary. As such, this publication should never be considered a substitute for insurance. Whether you receive any payments for medical expenses and whether or not this publication continues to operate, you are always liable for any unpaid bills.

South Dakota Statute Title 58-1-3.3

Notice: The organization facilitating the sharing of medical expenses is not an insurance company, and neither its guidelines nor plan of operation is an insurance policy. Whether anyone chooses to assist you with your medical bills will be totally voluntary because no other participant will be compelled by law to contribute toward your medical bills. As such, participation in the organization or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive any payments for medical expenses or whether this organization continues to operate, you are always personally responsible for the payment of your own medical bills.

Texas Code Title 8, K, 1681.001

Notice: This health care sharing ministry facilitates the sharing of medical expenses and is not an insurance company, and neither its guidelines nor its plan of operation is an insurance policy. Whether anyone chooses to assist you with your medical bills will be totally voluntary because no other participant will be compelled by law to contribute toward your medical bills. As such, participation in the ministry or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive any payment for medical expenses or whether this ministry continues to operate, you are always personally responsible for the payment of your own medical bills. Complaints concerning this health care sharing ministry may be reported to the office of the Texas attorney general.

The ministry will assign a recommended cost sharing amount to the membership each month ("Monthly Share Amount"). By submitting the Monthly Share Amount, you instruct the ministry to assign your contribution as prescribed by the Guidelines. Up to 40% of your member contribution goes towards the administration of this plan. Administration costs are not all inclusive of vendor costs, which could account for up to 32% of the member contribution (monthly recommended share amount). Contributions to the member "Share Box" will never be less than 28% of the member monthly recommended share amount.

Virginia Code 38.2-6300-6301

Notice: This publication is not insurance, and is not offered through an insurance company. Whether anyone chooses

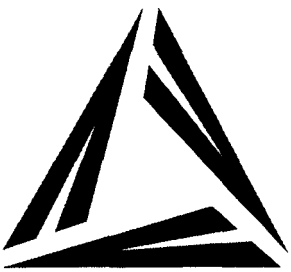
APPENDIX C: LEGAL NOTICES

to assist you with your medical bills will be totally voluntary, as no other member will be compelled by law to contribute toward your medical bills. As such, this publication should never be considered to be insurance. Whether you receive any payments for medical expenses and whether or not this publication continues to operate, you are always personally responsible for the payment of your own medical bills.

Wisconsin Statute 600.01 (1) (b) (9)

ATTENTION: This publication is not issued by an insurance company, nor is it offered through an insurance company. This publication does not guarantee or promise that your medical bills will be published or assigned to others for payment. Whether anyone chooses to pay your medical bills is entirely voluntary. This publication should never be considered a substitute for an insurance policy. Whether or not you receive any payments for medical expenses, and whether or not this publication continues to operate, you are responsible for the payment of your own medical bills.

This is NOT Insurance.



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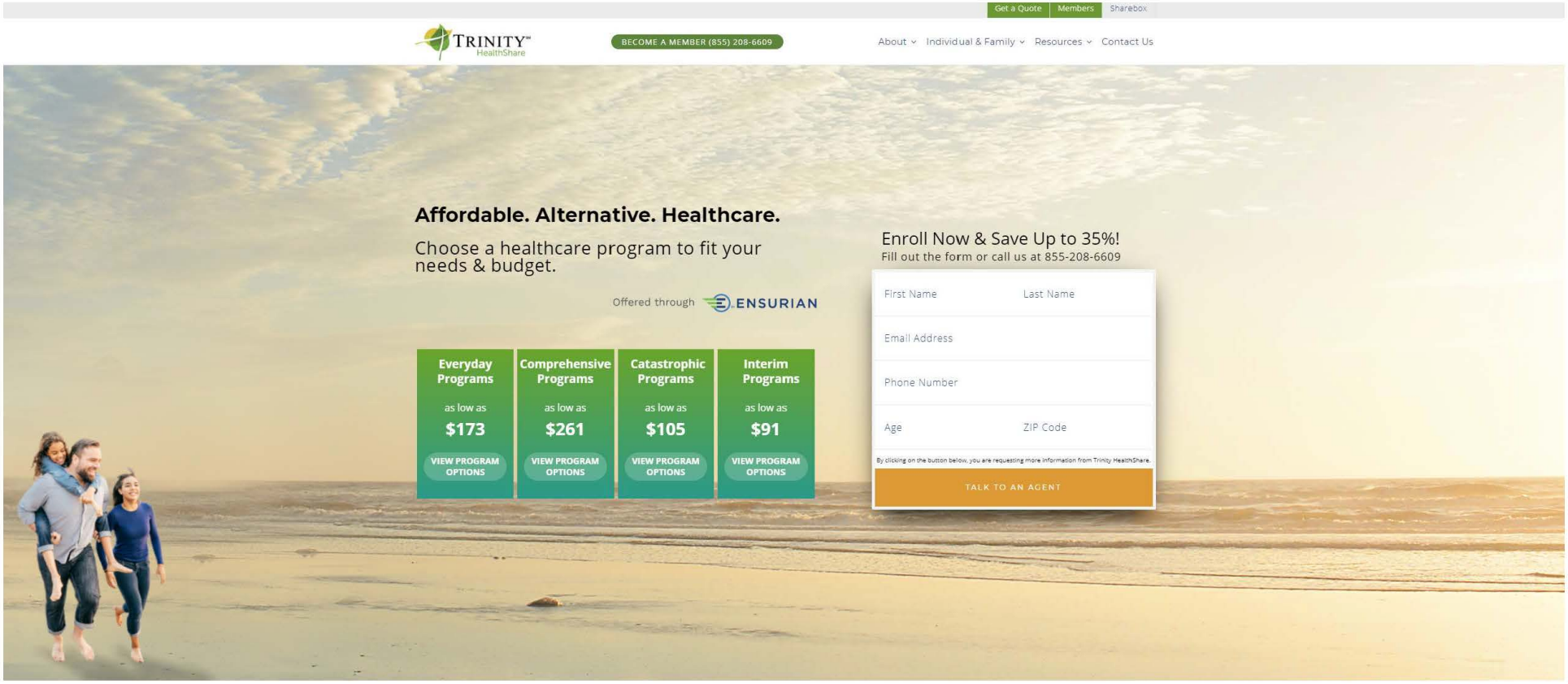
ALIERACARE™
VALUE | PLUS | PREMIUM

TRINITY HealthShare

990 Hammond Drive, Suite 700
Atlanta, GA 30328
Toll-Free 844-834-3456
www.alierahealthcare.com

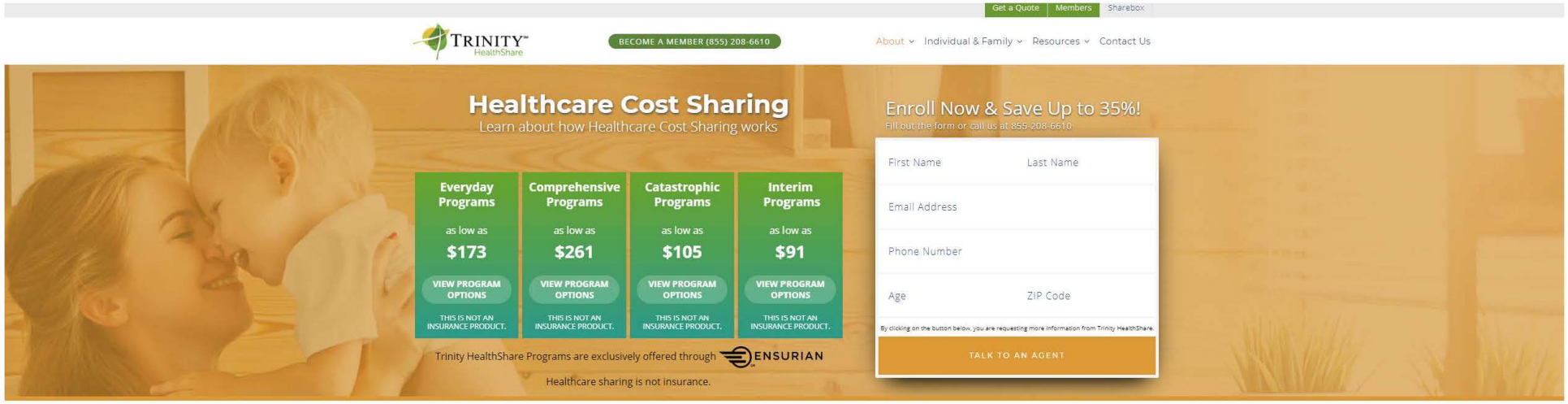
APPENDIX C



Our healthcare sharing programs put you and your family at the center of great healthcare.

If you are looking for an alternative solution to the rising costs of health insurance without sacrificing on great healthcare—Trinity healthcare sharing programs are right for you. Discover why thousands of people have joined Trinity HealthShare and believe our health sharing ministry is a positive alternative to traditional health insurance.

Solutions that work for *you* CONTACT US TODAY



Medical Cost Sharing: A Viable Alternative to Traditional Healthcare

With the rising costs of health insurance, people are looking for alternatives. Nobody wants to pay more for less, yet that is what is happening in the insurance market today: Coverage is going down as cost is going up. Trinity HealthShare's medical cost sharing programs provide affordable and effective alternatives for those who believe in individual responsibility, healthy living, and caring for one another.

Trinity HealthShare and traditional insurance are not the same

Trinity HealthShare is a Health Care Sharing Ministry (HCSM) and not traditional health insurance. With traditional health insurance, the insured are charged for copays and deductibles and patient responsibility amounts besides the premiums that are sent into the insurance agency. Those who strive to take care of their bodies end up paying to cover those who don't.

Traditional Health Insurance

- **Premiums**
  Every month, members pay a fee to insurance companies for coverage.

Trinity HealthShare – HCSM

- **Contributions**
  Every month, members send their contributions (premiums) to Trinity HealthShare where they're deposited into the members'

Trinity HealthShare is a Health Care Sharing Ministry (HCSM) and not traditional health insurance. With traditional health insurance, the insured are charged for copays and deductibles and patient responsibility amounts besides the premiums that are sent into the insurance agency. Those who strive to take care of their bodies end up paying to cover those who don't.

Traditional Health Insurance

- **Premiums**
  Every month, members pay a fee to insurance companies for coverage.
- **Deductibles**
  Before the insurance pays any bills, the deductible must be met. Once it's met, only a percentage of each bill is covered until the member reaches the maximum out-of-pocket. Some insurances have a separate prescription deductible.
- **Copays**
  Every time a member goes to the doctor, lab, specialist, hospital or picks up a prescription, he or she must pay a copay that does not go towards the deductible.
- **Maximum out-of-pocket**
  All expenses except for co-expenses add together to reach the member's maximum out-of-pocket. Once it is reached, the insurance cost-shares 100%.

Trinity HealthShare – HCSM

- **Contributions**
  Every month, members send their contributions (premiums) to Trinity HealthShare where they're deposited into the members' "shareboxes," awaiting dispersal to a member's medical bills.
- **Member Shared Responsibility Amount (MSRA)**
  Similar to a deductible in that it is a set amount that must be met before medical bills are paid, once the MSRA is met, the money from members' shareboxes are used to cover eligible medical expenses.
- **Co-expenses**
  Every time a member goes to the doctor, specialist or hospital, a co-expense is paid.
- **Maximum out-of-pocket**
  All expenses except for co-expenses add together to reach the member's maximum out-of-pocket amount. Once the maximum out-of-pocket amount is reached, Trinity HealthShare cost-shares 100%.
- **Telemedicine**
  Helping members eliminate expenses, individuals can "see" a U.S. board-certified doctor over the phone or via video chat at no expense. These doctors can make diagnoses, write prescriptions, and make referrals.

In addition to eliminating hidden costs, health care sharing ministries encourage wholesome living by requiring members to sign agreements stating they will maintain a healthy lifestyle and avoid foods, behaviors or habits that produce sickness or disease in themselves or others. A healthy way of life translates into lower monthly contributions and lower medical costs for the membership as a whole. Higher MSRAs also help reduce monthly contributions, allowing members to set aside the savings to help pay the higher MSRA if they need to.

Trinity HealthShare is a HCSM and bases its principles of healthcare upon sharing one another's burdens. With most medical cost sharing programs, individuals come together around a common religious or ethical belief, or both. Members must sign a statement of beliefs in order to join a HCSM.

Learn about how healthcare sharing programs work.

Trinity HealthShare's healthcare sharing programs are quite simple, with only six steps involved.

1

Member Contribution

You send your contribution to Trinity

Everyone's monthly "share" is placed in their "Sharefile" until it is matched to another member's eligible bills.

2

Activate

Activate Your Membership

Activate your membership through our partners website here.

3

Visit Network Doctor

Call the concierge line for appointments

Show your member ID when you experience medical costs. Your doctor should recognize the network.

4

Doctor Submits Bill

Your doctor sends the bill to Trinity

Your doctor sends bills electronically to Trinity HealthShare or the TPA for Trinity. Trinity performs an analysis and pays a reasonable amount.

5

We Share Bill

Everyone shares in the cost

Members contribute from their "Sharefile" to your secure online Sharefile account.

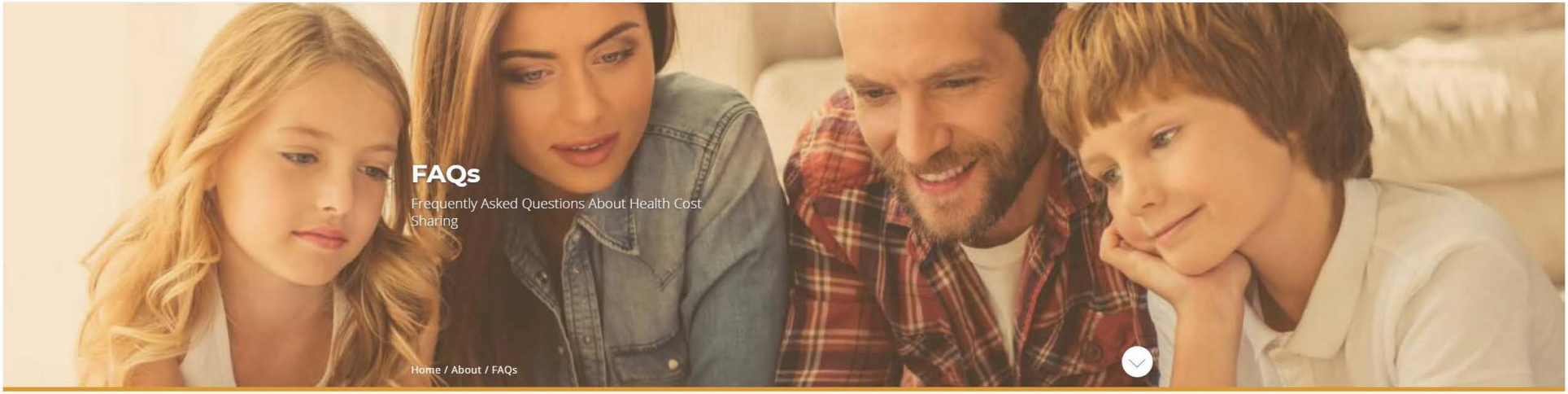
6

Payments To Doctors

Doctors and Hospitals are Paid

Trinity HealthShare pays the shareable amount of medical bills to your healthcare providers, but it will not pay inflated rates.

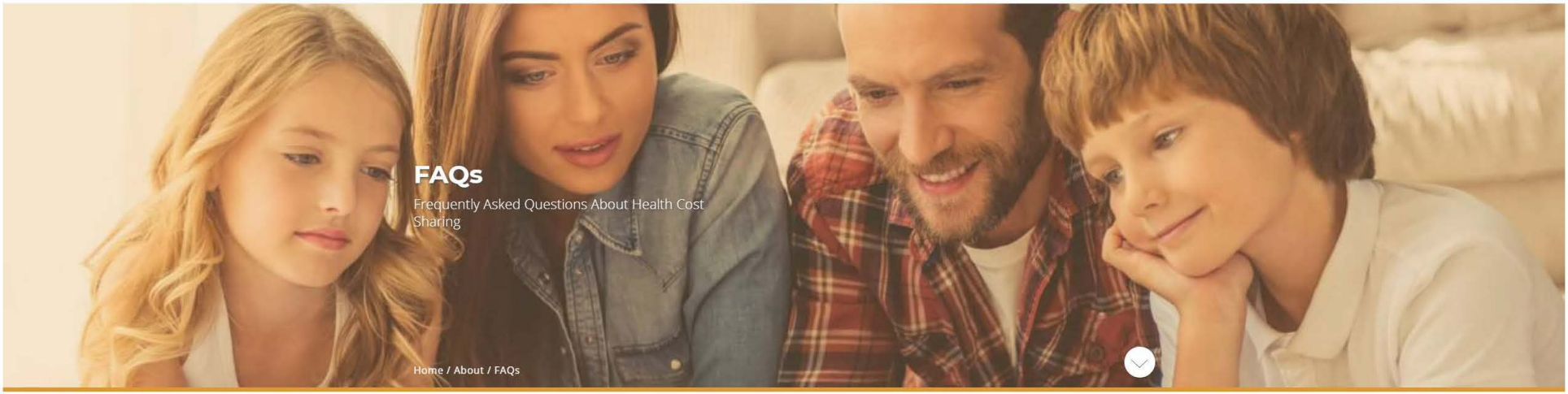
Affordable quality healthcare sharing programs can be found for those who embrace a healthy lifestyle. No longer does quality have to be sacrificed because of cost. With Trinity HealthShare, there is a viable alternative to traditional healthcare.



FAQs

What medical needs are eligible for sharing?

Medical needs eligible to be shared by Trinity HealthShare members compare favorably to their prior medical coverage. Eligible medical needs are listed in the membership guidelines.



FAQs

▸ What medical needs are eligible for sharing?

▾ Are maternity benefits included?

Yes. In the Premium offerings maternity benefits are available after 10 consecutive months of membership prior to conception. Trinity HealthShare will share up to $5,000 per natural delivery, up to $8,000 for a cesarean section delivery when medically necessary and up to $50,000 should difficulties or medical complications arise.

FAQs

- What medical needs are eligible for sharing?
- Are maternity benefits included?
- How do I become a member?

Becoming a member is simple; complete the membership application process online.

FAQs

- What medical needs are eligible for sharing?
- Are maternity benefits included?
- How do I become a member?
- How much will Trinity HealthShare cost?

Your monthly contribution depends on the number of members in your family and the type of membership you desire.

FAQs

- What medical needs are eligible for sharing?
- Are maternity benefits included?
- How do I become a member?
- How much will Trinity HealthShare cost?
- Do contributions fluctuate each month?

No. The contributions do not fluctuate from month-to-month. However, contributions are subject to review by the Board of Directors on an annual basis. Adjustments may be made periodically, usually on an annual basis, to meet the needs of the membership.

FAQs

- What medical needs are eligible for sharing?
- Are maternity benefits included?
- How do I become a member?
- How much will Trinity HealthShare cost?
- Do contributions fluctuate each month?
- Are there religious restrictions for membership in Trinity HealthShare?

  Trinity HealthShare welcomes members of all faiths who can honor the Statement of Beliefs, by which the Trinity HealthShare program operates.

FAQs

- What medical needs are eligible for sharing?
- Are maternity benefits included?
- How do I become a member?
- How much will Trinity HealthShare cost?
- Do contributions fluctuate each month?
- Are there religious restrictions for membership in Trinity HealthShare?
- What about pre-existing conditions?

Any illness or accident for which a person has been diagnosed, received medical treatment, been examined, taken medication, or had symptoms within 24 months prior to the application date is considered a pre-existing condition. Symptoms include but are not limited to the following: abnormal discharge or bleeding; abnormal growth; break; cut or tear; discoloration; deformity; full or partial loss of use; obvious damage, illness or abnormality; impaired breathing; impaired motion; inflammation or swelling; itching; numbness; pain that interferes with normal use; unexplained or unplanned weight gain or loss exceeding 25% of the total body weight occurring within a six-month period; fainting, loss of consciousness, or seizure; abnormal results from a test administered by a medical practitioner.

FAQs

- What medical needs are eligible for sharing?
- Are maternity benefits included?
- How do I become a member?
- How much will Trinity HealthShare cost?
- Do contributions fluctuate each month?
- Are there religious restrictions for membership in Trinity HealthShare?
- What about pre-existing conditions?
- Is membership with Trinity HealthShare a contract or can I quit anytime?

It is NOT a contract. You can choose to quit the membership at any time. There is a $125 application fee and a non-refundable $25 fee for Trinity Ministries if you chose to quit after being accepted to the membership. Trinity HealthShare requests proper notification from a member who chooses to quit for any reason. For more information please see Member Guidelines.

FAQs

- What medical needs are eligible for sharing?
- Are maternity benefits included?
- How do I become a member?
- How much will Trinity HealthShare cost?
- Do contributions fluctuate each month?
- Are there religious restrictions for membership in Trinity HealthShare?
- What about pre-existing conditions?
- Is membership with Trinity HealthShare a contract or can I quit anytime?
- What guarantees do I have that my contributions will be used correctly?

Financial integrity and accountability of Trinity HealthShare is very important. We adhere to the highest standards for operating and maintaining the utmost level of accountability through our auditing procedures and board of directors. Trust from our members is very important to us and there are several ways in which we maintain our trust from all members.

FAQs

- What medical needs are eligible for sharing?
- Are maternity benefits included?
- How do I become a member?
- How much will Trinity HealthShare cost?
- Do contributions fluctuate each month?
- Are there religious restrictions for membership in Trinity HealthShare?
- What about pre-existing conditions?
- Is membership with Trinity HealthShare a contract or can I quit anytime?
- What guarantees do I have that my contributions will be used correctly?
- What happens if my monthly contribution is late?

  Monthly contributions are due on the 1st or 15th of each month, dependent on effective date. If the monthly contribution is not received by the due date, an administrative fee will be assessed to track, receive, and post the monthly contribution. If the monthly contribution is not received by the end of the month, a membership becomes inactive as of the last day of the preceding month in which a monthly contribution was received.

FAQs

- What medical needs are eligible for sharing?
- Are maternity benefits included?
- How do I become a member?
- How much will Trinity HealthShare cost?
- Do contributions fluctuate each month?
- Are there religious restrictions for membership in Trinity HealthShare?
- What about pre-existing conditions?
- Is membership with Trinity HealthShare a contract or can I quit anytime?
- What guarantees do I have that my contributions will be used correctly?
- What happens if my monthly contribution is late?
- How does my doctor or hospital get paid?

  Once your medical provider has properly processed your medical claim to be shared by the membership, the medical need is adjudicated and payment is issued directly to the provider.

FAQs

- What medical needs are eligible for sharing?
- Are maternity benefits included?
- How do I become a member?
- How much will Trinity HealthShare cost?
- Do contributions fluctuate each month?
- Are there religious restrictions for membership in Trinity HealthShare?
- What about pre-existing conditions?
- Is membership with Trinity HealthShare a contract or can I quit anytime?
- What guarantees do I have that my contributions will be used correctly?
- What happens if my monthly contribution is late?
- How does my doctor or hospital get paid?
- What happens if I have a discrepancy with a non-eligible medical need?

If a need is denied as not eligible, and there is a dispute, the aggrieved member or any other aggrieved party may seek reconsideration only through the appeal procedure described in the Member Guidelines.

FAQs

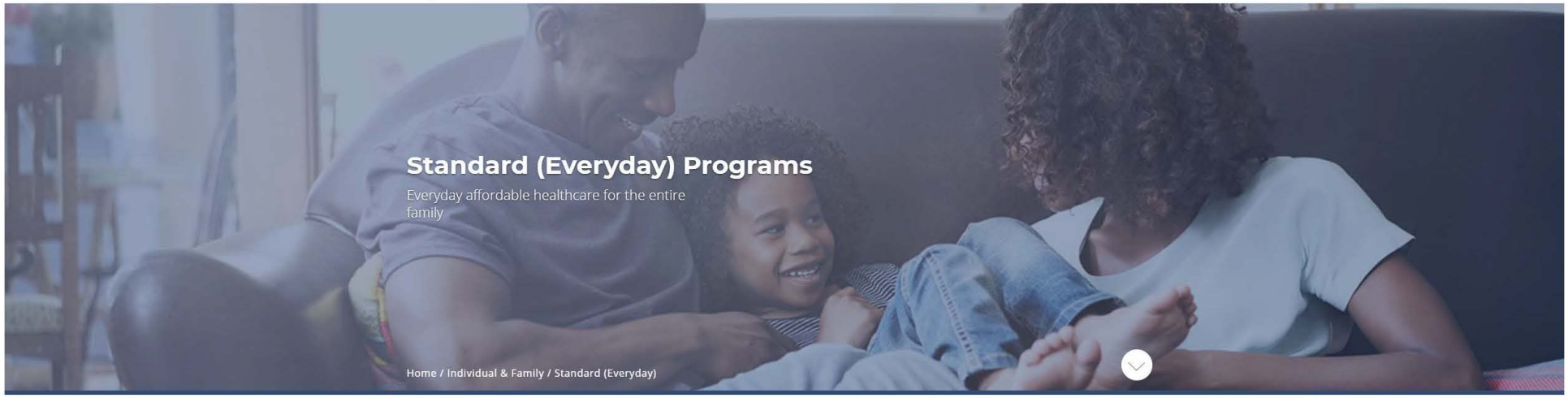
- What medical needs are eligible for sharing?
- Are maternity benefits included?
- How do I become a member?
- How much will Trinity HealthShare cost?
- Do contributions fluctuate each month?
- Are there religious restrictions for membership in Trinity HealthShare?
- What about pre-existing conditions?
- Is membership with Trinity HealthShare a contract or can I quit anytime?
- What guarantees do I have that my contributions will be used correctly?
- What happens if my monthly contribution is late?
- How does my doctor or hospital get paid?
- What happens if I have a discrepancy with a non-eligible medical need?
- Can I be a member of Trinity HealthShare and also have medical insurance?

Yes, a member can have health insurance through work or another source. If a member has medical insurance and a Trinity HealthShare membership, the medical insurance is the primary source for paying medical claims. Trinity HealthShare membership shares in the portion that the health insurance plan does not cover.

FAQs

- What medical needs are eligible for sharing?
- Are maternity benefits included?
- How do I become a member?
- How much will Trinity HealthShare cost?
- Do contributions fluctuate each month?
- Are there religious restrictions for membership in Trinity HealthShare?
- What about pre-existing conditions?
- Is membership with Trinity HealthShare a contract or can I quit anytime?
- What guarantees do I have that my contributions will be used correctly?
- What happens if my monthly contribution is late?
- How does my doctor or hospital get paid?
- What happens if I have a discrepancy with a non-eligible medical need?
- Can I be a member of Trinity HealthShare and also have medical insurance?
- Is Trinity HealthShare insurance?

No, Trinity HealthShare is not insurance. This publication or membership is not issued by an insurance company, nor is it offered through an insurance company.



‹ Home

Individual & Family

- Catastrophic
  - CarePlus Advantage
- Standard (Everyday)
  - AlieraCare VPP
- Comprehensive
  - AlieraCare BSG
- Interim Medical
  - InterimCare
- Supplemental
  - Dental
  - Vision

Standard Healthcare Program: An Economic Program for the Family

With the rising cost of health insurance and the frustrations of trying to obtain the desired healthcare in either the private sector or the Marketplace, Trinity HealthShare offers a refreshing alternative. Not a traditional medical plan, Trinity offers an everyday program that has broad services at a reasonable price. A refreshing option in today's frustrating market.

Ready To Enroll? VIEW PROGRAM OPTIONS

- **Interim Medical**
  - InterimCare
- **Supplemental**
  - Dental
  - Vision
- **Healthcare Cost Sharing**
  - How it Works
  - FAQs
- **Basic Care**
  - PrimaCare

This is a Healthcare Sharing Ministry (HCSM) Product

OFFERED THROUGH ENSURIAN

Ready To Enroll?

VIEW PROGRAM OPTIONS

Trinity's standard healthcare program

Trinity's affordable health program alternative—AlieraCare Value | Plus | Premium—offers low-cost healthcare for both individuals and families. This affordable individual healthcare provides individuals and families with immediate access to doctors through office visits, urgent care, and telemedicine.

Telemedicine allows members to reach a U.S. board-certified doctor 24/7 from the comfort of their home rather than having to brave the crowds when feeling ill. Members can speak with a physician on the phone or by video and can receive prescriptions and follow-up recommendations without having to take time off of work or wait in crowded waiting rooms. With this affordable healthcare, unlimited telemedicine is offered through the program.

Preventive care is also eligible for cost-sharing with zero out-of-pocket expenses and no member responsible shared amount (MRSA) for in-network providers and labs. Flu shots, regular annual screenings, and immunizations are all eligible with this low-cost individual healthcare. An average savings of 55% on every prescription is seen by members.

Trinity's affordable individual health program include primary care physician visits, pharmaceuticals, basic eye and hearing exams, both in and outpatient procedures, extended hospitalizations, urgent care needs, labs, and diagnostic procedures. It's an all-inclusive, affordable healthcare option. Even people with pre-existing conditions can get good healthcare—reaching a doctor whenever they need through telemedicine.

The difference between standard (everyday) healthcare program and major medical

Major medical typically includes preventive care, a prescription drug program, emergency services, hospitalization, and its associated costs. While carrying major medical can be reassuring, the soaring costs of healthcare and rigid open enrollment periods have made it very difficult and often unattainable for many hard-working Americans.

Trinity program are not considered "insurance" which means they don't have to cut through the red tape required by traditional insurance mandates. Trinity program such as AlieraCare Value | Plus | Premium allow members to achieve comparable cost assurances for catastrophic healthcare services (including preventative care and immediate access to doctors through office visits, urgent care, and telemedicine) at a much lower cost because they are supported by a healthcare sharing organization that facilitates medical cost sharing between members.

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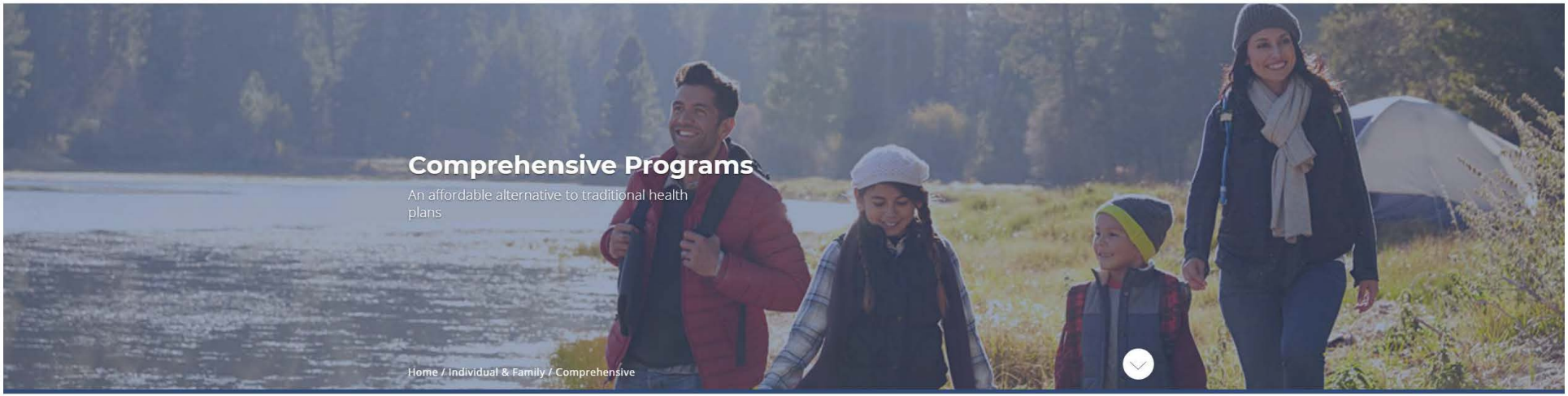
The standard healthcare plan's ideal candidate

Trinity's standard healthcare is ideal for individuals and families who want both physician and hospitalization at lower costs. With low monthly contribution costs, members can set aside money to help pay for the higher MSRA, which works like a deductible in traditional insurance. Members can also choose how high or low they want the MSRA to be with three programs setting the MSRA to $5,000, $7,500, or $10,000.

Known in the industry as everyday health programs or low-cost comprehensive healthcare, Trinity's standard health program option is paving the way to a new style of healthcare.



Comprehensive Programs

An affordable alternative to traditional health plans

‹ Home

Individual & Family

- **Catastrophic**
  CarePlus Advantage
- **Standard (Everyday)**
  AlieraCare VPP
- **Comprehensive**
  AlieraCare BSG
- **Interim Medical**
  InterimCare
- **Supplemental**
  Dental
  Vision
- **Healthcare Cost Sharing**

Comprehensive Healthcare: An Alternative to Major Medical

The cost of traditional medical plans continues to rise, even as the quality and quantity of healthcare services they offer decreases. The one-size-fit-all model of care isn't really a solution for a lot of people. That's why Trinity HealthShare provides a variety of comprehensive healthcare programs that give individuals and families quality healthcare choices at a price they can afford.

Ready To Enroll? VIEW PROGRAM OPTIONS

This is a Healthcare Sharing Ministry (HCSM) Product

OFFERED THROUGH ENSURIAN

What is a Trinity comprehensive program?

Comprehensive healthcare programs provide services for a full spectrum of medical needs—from wellness, preventive and sick care to help with unforeseen medical emergencies.

Services included in a Trinity comprehensive program:

- Free telemedicine
- Unlimited wellness & preventive
- Primary care
- Urgent care
- Specialty care
- Prescription discount program
- Maternity care
- Emergency room
- Hospitalization
- Surgical

The ideal candidate for a comprehensive medical program

A comprehensive healthcare program is designed to meet a member's full range of medical needs. It is a perfect solution for those who have pre-existing conditions, need chronic medical care or have growing families. It's also great for those who simply want to have peace of mind, knowing that they will be able to receive the healthcare services they need, when they need them.

Consider a Trinity comprehensive healthcare program if you:

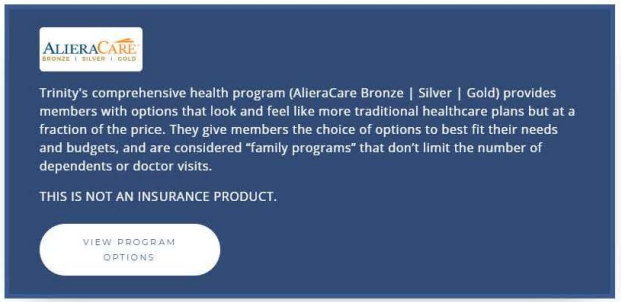
- Can't afford a traditional medical plan through Healthcare.gov or your employer
- Are not eligible for government subsidies
- Want a more comprehensive solution—similar to the traditional options you may be accustomed to seeing
- Missed open enrollment

How Trinity's comprehensive healthcare program works

Because Trinity's comprehensive health programs are based on cost sharing, monthly contributions are much lower than with traditional major medical plans. The trade-off is that the member shared responsibility amount (MSRA) is high. The MSRA is the amount of money a member must pay out of pocket before cost sharing begins. Once the MSRA is reached, members share a portion of all eligible services until the yearly out-of-pocket maximum is met. With several different types of programs to choose from, individuals can pick a yearly MSRA anywhere from $1,000 to $10,000; families between $3,000 and $30,000.

Trinity HealthShare's membership requirements

The only requirement to participate in a comprehensive medical healthcare program is that members must complete an enrollment form in which they agree to and sign a short Statement of Beliefs. Like any healthcare plan, there are limitations and exclusions to the services offered with each of the Trinity solutions; therefore, it's important that members understand the advantages and disadvantages of the plans they choose.



Get a Quote | Members | Sharebox

TRINITY HealthShare

BECOME A MEMBER (855) 208-6610

About | Individual & Family | Resources | Contact Us

‹ Home

Individual & Family

- **Catastrophic**
  CarePlus Advantage
- **Standard (Everyday)**
  AlieraCare VPP
- **Comprehensive**
  AlieraCare BSG
- **Interim Medical**
  InterimCare
- **Supplemental**
  Dental
  Vision

Health sharing programs that provide you and your family with peace of mind

Today, most people get their healthcare plans through work. But every year, more people are choosing to shop in the private marketplace.

For some individuals and families, there are key advantages to choosing their own personal medical plans over employer options—affordability, portability and customization. Whether you are a single individual, have a family, are self-employed, are a student, or are just looking for the best health plan for your unique needs, you should consider a program from Trinity HealthShare.

Catastrophic

Trinity's catastrophic healthcare plan, CarePlus Advantage, is best suited for individuals and families who are primarily healthy and looking to provide security to their family knowing they are eligible for cost sharing for catastrophic hospitalization events or needs, plus emergency room cost sharing.

THIS IS NOT AN INSURANCE PRODUCT

VIEW PROGRAM OPTIONS

Standard (Everyday)

Trinity's standard healthcare plan, Trinity Value | Plus | Premium, is recommended for individuals and families who are primarily healthy and whose main concern is preventive services and basic medical needs, as well as cost sharing for a catastrophic care event.

THESE ARE NOT INSURANCE PRODUCTS

VIEW PROGRAM OPTIONS

Comprehensive

Trinity's comprehensive health plan, Trinity Bronze | Silver | Gold, is designed for those who want comprehensive healthcare closer to traditional medical plans, but are seeking affordable alternatives to major medical. From the doctor's office to the operating table, access comprehensive medical services when you need them most.

THESE ARE NOT INSURANCE PRODUCTS

VIEW PROGRAM OPTIONS

Supplemental

Life is full of unpredictable events, and unfortunately they often come when you least expect—and can least afford—it. Supplemental health plans help with out-of-pocket expenses associated with eye exams, teeth cleanings, ER visits, or prescription drugs.

THESE ARE NOT INSURANCE PRODUCTS

VIEW PLAN OPTIONS

Basic Care

Our basic care plans are a healthcare solution centered around the importance of primary care. Regardless of a person's age there is a critical need for regular preventive care, making a basic healthcare plan a necessity at minimum.

THESE ARE NOT INSURANCE PRODUCTS

VIEW PLAN OPTIONS

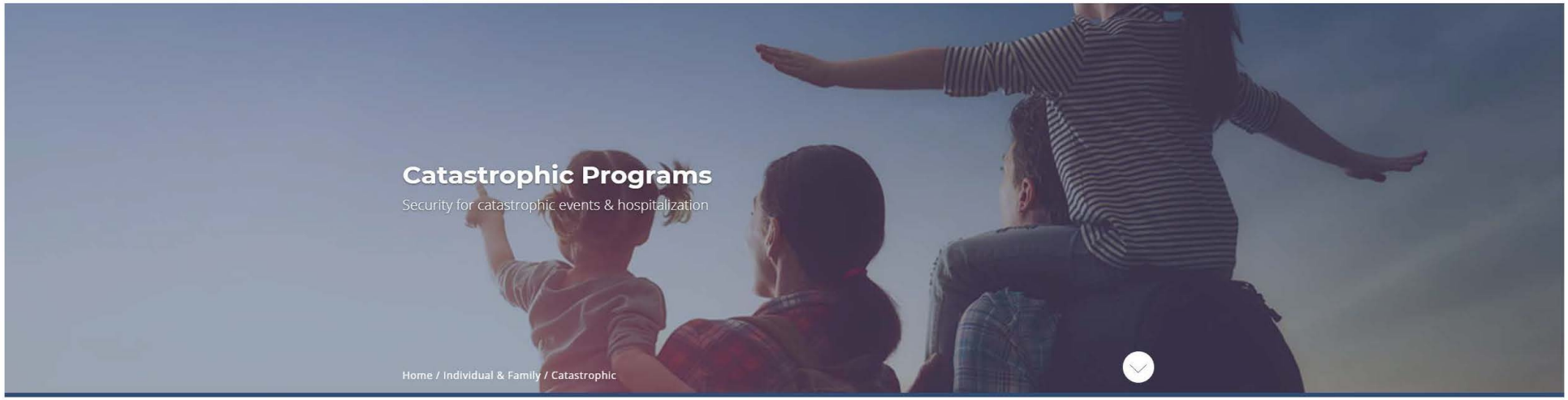
Interim Medical

Trinity's interim medical health plan, InterimCare, is a great option for those in-between medical plans. Our interim plans are affordable, and are designed to cost share you and your family's healthcare expenses during a transition. InterimCare offers low cost care when you know you have infrequent medical needs, but still need peace of mind.

THESE ARE NOT INSURANCE PRODUCTS

VIEW PROGRAM OPTIONS

OPTIONS



‹ Home

Individual & Family

- Catastrophic
  CarePlus Advantage
- Standard (Everyday)
  AlieraCare VPP
- Comprehensive
  AlieraCare DSG
- Interim Medical
  InterimCare
- Supplemental
  Dental
  Vision

Catastrophic Healthcare Program: Is It for Me?

People often worry about the cost of hospitalization and surgery. They're concerned that when the unexpected hits, they won't be able to afford the costs. Generally, they're pretty healthy, but what if an accident happens or the unthinkable occurs? Catastrophic health programs can give peace of mind that the high costs of medical treatment will be eligible for cost-sharing if the unforeseen becomes today's reality.

Ready To Enroll? VIEW PROGRAM OPTIONS

- **Healthcare Cost Sharing**
  - How it Works
  - FAQs
- **Basic Care**
  - PrimaCare

This is a Healthcare Sharing Ministry (HCSM) Product

OFFERED THROUGH ENSURIAN

Catastrophic healthcare cost sharing can give you peace of mind

Catastrophic healthcare offers assistance with the cost of major medical events—such as hospitalizations, traumas, sudden illnesses, and accidents—Trinity's catastrophic healthcare program offers services such as inpatient and outpatient surgeries, performed in hospitals and ambulatory surgical centers (ASC). Catastrophic healthcare plans have limited services and do not offer regular office visits and medications.

The ideal candidate for a catastrophic medical program

Catastrophic medical programs are an ideal choice to assist with the costs of those unforeseen emergencies, and are intended for those who either have no other healthcare, or who can simply not afford the high price of a traditional, full-coverage medical plan. Catastrophic health programs are also a viable option for those who are healthy and don't spend a lot of time at the doctor's office. Catastrophic healthcare allows them to save money each month.

Since doctor's visits and prescriptions are not eligible for cost sharing, those who tend to be in the doctor's office frequently or have a pre-existing condition, should consider carrying a different type of program. Pre-existing conditions are not eligible for cost sharing with CarePlus Advantage.

The difference between catastrophic healthcare programs and major medical

Major medical typically includes preventive care, a prescription drug program, emergency services, hospitalization, and its associated costs. While carrying major medical can be reassuring, the soaring costs of healthcare and rigid open enrollment periods have made it very difficult and often unattainable for many hard-working Americans.

Trinity programs are not considered "insurance" which means they don't have to cut through the red tape required by traditional insurance mandates. Trinity programs such as CarePlus Advantage allow members to achieve comparable cost assurances for catastrophic healthcare services (including emergency care and hospitalization) at a much lower cost because they are supported by a healthcare sharing organization that facilitates medical cost sharing between members.

How Trinity's catastrophic healthcare program works

Members pay all medical expenses until the individual's Member Shared Responsibility Amount (MSRA) has been reached. Upon reaching the MSRA, all eligible hospitalization, surgical, or emergency room expenses are submitted for cost-sharing at 100%. If a visit to the emergency room happens, the member is responsible for a $300 consult fee. Upon admittance to the hospital, the $300 then gets applied to the MSRA.

How Trinity's catastrophic healthcare program works

Members pay all medical expenses until the individual's Member Shared Responsibility Amount (MSRA) has been reached. Upon reaching the MSRA, all eligible hospitalization, surgical, or emergency room expenses are submitted for cost-sharing at 100%. If a visit to the emergency room happens, the member is responsible for a $300 consult fee. Upon admittance to the hospital, the $300 then gets applied to the MSRA.

Monthly contributions for catastrophic programs vary depending on age and the chosen MSRA. Low monthly contributions give members peace of mind knowing they are protected against major catastrophic events that could cripple them financially. Catastrophic healthcare programs provide a great combination of low price and good hospital services.

Having adequate healthcare is important. When illness strikes, no one wants to be worrying about medical expenses while trying to get well. Catastrophic healthcare programs help give peace of mind in case the unimaginable happens.

APPENDIX D

ALIERA™ HEALTHCARE

Welcome to Your Healthcare Sharing Plan

T236 P1 110 ****AUTO**ALL FOR AADC 800
Ellen Larson
[redacted]
Colorado Springs CO [redacted]

Aliera Healthcare, Inc.
990 Hammond Dr., Suite 700
Atlanta, GA 30328

Dear Member,

Thank you for being an Aliera Healthcare member. Please find the enclosed ID cards and your 2018-2019 Member Guide which features a detailed overview of the healthcare services and related terms included in your plan. As part of our comprehensive membership program, Aliera's Concierge Service is dedicated to providing the support you need for everything from questions about eligibility and cost-sharing, to help scheduling in-network healthcare services for preventive, primary, specialty, emergency, urgent care, and more.

Please take a moment to examine your membership card (enclosed/attached) to ensure the details are correct and note your effective/annual renewal date. Keep your membership card with you at all times, because you will be asked to present it to your healthcare provider when you receive healthcare services.

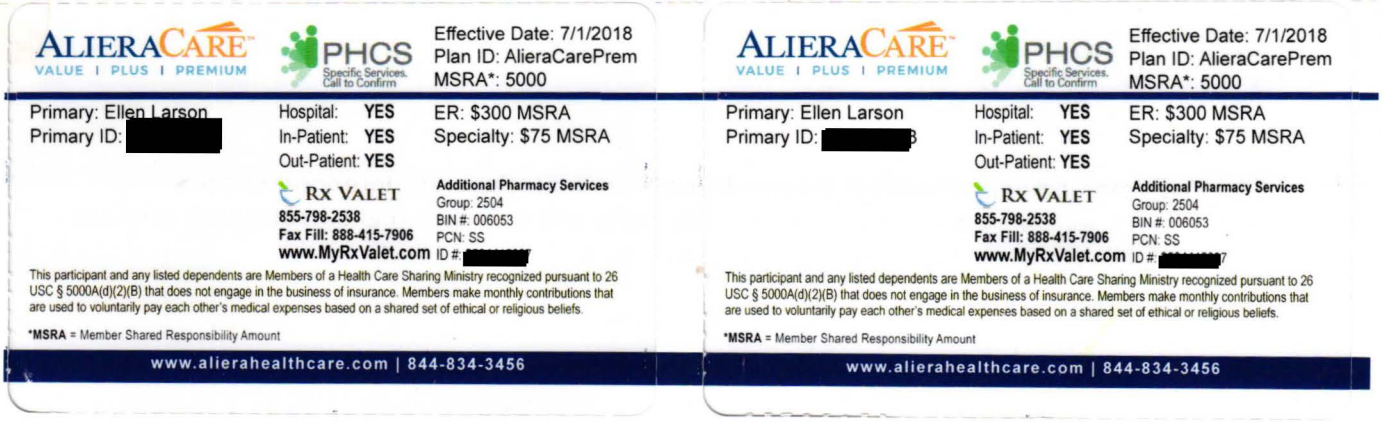
For more information:
www.alierahealthcare.com
memberservices@alierahealthcare.com

Member Services:
Toll-free at 844-834-3456, Monday through Friday, 8 a.m. to 8 p.m. ET

Thank you for being a part of the Aliera Healthcare community!

Your Aliera Healthcare Team

Please note: The activation instructions for FirstCall Telemedicine are on the back of this page.



FirstCall Telemedicine

FirstCallTelemed.com (FirstCall Telemedicine)***** consultations are intended to be a supplement for non-emergency primary care visits and can help make healthcare services more affordable and accessible for your entire family.

- For members and their entire immediate family
- Talk to a board-certified doctor by phone, email, or web-based video call 24/7, 365 days/year
- Intended for diagnosis and treatment of common ailments such as colds, flu, sinus infections, allergies, pink eye, etc.
- May include discussions about symptoms, treatment options, and prescription medications
- Provides flexibility for scheduling a specific consultation time or to request a call back within two hours
- When appropriate, the doctor may prescribe a medication to pick up at your selected local pharmacy

HOW TO USE

1. Members activate account by going to www.FirstCallTelemed.com or by calling 1-866-920-DOCS (3627).
2. Members complete medical profiles for themselves and their immediate family members who are under 18 years of age.
3. Any dependent who is 18 years of age or older is required to create his/her own log in at www.FirstCallTelemed.com and complete a medical profile.
4. Consultations may be requested by logging into the member portal at www.FirstCallTelemed.com or by calling 1-866-920-DOCS (3627).

***Disclaimer:** FirstCall Telemedicine does not guarantee that a prescription will be written. FirstCall Telemedicine does not prescribe DEA controlled substances, lifestyle drugs, or drugs with potential for abuse. FirstCall Telemedicine physicians reserve the right to deny care for potential misuse of services. Telemedicine is not available in Arkansas. Only video consults are available in Idaho.

PHCS Provider Services
Confirm specific services or urgent care at 844-457-7726
Visit multiplan.com or call 800-922-4362 for your PHCS provider.

Completed Claims Forms:
Aliera Healthcare
P.O. Box 16818
Lubbock, TX 79490-6818
or EDI # : ALH01 | 1-800-252-3684

ALIERACARE
VALUE | PLUS | PREMIUM
Member Services: **844-834-3456**
Telemedicine: **866-920-3627**
Pharmacy: **855-798-2538**
Eligibility: **844-457-7726**

Providers should verify eligibility before treatment or service 844-457-7726

AlieraCare
PCP: $20
Urgent Care: $20
Preventive: $0
X-Ray Read Fee: $25 ea.
ER/Surg: See Trinity ▶

Trinity HealthShare
Specialty: $75 Consult fee, Prem only
ER: Val MSRA | Plus $500 | Prem $300
Surgical Services*: Verify eligibility
Maternity: $5000 max, Prem only
Pharmacy: Rx Valet, see front for details

Services
FirstCall Telemedicine
www.firstcalltelemed.com

*Surgical benefits not available for the first 60 to 180 days, depending on AlieraCare Plan. Verify eligibility before receiving any surgical services.

www.alierahealthcare.com | 844-834-3456

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www.alierahealthcare.com | 844-834-3456

APPENDIX E

BEFORE THE DIVISION OF INSURANCE, STATE OF COLORADO

Case File No. 268068
DOI Order No. O-20-006

***EX PARTE* EMERGENCY ORDER TO CEASE AND DESIST THE UNAUTHORIZED AND UNLAWFUL TRANSACTION OF THE BUSINESS OF INSURANCE IN THE STATE OF COLORADO**

In the Matter of ALIERA HEALTHCARE, INC.

Respondent.

This matter comes before Michael Conway, Commissioner of Insurance for the state of Colorado ("Commissioner"), pursuant to the provisions of the Regulation of Unauthorized Insurance Act, §§ 10-3-901 through 10-3-910, C.R.S., whereby the Commissioner is authorized to issue an *ex parte* emergency cease and desist order to prevent the unauthorized transaction of insurance business in Colorado.

PARTIES AND JURISDICTION

1. Pursuant to § 10-1-108(7), C.R.S., the Commissioner has the duty and responsibility to supervise the business of insurance in the state of Colorado to assure it is conducted in accordance with Colorado law and in such a manner as to protect policyholders and the general public.

2. The Colorado Division of Insurance ("Division") is an agency charged with the execution of laws relating to insurance and has supervising authority over the business of insurance in this state pursuant to § 10-1-103(1), C.R.S. Pursuant to § 10-1-104(2), C.R.S., the Commissioner has delegated the duties and responsibilities of investigating, enforcing, and taking actions to enforce compliance with the insurance laws of Colorado to the Division and its staff.

3. Respondent, Aliera Healthcare, Inc. ("Respondent") is a foreign, for-profit corporation organized under the laws of Delaware and doing business in Colorado.[1]

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[1] Upon information and belief, Aliera Healthcare, Inc. has initiated a name change to The Aliera Companies, Inc. This name change has occurred on the entity's website and in its foreign corporation filings in at least Texas and Georgia. Both Aliera Healthcare, Inc. and The Alieria Companies, Inc. are Delaware corporations.

4. Respondent first incorporated in the state of Delaware on September 29, 2011.

5. Respondent is licensed as a non-resident insurance producer with life, and accident and health lines of authority, license number 544844.

6. Trinity Healthshare, Inc. ("Trinity") is a foreign corporation organized under the laws of Delaware.

7. Trinity first incorporated in the state of Delaware on June 27, 2018.

8. Trinity represents itself as a healthcare sharing ministry ("HCSM") as defined by 26 USC §5000A.[2]

9. Trinity does not hold a certificate of authority in the state of Colorado.

10. Section 10-1-102(12), C.R.S., defines 'insurance' as, a contract whereby one, for consideration, undertakes to indemnify another or to pay a specified or ascertainable amount or benefit upon determinable risk contingencies.

11. Pursuant to § 10-1-108(5), C.R.S., the Commissioner has the duty to make such investigations and examinations as are authorized by Title 10 of the Colorado Revised Statutes and to investigate such information as is presented to the Commissioner by authority that the Commissioner believes to be reliable pertaining to violations of Colorado insurance laws.

12. Section 10-1-102(6)(a), C.R.S., defines insurance company[3] to include all corporations, associations, partnerships, or individuals engaged as insurers in the business of insurance.

13. Pursuant to § 10-2-102(13), C.R.S., an insurer is every person engaged as principal, indemnitor, surety, or contractor in the business of making contracts of insurance.

14. Pursuant to § 10-3-105(1), C.R.S., no foreign or domestic insurance company shall transact any insurance business in this state, unless it first procures from the commissioner a certificate of authority stating that the requirements of the laws of this state have been complied with and authorizing it to do business.

[2] Trinity does not qualify as an HCSM under federal law as it has not been in operation and continuously sharing member health care costs since at least December 31, 1999. See 26 U.S.C. § 5000A(d)(2)(B).
[3] The section defines "company", "corporation", "insurance company", or "insurance corporation."

15. Pursuant to § 10-3-903, C.R.S., the making of, or proposing to make, as an insurer, an insurance contract, by an unauthorized insurer, constitutes transacting insurance business in this state.

16. Pursuant to § 10-3-904.5, C.R.S., when the Commissioner believes that an unauthorized person is engaging in the transaction of insurance business in violation of §§ 10-3-105 or 10-3-903, C.R.S., or any rule promulgated by the Commissioner, and when it appears to the Commissioner that such conduct is fraudulent, creates an immediate danger to the public safety, or is causing or can be reasonably expected to cause significant, imminent, and irreparable public injury, the Commissioner may issue an *ex parte* emergency cease and desist order to such unauthorized person to immediately cease and desist from such unlawful conduct.

17. The Commissioner has jurisdiction over Respondent and the subject matter of this *Ex Parte* Emergency Cease and Desist Order ("Order") pursuant to §§ 10-3-901 through 10-3-910, C.R.S.

FINDINGS OF FACT

18. On or around August 13, 2018, Respondent and Trinity entered into a Marketing and Administration Agreement ("Agreement").

19. Under the Agreement, Respondent is the administrator, marketer, and program manager for Trinity.

20. As program manager for Trinity, Respondent is responsible for the development of plan designs, pricing, and marketing materials, and vendor management, and recruitment and maintenance of a national sales force to market plans.

21. Under the Agreement, Respondent has the exclusive right to design, market and sell the Trinity HCSM.

22. Respondent markets Trinity's HCSM products as alternatives to traditional health insurance.

23. Respondent markets Trinity's HCSM products to Colorado consumers and utilizes licensed resident insurance producers to sell Trinity's HCSM products within the state of Colorado.

24. Moreover, an investigation by the Division has revealed that Respondent is the subject of administrative actions in Texas, Washington, and New Hampshire.

25. The Division has also received consumer complaints regarding Respondent's business transactions and products.

CONCLUSIONS OF LAW

26. The Commissioner fully incorporates by reference the paragraphs set forth above as though fully set forth herein.

27. The Commissioner has jurisdiction over Respondent and the subject matter of this Order.

28. Trinity is an insurance company as defined by § 10-1-102(6)(a), C.R.S.

29. Trinity does not hold a certificate of authority in the state of Colorado as required by § 10-3-105, C.R.S.

30. The Trinity HCSM products offered by Respondent within the state of Colorado constitute insurance products as defined by § 10-1-102(12), C.R.S.

31. Based on the conduct described herein and above, the Commissioner believes that Respondent's conduct developing, pricing, and marketing Trinity's HCSM products violates of the provisions of §§ 10-3-105 or 10-3-903, C.R.S.

32. Based on the conduct described herein and above, the Commissioner believes that Respondent's conduct developing, pricing, and marketing Trinity's HCSM products violates of the provisions of § 10-2-801(1)(i), C.R.S.

33. It further appears to the Commissioner that Respondent's conduct, as described above and herein, is fraudulent, creates an immediate danger to public safety, and/or is causing or can be reasonably expected to cause significant, imminent, and irreparable public injury.

ORDER

34. Based upon the above Findings of Facts and Conclusions of Law, the Commissioner of Insurance ORDERS that any and all of Respondent and all of its agents, affiliates, employees, contractors, successors in interest, and or authorized representatives **CEASE AND DESIST** from the solicitation, negotiation, sale, or effectuation of any and all Trinity HCSM products in the state of Colorado.

OTHER MATTERS

35. Pursuant to § 10-3-904.6(1), C.R.S., Respondent may contest this Order and request a hearing **within 60 days** of the date of this Order in accordance with

§ 24-4-105(12), C.R.S. Such request for hearing must be received by the Division on or before the expiration of 60 days from the date of this Order.

36. Pursuant to § 10-3-904.6(5), C.R.S., upon determination of a violation of this Order, the Commissioner may impose a civil penalty of $25,000.00 for each act in violation and/or direct restitution.

37. This Order contains a total of six (6) pages, including the Certificate of Service.

38. The Commissioner reserves the right to amend this Order to add any individual, entity or company that is directly or indirectly affiliated or associated with the named entity in this Order or has any type of business or contractual relationship with the named entity in this Order that relate to the unauthorized transaction of insurance business based upon evidence acquired through the Division's continuing investigation.

39. This Order is effective immediately upon execution by the Commissioner or his designee.

40. A facsimile or other copy of this Order shall be treated as an original.

Dated this 12 day of August, 2019.

KATE HARRIS
CHIEF DEPUTY COMMISSIONER
LIFE & HEALTH POLICY

APPENDIX F

BEFORE THE DIVISION OF INSURANCE, STATE OF COLORADO

Case File No. 268068
DOI Order No. O-20-005

***EX PARTE* EMERGENCY ORDER TO CEASE AND DESIST THE UNAUTHORIZED AND UNLAWFUL TRANSACTION OF THE BUSINESS OF INSURANCE IN THE STATE OF COLORADO**

In the Matter of TRINITY HEALTHSHARE, INC.

Respondent.

This matter comes before Michael Conway, Commissioner of Insurance for the state of Colorado ("Commissioner"), pursuant to the provisions of the Regulation of Unauthorized Insurance Act, §§ 10-3-901 through 10-3-910, C.R.S., whereby the Commissioner is authorized to issue an *ex parte* emergency cease and desist order to prevent the unauthorized transaction of insurance business in Colorado.

PARTIES AND JURISDICTION

1. Pursuant to § 10-1-108(7), C.R.S., the Commissioner has the duty and responsibility to supervise the business of insurance in the state of Colorado to assure it is conducted in accordance with Colorado law and in such a manner as to protect policyholders and the general public.

2. The Colorado Division of Insurance ("Division") is an agency charged with the execution of laws relating to insurance and has supervising authority over the business of insurance in this state pursuant to § 10-1-103(1), C.R.S. Pursuant to § 10-1-104(2), C.R.S., the Commissioner has delegated the duties and responsibilities of investigating, enforcing, and taking actions to enforce compliance with the insurance laws of Colorado to the Division and its staff.

3. Respondent, Trinity Healthshare, Inc. ("Respondent") is a foreign corporation organized under the law of Delaware.

4. Respondent first incorporated in the state of Delaware on June 27, 2018.

5. Respondent represents itself as a healthcare sharing ministry ("HCSM") as defined by 26 USC §5000A.[1]

6. Respondent does not hold a certificate of authority in the state of Colorado.

7. Section 10-1-102(12), C.R.S., defines 'insurance' as, a contract whereby one, for consideration, undertakes to indemnify another or to pay a specified or ascertainable amount or benefit upon determinable risk contingencies.

8. Pursuant to § 10-1-108(5), C.R.S., the Commissioner has the duty to make such investigations and examinations as are authorized by Title 10 of the Colorado Revised Statutes and to investigate such information as is presented to the Commissioner by authority that the Commissioner believes to be reliable pertaining to violations of Colorado insurance laws.

9. Section 10-1-102(6)(a), C.R.S., defines insurance company[2] to include all corporations, associations, partnerships, or individuals engaged as insurers in the business of insurance.

10. Pursuant to § 10-2-102(13), C.R.S., an insurer is every person engaged as principal, indemnitor, surety, or contractor in the business of making contracts of insurance.

11. Pursuant to § 10-3-105(1), C.R.S., no foreign or domestic insurance company shall transact any insurance business in this state, unless it first procures from the commissioner a certificate of authority stating that the requirements of the laws of this state have been complied with and authorizing it to do business.

12. Pursuant to § 10-3-903, C.R.S., the making of, or proposing to make, as an insurer, an insurance contract, by an unauthorized insurer, constitutes transacting insurance business in this state.

13. Pursuant to § 10-3-904.5, C.R.S., when the Commissioner believes that an unauthorized person is engaging in the transaction of insurance business in violation of §§ 10-3-105 or 10-3-903, C.R.S., or any rule promulgated by the Commissioner, and when it appears to the Commissioner that such conduct is fraudulent, creates an immediate danger to the public safety, or is causing or can be reasonably expected to cause significant, imminent, and irreparable public injury, the Commissioner may issue an *ex parte* emergency cease and desist order to such unauthorized person to immediately cease and desist from such unlawful conduct.

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[1] Respondent does not qualify as an HCSM under federal law as it has not been in operation and continuously sharing member health care costs since at least December 31, 1999. See 26 U.S.C. § 5000A(d)(2)(B).

[2] The section defines "company", "corporation", "insurance company", or "insurance corporation."

14. The Commissioner has jurisdiction over Respondent and the subject matter of this *Ex Parte* Emergency Cease and Desist Order ("Order") pursuant to §§ 10-3-901 through 10-3-910, C.R.S.

FINDINGS OF FACT

15. Respondent, by and through its agents and affiliates, offers insurance products in the state of Colorado.

16. Respondent offers its HCSM products as alternatives to traditional health insurance.

17. Respondent, by and through its agents and affiliates, is selling insurance products within the state of Colorado. Respondent utilizes licensed resident insurance producers to sell its products in Colorado.

18. Respondent does not hold a certificate of authority in the state of Colorado.

19. Moreover, an investigation by the Division has revealed that Respondent is the subject of administrative enforcement actions in Texas and Washington.

20. The Division has also received consumer complaints regarding Respondent's business transactions and products.

CONCLUSIONS OF LAW

21. The Commissioner fully incorporates by reference the paragraphs set forth above as though fully set forth herein.

22. The Commissioner has jurisdiction over Respondent and the subject matter of this Order.

23. The products offered by Respondent within the state of Colorado constitute insurance products as defined by § 10-1-102(12), C.R.S.

24. By offering these products, Respondent is transacting insurance business within the state of Colorado as defined by § 10-3-903, C.R.S.

25. Respondent is an insurance company as defined by § 10-1-102(6)(a), C.R.S.

26. Respondent does not hold a certificate of authority in the state of Colorado as required by § 10-3-105, C.R.S.

27. Based on the conduct described herein and above, the Commissioner believes that Respondent is engaging in the business of insurance in violation of the provisions of §§ 10-3-105 or 10-3-903, C.R.S.

28. It further appears to the Commissioner that Respondent's conduct, as described above and herein, is fraudulent, creates an immediate danger to public safety, and/or is causing or can be reasonably expected to cause significant, imminent, and irreparable public injury.

ORDER

29. Based upon the above Findings of Facts and Conclusions of Law, the Commissioner of Insurance ORDERS that Respondent **CEASE AND DESIST** from transacting the business of insurance in the State of Colorado, as defined in § 10-3-903, C.R.S., and as specifically described herein. Except that, pursuant to § 10-3-906, C.R.S., the Commissioner of Insurance ORDERS that Respondent honor and maintain any and all existing contracts, plans, policies or memberships with Colorado entities and consumers until the Commissioner of Insurance releases such obligation.

30. Based upon the above Findings of Facts and Conclusions of Law, the Commissioner of Insurance ORDERS that any and all of Respondent's agents, affiliates, employees, contractors, successors in interest, and or authorized representatives **CEASE AND DESIST** from the solicitation, negotiation, sale, or effectuation of any and all of Respondent's products in the state of Colorado.

OTHER MATTERS

31. Pursuant to § 10-3-904.6(1), C.R.S., Respondent may contest this Order and request a hearing **within 60 days** of the date of this Order in accordance with § 24-4-105(12), C.R.S. Such request for hearing must be received by the Division on or before the expiration of 60 days from the date of this Order.

32. Pursuant to § 10-3-904.6(5), C.R.S., upon determination of a violation of this Order, the Commissioner may impose a civil penalty of $25,000.00 for each act in violation and/or direct restitution.

33. This Order contains a total of six (6) pages, including the Certificate of Service.

34. The Commissioner reserves the right to amend this Order to add any individual, entity or company that is directly or indirectly affiliated or associated with the named entity in this Order or has any type of business or contractual relationship with the named entity in this Order that relate to the unauthorized transaction of insurance business based upon evidence acquired through the Division's continuing investigation.

35. This Order is effective immediately upon execution by the Commissioner or his designee.

36. A facsimile or other copy of this Order shall be treated as an original.

Dated this 12 day of August, 2019.

KATE HARRIS
CHIEF DEPUTY COMMISSIONER
LIFE & HEALTH POLICY

APPENDIX G

Cause No. D-1-GN-19-003388

STATE OF TEXAS, Plaintiff,	§ § §	IN THE DISTRICT COURT OF
v.	§ §	TRAVIS COUNTY, TEXAS
ALIERA HEALTHCARE, INC., Defendant	§ §	53RD JUDICIAL DISTRICT

FIRST AMENDED PETITION SEEKING INJUNCTIVE RELIEF, CIVIL PENALTIES, TEMPORARY RESTRAINING ORDER AND TEMPORARY INJUNCTION

The State of Texas, acting by and through the Attorney General of Texas, pursuant to Tex. Ins. Code § 101.105, files this First Amended Petition Seeking Injunctive Relief, Civil Penalties, Temporary Restraining Order and Temporary Injunction against Aliera Healthcare, Inc., and in support thereof would show the Court as follows:

I.
INTRODUCTION

The Defendant Aliera Healthcare, Inc., is engaged in the business of insurance in this State without a license, in violation of Tex. Ins. Code § 101.101. The company claims to have revenue of over $180 million per year, and has signed up over 17,000 Texas customers claiming to offer "great healthcare with comprehensive medical plans" at cut-rate prices. These unregulated plans come

with disclaimers stating that in reality, the customers of Aliera Healthcare have no legal basis to enforce the plans' promises, even after making all required monthly payments.

In meetings with State regulators, Aliera representatives have asserted that Aliera is exempt from state regulation because it merely administers a "health care sharing ministry." Aliera is no ministry, however; it is a multi-million dollar for-profit business that admittedly siphons off over 70% of every dollar collected from its members to "administrative costs." Texas law does offer a safe harbor for faith-based non-profit organizations that operate only to facilitate the sharing of medical expenses among participants. Aliera does not meet these requirements, and it should be enjoined from continuing to offer its unregulated insurance products to the public.

II.
DISCOVERY CONTROL PLAN

1. This action is governed by Discovery Control Plan Level 2 under the Texas Rules of Civil Procedure.

III.
PARTIES

2. The Attorney General brings this action pursuant to Tex. Ins. Code § 101.105, in the name of the State of Texas, in order to protect the people of this State from unauthorized insurance products that endanger the public.

3. Aliera Healthcare, Inc. is a foreign, for-profit corporation organized under the laws of Delaware doing business in Texas. Aliera's registered agent for service is CT Corporation System, 1999 Bryan Street, Suite 900, Dallas, Texas 75201-3136. Aliera's corporate address is 5901-B Peachtree Dunwoody Road, #200, Atlanta, Georgia, 30328.

4. After the State of Texas filed its Original Complaint against Aliera Healthcare, Inc. on June 13, 2019, Aliera announced that effective July 1, 2019, the name of Aliera Healthcare, Inc. would be changed to the Aliera Companies, and become a holding company for multiple wholly owned subsidiaries. This announcement was made on the website alierahealthcare.com, and in communications to sales agents. *See* Exhibit A (copy of current home page located at alierahealthcare.com). When referenced in this document, Aliera refers to Aliera Healthcare, Inc., as well as its successors, subsidiaries, agents and assigns.

IV.
JURISDICTION AND VENUE

5. This Court has jurisdiction over this matter, and venue is proper in Travis County, Texas.

6. Tex. Ins. Code § 101.105(b) provides as follows: "The commissioner [of insurance] may request that the attorney general institute a civil action in a district court in Travis County for injunctive relief to restrain a person or entity,

including an insurer, from continuing a violation or threat of violation described by Section 101.103(a). On application for injunctive relief and a finding that a person or entity, including an insurer, is violating or threatening to violate this chapter or Chapter 226, the district court shall grant the injunction relief and issue an injunction without bond."

7. Tex. Ins. Code § 101.105(c) provides as follows: "On request by the commissioner, the attorney general shall institute and conduct a civil suit in the name of the state for injunctive relief, to recover a civil penalty, or for both injunctive relief and a civil penalty, as authorized under this subchapter."

V.
VERIFIED ALLEGATIONS OF FACT BASED ON SWORN TESTIMONY AND COURT RECORDS

A. Aliera is founded in December 2015, with a focus on offering unregulated insurance products.

8. Aliera was formed in December 2015 by Timothy Moses, a resident of Marietta, Georgia; his wife, Shelley Steele; and their son, Chase Moses, a resident of Atlanta, Georgia. Timothy Moses was named as the executive director of Aliera, and Shelley Steele was named as the Chief Executive Officer. Chase Moses is currently named as President of Aliera, at least as of the filing of the Original Complaint in this matter.

9. Before forming Aliera, Timothy Moses served as the president and CEO of International BioChemical Industries, Inc. (IBCL). IBCL declared bankruptcy in 2004 after Timothy Moses was charged with securities fraud and perjury related to a series of false press releases issued by the company, and a deposition in which Timothy Moses gave false testimony in a civil enforcement action brought by the Securities and Exchange Commission. *See* Exhibit B (collecting documents related to *United States v. Moses*, Case No. 1:04-cr-00508-CAP-JMF, filed in the United States District Court for the Northern District of Georgia, Atlanta Division). Timothy Moses was sentenced to over 6 years in prison on these charges, and ordered to pay $1.65 million in restitution to IBCL shareholders. *Id.* Timothy Moses was only released from supervision on these charges in April 2015, after being sentenced to (and subsequently spared from) an additional prison term for failing to provide truthful financial disclosures to his probation officer in 2012, 2013 and 2014. *Id*. The lawyer who convinced United States District Judge Charles A. Pannell, Jr. not to send Timothy Moses back to prison was G. Michael Smith of Atlanta, Georgia, who was subsequently named General Counsel for Aliera. *Id.* Timothy Moses only satisfied the criminal restitution judgment against him a few months ago, in April 2019. *Id.*

10. Most states will not license a company to sell insurance if it is closely held by a person who has been convicted of any felony, especially a crime

involving financial fraud or dishonesty. In light of these limitations, it is not surprising that Aliera has focused, since its inception, on offering purportedly unregulated, insurance-like products.

B. In 2016, Timothy Moses convinces a small Mennonite ministry in Virginia to partner with Aliera, but after Moses is caught writing checks to himself from non-profit funds, Aliera creates its own ministry.

11. In October 2016, Timothy Moses met with Tyler Hochstetler, the director of Anabaptist Healthshare, a non-profit corporation based in Virginia, that operated a health care sharing ministry limited to members of the Gospel Light Mennonite Church of the Anabaptist faith. At the time of this meeting, the concept of a "health care sharing ministry" in which church members would help each other pay medical bills was not new. Ministries such as Anabaptist, however, were only recently coming to the attention of the general public because under a relatively obscure provision of the Affordable Care Act (ACA), members of a recognized health care sharing ministry were exempted from the individual mandate. As required by the ACA, Anabaptist had requested and been granted certification as a health care sharing ministry by the United States Department of Health and Human Services. *See* Exhibit C at p. 43-46 (testimony of Tyler Hochstetler, given at an evidentiary hearing on Anabaptist's motion for preliminary injunction, held in Civil Action File No. 2018CV308981, *Aliera*

Healthcare, Inc. v. Anabaptist Healthshare and Unity Healthshare LLC, pending in the Superior Court of Fulton County, Georgia).

12. On October 27, 2016, the day that Tyler Hochstetler and his father, Eldon Hochstetler, sat down with Timothy Moses at a Holiday Inn Express in Ruckersburg, Virginia, Anabaptist Healthshare had approximately 800 members with assets of about $48,000, and was run mostly out of Tyler Hochstetler's home office. Exhibit C. at pp. 94-97 (testimony of Tyler Hochstetler).

13. At the meeting, Timothy Moses shared a proposal with the Hochstetlers to expand access to health care sharing ministry plans, with fees paid to Aliera for marketing and selling these plans. Exhibit C at pp. 50-52 (testimony of Tyler Hochstetler). The result of that meeting was a Memorandum of Understanding, signed on October 31, 2016, between Aliera and Anabaptist Healthshare, providing that Aliera would market certain health care sharing ministry (HCSM) plans in exchange for a per member per month fee, and that additional per member per month fees would be paid personally to Tyler Hochstetler and his father. The October 2016 MOU, along with a subsequent Amended Memorandum of Understanding (AMOU), signed November 10, 2016, also contemplated the forming of an Anabaptist subsidiary, to be known as Unity Healthshare.

14. Aliera was successful in signing up thousands of members using the Unity HCSM, but in 2018, the deal unraveled after Hochstetler found out that Timothy Moses had used his signature authority on Unity accounts to "take whatever he wanted" from Unity as payment to Aliera. Exhibit. C at pp. 79-86 (Hochstetler testimony). In addition to paying Aliera, Timothy Moses wrote approximately $150,000 worth of checks to himself from Unity funds without board approval. Id. In an affidavit filed later in a Georgia state court, Moses explained that he did in fact receive this money, which he believed was justified because "[p]rior to being issued these checks, I talked with Tyler [Hochstetler] about the fact that I do not receive a salary from Aliera or Unity and that I perform substantial work on behalf of furthering the relationship between Aliera and Unity. Tyler did not object to me receiving income from Unity, which totaled approximately $150,000 over approximately 4-5 months." Exhibit D (affidavit of Timothy Moses). On advice of counsel, Timothy Moses did return the money. Id.

15. As it became clear to the Hochstetlers and the Moseses over the summer of 2018 that their relationship would not be able to continue, Aliera caused a new corporation to be created, known as Trinity Healthshare. The Chief Executive Officer of this new entity was a former Aliera employee with ties to the Moses family. Exhibit E at pp. 274-276; 299-303 (testimony of Chase Moses). Like Unity, Aliera entered into a contract with Trinity. This contract allowed

Aliera to use Trinity's non-profit status to sell health care plans purporting to be sharing ministry plans, but Aliera would keep complete control of the money and the administration of the plans.

16. The dissolution of the Aliera/Unity relationship is currently the subject of a state court lawsuit in Georgia, in which multiple Aliera executives have provided sworn testimony to the effect that all of the alleged ministry members were, in reality, customers of Aliera. *See, e.g.*, Exhibit F (December 23, 2018 Affidavit of Chase Moses at ¶ 16, 18, 20, 23); Exhibit G (Affidavit of G. Michael Smith at ¶ 7); Exhibit H (Affidavit of Shelley Steele, ¶ 14). Chase Moses, testifying in the Georgia state suit in January 2019, testified that Aliera was not merely an administrator of Unity ministry products, but instead that the Unity ministry was essentially a "vendor" for Aliera. *See* Exhibit E at pp. 305-306 (testimony of Chase Moses); Exhibit F (December 23, 2018 Affidavit of Chase Moses at ¶ 16, 18, 20, 23).

C. Aliera Healthcare's advertisements and offerings in Texas raise concerns at TDI, and Aliera executives meet with TDI staff in February 2019.

17. In correspondence dated February 19, 2019, a staff attorney with the Texas Department of Insurance wrote to Reba Leonard, then the chief compliance officer for Aliera, questioning whether Aliera's operations complied with Texas

insurance laws. TDI requested a meeting with Aliera to discuss its business operations.

18. At the time this correspondence was sent, the website located at alierahealthcare.com contained multiple advertisements for obvious insurance products. The website stated that Aliera offered various low-cost healthcare options for both individuals and families. For a monthly membership fee, the plans offered access to health care providers through office visits, urgent care and telemedicine. A brochure, in substantially the same form attached as Exhibit I, was accessible through the website, and set out plan comparison charts describing what services were offered, and at what percentage or amount these services would be covered. A copy of the website downloaded on or about June 13, 2019, is attached as Exhibit J, and this content appears to be substantially similar to the way that the website appeared in February 2019.

19. Following this inquiry, Aliera executives agreed to a meeting at TDI's offices in Austin, which was held on February 25, 2019. Reba Leonard, Dwight Francis, Aliera's legal counsel, and Danny Saenz, a consultant, attended on behalf of Aliera. Various TDI staff attended the meeting, including Jamie Walker, Deputy Commissioner for Financial Regulation. The Aliera team came with a slide presentation that they provided in hard copy to TDI. A copy of that slide presentation is attached as Exhibit K.

20. As noted in the slide presentation, Aliera claimed to TDI that it offered a sharing ministry plan through Trinity Healthshare, and also other offerings that were separate from the sharing ministry. With respect to the sharing ministry plans, Aliera claimed that it was acting merely as an agent for Trinity in marketing and administering these plans. At that meeting, Aliera did not provide TDI with any of the affidavits or testimony that Shelley Steele, Michael Smith and Chase Moses had personally offered on behalf of Aliera in state court in Georgia, stating that Aliera was the architect of the ministry plans and owned all of the customers. TDI later obtained copies of testimony and documents filed in the Georgia litigation.

21. With respect to those products offered by Aliera that were admittedly outside the sharing ministry, TDI staff had questions regarding how these offerings would qualify as anything but insurance. The Aliera executives had no substantive response to this issue, other than to note that they believed that many sharing ministry plans offered similar “add-ons”.

22. The meeting closed with TDI staff requesting additional information regarding Aliera’s relationship with Trinity Healthshare, as well as any other contracts with telemedicine or prescription benefit providers. Over the next few months, Aliera did provide additional information to TDI, culminating in a May 1,

2019 meeting at TDI's offices, at which Aliera delivered a binder compiling the bulk of documents that Aliera had previously provided.

23. The contract between Aliera and Trinity is included in the binder, and it is crystal clear about who is in charge of these alleged ministry plans. In the opening "whereas" clauses, the contract explicitly states that "Trinity has no members in its HCSM, and the Parties intend that the members who enroll in the Plans become 'customers' of Aliera, and that Aliera maintain ownership of the 'Membership Roster,' which shall include the name, contact information, social security number, type of Plan and agent information (if applicable), among other necessary information, for each member who enrolls in the Plans." *See* Exhibit L at p. 1 (copy of Aliera/Trinity Agreement).

24. The Aliera/Trinity contract further provides that Aliera will "develop, market and sell the HCSM plans," and that "Aliera will be responsible for plan design (defining the schedule of medical services eligible for sharing), and pricing of the Plans." Ex. L at p. 2. Aliera will also "enroll new members in the Plans," and "Aliera is authorized to accept any enrollment from members in the Plans in its sole discretion." *Id.* Pursuant to the agreement, "Trinity acknowledges and agrees that because Aliera is the sole party developing and marketing the Plans (including the HCSM component) and making the sole effort to develop members, Aliera has exclusive ownership rights to the Membership Roster, and Trinity is not authorized

to contact any members or use any information contained in the Membership Roster for any purpose without the prior written consent of Aliera." *Id.*

25. With respect to finances, the agreement provides that "[a]ll member share contributions (the monthly share amount that each member contributes for each of the Plans and Member Enrollment Fees will be first paid directly to a banking account in the name of Aliera." Ex. L at p. 5. Aliera will then "transfer the funds attributable to the HCSM portion of the Plans into a banking account in the name of Trinity, which funds will be the net amount after any payments due from Trinity . . . have been distributed by Aliera." *Id.* Transfer to a Trinity bank account means little, however, given that the agreement also provides that "[p]ursuant to resolutions of the board of directors of Trinity, Aliera is an authorized signatory, and is authorized to make payments from each and all banking accounts opened in Trinity's name in connection with this Agreement." *Id.* Aliera is also "authorized to make, or cause to be made, deposits into, and payments from, such Trinity banking account, in accordance with the Revenue and Expense Structure." *Id.*

26. Several of Aliera's contracts with third-party providers were also included in the binder. These contracts are clearly "capitated", meaning that Aliera has agreed to pay a set price for a certain number of individual visits or individual members. A capitated contract is a classic example of an agreement routinely

entered into by HMOs or other insurers to mitigate the risk these companies assume from their members by agreeing in advance to a set, discounted rate with providers.

27. Within days of the May 1, 2019, meeting, the Department instituted cease and desist proceedings against Aliera and Trinity Healthshare, Timothy Moses, Shelley Steele and Chase Moses. *See* Exhibit M (copy of Notice of Hearing, issued May 7, 2019). The notice also named Anabaptist Healthshare and Unity Healthshare, although the Department later nonsuited Anabaptist and Unity when it became apparent that Anabaptist and Unity no longer intended to work with Aliera.

D. Aliera and Trinity convince ALJ O'Malley and Judge Gamble of this Court that a continuance of the hearing was warranted.

28. The Notice of Hearing for the cease and desist proceedings was originally set for May 28, 2019, but attorneys for Aliera and Trinity filed multiple pretrial motions, and convinced Administrative Law Judge Michael O'Malley that they needed a continuance. The Department attempted to force ALJ O'Malley to hold the cease and desist hearing within the 30-day window provided by Tex. Ins. Code § 101.152, but Aliera and Trinity were able to stop the hearing by filing a lawsuit and seeking emergency relief. These suits were filed in Travis County District Court, styled *Aliera Healthcare, Inc. v. Sullivan, et al.,* Cause No. D-1-

GN-19-003088 and *Trinity Healthshare v. Sullivan, et al*., Cause No. D-1-GN-19-003073.

29. Judge Maya Guerra Gamble presided over the hearing on Aliera and Trinity's motions for temporary restraining order. At that hearing, held on June 5, 2019, the arguments focused not on the merits of the cease and desist proceeding, but on the issue of whether ALJ O'Malley had properly granted a continuance of the original hearing date, based on his concerns about preserving the due process rights of the parties. After the hearing, Judge Gamble ruled from the bench that she would grant the temporary restraining order, and prevent the cease and desist hearing from going forward as scheduled on the following day, June 6, 2019. Specifically, her ruling found that "there is evidence that harm is imminent to Plaintiffs and if the Court does not issue the temporary restraining order, Plaintiffs will be irreparably injured because they will be deprived of [their] rights to the due process of law, including their right to fair notice of the claims asserted against them and the opportunity to present a defense on the merits of those claims." *See* Exhibit N (copy of Order Granting Temporary Restraining Order).

30. Following this ruling, the Department nonsuited its cease and desist proceeding. This lawsuit was filed the same day.

VI.
ALLEGATIONS OF LAW AND VERIFIED FACTS REGARDING THE BUSINESS OF INSURANCE IN TEXAS

A. The business of insurance is defined broadly under Texas law, and the core feature of insurance is sharing risk in exchange for payment.

31. Chapter 101 of the Texas Insurance Code protects Texas residents from the unauthorized practice of insurance. Tex. Ins. Code § 101.102 prohibits any person, including an insurer, from "directly or indirectly doing an act that constitutes the business of insurance under this chapter, except as authorized by statute."

32. Conduct that constitutes the business of insurance is described in Tex. Ins. Code §101.051(b), and includes "making or proposing to make, as an insurer, an insurance contract," "taking or receiving an insurance application," "receiving or collecting any consideration for insurance," "issuing or delivering an insurance contract to a resident of this state," "contracting to provide in this state indemnification or expense reimbursement for a medical expense by direct payment, reimbursement or otherwise to a person domiciled in this state" through any funding mechanism, "doing any kind of insurance business specifically recognized as constituting insurance business within the meaning of statutes relating to insurance," and "doing or proposing to do any insurance business that is

in substance equivalent to conduct described by [this statute] in a manner designed to evade statutes relating to insurance."

33. At its core, insurance is "'an undertaking by one party to protect the other party from loss arising from named risks, for consideration and upon terms and under the conditions recited.'" *Nat'l Auto Serv. Corp. v. State*, 55 S.W.2d 209, 210–11 (Tex. Civ. App.—Austin 1932 writ dism'd) quoting 12 Couch's Cyc. of Insurance Law, vol. 1, p. 2. The buyer of an insurance policy pays present consideration to protect against future risk. *Employers Reinsurance Corp. v. Threlkeld & Co. Ins. Agency*, 152 S.W.3d 595, 597 (Tex. App.—Tyler 2003 pet. denied).

34. An essential element of insurance is the spreading or pooling of risk. *Employers Reinsurance Corp*., 152 S.W.3d at 598. In determining whether an arrangement is insurance, courts examine its purpose, effect, contents, and import, and not necessarily the terminology used, including declarations to the contrary. *Nat'l Auto*, 55 S.W.2d at 210-211. Merely stating that a particular business is "not insurance" will not suffice to take that business out of the realm of insurance regulation.

B. Aliera's Member Guide, and the contracts it signs with providers demonstrate that Aliera is collecting money in exchange for assuming risk.

35. Aliera's 2019 Member Guide is clear that Aliera is taking money from its members in exchange for assuming the risk of its members healthcare costs. Part I of the Guide is titled "How to Use Your Membership," and it lists the following services that are provided to members: telemedicine, preventative care, labs and diagnostics, urgent care, primary care, specialty care, hospitalization, and PPO network. Part II of the Member Guide is entitled "How Your Healthcare Cost-Sharing Ministry (HCSM) Works" and describes how payment for the services described in Part I will be made. Part III is entitled "Your Summary of Cost-Sharing" and describes categories of "Eligible Medical Expenses," followed by "Limits of Sharing," "Cost-Sharing for Pre-Existing Conditions," lists of "Medical Expenses Not Generally Shared by HCSM," and provisions regarding pre-authorization of certain medical expenses, titled "Pre-Authorization Required." *See* Exhibit O (copy of 2019 Member Guide).

i. The Member Guide makes clear that Aliera is collecting monthly payments in exchange for assuming risk.

36. In Part I, the Member Guide describes the "Telemedicine" program, and the first bolded heading under this description is "Offerings of the Telemedicine Program." In several bullet points, the Member Guide describes the offering as follows:

"At home, at work, or while traveling in the US, speak to a telemedicine doctor from ***anywhere, anytime,*** on the go."

"Save time and money by avoiding expensive emergency room visits, waiting for an appointment, or driving to a local facility."

"Telemedicine consultations are ***free for you and your dependents on your Plan***." Ex. O (emphasis added).

37. In Part I, under "Preventative Care," the Member Guide states that "Members have ***no out-of-pocket expenses*** for preventative services, which include, but are not limited to, routine in-network checkups, pap smears, flu shots and more." Ex. O (emphasis added).

38. In Part I, under "Urgent Care," the Member Guide states: "AlieraCare Bronze, Silver, and Gold plans have ***unlimited Urgent Care visits,***" and "X-rays are included, and subject to $25 per read fee at Urgent Care." Ex. O (emphasis added).

39. In Part I, under "Primary Care," the Member Guide states: "AlieraCare Bronze, Silver, and Gold plans have ***unlimited Primary Care visits***." Ex. O (emphasis added).

40. In Part I, under "Hospitalization," the Member Guide states:

> 1. Members are required to pre-authorize all hospitalization services and visits unless it is an obvious medical emergency. Please see pre-authorization section for instructions.

> 2. The member will be responsible for first reaching their MSRA before any cost-sharing will be available. Once the MSRA has been reached in full, the sharing will then be reimbursed ***directly back to the providers and hospital facilities***.
>
> 3. Several plans allow for ***fixed cost-sharing*** in the emergency room. Please see Appendix for your exact plan details.

Ex. O (emphasis added).

41. In Part I, under "PPO Network," the Member Guide states: "With a growing nationwide PPO network of more than 1,000,000 healthcare professionals and more than 6,000 facilities, Multiplan PHCS network offers Plan Members a range of quality choices to help them stay healthy." Ex. O.

42. Part II of the Member Guide begins by describing Trinity HealthShare as a "clearing house that administers voluntary sharing of healthcare needs for qualifying members," and attempts to disclaim that anything in the Member Guide "create[s] a legally enforceable right on the part of any contributor." Ex. O. These statements simply ignore the entire import of the Member Guide, which describes what services are available with which plans, and are followed by other statements describing the member's obligation of "financial participation," and what actions Aliera may take in the event that "a member's eligible bills exceed the available shares to meet those needs." Ex. O.

43. With respect to "financial participation," the Member Guide states that contributions should be received "by the 1st or 15th of each month depending on the member's effective date," and that if the contribution "is not received within 5 days of the due date, an administrative fee may be assessed." Ex. O. "If the monthly contribution is not received by the end of the month, a membership will become inactive as of the last day of the month in which a monthly contribution was received," and "[n]eeds occurring after a member's inactive date . . . are not eligible for sharing." Ex. O.

44. Part II of the Member Guide also contains provisions that address what actions Aliera may take if the "suggested share amounts" collected from its members do not meet the "eligible needs submitted for sharing." Ex. O. One possibility is that Aliera may institute a "pro-rata sharing of eligible needs . . . whereby the members share a percentage of eligible medical bills within that month and hold back the balance of those needs to be shared the following month." Ex. O. In the event that the "suggested share amount is not adequate to meet the eligible needs submitted for sharing over a 60-day period, then the suggested share amount may be increased in sufficient proportion to satisfy the eligible needs," an action which "may be undertaken temporarily or on an ongoing basis." Ex. O.

45. At the end of Part II, in a section titled "Contributors' Instructions and Conditions," the Guide states: "By submitting monthly contributions, the

contributors instruct Trinity HealthShare to share clearing house funds in accordance with the membership instructions." Ex. O.

46. Part III of the Member Guide, "Your Summary of Cost-Sharing," begins with a list of "eligible medical expenses." This list contains 41 numbered paragraphs, with statements such as:

> 34. Sleep Disorders. Overnight Sleep Testing Limit: All components of a polysomnogram must be completed in one session. A second overnight test will not be eligible for sharing under any circumstance. Overnight sleep testing must be medically necessary and will require pre-authorization. ***Allowed charges will not exceed the Usual, Customary, and Reasonable charges for the area.***
>
> . . .
>
> 36. Specialty Care. For most everyday medical conditions, your PCP is your one-stop medical shop. However, there are cases when it's time to see a specialist who's had additional education and been board certified for that specialty. ***For situations like these, the AlieraCare Bronze, Silver, and Gold plans provides specialty care offerings at the cost of just a consult fee.*** A member will need to receive a PCP referral to see a specialist for treatment or consultation outside of their scope of knowledge.
> . . .
>
> 38. Surgical Offerings. Non-life-threatening surgical offering are not available for the first 60 days of membership. ***Please verify eligibility by calling Member Services before receiving any surgical services.***

Ex. O (emphasis added).

47. Following these three sections, the Member Guide contains five appendices. Appendixes A, B and C provide "Plan Details" for the "Bronze"

"Silver" and "Gold" plans, respectively. Ex. O. Each of these appendices contain a chart that appears virtually indistinguishable from any plan comparison chart that any consumer would get from a licensed insurance company. Ex. O. The charts list percentages of what will be covered, such as Wellness & Preventative Care: 100%; Primary Care: $50 Consult Fee; and Specialty Care: $125 Consult Fee. Ex. O.

48. Appendix D is titled "Terms, Conditions and Special Considerations," and lists eighteen separate items, followed by five numbered "Disclaimers." Ex. O. Most of the initial items address Aliera's telemedicine service. Ex. O. The second item on the disclaimer list, at page 43 of the Member Guide, states: "Aliera and Trinity programs are NOT insurance. Aliera Healthcare, Inc./Trinity HealthShare does not guarantee the quality of services or products offered by individual providers. Members may change providers upon 30 days' notice if not satisfied with the medical services provided." Number 5 on the disclaimer list states: "This membership is issued ***in consideration of the Member's application and the Member's payment of a monthly fee as provided under these Plans***. Omissions and missatements, or incorrect, incomplete, fraudulent, or intentional misrepresentation ***to the assumed risk in your application*** may void your membership, and services may be denied." Ex. O (emphasis added).

49. Appendix E is titled "Legal Notices" and over 7 pages, it lists 22 separate state notices in alphabetical order. The disclaimer required by Texas law is listed on page 50 of the Member Guide, and states as follows:

> Notice: This health care sharing ministry facilitates the sharing of medical expenses and is not an insurance company, and neither its guidelines nor its plan of operation is an insurance policy. Whether anyone chooses to assist you with your medical bills will be totally voluntary because no other participant will be compelled by law to contribute toward your medical bills. As such, participation in the ministry or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive any payment for medical expenses or whether this ministry continues to operate, you are always personally responsible for the payment of your own medical bills. Complaints concerning this health care sharing ministry may be reported to the office of the Texas attorney general.
>
> The ministry will assign a recommended cost sharing amount to the membership each month ("Monthly Share Amount"). ***By submitting the Monthly Share Amount, you instruct the ministry to assign your contribution as prescribed by the Guidelines.*** Up to 40% of your member contribution goes towards the administration of this plan. Administration costs are not all inclusive of vendor costs, which could account for up to 32% of the member monthly contribution (monthly recommended share amount). Contributions to the member "Share Box" will never be less than 28% of the member monthly recommended share amount."

Ex. O (emphasis added).

50. The "sharing arrangement" offered by Aliera is insurance. Members each contribute present consideration to the sharing reserve to protect against future risk.

51. Aliera's membership documents establish a defined structure for claims to be paid from the sharing reserve. The membership documents further establish a mechanism to pay claims if the sharing reserve is depleted. Statements in Aliera's membership documents to the effect that the members have no guarantee of payment appear to be disclaimers asserted in an effort to avoid state insurance regulation.

52. To be eligible for a claim payment out of the sharing reserve, a member must pay fixed monthly membership fees into the sharing reserve. Aliera's guidelines state, "This membership is issued in consideration of the Member's application and the Member's payment of a monthly fee as provided under these Plans." If a member does not pay the monthly membership fee, the membership becomes "inactive," and the member is no longer eligible for claim payments out of the sharing reserve. It is a *quid pro quo*. In reality, members are paying their monthly membership fees in exchange for the right to insurance coverage for medical services.

ii. Aliera's contracts with third-party providers demonstrate that Aliera has taken on risk from its members in exchange for monthly payments.

53. At TDI's request, Aliera has provided copies of several contracts that Aliera has currently or did have with certain third-party providers. These contracts include (1) Multi-Service Provider Agreement between CityDoc Urgent Care

Center 4, PLLC, and Aliera (then doing business as HealthPass USA), dated December 10, 2015; (2) Teladoc Services Agreement, dated June 12, 2015; and (3) Laboratory Services Agreement between Aliera and Quest Diagnostics, Inc., dated October 1, 2015. These contracts provide additional documentary evidence that Aliera has taken on risk from its members, because in these contracts, Aliera uses "per member per month" payments to limit the risk it has taken on.

54. The Urgent Care agreement contains the following provisions:

"pay to Provider a portion of the membership fee in accordance with Exhibit A for members that are assigned to Provider for delivery of medical services contained herein and as currently performed at the provider's facility." Contract at p. __ (copy has been provided by counsel and stamped "confidential"; copy will not be filed with this amended petition but will be provided to the Court at a hearing upon request). "As a provider in the Organizers programs, Provider agrees to . . . provide medically necessary care in a timely manner," and agrees that it "shall perform all services currently performed by the practice to all members at no additional cost in accordance with Exhibit A schedule of services and payment parameters . . ."

55. The Urgent Care Agreement also provides: "Provider agrees to accept the Per Member Per Month (PMPM) payment rates set forth in Exhibit A as the total amount to be received by the Provider monthly for all covered services.

Organizer, its parent of affiliate shall pay only the amount due to Provider for monthly per member per month services rendered to Member, based the provisions of the applicable plan and Provider agrees to look to Organizer or its parent or affiliates only for said per member per month fee of such covered services except for any amounts required to be paid by Member pursuant to the Organizers appropriate plan." Urgent Care Agreement at p. __.

56 The termination of coverage provisions are similarly explicit: "2. Termination of Coverage of Members. Coverage for each Member may be terminated by Member or Organizer. When a Member whose coverage has terminated receives services from Provider, Provider agrees to bill Member directly. Organizer shall not be liable to Provider for any bills incurred by a Member whose coverage has been terminated. Provider shall verify eligibility through available electronics means or by calling the eligibility phone number provided by the organizer."

57. With respect to the Teladoc Agreement, the terms are similarly explicit: "8. Payment Terms. Teledoc shall invoice the RESELLER a PEPM fee on the 5th day of each month for the Program services to be provided in that month. . . . The RESELLER specifically acknowledges that it is responsible for paying all applicable PEPM fees and the other fees identified herein to Teladoc regardless of whether it has collected such fees from the Clients."

58. "9. Service Fees. Teladoc agrees to provide the services of the Program in exchange for the fees described in Attachment 2, which shall be paid by the RESELLER to Teladoc and adjusted quarterly based up the aggregate number of Covered lives in the Resellers book of business."

59. In the Quest Diagnostics Agreement, under "Duties of Company and Compensation," the agreement provides that "(a) Laboratory agrees to accept a per member per month fee from Company for lab services outlined in Exhibit B. With respect to such services, Laboratory agrees to accept the rates set forth in Exhibit B of this Agreement as full compensation for such services. Laboratory agrees to comply with pricing schedules for any additional service or direct cash payment from any HP USA member in accordance with Exhibit C contained herein for any HP USA member. Company will provide enrollment eligibility electronically in a mutually agreed upon format on a monthly basis."

60. Health maintenance organizations (HMOs) operate in much the same way. Members pay a fixed premium and the HMO provides specific health care services to their members either directly or by contracting with providers. Notably, capitation agreements with providers are an important tool that HMOs use to control costs. Because HMOs spread risk and essentially function in the same way as traditional health insurers, many courts have recognized that HMOs provide insurance. *See, e.g., Corp. Health Ins., Inc. v. Texas Dep't of Ins.*, 215 F.3d 526,

538 (5th Cir. 2000) (recognizing that an HMO provides insurance); *see also Kentucky Ass'n of Health Plans, Inc. v. Nichols*, 227 F.3d 352, 364-365 (6th Cir. 2000); *Washington Physicians Serv. Ass'n v. Gregoire*, 147 F.3d 1039, 1046 (9th Cir. 1998) ("HMOs function the same way as a traditional health insurer: The policyholder pays a fee for a promise of medical services in the event that he should need them. It follows that HMOs (and HCSCs) are in the business of insurance."); *Anderson v. Humana, Inc.*, 24 F.3d 889, 892 (7th Cir. 1994) ("Because HMOs spread risk—both across patients and over time for any given person—they are insurance vehicles under Illinois law."); *Ocean State Physicians Health Plan, Inc. v. Blue Cross & Blue Shield of Rhode Island*, 883 F.2d 1101, 1107 (1st Cir. 1989).

C. Aliera does not qualify for the faith-based "safe harbor" established by Tex. Ins. Code 1681.

61. A health care sharing ministry (HCSM) is a not-for-profit health care cost-sharing arrangement among persons of similar and sincerely held beliefs. Insurance Code Chapter 1681 establishes the requirements of a HCSM. Under Section 1681.001, a "faith-based, nonprofit organization that is tax-exempt under the Internal Revenue Code of 1986 qualifies for treatment as a health care sharing ministry under this chapter if it: (1) limits its participants to individuals of a similar faith; (2) acts as a facilitator among participants [for the payment of medical bills].

. .; (3) provides for the payment of medical bills of a participant through contributions from one participant to another; (4) provides amounts that participants may contribute with no assumption of risk or promise to pay by the health care sharing ministry to the participants; (5) provides a written monthly statement to all participants . . .; (6) discloses administrative fees and costs to participants; and (7) provides that any card issued to a participant for the purpose of presentation to a health care provider clearly indicates that the participant is part of a health care sharing ministry that is not engaging in the business of insurance."

62. Aliera does not allege that it is a faith-based, nonprofit organization. It is a for-profit corporation. Aliera contends that it only contractually administers the Trinity HCSM, and previously only contractually administered Unity's HCSM. Trinity and Unity are both nonprofit organizations that are tax-exempt under the Internal Revenue Code of 1986. However, Trinity, and Unity before it, are being used by Aliera in an attempt to disguise Aliera's profit-making venture as a HCSM and avoid insurance regulation.

63. Aliera has asserted in court documents filed in its home state of Georgia that at the time of Aliera's agreement with Unity Healthshare, the parties understood that "all products developed by Aliera, regardless of whether such products included an HCSM component, would remain the property of Aliera, not Unity or [Anabaptist]." Aliera's First Amended Complaint, *Aliera Healthcare, Inc.*

v. Anabaptist Healthshare, et al., Civil Action File No. 2018-CV-308981 (Superior Court of Fulton County, Georgia Dec. 3, 2018).

64. In court documents, Aliera further noted that under the Unity Agreement, Eldon Hochstetler and Tyler Hochstetler, director of Anabaptist and Unity, respectively, would each individually "receive $2.50 per enrolled member in Unity Healthshare, per month, for as long as Unity Healthshare exists, regardless of how many members enroll in Unity Healthshare." Aliera described this as a "*profit-sharing arrangement* with [Aliera]." (emphasis added). In less than two years under the Unity Agreement, Eldon Hochstetler and Tyler Hochstetler were each individually paid approximately $700,000. Aliera's First Amended Complaint, *Aliera Healthcare, Inc. v. Anabaptist Healthshare, et al.*, Civil Action File No. 2018-CV-308981 (Superior Court of Fulton County, Georgia Dec. 3, 2018).

65. Similarly, under the Trinity Agreement, Aliera is responsible for almost all aspects of the HCSM, including "plan design (defining the schedule of medical services eligible for sharing), and plan pricing." The Trinity Agreement also entitles Aliera to a large portion of member payments. Aliera retains contributions and/or management fees range from 20 cents per membership dollar to 71 cents per membership dollar. Agent sales commissions range from 10 cents per membership dollar to 40 cents per membership dollar. Because of these and other Aliera profit

centers, member sharing reserve amounts top out at 35 cents per membership dollar, but typically are around 8 to 15 cents per membership dollar.

66. Aliera, together with Trinity, and previously with Unity, is and always has been a profit-making venture. According to an affidavit filed by Aliera's comptroller, James Butler, Aliera earned more than $180,000,000 in revenue in 2018. Exhibit C at p. 315 (Butler testimony).

67. In the regulatory context, courts are permitted to disregard principles of corporate separateness when necessary to prevent corporations from "circumventing statutes and frustrating legislative intent by using a legislatively authorized corporate form to avoid a statute's reach and allow harms the Legislature set out to prevent." *Cadena*, 518 S.W.3d at 333. This principle is especially relevant here where Aliera's own documents demonstrate that it is using corporate fictions to control and operate a purported non-profit health sharing ministry, even stating in writing that Aliera "is authorized to make payments from each and all banking accounts opened ***in Trinity's name*** in connection with this Agreement." Aliera/Trinity Agreement at p. __ (emphasis added) [Exhibit J].

68. Aliera does not act as a facilitator among participants for the payment of medical bills, does not provide for the payment of medical bills by contributions from one participant to another, assumes risk and promises to pay.

69. Under Aliera's business model, members are required to pay a fixed amount to Aliera so that Aliera can pay covered claims directly to providers. Contributions are not made from one participant to another.

70. Membership contributions to the sharing reserve are not voluntary. To become and stay a member of one of Aliera's plans, a member must contribute a specified amount each month, a portion of which goes to the sharing reserve. If a member does not pay the total monthly fee within 5 days of the due date, the member is assessed a late fee. If the member does not pay the total monthly fee by the end of the month, the membership becomes inactive, and the member's covered medical expenses are not eligible for payment out of the sharing reserve. Additionally, if the sharing reserve is depleted in any given month, Aliera can initiate what is essentially an assessment of members to pay the outstanding needs.

72. Aliera's ability to assess members and raise monthly fees in response to the depletion of the sharing reserve also means that members are assuming risk. To maintain membership and health coverage, the member must pay the assessment or increased monthly fees.

D. Regulatory agencies in the state of Washington and Maryland have issued cease and desist orders to Aliera Healthcare based on these and similar allegations.

73. The State of Washington issued a cease and desist order against Aliera on May 13, 2019. In summarizing the findings of the investigation of the

Washington Insurance Commissioner, the order states that Aliera "provided misleading training to prospective agents about the nature of its HCSM products . . . provided misleading advertisements to the public and prospective HCSM customers about the nature of its HCSM products, [and] held itself out as health care service contractor without being registered." *See* Exhibit M. The Order notes "Aliera's repeated use of insurance terminology in its agent training and marketing materials," which "has the capacity to deceive both prospective agents and prospective consumers into believing they are purchasing a non-traditional *insurance* plan." Order at p. 3 (emphasis in original). The Order further finds that "Aliera solicits and sells plans to Washington consumers that are built on an extensive network of preferred providers and include other healthcare 'essentials' that may mislead consumers into thinking they are purchasing healthcare insurance." Order at p. 4.

74. Similarly, the Maryland Insurance Commissioner issued an order dated April 30, 2018, mandating that Aliera cease selling its plans in Maryland and pay a civil fine of $7,500.00. The order was based on conclusions of law that Aliera was engaged in the business of insurance in Maryland, and did not qualify for the health care sharing ministry exception granted under Maryland law. Aliera consented to the terms of this order.

75. Since filing its original complaint in this matter on June 13, 2019, state officials have received numerous inquiries from other regulatory agencies. Additional factual information arising out of these communications will be provided to the Court as it becomes available.

VII.
ALLEGATIONS OF IRREPARABLE HARM

76. The factual allegations set out above are incorporated as if fully repeated in support of the State's allegations of irreparable harm.

77. In addition, the State of Texas offers the following verified, sworn assertions regarding irreparable harm.

78. As described above, the defendant Aliera, as well as those acting in concert or participation with it, is selling unauthorized insurance products to the people of this State, which is recognized as an inherently harmful activity by our Legislature, our courts, and our executive agencies.

79. In addition, the Texas Department of Insurance has collected evidence of significant customer complaints as part of its investigation of Aliera. As of May 10, 2019, the Better Business Bureau had 95 complaints on file for Aliera, with about 10% of those from Texas. As of June 10, 2019, the online review platform Yelp had collected 69 one-star reviews for Aliera - again, about 10% from Texas - warning people that Aliera was a scam, and would not pay claims.

See Exhibit N. A recent article in the Houston Chronicle highlights one couple in Dallas who purchased an Aliera plan but had a claim for an expensive surgery denied. The article notes that "the similarities between traditional health insurance plans and the products Aliera promotes can be striking." Exhibit O.

80. Over the last few weeks, an investigator with the Texas Department of Insurance has attempted to reach some of the individuals who filed these complaints, and succeeded in making contact with eight of them. Each of the individuals contacted indicated that they believed the product Aliera offered was insurance, and were surprised when their claims were not paid.

81. In addition, this investigator submitted an online form expressing interest in Aliera's products, and was contacted by an insurance agent who was willing to take an application over the telephone, but would not provide written materials unless the investigator provided her credit card number for payment. Acknowledgement that the product was "not insurance" only came after the investigator specifically inquired about this issue.

82. The disclaimers provided in Aliera Healthcare's written materials are similarly alarming. As stated in the Member Guide, the first two monthly payments of any membership are completely taken for administrative costs. In addition, the Texas disclaimer provided on page 50 of the 2019 Member Guide states that of every dollar of share contributions, Aliera can only commit that 28

cents will go toward the "sharing fund" that would be used to pay claims. While the State does not currently have detailed financial evidence to offer at this time, it is difficult to see how any business model with this ratio of payment could survive unless it is sustained by a constant influx of new members.

83. Even with state-required disclaimers, the language of the 2019 Member Guide considered as a whole, increases the chances that consumers are being misled into believing that Aliera products are insurance and that by signing up with Aliera, these consumers are entering into an enforceable agreement for Aliera to pay claims in exchange for member fees.

84. Most recently, since the original petition in this case was filed on June 13, 2019, state regulators have learned that Aliera is once again attempting to evade responsibility for its unauthorized business by changing its corporate name and possibly engaging in other restructuring activities. In order to protect the public, this Court is empowered to enjoin not only the named defendant, Aliera Healthcare, but also any individual or entity acting in active concert or participation with it.

VIII.
CAUSES OF ACTION

Count I: Injunctive relief against Aliera for the unauthorized business of insurance.

85. The factual allegations set out above are incorporated as if fully repeated in support of this cause of action.

86. Aliera is directly or indirectly engaging in the business of insurance as defined in Tex. Ins. Code § 101.051.

87. Aliera has no authorization to engage in the business of insurance in Texas.

88. Aliera is violating Tex. Ins. Code § 101.102 because it is directly or indirectly doing an act or acts that constitute the business of insurance under Chapter 101 of the Texas Insurance Code without authorization.

89. Aliera is proposing to make and is making insurance contracts in Texas as an insurer. Aliera is actively promoting and selling insurance products in Texas and currently has more than 17,000 members in Texas. Aliera's membership certificates, applications, and guidelines, as provided on the website and also to customers directly, establish a contract of insurance, and Aliera is "a corporation, association, partnership, or individual engaged as a principal in the business of insurance." Tex. Ins. Code §101.002(1)(A).

90. Aliera takes and receives applications for its own insurance products and for Trinity's insurance products, including over the phone and through its agents. At least one TDI investigator has communicated with an agent attempting

to sell Aliera products and has been asked to provide credit card information in order to sign up with the plan after an application taken over the phone.

91. Aliera collects and receives consideration for its insurance products through Aliera's membership fees. Aliera's membership guide also states that it may assess its members for deficiencies in the sharing reserve.

92. Aliera issues and delivers insurance contracts to residents of Texas. More than 17,000 Texas residents have insurance contracts with Aliera. The insurance contract consists of membership certificate, application, and guidelines.

93. Aliera directly and indirectly sells insurance products to Texas residents both directly and through licensed Texas insurance agencies. Aliera offers commission of up to 40%, which is significantly higher than commission paid for the sale of authorized insurance products. Through its member guide and website, Aliera disseminates information relating to insurance coverage and rates and it receives and approves member applications. Aliera also sets the rates for the insurance products and delivers the insurance contracts. Further, Aliera adjusts claims directly and through contracted entities.

94. Aliera has capitated contracts with providers in Texas to pay the costs of its members healthcare expenses. Aliera also reimbursed providers and members in Texas directly for medical expenses under Aliera's sharing arrangement.

95. Aliera has deliberately designed its corporate structure and healthcare products to avoid insurance regulation. Aliera has attempted to structure its business to appear on its surface to fit within a legitimate exemption from insurance regulation. By avoiding insurance regulation up to this point, it has been able to offer healthcare plans to Texas that are significantly cheaper than plans offered by authorized insurance carriers, but without any of the statutory protections to Aliera's customers.

96. On application for injunctive relief and a finding that a person or entity, including an insurer, is violating or threatening to violate Chapter 101, the district court shall grant the injunctive relief and issue an injunction without bond. *See* Tex. Ins. Code § 101.105.

Count II: Civil penalties against Aliera Healthcare for the unauthorized business of insurance.

97. The allegations set out above are incorporated as if fully repeated in support of this cause of action.

98. A person or entity, including an insurer, that violates Chapter 101 is subject to a civil penalty of not more than $10,000 for each act of violation and for each day of violation. *See* Tex. Ins. Code § 101.105.

99. The State of Texas brings suit for the recovery of civil penalties against Aliera in the amount of $10,000 for each of Aliera's acts of violation and for each day of violation of Texas Insurance Code Chapter 101.

IX.
REQUEST FOR TEMPORARY RESTRAINING ORDER AND TEMPORARY INJUNCTION

100. The State of Texas asks that this Court enter a temporary restraining order prohibiting the defendant Aliera Healthcare from signing up any new Texas customers until the merits of this suit can be resolved. Further, the State asks that this Court further provide in its temporary orders that all money in the possession of Aliera, from Texas customers, and any money received from Texas customers during the pendency of this case be put into an escrow account with disbursements allowed only to pay claims from Texas customers pursuant to the terms and conditions of Aliera's Management and Administrative Agreement with Trinity Healthshare, Inc. or other contract governing disbursement from the Share Box Member Reserve. Further, the State asks this Court to provide in its temporary orders that Aliera must maintain an accounting of disbursements from the escrow account, which will be made available to TDI, the Texas Office of the Attorney General, or the Court, for inspection and copying, upon request.

101. Temporary injunctive relief is warranted when the plaintiff has (1) asserted a cause of action against the defendant, (2) is likely to succeed on the

merits of its cause of action, and (3) will suffer probable imminent, and irreparable injury if the injunction is not granted for which there is no adequate remedy at law. *Taylor Housing Auth. v. Shorts*, 549 S.W.3d 865, 877 (Tex. App. – Austin, 2018) citing *Butnaru v. Ford Motor Co.*, 84 S.W.3d 198, 204 (Tex. 2002); *Tex. Civ. Prac. & Rem. Code § 65.011*.

102. The State of Texas is likely to succeed on the merits. This petition presents substantial evidence that Aliera Healthcare is engaging in the unauthorized business of insurance in this state without a license. The bulk of these allegations come from statements made by Aliera Healthcare itself, through its website, its marketing materials, its Member Guide, and its executives submitting sworn testimony in the Georgia state litigation. Two other states have already issued cease and desist orders to Aliera based on these and similar allegations.

103. With respect to irreparable harm, the Texas Insurance Code is clear that "[i]t is the policy of this state to protect residents against acts by a person or insurer who is not authorized to do business in this state." Tex. Ins. Code § 101.001. In addition, "[i]t is a state concern" that residents holding policies from unauthorized insurers "face often insurmountable obstacles in asserting legal rights under the policies in foreign forums under unfamiliar laws and rules of practice." Tex. Ins. Code § 101.001(a). Courts in this State have often recognized the

seriousness of a charge of unauthorized insurance. See, e.g., *Strayhorn; Mid-American Indem. Ins. Co. v. King,* 22 S.W.3d 321, 326-327 (Tex. 1995) ("Both this Court and the United States Supreme Court have consistently recognized the right of the states to regulate the insurance industry in its operations affecting the public welfare.") (internal quotation marks omitted); *Southwest Professional Indem. Corp. v. Texas Dept. of Ins.*, 914 S.W.2d 256, 263 (Tex. App. – Austin 1996) ("The government . . . has a great interest in protecting citizens from the unauthorized practice of insurance.").

In *Republic Western Ins. v. State of Texas*, 985 S.W.2d 698, 706 (Tex. App. - Austin 1999), a temporary restraining order was upheld without specific findings on irreparable harm and no adequate remedy at law because the language of the statute was mandatory, providing that "an injunction shall issue if the court determines that a violation of that article has occurred." This specific provision has been repealed, but Tex. Ins. Code § 101.105 contains similar mandatory language. Tex. Ins. Code § 101.105 ("On application for injunctive relief and a finding that the person or entity . . . is violating or threatening to violate this chapter . . . the district court shall grant the injunctive relief and issue an injunction without bond.").

Even if findings as to irreparable harm are necessary, the allegations stated above demonstrate that Aliera Healthcare has failed to resolve numerous, serious

complaints regarding communications with customers and payment of claims. Also, this Court is entitled to take judicial notice that Aliera continued to employ Timothy Moses well after he admitted to taking non-profit funds without authorization.

104. Because the State has shown a likelihood of success on the merits, and multiple avenues for irreparable harm, Aliera Healthcare should be enjoined immediately from continuing to sell its health care products in Texas during the pendency of this case. Provisions in the Order should also be made for the treatment of funds collected from the over 17,000 members of Aliera Healthcare living in Texas. Aliera currently claims that it is entitled to retain over 70% of these funds for "administrative costs." During the pendency of this case, however, funds collected from Texas members should be segregated and placed in escrow with this Court, to be disbursed only with a proper accounting, reviewable upon request by TDI, the Office of the Attorney General or this Court.

106. Accordingly, the State of Texas brings suit for a temporary restraining order and temporary injunction against Aliera Healthcare, Inc. to remain in effect during the pendency of this case to be made into a permanent injunction to prevent Aliera Healthcare from engaging in the business of insurance in violation of Texas law after final trial.

Respectfully submitted.

KEN PAXTON
Attorney General of Texas

JEFFREY C. MATEER
First Assistant Attorney General

DARREN L. McCARTY
Deputy Attorney General for Civil Litigation

JOSHUA R. GODBEY
Division Chief
Financial Litigation and Charitable Trusts Division

/s/ H. Melissa Mather
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Telecopier: (512) 477-2348

Counsel for the State of Texas

CERTIFICATE OF SERVICE

I certify that a true and correct copy of the foregoing was sent to counsel of record electronically via eFileTexas.gov on July 11, 2019, as indicated below:

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Of Counsel for Aliera Healthcare, Inc.

/s/ H. Melissa Mather
H. Melissa Mather

VERIFICATION

STATE OF TEXAS §
§
TRAVIS COUNTY §

My name is Jamie Walker. I am Deputy Commissioner for Financial Regulation for the Texas Department of Insurance and I am legally competent to make this affidavit. The factual allegations in the first amended petition, paragraphs 8-29, 35-60, 62-78, and 82-84 are either within my personal knowledge or reported to me, from personal knowledge, by other TDI employees, or based on a review of available information existing and available at the time of the filing of this first amended petition.

Jamie Walker
Deputy Commissioner for Financial Regulation

This verification was acknowledged and executed before me, the undersigned authority, on July 11, 2019, by Jamie Walker, a person known to me, and she swore or affirmed that the facts stated above are true and correct and within her personal knowledge except where otherwise stated.

TOMMY TRAN
Notary Public-State of Texas
Notary ID #13135673-5
Commission Exp. NOV. 15, 2021
Notary without Bond

Notary Public in the State of Texas

VERIFICATION

STATE OF TEXAS §
§
TRAVIS COUNTY §

My name is Andy Buhl. I am an Investigator for the Texas Department of Insurance and I am legally competent to make this affidavit. The factual allegations in the first amended petition describing consumer complaints are within my personal knowledge or based on a review of available information available at the time of the filing of this first amended petition.

Andy Buhl
Investigator

This verification was acknowledged and executed before me, the undersigned authority, on July 11th, 2019, by Andy Buhl, a person known to me, and she swore or affirmed that the facts stated above are true and correct and within her personal knowledge except where otherwise stated.

Notary Public in the State of Texas

MARY RUIZ
NOTARY PUBLIC
ID# 13079242-7
State of Texas
Comm. Exp. 08-23-2020
WITHOUT BOND

APPENDIX H

STATE OF WASHINGTON
OFFICE OF THE INSURANCE COMMISSIONER

In the Matter of	
TRINITY HEALTHSHARE, INC.	Order No. 19-0252
Unauthorized Entity.	ORDER TO CEASE AND DESIST
Respondent.	

Pursuant to RCW 48.02.080, RCW 48.15.020, and RCW 48.15.023, the Insurance Commissioner of the state of Washington ("Insurance Commissioner") orders the above-named Respondent, and its officers, directors, trustees, employees, agents, and affiliates to immediately cease and desist from:

A. Engaging in or transacting the unauthorized business of insurance in the state of Washington;

B. Seeking, pursuing and obtaining any insurance business in the state of Washington;

C. Soliciting Washington residents to sell any insurance issued or to be issued by an unauthorized insurer;

D. Soliciting Washington residents to purchase any insurance contract.

BASIS:

1. Trinity HealthShare, Inc. ("Trinity") is a nonresident corporation domiciled in Delaware. Trinity represents itself as a health care sharing ministry ("HCSM") as defined by 26 USC §5000A and incorporated by reference under RCW 48.43.009. Trinity does not hold a certificate of authority in the state of Washington.

2. To qualify as a health care sharing ministry under the Internal Revenue Service (IRS) and Washington law, a HCSM must be a 501(c)(3) organization whose members share a common set of ethical or religious beliefs and share medical expenses among members in accordance with those beliefs. A HCSM must also have been in operation and continuously sharing member health care costs since at least December 31, 1999.

3. Washington adopts the IRS definition of HCSM under RCW 48.43.009. HCSMs that comply with the required federal provisions are not considered Washington health carriers or insurers and are exempt from regulation under Washington's insurance code.

4. Following receipt of a complaint, the Insurance Commissioner investigated to determine whether Trinity is accurately representing itself to Washington consumers as a HCSM in compliance with state and federal law. The complaint alleged that Trinity's corporate partner, Aliera Healthcare, Inc. ("Aliera"), is soliciting and recruiting agents to sell misleading products to Washington consumers because the co-branded marketing materials use language that may lead the average consumer to believe they are purchasing healthcare insurance rather than a HCSM membership.

5. The investigation determined that Trinity does not meet the legal definition of a HCSM and is therefore acting as an unauthorized insurer in the state of Washington.

6. Trinity first incorporated in the state of Delaware on June 27, 2018. Approximately six weeks later, Trinity entered into a Management and Administration Agreement ("the Agreement") with Aliera. The Agreement was effective August 13, 2018, and stated Trinity's intent to partner with Aliera to include Trinity's HCSM program as a component of Aliera's new and existing healthcare products. Trinity also grants its corporate affiliate Aliera the exclusive right to develop, market, and sell its HCSM plans to individuals who agree to Trinity's statement of faith and lifestyle requirements.

7. Trinity has been in existence less than one (1) year. Further, at the time of the Agreement with Aliera, Trinity had zero members in its HCSM and there was no predecessor organization in which Trinity's members were sharing medical costs. Trinity, with zero members, further provided that any future enrolled members would become "customers" of Aliera, who would maintain ownership over the "membership roster." Trinity has not "been in operation and continuously sharing member health care costs since at least December 31, 1999" as required to qualify for exemption from state insurance regulation.

8. Trinity espouses contradictory versions of the required "common set of ethical or religious beliefs" that vary based on the intended audience. If Trinity's members do not share common beliefs – regardless of the content of such beliefs – and share medical burdens in accordance with those common beliefs, Trinity cannot represent itself as a HCSM.

9. Trinity has communicated to state and federal regulatory authorities that it holds to a Protestant expression of the Christian faith. Trinity's own bylaws obligate its members to affirm this expression of faith. However, according to its website, Trinity offers an alternative solution to health insurance and offers membership to individuals of "all faiths." In training materials to prospective agents, Trinity's statement of faith becomes simply a belief in a higher power, whether a Christian, Buddhist, or Jewish God. This statement of faith, as presented to the public, is materially different from and inconsistent with the statement of faith that Trinity has claimed to regulatory authorities, demonstrating that Trinity and its ministers do not share "a common set of ethical or religious beliefs" as required to qualify for exemption from state insurance regulation.

10. Finally, Trinity also grants Aliera the contractual right to "agree upon" the required statement of beliefs. Conditioning its common set of ethical or religious beliefs on the consent of its for-profit corporate partner is contradictory to Trinity's own statements about its religious traditions.

11. RCW 48.05.030(1) states no person shall act as an insurer and no insurer shall transact insurance in this state other than as authorized by a certificate of authority issued to it by the Insurance Commissioner and then in force; except, as to such transactions as are expressly otherwise provided for in this code.

12. RCW 48.30.040 states no person shall knowingly make, publish, or disseminate any false, deceptive or misleading representation or advertising in the conduct of the business of insurance, or relative to the business of insurance or relative to any person engaged therein.

13. RCW 48.02.080(3) states if the Insurance Commissioner has cause to believe that any person is violating or is about to violate any provision of this code or any regulation or order of the Insurance Commissioner, he or she may: (a) issue a cease and desist order.

14. RCW 48.15.023(5)(a) states if the Insurance Commissioner has cause to believe that any person has violated the provisions of RCW 48.15.020(1), the Insurance Commissioner may: (i) issue and enforce a cease and desist order in accordance with the provisions of RCW 48.02.080.

15. RCW 48.44.015(1) provides that a person may not in this state, by mail or otherwise, act as or hold himself or herself out to be a health care service contractor, as defined in RCW 48.44.010 without first being registered with the Insurance Commissioner.

16. The Respondent's actions described herein violate Insurance Code provisions that include RCW 48.05.030 (certificate of authority required), RCW 48.14.020 (failure to timely pay premium tax), RCW 48.15.020 (solicitation by unauthorized insurer prohibited), and RCW 48.30.040 (unfair practices and frauds).

IT IS FURTHER ORDERED that nothing herein shall prevent the Respondent from fulfilling the terms of contracts formed prior to the effective date of this Order pursuant to RCW 48.15.020(2)(b).

Any violation of the terms of this Order by the Respondent and its officers, directors, trustees, employees, agents, and affiliates or the Respondent's failure to fulfill or perform its contracts subject to this Order will render the violator(s) subject to the full penalties authorized by RCW 48.02.080, 48.15.023, and other applicable sections of the Insurance Code of the state of Washington.

The Respondent has the right to demand a hearing in accordance with RCW 48.04.010, WAC 284-02-070, and WAC 10-08-110.

This Order shall remain in effect subject to the further order of the Insurance Commissioner.

THIS ORDER IS EFFECTIVE IMMEDIATELY AND IS ENTERED at Tumwater, Washington, this 13TH day of MAY, 2019.

Mike Kreidler

MIKE KREIDLER
Insurance Commissioner

By and through his designee

Kimberly Tocco

KIMBERLY TOCCO
Insurance Enforcement Specialist
Legal Affairs Division

CERTIFICATE OF MAILING

The undersigned certifies under the penalty of perjury under the laws of the state of Washington that I am now and at all times herein mentioned, a citizen of the United States, a resident of the state of Washington, over the age of eighteen years, not a party to or interested in the above-entitled action, and competent to be a witness herein.

On the date given below I caused to be served the foregoing Order to Cease and Desist on the following individual(s) in the manner listed below:

By depositing in the U.S. mail via state Consolidated Mail Service with proper postage affixed to:

Trinity Healthshare
5901 Peachtree Dunwoody Rd., Ste 160
Atlanta, GA 30328

By email and by depositing in the U.S. mail via state Consolidated Mail Service with proper postage affixed to:

J. Joseph Guilkey
BakerHostetler
200 Civic Center Drive, Ste. 1200
Colombus, OH 43215
jguilkey@bakerlaw.com

Dated this 13th day of May, 2019, in Tumwater, Washington.

Christine Tribe
CHRISTINE TRIBE
Paralegal
Legal Affairs Division

APPENDIX I

STATE OF WASHINGTON
OFFICE OF THE INSURANCE COMMISSIONER

In the Matter of **ALIERA HEALTHCARE INC.,** Unauthorized Entity. Respondent.	Order No. 19-0251 ORDER TO CEASE AND DESIST

Pursuant to RCW 48.02.080 RCW 48.15.023, RCW 48.17.063, RCW 48.30.010, RCW 48.44.016, and RCW 48.155.130(1) the Insurance Commissioner of the state of Washington ("Insurance Commissioner") orders the above-named Respondent, and its officers, directors, trustees, employees, agents, and affiliates to immediately cease and desist from:

A. Engaging in or transacting the unauthorized business of insurance or acting as an unregistered health care service contractor or as an unlicensed discount plan organization in the state of Washington;

B. Seeking, pursuing and obtaining any insurance or discount plan business in the state of Washington;

C. Soliciting Washington residents to purchase any insurance or discount plan to be issued by an unauthorized insurer or unlicensed discount plan organization;

D. Soliciting Washington residents to induce them to purchase any insurance contract or discount plan.

BASIS:

1. Aliera Healthcare Inc. ("Aliera") is a nonresident corporation domiciled in Delaware and incorporated on December 18, 2015. Aliera does not hold a certificate of authority and is not licensed to sell, solicit, or negotiate insurance in the state of Washington. Aliera is also

not registered as a health care service contractor or licensed as a discount plan organization in the state of Washington.

2. Trinity HealthShare, Inc. ("Trinity") is a nonresident corporation domiciled in Delaware. Trinity represents itself as a health care sharing ministry ("HCSM") as defined by 26 USC §5000A and incorporated by reference under RCW 48.43.009. Trinity does not hold a certificate of authority in Washington. Trinity HealthShare, Inc. is the subject of a separate but related Cease and Desist Order. See Order No. 19-0152.

3. To qualify as a health care sharing ministry under the Internal Revenue Service (IRS) and Washington law, a HCSM must be a 501(c)(3) organization whose members share a common set of ethical or religious beliefs and share medical expenses among members in accordance with those beliefs. A HCSM must also have been in operation and continuously sharing member health care costs since at least December 31, 1999.

4. Aliera is the administrator, marketer, and program manager for Trinity and is solely responsible for the development of HCSM plan designs, pricing, marketing materials, vendor management, and recruitment and maintenance of a national sales force on behalf of Trinity.

5. By the terms of their Management and Administration Agreement ("the Agreement"), Aliera has the right, at its sole discretion, to develop and market "the schedule of medical services eligible for sharing under the HCSM" with other purportedly "non-insurance" health care products developed and managed by Aliera. Such products include telemedicine, discount prescription drugs, and concierge services to locate in-network providers. In order to purchase any of Aliera's HCSM-inclusive plans, individuals must acknowledge Trinity's statement of faith and lifestyle requirements, as deemed necessary by Trinity and agreed upon by Aliera.

6. Following receipt of a complaint, the Insurance Commissioner investigated to determine whether Aliera is accurately representing its products to Washington consumers as a HCSM in compliance with state and federal law. The complaint alleged that Aliera is soliciting and recruiting agents to sell misleading products to Washington consumers by using marketing materials that may lead the average consumer to believe they are purchasing healthcare insurance rather than a HCSM membership.

7. The investigation determined that Aliera 1) failed to represent Trinity's actual statement of faith, as defined by Trinity's own bylaws, 2) provided misleading training to

prospective agents about the nature of its HCSM products, 3) provided misleading advertisements to the public and prospective HCSM customers about the nature of its HCSM products, 4) held itself out as health care service contractor without being registered, and 5) is doing business as an unlicensed discount plan organization.

8. Trinity has communicated to state and federal regulatory authorities that it holds to a Protestant expression of the Christian faith. Trinity's own bylaws obligate its members to affirm this expression of faith. However, as marketed by Aliera, Trinity offers an alternative solution to health insurance and offers membership to individuals of "all faiths." In training materials to prospective agents, Aliera describes Trinity's statement of faith as simply a belief in a higher power, whether a Christian, Buddhist, or Jewish God. This statement of faith, as presented to the public, is materially different from and inconsistent with the statement of faith that Trinity has represented to regulatory authorities. Aliera also has the contractual right to "agree upon" Trinity's required statement of beliefs.

9. Aliera's web-based advertisement to recruit prospective agents to sell its HCSM products touts the opportunity to sell "the next generation Healthcare products" and suggests Aliera can offer employers "a healthcare plan that saves money." The advertisement does not include any reference to a required affirmation of a common set of ethical or religious beliefs. Likewise, Aliera's prospective agent training portal provides required training videos that explain Aliera's HCSM plan offerings with no reference to consumers' required affirmation of a common set of ethical or religious beliefs.

10. A video seminar for prospective agents refers to Aliera's "individual alternative market" as the company's "bread and butter." The narrator/trainer states that Aliera's comprehensive HCSM plans not only "mirrors traditional insurance, but truly provide comprehensive healthcare for an individual." The narrator/trainer also describes one of Aliera's HCSM plans (InterimCare) as "our short-term medical plan." Aliera's repeated use of insurance terminology in its agent training and marketing materials has the capacity to deceive both prospective agents and prospective consumers into believing they are purchasing a non-traditional *insurance* plan.

11. In another video seminar for prospective Aliera agents, a trainer represents Trinity's statement of faith in the following manner:

> *Just to give you a general overall synopsis of what it's saying ... It basically is saying that you believe in a higher power. It doesn't necessarily have to be a Christian God, or a Buddhist God, or a Jewish God. It doesn't ... it doesn't matter as long as we all believe that there is a higher power and we're all living our life that the best way that we possibly can. We're maintaining a healthy lifestyle. We're trying to avoid those types of foods, behaviors, habits - things that, you know, cause us illness that are in our control. As long as we're doing those types of things, we're all like-minded individuals. So if you feel that way, and you are a like-minded individual, that's all we're trying to find out. And, if you are, you're gonna say, "Yes," you believe in the five same statement of beliefs that we all do.*

12. Aliera solicits and sells plans to Washington consumers that are built on an extensive network of preferred providers and include other healthcare "essentials" that may mislead consumers into thinking they are purchasing healthcare insurance. Aliera's HCSM plans include telemedicine, prescription drug discounts, and access to in-network labs and diagnostics.

13. RCW 48.30.040 states no person shall knowingly make, publish, or disseminate any false, deceptive or misleading representation or advertising in the conduct of the business of insurance, or relative to the business of insurance or relative to any person engaged therein.

14. RCW 48.15.020(2)(a) provides that a person may not, in this state, represent an unauthorized insurer except as provided in this chapter.

15. RCW 48.17.060(1) provides that a person shall not sell, solicit, or negotiate insurance in this state for any line or lines of insurance unless the person is licensed for that line of authority in accordance with this chapter.

16. RCW 48.02.080(3) states if the Insurance Commissioner has cause to believe that any person is violating or is about to violate any provision of this code or any regulation or order of the Insurance Commissioner, he or she may: (a) issue a cease and desist order.

17. WAC 284-50-050(1) states the format and content of an advertisement to which these rules apply shall be sufficiently complete and clear to avoid deception or the capacity or tendency to mislead or deceive. Whether an advertisement has a capacity or tendency to mislead or deceive shall be determined by the insurance commissioner from the overall impression that the advertisement may be reasonably expected to create upon a person of average education or intelligence, within the segment of the public to which it is directed.

18. WAC 284-50-050(2) states advertisements shall be truthful and not misleading in fact or in implication. Words or phrases, the meaning of which is clear only by implication or by familiarity with insurance terminology, shall not be used.

19. WAC 284-50-060(1) states no advertisement shall omit information or use words, phrases, statements, references, or illustrations if the omission of such information or use of such words, phrases, statements, references, or illustrations has the capacity, tendency, or effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of any policy benefit payable, loss covered, or premium payable. The fact that the policy offered is made available to a prospective insured for inspection prior to consummation of the sale or an offer is made to refund the premium if the purchaser is not satisfied, does not remedy misleading statements.

20. RCW 48.44.015(1) provides that a person may not in this state, by mail or otherwise, act as or hold himself or herself out to be a health care service contractor, as defined in RCW 48.44.010 without first being registered with the commissioner.

21. RCW 48.155.020(1) provides that, before conducting discount plan business to which this chapter applies, a person must obtain a license from the commissioner to operate as a discount plan organization.

22. The Respondent's actions described herein violate Insurance Code provisions that include RCW 48.15.020 (representation of an unauthorized insurer prohibited), RCW 48.17.060 (license required), RCW 48.30.040 (false information and advertising), RCW 48.44.015(1) (registration by health care service contractors required), and RCW 48.155.020(1) (discount plan organization license required).

IT IS FURTHER ORDERED that nothing herein shall prevent the Respondent from fulfilling the terms of contracts formed prior to the effective date of this Order pursuant to RCW 48.15.020(2)(b).

Any violation of the terms of this Order by the Respondent and its officers, directors, trustees, employees, agents, and affiliates or the Respondent's failure to fulfill or perform its contracts subject to this Order will render the violator(s) subject to the full penalties authorized by RCW 48.02.080, 48.15.023, and other applicable sections of the Insurance Code of the state of Washington.

The Respondent has the right to demand a hearing in accordance with RCW 48.04.010, WAC 284-02-070, and WAC 10-08-110.

This Order shall remain in effect subject to the further order of the Insurance Commissioner.

THIS ORDER IS EFFECTIVE IMMEDIATELY AND IS ENTERED at Tumwater, Washington, this 13th day of May, 2019.

Mike Kreidler

MIKE KREIDLER
Insurance Commissioner

By and through his designee

Kimberly Tocco

KIMBERLY TOCCO
Insurance Enforcement Specialist
Legal Affairs Division

CERTIFICATE OF MAILING

The undersigned certifies under the penalty of perjury under the laws of the state of Washington that I am now and at all times herein mentioned, a citizen of the United States, a resident of the state of Washington, over the age of eighteen years, not a party to or interested in the above-entitled action, and competent to be a witness herein.

On the date given below I caused to be served the foregoing Order to Cease and Desist on the following individual(s) in the manner listed below:

By depositing in the U.S. mail via state Consolidated Mail Service with proper postage affixed to:

Aliera Healthcare Inc.
The Corporation Trust Company
Corporation Trust Center
1209 Orange St
Wilmington, DE 19801

By email and by depositing in the U.S. mail via state Consolidated Mail Service with proper postage affixed to:

Dwight Francis
Sheppard, Mullin, Richter & Hampton LLP
2200 Ross Ave, Ste. 2400
Dallas, TX 75201
dfrancis@sheppardmullin.com

Aliera Healthcare Inc.
5901 Peachtree Dunwoody Rd Ste B-200
Atlanta, GA 30328
tmoses@aliera.com

Reba Leonard
Vice President, Compliance and Regulatory Affairs
15301 Dallas Parkway, Suite 920
Addison, TX 75001
rleonard@alierahealthcare.com

Dated this 13th day of May, 2019, in Tumwater, Washington.

Christine Tribe
CHRISTINE TRIBE
Paralegal
Legal Affairs Division

APPENDIX J

001392427 12/23/2019 150,000.00

STATE OF WASHINGTON
OFFICE OF THE INSURANCE COMMISSIONER

In the Matter of

TRINITY HEALTHSHARE, INC.,

Respondent.

Order No. 19-0375

CONSENT ORDER LEVYING A FINE

This Consent Order Levying a Fine ("Order") is entered into by the Insurance Commissioner of the state of Washington ("Insurance Commissioner"), acting pursuant to the authority set forth in RCW 48.02.060 and RCW 48.15.023, and Trinity Healthshare, Inc. This Order is a public record and will be disseminated pursuant to Title 48 RCW and the Insurance Commissioner's policies and procedures.

BASIS:

1. Trinity Healthshare, Inc. ("Trinity" or "the Company") is a nonresident corporation domiciled in Delaware. Trinity represents itself as a health care sharing ministry ("HCSM") as defined by RCW 48.43.009. Trinity does not hold a certificate of authority to transact insurance in the state of Washington.

2. On May 13, 2019, the Insurance Commissioner ordered Trinity to cease and desist from the unauthorized business of insurance in the state of Washington under Order to Cease and Desist No. 19-0252 (the "Order"). Trinity fully complied with the Order and immediately stopped enrolling new Washington residents in its HCSM Sharing Program. Consistent with the Order, Trinity continued to facilitate sharing among state of Washington members who enrolled in Trinity Sharing Programs prior to May 13, 2019.

3. Under RCW 48.43.009, qualified HCSMs are not considered Washington health carriers or insurers and are exempt from regulation under the Washington insurance code.

4. The Insurance Commissioner opened this investigation following a complaint from an insurer related to the potential misrepresentation of certain "health share" products as insurance

and the recruitment of prospective brokers to sell these products to Washington consumers. The complaint alleged that Aliera Healthcare, Inc. ("Aliera"), which provides management and administrative services to Trinity, was soliciting and recruiting agents to sell misleading products to Washington consumers by using co-branded marketing communications containing language that may lead the average consumer to believe they are purchasing healthcare insurance rather than a HCSM membership.

5. Aliera is the subject of a separate but related enforcement action. *See* Consent Order Levying A Fine No. 19-0376.

6. Following receipt of the complaint, the Insurance Commissioner investigated to determine whether Trinity is accurately representing itself to Washington consumers as a HCSM in compliance with state law.

7. As a result of this investigation, the Insurance Commissioner has cause to believe that Trinity does not qualify as a HCSM under Washington law and is acting as an unauthorized insurer in the state of Washington.

8. To meet the definition of a health care sharing ministry under Washington law, a HCSM must be a 501(c)(3) organization exempt from taxation under section 501(a), whose members share a common set of ethical or religious beliefs and share medical expenses among members in accordance with those beliefs. A HCSM, or a predecessor of which, must also have been in existence at all times since December 31, 1999 and continuously sharing member medical expenses without interruption since at least December 31, 1999.

9. Trinity incorporated in the state of Delaware on June 27, 2018.

10. Effective August 13, 2018, Trinity entered into a Management and Administration Agreement ("the Agreement") with Aliera. The Agreement stated Trinity's intent to include Trinity's HCSM program as a component of Aliera's new and existing healthcare products. Trinity had no members in its HCSM program at this time.

11. As a result of the investigation, the Insurance Commissioner has cause to believe that Trinity cannot qualify for an exemption from Washington state insurance regulation as a HCSM because neither Trinity, nor a predecessor of Trinity, have been in existence at all times and continuously sharing member health care costs since at least December 31, 1999.

12. In response to the Insurance Commissioner's investigation, Trinity stated its position that it meets the definition of a HCSM under RCW 48.43.009 and is therefore not a health

carrier as defined in RCW 48.43.005 or insurer as defined in RCW 48.01.050, and is exempt from regulation under the Washington insurance code. Trinity also stated its position that its operations do not constitute insurance under Washington law because Trinity does not promise to pay members anything or undertake any obligation to pay members.

13. As of June 15, 2019, 3,058 Washington consumers were actively enrolled in Trinity plans.

14. RCW 48.01.030 states the business of insurance is one affected by the public interest, requiring that all persons be actuated by good faith, abstain from deception, and practice honesty and equity in all insurance matters. Upon the insurer, the insured, their providers, and their representatives rests the duty of preserving inviolate the integrity of insurance.

15. RCW 48.01.040 states that "insurance" is a contract whereby one undertakes to indemnify another or pay a specified amount upon determinable contingencies.

16. RCW 48.01.050 states in relevant part that "insurer" as used in this code includes every person engaged in the business of making contracts of insurance.

17. RCW 48.43.009 states that health care sharing ministries are not health carriers as defined in RCW 48.43.005 or insurers as defined in RCW 48.01.050. For purposes of this section, "health care sharing ministry" has the same meaning as in 26 U.S.C. Sec. 5000A.

18. 26 U.S.C. Sec. 5000A states the term "health care sharing ministry" means an organization—(I) which is described in section 501(c)(3) and is exempt from taxation under section 501(a), (II) members of which share a common set of ethical or religious beliefs and share medical expenses among members in accordance with those beliefs and without regard to the State in which a member resides or is employed, (III) members of which retain membership even after they develop a medical condition, (IV) which (or a predecessor of which) has been in existence at all times since December 31, 1999, and medical expenses of its members have been shared continuously and without interruption since at least December 31, 1999, and (V) which conducts an annual audit which is performed by an independent certified public accounting firm in accordance with generally accepted accounting principles and which is made available to the public upon request.

19. RCW 48.05.030(1) states that no person shall act as an insurer and no insurer shall transact insurance in this state other than as authorized by a certificate of authority issued to it by

the Insurance Commissioner and then in force; except, as to such transactions as are expressly otherwise provided for in this code.

20. RCW 48.15.020(1) states that an insurer that is not authorized by the Insurance Commissioner may not solicit or transact insurance business in this state.

21. RCW 48.15.023(2) states that for the purpose of this section, an act is committed in this state if it is committed, in whole or in part, in the state of Washington, or affects persons or property within the state and relates to or involves an insurance contract.

22. RCW 48.15.023(3) states that any person who knowingly violates RCW 48.15.020(1) is guilty of a class B felony punishable under chapter 9A.20 RCW.

23. RCW 48.15.023(4) states that any criminal penalty imposed under this section is in addition to, and not in lieu of, any other civil or administrative penalty or sanction otherwise authorized under state law.

24. RCW 48.15.023(5)(a) states if the Insurance Commissioner has cause to believe that any person has violated the provisions of RCW 48.15.020(1), the Insurance Commissioner may:

(i) Issue and enforce a cease and desist order in accordance with the provisions of RCW 48.02.080; and/or

(ii) Assess a civil penalty of not more than twenty-five thousand dollars for each violation, after providing notice and an opportunity for a hearing in accordance with chapters 34.05 and 48.04 RCW.

25. As a result of this investigation, the Insurance Commissioner has cause to believe that Trinity does not meet the requirements for an exemption from insurance regulation under RCW 48.43.009 and is acting as an unauthorized insurer in the state of Washington. In view of the complex issues raised and the probability that long-term litigation or administrative proceedings would be required to resolve these disputes, Trinity desires to resolve this matter by entering into this Order and does not contest that as a result of this investigation the Insurance Commissioner has cause to believe Trinity does not meet the requirements for an exemption from insurance regulation under RCW 48.43.009 and is acting as an unauthorized insurer in the state of Washington.

26. As a result of this investigation the Insurance Commissioner has cause to believe that Trinity's activities in Washington violated RCW 48.05.030(1) and RCW 48.15.020(1), justifying imposition of a fine under RCW 48.15.023(5)(a)(ii). In view of the complex issues raised

and the probability that long-term litigation or administrative proceedings would be required to resolve these disputes, Trinity desires to resolve this matter by entering into this Order and does not contest that as a result of this investigation the Insurance Commissioner has cause to believe that Trinity's activities in Washington violated RCW 48.05.030(1) and RCW 48.15.020(1).

CONSENT TO ORDER:

The Insurance Commissioner of the state of Washington and Trinity agree the best interest of the public will be served by entering into this Order. NOW, THEREFORE, Trinity consents to the following in consideration of its desire to resolve this matter without further administrative or judicial proceedings. The Insurance Commissioner consents to settle this matter in consideration of Trinity's payment of a fine, and upon such terms and conditions as are set forth below:

1. Trinity acknowledges its duty to comply fully with the applicable laws of the state of Washington.

2. Trinity consents to the entry of this Order, waives any and all hearing or other procedural rights, and further administrative or judicial challenges to this Order.

3. By agreement of the parties, the Insurance Commissioner will impose a fine of One Hundred Fifty Thousand Dollars ($150,000.00) to be paid by **December 27, 2019**.

4. By agreement of the parties, Trinity will not solicit state of Washington residents to enroll in its HCSM Sharing Programs. Additionally, within ten (10) days of the entry of this Order, Trinity will notify all state of Washington residents who were enrolled in Trinity HCSM Sharing Programs prior to May 13, 2019, that Trinity will no longer be offering its Sharing Programs in the state of Washington. Trinity may continue to facilitate sharing among current state of Washington Trinity members for one (1) year after the entry of this Order such that members have sufficient time to find alternative options.

5. Trinity understands and agrees that any further findings that Trinity has failed to comply with the statutes and/or regulations that are the subject of this Order constitute grounds for further penalties, which may be imposed in direct response to further violations.

6. This Order and the violations set forth herein constitute admissible evidence that may be considered in any future action by the Washington Insurance Commissioner involving Trinity.

7. This Order is based solely on the application of the Washington State insurance code to the specific facts of the Insurance Commissioner's investigation in this case. Trinity and the Washington Insurance Commissioner are the only parties to this Order. Therefore, this Order, and any provision, findings, or conclusions contained herein, do not, and is not intended to, determine any factual or legal issue in any other jurisdiction, or have any preclusive or collateral estoppel effects in any lawsuit or action by any person or party other than the Washington State Insurance Commissioner.

EXECUTED this 20th day of December, 2019.

TRINITY HEALTHSHARE, INC.

By: William H. Thead III

Printed Name: William H. Thead III

Printed Corporate Title: Chairman

AGREED ORDER:

Pursuant to the foregoing factual Basis and Consent to Order, the Insurance Commissioner of the state of Washington hereby Orders as follows:

1. Trinity shall pay a fine in the amount of One Hundred Fifty Thousand Dollars ($150,000.00), receipt of which is hereby acknowledged by the Insurance Commissioner.

2. Trinity will not solicit state of Washington residents to enroll in its HCSM Sharing Programs. Additionally, within ten (10) days of the entry of this Order, Trinity will notify all state of Washington residents who were enrolled in Trinity HCSM Sharing Programs prior to May 13, 2019, that Trinity will no longer be offering its Sharing Programs in the state of Washington. Trinity may continue to facilitate sharing among current state of Washington Trinity members for one (1) year after the entry of this Order such that members have sufficient time to find alternative options.

3. This Order is based solely on the application of the Washington State insurance code to the specific facts of the Insurance Commissioner's investigation in this case. Trinity and the Washington Insurance Commissioner are the only parties to this Order. Therefore, this Order, and any provision, findings, or conclusions contained herein, do not, and is not intended to, determine any factual or legal issue in any other jurisdiction, or have any preclusive or collateral estoppel effects in any lawsuit or action by any person or party other than the Washington State Insurance Commissioner.

ENTERED at Tumwater, Washington, this 30TH day of DECEMBER 2019.

Mike Kreidler

MIKE KREIDLER
Insurance Commissioner

By and through his designee

Kimberly Tocco

KIMBERLY TOCCO
Insurance Enforcement Specialist
Legal Affairs Division

APPENDIX K

STATE OF NEW HAMPSHIRE
INSURANCE DEPARTMENT

In re: Aliera Healthcare, Inc. (dba The Aliera Companies, Inc.)
& Trinity Healthshare Inc.

Docket No.: INS No. 19-027-EP

CEASE AND DESIST ORDER

The Commissioner of the New Hampshire Insurance Department ("NHID"), pursuant to his authority under RSA 400-A:3, orders the Respondents Aliera Healthcare, Inc. and Trinity Healthshare Inc. to immediately Cease and Desist from engaging in the unlicensed business of insurance; administering health insurance plans without being certified as a third party administrator; falsely holding out products as exempt from insurance regulation in New Hampshire; and misleading New Hampshire consumers by offering, marketing and administering health coverage that does not meet state and federal requirements.

In support this Order to Cease & Desist, the NHID states as follows:

Factual Allegations

1. Respondent Aliera Healthcare, Inc. ("Aliera") is a foreign, for-profit corporation organized under the laws of Delaware with a business address of 5901-B Atlanta, Peachtree Dunwoody Rd. #200, Atlanta, GA 30328.

2. Aliera is a non-resident business entity insurance producer (NPN # 18501490) that is licensed to sell Life, Accident and Health insurance products. Aliera holds no appointments in New Hampshire.

3. Aliera is not licensed as an insurance company and, other than its insurance producer license, holds no licenses, certificates, or other approvals to engage in the business of insurance in New Hampshire.

4. Aliera does not hold a certificate of authority to act as a Third Party Administrator ("TPA") in New Hampshire.

5. Aliera markets and administers health plans in New Hampshire on behalf of Respondent Trinity Healthshare ("Trinity"). Prior to August 10, 2018 Aliera marketed and administered health plans on behalf of Unity Health Share ("Unity.") This relationship ended when Unity terminated its agreement with Aliera on August 10, 2018.

6. Trinity was created in Delaware on June 27, 2018 by Aliera and its principals.

7. Trinity holds no licenses, certificates, or other approvals to engage in the business of insurance in New Hampshire.

8. Trinity claims to be Health Care Sharing Ministry ("HCSM") that is exempt from insurance regulation in New Hampshire under RSA 126-V. Like a health insurance company, Trinity collects fixed monthly payments from its members, payments that vary according to the level of coverage and conducts medical underwriting to screen for pre-existing conditions. There is also a schedule of covered and excluded services, a schedule of copayments and deductibles, a claim adjudication process, use of provider networks and annual or lifetime limits.

9. August 13, 2018 Aliera and Trinity entered into a Marketing and Administration Agreement. Under this agreement Aliera is the program manager for Trinity's health care sharing ministry plans, responsible for the development of plan designs, pricing, marketing, vendor management, recruitment and maintenance of the a national sales force and accounting and management of sales commissions on behalf of the ministry.

10. Aliera has the exclusive right to design market and sell HCSM plans to its existing members and prospective members.

11. Per the agreement, Aliera also maintains ownership of the "Membership Roster" of all Trinity enrollees.

12. Aliera markets Trinity HCSM products as alternatives to traditional health insurance to New Hampshire consumers and utilizes licensed resident insurance producers to sell Trinity's products within the state.

13. Aliera has made false and misleading claims to New Hampshire consumers concerning the Aliera and Trinity products it markets and administers.

14. Aliera and Trinity are currently the subject of administrative actions in Texas, Washington and Colorado.

Applicable New Hampshire Laws

15. Per NH RSA 405:1, no foreign insurance company shall engage in the insurance business in New Hampshire unless it has first obtained a license to do so.

16. The following acts, when done on behalf of an unlicensed insurer, are deemed to constitute the transaction or doing of insurance business in this state:

a. The making of or proposing to make an insurance contract;
b. The taking or receiving of any application for insurance;
c. The receiving or collection of any premium, commission, membership fees, assessments, dues or other consideration for any insurance;
d. The issuance or delivery of contracts or certificates of insurance to residents of this state;
e. Directly or indirectly acting as an agent for or otherwise representing or aiding another person or insurer in the solicitation, negotiation, procurement, or effectuation of insurance or renewals thereof, or in the dissemination of information as to coverage or rates, or forwarding of applications, or delivery of policies or contracts, or inspection of risks, a fixing of rates or investigation or adjustment of claims or losses or in the transaction of matters subsequent to effectuation of the contract and arising out of it, or in any other manner representing or assisting a person or insurer in the transaction of insurance with respect to subjects of insurance resident, located or to be performed in this state; or
f. Doing any kind of insurance business specifically recognized as constituting the doing of an insurance business within the meaning of the insurance statutes. RSA 406-B:2.

17. New Hampshire law exempts health care sharing organizations from insurance regulation if they meet the requirements of RSA 126-V:1.

18. To qualify for the exemption from insurance regulation under RSA 126-V:1, II, a health care sharing organization must meet all of the following criteria:

a. Be a nonprofit organization that is tax-exempt pursuant to section 501(c)(3) of the Internal Revenue Code;
b. Have been in existence continuously and have facilitated the sharing of medical expenses of participants without interruption since December 31, 1999, including predecessor organizations;
c. Be faith-based and limit its participants to individuals who share a common set of ethical or religious beliefs; and
d. Share medical expenses among its participants in accordance with those beliefs.

19. Qualifying organizations are subject to other requirements, including providing a notice to consumers warning that the organizations do not offer insurance and are not regulated by the NHID. RSA 126-V:1, III(g). Providing the notice to consumers is not sufficient to qualify an organization for the exemption if the requirements of RSA 126-V:1, II are not also met.

20. Under Title XXXVII, as well as applicable federal requirements, health insurance coverage in New Hampshire is subject to numerous requirements including prior form and rate approval, coverage requirements for specified services, and limitations on medical underwriting and preexisting condition exclusions.

21. Under New Hampshire's Managed Care Law, RSA Chapter 420-J, network-based health insurance is subject to numerous requirements designed to protect members, including grievances and appeals procedures, network adequacy requirements, and the obligation to protect members from balance billing by providers.

22. Under New Hampshire law, "administrator" or "third party administrator" or "TPA" is defined as "a person who directly or indirectly underwrites, collects charges or premiums from, or adjusts or settles claims on residents of this state, in connection with life, annuity, or health coverage or workers' compensation insurance . . ." RSA 402-H:1, I. "Underwrites or Underwriting" is further defined, though not limited to, accepting employer or individual applications in accordance with the written rules of the insurer or self-funded plan for the overall planning and coordinating of a benefits program. RSA 402-H:1, XIII.

23. New Hampshire law provides that "[n]o person shall act as, or offer to act as, or hold himself or herself out to be an administrator in this state without a valid certificate of authority as an administrator issued by the commissioner." RSA 402-H:11.

Legal Allegations/Violations

24. Trinity cannot meet the exemption requirements of RSA 126-V:1, II, specifically in that it has not been in existence continuously and have facilitated the sharing of medical expenses of participants without interruption since December 31, 1999. Trinity had no members as of August 13, 2018 when it signed the Management and Administrative Agreement with Aliera.

25. Trinity also fails to establish that it is faith based and limits its membership to individuals who share a common set of ethical or religious beliefs. Trinity's bylaws indicate that the organization adheres to a Christian expression of faith; however, its applications and policy documents only ask participants to believe in nonsectarian religious views. This statement of faith is inconsistent with the religious views purportedly held by Trinity.

26. Further, Aliera also offers Trinity HCSM plans, not only to individuals, but also to employer groups. This is inconsistent with RSA 126-V:1 II, which limits participation in HCSM to individuals.

27. As Trinity does not meet the required elements to designate it as a HCSM under RSA 126-V, it is operating as an unlicensed insurance company in violation of RSA 406-B:3 and RSA 405:1.

28. Based on the conduct described herein, Aliera, through its arrangement with Trinity, is engaging in the "insurance business," as defined by RSA 406-B:2, by acting as an

unlicensed insurance company in New Hampshire without the proper license or authorization in violation of RSA 406-B:3 and RSA 405:1.

29. Alternatively, Aliera, by directly or indirectly underwriting, collecting charges or premiums from, and adjusting and settling claims on behalf New Hampshire residents in connection with Trinity, is operating as a unlicensed Third Party Administrator for a health insurance company within the meaning of RSA 402-H.

30. Aliera does not qualify for any exemption from the requirement to be certified as a TPA in New Hampshire under RSA 402-H. Aliera marketing and administration activities with respect to Trinity health plans go beyond the sale of these plans as a producer, and Aliera is not authorized to transact insurance in New Hampshire, nor is Aliera a subsidiary or affiliated corporation of a licensed insurer.

31. Aliera is operating as an unlicensed TPA in violation of RSA 402-H.

32. Based upon the information and allegations recited above, the New Hampshire Commissioner of Insurance hereby ORDERS that Trinity and Aliera immediately CEASE AND DESIST from writing any new coverage or renewing any coverage for New Hampshire insurance consumers.

33. Pursuant to RSA 400-A:17, the Respondents may request a hearing regarding this Order by filing a written application for hearing with the Commissioner within 30 (thirty) days of the date the Respondents either knew or should have known of the issuance of this Order.

SO ORDERED

NEW HAMPSHIRE
INSURANCE DEPARTMENT

Date: 10/30/19

John Elias, Commissioner

CERTIFICATION OF SERVICE

I certify that the a copy of the foregoing Cease and Desist Order has been served upon the above-captioned Respondents by United States first class mail, postage prepaid. Said Order was mailed to the Aliera Healthcare Inc. 5901 Peachtree Dunwoody Rd. Ste B-200, Atlanta GA, 30328 and Trinity Healthshare Inc. 5901 Peachtree Dunwoody Rd. Ste C-160, Atlanta, GA 30328

Date: 10/30/2019

M. B

Mary C. Bleier, Esq.

APPENDIX L

FOR IMMEDIATE RELEASE: May 14, 2019

Contact: Eireann Aspell Sibley, communications director, (603) 271-3781, eireann.sibley@ins.nh.gov

Consumer Alert on Potential Unlicensed Health Insurance Company

CONCORD, NH – As a result of a recent Georgia court order, the New Hampshire Insurance Department is advising consumers that Aliera, a company that markets itself as a health care sharing ministry, may be operating illegally in New Hampshire.

In the past, Aliera acted as a plan administrator to Unity Healthshare, which is a qualified health care sharing ministry. In a recent letter, Unity Healthshare members were notified about a pending legal action in the Superior Court of Fulton County, Georgia between Aliera and Unity Healthshare. It includes a court order which made findings about Aliera, Unity, and certain individuals involved with Aliera's operations.

The Georgia court found that "the evidence shows that Aliera has taken actions to misappropriate [Unity's] assets; namely by unilaterally attempting to transition the Unity HCSM plans to Trinity." The court also found that the company misrepresented itself to state insurance regulators, and that "Timothy Moses, who exercises substantial control over Aliera, was convicted of felony securities fraud and perjury in federal court."

The court also found that Aliera is a for-profit company and cannot qualify as a health care sharing ministry under state or federal law. The Insurance Department is concerned about potential fraudulent or criminal activity on the part of Aliera. Since the company may be an illegitimate health care sharing ministry, consumers should be aware that if they remain in an Aliera product, they may be covered by an unlicensed insurance company.

Unity Healthshare, now known as OneShare Health, was authorized by the court to reach out to Unity members about their options, and consumers who have purchased a Unity/Aliera product should be aware that they may be receiving this communication.

"I urge consumers to proceed with caution when purchasing health coverage options outside of Affordable Care Act compliant plans. It is critical to review all of your plan documents and ask questions of your insurance agent to ensure the coverage is right for you," said Insurance Commissioner John Elias. "If you are ever unsure about an insurance company or an agent you are working with, stop before signing any paperwork and call the Insurance Department to confirm the company or agent offering the coverage is legitimate and licensed in the state."

A few health care sharing ministries (also known as health care sharing organizations) operate in New Hampshire. These organizations do not offer health insurance, but may present plans in a way that looks and feels similar to a health insurance plan. Members of these organizations "share" health costs on a voluntary basis. Consumers should be aware that these plans have no obligation to pay for any medical services and have no requirement to cover any particular categories of health care services, such as preventative care. In New Hampshire, some health care sharing ministries are exempt from insurance

regulation due to state law. However, if an organization does not meet the standard for an exemption under state law (for instance, if it is a for-profit company), it may be operating as an unlicensed insurance company. More information about health care sharing ministries can be found on the Department's website.

If a consumer has questions or concerns about a health coverage option they should contact the Department, especially if (1) the plan is presented as "ACA compliant" but it is not listed on HealthCare.gov; (2) if the plan seems like a deal that is "too good to be true;" and/or (3) if the plan is presented as exempt from Department oversight, but does not appear to meet health care sharing ministry exemption criteria.

The New Hampshire Insurance Department Can Help:

The New Hampshire Insurance Department's mission is to promote and protect the public good by ensuring the existence of a safe and competitive insurance marketplace through the development and enforcement of the insurance laws of the State of New Hampshire. Contact us with any questions or concerns you may have regarding your insurance coverage at 1-800- 852-3416 or (603) 271-2261, or by email at consumerservices@ins.nh.gov. For more information, visit www.nh.gov/insurance.

APPENDIX M

ALIERA HEALTHCARE

1/7/2019

Aliera Healthcare
5901 Peachtree Dunwoody Rd.
Building B, Suite 200
Atlanta, GA 30328

Re: Ellen Larson
DOB: [redacted]
Member ID: [redacted]

Ellen Larson
[redacted]
Colorado Springs, CO [redacted]

To Whom This May Concern,

Aliera Healthcare, LLC is in receipt of your appeal regarding our determination of eligibility for your sharing request in the amounts of $6,510.12 for the date of service 7/3/2018.

Following a review of the medical services provided, Aliera Healthcare has **APPROVED** your appeal and will process your request for sharing.

If you have immediate questions regarding this appeal decision, please phone us at (404) 618-0602.

Any additional information about the offered sharing plans that are available from Aliera Healthcare, Inc. can be found at www.alierahealthcare.com.

Sincerely,

Aliera Healthcare – Claims Dept.

ALIERA™ HEALTHCARE

Ellen Larson
[redacted]
Colorado Springs, CO [redacted]

Aliera Healthcare Inc.
5901 Peachtree Dunwoody Rd., Suite B-200, Atlanta, GA 30328

844-834-3456 Toll Free | 404-618-0602 Direct
www.alierahealthcare.com

APPENDIX N

ALIERA™ HEALTHCARE

02/11/2019

Aliera Healthcare
5901 Peachtree Dunwoody Rd.
Building B. Suite 200
Atlanta, GA 30328

Re: Ellen Larson
DOB: [redacted]
Member ID: [redacted]

Ellen Larson
[redacted]
Colorado Springs, CO[redacted]

To Whom This May Concern,

Aliera Healthcare, LLC is in receipt of your appeal regarding our determination of eligibility for your sharing request in the amount of $54,688.58 for the date of service 08/04/2018.

Following a review of the medical services provided, Aliera has determined that your appeal is denied for the following reason:

- ☐ Not a life-threatening emergency.
- ☐ The services are not eligible for sharing under the Aliera Master Guidelines.
- ☐ The claim was processed correctly with the billing code that was provided.
- ☐ The services were provided by an out of network provider or facility and are not eligible for sharing under the Aliera Master Guidelines.
- ☒ Medical condition is self-inflicted in contradiction to elements of a healthy and spiritual lifestyle as enumerated in the Aliera Master Guidelines as follows:

1. Refrain from tobacco use in any form.
2. Follow spiritual teachings on the use or abuse of alcohol.
3. Avoid abuse of prescription drugs, which means consuming prescription medications in a manner not intended by the prescriber that would likely result in bodily harm or dependency.
4. Abstain from the use of illegal drugs including, without limitation, any hallucinogenic substance, barbiturates, amphetamines, cocaine, heroin or other opiates, marijuana, illegal intravenous drugs, or narcotics.
5. Exercise regularly and eat healthy foods that do not harm the body.

If you are in possession of documentation that refutes our findings, we will gladly take that information into account. Please mail copies of supporting documentation to:

Aliera Healthcare, LLC
5901 Peachtree Dunwoody Rd. Suite C 160
Atlanta, GA 30328

If you have immediate questions regarding this appeal decision, please phone us at (404) 618 0602.

You are also welcome to email your documentation to our Administrator, Aliera Healthcare, Inc at Claimsaccess@alierahealthcare.com, or you can fax them to (404) 420 5750. Please clearly indicate that you are submitting documents for consideration of your appeal request.

If you have no additional documentation to submit, and the medical expense is creating a true financial hardship, please contact us at (800) 847-9794 to request a hardship request form. If Aliera determines that you have a true financial hardship, your request will be considered for sharing.

Additional information about the Aliera health care sharing ministry plans can be found at www.Alierahealthcare.com

Sincerely,

Aliera Healthcare – *Claims Dept.*

ALIERA™ HEALTHCARE

Ellen Larson
[redacted]
Colorado Springs, CO [redacted]

Aliera Healthcare Inc.
5901 Peachtree Dunwoody Rd., Suite B-200, Atlanta, GA 30328

844-834-3456 Toll Free | 404-618-0602 Direct
www.alierahealthcare.com

AO 440 (Rev. 06/12) Summons in a Civil Action

UNITED STATES DISTRICT COURT

for the

District of Colorado

ELLEN LARSON, individually and on behalf of all others similarly situated,

Plaintiff(s)

v.

THE ALIERA COMPANIES, INC., a Delaware corporation; ALIERA HEALTHCARE, INC., a Delaware corporation; TRINITY HEALTHSHARE CORPORATION, a Delaware corporation,

Defendant(s)

Civil Action No.

SUMMONS IN A CIVIL ACTION

To: *(Defendant's name and address)*

THE ALIERA COMPANIES, INC.
c/o The Corporation Trust Company, its registered agent Corporation Trust Center
1209 Orange St.
Wilmington, DE 19801
302-658-7581

A lawsuit has been filed against you.

Within 21 days after service of this summons on you (not counting the day you received it) — or 60 days if you are the United States or a United States agency, or an officer or employee of the United States described in Fed. R. Civ. P. 12 (a)(2) or (3) — you must serve on the plaintiff an answer to the attached complaint or a motion under Rule 12 of the Federal Rules of Civil Procedure. The answer or motion must be served on the plaintiff or plaintiff's attorney, whose name and address are:

Michael David Myers
MYERS & COMPANY PLLC
1530 Eastlake Avenue East
Seattle, WA 98102
Tel. (206) 398-1188
Email: mmyers@myers-company.com

If you fail to respond, judgment by default will be entered against you for the relief demanded in the complaint. You also must file your answer or motion with the court.

CLERK OF COURT

Date: _____

_____
Signature of Clerk or Deputy Clerk

Civil Action No.

PROOF OF SERVICE

(This section should not be filed with the court unless required by Fed. R. Civ. P. 4 (l))

This summons for *(name of individual and title, if any)* _____ was received by me on *(date)* _____ .

❒ I personally served the summons on the individual at *(place)* _____ on *(date)* _____ ; or

❒ I left the summons at the individual's residence or usual place of abode with *(name)* _____ , a person of suitable age and discretion who resides there, on *(date)* _____ , and mailed a copy to the individual's last known address; or

❒ I served the summons on *(name of individual)* _____ , who is designated by law to accept service of process on behalf of *(name of organization)* _____ on *(date)* _____ ; or

❒ I returned the summons unexecuted because _____ ; or

❒ Other *(specify):*

My fees are $ _____ for travel and $ _____ for services, for a total of $ 0.00 .

I declare under penalty of perjury that this information is true.

Date: _____

_____
Server's signature

_____
Printed name and title

_____
Server's address

Additional information regarding attempted service, etc:

AO 440 (Rev. 06/12) Summons in a Civil Action

UNITED STATES DISTRICT COURT

for the

District of Colorado

ELLEN LARSON, individually and on behalf of all others similarly situated,

Plaintiff(s)

v.

THE ALIERA COMPANIES, INC., a Delaware corporation; ALIERA HEALTHCARE, INC., a Delaware corporation; TRINITY HEALTHSHARE CORPORATION, a Delaware corporation,

Defendant(s)

Civil Action No.

SUMMONS IN A CIVIL ACTION

To: *(Defendant's name and address)*

ALIERA HEALTHCARE, INC.
c/o INCFILE.COM, its registered agent
2035 Sunset Lake Road, Suite B-2
Newark, DE 19702
888-462-3453

A lawsuit has been filed against you.

Within 21 days after service of this summons on you (not counting the day you received it) — or 60 days if you are the United States or a United States agency, or an officer or employee of the United States described in Fed. R. Civ. P. 12 (a)(2) or (3) — you must serve on the plaintiff an answer to the attached complaint or a motion under Rule 12 of the Federal Rules of Civil Procedure. The answer or motion must be served on the plaintiff or plaintiff's attorney, whose name and address are:

Michael David Myers
MYERS & COMPANY PLLC
1530 Eastlake Avenue East
Seattle, WA 98102
Tel. (206) 398-1188
Email: mmyers@myers-company.com

If you fail to respond, judgment by default will be entered against you for the relief demanded in the complaint. You also must file your answer or motion with the court.

CLERK OF COURT

Date: _____

_____
Signature of Clerk or Deputy Clerk

Civil Action No.

PROOF OF SERVICE

(This section should not be filed with the court unless required by Fed. R. Civ. P. 4 (l))

This summons for *(name of individual and title, if any)* _____ was received by me on *(date)* _____ .

❒ I personally served the summons on the individual at *(place)* _____ on *(date)* _____ ; or

❒ I left the summons at the individual's residence or usual place of abode with *(name)* _____ , a person of suitable age and discretion who resides there, on *(date)* _____ , and mailed a copy to the individual's last known address; or

❒ I served the summons on *(name of individual)* _____ , who is designated by law to accept service of process on behalf of *(name of organization)* _____ on *(date)* _____ ; or

❒ I returned the summons unexecuted because _____ ; or

❒ Other *(specify):*

My fees are $ _____ for travel and $ _____ for services, for a total of $ 0.00 .

I declare under penalty of perjury that this information is true.

Date: _____

_____
Server's signature

_____
Printed name and title

_____
Server's address

Additional information regarding attempted service, etc:

AO 440 (Rev. 06/12) Summons in a Civil Action

UNITED STATES DISTRICT COURT

for the

District of Colorado

ELLEN LARSON, individually and on behalf of all others similarly situated,

Plaintiff(s)

v.

THE ALIERA COMPANIES, INC., a Delaware corporation; ALIERA HEALTHCARE, INC., a Delaware corporation; TRINITY HEALTHSHARE CORPORATION, a Delaware corporation,

Defendant(s)

Civil Action No.

SUMMONS IN A CIVIL ACTION

To: *(Defendant's name and address)*

TRINITY HEALTHSHARE, INC.
c/o The Corporation Trust Company, its registered agent
Corporation Trust Center
1209 Orange St.
Wilmington, DE 19801
302-658-7581

A lawsuit has been filed against you.

Within 21 days after service of this summons on you (not counting the day you received it) — or 60 days if you are the United States or a United States agency, or an officer or employee of the United States described in Fed. R. Civ. P. 12 (a)(2) or (3) — you must serve on the plaintiff an answer to the attached complaint or a motion under Rule 12 of the Federal Rules of Civil Procedure. The answer or motion must be served on the plaintiff or plaintiff's attorney, whose name and address are:

Michael David Myers
MYERS & COMPANY PLLC
1530 Eastlake Avenue East
Seattle, WA 98102
Tel. (206) 398-1188
Email: mmyers@myers-company.com

If you fail to respond, judgment by default will be entered against you for the relief demanded in the complaint. You also must file your answer or motion with the court.

CLERK OF COURT

Date: _____

_____
Signature of Clerk or Deputy Clerk

Civil Action No.

PROOF OF SERVICE

(This section should not be filed with the court unless required by Fed. R. Civ. P. 4 (l))

This summons for *(name of individual and title, if any)* _____ was received by me on *(date)* _____ .

❒ I personally served the summons on the individual at *(place)* _____ on *(date)* _____ ; or

❒ I left the summons at the individual's residence or usual place of abode with *(name)* _____ , a person of suitable age and discretion who resides there, on *(date)* _____ , and mailed a copy to the individual's last known address; or

❒ I served the summons on *(name of individual)* _____ , who is designated by law to accept service of process on behalf of *(name of organization)* _____ on *(date)* _____ ; or

❒ I returned the summons unexecuted because _____ ; or

❒ Other *(specify):*

My fees are $ _____ for travel and $ _____ for services, for a total of $ 0.00 .

I declare under penalty of perjury that this information is true.

Date: _____

_____
Server's signature

_____
Printed name and title

_____
Server's address

Additional information regarding attempted service, etc:

JS 44 (Rev. 06/17) District of Colorado

CIVIL COVER SHEET

The JS 44 civil cover sheet and the information contained herein neither replace nor supplement the filing and service of pleadings or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. *(SEE INSTRUCTIONS ON NEXT PAGE OF THIS FORM.)*

I. (a) PLAINTIFFS

ELLEN LARSON, individually and on behalf of all others similarly situated,

(b) County of Residence of First Listed Plaintiff El Paso
(EXCEPT IN U.S. PLAINTIFF CASES)

(c) Attorneys *(Firm Name, Address, and Telephone Number)*
Michael David Myers, MYERS & COMPANY PLLC,
1530 Eastlake Avenue East, Seattle, WA 98102
Tel. (206) 398-1188, Email: mmyers@myers-company.com

DEFENDANTS

THE ALIERA COMPANIES, INC., a Delaware corporation;
ALIERA HEALTHCARE, INC., a Delaware corporation;
TRINITY HEALTHSHARE CORPORATION, a Delaware corporation

County of Residence of First Listed Defendant
(IN U.S. PLAINTIFF CASES ONLY)

NOTE: IN LAND CONDEMNATION CASES, USE THE LOCATION OF THE TRACT OF LAND INVOLVED.

Attorneys *(If Known)*

II. BASIS OF JURISDICTION *(Place an "X" in One Box Only)*

- ❒ 1 U.S. Government Plaintiff
- ❒ 3 Federal Question *(U.S. Government Not a Party)*
- ❒ 2 U.S. Government Defendant
- ☒ 4 Diversity *(Indicate Citizenship of Parties in Item III)*

III. CITIZENSHIP OF PRINCIPAL PARTIES *(Place an "X" in One Box for Plaintiff and One Box for Defendant)*

(For Diversity Cases Only)

	PTF	DEF		PTF	DEF
Citizen of This State	☒ 1	❒ 1	Incorporated *or* Principal Place of Business In This State	❒ 4	❒ 4
Citizen of Another State	❒ 2	❒ 2	Incorporated *and* Principal Place of Business In Another State	❒ 5	☒ 5
Citizen or Subject of a Foreign Country	❒ 3	❒ 3	Foreign Nation	❒ 6	❒ 6

IV. NATURE OF SUIT *(Place an "X" in One Box Only)*

Click here for: Nature of Suit Code Descriptions.

CONTRACT	TORTS		FORFEITURE/PENALTY	BANKRUPTCY	OTHER STATUTES
☒ 110 Insurance	PERSONAL INJURY	PERSONAL INJURY	❒ 625 Drug Related Seizure of Property 21 USC 881	❒ 422 Appeal 28 USC 158	❒ 375 False Claims Act
❒ 120 Marine	❒ 310 Airplane	❒ 365 Personal Injury - Product Liability	❒ 690 Other	❒ 423 Withdrawal 28 USC 157	❒ 376 Qui Tam (31 USC 3729(a))
❒ 130 Miller Act	❒ 315 Airplane Product Liability	❒ 367 Health Care/ Pharmaceutical Personal Injury Product Liability		PROPERTY RIGHTS	❒ 400 State Reapportionment
❒ 140 Negotiable Instrument	❒ 320 Assault, Libel & Slander	❒ 368 Asbestos Personal Injury Product Liability		❒ 820 Copyrights	❒ 410 Antitrust
❒ 150 Recovery of Overpayment & Enforcement of Judgment	❒ 330 Federal Employers' Liability	PERSONAL PROPERTY	LABOR	❒ 830 Patent	❒ 430 Banks and Banking
❒ 151 Medicare Act	❒ 340 Marine	❒ 370 Other Fraud	❒ 710 Fair Labor Standards Act	❒ 835 Patent - Abbreviated New Drug Application	❒ 450 Commerce
❒ 152 Recovery of Defaulted Student Loans (Excludes Veterans)	❒ 345 Marine Product Liability	❒ 371 Truth in Lending	❒ 720 Labor/Management Relations	❒ 840 Trademark	❒ 460 Deportation
❒ 153 Recovery of Overpayment of Veteran's Benefits	❒ 350 Motor Vehicle	❒ 380 Other Personal Property Damage	❒ 740 Railway Labor Act	SOCIAL SECURITY	❒ 470 Racketeer Influenced and Corrupt Organizations
❒ 160 Stockholders' Suits	❒ 355 Motor Vehicle Product Liability	❒ 385 Property Damage Product Liability	❒ 751 Family and Medical Leave Act	❒ 861 HIA (1395ff)	❒ 480 Consumer Credit
❒ 190 Other Contract	❒ 360 Other Personal Injury		❒ 790 Other Labor Litigation	❒ 862 Black Lung (923)	❒ 490 Cable/Sat TV
❒ 195 Contract Product Liability	❒ 362 Personal Injury - Medical Malpractice		❒ 791 Employee Retirement Income Security Act	❒ 863 DIWC/DIWW (405(g))	❒ 850 Securities/Commodities/ Exchange
❒ 196 Franchise				❒ 864 SSID Title XVI	❒ 890 Other Statutory Actions
				❒ 865 RSI (405(g))	❒ 891 Agricultural Acts
					❒ 893 Environmental Matters
					❒ 895 Freedom of Information Act
REAL PROPERTY	CIVIL RIGHTS	PRISONER PETITIONS	IMMIGRATION	FEDERAL TAX SUITS	❒ 896 Arbitration
❒ 210 Land Condemnation	❒ 440 Other Civil Rights	Habeas Corpus:	❒ 462 Naturalization Application	❒ 870 Taxes (U.S. Plaintiff or Defendant)	❒ 899 Administrative Procedure Act/Review or Appeal of Agency Decision
❒ 220 Foreclosure	❒ 441 Voting	❒ 463 Alien Detainee	❒ 465 Other Immigration Actions	❒ 871 IRS—Third Party 26 USC 7609	❒ 950 Constitutionality of State Statutes
❒ 230 Rent Lease & Ejectment	❒ 442 Employment	❒ 510 Motions to Vacate Sentence			
❒ 240 Torts to Land	❒ 443 Housing/ Accommodations	❒ 530 General			
❒ 245 Tort Product Liability	❒ 445 Amer. w/Disabilities - Employment	❒ 535 Death Penalty			
❒ 290 All Other Real Property	❒ 446 Amer. w/Disabilities - Other	Other:			
	❒ 448 Education	❒ 540 Mandamus & Other			
		❒ 550 Civil Rights			
		❒ 555 Prison Condition			
		❒ 560 Civil Detainee - Conditions of Confinement			

V. ORIGIN *(Place an "X" in One Box Only)*

☒ 1 Original Proceeding ❒ 2 Removed from State Court ❒ 3 Remanded from Appellate Court ❒ 4 Reinstated or Reopened ❒ 5 Transferred from Another District *(specify)* ❒ 6 Multidistrict Litigation - Transfer ❒ 8 Multidistrict Litigation - Direct File

VI. CAUSE OF ACTION

Cite the U.S. Civil Statute under which you are filing ***(Do not cite jurisdictional statutes unless diversity)***:
28 U.S.C. § 1332(a) and § 1367

Brief description of cause:
Lawsuit over sale of illegal insurance contracts and CPA violations

❒ AP Docket

VII. REQUESTED IN COMPLAINT:

☒ CHECK IF THIS IS A **CLASS ACTION** UNDER RULE 23, F.R.Cv.P.

DEMAND $ Over $75,000

CHECK YES only if demanded in complaint:
JURY DEMAND: ❒ Yes ☒ No

VIII. RELATED CASE(S) IF ANY

(See instructions):
JUDGE _____ DOCKET NUMBER _____

DATE 1/13/2020

SIGNATURE OF ATTORNEY OF RECORD /s/ Michael David Myers

FOR OFFICE USE ONLY

RECEIPT # _____ AMOUNT _____ APPLYING IFP _____ JUDGE _____ MAG. JUDGE _____

INSTRUCTIONS FOR ATTORNEYS COMPLETING CIVIL COVER SHEET FORM JS 44

Authority For Civil Cover Sheet

The JS 44 civil cover sheet and the information contained herein neither replaces nor supplements the filings and service of pleading or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. Consequently, a civil cover sheet is submitted to the Clerk of Court for each civil complaint filed. The attorney filing a case should complete the form as follows:

I.(a) **Plaintiffs-Defendants.** Enter names (last, first, middle initial) of plaintiff and defendant. If the plaintiff or defendant is a government agency, use only the full name or standard abbreviations. If the plaintiff or defendant is an official within a government agency, identify first the agency and then the official, giving both name and title.

(b) **County of Residence.** For each civil case filed, except U.S. plaintiff cases, enter the name of the county where the first listed plaintiff resides at the time of filing. In U.S. plaintiff cases, enter the name of the county in which the first listed defendant resides at the time of filing. (NOTE: In land condemnation cases, the county of residence of the "defendant" is the location of the tract of land involved.)

(c) **Attorneys.** Enter the firm name, address, telephone number, and attorney of record. If there are several attorneys, list them on an attachment, noting in this section "(see attachment)".

II. **Jurisdiction.** The basis of jurisdiction is set forth under Rule 8(a), F.R.Cv.P., which requires that jurisdictions be shown in pleadings. Place an "X" in one of the boxes. If there is more than one basis of jurisdiction, precedence is given in the order shown below.
United States plaintiff. (1) Jurisdiction based on 28 U.S.C. 1345 and 1348. Suits by agencies and officers of the United States are included here.
United States defendant. (2) When the plaintiff is suing the United States, its officers or agencies, place an "X" in this box.
Federal question. (3) This refers to suits under 28 U.S.C. 1331, where jurisdiction arises under the Constitution of the United States, an amendment to the Constitution, an act of Congress or a treaty of the United States. In cases where the U.S. is a party, the U.S. plaintiff or defendant code takes precedence, and box 1 or 2 should be marked.
Diversity of citizenship. (4) This refers to suits under 28 U.S.C. 1332, where parties are citizens of different states. When Box 4 is checked, the citizenship of the different parties must be checked. (See Section III below**; NOTE: federal question actions take precedence over diversity cases.**)

III. **Residence (citizenship) of Principal Parties.** This section of the JS 44 is to be completed if diversity of citizenship was indicated above. Mark this section for each principal party.

IV. **Nature of Suit.** Place an "X" in the appropriate box. If there are multiple nature of suit codes associated with the case, pick the nature of suit code that is most applicable. Click here for: Nature of Suit Code Descriptions.

V. **Origin.** Place an "X" in one of the seven boxes.
Original Proceedings. (1) Cases which originate in the United States district courts.
Removed from State Court. (2) Proceedings initiated in state courts may be removed to the district courts under Title 28 U.S.C., Section 1441. When the petition for removal is granted, check this box.
Remanded from Appellate Court. (3) Check this box for cases remanded to the district court for further action. Use the date of remand as the filing date.
Reinstated or Reopened. (4) Check this box for cases reinstated or reopened in the district court. Use the reopening date as the filing date.
Transferred from Another District. (5) For cases transferred under Title 28 U.S.C. Section 1404(a). Do not use this for within district transfers or multidistrict litigation transfers.
Multidistrict Litigation – Transfer. (6) Check this box when a multidistrict case is transferred into the district under authority of Title 28 U.S.C. Section 1407.
Multidistrict Litigation – Direct File. (8) Check this box when a multidistrict case is filed in the same district as the Master MDL docket.
PLEASE NOTE THAT THERE IS NOT AN ORIGIN CODE 7. Origin Code 7 was used for historical records and is no longer relevant due to changes in statue.

VI. **Cause of Action.** Report the civil statute directly related to the cause of action and give a brief description of the cause. **Do not cite jurisdictional statutes unless diversity.** Example: U.S. Civil Statute: 47 USC 553 Brief Description: Unauthorized reception of cable service

VII. **Requested in Complaint.** Class Action. Place an "X" in this box if you are filing a class action under Rule 23, F.R.Cv.P.
Demand. In this space enter the actual dollar amount being demanded or indicate other demand, such as a preliminary injunction.
Jury Demand. Check the appropriate box to indicate whether or not a jury is being demanded.

VIII. **Related Cases.** This section of the JS 44 is used to reference related pending cases, if any. If there are related pending cases, insert the docket numbers and the corresponding judge names for such cases.

Date and Attorney Signature. Date and sign the civil cover sheet.