UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF MISSOURI
SOUTHERN DIVISION

GEORGE T. KELLY, III, and THOMAS BOOGHER, individually and on behalf of all others similarly situated, Plaintiffs, v. THE ALIERA COMPANIES, INC., formerly known as Aliera Healthcare, Inc., a Delaware corporation; and TRINITY HEALTHSHARE, INC., a Delaware corporation, Defendants.	Civil Action No. 3:20-CV-05038-MDH

PLAINTIFFS' SUGGESTIONS IN OPPOSITION TO DEFENDANTS' MOTION TO ALTER OR AMEND

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I. INTRODUCTION

The Court found Defendants' dispute resolution "agreement" unenforceable because it lacks offer, acceptance, and bargained for consideration. The Court did not make a mistake — let alone a "manifest error" warranting reconsideration. To be valid, an agreement to arbitrate must be the product of a conscious decision where both parties agree to use a specific set of rules to resolve disputes — a meeting of minds that did not occur here. It also must be fair to both parties and not otherwise prohibited by law. Defendants here seek to enforce arbitration clauses that do not meet any of these requirements. Defendants' motion repeats arguments the parties already briefed, and the Court already rejected. Indeed, the Defendants' motion makes the Court's conclusion even more inescapable. Defendants' latest bite at the apple should be denied.

II. LEGAL STANDARD

Rule 59(e) motions serve the limited function of correcting manifest errors of law or fact or to present newly discovered evidence. *Ryan v. Ryan*, 889 F.3d 499, 507 (8th Cir. 2018) (quoting *United States v. Metro. St. Louis Sewer Dist.*, 440 F.3d 930, 933 (8th Cir. 2006)). Such motions cannot be used to introduce new evidence, tender new legal theories, or raise arguments that could have been offered or raised before the entry of judgment. *Id*. Rule 59(e) motions are "not intended to routinely give litigants a second bite at the apple, but to afford an opportunity for relief in extraordinary circumstances." *Dale and Selby Superette & Deli v. U.S. Dept. of Agriculture*, 838 F. Supp. 1346, 1348 (D. Minn. 1993).

Defendants bear the burden of proving that a valid and enforceable agreement exists. *See*, *Shockley v. PrimeLending*, 929 F.3d 1012, 1017 (8th Cir. 2019). Moreover, where the parties dispute whether an arbitration agreement exists, the party moving to compel arbitration bears a

burden like what a movant for summary judgment faces. *Neb. Mach. Co. v. Cargotec Solutions, LLC*, 762 F.3d 737, 741 (8th Cir. 2014). If the moving party carries this burden, the burden shifts to the non-moving party to show a genuine issue of material fact. *E.g.*, *Prudential Ins. Co. v. Hinkel*, 121 F.3d 364, 366 (8th Cir. 1997). Courts should give the non-moving party the benefit of all reasonable doubts and inferences. *E.g.*, *id*; *Neb. Mach.*, 762 F.3d at 741. Most fundamentally, an arbitration agreement is unenforceable if it lacks offer, acceptance, and bargained-for consideration. *E.g.*, *Shockley*, 929 F.3d at 1017; *Campbell v. Adecco USA, Inc.*, 2016 U.S. Dist. LEXIS 76234, *3 (W.D. Mo. June 13, 2016). In determining whether a "positive and unambiguous acceptance has been effective," [t]he critical question . . . is whether the signals sent . . . objectively manifest [an] intent to be presently bound." *Shockley*, 929 F.3d at 1019. And "the general knowledge or awareness of the existence of a contract does not constitute the positive and unambiguous unequivocal acceptance required to form a contract." *Id*. Finally, "silence generally cannot be translated into acceptance." *Katz v. Anheuser-Busch*, 347 S.W. 3d 533, 545 (Mo. Ct. App. 2011).

III. ARGUMENT

The Court detailed the allegations, the facts, the parties' arguments, and the procedural background in its Order denying Defendants' motions to dismiss and stay. The information need not be repeated here. However, what is crucial to review is the Court's rationale for its finding that the agreement is unenforceable. It explained:

> [T]he documents signed by Plaintiffs . . . do not reference arbitration or contain an arbitration provision. . . . [I]t is only after a member has completed the online forms that "as part of the membership" Plaintiffs receive a copy of the Member Guide . . . There is no evidence Plaintiffs received, reviewed, or specifically acknowledged the specific terms of the Member Guide when they electronically signed the online forms to become

> a member. . . . At best, Plaintiffs acknowledge the Member Guide in the 15 page online application that repeatedly states the signed document "is not a contract." . . . In fact, Plaintiffs allege it was after they enrolled and made the initial payments that they received the Member Guide. . . Further after Plaintiffs enrolled online, Defendants inform the members that their membership packets will arrive within 10-14 business days after payment. . . . There is nothing in the record showing Plaintiff's signed, or even reviewed, the Member Guide upon their enrollment with Defendants. . . . Defendants fail to establish how there was a mutually accepted contract formed between the parties regarding the agreement to arbitrate. Defendants argue that Plaintiffs signed a document (that repeatedly states is not a contract) that provides the Member Guidelines would govern. However, there is no evidence Plaintiffs were actually provided the Member Guidelines until after they signed the online form.

Dkt. 62, pg. 9-10.

Defendants do not, because they cannot, dispute a single fact relied on by the Court. The crux of Defendants' motion is a repetition of their arguments that (i) Plaintiffs had notice of the arbitration provision because they each received the Member Guides before their respective enrollments' effective dates and (ii) manifested their assent by making monthly premium payments. Concerning consideration, Defendants posit that "while the Member Guides clearly disclose that Aliera and Trinity make no guarantee or contract to pay or indemnify Plaintiffs' medical expenses, they do contain various binding provisions." Defendants also suggest that factual disputes, if any, should be resolved by trial.

The Court already considered and rejected each of Defendants' arguments. Any new case law cited by Defendants is either inapposite, irrelevant, or non-controlling. Similarly, Defendants raise no new or disputed facts. Consistent with the high bar for Rule 59(e) motions, the Court should disregard theories, arguments, or evidence, if any, that could have been offered or raised by Defendants before it correctly denied their motions to dismiss and compel arbitration.

First, it is undisputed that members do not sign or even receive anything suggesting an agreement to arbitrate until ***after*** they have enrolled and made their first payment. Defendants

show no evidence that they disclosed the existence or the terms of any arbitration provision before Plaintiffs committed to purchasing their healthcare coverage. Nothing in Defendants' advertising materials or representations made to those considering purchasing the plans suggests the requisite offer and agreement. *See* Dkt. Nos. 30-4, 30-6. Nor did the enrollment forms signed by Plaintiffs suggest that they agreed to arbitrate disputes. Dkt. Nos. 38-2, 38-4, 38-6. Defendants now claim Plaintiffs agreed to undefined "guidelines" by signing the enrollment form. The terms set forth under the "Guidelines" or "Terms and Conditions" caption of the enrollment forms, however, say nothing about arbitration. Dkt. 38-2, p. 7; 38-4, pp. 3-4. It is undisputed that these enrollment forms did not provide any link to the "Member Guide" that contains the arbitration clause. As Defendants point out, the enrollment forms state that the "guidelines" that they claim Plaintiffs agreed to "are not a contract." Dkt. 38-2, at p. 4; Dkt. 38-4, at p. 4 ("I understand that the guidelines are not a contract . . . but instead are for [the HCSM's] reference . . ."). There is no basis for claiming that by signing these enrollment forms Plaintiffs were on notice of an enforceable contract to arbitrate that might be found in undisclosed "guidelines" that were described as "not a contract."

Second, Defendants' suggestion that "Plaintiffs had notice prior to the effective dates of their respective memberships that their applicable Member Guides contained dispute resolution provisions" is specious. Defendants provided access to the Member Guide through hyperlinks buried in the "welcome emails" sent to each Plaintiff only ***after*** they paid and enrolled. Dkt. 38-2, p.12; 38-4, p. 7. Plaintiff Kelly's "welcome email" arrived two weeks after he enrolled, and less than two days before the effective date of the plan. Dkt. 38-2, pp. 9, 10. The emails are grossly inadequate disclosures of any arbitration provision. They do not mention arbitration, and nothing in the emails suggests that the linked Member Guide would contain an arbitration agreement. *See, e.g.*, *Shockley*, 929 F.3d at 1017 (plaintiff did not agree to arbitrate merely by clicking on the online

employment handbook that contained the arbitration provisions).

Moreover, the emailed link is inconspicuous, difficult to find, and appears below the caption: "become familiar with the ***benefits*** of your membership." Dkt. 38-2, p.12; 38-4, p. 7. (emphasis added). After instructing each Plaintiff to consult the Member Guide for "everything you need to know regarding your healthcare plan," the email provides instructions on how to take advantage of the plans, including registering for telemedicine, activating the insurance card, and accessing the member portal. *Id*. Against that backdrop, Plaintiffs and putative class members could reasonably conclude that the Member Guide would provide details about the plan's benefits only and not a one-sided waiver of legal rights.

In addition, unlike "clickwrap agreement" cases where members are required to click a dialog box indicating "consent to terms and conditions" to proceed with a given transaction, nothing in Defendants' emails requires Plaintiffs to agree to the terms of the Member Guide. For example, in the *Margulis v. HomeAdvisor, Inc*. case cited by Defendants, the court found that the "conspicuous display" of a blue "Terms and Conditions" hyperlink directly beneath the button that users needed to click to proceed with the transaction coupled with the fact that the link was displayed on nearly every page of the HomeAdvisor website was sufficient to provide constructive notice of the arbitration agreement. *Margulis v. HomeAdvisor, Inc*., 2020 U.S. Dist. LEXIS 144699, *12-13 (E.D. Mo. Aug. 12, 2020).

Here, among other things, Defendants' inconspicuous link was buried in an email provided after Plaintiffs enrolled and made an initial payment. Defendants hid the ball even further by suggesting that members review the Member Guide to learn of the plans' "benefits" without indicating that the guide also included a waiver of legal rights. The emails also do not advise Plaintiffs to immediately terminate coverage if they disagree with the arbitration provision in the

back of the linked Member Guide. Nor do the emails suggest that Plaintiffs will be fully reimbursed if they choose to terminate. Despite the Defendants' best efforts to spin the facts in their favor, the emails do not evidence the "meeting of the minds" necessary for contract formation or that plaintiffs consented to arbitration when they paid and enrolled. *See, e.g., Baier v. Darden Restaurants*, 420 S.W.3d 733, 738 (Mo. App. 2014) ("[o]ffer and acceptance requires a mutual agreement [, which] is reached when 'the minds of the contracting parties meet upon and assent to the same thing in the same sense at the same time.") (quoting *Kunzie v. Jack-In-The-Box, Inc.*, 330 S.W.3d 476, 484 (Mo. Ct. App. 2010)); *Katz*, 347 S.W.3d at 545 (an acceptance of an offer to arbitrate is present when the offeree signifies assent to the terms of the offer in a "positive and unambiguous" manner; silence cannot be translated into acceptance); *Holley v. Bitesquad LLC,* 416 F. Supp. 3d 809, 812 (E.D. Ark. 2019) (requiring arbitration only where potential employee specifically signed and agreed to an "Arbitration Agreement"); *Kauders v. Uber Technologies, Inc*., 2021 Mass. LEXIS 1, *39 (Mass. Jan. 4, 2021) (tech company's arbitration agreement was unenforceable because its non-clickwrap registration process did not provide users with reasonable notice of the terms and conditions and did not obtain a clear manifestation of assent to the terms, both of which could have been easily achieved).

Shockley is instructive. The arbitration agreement in that case was in a handbook accessible to employees online. *Shockley*, 929 F.3d at 1016. Shockley, the employee, accessed the handbook a couple of times, and the system logged an acknowledgment of her review. *Id*. However, there was no other evidence to suggest that she ever opened or examined the handbook's full text. *Id*. The Eighth Circuit denied Defendants' motion to compel arbitration, reasoning that even if the

employer had made an offer to the employee, she never accepted it despite her continued employment and acknowledgement of review. *Id*. at 1019.[1]

Here, as the Court noted, "there is no evidence Plaintiffs received, reviewed, or specifically acknowledged the specific terms of the Member Guide when they electronically signed the online forms to become a member." Dkt. 62, p. 10. Nor is there evidence that the Plaintiffs clicked on the link buried in the welcome email or reviewed or specifically acknowledged its specific terms. If *Shockley*'s multiple acknowledgments of a review of offered terms and continued employment did not qualify as an assent, the Court did not make a "manifest error" when it determined that the undisputed facts here do not constitute an open and unambiguous manifestation of acceptance. *See also Esser v. Anheuser-Busch, LLC*, 567 S.W.3d 644, 651-52 (Mo. App. 2018) (the fact that arbitration agreement was mailed to plaintiff, posted on defendant's website, and explained in presentations generally was insufficient to establish by clear and unmistakable evidence that plaintiff agreed to arbitrate).

Third, payment of monthly premiums is not an "assent" to arbitration. Defendants claim that Plaintiffs "manifested their assent by paying their monthly membership fee." Dkt. 74, at 8. However, continued payment does not cure the lack of assent at contract formation. As explained above, the welcome emails sent to Plaintiffs after they enrolled and made their initial payments provided only a link to the Member Guide with no suggestion that it contained an arbitration clause. As noted, unlike clickwrap cases, the welcome emails also did not require Plaintiffs to confirm that they reviewed and agreed to the terms of the Member Guide. *Id*. at 812. Moreover,

[1]Defendant Aliera points to caselaw suggesting that the employment context is unique. *See* Dkt 58, pp 1-4. However, those cases are expressly about the consideration prong of contract given the unilateral dynamics of at-will employment. *E.g*., *Wilder v. John Youngblood Motors, Inc*., 534 S.W.3d 902, 908-09 (Mo. App. 2017). Plaintiffs cite to those cases for their analysis of the acceptance prong.

Plaintiffs were not given an opportunity to opt-out of the arbitration clause or a meaningful opportunity to be refunded fees. Under those circumstances, continued payment is far from a positive and unambiguous manifestation of assent. *See, e.g., Shockley,* 929 F.3d at 1016 (employee's mere review of the subject materials on her employer's network did not constitute an acceptance on her part despite continued employment, and without an acceptance, no contract was formed as to the delegation provision); *Katz,* 347 S.W.3d at 545 (an acceptance is present when the offeree signifies assent to the terms of the offer in a "positive and unambiguous" manner).

Defendants, through their acts, have also negated any inference of "notice" or affirmation. As members pay their monthly premiums and incur expenses that they believe Defendants are obligated to pay, they receive Explanations of Benefits ("EOBs") from the Defendants. These include a section headed "Important Information About Your Appeals Rights." Dkt 30-7, pp. 3, 5, 7. If Defendants intended their members to follow the Dispute Resolution Procedure including binding arbitration, they would have outlined that Procedure or referred to the Procedure in the Member Guide. Instead, the EOBs only refer policyholders to the Missouri Department of Insurance – despite Defendants' insistence that their plans are not insurance – and say nothing about appeals, mediation, or arbitration. Defendants have purposely hidden their arbitration clause.

Defendants' claim that Plaintiffs' payments are "voluntary" is meaningless. The payments were no more "voluntary" than payment of any insurance premium. A member cannot "terminate" a health plan at any time without serious repercussions. If a member "voluntarily" fails to make monthly payments, she becomes effectively uninsured and ineligible for coverage if she incurs health care expenses. Dkt. 30-2, p. 7 of 19. If the termination is outside the open enrollment period, the individual may not be able to purchase other coverage. Besides, a member may have already paid out-of-pocket towards her deductible — which Defendants call a "Member Shared

Responsibility Amount (MSRA) — and would lose the benefit of the accumulated out-of-pocket expenses. See, Dkt. 30-7 (EOBs sent to Plaintiff Kelly showing amounts assigned to "MSRA.") In fact, when Defendants requested Plaintiff Boogher to acknowledge the transfer of his plan from a Unity to a Trinity plan, it touted the fact that his payments toward his MSRA would "track" under the Trinity plan. Dkt. 38-6.

Chase Moses, Aliera's Executive Vice President, admitted in sworn testimony in the Georgia Litigation that these health plans cannot simply be "terminated:"

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

Exhibit A, ¶ 11.

Defendants' reliance on a single unpublished and non-controlling opinion, *McKeage v. Bass Pro Outdoor World* 2014 U.S. Dist. LEXIS 204114 (W.D. Mo. 2014), is misplaced. *See* Dkt. 74, p. 3-4. Among other distinctions, in *McKeage*, the putative class members received the form at issue ***prior*** to the parties' agreement and performance. Here, however, it is undisputed that members do not sign or even receive anything suggesting an agreement to arbitrate until ***after*** they have enrolled and made their first payment. Defendants then negated any inference of "notice" or affirmation when they ultimately provided the Member Guide by misleadingly implying that the document only conveyed benefits, not legal waiver. Against that backdrop and faced with the prospects of remaining uninsured for failure to pay premiums, Plaintiffs' payments are far from an indication of assent to the Member Guide's arbitration provision.

Fourth, in addition to the lack of assent, the agreement is unenforceable for lack of consideration. Dkt. No. 30-2, p. 4; 30-15, p. 4 ("This is not a legally binding agreement to reimburse any member for medical needs …"); Dkt. No. 38, p. 9 (no "quid pro quo"). *See also, e.g., Patrick v. Altria Group Distrib. Co.,* 570 S.W. 3d 138 (Mo. App. 2019); *Greene v. Alliance Auto., Inc.,* 435 S.W.3d 646, 654 (Mo. App. 2014); *Goolsby v. Primeflight Aviation Servs.,* 2017 U.S. Dist. LEXIS 221406 (W.D. Mo. Aug. 9, 2017).

Among other things, the arbitration clause itself is not a mutual agreement to arbitrate. Instead, the Member Guides purport to require members to arbitrate any claims, not the Defendants. Dkt. Nos. 30-2, p. 13; 30-15, p. 18. *See also, id.,* at p. 19 ("Sharing members . . . expressly waive their right to file a lawsuit. . ."). Members are required to reimburse Defendants for the full costs associated with the arbitration if the member loses. However, Defendants do not have to repay the policyholder for such costs if they lose. *Id. See Wilder v. John Youngblood Motors, Inc.,* 534 S.W.3d 902, 911 (Mo. App. 2017) (no consideration for arbitration, despite agreement to pay arbitrator's fees, when the agreement also allows an award of costs and fees to the prevailing party).

Fifth, the Court's findings are straightforward legal determinations based on undisputed facts. Defendants assert that "to the extent there are genuine disputes of material fact regarding whether the Parties formed agreements to arbitrate, these disputes are to be decided by trial." However, Defendants fail to identify a single such fact issue, and the cases cited by Defendants in support of their assertion are distinguishable.

In the first case cited by Defendants, *Neb. Mach. Co,* 762 F.3d, 743-44, the parties disputed whether they received each other's documents. In reversing the district court, the Eighth Circuit noted "there were facts left to try, namely determining which side was credible and resolving the

factual disputes surrounding the documents the parties actually sent and received." Unlike the credibility determination in *Neb. Mach*, the Court's order here is an application of undisputed facts to governing law. It is undisputed that "the documents signed by Plaintiffs . . . do not reference arbitration or contain an arbitration provision"; "[t]here is no evidence Plaintiffs received, reviewed, or specifically acknowledged the specific terms of the Member Guide when they electronically signed the online forms to become a member"; the only documents signed by Plaintiffs repeatedly state they are not contracts; and "there is no evidence Plaintiffs were actually provided the Member Guidelines until after they signed the online form." Dkt. 62, pg. 9-10. Considering these facts, the Court correctly determined the legal elements of contract formation were not satisfied.

Defendants' reference to *Margulis v. HomeAdvisor, Inc*., is misplaced, as the parties there disputed whether the plaintiff had, in fact, set up a customer account with the defendant's home service referral business. *Margulis v. HomeAdvisor, Inc.,* 2020 U.S. Dist. LEXIS 17752, *8-9 (E.D. Mo. Jan. 31, 2020). And that factual dispute precluded "a conclusive showing that the service request submitted in [plaintiff's] name was actually submitted by him" and, consequently, a finding concerning contract formation. *Id*. Here, however, the Court relied on undisputed facts and did not make a credibility determination. Defendants challenge the legal import of those undisputed facts, not their existence.

IV. CONCLUSION

For the reasons stated above, Plaintiffs request that this Court deny Defendants' Motion to Alter or Amend Order Denying Defendant's Motions to Dismiss or Stay Pending Arbitration and Request to Stay Proceeding and/or dismiss in their entirety.

DATED: January 8, 2020.

Respectfully Submitted,

/s/Jay Angoff _____

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CERTIFICATE OF SERVICE

The undersigned hereby certifies that on January 8, 2021, the undersigned filed the foregoing with the Court's CM/ECF system, which will cause a true and correct copy of the same to be served electronically on all registered counsel of record.

/s/Jay Angoff
Jay Angoff

Exhibit 1

IN THE SUPERIOR COURT OF FULTON COUNTY
STATE OF GEORGIA

ALIERA HEALTHCARE, INC.,	)	
	)	
Plaintiff,	)	
	)	
v.	)	
	)	
ANABAPTIST HEALTHSHARE, n/k/a KINGDOM HEALTHSHARE INTERNATIONAL, UNITY HEALTHSHARE, LLC, n/k/a KINGDOM HEALTHSHARE MINISTRIES, LLC, ALEXANDER CARDONA, TYLER HOCHSTETLER, VICTOR MENSAVAGE, and JEREMY HULKENBERG,	)	**CIVIL ACTION FILE NO. 2018-CV-308981**
	)	
Defendants.	)	

AFFIDAVIT OF CHASE MOSES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

FURTHER AFFIANT SAYETH NAUGHT.

Chase Moses

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

Notary Public

My Commission Expires: 5-15-20

KEISHA M MACKIE NOTARY PUBLIC FULTON COUNTY, GEORGIA MY COMMISSION EXPIRES MAY 15, 2020